IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

TEXAS MEDICAL ASSOCIATION, et al.,	)	
	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	Case No. 6:23-cv-00059-JDK
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,	)	
	)	
	)	
Defendants.	)	

BRIEF *AMICUS CURIAE* OF
THE EMERGENCY DEPARTMENT PRACTICE MANAGEMENT ASSOCIATION
IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION AND INTEREST OF *AMICUS CURIAE*

The Emergency Department Practice Management Association ("EDPMA") submits this Brief *Amicus Curiae* in support of Plaintiffs' Motion for Summary Judgment (Dkt. 18).

In a Fee Guidance dated December 23, 2022, the defendant Departments announced a surprise, and entirely arbitrary, *sevenfold* increase in the nonrefundable administrative fee each party must pay to access the Independent Dispute Resolution ("IDR") process under the No Surprises Act ("NSA"), 42 U.S.C. § 300gg-111.[1] As recently as October 2022, the Departments had concluded that $50 was the appropriate administrative fee for Calendar Year 2023. In December, however, the Departments suddenly raised that amount to $350. The December 2022 Fee Guidance, together with the Departments' September 2021 Rule regarding "batching" of claims for IDR,[2] will make accessing IDR cost-prohibitive for many physicians, including emergency physicians. The Departments' actions will thereby deprive physicians of the only recourse left to them to obtain fair and reasonable reimbursement for their services.

EDPMA is a physician trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all sizes, as well as billing, coding, and other professional support organizations that assist physicians in our nation's emergency departments. EDPMA's members provide direct patient care and/or support the provision of care for approximately half of the 146 million patients that visit emergency departments each year. For more than 25 years, EDPMA has advocated for the rights of emergency medicine physicians, physician groups, and their patients at

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[1] *Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process under the No Surprises Act: Change in Administrative Fee*, available at https://www.cms.gov/cciio/resources/regulations-andguidance/downloads/amended-cy2023-fee-guidance-federal-independentdispute-resolution-process-nsa.pdf (Ex. 1).

[2] 86 Fed. Reg. 55,980 (Oct. 7, 2021); 45 C.F.R. § 149.510.

the state and federal levels, including with respect to the NSA.

EDPMA strongly supports the NSA's goal of protecting patients from "surprise" healthcare bills—bills for emergency medical services furnished by out-of-network physicians and facilities, or non-emergency services furnished by out-of-network physicians at in-network facilities. The NSA accomplishes this goal by prohibiting physicians from "balance-billing" patients—charging them more than what they would have paid had those services been furnished in-network. At the same time, the NSA recognizes the importance of ensuring fair reimbursement for physicians.

Accordingly, the NSA establishes a process whereby patients are removed from billing disputes. Instead, out-of-network physicians and payers must negotiate among themselves to arrive at a reasonable payment for the physicians' services. Should those negotiations fail, either party may invoke the IDR process, a "baseball-style" arbitration in which the arbitrator must choose one party's offer, and the losing party must pay the arbitrator's fee. To invoke the IDR process, IDR participants must pay a nonrefundable administrative fee. This fee is paid to the government, not the IDR entity. The Departments have now increased this administrative fee from $50 to $350. That sevenfold increase is the subject of this lawsuit.

The Departments' fee increase is the latest in a series of regulatory actions that have thwarted the intent of Congress in enacting the NSA.[3] In *TMA I* and *TMA II*, this Court invalidated the Departments' September 2021 Rule and August 2022 Final Rule regarding how the IDR entity must assess the statutory factors in determining the out-of-network reimbursement amount. The Court held that these Rules conflicted with the NSA because they treated the Qualifying Payment

[3] *Texas Med. Ass'n v. United States Dep't of Health & Hum. Servs.*, 587 F. Supp. 3d 528 (E.D. Tex. 2022) ("*TMA I*"); *Tex. Med. Ass'n v. United States Dep't of Health & Human Servs.*, No. 6:22-cv-372, 2023 WL 1781801 (Feb. 6, 2023) ("*TMA II*"); *Texas Med. Ass'n v. United States Dep't of Health & Hum. Servs.*, No. 6:22-cv-00450-JDK (E.D. Tex.) ("*TMA III*").

Amount ("QPA")—"an insurer-determined number—as the default payment amount and impose[ed] on any provider attempting to show otherwise a heightened burden of proof that appears nowhere in the statute." *TMA I*, 587 F. Supp. 3d at 543; *see TMA II*, 2023 WL 1781801, at *10-14.[4]

TMA III concerns the Departments' July 2021 Rule regarding calculation of the QPA itself. The QPA is the payer's median contracted (i.e., *in-network*) rate, anchored to 2019 but adjusted annually for inflation.[5] Rather than serving to increase the QPA as required by the NSA, the July 2021 Rule has skewed that rate *downward* by giving payers unchecked latitude over the QPA calculations, with no real disclosure to physicians or oversight by the Departments. Emboldened by the Departments' rulemaking, payers have gamed the system by offering reimbursement to providers based on those artificially low, below-market, and payer-manipulated QPAs. Indeed, out-of-network payments to emergency physicians have decreased 92% of the time compared to pre-NSA rates, with an average decrease of more than 32%. These dramatic reductions in reimbursement rates have forced providers to invoke IDR in numbers far exceeding earlier estimates, resulting in a backlog of cases and delays in payments.[6]

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[4] On February 10, 2023, HHS announced a temporary halt to reimbursement decisions, as well as a vacatur of decisions reached after February 6, 2023, pending review of this Court's ruling in *TMA II* invalidating the August 2022 Final Rule. (Ex. 2.) The announcement is an implicit admission that IDR entities have been applying the Final Rule's improper presumption in favor of the QPA. But the IDR entities should not have been applying the Final Rule at all. The Final Rule applies to claims for dates of service on or after October 25, 2022. Because it takes several months from the date of service to IDR submission, the IDR entities should have been applying the April 2022 Guidance, not the improper presumption in favor of the QPA in the Final Rule. (*See* Ex. 3.)

[5] Unlike Defendants, other governmental agencies have recognized that the QPA must be adjusted upward for inflation. For example, in December 2022, the Internal Revenue Service released specific calculations associated with inflationary adjustments for 2023 QPAs. (Ex. 4.)

[6] From April 15–September 30, 2022, disputing parties initiated 90,078 disputes through the Federal IDR portal, significantly more than the number of disputes the Departments initially

The December 2022 Fee Guidance will now foreclose many providers from accessing IDR at all by making IDR economically untenable. The newly increased $350 administrative fee might be tolerable if providers could "batch" a large number of claims against the same payer into a single IDR proceeding. As explained below, however, payers do not provide physicians with the information necessary to determine which claims can be batched. Consequently, physicians are faced with the prospect of invoking IDR for a single claim for services to an individual patient—often for amounts in dispute less than the nonrefundable $350 administrative fee. Requiring a payment of $350 to collect less than that amount completely undercuts congressional intent.

The Departments purport to justify this fee increase by citing to the increased costs of IDR eligibility determinations—that is, determining whether a claim is even subject to IDR—due to the unanticipated number of IDR cases. But those determinations are supposed to be made by the *IDR entities*, not by the government. Indeed, the IDR entities certified that they have the resources and capacity to make such determinations, and they are compensated for those determinations through a separate IDR entity fee paid by the losing party. The Departments thus have improperly shifted the costs of IDR eligibility determinations to the parties by imposing on them nonrefundable fees to pay for services for which the IDR entity is already being compensated.

All healthcare physicians have been materially and adversely affected by the Departments' actions, but emergency physicians particularly so. Under the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, emergency physicians and facilities are required to treat and stabilize all emergency room patients, regardless of their insurance status or ability to pay. Indeed, more than two-thirds of uncompensated medical care in this country is provided in

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estimated would be submitted for an entire year. (Ex. 5.)

emergency rooms. The situation has long since passed a crisis point. The burden of uncompensated care is growing, closing many emergency departments and hospitals, and threatening the ability of emergency departments to care for all patients, including the indigent and rural populations, who rely on emergency departments as an important safety net. (Ex. 6 at 2.)

Together with the other actions of the Departments, the December 2022 Fee Guidance will serve only to exacerbate this bleak situation and undermine the intent of Congress to ensure fair reimbursement to physicians, lest needed health care become unavailable, especially in already medically underserved areas. The Departments themselves recognized these perils: "[U]ndercompensation could threaten the viability of these providers [and] facilities . . . . This, in turn, could lead to participants, beneficiaries and enrollees not receiving needed medical care, undermining the goals of the No Surprises Act." 86 Fed. Reg. at 56,044.

The cost-prohibitive administrative fee of $350 will, as a practical matter, deprive emergency physicians of any recourse for obtaining fair reimbursement for their services to their patients. It also will further incentivize payers to make even lower reimbursements, knowing that IDR will not be a viable solution for these physicians. For these reasons, as explained in greater detail below, the arbitrary sevenfold increase in fee to access the IDR procedure should be vacated.

ARGUMENT

I. The Departments' Actions Are Arbitrary and Capricious and Contrary to Law.

The out-of-network reimbursement rate that an IDR entity must determine is defined by the NSA as (1) the amount determined by an All-Payer Model Agreement under the Social Security Act; or (2) if there is no such Agreement, by a "specified state law"; or (3) if there is no specified state law, by the amount determined through a 30-day "open negotiation" process culminating, if necessary, in IDR. *Id.* § 300gg-111(a)(3)(K). Thus, to determine whether to invoke

the "open negotiation" process and IDR, physicians must know if the NSA actually applies to those charges—in other words, whether the claim is "eligible" for IDR.

Physicians who invoke the IDR process must be prepared to pay two sets of fees. First is the fee at issue in this case: the nonrefundable[7] administrative fee—paid by both parties—which is intended to compensate the government for its costs in the IDR process. *Id.* § 300gg-111(c)(8). The second is the fee that compensates the IDR entity. That fee is paid only by the losing party. *Id.* § 300gg-111(c)(5)(F).

Congress recognized that the costs of arbitration may become prohibitive, particularly if the amounts at issue are relatively small. But Congress intended that all appropriate claims be permitted to proceed to IDR, no matter how small. In fact, Congress rejected bills that would have restricted the IDR process to claims satisfying a minimum dollar amount—in one case, $750; in another, $1,240. (*See* Dkt. 18 at 4.) Significantly, to make the arbitration of small claims economically viable, Congress authorized "batching" of certain related claims for resolution in a single IDR proceeding "for purposes of encouraging the efficiency (including minimizing costs) of the IDR process." 42 U.S.C. § 300gg-111(c)(3)(A).

The Departments' December 2022 Fee Guidance, and their rules regarding "batching" of claims for IDR, were issued without the notice and comment required by the APA. As demonstrated in Plaintiffs' summary judgment brief, there was no lawful basis for bypassing notice and comment. Moreover, in announcing the sevenfold increase in fees to access the IDR process, the Departments did not disclose the data they used to justify the increase. Nor did the Departments even consider how the increased fees would affect the regulated parties, or how $350 in

[7] The administrative fee is nonrefundable even if the IDR entity "determines that the case does not qualify for the Federal IDR process." 86 Fed. Reg. at 56,001.

nonrefundable administrative fees would render IDR cost-prohibitive for many providers, or whether there were other, less draconian alternatives to such an increase. Plaintiffs' brief addresses these legal issues. EDPMA provides below additional information for the Court's consideration.

A. The December 2022 Fee Guidance Improperly Shifts to the Parties the Costs of Services That the IDR Entities Certified They Would Provide and for Which They Will Be Paid.

The NSA authorizes the Departments to set the amounts of nonrefundable administrative fees. The statute, however, explicitly provides that those administrative fees are intended to compensate solely the government—not the IDR entity—for its expenses. The administrative fee must be "equal to the amount of expenditures estimated to be made *by the Secretary* for such year in carrying out the IDR process":

> (8) Administrative fee
>
> (A) In general. Each party to [an IDR] determination . . . shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.
>
> (B) Amount of fee. The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated *to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process*.

42 U.S.C. § 300gg-111(c)(8) (emphasis added).

The stated rationale of the December 2022 Fee Guidance was that the sevenfold increase in administrative fees was necessary to cover the increased costs of IDR eligibility determinations that *the government* would incur as a result of the unanticipated flood of IDR claims. But as the Departments previously acknowledged, these eligibility determinations are supposed to be made *by the IDR entity*, not by the government. The IDR entity is already being compensated for those very services by the "loser pays" IDR entity fee. Thus, the costs on which the Departments are

basing the extraordinary fee increase should not be costs of the government at all.

The December 2022 Fee Guidance is directly contrary to prior agency statements. Concurrently with the September 2021 Rule, CMS issued a fee guidance setting the IDR entity and administrative fees for Calendar Year 2022. (Ex. 7.) CMS set the IDR entity fees at a range of $200-$500 for single determinations and $268-$670 for batched determinations. The agency noted that it had considered a number of factors, including ensuring that the fees would not make "participating in the Federal IDR process . . . cost-prohibitive, especially for smaller providers and facilities." *Id.* at 3. CMS therefore set the nonrefundable administrative fee for 2022 at $50, based on "review of anticipated expenditures *by the Departments* in carrying out the Federal IDR process for 2022." *Id*. (emphasis added).

On October 31, 2022, CMS issued fee guidance for Calendar Year 2023. (Ex. 8.) This guidance raised the IDR entity fees $200-$700 for single determinations and $268-$938 for batched determinations. *Id.* at 6. The Departments stated that this increase in the IDR entity fees was necessary given the high volume of disputes and complex eligibility determinations. *Id.* at 5. The guidance, however, left the $50 nonrefundable administrative fee in place, concluding that existing data did not require a change for 2023. *See id.* at 3-4.

Yet not even two months later, the Departments increased the administrative fees to $350, allegedly because of the *government's* increased costs in conducting eligibility reviews:

> [T]here is a *significant backlog of disputes pending eligibility determinations* before certified IDR entities which has continued to grow since the publication of the prior 2023 guidance [a mere two months earlier]. To address this issue, the *Departments have engaged a contractor and government staff to conduct pre-eligibility reviews,* which include outreach and technical assistance in support of the certified IDR entities' eligibility determinations.

(Ex. 1 at 3 (emphasis added).)

But the Departments' justification flatly contradicted their previous statements, which required that, as a condition of certification, potential IDR entities represent that *they* have the capacity and ability to make these IDR eligibility determinations. For example, in the September 2021 Rule, the Departments set forth the services IDR entities must provide to receive certification:

> In order to be certified, an IDR entity must possess (directly or through contracts or other arrangements) and demonstrate sufficient arbitration and claims administration of health care services, managed care, billing, coding, medical, and legal expertise. With regard to medical expertise, where the payment determination depends on the patient acuity or the complexity of furnishing the qualified IDR item or service, or the level of training, experience, and quality and outcome measurements of the provider or facility that furnished the qualified IDR item or service, the IDR entity should have available medical expertise with the appropriate training and experience in the field of medicine involved in the qualified IDR item or service. Additionally, *the IDR entity must employ (directly or through contracts or other arrangements) sufficient personnel to make determinations within the 30 business days allowed for such determinations.* To satisfy this standard, the written documentation the IDR entity submits must include a description of its organizational structure and capabilities, including an organizational chart and the credentials, responsibilities, and number of personnel employed to make determinations.

86 Fed. Reg. at 56,002 (emphasis added).

The Departments also expressly stated that the IDR entities' ability to provide such services—including eligibility determinations—will be factored into the *IDR entity fee*, not into the nonrefundable administrative fee that is paid to the government:

> The Departments will also consider the anticipated time and resources needed for certified IDR entities to meet the requirements of these interim final rules, such as the time and resources needed to obtain certification, making payment determinations *(including determining whether the dispute belongs in the Federal IDR process)*, data reporting, and audits. The Departments will also consider factors such as the anticipated volume of payment determinations under the Federal IDR process and adequacy of the Federal IDR process capacity to efficiently handle the volume of IDR initiations and payment determinations. The Departments will review and update the allowable fee range annually based on these factors and the impact of inflation and other cost increases. The Departments seek comment on these factors and any additional factors that should be considered *when determining the range for allowable certified IDR entity fees*.

Id. at 56,005 (emphasis added).

Accordingly, the entire basis for the $350 administrative fee—the government's alleged increased costs in making eligibility determinations—is contradicted by the Departments' previous acknowledgement that such determinations are the province of the IDR entity, which will be paid for those determinations through the IDR entity fee. The Departments have failed to give any explanation for this about-face, and there is no lawful basis for the December 2022 Fee Guidance.

In fact, the fee increase was entirely unnecessary. All information needed to determine claim eligibility for the federal IDR process is in the possession of the payers. The Departments needed merely to require payers to provide clear and readily decipherable eligibility information to physicians with the initial payment (or denial) remitted. In that way, physicians could easily be able to identify eligible claims for the federal IDR process, as opposed to claims subject to other state statutes and regulations. Physicians would therefore present only eligible claims for consideration by the IDR entities. This time- and money-saving solution would benefit all concerned by eliminating claims that proceed to IDR but are only later determined to be ineligible. Thus far, however, the Departments have refused to impose on payers this minimal obligation.

B. The Departments' "Batching" Provisions Are Not a Viable Solution.

Congress recognized that the costs of IDR—the nonrefundable administrative fee, together with the IDR entity's fee—could make IDR effectively unavailable to physicians if they have to arbitrate one claim at a time. When the potential reimbursement obtained through IDR will be less than the costs of attempting to obtain it, IDR makes no economic sense.

That certainly is the case with emergency medicine. Emergency physicians deliver specific services in the emergency department setting that correspond to CPT codes describing emergency care evaluation and management (E/M) services (*i.e.*, CPT E/M Codes 99281–99285). Although physician practice reimbursement for these services varies by contract, the total incremental

differential payment rate for an emergency E/M visit between what is generally remitted as the QPA and what historically was remitted to providers before implementation of the NSA, even the highest level visit, is generally less than the $350 administrative fee. This means that the amount in dispute in IDR for a single emergency E/M visit will be even less than $350 administrative fee in the December 2022 Fee Guidance. (Ex. 9.)

Congress provided a solution to this problem. The NSA allows for "batching" of related claims in a single IDR proceeding if (1) the services are provided by the same physician, (2) payments for those services is required to be made by the same plan or issuer; (3) the services are related to the treatment of a similar condition; and (4) the services were furnished within the same 30-day period. 42 U.S.C. § 300gg-111(c)(3)(A)(i)–(iv).

For batching to function properly and achieve the economies of scale envisioned by Congress, payers must provide physicians with sufficient information to determine—at the most fundamental level—whether a claim is even subject to the NSA or, instead, is governed by a "specified state law," *see supra* p. 5, and whether it makes sense to proceed to arbitration, including an analysis whether all the other batching requirements set out in the NSA have been satisfied. But the Department's implementation of the NSA, including their failure to require payers to supply physicians with basic information,[8] has left physicians with no meaningful options for challenging—or even ascertaining the basis of—insurers' reimbursements.

For example, EDPMA has found that insurers routinely fail to comply with the NSA's QPA disclosure requirements. Insurers often do not indicate that the QPA applies for purposes of

[8] Congress charged the Departments with enforcing the transparency requirements of the NSA, including specifying the information that insurers "shall share" with providers when determining the QPA, as well as "a process to receive complaints of violations" of the QPA requirements. 42 U.S.C. § 300gg-111(a)(2)(B)(ii), (iv).

determining the cost-sharing amount for out-of-network services (the "recognized amount"). (Ex. 10 at 1-5; Ex. 11 at 3-4, 7-9; Ex. 12.) When it is unclear whether the cost-sharing amount included in the remittance notice *is* the recognized amount, physicians are unable to verify whether that amount is accurate, resulting in confusion for both patients and providers, and sometimes resulting in patients being billed for incorrect amounts—putting patients right back into the middle of billing disputes, contrary to one of the key purposes of the NSA. (Ex. 10 at 2-4.)

Indeed, EDPMA has found that insurers fail readily to provide the QPA *at all* in 91% of their initial payments or notices of denial, often off-loading it onto separate portals or look-up tools, imposing unnecessary obligations on an already overburdened delivery system. (Ex. 13 at 1.) This dearth of information is particularly problematic in the emergency medicine context. Because of the realities of acute, non-scheduled care, emergency medicine providers often receive little to no information at the time the patient is treated. In fact, because of the unique requirements of EMTALA, emergency medicine groups do not collect billing or cost-sharing information before stabilizing the patient. (Ex. 10 at 1-4.) Instead, emergency medicine practices must wait until after care has been rendered, and then wade through the staggering morass of individual policy benefits, which often requires extensive back-and-forth with the insurer and the patient.

The lack of information is even more problematic when it comes to self-insured/self-funded group health plans. Physicians cannot batch together all such claims by a third-party administrator or a labor union (for example, they cannot batch all self-insured BlueCross claims, or all self-insured Aetna claims). To accurately batch claims from self-insured/self-funded group health plans, providers must engage in a three-part analysis: (1) whether the relevant plan is self-insured (for example, if BlueCross is acting as an insurer or third-party administrator), and, if so, (2) whether it is an employer- or union-sponsored plan, and (3) who is the employer or labor union

sponsor. This basic information is generally not being provided by payers, and when it is, it is not readily accessible or decipherable. (Exs. 9, 12.) As a result, disputes that otherwise would be "batchable" and combined for economic efficiency now must be separated into single-payment determination requests—each of which requires payment of the $350 administrative fee. Without a requirement specifying the information that payers must share with providers, batching cannot be effective, and physicians are left with no means of recovering the fair and reasonable reimbursement that Congress intended.

II. The Departments' Actions Will Result in Serious Adverse Consequences for the Delivery of Emergency Care to Patients.

The inability of emergency physicians to obtain fair reimbursement for their services does not harm only physicians. It has serious adverse consequences for the delivery of emergency care to patients in this country.

Key congressional architects of the NSA warned of the devastating consequences for this nation's healthcare system of inadequate physician reimbursement rates:

> [W]e already know insurers are looking for any way they can pay the least amount possible. They will work to push those rates down, regardless of what it means for community providers like physicians, hospitals, and our constituents who they employ. With no federal network adequacy standards, plans can push rates down and drop providers from networks with no consequences, leaving patients holding the bag.

(Ex. 14.) Legislators also specifically warned the Departments that their implementation of the NSA "could incentivize insurance companies to set artificially low payment rates, which could narrow networks and jeopardize patient access to care—the exact opposite of the goal of the law." (Ex. 15 at 2.)

What members of Congress feared has already come true. First, out-of-network reimbursement rates for physicians have declined dramatically since the Departments' implementation of the NSA. This means that emergency physicians must attempt to recover

through IDR greater amounts than ever before—or lose any chance to obtain fair and reasonable reimbursement for their services to their patients.

EDPMA has analyzed data from its members to ascertain the effects of the implementation of the NSA on emergency medicine. In a 2022 survey of its members, EDPMA compared pre-NSA (2021) out-of-network allowed amounts to post-NSA (2022) allowed amounts. EDPMA found that post-NSA out-of-network payments *decreased 92% of the time* compared to pre-NSA amounts, with an average decrease of 32% per emergency room visit. (Ex. 13 at 1.) Furthermore, the allowed amounts for emergency medicine services ranged from a weighted average of 126%-145% of Medicare rates. This represents cuts of at *least* 25-65% from pre-NSA average out-of-network reimbursement levels for emergency medicine. (Ex. 13 at 2 n.4.)

For example, EDPMA reviewed a dataset sample for pre- and post-NSA out-of-network reimbursements for a Level 4 service (CPT Code 99284) and a Level 5 service (CPT Code 99285). Before the NSA, the average out-of-network reimbursement was $413.92 for a Level 4 visit, and $592.50 for a Level 5 visit. (Ex. 16.) After the NSA, the average out-of-network reimbursement for a Level 4 visit declined by 57% ($236.78) down to $177.14; and the average reimbursement for a Level 5 visit declined by 55% ($328.06), down to $264.44. (*Id.*) In both cases, it would make no economic sense for a physician to attempt to recoup those amounts in IDR, when the Departments' new $350 nonrefundable administrative fee alone is greater than the potential recovery. And that is before the physician takes into account the possibility of losing the IDR and therefore having to pay the IDR entity's fees *on top of* the nonrefundable administrative fees.

These adverse consequences have not been limited to out-of-network reimbursements, but have affected in-network reimbursements as well. The Departments' implementation of the NSA already has had the effect of narrowing provider networks and thereby reducing the availability of

healthcare to patients. Numerous physician practices have received from insurers termination notices of longstanding network agreements (including agreements that currently protect patients in rural and underserved communities) or threats to terminate existing agreements unless the physicians agree to substantial discounts from their contracted rates. (Ex. 17.) Some of those termination letters even cited the Rules as justification. (*See* Ex. 18; *see also* Exs. 19, 20.) These factors have exacerbated existing health disparities and patient access issues in rural and urban underserved communities." (Ex. 15 at 2.)

Because of the dramatic and unexpected reduction in reimbursements by commercial payers, previous subsidizing cross-funding that had guaranteed a patient's access to emergency care under EMTALA no longer exists. Instead, hospitals—many of which are already in severe financial distress—are now being asked to shoulder the brunt of these costs, potentially crippling this country's healthcare safety net. (Ex. 13 at 2.) Moreover, emergency medicine physicians as a whole are expected to see a reduction in commercial reimbursement of almost *$1 billion* annually as a result of payers leveraging the unintended consequences of the NSA. (*Id.*)[9] If the Departments' implementation of the NSA is upheld, the current understaffing of emergency departments will only worsen, reducing patient access to emergency care, particularly in underserved and rural communities. (*Id.*)

CONCLUSION

EDPMA requests that the Court grant Plaintiffs' Motion for Summary Judgment.

DATED: February 21, 2023

Respectfully submitted,
/s/Jack R. Bierig
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(Admitted *Pro Hac Vice*)
Illinois State Bar No. 0207039

[9] At the same time, commercial payers are seeing record earnings. (*See, e.g.*, Ex. 21.)

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CERTIFICATE OF SERVICE

I hereby certify that on February 21, 2023, a true and correct copy of the foregoing document was served on all counsel of record through this Court's CM/ECF filing system.

/s/ Jack R. Bierig
Jack R. Bierig

EXHIBIT 1

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

Center for Consumer Information & Insurance Oversight

DATE: DECEMBER 23, 2022

SUBJECT: AMENDMENT TO THE CALENDAR YEAR 2023 FEE GUIDANCE FOR THE FEDERAL INDEPENDENT DISPUTE RESOLUTION PROCESS UNDER THE NO SURPRISES ACT: CHANGE IN ADMINISTRATIVE FEE

Summary of Major Updates: This guidance amends the previous "Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process under the No Surprises Act" released on October 31, 2022 (prior 2023 guidance).[1] The Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) are amending the prior 2023 guidance to increase the administrative fee for the Federal independent dispute resolution (IDR) process from **$50** to **$350** per party for disputes initiated during the calendar year beginning January 1, 2023, due to supplemental data analysis and increasing expenditures in carrying out the Federal IDR process since the development of the prior 2023 guidance. These changes are described further in Section II of this guidance. No changes have been made to the 2023 certified IDR entity fee ranges for single or batched determinations.

I. Introduction

Section 9816(c) of the Internal Revenue Code (Code), section 716(c) of the Employee Retirement Income Security Act of 1974 (ERISA), and section 2799A–1(c) of the Public Health Service Act (PHS Act), as added by the No Surprises Act (NSA), direct the Departments to establish a Federal IDR process that nonparticipating facilities, nonparticipating providers, group health plans, health insurance issuers, and Federal Employees Health Benefits (FEHB) carriers (the parties)[2] may use following the end of an open negotiation period to determine the out-of-network rate for out-of-network emergency services and certain items and services provided by nonparticipating providers at in-network facilities, when a specified state law or All-Payer Model Agreement does not apply. Code section 9817, ERISA section 717, and PHS Act section 2799A–2(b), also added by the NSA, direct the Departments to establish a similar Federal IDR process that nonparticipating providers of air ambulance services, plans, issuers, and FEHB carriers may use following the end of an open negotiation period to determine payment for qualified services furnished by nonparticipating providers of air ambulance services when a specified state law or All-Payer Model Agreement does not apply.

[1] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf.

[2] Section 102 of the NSA amends the Federal Employees Health Benefits (FEHB) Program statute to require each contract with a carrier to require the carrier to comply with requirements described in the provisions of these sections of the Code, ERISA, and the PHS Act. Accordingly, the Federal IDR process will be available to resolve eligible disputes involving FEHB carriers.

On October 7, 2021, the Departments issued interim final rules titled *Requirements Related to Surprise Billing; Part II* (interim final rules) to implement the Federal IDR process under the NSA.[3] The interim final rules establish the parameters governing the administrative fees and the certified IDR entity fees that certified IDR entities are to collect from the parties.

Under the interim final rules, each party must pay a non-refundable administrative fee for participating in the Federal IDR process.[4] The certified IDR entity may invoice the parties for the administrative fee at the time the certified IDR entity is selected, and the parties must pay the administrative fee by the time of offer submission.[5] The administrative fee is paid by each party to the certified IDR entity and remitted to the Departments.[6] The administrative fee is established annually in a manner so that the total administrative fees collected for a year are estimated to be equal to the amount of expenditures estimated to be made by the Departments to carry out the Federal IDR process for that year.[7]

Additionally, under the interim final rules, each party must also pay a certified IDR entity fee to the certified IDR entity at the time that the party submits its offer.[8] However, the non-prevailing party is ultimately responsible for the full certified IDR entity fee, which is retained by the certified IDR entity for the IDR services it performed.[9] The certified IDR entity fee that was paid by the prevailing party will be returned to the prevailing party by the certified IDR entity within 30 business days following the date of the payment determination.[10] If the parties reach an agreement after initiating the Federal IDR process but before the certified IDR entity makes a payment determination, the certified IDR entity fee will be split evenly between the parties, unless the parties agree on an alternative method for allocating the certified IDR entity fee.[11] If the initiating party withdraws a dispute after a certified IDR entity has been assigned but before the certified IDR entity makes a payment determination, similarly the certified IDR entity fee will be split evenly between the parties. In the case of batched determinations,[12] the certified IDR entity may make different payment determinations for each qualified IDR item or service under dispute. In these cases, the party with the fewest determinations in its favor is considered the non-prevailing party and is responsible for the full certified IDR entity fee. If each party

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[3] 86 FR 55980 (October 7, 2021). The Departments also issued *Requirements Related to Surprise Billing; Final Rules*; however, these final rules do not finalize the requirements related to the certified IDR entity fees or administrative fees. 87 FR 52618 (August 26, 2022).
[4] 26 CFR 54.9816-8T(d)(2)(i), 29 CFR 2590.716-8(d)(2)(i), and 45 CFR 149.510(d)(2)(i).
[5] *See* Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties, *available at:* https://www.cms.gov/files/document/rev-102822-idr-guidance-disputing-parties.pdf.
[6] 26 CFR 54.9816-8T(e)(2)(ix), 29 CFR 2590.716-8(e)(2)(ix), and 45 CFR 149.510(e)(2)(ix). The NSA directed the Departments to jointly establish one Federal IDR process. To operationalize the Federal IDR process, HHS collects administrative fees for all disputes initiated under the Federal IDR process, including the administrative fees paid in connection with the Federal IDR process for health plans that are subject to the Code or ERISA.
[7] 26 CFR 54.9816-8T(d)(2)(ii), 29 CFR 2590.716-8(d)(2)(ii), and 45 CFR 149.510(d)(2)(ii).
[8] 26 CFR 54.9816-8T(d)(1)(ii), 29 CFR 2590.716-8(d)(1)(ii), and 45 CFR 149.510(d)(1)(ii).
[9] 26 CFR 54.9816-8T(d)(1)(i), 29 CFR 2590.716-8(d)(1)(i), and 45 CFR 149.510(d)(1)(i).
[10] 26 CFR 54.9816-8T(d)(1)(ii), 29 CFR 2590.716-8(d)(1)(ii), and 45 CFR 149.510(d)(1)(ii).
[11] 26 CFR 54.9816-8T(c)(2)(ii), 29 CFR 2590.716-8(c)(2)(ii), and 45 CFR 149.510(c)(2)(ii).
[12] Batched determinations involve multiple qualified IDR items or services that are considered jointly by a certified IDR entity for purposes of the Federal IDR process. 26 CFR 54.9816-8T(a)(2)(i), 29 CFR 2590.716-8(a)(2)(i), and 45 CFR 149.510(a)(2)(i).

prevails in an equal number of determinations, the certified IDR entity fee will be split evenly between the parties.[13]

On September 30, 2021, the Departments issued "Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process under the No Surprises Act," which provided fee guidance for calendar year 2022 (the 2022 guidance).[14] Under the 2022 guidance, the Departments established an administrative fee of $50 due from each party participating in the Federal IDR process. The 2022 guidance also established the range for fixed certified IDR entity fees for single determinations as $200–$500, and the range for fixed certified IDR entity fees for batched determinations as $268–$670, unless otherwise approved by the Departments.

On October 31, 2022, the Departments issued the prior 2023 guidance,[15] which provided fee guidance for calendar year 2023. In the prior 2023 guidance, the Departments provided that the administrative fee due from each party participating in the Federal IDR process would remain $50 in 2023. The prior 2023 guidance also established the range for fixed certified IDR entity fees for single determinations as $200–$700, and the range for fixed certified IDR entity fees for batched determinations as $268–$938, unless otherwise approved by the Departments.

As stated in both the prior 2023 guidance and the Federal IDR process status update,[16] and as described more fully in Section II of this amended guidance, there is a significant backlog of disputes pending eligibility determinations before certified IDR entities which has continued to grow since the publication of the prior 2023 guidance. To address this issue, the Departments have engaged a contractor and government staff to conduct pre-eligibility reviews, which include outreach and technical assistance in support of the certified IDR entities' eligibility determinations.[17] The Departments' intent is that these pre-eligibility reviews will facilitate certified IDR entities' eligibility decisions for disputes where the Federal IDR process eligibility is in question by providing recommendations to certified IDR entities regarding eligibility of disputes. Because the NSA establishes specific parameters for eligibility for the Federal IDR process, a significant amount of information is required to determine whether a dispute is eligible for the process based on statutory and regulatory requirements. As detailed in the "Contested Dispute Eligibility" section of the *Initial Report on the Federal Independent Dispute Resolution (IDR) Process, April 15 – September 30, 2022*,[18] this work is time and resource intensive, especially when both parties do not provide all information required during the Federal IDR

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[13] 86 FR 55980, 56001.

[14] *See* Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act, *available at:* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Technical-Guidance-CY2022-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf.

[15] *See* Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process under the No Surprises Act, *available at:* https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf.

[16] *See* Federal Independent Dispute Resolution Process Status Update, *available at:* https://www.cms.gov/files/document/federal-idr-process-status-update-august-2022.pdf.

[17] *See* Notice of the Federal Independent Dispute Resolution (IDR) Team Technical Assistance to Certified Independent Dispute Resolution Entities (IDREs) in the Dispute Eligibility Determination Process, *available at:* https://www.cms.gov/files/document/idre-eligibility-support-guidance-11212022-final-updated.pdf.

[18] *See* the Initial Report on the Federal Independent Dispute Resolution (IDR) Process, April 15 – September 30, 2022, *available at*: https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets.

process initiation, and delays certified IDR entities' eligibility determinations. The goal of the pre-eligibility reviews is to resolve the dispute backlog and ensure more timely processing of disputes assigned to certified IDR entities.

As stated above, the administrative fee must be established in a manner so that the total administrative fees collected are estimated to be equal to the amount of expenditures estimated to be made by the Departments to carry out the Federal IDR process.[19] Accordingly, this amended guidance modifies the administrative fee announced in the prior 2023 guidance to reflect the rising volume of disputes and additional expenditures associated with the Departments' enhanced role in 2023 in conducting pre-eligibility reviews to address the backlog of disputes. This amended guidance also restates, but does not change, the allowable ranges for certified IDR entity fees related to single determinations and batched determinations for calendar year 2023 as set forth in the prior 2023 guidance. Additionally, this guidance does not change the information that IDR entities seeking certification and certified IDR entities must provide to the Departments if they seek approval to charge certified IDR entity fees outside of the allowable ranges set by the Departments, or the process for providing that information. Accordingly, that information is omitted from this amended guidance.

II. Administrative Fee for Calendar Year 2023

The interim final rules provide that the administrative fee amount will be established by the Departments in a manner so that the total administrative fees collected during a year are approximately equal to the estimated amount of expenditures made by the Departments in carrying out the Federal IDR process for that year.[20] In initially setting the administrative fee for 2023 in the prior 2023 guidance, the Departments considered the costs to administer the Federal IDR process during 2022, including the staffing and contracting costs related to certification and oversight of certified IDR entities; the costs of developing and publishing reports as required under Code sections 9816 and 9817, ERISA sections 716 and 717, and PHS Act sections 2799A–1 and 2799A–2; the costs of collecting the administrative fees from certified IDR entities; and the costs of maintaining the Federal IDR portal.[21] The Departments are now issuing this amended guidance to update the amount of the administrative fee to reflect the additional cost to the Departments to administer the Federal IDR process as a result of the Departments' enhanced role in calendar year 2023 in conducting pre-eligibility reviews to allow the certified IDR entities to complete their eligibility determinations more efficiently.

Between April 15, 2022 (the date the Departments launched the Federal IDR portal) and December 5, 2022, disputing parties initiated over 164,000 disputes through the Federal IDR portal. This case load is nearly ten times greater than the Departments initially estimated it would be over the course of a full calendar year. During that time, non-initiating parties challenged the eligibility of over 68,000 disputes for the Federal IDR process. These contested disputes involved complex eligibility determinations that have required certified IDR entities to expend considerable time and resources to review. Of the disputes initiated between April 15, 2022, and December 5, 2022, certified IDR entities rendered payment determinations for over 11,000

[19] 26 CFR 54.9816-8T(d)(2)(ii), 29 CFR 2590.716-8(d)(2)(ii), and 45 CFR 149.510(d)(2)(ii).
[20] 26 CFR 54.9816-8T(d)(2)(ii), 29 CFR 2590.716-8(d)(2)(ii), and 45 CFR 149.510(d)(2)(ii).
[21] 86 FR 55980, 56001-56002.

disputes, but found over 23,000 disputes ineligible for the Federal IDR process.[22] This situation has resulted in low collections of the administrative fee relative to the volume of disputes processed in the portal, and, as referenced in the *Initial Report on the Federal Independent Dispute Resolution (IDR) Process, April 15 – September 30, 2022*,[23] low collections of the administrative fee relative to the Departments' expenditures in the first two calendar quarters of Federal IDR process operations. Since September 30, 2022, the end of the period for which the Departments had estimated the number of disputes for the purpose of establishing the 2023 administrative fee in the prior 2023 guidance, the dispute initiation rate has continued to grow, with continued lower-than-expected administrative fee collections. For example, for the week of November 21, 2022, 13,304 disputes were submitted. This one-week number is over half of the approximately 22,000 disputes that the Departments anticipated before launching the Federal IDR portal would be submitted as part of the Federal IDR process each year.

The process of determining whether a dispute is eligible for the Federal IDR process has been a more significant burden for certified IDR entities than either the Departments or the certified IDR entities initially expected. To address the growing dispute backlog and reduce the burden on certified IDR entities associated with assessing eligibility, the Departments have engaged government staff and contractor resources to conduct pre-eligibility reviews by performing research and outreach on disputes pending eligibility determinations, including identifying and obtaining information necessary for certified IDR entities to determine eligibility, and the Departments will continue to do so in 2023.[24] Specifically, this outreach may involve collecting information on the details related to state/federal jurisdiction, correct batching and bundling, compliance with applicable timelines, completion of open negotiations, and other issues relevant to eligibility. The Departments anticipate that continuing these efforts in 2023, in addition to pursuing other major reforms to accelerate throughput, will allow certified IDR entities to focus on making payment determinations and expedite the resolution of initiated disputes.

During the first several months of the Federal IDR process, data system challenges prevented the Departments from being able to reliably aggregate certain data points that could be used to calculate the administrative fee. Since then, the Departments have been working to make systemic improvements to allow the aggregation of data needed to estimate the rate at which disputes are determined eligible for the Federal IDR process and the rate at which one or both parties pay the administrative fee for the purpose of calculating the administrative fee. As a result, the Departments have found that the $50 administrative fee set forth in the prior 2023 guidance will not be sufficient to ensure the total administrative fees will equal the estimated costs to the Departments of carrying out the functions of the Federal IDR process in 2023,

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[22] As noted above, certified IDR entities may invoice parties for the administrative fee at the time the certified IDR entity is selected, but the Departments permit parties to pay the administrative fee on or before the time of offer submission. If an offer is not submitted because the certified IDR entity determines the dispute is ineligible for the Federal IDR process, the administrative fee is often not collected.

[23] *See* "Administrative Fees and Expenditures" section in the Initial Report on the Federal Independent Dispute Resolution (IDR) Process, April 15 – September 30, 2022, *available at*: https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets.

[24] *See* Notice of the Federal Independent Dispute Resolution (IDR) Team Technical Assistance to Certified Independent Dispute Resolution Entities (IDREs) in the Dispute Eligibility Determination Process, *available at:* https://www.cms.gov/files/document/idre-eligibility-support-guidance-11212022-final-updated.pdf.

especially given the increased expenditures estimated to be made by the Departments to conduct pre-eligibility reviews.

The Departments have therefore recalculated the calendar year 2023 administrative fee amount to reflect their estimated increased expenditures. The administrative fee due from each party for participating in the Federal IDR process will increase from $50 set forth in the prior 2023 guidance to **$350** for disputes initiated during the calendar year beginning January 1, 2023.

III. Certified IDR Entity Fee Range for Calendar Year 2023

The preamble to the interim final rules states that the Departments will consider certain factors in setting the permitted certified IDR entity fee range, including the current IDR entity fees for state-managed IDR processes that are similar to the Federal IDR process, the anticipated time and resources needed for certified IDR entities to meet the requirements of the rules, such as the time and resources needed to make payment determinations (including determining whether the dispute belongs in the Federal IDR process), data reporting, and audits.[25] The Departments will also consider the anticipated volume of Federal IDR initiations and payment determinations and the adequacy of the Federal IDR process capacity to efficiently handle the volume of Federal IDR initiations and payment determinations.

As stated in the prior 2023 guidance, in setting the certified IDR entity fee ranges for calendar year 2023, the Departments considered the anticipated time and resources needed for certified IDR entities to meet the requirements of the Federal IDR process, such as the time and resources needed for IDR entity certifications, making payment determinations (including determining whether the dispute belongs in the Federal IDR process), data reporting, and responding to audits. As explained in Section II of this amended guidance, during calendar year 2022, certified IDR entities incurred more administrative burden than originally anticipated by the Departments. To account for this additional administrative burden in the upcoming calendar year, while also recognizing the need to keep the Federal IDR process from being cost prohibitive for disputing parties, the Departments have endeavored to strike a balance by increasing the range for permitted certified IDR entity fees for calendar year 2023 by a reasonable amount. A full description of the analysis and considerations the Departments made in setting the calendar year 2023 certified IDR entity fee ranges for single and batched determinations appears in the prior 2023 guidance.[26]

Accordingly, this amended guidance confirms that, beginning January 1, 2023, certified IDR entities are permitted to charge a fixed certified IDR entity fee for single determinations within the range of **$200–$700**, unless otherwise approved by the Departments.[27] The Departments remain of the view that this range will keep costs reasonable, thereby reducing the potential for

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[25] 86 FR 55980, 56005.

[26] *See* Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process under the No Surprises Act, *available at:* https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf.

[27] A description of the process for certified IDR entities to charge a fixed fee beyond the upper or lower bounds for calendar year 2023 is set forth in Section V of the prior 2023 guidance. *See* Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process under the No Surprises Act, *available at:* https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf.

excessive certified IDR entity fees that could result in inflated health care and insurance costs that could ultimately be passed on to consumers.

With regard to batched determinations, based on experience from calendar year 2022, the Departments also remain of the view that certified IDR entities incur increased workload based on the number of qualified IDR items or services (hereafter, "line items") within a batched determination. For example, it generally requires more work for the certified IDR entity to review a batched determination with 80 line items than one with 10 line items. The certified IDR entity must evaluate each line item within the batch to ensure it adheres to statutory and regulatory requirements and Federal IDR process guidance. Only when each line item is determined to meet these standards may the batch move forward in the process and be determined eligible for the Federal IDR process. If determined eligible, there are several further process steps that must occur before a payment determination can be made.

For calendar year 2023, this amended guidance confirms that if a certified IDR entity chooses to charge a different fixed certified IDR entity fee for batched determinations, that fee must be within a range of **$268–$938**, unless otherwise approved by the Departments. In addition, without the need to seek further approval, to account for the differential in the workload of batched determinations, a certified IDR entity may charge the following percentage of its approved certified IDR entity batched determination fee ("batching percentage") for batched determinations, based on the number of line items initially submitted in the batch:

- 2-20 line items: 100% of the approved batched determination fee
- 21-50 line items: 110% of the approved batched determination fee
- 51-80 line items: 120% of the approved batched determination fee
- 81 line items or more: 130% of the approved batched determination fee

The fee ranges for calendar year 2023 established under the prior 2023 guidance, and reiterated under this amended guidance, reflect the Departments' intent to minimize the costs of participating in the Federal IDR process in order to reduce the likelihood of these costs being passed on to consumers in the form of higher premiums, while balancing the need for the certified IDR entities to be compensated for the entirety of their work throughout the Federal IDR process. The Departments are of the view that these fee ranges will fund a robust Federal IDR process and keep the volume of disputed claims manageable.

The Departments will continue to review relevant data, such as the time and resources needed for certified IDR entities to make payment determinations, certified IDR entity reporting, and audits, as well as the volume of disputes and stakeholder feedback, and adjust the allowable certified IDR entity fee ranges for individual and batched determinations annually. Accordingly, the Departments will continue to publish guidance annually related to adjustments of these fee ranges.

IV. For Further Information Contact

For further information about the Federal IDR process or fee guidance, please contact FederalIDRQuestions@cms.hhs.gov.

EXHIBIT 2

Payment disputes between providers and health plans

Notices

February 10, 2023

On February 6, 2023, the U.S. District Court for the Eastern District of Texas issued a judgment and order in *Texas Medical Association, et al. v. United States Department of Health and Human Services*, Case No. 6:22-cv-372 *(TMA II)*, vacating certain portions of 45 C.F.R. § 149.510(c), 26 C.F.R. § 54.9816-8(c), and 29 C.F.R. § 2590-716-8(c), which are parallel provisions governing the Federal Independent Dispute Resolution (IDR) process applicable to all payment disputes. The court also vacated the entirety of 45 C.F.R. § 149.520(b)(3), 26 C.F.R. § 54.9817-2(b)(3), and 29 C.F.R. § 2590-717-2(b)(3), which are parallel provisions applicable to air ambulance payment disputes.

As a result of the *TMA II* decision, the Departments are in the process of evaluating and updating Federal IDR process guidance, systems, and related documents to make them consistent with the *TMA II* decision. Effective immediately, certified IDR entities should not issue new payment determinations until receiving further guidance from the Departments. **Certified IDR entities also should recall any payment determinations issued on or after February 6, 2023.** Certified IDR entities should continue working through other parts of the IDR process as they wait for additional direction from the Departments.

November 21, 2022

To support the certified IDREs engaged in making payment determinations under the Federal Independent Dispute Resolution process, the Federal IDR

Team is providing technical assistance to certified IDREs on dispute eligibility determinations. Learn more here.

November 10, 2022

Due to an unplanned system outage on 11/8/2022 and 11/9/2022, initiating parties may not have been able to submit the Notice of IDR Initiation webform. This system issue was resolved 11/10/2022. The Departments have granted a 4-day extension for initiating parties to access the Notice of IDR Initiation web form to submit IDR payment disputes where the open negotiation period expired on 11/8/2022, 11/9/2022, and 11/10/2022.

October 19, 2022

The Federal IDR portal has a new Notice of Offer webform that disputing parties must use to submit their offers to the IDR entity. Beginning October 19, 2022, all disputes that are not currently within the 10-business day notice of offer phase and that have not already received Notice of Offer forms will receive a web link from the certified IDR entity to submit the Notice of Offer through the Federal IDR portal. View a demo of the new Notice of Offer form.

September 7, 2022

Please be advised that, in order to accommodate the high volume of disputes currently being initiated in the Federal IDR portal, the Departments are allowing certified Independent Dispute Resolution entities additional time to collect information and evaluate the eligibility of disputes. Submitting a complete dispute with all supporting documentation will help to expedite review.

August 16, 2022

The Federal Independent Dispute Resolution (IDR) system is live. During the initial implementation of the program, as parties learn more about the process, some disputes are taking longer than expected to process. In response, the Departments are:

- Granting requests for extensions submitted by the parties or certified IDR entities, as appropriate.
- Monitoring the volume and providing additional guidance to certified IDR entities as necessary.

Please use the following newly published resources to avoid unnecessary delays when initiating disputes:

- Common mistakes and helpful tips for initiating a dispute.
- Technical Assistance for Certified Independent Dispute Resolution Entities-August 2022 Edition (PDF)

July 28, 2022

On July 26, 2022, the U.S. District Court for the Eastern District of Texas issued a judgment and order in *LifeNet, Inc v. United States Department of Health and Human Services (LifeNet)*, vacating the final sentences of 45 CFR 149.520(b)(2), 26 CFR 54.9817–2T(b)(2), and 29 CFR 2590.717–2 (b)(2), which are parallel provisions governing the Federal Independent Dispute Resolution (IDR) process applicable to air ambulance payment disputes. The sentence the court vacated states, "This information must also clearly demonstrate that the qualifying payment amount is materially different from the appropriate out-of-network rate."

As a result of the *LifeNet* decision, effective July 26, 2022, certified IDR entities may not apply the vacated standard in reaching a payment determination in any payment dispute related to air ambulance services. The Departments are directing certified IDR entities to comply with the court's judgment and order and are in the process of updating Federal IDR program guidance and related documents to make them consistent with the *LifeNet* decision. The Departments will issue these updates in the near future.

February 28, 2022

The Federal Independent Dispute Resolution (IDR) system is live. Due to a pause in the launch required to address a court ruling (see February 28 guidance (PDF)), there may be a backlog of Federal IDR requests and high initial case volume. This could cause delays in Federal IDR request processing. In response, the Departments will:

- Grant requests for extensions submitted by the parties or certified IDR entities, as appropriate.
- Monitor the volume and provide additional guidance, including updates to the timeframes under the Federal IDR process, as necessary. Updates will be announced here, and parties with disputes in process will be notified directly in advance of an update taking effect.

The "No Surprises" rules create new protections against out-of-network balance billing and establish a new process, called independent dispute resolution, which providers (including air ambulance providers), facilities, and health plans can use to resolve payment disputes for certain out-of-network charges. As of January 2022, providers, facilities, and health plans can use this process to determine the payment rates for those services.

When a provider or facility gets a payment denial notice or an initial payment from a health plan for certain out-of-network services, the health plan, provider, or facility must start an open negotiation period that lasts 30 business days. At the end of the negotiation period, if the health plan and provider or facility haven't agreed on a payment amount, either party can begin the independent dispute resolution process.

The independent dispute resolution process:

- Brings in a third-party, known as a certified independent dispute resolution entity, to decide the payment amount. The parties have an opportunity to select the independent dispute resolution entity from a list of certified organizations, and everyone involved must attest to having no conflicts of interest.
- Requires the provider or facility and the health plan submit payment offers to the dispute resolution entity and additional information supporting their payment offers.
- Requires the dispute resolution entity to select from the disputing parties' payment offers. Both the provider or facility and the health plan must abide by the entity's decision and payment must be made within 30 calendar days.

Note: A dispute can't be started until the required 30-business-day open negotiation period has ended, and must be started within 4 business days after the open negotiation period has ended, except in the circumstance described in this memorandum. (PDF)

Start A Dispute

Have the following information ready:

- Information to identify the qualified independent dispute resolution (IDR) items or services
- Dates and location of items or services
- Type of items or services such as emergency services and post-stabilization services

- Codes for corresponding service and place-of-service
- Attestation that items or services are within the scope of the Federal IDR process
- Your preferred certified IDR entity. See a list of certified independent resolution entities.

Need help? Try this job aid (PDF) or view other resources on the IDR process.

If the parties agree on a rate after a dispute is started

Disputing parties can continue to negotiate until the IDR entity makes a determination. If the parties agree on an out-of-network rate for a qualified IDR item or service after providing notice to the Departments of initiation of the Federal IDR process, but before the certified IDR entity has made its decision, the initiating party must notify the Departments. This notification must be sent no later than 3 business days after the date of the agreement. The initiating party should email the certified IDR entity and the Departments (at FederalIDRQuestions@cms.hhs.gov) and attach a document that contains the following:

1. The agreed-upon out-of-network rate for the qualified IDR item, or service (that is, the total payment amount, including both participant, beneficiary, or enrollee cost sharing and the total plan or coverage payment, including amounts already paid);
2. Allocation of how parties agree to pay certified IDR entity fee (i.e., if parties choose not to evenly split the fee); and
3. Signatures from authorized signatories for both the initiating and the non-initiating party.

This information must be submitted within 3 business days of the agreement.

Deadlines under extenuating circumstances

If the disputing parties experience extenuating circumstances during the IDR process that prohibit them from complying with deadlines to submit information, they may complete the Request for Extension of Federal IDR Process Time Periods Due to Extenuating Circumstances form and email it to the Departments at FederalIDRQuestions@cms.hhs.gov. Parties should include the IDR dispute reference number on the form.

Get more information about the independent dispute resolution process, including guidance, FAQs, and model notices.

State-by-state applicability of the Federal IDR process

Not all items and services are subject to the Federal Independent Dispute Resolution process. Some states have their own balance billing laws or other laws that determine out-of-network payment amounts.

The following resources can help determine whether items or services in a state are subject to the Federal process:

- Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process (PDF)
- Chart Regarding Applicability of the Federal Independent Dispute Resolution (IDR) Process in Bifurcated States (PDF)

If you have questions about the independent dispute resolution process or would like to report a potential violation of the process, contact the No Surprises Help Desk at 1-800-985-3059.

Timelines for dispute resolution processes are counted in business days, defined as 8 a.m. to 5 p.m. Monday through Friday, excluding federal holidays.

Independent Dispute Resolution Reporting

The Department of Health and Human Services, the Department of Labor, and the Department of the Treasury (the Departments) have released an initial report on the Federal Independent Dispute Resolution (IDR) process.

The No Surprises Act requires that the Departments make publicly available certain information on the Federal IDR process for each calendar quarter. This report is a partial fulfillment of that requirement for the first two calendar quarters of operation for the Federal IDR portal – that is, from April 15, 2022, through September 30, 2022. The Departments intend to issue a complete report for these quarters once all the required data elements are available.

This report makes available information on the number of disputes initiated; the number of disputes closed; the types of parties engaged in disputes; the types of services under dispute; and the states in which disputed items and services were provided. The report also makes available information on expenditures and administrative fees collected for the Federal IDR process.

Read the report here.

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Help with File Formats and Plug-Ins

EXHIBIT 3

EDPMA Chair Pushes for Clarity and Urgency in Restarting The Federal Independent Dispute Resolutions Process

EDPMA Chair of the Board, Don Powell, DO FACEP, released the following statement regarding the summary judgement issued in favor of the Texas Medical Association (TMA), Dr. Adam Corley and UT Tyler Regional Hospital (collectively "The TMA Plaintiffs") in "TMA II" and CMS' subsequent freeze of the federal Independent Dispute Resolution (IDR) process:

"The courts have again made clear for the second time in one year that the Departments of Health and Human Services, Treasury, and Labor (the Tri Departments) improperly implemented the No Surprises Act (NSA) when giving outsized weight to black-box Qualified Payment Amounts (QPA) calculated by health insurers in the IDR process," said Dr. Powell. "Last week's decision from the U.S. District Court Eastern District of Texas is an important step toward ensuring a fair and equitable process for resolving disputes and restoring the level playing field that Congress intended in the NSA."

"EDPMA understands the need for CMS to freeze IDR determinations while arbiters are properly trained to follow the letter of the law. It is crucial, however, that CMS issue new guidance that adheres strictly to the court's order by Friday, February 17, 2023. Any further delay risks exacerbating the already severely backlogged process. The backlog was created in part by the federal government's estimate that 17,000 IDRs would be filed in one year and, as their recent Dec. 2022 report showed, over 90,000 had been filed in less than six months in 2022. This left the entire IDR system under-resourced."

"Just as importantly, the freeze creates considerable uncertainty regarding various IDR deadlines. CMS must ensure to all deadlines related to the initiation of IDR are extended for the period between the court's decision on February 6th and at least one week following the release of updated guidance. This grace period will ensure all parties understand the criteria on which their submissions will be judged and avoid jeopardizing the eligibility of any claims otherwise caught in limbo by the temporary freeze. Finally, urgency in releasing updated guidance is necessary as the pre-existing backlog of IDR decisions continues to grow each day that IDR determinations are on hold."

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About EDPMA:

The Emergency Department Practice Management Association (EDPMA) is the nation's largest professional physician trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all sizes, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, EDPMA's members deliver (or directly support) health care for about half of the 146 million patients that visit U.S. emergency departments each year. Visit http://www.edpma.org.

EXHIBIT 4

Part III

Administrative, Procedural, and Miscellaneous

26 CFR 54.9816-6T: Calculating the qualifying payment amounts in 2023

Notice 2023-4

SECTION 1. PURPOSE AND SCOPE

Pursuant to Treas. Reg. § 54.9816-6T(c), 29 CFR 2590.716-6(c), and 45 CFR 149.140(c), this notice provides the percentage increase for calculating the qualifying payment amounts for items and services furnished during 2023 for purposes of sections 9816 and 9817 of the Internal Revenue Code (Code), sections 716 and 717 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 2799A-1 and 2799A-2 of the Public Health Service Act (PHS Act). This notice was drafted in consultation with the Departments of Labor and Health and Human Services. Similar guidance for items and services furnished during 2022 was published in Revenue Procedure 2022-11, 2022-3 IRB 449, and Notice 2022-11, 2022-14 IRB 939.[1] Percentage increases for calculating the qualifying payment amounts for items and services furnished in future years may be published in the annual revenue procedure containing inflation-adjusted items for the following tax year.

SECTION 2. BACKGROUND

The No Surprises Act was enacted as Title I of Division BB of the Consolidated Appropriations Act, 2021.[2] The No Surprises Act added sections 9816 and 9817 to the Code, sections 716 and 717 to ERISA, and sections 2799A-1 and 2799A-2 to the PHS

[1] https://www.irs.gov/pub/irs-drop/rp-22-11.pdf and https://www.irs.gov/pub/irs-drop/n-22-11.pdf.
[2] Pub. L. 116-260, 134 Stat. 1182 (2020).

Act. These provisions provide protections against surprise medical bills in certain circumstances. Surprise medical bills can occur when a patient unexpectedly receives health care from a provider, facility, or provider of air ambulance services that does not participate in the network of the individual's group health plan or group or individual health insurance coverage (an out-of-network or nonparticipating provider, facility, or provider of air ambulance services).[3]

Before the enactment of the No Surprises Act, when the terms of a group health plan or group or individual health insurance coverage did not provide for coverage of the entire amount billed by a nonparticipating provider, facility, or provider of air ambulance services, the provider, facility, or provider of air ambulance services could balance bill the patient for the amount in excess of the amount paid by the plan or coverage and any applicable patient cost sharing (unless prohibited under applicable state law). For non-emergency services and air ambulance services, the patient could also have been responsible for out-of-network cost-sharing amounts, which may have been higher than in-network cost-sharing amounts. Under the No Surprises Act, in certain circumstances, the nonparticipating provider, facility, or provider of air ambulance services can no longer balance bill the patient for the excess amount, and patient cost sharing is generally limited to in-network levels. The No Surprises Act and implementing regulations[4] provide that, generally, in the absence of an All-Payer Model Agreement

[3] The protections against surprise billing additionally apply to health benefits plans offered by carriers under the Federal Employees Health Benefits (FEHB) Act pursuant to 5 U.S.C. 8902(p). Accordingly, the guidance provided in this notice applies to FEHB carriers to the extent consistent with their contracts. See also 5 CFR 890.114.
[4] 86 FR 36872 (July 13, 2021).

under section 1115A of the Social Security Act or specified state law,[5] a patient's cost-sharing amount must be calculated based on the lesser of the qualifying payment amount[6] or the amount billed by the provider or facility. In the case of air ambulance services, the patient's cost-sharing amount must be calculated based on the lesser of the qualifying payment amount or the billed amount for the services.

Further, in the absence of an All-Payer Model Agreement or specified state law,[7] the No Surprises Act and its implementing regulations provide for a 30-business-day open negotiation period for group health plans or health insurance issuers offering group or individual health insurance coverage (plans and issuers) and the nonparticipating providers, facilities, or providers of air ambulance services to determine the amount to be paid by the plans or issuers as the out-of-network rate.[8] If the parties are unable to reach an agreement through open negotiation, the No Surprises Act provides for the out-of-network rate to be determined by a certified independent dispute resolution (IDR) entity through a Federal IDR process set forth in sections 9816(c) and 9817(b) of the Code, sections 716(c) and 717(b) of ERISA, and sections 2799A-1(c) and 2799A-2(b) of the PHS Act. The statute and implementing interim final regulations issued in October 2021[9] and the final regulations issued in August 2022[10] provide that, under the Federal IDR process, the certified IDR entity considers the qualifying payment

[5] If an All-Payer Model Agreement or specified state law applies, the applicable Agreement or law determines the cost-sharing amount. "Specified state law" is defined in § 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.
[6] "Qualifying payment amount" is defined in § 54.9816-6T(a)(16), 29 CFR 2590.716-6(a)(16), and 45 CFR 149.140(a)(16).
[7] If an All-Payer Model Agreement or specified state law applies, the applicable Agreement or law determines the out-of-network rate.
[8] "Out-of-network rate" is defined in § 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.
[9] 86 FR 55980 (October 7, 2021).
[10] 87 FR 52618 (August 26, 2022).

amount for the item or service, among other additional circumstances and information as provided for in the statute and implementing regulations, in determining which offer to select as the out-of-network rate.

Under § 54.9816-6T(c), 29 CFR 2590.716-6(c), and 45 CFR 149.140(c), for an item or service furnished during 2022, plans and issuers must calculate the qualifying payment amount by increasing the median contracted rate (as determined in accordance with § 54.9816-6T(b), 29 CFR 2590.716-6(b), and 45 CFR 149.140(b)) for the same or similar item or service under such plan or coverage, on January 31, 2019, by the combined percentage increase as published by the Department of the Treasury (Treasury Department) and the Internal Revenue Service (IRS) to reflect the percentage increase in the consumer price index for all urban consumers (U.S. city average) (CPI-U) over 2019, such percentage increase over 2020, and such percentage increase over 2021.[11] Pursuant to Rev. Proc. 2022-11, for items and services provided on or after January 1, 2022, and before January 1, 2023, the combined percentage increase to adjust the median contracted rate for the same or similar item or service under such plan or coverage, on January 31, 2019, is 1.0648523983. The revenue procedure also provides that plans and issuers may round to the nearest dollar any resulting qualifying payment amounts.

Pursuant to § 54.9816-6T(c)(3)(i), 29 CFR 2590.716-6(c)(3)(i), and 45 CFR 149.140(c)(3)(i), for an item or service furnished during 2022, a plan or issuer that does

[11] The calculations of the qualifying payment amounts for anesthesia services, air ambulance services, and certain other items or services furnished during 2022 for which a plan or issuer has sufficient information to calculate the median of the contracted rates in 2019 differ slightly, but all use the same formula for increasing a base rate by the combined percentage increase as published by the Treasury Department and the IRS to reflect the percentage increase in the CPI-U over 2019 and subsequent years. See § 54.9816-6T(c)(1)(iii)-(vii), 29 CFR 2590.716-6(c)(1)(iii)-(vii), and 45 CFR 149.140(c)(1)(iii)-(vii).

not have sufficient information to calculate the median of the contracted rates in 2019 for the same or similar item or service provided in a geographic region must calculate the qualifying payment amount by first identifying the rate that is equal to the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in 2021, determined by the plan or issuer through use of any eligible database, and then increasing that rate by the percentage increase in the CPI-U over 2021. Similarly, in the case of a newly covered item or service furnished during the first coverage year, when a plan or issuer does not have sufficient information to calculate the median of the contracted rates in the first coverage year for the item or service, the plan or issuer must calculate the qualifying payment amount by using an eligible database to determine the rate that is equal to the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in the year immediately preceding the first coverage year, and then increasing that rate by the percentage increase in the CPI-U over the preceding year.

Under § 54.9816-6T(c)(3)(ii), 29 CFR 2590.716-6(c)(3)(ii), and 45 CFR 149.140(c)(3)(ii), for an item or service furnished in a subsequent year (before the first sufficient information year for the item or service with respect to the plan or coverage), the plan or issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined for the item or service for the year immediately preceding the subsequent year, by the percentage increase in the CPI-U over the preceding year.

The percentage increase in the CPI-U for items and services provided in 2022 over the preceding year is the average CPI-U for 2021 over the average CPI-U for

2020. Pursuant to Notice 2022-11, the percentage increase from 2021 to 2022 is 1.0299772040. The notice also provides that plans and issuers may round any resulting qualifying payment amounts to the nearest dollar.

Under § 54.9816-6T(c)(2)(i), 29 CFR 2590.716-6(c)(2)(i), and 45 CFR 149.140(c)(2)(i), with respect to a sponsor of a plan or issuer offering group or individual health insurance coverage in a geographic region in which the sponsor or issuer did not offer any group health plan or health insurance coverage in 2019, for the first year in which the group health plan or group or individual health insurance coverage is offered in the region, if the plan or issuer does not have sufficient information to calculate the median of the contracted rates for an item or service provided in the geographic region, the plan or issuer must determine the qualifying payment amount pursuant to § 54.9816-6T(c)(3)(i), 29 CFR 2590.716-6(c)(3)(i), and 45 CFR 149.140(c)(3)(i) for an item or service furnished in 2022, as previously discussed. For each subsequent year the group health plan or group or individual health insurance coverage is offered in the region, the plan or issuer must calculate the qualifying payment amounts by increasing the qualifying payment amounts so determined for items or services provided in the immediately preceding year, by the percentage increase in the CPI-U over the preceding year.[12]

Under § 54.9816-6T(c)(4)(i), 29 CFR 2590.716-6(c)(4)(i), and 45 CFR 149.140(c)(4)(i), in the case of a plan or issuer that does not have sufficient information

[12] The calculations of the qualifying payment amounts for anesthesia services, air ambulance services, and certain other items or services furnished in a subsequent year differ slightly, but all use the same formula for increasing the indexed median contracted rate determined for the item or service in the immediately preceding year by the percentage increase. See § 54.9816-6T(c)(2)(ii), 29 CFR 2590.716-6(c)(2)(ii), and 45 CFR 149.140(c)(2)(ii).

to calculate the median of the contracted rates for the same or similar item or service provided in a geographic region and determine the qualifying payment amount in accordance with the previously described methodology because the item or service is billed under a new service code, for items or services furnished in 2022 (or for newly covered items and services, during the first coverage year for the item or service), the plan or issuer must calculate the qualifying payment amounts pursuant to § 54.9816-6T(c)(4)(i), 29 CFR 2590.716-6(c)(4)(i), and 45 CFR 149.140(c)(4)(i).

Under § 54.9816-6T(c)(4)(ii), 29 CFR 2590.716-6(c)(4)(ii), and 45 CFR 149.140(c)(4)(ii), for such an item or service furnished in a subsequent year (before the first sufficient information year for the item or service with respect to such plan or coverage or before the first year for which an eligible database has sufficient information to calculate a rate under § 54.9816-6T(c)(3)(i), 29 CFR 2590.716-6(c)(3)(i), and 45 CFR 149.140(c)(3)(i) in the immediately preceding year), the plan or issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined for the item or service for the year immediately preceding the subsequent year, by the percentage increase in the CPI-U over the preceding year.

SECTION 3. GUIDANCE

The percentage increase in the CPI-U over a preceding year is calculated by dividing the average CPI-U for the preceding year by the average CPI-U for the year immediately prior to the preceding year. For this purpose, the average CPI-U for a year is the average of the monthly CPI-Us published by the Bureau of Labor Statistics of the Department of Labor for the 12-month period ending on August 31 of each year, rounded to 10 decimal places. The percentage increase in the CPI-U for items and

services provided in 2023 over the preceding year is the average CPI-U for 2022 over the average CPI-U for 2021. Pursuant to this calculation, the percentage increase from 2022 to 2023 is 1.0768582128. Further, pursuant to this notice, plans and issuers may round any resulting qualifying payment amounts to the nearest dollar.

.01 Adjusting qualifying payment amounts based on January 31, 2019 rates.

For qualifying payment amounts calculated by increasing the median contracted rate for 2019[13], the qualifying payment amounts for items and services furnished in 2023 are determined by taking the qualifying payment amounts calculated for items and services furnished in 2022 and multiplying the 2022 adjusted qualifying payment amounts by the percentage increase from 2022 to 2023, that is, 1.0768582128.

For example: An item is furnished in 2023. The median contracted rate for the item on January 31, 2019 was $1,500. The 2022 adjusted qualifying payment amount for the item was $1,597 ($1,500 x 1.0648523983). The 2023 adjusted qualifying payment amount for the item is $1,720 ($1,597 x 1.0768582128).

.02 Adjusting qualifying payment amounts based on 2021 rates.

For items and services furnished in 2022, for which the qualifying payment amounts were calculated by increasing the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in 2021, drawn from any eligible database, by the percentage increase from 2021 to 2022[14], the qualifying payment amounts for items and services furnished in 2023 are determined by

[13] These qualifying payment amounts are calculated by increasing the median contracted rate for the same or similar item or service under the plan or coverage, on January 31, 2019, by the combined percentage increase (2019, 2020, and 2021) published in Rev. Proc. 2022-11 (that is, 1.0648523983).
[14] These qualifying payment amounts are calculated by multiplying the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in 2021, drawn from any eligible database, by the percentage increase from 2021 to 2022 (that is, 1.0299772040).

taking the qualifying payment amounts calculated for the items and services furnished in 2022 and multiplying the 2022 adjusted qualifying payment amounts by the percentage increase from 2022 to 2023 (that is, 1.0768582128).

For example: A newly covered service for which the plan or issuer does not have sufficient information to calculate the median of the contracted rates is furnished in 2022. The median of the in-network allowed amounts for the same or similar service provided in the geographic region in 2021, drawn from an eligible database, was $2,100. The 2022 adjusted qualifying payment amount for the service was $2,163 ($2,100 x 1.0299772040). The 2023 adjusted qualifying payment amount for the service is $2,329 ($2,163 x 1.0768582128).

The adjustment to the qualifying payment amounts will be applied similarly for items and services covered by a new plan or new group or individual health insurance coverage that was not offered in a geographic region in a prior year. For items and services first offered by a new plan or new group or individual health insurance coverage in a geographic region in 2022 for which the plan or issuer does not have sufficient information to calculate the median of the contracted rates for the items or services provided in the geographic region[15], the qualifying payment amounts would be calculated by increasing the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in 2021, drawn from any eligible database, by the percentage increase from 2021 to 2022 (1.0299772040). For that plan or coverage, the qualifying payment amounts for items and services furnished

[15] These qualifying payment amounts are calculated by multiplying the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in 2021, drawn from any eligible database, by the percentage increase from 2021 to 2022 (that is, 1.0299772040).

in 2023 is determined by taking the qualifying payment amounts calculated for items and services furnished in 2022 and multiplying the 2022 adjusted qualifying payment amounts by the percentage increase from 2022 to 2023, that is, 1.0768582128.

.03 Calculating qualifying payment amounts when 2023 is the first coverage year.

For newly covered items and services furnished in 2023 for which the plan or issuer does not have sufficient information, when 2023 is the first coverage year for the item or service with respect to the plan or coverage, the qualifying payment amounts for the items and services first furnished in 2023 are determined by multiplying the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in 2022, drawn from any eligible database, by the percentage increase from 2022 to 2023, that is, 1.0768582128.

For example: A newly covered service is furnished in 2023. The median of the in-network allowed amounts for the service provided in the geographic region in 2022, drawn from an eligible database, was $3,000. The 2023 adjusted qualifying payment amount for the service is $3,231 ($3,000 x 1.0768582128).

SECTION 4. EFFECTIVE DATE

The effective date of this notice is January 1, 2023.

SECTION 5. DRAFTING INFORMATION

The principal author of this notice is Jason Sandoval of the Office of Associate Chief Counsel (Employee Benefits, Exempt Organizations, and Employment Taxes). For further information regarding this notice, contact Jason Sandoval at 202-317-5500 (not a toll-free call).

EXHIBIT 5

Initial Report on the Independent Dispute Resolution (IDR) Process

April 15 – September 30, 2022

Introduction

The No Surprises Act[1] (NSA) and its implementing regulations[2] establish a Federal Independent Dispute Resolution (IDR) process that out-of-network (OON) providers, facilities, and providers of air ambulance services, and group health plans, health insurance issuers in the group and individual markets, and Federal Employees Health Benefits (FEHB) Program carriers[3] (collectively, the disputing parties) may use to determine the OON rate for applicable items or services after an unsuccessful open negotiation period. For each calendar quarter in 2022 and each calendar quarter in subsequent years, the Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) are required to publish on a public website certain information about the Federal IDR process. This information includes the following:

1. The number of Notices of IDR Initiation submitted during the calendar quarter.
2. In the case of items or services that are not air ambulance services, the size of the provider practices and the size of the facilities submitting Notices of IDR Initiation during the calendar quarter.
3. The number of Notices of IDR initiation for which a final determination was made, including for each final determination:
    - A description of each item and service or air ambulance service (as applicable);
    - The geographic area in which the items and services were provided;
    - The amount of the offer submitted by each party expressed as a percentage of the qualifying payment amount (QPA);
    - Whether the offer selected by the certified IDR entity was the offer submitted by the plan or issuer (as applicable) or was the offer submitted by the nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services (as applicable) and the amount of the selected offer expressed as a percentage of the QPA;
    - In the case of items or services that are not air ambulance services, the category and practice specialty of each provider or facility involved in furnishing such items and services;
    - In the case of air ambulance services, the air ambulance vehicle type; including the clinical capability level of such vehicle;
    - The identity of the health plan or health insurance issuer, provider, or facility;
    - The length of time in making each determination; and

[1] Enacted as part of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260).
[2] Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36872 (July 13, 2021), https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i.; Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980 (October 7, 2021), https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii; and Requirements Related to Surprise Billing, 87 Fed. Reg. 52618 (August 26, 2022), https://www.federalregister.gov/documents/2022/08/26/2022-18202/requirements-related-to-surprise-billing.
[3] Under 5 U.S.C. 8902(p), Federal Employees Health Benefits Act contracts must require FEHB carriers to comply with requirements described in these IDR provisions in the same manner as such provisions apply to group health plans and health insurance issuers.

- The compensation paid to the certified IDR entity.

4. The number of times the payment amount determined (or agreed to) exceeds the QPA, specified by items and services.
5. The amount of expenditures made by the Departments during the calendar quarter to carry out the Federal IDR process.
6. The total amount of administrative fees paid during the calendar quarter.
7. The total amount of compensation paid to certified IDR entities during the calendar quarter.[4]

The Departments are committed to publishing this required data, bringing transparency to the Federal IDR process, and providing important information to the public, disputing parties, and Congress.

The Departments are working to automate to the extent feasible all aspects of the Federal IDR process and have successfully done so for many key operational steps. However, at the time of publishing this report, the reporting functionality of the Federal IDR portal remains largely manual, including cleaning data and redacting personal information related to disputes. The Departments published a status update on the Federal IDR process in August,[5,6] included data on the Federal IDR process in the Calendar Year 2023 Fee Guidance,[7] and are publishing this initial, partial report representing the reporting period, April 15, 2022, through September 30, 2022 (i.e., two calendar quarters of Federal IDR process operations) today.

The Departments opened the Federal IDR portal on April 15, 2022, just over 15 months after the NSA was signed into law. The portal's launch was delayed to incorporate changes needed to comply with a Federal District Court ruling in *Texas Medical Association v. HHS*.[8] Since the Federal IDR portal first opened, as the Departments noted both in the status update published on August 19, 2022, and in the Calendar Year 2023 Fee Guidance published on October 31, 2022, parties have been submitting significantly more disputes than the Departments initially projected.

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[4] Public Health Service Act sections 2799A-1(c)(7) and 2799A-2(b)(7) (codified at 42 U.S.C. 300gg-111(c)(7) and 42 U.S.C. 300gg-112(b)(7)), Employee Retirement Income Security Act sections 716(c)(7) and 717(b)(7) (codified at 29 U.S.C. 1185e(c)(7) and 29 U.S.C. 1185f(b)(7)), and Internal Revenue Code sections 9816(c)(7) and 9817(b)(7). Under 5 U.S.C. 8902(p), Federal Employees Health Benefits Act (FEHBA) contracts must require FEHB carriers to comply with requirements described in these IDR provisions in the same manner as such provisions apply to group health plans and health insurance issuers.

[5] https://www.cms.gov/files/document/federal-idr-process-status-update-august-2022.pdf.

[6] The numbers published in this initial report differ from the August 2022 status update because they cover a different reporting period. The status update reported data from April 15 – August 11, 2022, whereas this initial report includes data from the second and third calendar quarters of 2022, April 15 – September 30, 2022.

[7] https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets.

[8] On February 23, 2022, the United States District Court for the Eastern District of Texas, in *Texas Medical Ass'n, et al. v. United States Department of Health and Human Services, et al*., Case No. 6:21-cv-425 (E.D. Tex.), invalidated portions of an interim final rule, Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980 (Oct. 7, 2021) (the "Rule"), issued by the Departments, which governed aspects of the Federal IDR process. Also, on July 26, 2022, the U.S. District Court for the Eastern District of Texas issued a judgment and order in *LifeNet, Inc v. United States Department of Health and Human Services, et al*., Case No. 6:22-cv-162-JDK (E.D. Tex.), invalidating portions of the Rule which governed aspects of the Federal IDR process applicable to air ambulance payment disputes.

In addition, determining the eligibility of disputes for the Federal IDR process is requiring significantly more review and processing by certified IDR entities than initially anticipated.

It is within this context that the Departments are working to enhance the Federal IDR portal's ability to intake and process disputes and associated data. Because this first report requires substantial manual processing by both certified IDR entities and the Departments, the Departments are limiting the scope of this report to a partial report of the first and second calendar quarters (2022 Q2 and 2022 Q3). Moreover, the Departments are providing additional detail and context to help stakeholders understand the data being provided in this initial report. The Departments intend to later supplement this report with a full report for each of these two calendar quarters. Subsequent reports may be issued in a different format as parts of the Federal IDR portal become more automated. Publishing a partial report now, rather than prioritizing pulling and cleaning data needed for a full report, allows certified IDR entities to focus on issuing eligibility and payment determinations, and gives the Departments time to continue automating the Federal IDR portal to improve processing of disputes.

The Departments look forward to providing the public and Congress a full report for these quarters and for future quarters and are committed to working with certified IDR entities and stakeholders to continue to strengthen and improve the Federal IDR process.

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Background

Beginning January 1, 2022, the NSA prohibits surprise billing[9] nationally in certain circumstances in which surprise billing was common.[10] Specifically, the NSA provides protections against surprise billing with respect to the following services:

- Emergency services (including post-stabilization services),[11]
- Non-emergency items or services furnished by OON providers at certain in-network health care facilities,[12] and
- Air ambulance services furnished by OON providers of air ambulance services.

The NSA also establishes a Federal IDR process to allow the disputing parties to settle disagreements about payment for qualified items and services covered by the NSA, in the event that good faith negotiations are unsuccessful.[13]

The Departments issued interim final rules to implement the surprise billing protections in the NSA, which appeared in the July 13, 2021 Federal Register.[14] As part of this rulemaking, the Office of Personnel Management (OPM) issued provisions applying the same protections under the FEHB Act.

In situations covered by the NSA, patients will be required to pay no more than in-network cost-sharing amounts for these services. Health plans, issuers, and FEHB Carriers must pay the OON provider, facility, or provider of air ambulance services an amount in accordance with a state All-Payer Model Agreement or specified state law, if applicable. In the absence of an applicable All-Payer Model Agreement or specified state law, the plan must make an initial payment or a denial of payment within 30 calendar days. If either party believes that the payment amount is not appropriate (it is either too high or too low), it has 30 business days from the date of initial payment or denial of payment to notify the other party that it would like to negotiate. If the open negotiation is unsuccessful, the NSA provides for a Federal IDR Process whereby a certified IDR entity will review the specifics of the case and the items or services received and determine the final payment amount.

To implement the Federal IDR process, the Departments issued interim final rules that appeared in the October 7, 2021 Federal Register and a final rule that appeared in the August 26, 2022 Federal Register, which applies to services rendered on or after October 25, 2022. The statute and rules provide that if the disputing parties are not able to arrive at an agreed-upon payment amount during a 30-day open negotiation period, either party may initiate the Federal IDR

[9] "Surprise billing" refers to situations when an out-of-network health care provider or facility unexpectedly bills an individual directly for the difference between what the provider or facility charges for an item or service and what the individual's group health plan or health insurance coverage will pay.
[10] Some states had existing laws to protect consumers from surprise billing before the NSA went into effect.
[11] See 26 CFR 54.9816-4T(c)(2), 29 CFR 2590.716-4(c)(2), and 45 CFR 149.110(c)(2).
[12] See 26 CFR 54.9816–3T, 29 CFR 2590.716–3, and 45 CFR 149.30.
[13] The Federal IDR Process does not apply in cases where a specified state law or All-Payer Model Agreement under Section 1115A of the Social Security Act provides a method for determining the total amount payable under a group health plan or group or individual health insurance coverage with respect to the OON items and services furnished by the provider or facility.
[14] See *supra* note 2.

process by submitting a Notice of IDR Initiation to the other party and to the Departments within 4 business days after the close of the open negotiation period.[15] The parties then may jointly select a certified IDR entity to resolve the dispute. The certified IDR entity must attest to having no conflicts of interest with either party. If the parties cannot jointly select a certified IDR entity, the Departments will do so through random selection. After a certified IDR entity is selected, the parties will submit their offers for payment along with supporting documentation to the certified IDR entity. Upon consideration of all permitted information, the certified IDR entity must select one of the parties' offers as the OON payment amount and issue a binding, written payment determination. Both parties must pay a non-refundable administrative fee ($50 each for 2022), and the non-prevailing party is responsible for paying the certified IDR entity fee for using this process[16]

On April 15, 2022, the Departments launched the Federal IDR portal to facilitate the Federal IDR process for items and services subject to the surprise billing protections in the NSA. If parties had an open negotiation period that expired before April 15, 2022, they were permitted to initiate the Federal IDR process within 15 business days of the portal launching. Therefore, this report includes data on items and services rendered beginning January 1, 2022, when the surprise billing protections became effective, that would have been eligible for the Federal IDR process before April 15, 2022.

Dispute Volume

From April 15 – September 30, 2022, disputing parties initiated 90,078 disputes through the Federal IDR portal, significantly more than the number of disputes the Departments initially estimated would be submitted for a full year.[17] Disputing parties initiated 18,163 disputes in the second calendar quarter (April 15 – June 30, 2022). Disputes initiated in the second calendar quarter included disputes over items and services that would have been eligible for the Federal IDR process beginning January 1, 2022, when the surprise billing protections became effective. Disputing parties initiated 71,915 disputes in the third calendar quarter (July 1 – September 30, 2022), nearly four times more than in the second calendar quarter.[18]

Most disputes initiated in the second and third calendar quarters (86,807) were for emergency or non-emergency items or services,[19] and the vast majority of those disputes were submitted by

[15] See *supra* note 13.
[16] To learn more about the 2022 administrative fee and allowable certified IDR entity fee ranges for 2022, see Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act.
[17] Supporting Statement For Paperwork Reduction Act 1995: Independent Dispute Resolution Process, p. 16: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-1.pdf.
[18] This increase in dispute volume in the third calendar quarter is particularly notable because disputes initiated in the second calendar quarter represented more months of claims with items or services subject to surprise billing protection.
[19] The term "emergency or non-emergency items or services" in this report excludes air ambulance services.

OON health care providers and health care facilities.[20] The remaining 3,271 disputes were for OON air ambulance services. Table 1 shows the number of disputes initiated in each calendar quarter.

Table 1: Disputes Initiated, April 15 – September 30, 2022

Type of Items or Services	Disputes Initiated		
	2022 Q2	2022 Q3	Overall
OON Emergency or Non-Emergency Items or Services	17,465	69,342	86,807
OON Air Ambulance Services	698	2,573	3,271
Total Disputes Initiated	18,163	71,915	90,078

Source: Notices of IDR Initiation submitted to the Federal IDR portal, April 15 – September 30, 2022. Disputes submitted during 2022 Q2 include disputes beginning January 1, 2022.

Closed Disputes

23,107 disputes were closed from April 15 – September 30, 2022. Certified IDR entities reached a payment determination in 3,576 disputes (15% of closed disputes) and found 15,895 disputes (69% of closed disputes) ineligible for the Federal IDR process. The remaining closed disputes were either withdrawn by the disputing parties, were closed because the parties reached an outside settlement, or were closed for other reasons including incorrect batching, data entry errors, or unpaid fees. Table 2 shows the reasons for closure of disputes from April 15 – September 30, 2022.

Table 2: Reasons for Closure of Disputes, April 15 – September 30, 2022

Closure Reason	2022 Q2	2022 Q3	Overall
Payment Determinations Reached	328	3,248	3,576
Found Ineligible	1,731	14,164	15,895
Other	386	3,250	3,636
Total Closed Disputes	2,445	20,662	23,107

Source: Data from the Federal IDR portal, April 15 – September 30, 2022.
Notes: This table reflects disputes closed in the Federal IDR portal by the end of 2022 Q2 (June 30, 2022) and 2022 Q3 (September 30, 2022). Data from the Federal IDR portal was analyzed as of October 31, 2022. There may be some lag between when certified IDR entities send a determination notice to parties and when a dispute is updated to closed status in the Federal IDR portal.

Contested Dispute Eligibility

While many disputes for Q2 and Q3 were closed, others remain unresolved, often because one party has contested the eligibility of the dispute. The primary cause of delays in processing disputes has been the complexity of determining whether disputes are eligible for the Federal

[20] The type of initiating party (health care provider, health care facility, provider of air ambulance services, group health plan, health insurance issuer, or FEHB carrier) is indicated on the Federal IDR Notice of IDR Initiation. Although a third-party administrator or vendor may represent health insurance issuers, group health plans, or FEHB carriers in disputes, the third-party administrator or vendor itself is not the initiating party.

IDR process. Eligibility for the Federal IDR process depends on several factors, including determining state versus federal jurisdiction, correct batching and bundling, compliance with applicable time periods,[21] and completion of open negotiations.

Disputing parties that did not initiate the dispute (non-initiating parties) challenged eligibility for the Federal IDR process in 41,814 disputes from April 15 – September 30, 2022, nearly half of those initiated. This did not necessarily mean that these claims were ineligible, only that one party challenged the eligibility of a claim and therefore that additional processing by the certified IDR entity was necessary to determine eligibility.[22] Of the 11,316 disputes that were closed by September 30, 2022 and were challenged as ineligible by the non-initiating party, 9,031 disputes (80%) were ultimately found ineligible for the Federal IDR process.

Incomplete Submissions

Eligibility reviews conducted by certified IDR entities are processed more quickly when both parties provide all information required during Federal IDR process initiation, including the disclosures (in particular, disclosures of the QPA and necessary contact information) required of plans, issuers, and FEHB carriers when they make an initial payment or provide a notice of denial of payment. This information is provided on the Notice of IDR Initiation as part of a complete submission by the initiating party. In the first six months that the Federal IDR process was operational, many disputes were initiated with missing or incorrect contact information for the non-initiating party, missing QPAs, or missing proof of open negotiations. Incomplete submissions require further outreach by certified IDR entities to both parties to collect information required for Federal IDR process initiation and eligibility review, which delays processing disputes.

For this reason, on June 3, 2022, the Departments published a checklist for plans, issuers, and FEHB carriers identifying the information they must disclose with the initial payment or notice of denial of payment.[23] The Departments are of the view that increased understanding of and compliance with disclosure requirements and complete submissions by initiating and non-initiating parties will foster the exchange of necessary information within the Federal IDR process, resulting in faster completion of eligibility reviews. To that end, the Departments are

[21] The parties must exhaust a 30-business-day open negotiation period. Either party may initiate the Federal IDR Process by submitting a Notice of IDR Initiation to the other party and to the Departments within 4 business days after the close of the open negotiation period. Disputes initiated after this 4-business day period would be found ineligible, unless a cooling off period applies. The cooling off period is the 90-calendar-day period following a payment determination when the initiating party cannot submit a subsequent Notice of IDR Initiation involving the same party with respect to a claim for the same or similar item or service that was the subject of the initial Notice of IDR Initiation. If a cooling off period applies, either party must submit the Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. The 30-business-day period begins on the day after the last day of the cooling off period.

[22] Even if the non-initiating party does not challenge eligibility of the dispute, the certified IDR entity does some processing to confirm the dispute is eligible for the Federal IDR process. For example, the certified IDR entity checks whether the dispute was compliant within applicable time periods and whether the dispute belongs in the federal or state process.

[23] https://www.cms.gov/files/document/caa-NSA-Issuer-Requirements-Checklist.pdf.

continuing to publish technical assistance to help disputing parties and certified IDR entities resolve disputes expeditiously, including the most recent set of guidance for certified IDR entities and for disputing parties.[24, 25, 26]

Federal vs. State Jurisdiction

22 states have specified state laws or All-Payer Model Agreements that protect consumers from surprise billing and provide a method for determining the OON rate in certain circumstances; many of these state laws were in effect at the time the NSA was passed.[27] Generally, the Federal IDR process does not apply in instances where a specified state law or All-Payer Model Agreement under Section 1115A of the Social Security Act provides a method for determining the total amount payable under a group health plan or group or individual health insurance coverage with respect to the OON items and services furnished by the provider or facility.

In many states, some items or services provided by OON providers, facilities, or providers of air ambulance services may be subject to the Federal IDR process, while other items and services are subject to a specified state law or All-Payer Model Agreement (bifurcated states). Disputes submitted in these bifurcated states require further review by certified IDR entities to determine eligibility for the Federal IDR process. Over two-thirds of the disputes submitted to the Federal IDR portal in the first six months involved items or services furnished in bifurcated states, particularly in Texas (24,987), Florida (9,695), and Georgia (7,288).

Determining whether the Federal IDR process is applicable to an item or service that is the subject of a payment dispute in a bifurcated state is complex. To assist certified IDR entities with this determination, the Departments published a Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process and the Chart Regarding Applicability of the Federal Independent Resolution (IDR) Process in Bifurcated States on August 23, 2022.[28]

The health plan type is nearly always required to determine whether the payment dispute is subject to state law or the Federal IDR process. The Federal IDR process generally applies to self-insured plans sponsored by private employers or private employee organizations in all states, except in cases where a self-insured plan has opted into a specified state law, in a state that permits these plans to opt in.[29] In addition, the Federal IDR process generally applies to FEHB plans in all states, except in cases where an OPM contract with an FEHB carrier includes terms that adopt the state process.

Certified IDR entities can determine eligibility more efficiently when information about the health plan type is made available to the provider by the plan, issuer or carrier with the initial

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[24] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Federal-Independent-Dispute-Resolution-Process-Guidance-for-Certified-IDR-Entities.pdf.
[25] https://www.cms.gov/files/document/TA-certified-independent-dispute-resolution-entities-August-2022.pdf.
[26] https://www.cms.gov/files/document/federal-independent-dispute-resolution-guidance-disputing-parties.pdf.
[27] https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf.
[28] https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets.
[29] Currently, there are 6 states that permit self-insured plans to opt in: New Jersey, Nevada, Maine, Georgia, Washington, and Virginia.

payment or notice of denial of payment or upon request during open negotiations.[30] However, the health plan type was unknown upon dispute initiation in more than half of disputes initiated from April 15 – September 30, 2022, causing certified IDR entities to conduct additional outreach, and further delaying the eligibility review process.

It is easier for disputing parties and certified IDR entities to determine eligibility for the Federal IDR process when state regulators publish the list of self-insured plans that have opted-in to the use of a specified state law. For example, state regulators in four of the six states that permit self-insured plans to opt-in (New Jersey, Nevada, Virginia, and Washington) publish lists of self-insured plans that have opted-in to a specified state law.[31, 32, 33, 34]

Incorrect Batching

The NSA and its implementing regulations allow for multiple qualified IDR items or services to be submitted as a batched dispute when certain conditions are met. The qualified IDR items or services must be:

- billed by the same provider or group of providers;
- paid by the same payer;
- of the same service code or a similar service code under a different procedural coding system; and
- furnished within the same 30-business-day period (or had open negotiation periods ending within a 90-calendar-day cooling off period).[35]

However, in the initial months of Federal IDR process operation, many disputes were incorrectly batched. For example, many initiating parties submitted multiple service codes from the same patient encounter as one dispute, rather than separating these different service codes into separate disputes in the manner the regulations describe. Incorrectly batched disputes result in delays in processing and require additional actions by the parties. The Departments published additional guidance for disputing parties and certified IDR entities to further explain batching and bundling in August 2022.[36] If a dispute is incorrectly batched, the certified IDR entity selects one service code to continue through the Federal IDR process and asks the party to re-submit the other service codes as separate disputes.

Information about health plan type (fully-insured or self-insured plan) helps initiating parties accurately batch items or services together from the same issuer, or from the same self-insured health plan. For example, items or services may be submitted as a batched dispute if the payment (or notice of denial of payment) for the qualified IDR items or services is made by the same

[30] Plans, issuers, and FEHB carriers are not currently required to specify health plan type with the initial payment or notice of denial of payment.
[31] https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/Programs/CHA/Self_Insured_Opt_Ins_as_of_10_10_2022.pdf.
[32] https://www.nj.gov/dobi/division_insurance/mewaapps.htm.
[33] https://scc.virginia.gov/balancebilling.
[34] https://www.insurance.wa.gov/self-funded-group-health-plans.
[35] See 26 CFR 54.9816-8T(c)(3), 29 CFR 2590.716-8(c)(3) and 45 CFR 149.510(c)(3).
[36] https://www.cms.gov/files/document/TA-certified-independent-dispute-resolution-entities-August-2022.pdf.

group health plan, health insurance issuer, or FEHB carrier. For fully-insured health plans, this means that qualified IDR items or services can be batched if payment is made by the same issuer even if the qualified IDR items and services relate to claims from different fully-insured group or individual health plans offered by the issuer. For self-insured group health plans, qualified IDR items or services can be batched only if payment is made by the same plan, even if the same third-party administrator administers multiple self-insured plans.

Federal Dispute Initiations by State

The states with the most Federal IDR disputes initiated during this reporting period were Texas, Florida, Georgia, Tennessee, and North Carolina. These states represented 60% of all disputes initiated from April 15 – September 30, 2022. Nearly 25,000 disputes were initiated in Texas, representing 28% of disputes initiated overall. It is notable that Texas, Florida, and Georgia have a high number of federal payment dispute initiations despite specified state laws that would apply to many payment disputes in these states. It is possible that these disputes involve self-insured plans that are not subject to state laws, but this is difficult to determine because the health plan type is not provided upon dispute initiation in around half of disputes. When health plan type is reported on dispute initiation, the majority of disputes in these bifurcated states involve fully-insured private group health plans, which would likely be subject to state law.

The states with the fewest disputes initiated were Maine, South Dakota, New Hampshire, North Dakota, and Hawaii, with fewer than 30 total disputes initiated per state from April 15 – September 30, 2022. Of these 5 states, Maine and New Hampshire have bifurcated state processes where specified state laws would apply to many payment disputes. The low number of disputes in these five states may also be explained by their smaller state populations.

Table 3 shows the number of payment disputes initiated from April 15 – September 30, 2022, in each state or territory, based on the location where the item or service was furnished.

Table 3: Disputes Initiated in State or Territory, April 15 – September 30, 2022

State or Territory	Overall Disputes Initiated	OON Emergency and Non-Emergency Items or Services		OON Air Ambulance Services	
		2022 Q2	2022 Q3	2022 Q2	2022 Q3
Texas+	24,987	5,540	18,999	95	353
Florida+	9,695	648	8,891	41	115
Georgia+	7,288	989	6,132	55	112
Tennessee	6,819	2,051	4,605	45	118
North Carolina	5,040	950	3,935	26	129
Virginia+	4,079	177	3,822	21	59
New York+	3,603	872	2,687	17	27
Arizona	3,469	999	2,323	40	107
Indiana	2,434	516	1,873	5	40
New Jersey+	2,276	502	1,743	8	23
Missouri+	1,930	215	1,682	7	26
California+	1,668	359	1,000	45	264
Louisiana	1,581	197	1,352	6	26
Illinois+	1,520	244	1,242	6	28
Mississippi	1,213	230	886	23	74
Oklahoma	1,179	254	880	9	36
Maryland+	1,106	568	504	9	25
Massachusetts	1,081	364	701	3	13
Ohio+	989	148	757	16	68
Kentucky	860	226	585	11	38
Oregon	813	159	593	11	50
Pennsylvania	694	110	464	40	80
Arkansas	646	95	462	7	82
Washington+	527	87	331	15	94
South Carolina	513	80	393	5	35
New Mexico+	511	65	316	19	111
Iowa	394	80	303	5	6
Alabama	355	79	239	11	26
Colorado+	344	48	211	14	71
Nevada+	344	43	268	6	27
West Virginia	332	65	212	15	40
Rhode Island	327	174	153	-	-
Idaho	277	84	179	5	9
Wisconsin	238	30	163	9	36
Kansas	159	28	69	13	49
Delaware+	149	6	121	3	19
Wyoming	143	69	40	8	26
Connecticut+	137	21	109	2	5

Minnesota	137	84	35	6	12
Michigan+	121	41	66	4	10
Nebraska+	98	-	43	10	45
Utah	91	26	55	-	10
Alaska+	82	11	26	2	43
Vermont	39	22	15	2	-
Montana	31	-	19	1	11
Maine+	28	13	15	-	-
South Dakota	26	1	16	2	7
New Hampshire+	20	4	16	-	-
North Dakota	11	-	1	2	8
District of Columbia	8	-	6	1	1
Hawaii	7	-	-	2	5
American Samoa	5	3	2	-	-
Puerto Rico	2	-	2	-	-
US Virgin Islands	2	-	2	-	-
Guam	1	-	1	-	-
Northern Mariana Islands	-	-	-	-	-

Source: Notices of IDR Initiation submitted to the Federal IDR portal, April 15 – September 30, 2022.
Notes: +State has specified state law or All-Payer Model Agreement that applies to certain OON payment disputes. The sum of disputes per state is greater than the total number of disputes because some batched disputes involved items or services located across several states – these disputes are included in the per state total for each state. These disputes may represent incorrectly batched items and services.

OON Emergency and Non-Emergency Items or Services

The NSA provides protections for consumers against surprise billing and out-of-network cost sharing with respect to emergency services (including post-stabilization services),[37] and non-emergency items and services furnished by OON providers at certain in-network health care facilities.[38]

OON providers and emergency facilities are prohibited from balance billing[39] for the following **emergency services**:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate the emergency medical condition;

[37] See 26 CFR 54.9816-4T(c)(2), 29 CFR 2590.716-4(c)(2), and 45 CFR 149.110(c)(2).
[38] See 26 CFR 54.9816–5T, 29 CFR 2590.716–5, and 45 CFR 149.120.
[39] Balance billing refers to when a provider bills the consumer for the balance remaining on the bill that the plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount.

- Such further medical examination and treatment as are required to stabilize the individual (regardless of the department of the hospital in which the further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department; and
- Items and services furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant or beneficiary is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described above are furnished, subject to circumstances in which notice and waiver of balance billing protections may be permitted.

OON providers are prohibited from balance billing an individual who gets covered, **non-emergency services** that are part of a visit to an in-network health care facility, without notice and consent.[40] The primary set of non-emergency services protected from balance billing are **ancillary services**, over which individuals typically have little control. OON providers are prohibited from balance billing for ancillary services, regardless of whether notice and consent is provided. The NSA defines these types of ancillary services at in-network facilities as:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, provided by either a physician or non-physician practitioner;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and
- Items and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network health care facility.

Note that certain ancillary services (such as a CT scan or X-ray) can be provided as emergency or non-emergency services.

Volume of Disputes for Emergency and Non-Emergency Items or Services

Disputing parties initiated 86,807 disputes through the Federal IDR portal for emergency and non-emergency items or services from April 15 – September 30, 2022. Disputing parties initiated 17,465 disputes in the second calendar quarter (April 15 – June 30, 2022)[41] and 69,342 disputes in the third calendar quarter (July 1 – September 30, 2022), nearly four times more than the prior quarter.[42]

The majority of disputes for emergency and non-emergency services (84%) were submitted by health care providers, while 15% of disputes were submitted by health care facilities.[43] The

[40] Section 2799B-2 of the PHS Act, as implemented in 45 CFR 149.410 and 149.420, allows nonparticipating providers and facilities to seek consent from an individual to waive the individual's balance billing and cost-sharing protections in certain situations. In order to seek that consent, the nonparticipating provider or facility must provide written notice to participants, beneficiaries, or enrollees in accordance with guidance issued by HHS, and in the form and manner specified in guidance.
[41] Disputes initiated in the second calendar quarter included disputes over items and services beginning January 1, 2022 when the surprise billing protections became effective, that would have been eligible for the Federal IDR process before April 15, 2022.
[42] See *supra* note 18.
[43] See *supra* note 20.

remaining disputes were submitted by group health plans, health insurance issuers, or FEHB carriers (<1%).

Disputing Parties for Emergency and Non-Emergency Items or Services

More than 500 unique initiating parties or their representatives[44] initiated the Federal IDR process for disputes involving OON emergency and non-emergency items or services from April 15 – September 30, 2022. The top ten parties initiated 75% of all disputes involving OON emergency and non-emergency items and services. Many of the top parties were large practice management companies, medical practices, or revenue management companies representing hundreds of individual practices, providers, or facilities. For example, the top party (SCP Health) represents thousands of clinicians across multiple states and accounts for approximately a third of all disputes initiated for emergency and non-emergency items or services from April 15 – September 30, 2022. Table 4 shows the top 10 initiating parties or their representatives for disputes involving OON emergency and non-emergency items or services, for disputes initiated from April 15 – September 30, 2022.

Table 4: Top 10 Initiating Parties or their Representatives for Disputes Involving OON Emergency and Non-Emergency Items or Services, April 15 – September 30, 2022

Initiating Party or their Representative	2022 Q2	2022 Q3	Overall	Percent of All Emergency and Non-Emergency Services Disputes
SCP Health	2,134	26,062	28,196	32%
R1 Revenue Cycle Management	1,563	8,304	9,867	11%
LogixHealth	2,987	3,750	6,737	8%
Roundtable Medical Consultants	1,611	3,178	4,789	6%
TEAMHealth	204	3,365	3,569	4%
Envision Healthcare	466	2,332	2,798	3%
Providence Anesthesiology	740	1,993	2,733	3%
Singleton Associates, P.A.	670	1,454	2,124	2%
Gryphon Healthcare	1,078	952	2,030	2%
HCA Healthcare	1,021	850	1,871	2%

Source: Notices of IDR Initiation submitted to the Federal IDR portal, April 15 – September 30, 2022.
Notes: Parties and their representatives were identified and aggregated by the email domain of the initiating party on the Notice of IDR Initiation.

More than 600 unique non-initiating parties or their representatives (consisting of plans, issuers, FEHB carriers, third-party administrators, and vendors) were parties to disputes involving

[44] Initiating parties or their representatives were identified and aggregated by the email domain of the initiating party on the Notice of IDR Initiation. Many parties represent hundreds of providers or facilities.

emergency or non-emergency items and services from April 15 – September 30, 2022.[45] Many parties were health insurance issuers, group health plans, or FEHB carriers that operate across multiple states and market segments; third-party administrators that represent several group health plans across multiple states; or vendors that provide administrative services to issuers and group health plans.[46] The top party, United Healthcare, represented approximately one quarter of all disputes for emergency and non-emergency items or services. Table 5 shows the top 10 non-initiating parties or their representatives for disputes involving emergency and non-emergency services, for disputes initiated from April 15 – September 30, 2022.

Table 5: Top 10 Non-Initiating Parties or their Representatives for Disputes Involving Emergency and Non-Emergency Services, April 15 – September 30, 2022

Non-Initiating Party or their Representative	2022 Q2	2022 Q3	Overall	Percent of All Disputes Involving Emergency and Non-Emergency Items or Services
United Healthcare	4,170	16,880	21,050	24%
Aetna	3,070	9,220	12,290	14%
MultiPlan	1,013	8,283	9,296	11%
Anthem	488	7,863	8,351	10%
Cigna	1,800	6,329	8,129	9%
BlueCross BlueShield of Texas	1,764	3,000	4,764	5%
Clear Health Strategies	492	2,946	3,438	4%
Florida Blue	15	3,386	3,401	4%
BlueCross BlueShield of Illinois	140	1,991	2,131	2%
BlueCross BlueShield of Tennessee	1,000	935	1,935	2%

Source: Notices of IDR Initiation submitted to the Federal IDR portal, April 15 – September 30, 2022.
Notes: Parties and their representatives were identified and aggregated by the email domain of the non-initiating party on the Notice of IDR Initiation.

Contested Dispute Eligibility for Emergency and Non-Emergency Items or Services

Non-initiating parties challenged eligibility for the Federal IDR process in 40,517 disputes for emergency or non-emergency services from April 15 – September 30, 2022, nearly half of those initiated. This does not necessarily mean that these disputes were ineligible, only that one party challenged the eligibility of a dispute and that additional processing by certified IDR entities was necessary to determine eligibility. Of the 11,030 disputes for emergency or non-emergency items and services that were closed by September 30, 2022, and had eligibility challenged by the non-

[45] Non-initiating parties and their representatives were identified and aggregated by the email domain of the non-initiating party on the Notice of IDR Initiation.
[46] Although a third-party administrator or vendor may represent health insurance issuers, group health plans, or FEHB carriers in disputes, the third-party administrator or vendor itself is not the non-initiating party.

initiating party, 8,843 disputes (80%) were ultimately found ineligible for the Federal IDR process.[47]

Closed Disputes for Emergency and Non-Emergency Items or Services

22,194 disputes for emergency and non-emergency items or services were closed from April 15 – September 30, 2022. Certified IDR entities reached a payment determination in 3,339 disputes (15% of closed disputes) and found 15,485 disputes (70% of closed disputes) ineligible for the Federal IDR process. The remaining closed disputes were either withdrawn by the disputing parties or were closed because the parties reached an outside settlement, or for other reasons including incorrect batching, data entry errors or unpaid fees. Table 6 shows the reasons for closure of disputes involving emergency and non-emergency items and services from April 15 – September 30, 2022.

Table 6: Reasons for Closure of Emergency and Non-Emergency Disputes, April 15 – September 30

Closure Reason	2022 Q2	2022 Q3	Overall
Payment Determinations Reached	282	3,057	3,339
Found Ineligible	1,709	13,776	15,485
Other	339	3,031	3,370
Total Closed Disputes	2,330	19,864	22,194

Source: Data from the Federal IDR portal, April 15 – September 30, 2022.
Notes: This table reflects disputes closed in the Federal IDR portal by the end of 2022 Q2 (June 30, 2022) and 2022 Q3 (September 30, 2022). Data from the Federal IDR portal was analyzed as of October 31, 2022. There may be some lag between when certified IDR entities send a determination notice to parties and when they update a dispute to closed status in the Federal IDR portal.

Types of Emergency and Non-Emergency Items or Services

To analyze the types of disputed items and services, the Departments compared service type as indicated by the initiating party to the service codes and place of service codes on the Notice of IDR Initiation. The Departments used this information to report the number of disputes for emergency services and certain ancillary services, which are the primary set of non-emergency services protected from surprise billing.

Table 7 shows the most common place of service codes for emergency and non-emergency items and services disputed from April 15 – September 30, 2022. Place of service codes are used on professional claims to specify the location where service(s) were rendered.

[47] 15,485 disputes for emergency and non-emergency items and services were found ineligible from April 15 - September 30, 2022. This includes 8,843 disputes where eligibility was contested by the non-initiating party during certified IDR entity selection and an additional 6,642 disputes where the non-initiating party did not contest eligibility but the certified IDR entity nevertheless found the dispute to be ineligible. For example, certified IDR entities found disputes that were filed untimely as ineligible.

Table 7: Top Places of Service for Emergency and Non-Emergency Services**,** April 15 – September 30, 2022

Place of Service Code	2022 Q2	2022 Q3	Overall	Percent of Disputes
23 – Emergency Room – Hospital	13,799	56,272	70,071	81%
21 – Inpatient Hospital	2,866	8,566	11,432	13%
22 – On Campus-Outpatient Hospital	2,562	5,227	7,789	9%
24 – Ambulatory Surgical Center	424	1,566	1,990	2%
19 – Off Campus-Outpatient Hospital	553	503	1,056	1%
11 – Office[48]	166	162	328	<1%

Source: Notices of IDR Initiation submitted to the Federal IDR portal, April 15 – September 30.
Note: The sum of percent of disputes is greater than 100% because some disputes include several different place of service codes.

Emergency services

The vast majority of emergency and non-emergency disputes initiated from April 15 – September 30, 2022, involved emergency services. Initiating parties indicated that 71,513 disputes involved emergency services, 82% of all disputes initiated for emergency or non-emergency services in this period. This includes 70,071 disputes for services provided in a hospital emergency room. 57,505 disputes (over half of all disputes) include one of five emergency department visit codes (99281 – 99285).

For 1,925 disputes, initiating parties indicated that the dispute involved post-stabilization services. However, this self-reported data has some limitations and may not always be reliable. For example, over half of the indicated post-stabilization services had service codes listed as "NA" or "None" on the Notice of IDR Initiation, limiting the Departments' ability to verify whether these disputes actually represent post-stabilization services.[49] Moreover, initiating parties indicated that 4,017 disputes involved emergency services, while listing an inpatient hospital place of service code. The Departments speculate that some of these disputes may have actually involved unreported post-stabilization services.

Ancillary services

Ancillary services represented a large number of disputed services from April 15 – September 30, 2022. 16,932 disputes included service codes for common ancillary services (anesthesia, radiology, pathology, or neonatology), about 19% of all emergency and non-emergency services disputed from April 15 – September 30, 2022.

[48] With respect to non-emergency services, the NSA surprise billing protections for insured patients apply only if the item or service was provided with respect to the patient's visit to an in-network hospital, critical access hospital, hospital outpatient department, or ambulatory surgical center. However, if the non-emergency service is being provided by a nonparticipating provider outside of such an in-network health care facility, but with respect to a patient visit to such an in-network health care facility, it is subject to the NSA billing prohibitions that apply to non-emergency services. For example, a radiology service performed in an office setting with respect to a patient visit to an in-network hospital would still be subject to the NSA surprise billing protections and eligible for the Federal IDR process. See 45 CFR 149.30.

[49] Disputes that do not contain valid service codes do not typically continue in the Federal IDR process and are either closed as ineligible or due to data entry errors.

Some ancillary services were provided in the emergency department of a hospital, while others were provided at a hospital or ambulatory surgical center as part of non-emergency services. Table 8 shows the place of service codes for common ancillary services with respect to Current Procedural Terminology (CPT) codes.

Table 8: Places of Service for Common Ancillary Services, April 15 – September 30

CPT Codes	CPT Code Category	Number of Disputes	Place of Service				
			Emergency Room – Hospital	Inpatient Hospital	Outpatient Hospital	Office[50]	Ambulatory Surgical Center
00100 - 01999	Anesthesia	6,021	19%	14%	33%	2%	32%
70010 - 79999	Radiology	8,238	42%	17%	39%	1%	1%
80047 - 89398	Pathology	3,538	94%	1%	1%	3%	<1%

Source: Notices of IDR Initiation submitted to the Federal IDR portal, April 15 – September 30, 2022.
Notes: The sum of disputes is greater than 16,932 because some incorrectly batched disputes include several different service codes from different CPT categories.

For 12,988 disputes, parties indicated that the dispute involved items or services furnished by a nonparticipating provider at a participating health care facility. This represents around 15% of all emergency and non-emergency services disputed from April 15 – September 30, 2022. Many of these services were ancillary services. Anesthesia[51] and neurology and neuromuscular procedures[52] (such as continuous remote monitoring of the nervous system during an operation) represented the majority of services furnished by a nonparticipating provider at a participating health care facility.

CPT Code Types

CPT codes made up the vast majority (90%) of service codes submitted in disputes involving emergency or non-emergency items and services during this period. The most common CPT codes disputed were emergency department service codes (66% of disputes), radiology codes (9% of disputes), and anesthesia codes (7% of disputes). Approximately 5% of disputes included surgery codes, such as removals of the appendix or gallbladder and treatment of broken bones, and 4% of disputes included codes for pathology and lab. Approximately 4% of disputes included codes for neurology and neuromuscular procedures such as monitoring of the nervous system during an operation. Approximately 3% of disputes included codes for cardiovascular procedures such as ultrasounds, electrocardiograms (ECGs), and other monitoring services.

[50] See *supra* note 48.
[51] CPT Codes 00100 – 01999.
[52] CPT Codes 95700 – 96020.

Table 9 summarizes the types of CPT codes submitted. For each code type, the table includes the number of disputes and the percent of overall disputes initiated with such code types from April 15 – September 30, 2022.

Table 9: Disputes by Type of CPT Code, April 15 – September 30, 2022

CPT Codes	CPT Type	Frequency	Percent
99281 - 99288	Emergency Department Services	57,505	66%
70010 - 79999	Radiology	8,238	9%
00100 - 01999	Anesthesia	6,021	7%
10004 - 69990	Surgery	4,417	5%
80047 - 89398	Pathology and Lab	3,538	4%
95700 - 96020	Neurology and Neuromuscular Procedures	3,501	4%
99291 - 99292	Critical Care Services	3,073	4%
92920 - 93799	Cardiovascular Procedures	2,934	3%
96360 - 96549	Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration	2,520	3%
99217 - 99226	Hospital Observation Services	1,201	1%
99221 - 99239	Hospital Inpatient Services	1,101	1%
0001U - 0354U	Proprietary Laboratory Analyses	1,035	1%
94002 - 94799	Pulmonary Procedures	877	1%
99466 - 99480	Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services	751	1%
93880 - 93998	Non-Invasive Vascular Diagnostic Studies	338	< 1%
99000 - 99091	Special Services, Procedures and Reports	314	< 1%
99151 - 99157	Moderate (Conscious) Sedation	97	< 1%
99202 - 99215	Office or Other Outpatient Services	83	< 1%
90460 - 90474	Immunization Administration for Vaccines/Toxoids	77	< 1%
90476 - 90759	Vaccines, Toxoids	76	< 1%
99100 - 99140	Qualifying Circumstances for Anesthesia	45	< 1%
97010 - 97799	Physical Medicine and Rehabilitation Evaluations	39	< 1%
99460 - 99463	Newborn Care Services	30	< 1%
92502 - 92700	Special Otorhinolaryngologic Services and Procedures	28	< 1%
99241 - 99255	Consultation Services	28	< 1%
99354 - 99417	Prolonged Services	17	< 1%
99464 - 99465	Delivery/Birthing Room Attendance and Resuscitation Services	16	< 1%
92002 - 92499	Ophthalmology Services and Procedures	9	< 1%
0042T - 0737T	Various Services Category III Codes	5	< 1%
98925 - 98929	Osteopathic Manipulative Treatment Procedures	4	< 1%
99304 - 99318	Nursing Facility Services	3	< 1%

CPT Codes	CPT Type	Frequency	Percent
99170 - 99199	Other Medicine Services and Procedures	3	< 1%
90785 - 90899	Psychiatry Services and Procedures	2	< 1%
99497 - 99498	Advance Care Planning Evaluation and Management Services	1	< 1%
99499 - 99499	Other Evaluation and Management Services	1	< 1%

Source: Notices of IDR Initiation submitted to the Federal IDR portal, April 15 – September 30, 2022
Notes: The sum of percent of disputes may be greater than 100% because some incorrectly batched disputes included several different types of CPT codes. For example, some disputes included all service codes from a single patient visit.

Table 10 summarizes the top 50 service codes of the more than 3,300 unique service codes submitted for emergency and non-emergency services disputed, the number of disputes that include the code, and the percent of disputes that include the code for disputes initiated from April 15 – September 30, 2022.

Table 10: Top 50 Service Codes Submitted, April 15 – September 30, 2022

Code Type	Service Code	Description of Item or Service	2022 Q2	2022 Q3	Total	Percent
CPT	99285	Emergency department visit for life threatening or functioning severity	3,715	18,895	22,610	26%
CPT	99284	Emergency department visit for problem of high severity	3,396	16,482	19,878	23%
CPT	99283	Emergency department visit for problem of moderate severity	2,667	13,508	16,175	19%
CPT	99291	Critical care, first 30-74 minutes	722	2,241	2,963	3%
CPT	95941	Continuous remote monitoring of nervous system during operation, each hour	258	1,956	2,214	3%
CPT	74177	CT scan of abdomen and pelvis with contrast	870	1,152	2,022	2%
CPT	85025	Complete blood cell count (red cells, white blood cell, platelets), automated test and automated differential white blood cell count	392	1,584	1,976	2%
CPT	71045	X-ray of chest, 1 view	898	1,001	1,899	2%
CPT	71046	X-ray of chest, 2 views	689	959	1,648	2%
CPT	70450	CT scan head or brain without contrast	670	883	1,553	2%
CPT	95938	Placement of skin electrodes and measurement of stimulated sites on arms and legs	260	1279	1,539	2%
CPT	93010	Routine ECGs using at least 12 leads with interpretation and report only	597	908	1,505	2%
CPT	74176	CT scan of abdomen and pelvis without contrast	482	841	1,323	2%
CPT	80053	Blood test, comprehensive group of blood chemicals	221	953	1,174	1%

Code Type	Service Code	Description of Item or Service	2022 Q2	2022 Q3	Total	Percent
Revenue[53]	0450	Emergency room, general	473	678	1,151	1%
CPT	96374	Injection of drug or substance into vein	241	884	1,125	1%
CPT	81003	Automated urinalysis test	222	836	1,058	1%
CPT	77067	Screening mammography	449	536	985	1%
CPT	71275	CT scan of blood vessels of chest with contrast	451	495	946	1%
CPT	99282	Emergency department visit for problem of mild to moderate severity	368	578	946	1%
HCPCS	J1885	Injection, ketorolac tromethamine, per 15 mg	189	714	903	1%
CPT	77063	Screening 3D breast mammography	422	480	902	1%
CPT	93005	Routine ECGs using at least 12 leads with tracing	205	692	897	1%
CPT	95939	Placement of skin electrodes and measurement of central motor stimulation in arms and legs	129	766	895	1%
CPT	0202U	Test for detection of respiratory disease-causing organisms from back of nose and throat (nasopharynx) specimen, 22 target organisms including severe acute respiratory syndrome coronavirus 2	193	701	894	1%
CPT	96372	Injection of drug or substance under skin or into muscle	236	643	879	1%
CPT	96375	Injection of additional new drug or substance into vein	159	708	867	1%
HCPCS	J7030	Infusion, normal saline solution, 1000 cc	163	694	857	1%
CPT	76705	Limited ultrasound scan of abdomen	383	466	849	1%
CPT	96361	Infusion into a vein for hydration, each additional hour	165	663	828	1%
CPT	95937	Testing of nerve-muscle junction	163	663	826	1%
HCPCS	J2405	Injection, ondansetron hydrochloride, per 1 mg	131	568	699	1%
CPT	87426	Detection test by immunoassay technique for severe acute respiratory syndrome coronavirus	248	449	697	1%
CPT	87880	Detection test by immunoassay with direct visual observation for Streptococcus, group A (strep)	222	462	684	1%
CPT	72125	CT scan of upper spine without contrast	282	368	650	1%
CPT	84484	Troponin (protein) analysis, quantitative	139	511	650	1%

[53] The Departments do not consider revenue codes to be service codes but rather service code modifiers. As stated in the preamble to the interim final rules that appeared in the July 13, 2021 Federal Register, Requirements Related to Surprise Billing; Part I (July 2021 interim final rules), revenue codes are modifiers to service codes and indicate the department or place in the hospital where a procedure or treatment was performed. Qualified IDR items or services with different service codes (regardless of their revenue codes) may not be batched. Batched disputes where the initiating party submitted revenue codes as service codes were considered incorrectly batched.

Code Type	Service Code	Description of Item or Service	2022 Q2	2022 Q3	Total	Percent
CPT	74018	X-ray of abdomen, 1 view	296	318	614	1%
CPT	36415	Insertion of needle into vein for collection of blood sample	68	538	606	1%
HCPCS	J8499	Prescription drug, oral, non chemotherapeutic, nos	117	465	582	1%
CPT	93042	ECG 1 to 3 leads with review by physician only	231	351	582	1%
CPT	82150	Amylase (enzyme) level	96	465	561	1%
HCPCS	G0453	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)	43	507	550	1%
HCPCS	Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	140	394	534	1%
CPT	76830	Ultrasound scan of uterus, ovaries, tubes, cervix and pelvic area through vagina	253	276	529	1%
CPT	71260	CT scan of chest with contrast	238	288	526	1%
CPT	95861	Needle measurement of electrical activity in arm or leg muscles, 2 extremities	62	444	506	1%
CPT	76856	Complete ultrasound scan of pelvis	231	274	505	1%
CPT	82977	Glutamyltransferase (liver enzyme) level	88	413	501	1%
CPT	82040	Albumin (protein) level	87	404	491	1%
CPT	82247	Bilirubin level, total	89	399	488	1%

Source: Notices of IDR Initiation submitted to the Federal IDR portal, April 15 – September 30.
Notes: The sum of percent of disputes may be greater than 100% because some incorrectly batched disputes include several different types of CPT codes. For example, some disputes included all service codes from a single patient visit. If a dispute is incorrectly batched, the certified IDR entity selects one service code to continue through the Federal IDR process and asks the party to re-submit the other service codes as separate disputes.

OON Air Ambulance Services

The NSA prohibits OON air ambulance service providers from balance billing an individual for covered air ambulance services. OON air ambulance service providers cannot balance bill for the following air ambulance services, including medical supplies and services provided in transport:

- Medical transport by helicopter ("rotary wing" ambulance); and
- Medical transport by airplane ("fixed wing" ambulance).

Volume of Disputes for Air Ambulance Services

From April 15 – September 30, 2022, disputing parties initiated 3,271 disputes for air ambulance services through the Federal IDR portal. Disputing parties initiated 698 disputes in the second calendar quarter (April 15 – June 30, 2022)[54] and 2,574 disputes in the third calendar quarter (July 1 – September 30, 2022), nearly four times more than in the prior quarter.[55]

The vast majority of these disputes were submitted by an OON provider of air ambulance services, and the remaining were initiated by a group health plan, health insurance carrier, or FEHB carrier (<1%).[56]

Disputing Parties for Air Ambulance Services

More than 50 unique initiating parties or their representatives submitted disputes involving OON air ambulance services from April 15 – September 30, 2022.[57] The top 10 parties represent about 91% of all disputes involving OON air ambulance services. Many of these parties are air ambulance providers that serve communities across several states. The top party (Global Medical Response) represents 39% of all disputes initiated for OON air ambulance services from April 15 – September 30, 2022. Table 11 shows the top 10 initiating parties or their representatives for disputes involving OON air ambulance services.

[54] See *supra* note 41.
[55] See *supra* note 18.
[56] See *supra* note 20.
[57] See *supra* note 44.

Table 11: Top 10 Initiating Parties or their Representatives for Air Ambulance Disputes, April 15 – September 30, 2022

Initiating Party or their Representative	2022 Q2	2022 Q3	Total	Percent of All Air Ambulance Disputes
Global Medical Response	273	1,006	1,279	39%
Air Methods	157	426	583	18%
PHI Air Medical	94	457	551	17%
Apollo MedFlight	16	137	153	5%
Life Flight Network	21	82	103	3%
Health Services	25	67	92	3%
UPMC	30	47	77	2%
Classic Air Care	2	65	67	2%
HealthNet Aeromedical	8	49	57	2%
Airlift Northwest	4	44	48	1%

Source: Notices of IDR Initiation submitted to the Federal IDR portal, April 15 – September 30, 2022.
Notes: Parties and their representatives were identified and aggregated by the email domain of the initiating party on the Notice of IDR Initiation.

More than 150 unique non-initiating parties or their representatives were parties to disputes involving OON air ambulance services from April 15 – September 2022.[58] Many of the top parties were health insurance issuers, group health plans, or FEHB carriers that operate across multiple states and market segments; third-party administrators that represent several group health plans across multiple states; or vendors who provide administrative services to issuers and group health plans. The top party, Aetna, represented 17% of all disputes for OON air ambulance services. Table 12 shows the top 10 non-initiating parties or their representatives for disputes involving OON air ambulance services, for disputes initiated from April 15 – September 30, 2022.

[58] See *supra* note 45.

Table 12: Top 10 Non-Initiating Parties or their Representatives for Air Ambulance Disputes, April 15 – September 30, 2022

Non-Initiating Party or their Representative	2022 Q2	2022 Q3	Total	Percentage of All Air Ambulance Disputes
Aetna	216	352	568	17%
Zelis	88	335	423	13%
Centene	48	204	252	8%
United Healthcare	42	171	213	6%
Kaiser Permanente	2	201	203	6%
BlueCross BlueShield of Illinois	43	150	193	6%
MultiPlan	31	129	160	5%
Cigna	29	54	83	3%
Highmark	18	52	70	2%
Clear Health Strategies	1	63	64	2%

Source: Notices of IDR Initiation submitted to the Federal IDR portal, April 15 – September 30, 2022.
Notes: Parties and their representatives were identified and aggregated by the email domain of the non-initiating party on the Notice of IDR Initiation.

Contested Dispute Eligibility for Air Ambulance Services

Non-initiating parties or their representatives challenged eligibility for the Federal IDR process in 1,297 OON air ambulance disputes, approximately 40% of those initiated. Of the 286 air ambulance disputes that were closed by September 30, 2022, and had eligibility challenged by the non-initiating party, 188 disputes (66%) were ultimately found ineligible for the Federal IDR process.[59]

Closed Disputes for Air Ambulance Services

913 air ambulance disputes were closed from April 15 – September 30, 2022. Certified IDR entities reached a payment determination in 237 air ambulance disputes (26% of closed disputes) during this period and found 410 air ambulance disputes (45% of closed disputes) ineligible for the Federal IDR process. Compared to emergency and non-emergency services, disputed air ambulance services were more likely to reach a payment determination and fewer were found to be ineligible for the Federal IDR process. This may be in part because determining Federal vs. state jurisdiction is more straightforward, as air ambulance services are subject to the Federal IDR process in almost all states. The remaining closed disputes were either withdrawn by the disputing parties, or were closed because the parties reached an outside settlement or for other

[59] 410 disputes for air ambulance services were found ineligible from April 15 - September 30, 2022. This includes 188 disputes where eligibility was contested by the non-initiating party during certified IDR entity selection and an additional 222 disputes where the non-initiating party did not contest eligibility but the certified IDR entity nevertheless found the dispute to be ineligible. For example, certified IDR entities found disputes that were filed untimely ineligible.

reasons including incorrect batching, data entry errors, or unpaid fees. Table 13 shows the reasons for closure of air ambulance disputes from April 15 – September 30, 2022.

Table 13: Reasons for Closure of Air Ambulance Disputes, April 15 – September 30, 2022

Closure Reason	2022 Q2	2022 Q3	Overall
Payment Determinations Reached	46	191	237
Found Ineligible	22	388	410
Other	47	219	266
Total Closed Disputes	115	798	913

Source: Data from the Federal IDR portal was analyzed as of October 31, 2022.
Notes: This table reflects disputes closed in the Federal IDR portal by the end of 2022 Q2 (June 30, 2022) and 2022 Q3 (September 30, 2022). There may be some lag between when certified IDR entities send a determination notice to parties and when they update a dispute to closed status in the Federal IDR portal.

Types of Air Ambulance Services

Approximately 80% of air ambulance disputes involved medical transport by helicopter (rotary wing), while 11% of air ambulance disputes involved medical transport by airplane (fixed wing). Air ambulance disputes also included codes for services provided in transport, such as oxygen supplies, ECGs, blood transfusions, or injections of drugs. Table 14 shows the unique service codes submitted on air ambulance disputes, the number of disputes involving each code, and the percent of air ambulance disputes involving each code for April 15 – September 30, 2022.

Table 14: OON Air Ambulance Service Codes, April 15 – September 30, 2022

Code Type	Service Code	Description of Item or Service	2022 Q2	2022 Q3	Total	Percent
HCPCS	A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	632	1,999	2,631	80%
HCPCS	A0436	Rotary wing air mileage, per statute mile	622	1,993	2,615	80%
HCPCS	A0398	ALS routine disposable supplies	113	245	358	11%
HCPCS	A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	56	299	355	11%
HCPCS	A0435	Fixed wing air mileage, per statute mile	54	292	346	11%
HCPCS	A0422	Ambulance (advanced life support or basic life support) oxygen and oxygen supplies, life sustaining situation	76	162	238	7%
CPT	93041	ECG 1 to 3 leads	67	170	237	7%
HCPCS	A0420	Ambulance waiting time (advanced life support or basic life support), one half (1/2) hour increments	61	120	181	6%
CPT	96374	Injection of drug or substance into vein	34	81	115	4%
CPT	94002	Initial hospital inpatient or observation ventilation assistance and management	37	63	100	3%
HCPCS	J3010	Injection, fentanyl citrate, 0.1 mg	26	50	76	2%
CPT	82962	Blood glucose (sugar) test performed by hand-held instrument	25	51	76	2%
HCPCS	J3490	Unclassified drugs	15	34	49	1%

Code Type	Service Code	Description of Item or Service	2022 Q2	2022 Q3	Total	Percent
CPT	96375	Injection of additional new drug or substance into vein	15	30	45	1%
Revenue[60]	0545	Ambulance, air	0	43	43	1%
CPT	96379	Injection or infusion into a vein or artery for therapy, prevention, or diagnosis	14	29	43	1%
HCPCS	J2405	Injection, ondansetron hydrochloride, per 1 mg	5	25	30	1%
HCPCS	J2250	Injection, midazolam hydrochloride, per 1 mg	7	15	22	1%
CPT	36430	Transfusion of blood or blood products	7	13	20	1%
HCPCS	A0394	ALS specialized service disposable supplies; iv drug therapy	2	15	17	1%
CPT	93005	Routine ECG using at least 12 leads with tracing	6	6	12	<1%
HCPCS	J7030	Infusion, normal saline solution, 1000 cc	4	5	9	<1%
HCPCS	J2060	Injection, lorazepam, 2 mg	0	7	7	<1%
HCPCS	J2270	Injection, morphine sulfate, up to 10 mg	2	5	7	<1%
CPT	94760	Test to measure oxygen level in blood using ear or finger device	0	7	7	<1%
HCPCS	A0999	Unlisted ambulance service	1	5	6	<1%
CPT	36680	Insertion of needle for infusion into bone	4	2	6	<1%
HCPCS	A0424	Extra ambulance attendant, ground (ALS or bls) or air (fixed or rotary winged); (requires medical review)	0	5	5	<1%
HCPCS	A0434	Specialty care transport (sct)	0	6	6	<1%
HCPCS	A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)	0	6	6	<1%
HCPCS	J7120	Ringers lactate infusion, up to 1000 cc	3	0	3	<1%
HCPCS	J7040	Infusion, normal saline solution, sterile (500 ml = 1 unit)	0	3	3	<1%
CPT	36620	Insertion of artery tube for blood sampling or infusion through skin	0	3	3	<1%
CPT	99283	Emergency department visit for problem of moderate severity	1	0	1	<1%
HCPCS	J0171	Injection, adrenalin, epinephrine, 0.1 mg	0	2	2	<1%
Revenue[61]	0436	Reserved occupational therapy	2	0	2	<1%
HCPCS	J2001	Injection, lidocaine hcl for intravenous infusion, 10 mg	0	2	2	<1%
CPT	99284	Emergency department visit for problem of high severity	1	0	1	<1%

Source: Notices of IDR Initiation submitted to the Federal IDR portal, April 15 – September 30, 2022
Notes: The sum of percent of disputes is greater than 100% because some incorrectly batched disputes included several different service codes. For example, many air ambulance disputes were submitted with codes for both transport and mileage.

[60] See *supra* note 53.
[61] *Id.*

Administrative Fees and Expenditures

The NSA directed the Departments to establish a single Federal IDR process jointly. The Requirements Related to Surprise Billing; Part II interim final rules establish the parameters governing the administrative fees that certified IDR entities collect from the parties. Under these rules, each party must pay an administrative fee for participating in the Federal IDR process.[62] The administrative fee is paid by each party to the certified IDR entity and subsequently remitted to the Departments. The administrative fee is established annually in a manner such that the total administrative fees collected for a year are estimated to be equal to the amount of expenditures estimated to be made by the Departments to carry out the Federal IDR process for that year.[63] The Secretary of HHS is responsible for collecting administrative fees on behalf of the Departments.

Table 15: Federal IDR Process Expenditures and Administrative Fees

Federal IDR Process Expenditures and Administrative Fees	**2022 Q2**	**2022 Q3**
Federal agency expenditures to implement and carry out[64] the Federal IDR process for disputes involving OON emergency or non-emergency items and services and OON air ambulance services	$3,429,003	$4,903,290
Total administrative fees collected by HHS for disputes involving OON emergency or non-emergency items and services[65]	$0	$76,850
Total administrative fees collected by HHS for disputes involving OON air ambulance services[66]	$0	$11,900
Total administrative fees collected by HHS for all disputes[67]	$0	$88,750

[62] 26 CFR 54.9816-8T(d)(2)(i), 29 CFR 2590.716-8(d)(2)(i) and 45 CFR 149.510(d)(2)(i).
[63] 26 CFR 54.9816-8T(d)(2)(ii), 29 CFR 2590.716-8(d)(2)(ii) and 45 CFR 149.510(d)(2)(ii).
[64] As described further in the section below titled "Federal Agency Expenditures for Disputes Involving OON Emergency or Non-Emergency Items and Services and OON Air Ambulance Services," these expenditures for 2022 Q2 and Q3 include costs associated with initial implementation of the Federal IDR process (implementation costs) and costs associated with carrying out daily activities necessary for processing payment disputes (ongoing costs).
[65] Current Federal IDR administrative fee collection by HHS is not an accurate representation of administrative fees paid by parties, because the certified IDR entity does not report to HHS that administrative fees have been paid until after a payment determination is made and the dispute is closed. HHS invoices the certified IDR entities on a monthly basis for administrative fees once the certified IDR entity identifies to HHS that administrative fees have been paid. Due to the limited reporting period captured by this report, few disputes were fully processed and closed, which would trigger HHS invoicing. Additionally, because disputes can be closed prior to the certified IDR entity collecting administrative fees from both parties, some disputes that are initiated will not necessarily result in full payment of administrative fees to HHS. This most commonly occurs when a dispute is deemed ineligible for the Federal IDR process.
[66] *Id.*
[67] *Id.*

Federal Agency Expenditures for Disputes Involving OON Emergency or Non-Emergency Items and Services and OON Air Ambulance Services

Overall, to implement and carry out the Federal IDR process for OON emergency or non-emergency items and services and OON air ambulance services, the Secretary of HHS[68] expended $3,429,003 in 2022 Q2 and $4,903,290 in 2022 Q3. These expenditures for 2022 Q2 and Q3 include costs associated with initial implementation of the Federal IDR process (implementation costs) and costs associated with carrying out daily activities necessary for processing payment disputes (ongoing costs).

Implementation costs include costs associated with initial construction, development, and testing of the electronic platform that hosts the Federal IDR portal; subsequent increases in the functionality of the Federal IDR portal to improve the efficiency of the Federal IDR process; initial stakeholder trainings; development of certified IDR entity reporting capabilities; and HHS accounting system modifications and testing to accommodate NSA administrative fee payment requirements.

Ongoing costs associated with the Federal IDR process generally include those costs to carry out and support the daily activities of the Federal IDR process, including maintenance of the Federal IDR portal and related systems; reporting processes; IDR entity certification; case intake and management; software licenses; handling IDR-related complaints; and ongoing stakeholder support. The administrative fee is designed to recoup ongoing costs of the Federal IDR process.

Administrative Fees for Disputes Involving OON Emergency or Non-Emergency Items and Services

The total amount of Federal IDR administrative fees collected by the Secretary of HHS for disputes involving OON emergency or non-emergency items and services was $0 in 2022 Q2 and was $76,850 in 2022 Q3.[69] These dollar figures encompass administrative fees collected by HHS in 2022 Q2 and Q3 for disputes involving OON emergency or non-emergency items and services and exclude administrative fees related to disputes that were initiated in 2022 Q2 and Q3 and are not yet invoiced or paid (that is, these dollar figures exclude fees that have not yet been collected by HHS). Because disputes can be closed prior to the certified IDR entity collecting administrative fees from both parties, some disputes that are initiated will not necessarily result in full payment of administrative fees to HHS. This most commonly occurs when a dispute is deemed ineligible for the Federal IDR process.

Administrative Fees for Disputes Involving OON Air Ambulance Services

The total amount of Federal IDR administrative fees collected by the Secretary of HHS for disputes involving OON air ambulance services was $0 in 2022 Q2 and was $11,900 in 2022 Q3.[70] These dollar figures encompass administrative fees collected by HHS in 2022 Q2 and Q3 for disputes involving OON air ambulance services and exclude administrative fees related to

[68] The NSA directed that the Departments jointly establish one Federal IDR process. The Secretary of HHS has taken the lead in operationalizing the Federal IDR portal on behalf of the Departments. Because of this role, this total reflects all Department expenditures related to this category.
[69] See *supra* note 65.
[70] See *supra* note 65.

disputes that were initiated in 2022 Q2 and Q3 and are not yet invoiced or paid (that is, these dollar figures exclude fees that have not yet been collected by HHS). Because disputes can be closed prior to the certified IDR entity collecting administrative fees from both parties, some disputes that are initiated will not necessarily result in full payment of administrative fees to HHS. This most commonly occurs when a dispute is deemed ineligible for the Federal IDR process.

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Initial Report on the
Independent Dispute Resolution (IDR) Process
April 15 – September 30, 2022

EXHIBIT 6

HEALTH

This report is part of the RAND Corporation research report series. RAND reports present research findings and objective analysis that address the challenges facing the public and private sectors. All RAND reports undergo rigorous peer review to ensure high standards for research quality and objectivity.

RESEARCH REPORT

The Evolving Role of Emergency Departments in the United States

Kristy Gonzalez Morganti • *Sebastian Bauhoff* • *Janice C. Blanchard*

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HEALTH

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Preface

This project was performed to develop a more complete picture of how emergency departments (EDs) contribute to the U.S. health care system. Using a mix of quantitative and qualitative methods, it explores the evolving role that hospital EDs and the personnel who staff them play in evaluating and managing complex and high-acuity patients, serving as the major portal of entry to inpatient care, and serving as "the safety net of the safety net" for patients who are unable to get care elsewhere.

This work was sponsored by the Emergency Medicine Action Fund, a consortium of emergency medicine physician organizations sponsored by the American College of Emergency Physicians. The research was conducted by RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of publications, and ordering information can be found at www.rand.org/health.

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Executive Summary

Emergency departments (EDs) emerged with the rise of hospital-based medicine in the aftermath of World War II. Today, they play a pivotal role in the delivery of acute ambulatory and inpatient care. As our health care system evolves in response to economic, clinical, and political pressures, the role of EDs is evolving as well.

Because EDs charge higher prices for minor illness and injury care than other ambulatory care settings, ED care is frequently characterized as "the most expensive care there is." But this depiction ignores the many roles that EDs fill, and the statutory obligation of hospital EDs to provide care to all in need without regard for their ability to pay. To develop a more complete picture of how EDs contribute to our modern health care system, the Emergency Medicine Action Fund asked RAND to conduct this mixed-methods study.

At the outset of our effort, we reviewed recently published literature regarding ED use and used it to craft a conceptual model that depicts the various choices ED patients and providers make over the course of an episode of care. To quantify the importance of EDs as a major portal of entry to inpatient care, we analyzed four datasets compiled and maintained by the U.S. Department of Health and Human Services. Given a growing focus at the national and state levels on preventing non-urgent patients from seeking care in EDs, we analyzed data from the Community Tracking Study, a decade-long effort that describes changing patterns of health care utilization and delivery in 60 communities nationwide. To add context to the quantitative observations derived from these analyses, we conducted three focus groups with emergency medicine and hospitalist physicians, and interviewed 16 practicing primary care physicians who work in a variety of communities.

Key findings include the following:

- Between 2003 and 2009, inpatient admissions to U.S. hospitals grew at a slower rate than the population overall. However, nearly all of the growth in admissions was due to a 17 percent increase in unscheduled inpatient admissions from EDs. This growth in ED admissions more than offset a 10 percent decrease in admissions from doctors' offices and other outpatient settings. This pattern suggests that office-based physicians are directing to EDs some of the patients they previously admitted to the hospital.
- In addition to serving as an increasingly important portal of hospital admissions, EDs support primary care practices by performing complex diagnostic workups and handling overflow, after-hours, and weekend demand for care. Almost all of the physicians we interviewed—specialist and primary care alike—confirmed that office-based physicians increasingly rely on EDs to evaluate complex patients with potentially serious problems, rather than managing these patient themselves.
- As a result of these shifts in practice, emergency physicians are increasingly serving as the major decisionmaker for approximately half of all hospital admissions in the United States. This role has important financial implications, not only because admissions

generate the bulk of facility revenue for hospitals, but also because inpatient care accounts for 31 percent of national health care spending.

- Although the core role of EDs is to evaluate and stabilize seriously ill and injured patients, the vast majority of patients who seek care in an ED walk in the front door and leave the same way. Data from the Community Tracking Study indicate that most ambulatory patients do not use EDs for the sake of convenience. Rather, they seek care in EDs because they perceive no viable alternative exists, or because a health care provider sent them there.
- Medicare accounts for more inpatient admissions from EDs than any other payer. To gain insight into whether care coordination makes a difference in the likelihood of hospital admission from an ED, we compared ED admission rates among Medicare beneficiaries enrolled in a Medicare Choice plan versus beneficiaries enrolled in Medicare fee-for-service (FFS). We found no clear effect on inpatient admissions overall, or on a subset of admissions involving conditions that might be considered "judgment calls."
- Irrespective of the impact of care coordination, EDs may be playing a constructive role in constraining the growth of inpatient admissions. Although the number of non-elective ED admissions has increased substantially over the past decade, inpatient admissions of ED patients with "potentially preventable admissions" (as defined by the Agency for Healthcare Research and Quality) are flat over this time interval.

Our study indicates that: (1) EDs have become an important source of admissions for American hospitals; (2) EDs are being used with increasing frequency to conduct complex diagnostic workups of patients with worrisome symptoms; (3) Despite recent efforts to strengthen primary care, the principal reason patients visit EDs for non-emergent outpatient care is lack of timely options elsewhere; and (4) EDs may be playing a constructive role in preventing some hospital admissions, particularly those involving patients with an ambulatory care sensitive condition. Policymakers, third party payers, and the public should be aware of the various ways EDs meet the health care needs of the communities they serve and support the efforts of ED providers to more effectively integrate ED operations into both inpatient and outpatient care.

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Numerous individuals and organizations provided source material or substantive assistance to this report. Our quantitative analysis used data from several sources, including the Agency for Healthcare Research and Quality, the Center for Studying Health Systems Change and the Inter-university Consortium for Political and Social Research and the National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC). Several organizations allowed us to recruit from their memberships for focus groups. These include: the American College of Emergency Physicians (ACEP), the Society for Academic Emergency Medicine, The Patient Centered Primary Care Collaborative, and the Society for Hospital Medicine. Several individuals were particularly helpful to the recruiting effort: Susan Spradlin, Buck Beighley, and Peggy Brock (ACEP); Amy Gibson, Michelle Shaljian, Dr. Paul Grundy, Marci Nielsen, and Deborah Felsenthal (The Patient Centered Primary Care Collaborative), Dr. Joe Stubbs, former President of the American College of Physicians, and Dr. Todd Von Deak, Dr. Mark Williams, and Dr. Larry Wellikson (Society for Hospital Medicine). Finally, we are particularly grateful for the outstanding technical advice and analytical assistance we received from Ryan Mutter of the Agency for Healthcare Research and Quality, and the thoughtful comments and suggestions of Andrew Mulcahy and Lori Uscher-Pines of the RAND Corporation and Stephen R. Pitts of Emory University.

Abbreviations

ACEP	American College of Emergency Physicians
ACO	Accountable Care Organization
ACS	Ambulatory Care Sensitive
AHRQ	Agency for Healthcare Research and Quality
CCS	Clinical Classifications Software
CDC	Center for Disease Control and Prevention
CHIP	Children's Health Insurance Program
COPD	chronic obstructive pulmonary disease
CT	computerized tomographic
CTS	Community Tracking Study
ED	Emergency Department
EMAF	Emergency Medicine Action Fund
EMR	Electronic Medical Record
EMTALA	Emergency Medical Treatment and Labor Act
ER	Emergency Room
FFS	Fee-for-Service
GDP	Gross Domestic Product
HCUP	Healthcare Cost and Utilization Project
HMO	Health Maintenance Organization
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICU	Intensive Care Unit
IT	Information Technology
NEDS	Nationwide Emergency Department Sample
NHDS	National Hospital Discharge Survey
NCHS	National Center for Health Statistics
NIS	Nationwide Inpatient Sample
PCP	Primary Care Physician
PPO	Preferred Provider Organization
PQI	Prevention Quality Indicators
SEDD	State Emergency Department Database
SID	State Inpatient Database

1. Introduction

This report examines the evolving role of hospital emergency departments (EDs) in the U.S. health care system. RAND conducted the study at the request of the Emergency Medicine Action Fund to develop a comprehensive picture of how EDs contribute to modern health care and to suggest how ED care might be more effectively, and more cost-effectively, integrated with community care.

Trends Affecting the Evolution of Hospital EDs

The hospital ED is a relatively recent phenomenon that emerged in the years following World War II (A. L. Kellermann & Martinez, 2011). Beginning in the early 1970s and accelerating through the 1980s and 1990s, ED staffing shifted from part-time coverage by community physicians, rotating house officers, or moonlighters to full-time, around-the-clock coverage by residency-trained, board-certified emergency physicians (IOM, 2007). The highly specialized knowledge and skills these doctors possess have allowed hospital EDs to dramatically expand their capability to diagnose and manage a wide range of problems, from resuscitating critically ill and injured children and adults to managing complex patients with chronic diseases such as HIV–AIDS, cancer, renal failure, and diabetes. The enhanced capability to manage complex and time-critical problems has also given ED staff more options to diagnose and manage problems without resorting to hospital admission.

Overall Growth in Health Care Spending.

The evolving role of EDs in America's health care system must be viewed against the backdrop of a seemingly relentless rise in the rate of health care cost growth. For most of the past 60 years, U.S. health care spending outgrew gross domestic product (GDP) by an average of 2–2.3 percentage points per year (Fuchs, 2012). In 1990, the United States spent 12 percent of GDP, roughly $724 billion, on health care. In 2010, health care devoured 17.9 percent of GDP, $2.6 trillion (Center for Medicare and Medicaid Services, 2012). Spending growth has slowed since 2009 (Davis, 2011), but experts debate whether this reflects changes in health care delivery or a sluggish recovery from the recession that began the previous year.

Health care has grown so expensive that it is threatening the viability of employer-sponsored health insurance (Kaiser Family Foundation, 2012) and the solvency of the Medicare program. (Ginsburg, 2008). States have less money for education and other important priorities (Pew Center on the States, 2012). Between 1999 and 2009, health care cost growth wiped out the income gains of middle class families (Auerbach & Kellermann, 2011).

Spending growth is the top concern of policymakers; however, despite the fact that hospital ED use has increased, the ED contribution to spending growth is small. ED care is widely characterized as the most expensive care there is, but the real issue for EDs—one misunderstood by policymakers—is not the cost of non-urgent use. Rather, it is the growing role that EDs play as gateways to inpatient treatment, which accounts for 31 percent of health care spending.

Growing Use of Hospital EDs

Between 2001 and 2008, use of hospital EDs grew at roughly twice the rate of population growth (Kharbanda et al., 2013). During the same period, hospitals closed about 198,000 beds. With more patients seeking care and fewer inpatient beds available for those who need one, EDs grew crowded with admitted patients who could not be transitioned to inpatient care. (Kellermann, 2006).

Practice intensity has also increased in EDs, in part because EDs are treating older and sicker patients, and in part because emergency physicians are bringing more sophisticated and costly technology, such as more aggressive use of computerized tomographic (CT) scanning and other diagnostic tests, to bear in managing their patients' problems. In 2012, Pitts and colleagues noted that "EDs have become a central staging area for acutely ill patients, for the use of diagnostic technology, and for decisions about hospital admission, all of which makes ED care increasingly complex" (Pitts, Pines, Handrigan, & Kellermann, 2012). The combined effects of steady growth of ED visits, more-intensive workups, and fewer inpatient beds have extended ED lengths of stay, dramatically increasing the number of patients in hospital EDs at any hour of the day (Pitts et al., 2012). The crowding that results compromises patient safety and can worsen patient outcomes (Bernstein et al., 2009).

The increase in practice intensity also generated higher charges. Although emergency medicine's contribution to aggregate physician charges in the United States is relatively small, a team of Harvard analysts determined that emergency medicine has boosted its Medicare charges relative to its 2002 baseline faster than almost every other specialty, ranking second only to radiation oncology (Alhassani, Chandra, & Chernew, 2012).

Basic issues of access are key determinants of ED use. EDs are the only place in the U.S. health care system where the poor cannot be turned away. As a result, they are disproportionately used by low-income and uninsured patients who cannot reliably get care in other settings. In fact, the 4 percent of doctors who staff America's EDs manage 28 percent of all acute care visits in the United States, half of all the acute care provided to Medicaid and Children's Health Insurance Program (CHIP) beneficiaries, and two-thirds of the acute care provided to the uninsured (Pitts, Carrier, Rich, & Kellermann, 2010).

The Rising Cost of ED Care

ED charges for treatment of adults have grown dramatically. Between 2001 and 2010, physician claims for higher-paid services, particularly level 5 visits (the highest level of severity

in Medicare coding), grew from 27 percent to 48 percent of Medicare discharges (Office of Inspector General, 2012).

Politicians are fond of asserting that "emergency department care is the most expensive care there is." The numbers suggest otherwise. EDs provide 11 percent of all outpatient visits and are the portal of entry for roughly half of all hospital admissions (Pitts et al., 2010); however, they account for only 2–4 percent of total annual health care expenditures (American College of Emergency Physicians, 2012). Recently, the McKinsey Global Institute estimated that aggregate national spending on outpatient health care totaled about $850 billion in 2006 (McKinsey Global Institute, 2008). Of that, less than 10 percent ($75 billion) could be attributed to EDs, suggesting that aggregate spending for ED care is in line with its share of outpatient care delivery.

Studies of ED charges versus reimbursement have generated mixed results. Rates of reimbursement for pediatric ED visits decreased significantly from 1996 to 2003 (Hsia, MacIsaac, & Baker, 2008). Among adult patients, charges and associated payments for ED care have increased, due at least in part to the steady growth of ED visits (Pitts, Niska, Xu, & Burt, 2008).

Both inefficiencies in the health care system and legal requirements contribute to ED costs. Providers often feel obliged to repeat tests because they cannot get access to the patient's medical record. High levels of uncompensated care also figure prominently in ED costs. Because EDs are required under federal law to evaluate and stabilize all who present to the ED without regard for ability to pay, they serve as the "safety net of the safety net" for uninsured patients and Medicaid beneficiaries (Schuur & Venkatesh, 2012; Tang, Stein, Hsia, Maselli, & Gonzales, 2010). Nationwide, about 55 percent of emergency services are uncompensated (American College of Emergency Physicians, 2012).

Efforts to Discourage Non-Urgent Use of EDs

Cognizant of the high charges associated with ED visits, health plans and government are taking increasingly aggressive action to discourage non-urgent ED visits (Baker, 1994; Washington, Stevens, Shekelle, Henneman, & Brook, 2002). Arguing that such visits can be readily managed in less costly settings, policymakers and third-party payers have considered a variety of strategies to steer patients away from EDs and to deny payment for non-urgent ED visits (Cutler, 2010). Shifting ED patients to less expensive outpatient or office-based care is appealing in concept, but difficult to accomplish in practice (Florence, 2005). There is no standard definition of non-urgent care. In addition, it is notoriously difficult to determine at ER triage which patients are really sick and which are not (A. L. W. Kellermann, R. M., 2012). Raven and colleagues, analyzing data from the National Hospital Ambulatory Medical Care Survey-ED subsample, determined that many patients with the same presenting complaint as those who were felt to be inappropriate ED visitors were found to require immediate emergency care or hospital admission (Raven, Lowe, Maselli, & Hsia, 2013).

Timeliness also plays a role in ED use. Research teams that have asked patients why they sought treatment in EDs for non-urgent conditions found that the primary motivator is lack of options, not lack of judgment (J. Billings, Parikh, & Mijanovich, 2000; J. Billings, Parikh, N., Mijanovich, T.,, 2000; Delia & Cantor, 2009; Goodell, 2009; A. L. W. Kellermann, R. M., 2012; Taylor, 2006; Young, Wagner, Kellermann, Ellis, & Bouley, 1996)). Indeed, a major driver of ED use is lack of access to primary care. When Americans develop an acute health problem, they see their primary care provider less than half the time, especially when the symptoms involve a potentially serious problem, such as chest or abdominal pain, headache, shortness of breath, or other potentially serious problems (Pitts et al., 2010). A survey by the Centers for Disease Control and Prevention (CDC) conducted in 2011 showed that about 80 percent of adults who visited an ED did so because they lacked access to other providers. Nearly half reported "the doctor's office was not open" as the reason for their most recent ED visit (CDC, 2012).

EDs as Entry Points to Inpatient Care

Little thought has been given to the growing role that EDs play as gateways to inpatient treatment, which accounts for one-third of health care spending. Between 1993 and 2006, hospital admissions from the ED grew by 50 percent (from 11.5 million to 17.3 million). As a result, the share of inpatient stays that originated in the ED increased from 34 percent to 44 percent (Schuur & Venkatesh, 2012).

Although EDs are essential to hospital operations, many administrators consider their ED a "loss leader" (Hsia, Kellermann, & Shen, 2011; Simonet, 2009). This perception is due, in part, to the financial burden of uncompensated care that EDs are legally required to provide, and in part to accounting practices that attribute inpatient revenues to the admitting service, rather than the department where the admission originated (Institute of Medicine, 2007).

Recently, Smulowitz, Honigman and Landon (Smulowitz, Honigman, & Landon, 2013) proposed a novel framework that classifies ED visits into broad categories of severity and seeks to focus the attention of policymakers and health system managers on ED visits that present the most potential for improving outcomes while simultaneously reducing costs. The approach they devised suggests that the current focus on diverting low-acuity visits to less-costly sites of ambulatory care would not produce savings of the magnitude that could be achieved if EDs and their associated health systems focused on reducing preventable hospital admissions and, to a lesser extent, improving ED care of patients with what the authors term "intermediate or complex conditions." After outlining this framework, the authors proposed a variety of ways in which EDs might become more fully integrated into a health care delivery system that puts patients first.

The project described in this report was nearly finished when Smulowitz et al. published their paper; however, in many ways our study results have provided empirical support of their work.

Aims of the RAND Study

In a series of three reports published in 2006, the Institute of Medicine (IOM) examined the strengths, limitations, and future challenges of emergency care in the U.S. health system (Institute of Medicine, 2007). The IOM noted that tremendous progress has been made in the science of emergency medicine, the capabilities of emergency care providers, the development of emergency medical services (EMS), and the regionalization of trauma care. It also noted that hospital-based emergency care has grown so overburdened, it has reached "the breaking point" (Institute of Medicine, 2007).

With the exception of the IOM, few independent groups have examined the various roles that EDs play, the challenges they face, and the contributions they make to the functioning of our nation's health care system. This information gap makes it difficult to understand how EDs should be integrated into community-based care.

The overarching goal of our work was to help fill this information gap. Our study had five specific aims:

1. *Quantify and contrast the number and percentage of hospital admission decisions made by ED physicians compared with those of primary care physicians (PCPs) and other office-based specialists.* We hypothesized that the percentage of admissions entering the hospital through the ED has grown relative to the number of patients directly admitted from their physician's office.
2. *Quantify the proportion of non-elective admissions that enter hospitals through the ED versus direct admissions from physicians' offices and other primary care settings*. We hypothesized that the proportion of hospital admissions that is non-elective has increased and that this increase is being driven by admissions entering via the ED.[1]
3. *Determine the frequency and reasons why office-based physicians refer patients to the ED for evaluation and, if required, hospitalization, rather than directly admitting the patient themselves.* We hypothesized that office-based physicians are increasingly using the ED for evaluating and admitting non-elective patients.
4. *Determine ED admission rates by type of health care insurance for various sub-populations of interest.* We hypothesized that the number and rate of ED admissions (as a percentage of total ED visits by payer group) is growing more quickly among Medicare beneficiaries and privately insured patients than among Medicaid beneficiaries and the uninsured. Furthermore, we hypothesized that patients enrolled in a health plan that offers care coordination are less likely to be hospitalized than otherwise comparable patients who are covered by a fee-for-service (FFS) plan.
5. *Determine if EDs are playing a role in reducing preventable hospital admissions and readmissions of patients with ambulatory care sensitive (ACS) conditions* (e.g., asthma,

[1] Non-elective admissions are urgent/emergent hospitalizations dictated by the patient's medical condition and their treating physician's determination that hospitalization is required to address the problem. Generally speaking, they cannot be postponed. Elective admissions are chosen by the patient or their physician for reasons that are perceived to be beneficial to the patient, but are not urgent.

diabetes, heart failure, other chronic health conditions). We hypothesized that although ED use by patients with ACS conditions is growing, the number of hospitalizations involving these same clinical conditions is either flat or rising at a slower rate. If true, this may indicate that EDs are playing a constructive role in reducing preventable hospital admissions.

Organization of This Report

The discussion that follows is organized as follows. We describe our conceptual model of ED use (Chapter Two), methods (Chapter Three), findings (Chapter Four), and their implications (Chapter Five). We conclude by drawing conclusions for policy and practice (Chapter Six).

EXHIBIT 7

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
200 Independence Avenue SW, Mail Stop 739H
Washington, DC 20201

Center for Consumer Information & Insurance Oversight

TECHNICAL GUIDANCE NO. 2021-01

DATE: SEPTEMBER 30, 2021

SUBJECT: CALENDAR YEAR 2022 FEE GUIDANCE FOR THE FEDERAL INDEPENDENT DISPUTE RESOLUTION PROCESS UNDER THE NO SURPRISES ACT

I. Introduction

Section 9816(c) of the Internal Revenue Code (Code), section 716(c) of the Employee Retirement Income Security Act of 1974 (ERISA), and section 2799A–1(c) of the Public Health Service Act (PHS Act), as added by the No Surprises Act (NSA), direct the Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) to establish a federal independent dispute resolution (IDR) process that nonparticipating facilities, nonparticipating providers, and plans and issuers may use following the end of an open negotiation period to determine the out-of-network rate for out-of-network emergency services and certain items and services provided by nonparticipating providers at in-network facilities, when a specified state law or All-Payer Model Agreement does not apply. Code section 9817, ERISA section 717, and PHS Act section 2799A–2(b), also added by the NSA, direct the Departments to establish a similar Federal IDR process that nonparticipating providers of air ambulance services, plans, and issuers may utilize following the end of an open negotiation period to determine payment for qualified services furnished by nonparticipating providers of air ambulance services where an All-Payer Model Agreement or specified state law does not apply.[1]

The Departments issued interim final rules titled, *Requirements Related to Surprise Billing; Part II* to implement the Federal IDR process under the NSA. Under the *Requirements Related to Surprise Billing; Part II*, each party to an IDR payment determination under the Federal IDR process must pay an administrative fee for participating in the Federal IDR process at the time the certified IDR entity is selected. The administrative fee is paid by each party to the certified IDR entity and remitted to the Departments. The administrative fee is established annually in a manner so that the total administrative fees collected for a year are estimated to be equal to the amount of expenditures estimated to be made by the Departments to carry out the Federal IDR process for that year.

[1] Section 102 of the NSA amends the Federal Employees Health Benefits Program statute to require each contract with a carrier to require the carrier to comply with the provisions of these sections of the Code, ERISA, and the PHS Act. Accordingly, the Federal IDR process will be available to resolve eligible disputes involving FEHB carriers.

Additionally, under the *Requirements Related to Surprise Billing; Part II*, each party must also pay a certified IDR entity fee to the certified IDR entity at the time that party submits its offer. However, the non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the IDR services it performed. The certified IDR entity fee that was paid by the prevailing party will be returned to the prevailing party by the certified IDR entity at the conclusion of the process. In the case of batched claims,[2] the certified IDR entity may make different payment determinations for each qualified IDR item or service under dispute. In these cases, the party with fewest determinations in its favor is considered the non-prevailing party and is responsible for the certified IDR entity fee. In the event that each party prevails in an equal number of determinations, the certified IDR entity fee will be split evenly between the parties. If the parties reach a settlement before the certified IDR entity makes a payment determination, the certified IDR entity fee will be split evenly between the parties, unless the parties agree on an alternative method for allocating the certified IDR entity fee.

The interim final rules also provide that, as part of its application for certification, the IDR entity must submit to the Departments the amount of the IDR entity fees it intends to charge for payment determinations, which are limited to a specific fixed IDR entity fee amount for single determinations and a separate fixed IDR entity fee amount for batched determinations. Each of these fixed IDR entity fees must be within a range set forth in guidance by the Departments, unless the certified IDR entity receives written approval from the Departments to charge an IDR entity fee outside that range. The certified IDR entity may update its IDR entity fees and seek approval from the Departments to charge fixed IDR entity fees beyond the upper or lower limits for IDR entity fees annually.

This guidance announces the administrative fee for participating in the Federal IDR process for calendar year 2022. This guidance also announces the allowable ranges for certified IDR entity fees related to single determinations and batched determinations for calendar year 2022. Finally, this guidance describes the information that IDR entities seeking certification and certified IDR entities must provide to the Departments if they seek approval to charge certified IDR entity fees outside of the allowable ranges set by the Departments, and the process for providing that information.

II. Administrative Fee for Calendar Year 2022

The *Requirements Related to Surprise Billing; Part II* provide that the administrative fee amount will be established by the Departments in a manner so that the total administrative fees collected by the certified IDR entities and paid to the Departments during a calendar year are approximately equal to the estimated amount of expenditures by the Departments in carrying out the Federal IDR process for that calendar year. In setting the administrative fee for 2022, the Departments considered the estimated costs for the Departments to administer the Federal IDR process for the calendar year, including the staffing and contracting costs related to certification and oversight of certified IDR entities; the costs of developing and publishing reports as required

[2] Batched determinations involve multiple qualified IDR items or services that are considered jointly as part of a one payment determination by a certified IDR entity for purposes of the Federal IDR process.

under Code sections 9816 and 9817, ERISA sections 716 and 717, and PHS Act sections 2799A-1 and 2799A-2; the costs of collecting the administrative fees from certified IDR entities; and the costs of maintaining the Federal IDR portal. Based upon this review of anticipated expenditures by the Departments in carrying out the Federal IDR process for 2022, for the calendar year beginning January 1, 2022 the administrative fee due from each party for participating in the Federal IDR process is **$50**. In future years, estimated costs will be informed by the actual costs incurred by the Departments to carry out the Federal IDR process.

III. Certified IDR Entity Fee Range for Calendar Year 2022

The preamble to the *Requirements Related to Surprise Billing; Part II* states that the Departments will consider certain factors in setting the permitted certified IDR entity fee range, including the current IDR entity fees for state-managed IDR processes that are similar to the federal IDR process, the anticipated volume of the Federal IDR process, and the adequacy of the Federal IDR process capacity to efficiently handle the volume of IDR initiations and payment determinations. Based upon the Departments' research regarding existing IDR processes in states that have implemented similar surprise billing protections, the Departments understand that IDR entities typically charge between $300-$600 per arbitration.[3] The Departments found that entities in several states charge lower fees, often ranging between $225-$500.[4] The Departments acknowledge that in some states, individual arbitrators have charged as little as $270 and as much as $6,000 per arbitration.[5] However, the Departments are of the view that such drastic ranges of certified IDR entity fees would risk inflating costs of care that ultimately could be passed on to consumers. Based on research discussed above and the typical range charged, the Departments estimate that on average the certified IDR entity fee will be approximately $400. In listening sessions, stakeholders stated that Federal certified IDR entity fees should be similar to those charged in most states, which stakeholders considered reasonable, so that participating in the Federal IDR process would not be cost-prohibitive, especially for smaller providers and facilities.

Certified IDR entities may charge a different fixed fee for batched determinations. States that allow batching have different models for the fee structure: some permit a fixed fee, some have a

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[3] See Hoadley, J., and Maanasa, K. "How States are Using Independent Dispute Resolution to Resolve Out-of-Network Payment in Surprise Billing," *To the Point* (blog), Commonwealth Funds, Feb. 27, 2020. https://doi.org/10.26099/pqt4-vy24.

[4] American College of Emergency Physicians, "Independent Dispute Resolution: The Best Federal Solution to Protect Patients from Surprise Billing" (estimating arbitration fee costs between $225-$325), *available a*t: https://www.acep.org/globalassets/sites/acep/media/advocacy/federal-advocacy-pdfs/acep-idr-facts.pdf; Virginia State Corporation Commission, "Arbitrator Search," *available at:* https://scc.virginia.gov/balancebilling#/Arbitrators (showing arbitrators charging $250-$500); *see also* Colorado Department of Regulatory Agencies, Division of Insurance, "List of Qualified Arbitrators and Their Fees for the Out-of-Network Payment Arbitration Program" (charging generally $365-450), *available at*: https://doi.colorado.gov/list-of-qualified-arbitrators-and-their-fees-for-the-out-of-network-payment-arbitration-program.

[5] https://www.kff.org/private-insurance/fact-sheet/surprise-medical-bills-new-protections-for-consumers-take-effect-in-2022/amp/.

tiered system, and some permit IDR entities to charge a flat rate per claim in a batched case.[6] Based upon the Departments' review, the fixed fee for batched determinations may average approximately 34% more than that for individual determinations.[7] Therefore, the Departments have determined a similar range for batched determinations under the Federal IDR process is appropriate. The Departments are of the view that a fixed fee is the best approach to ensure a certified IDR entity's time is compensated based on the level of effort, that administrative costs are reasonable, and that the Federal IDR process remains accessible.

In setting the certified IDR entity fee ranges, in addition to comparing potential certified IDR entity fee ranges with IDR entity fees charged in states with IDR processes similar to the Federal IDR process, the Departments considered the anticipated time and resources needed for certified IDR entities to meet the requirements of the Federal IDR process, such as the time and resources needed for IDR entity certification, making payment determinations (including determining whether the dispute belongs in the Federal IDR process), data reporting, and responding to audits. The Departments also considered the anticipated volume of the Federal IDR process and the adequacy of the Federal IDR process capacity to efficiently handle the volume of IDR initiations and payment determinations. The Departments estimate that 17,333 claims from nonparticipating providers and nonparticipating emergency facilities and 4,899 claims from nonparticipating providers of air ambulance services will go through the Federal IDR process annually. The fee ranges established by the Departments reflect the Departments' attempt to minimize the administrative costs of participating in the Federal IDR process in order to help reduce the likelihood of these costs from being passed on to consumers in the form of higher premiums. The Departments are of the view that these fee ranges will fund a robust Federal IDR process and keep the volume of disputed claims manageable. In particular, making batching claims more cost-effective will help protect against backlogs in certified IDR entities' workstreams.

For the calendar year beginning January 1, 2022, certified IDR entities must charge a fixed certified IDR entity fee for single determinations within the range of **$200-$500**, unless otherwise approved by the Departments pursuant to section IV of this guidance. This range was selected to keep administrative costs reasonable, thereby reducing the potential for excessive certified IDR entity fees that could result in inflated health care and insurance costs that could ultimately be passed on to consumers.

If a certified IDR entity chooses to charge a different fixed certified IDR entity fee for batched determinations, that fee must be within the range of **$268-$670**, unless otherwise approved by the Departments pursuant to section IV of this guidance.

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[6] For example, New Jersey permits IDR entities to disaggregate claims involving multiple claim lines and more than $2,000. State of New Jersey, Department of Banking and Insurance, "Claims Payment: Claims Handling Appeals and the Program for Independent Claims Payment Arbitration (PICPA)," *available at*: https://www.state.nj.us/dobi/chap352/352appealqanda.html#5;

[7] For example, Virginia provides public information on the fees charged by its arbitrators, who charge a separate fee for batched determinations. See Arbitrator Search, available at https://scc.virginia.gov/balancebilling#/Arbitrators.

The certified IDR entity is not permitted to charge more than the approved certified IDR entity fee by the Departments on the IDR entities application for certification for any particular determination. Therefore, to the extent the certified IDR entity seeks to pass incidental costs onto parties – for example, for service or processing fees – it must factor the costs of those fees into its certified IDR entity fee. Under no circumstances may a certified IDR entity charge a party for additional costs beyond the certified IDR entity fee and administrative fee.

As noted in the *Requirements Related to Surprise Billing; Part II*, the Departments will review relevant data, such as time and resources needed for certified IDR entities to make payment determinations, IDR entity reporting, and audits, as well as volume of disputes, and stakeholder feedback and adjust the allowable certified IDR entity fee ranges for individual determinations and for batched determinations annually. Accordingly, the Departments also will publish guidance annually related to adjustments of these fee ranges.

IV. Process for IDR Entities Seeking Certification and Certified IDR Entities to Apply to Charge a Fixed Fee Beyond the Upper or Lower Bounds for Calendar Year 2022

As stated in section I of this guidance, under the *Requirements Related to Surprise Billing; Part II*, a certified IDR entity may not charge a certified IDR entity fee that is beyond the upper or lower limits for fees set forth in this guidance unless the certified IDR entity requests, and can provide justification for, a higher or lower fee, and the Departments provide written approval for the certified IDR entity to charge a fee beyond the upper or lower limits for fees set forth in this guidance. An IDR entity seeking certification or a certified IDR entity can seek approval to charge a fee outside the permitted range at the time of certification, or annually thereafter.

To request approval to charge a certified IDR entity fee outside the permitted range, the IDR entity seeking certification or certified IDR entity must provide a justification for the higher or lower fee. Specifically, the IDR entity seeking certification or certified IDR entity must submit a written proposal through the Federal IDR portal[8] that includes:

(1) the alternative fixed fee the IDR entity seeking certification or certified IDR entity proposes as appropriate;

(2) a description of the circumstances that require the alternative fixed fee (this description could include, for example, a cost analysis showing the historical and anticipated volume of payment determinations the IDR entity seeking certification or certified IDR entity has conducted and expects to conduct, the historical and anticipated time and resources needed for the IDR entity seeking certification or certified IDR entity to meet and maintain compliance with applicable federal requirements, the number of personnel employed to make determinations, and the impact of inflation, market and geographic variations, and consistency of fees over time); and

(3) a description of how the alternative fixed fee will be used to mitigate the effects of these circumstances. The Departments will review the justification submitted with an IDR entity's

[8] The federal IDR portal can be accessed at https://www.nsa-idr.cms.gov.

certification application (or certified IDR entity's request) and issue written approval or denial of the request to vary fees beyond the permitted range in conjunction with an IDR entity's certification approval notice, as applicable, or following the certified IDR entity's request.

Any certified IDR entity that has received written approval from the Departments to charge a certified IDR entity fee outside of the permitted ranges generally may not be selected by the Departments to make a determination in a situation in which the Departments randomly select a certified IDR entity on behalf of the parties. However, if there are insufficient certified IDR entities that charge a fee within the allowed range of certified IDR entity fees available to adjudicate the dispute, the Departments will select a certified IDR entity that has received approval to charge a fee outside of the allowed range of certified IDR entity fees.

V. For Further Information Contact

For further questions about the Federal IDR process or fee guidance, please contact us at FederalIDRQuestions@cms.hhs.gov.

EXHIBIT 8

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

Center for Consumer Information & Insurance Oversight

DATE: OCTOBER 31, 2022

SUBJECT: CALENDAR YEAR 2023 FEE GUIDANCE FOR THE FEDERAL INDEPENDENT DISPUTE RESOLUTION PROCESS UNDER THE NO SURPRISES ACT

I. Introduction

Section 9816(c) of the Internal Revenue Code (Code), section 716(c) of the Employee Retirement Income Security Act of 1974 (ERISA), and section 2799A–1(c) of the Public Health Service Act (PHS Act), as added by the No Surprises Act (NSA), direct the Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) to establish a Federal independent dispute resolution (IDR) process that nonparticipating facilities, nonparticipating providers, and group health plans and health insurance issuers (the parties) may use following the end of an open negotiation period to determine the out-of-network rate for out-of-network emergency services and certain items and services provided by nonparticipating providers at in-network facilities, when a specified state law or All-Payer Model Agreement does not apply. Code section 9817, ERISA section 717, and PHS Act section 2799A–2(b), also added by the NSA, direct the Departments to establish a similar Federal IDR process that nonparticipating providers of air ambulance services, plans, and issuers may use following the end of an open negotiation period to determine payment for qualified services furnished by nonparticipating providers of air ambulance services when a specified state law or All-Payer Model Agreement does not apply.[1]

On October 7, 2021, the Departments issued interim final rules titled *Requirements Related to Surprise Billing; Part II* (interim final rules) to implement the Federal IDR process under the NSA.[2] The interim final rules establish the parameters governing the administrative fees and the certified IDR entity fees that certified IDR entities are to collect from the parties.

Under the interim final rules, each party must pay an administrative fee for participating in the Federal IDR process.[3] The certified IDR entity may invoice the parties for the administrative fee at the time the certified IDR entity is selected, and the parties must pay the administrative fee by

[1] Section 102 of the NSA amends the Federal Employees Health Benefits (FEHB) Program statute to require each contract with a carrier to require the carrier to comply with requirements described in the provisions of these sections of the Code, ERISA, and the PHS Act. Accordingly, the Federal IDR process will be available to resolve eligible disputes involving FEHB carriers.
[2] 86 FR 55980 (October 7, 2021). The Departments recently issued *Requirements Related to Surprise Billing; Final Rules*; however, these final rules do not finalize the requirements related to the certified IDR entity fees or administrative fees. 87 FR 52618 (August 26, 2022).
[3] 26 CFR 54.9816-8T(d)(2)(i), 29 CFR 2590.716-8(d)(2)(i), and 45 CFR 149.510(d)(2)(i).

the time of offer submission.[4] The administrative fee is paid by each party to the certified IDR entity and remitted to the Departments.[5] The administrative fee is established annually in a manner so that the total administrative fees collected for a year are estimated to be equal to the amount of expenditures estimated to be made by the Departments to carry out the Federal IDR process for that year.[6]

Additionally, under the interim final rules, each party must also pay a certified IDR entity fee to the certified IDR entity at the time that party submits its offer.[7] However, the non-prevailing party is ultimately responsible for the full certified IDR entity fee, which is retained by the certified IDR entity for the IDR services it performed.[8] The certified IDR entity fee that was paid by the prevailing party will be returned to the prevailing party by the certified IDR entity within 30 business days following the date of the payment determination.[9] If the parties reach an agreement after initiating the Federal IDR process but before the certified IDR entity makes a payment determination, the certified IDR entity fee will be split evenly between the parties, unless the parties agree on an alternative method for allocating the certified IDR entity fee.[10] If the initiating party withdraws a dispute after a certified IDR entity has been assigned but before the certified IDR entity makes a payment determination, similarly the certified IDR entity fee will be split evenly between the parties. In the case of batched determinations,[11] the certified IDR entity may make different payment determinations for each qualified IDR item or service under dispute. In these cases, the party with the fewest determinations in its favor is considered the non-prevailing party and is responsible for the full certified IDR entity fee. If each party prevails in an equal number of determinations, the certified IDR entity fee will be split evenly between the parties.[12]

The interim final rules also provide that, as part of its application for certification, the IDR entity must submit to the Departments the amount of the IDR entity fees it intends to charge for payment determinations, which is limited to a specific fixed certified IDR entity fee amount for single determinations and a separate fixed certified IDR entity fee amount for batched determinations. Each of these fixed certified IDR entity fees must be within a range set forth in guidance by the Departments, unless the certified IDR entity receives written approval from the Departments to charge a certified IDR entity fee outside that range. On an annual basis, the certified IDR entity may update its certified IDR entity fees within the range set forth in current

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[4] *See* Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties, *available at* https://www.cms.gov/files/document/federal-independent-dispute-resolution-guidance-disputing-parties.pdf.
[5] 26 CFR 54.9816-8T(e)(2)(ix), 29 CFR 2590.716-8(e)(2)(ix), and 45 CFR 149.510(e)(2)(ix). The NSA directed the Departments to jointly establish one Federal IDR process. To operationalize the Federal IDR process, HHS collects administrative fees for all disputes initiated under the Federal IDR process, including the administrative fees paid in connection with the Federal IDR process for health plans that are subject to the Code or ERISA.
[6] 26 CFR 54.9816-8T(d)(2)(ii), 29 CFR 2590.716-8(d)(2)(ii), and 45 CFR 149.510(d)(2)(ii).
[7] 26 CFR 54.9816-8T(d)(1)(ii), 29 CFR 2590.716-8(d)(1)(ii), and 45 CFR 149.510(d)(1)(ii).
[8] 26 CFR 54.9816-8T(d)(1)(i), 29 CFR 2590.716-8(d)(1)(i), and 45 CFR 149.510(d)(1)(i).
[9] 26 CFR 54.9816-8T(d)(1)(ii), 29 CFR 2590.716-8(d)(1)(ii), and 45 CFR 149.510(d)(1)(ii).
[10] 26 CFR 54.9816-8T(c)(2)(ii), 29 CFR 2590.716-8(c)(2)(ii), and 45 CFR 149.510(c)(2)(ii).
[11] Batched determinations involve multiple qualified IDR items or services that are considered jointly by a certified IDR entity for purposes of the Federal IDR process. 26 CFR 54.9816-8T(a)(2)(i), 29 CFR 2590.716-8(a)(2)(i), and 45 CFR 149.510(a)(2)(i).
[12] 86 FR 55980, 56001.

guidance and seek approval from the Departments to charge fixed certified IDR entity fees beyond the upper or lower limits for certified IDR entity fees.[13]

On September 30, 2021, the Departments issued "Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process under the No Surprises Act," which provided fee guidance for calendar year 2022 (the 2022 guidance).[14] Under the 2022 guidance, the Departments established an administrative fee of $50 due from each party participating in the Federal IDR process. The 2022 guidance also established the range for fixed certified IDR entity fees for single determinations as $200–$500, and the range for fixed certified IDR entity fees for batched determinations as $268–$670, unless otherwise approved by the Departments.

On April 15, 2022, the Departments launched the Federal IDR portal to facilitate initiation of the Federal IDR process for items and services subject to the surprise billing protections in the NSA and began accepting disputes.

This guidance sets forth the administrative fee for participating in the Federal IDR process for calendar year 2023. This guidance also sets forth the allowable ranges for certified IDR entity fees related to single determinations and batched determinations for calendar year 2023. Finally, this guidance describes the information that IDR entities seeking certification and certified IDR entities must provide to the Departments if they seek approval to charge certified IDR entity fees outside of the allowable ranges set by the Departments and the process for providing that information.

II. Administrative Fee for Calendar Year 2023

The interim final rules provide that the administrative fee amount will be established by the Departments in a manner so that the total administrative fees collected by the certified IDR entities and paid to the Departments during a calendar year are approximately equal to the estimated amount of expenditures made by the Departments in carrying out the Federal IDR process for that calendar year.[15] In setting the administrative fee for 2023, the Departments considered the costs for the Departments to administer the Federal IDR process during 2022, including the staffing and contracting costs related to certification and oversight of certified IDR entities; the costs of developing and publishing reports as required under Code sections 9816 and 9817, ERISA sections 716 and 717, and PHS Act sections 2799A–1 and 2799A–2; the costs of collecting the administrative fees from certified IDR entities; and the costs of maintaining the Federal IDR portal.[16]

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[13] 26 CFR 54.9816-8T(e)(2)(vii), 29 CFR 2590.716-8(e)(2)(vii), and 45 CFR 149.510(e)(2)(vii).
[14] *See* Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act, *available at:* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Technical-Guidance-CY2022-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf.
[15] 26 CFR 54.9816-8T(d)(2)(ii), 29 CFR 2590.716-8(d)(2)(ii), and 45 CFR 149.510(d)(2)(ii).
[16] 86 FR 55980, 56001-56002.

Because of program experience to date, and as a result of the changes to the Federal IDR process and the Federal IDR portal to address court rulings,[17] the Departments are of the view that current data regarding take-up and usage of the Federal IDR process is not reliable enough to support a change to either the estimated number of payment determinations for which administrative fees would be paid[18] or the estimated ongoing program costs for 2023. Therefore, the 2023 administrative fee amount due from each party for participating in the Federal IDR process will remain **$50** for the calendar year beginning January 1, 2023. In future years, the Departments expect to have more reliable data on the anticipated number of payment determinations for which administrative fees will be paid and the estimated expenditures for ongoing costs. This will allow the Departments to make a more informed calculation of the administrative fees for 2024 and beyond to better ensure that the administrative fees collected cover the costs associated with carrying out the Federal IDR process.

III. Certified IDR Entity Fee Range for Calendar Year 2023

The preamble to the interim final rules states that the Departments will consider certain factors in setting the permitted certified IDR entity fee range, including the current IDR entity fees for state-managed IDR processes that are similar to the Federal IDR process, the anticipated time and resources needed for certified IDR entities to meet the requirements of the rules, such as the time and resources needed to make payment determinations (including determining whether the dispute belongs in the Federal IDR process), data reporting, and audits.[19] The Departments will also consider the anticipated volume of Federal IDR initiations and payment determinations and the adequacy of the Federal IDR process capacity to efficiently handle the volume of Federal IDR initiations and payment determinations.

As stated in the 2022 guidance, the Departments understand that IDR entities typically charge between $300–$600 per arbitration in states that have implemented similar surprise billing protections and IDR processes.[20] The Departments found that entities in several states charge lower fees, often ranging between $225–$500.[21] The Departments acknowledge that in some

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[17] *See* Memorandum Regarding Continuing Surprise Billing Protections for Consumers, *available at:* https://www.cms.gov/files/document/memorandum-regarding-continuing-surprise-billing-protections-consumers.pdf.

[18] The Departments have received significantly more dispute initiation requests than expected but, notwithstanding that fact, the Departments still are unable to reliably estimate the expected number of payment determinations for which administrative fees would be paid in future years. Due to the need to allow growth for the newly established Federal IDR processes and set appropriate fees, the Departments' regulations indicate the program fees will be reviewed and published in guidance documents. Yearly evaluation and fee setting after implementation costs and the number of payment determinations for which administrative fees would be paid stabilize affords time for the program processes to normalize.

[19] 86 FR 55980, 56005.

[20] *See* Hoadley, J., and Maanasa, K., "How States are Using Independent Dispute Resolution to Resolve Out-of-Network Payment in Surprise Billing," *To the Point* (blog), Commonwealth Fund, Feb. 27, 2020, *available at*: https://doi.org/10.26099/pqt4-vy24.

[21] *See* American College of Emergency Physicians, "Independent Dispute Resolution: The Best Federal Solution to Protect Patients from Surprise Billing," *available at*: https://www.acep.org/globalassets/sites/acep/media/advocacy/federal-advocacy-pdfs/acep-idr-facts.pdf (estimating arbitration fee costs between $225–$325); *see also* Virginia State Corporation Commission, "Arbitrator Search," *available at*: https://scc.virginia.gov/balancebilling#/Arbitrators (showing arbitrators charging $250–$500); *see also*

states, individual arbitrators have charged as little as $270 and as much as $6,000 per arbitration.[22] However, the Departments are of the view that such broad ranges of certified IDR entity fees would risk inflating costs of care that ultimately could be passed on to consumers. States that allow batching of claims have different models for the fee structure: some permit a fixed fee, some have a tiered system, and some permit IDR entities to charge a flat rate per claim in a batched case.[23] Based upon the Departments' review, the fixed fee for batched determinations averages approximately 34% more than that for individual determinations.[24] In listening sessions, stakeholders stated that Federal certified IDR entity fees should be similar to those charged in most states, which stakeholders considered reasonable, so that participating in the Federal IDR process would not be cost-prohibitive, especially for smaller providers and facilities.

In establishing the initial fee amounts, the Departments also considered the anticipated volume of disputes the parties would initiate through the Federal IDR process and the number of ultimate payment determinations that certified IDR entities would render. For calendar year 2022, the Departments estimated that 17,435 claims from nonparticipating providers and nonparticipating emergency facilities and 4,968 claims from nonparticipating providers of air ambulance services would go through the Federal IDR process. The Departments have found, however, that certified IDR entities are now processing significantly more disputes than originally anticipated and investing far more effort than expected to determine the eligibility of those disputes. Between the launch of the Federal IDR portal on April 15, 2022, and September 30, 2022, parties initiated more than 90,000 disputes through the Federal IDR portal, which is substantially more than the Departments' initial estimates. During that time, non-initiating parties challenged over 41,000 disputes' eligibility for the Federal IDR process, which constitutes nearly half of all disputes initiated. These contested eligibility disputes involved complex eligibility determinations that have required certified IDR entities to expend considerable time and resources to review. As a result of eligibility challenges, as of September 30, 2022, certified IDR entities have found over 22,000 disputes ineligible for the Federal IDR process. While the process for eligibility determination informs the overall rate that certified IDR entities are permitted to charge, certified IDR entities may not collect fees for those cases that they ultimately determine are ineligible for the Federal IDR process. Further, only about 3,500 payment determinations were made by certified IDR entities. Because so many disputes have been found ineligible, certified IDR

Colorado Department of Regulatory Agencies, Division of Insurance, "List of Qualified Arbitrators and Their Fees for the Out-of-Network Payment Arbitration Program," *available at*: https://doi.colorado.gov/list-of-qualified-arbitrators-and-their-fees-for-the-out-of-network-payment-arbitration-program (showing arbitrators generally charging $365–$450).

[22] *See* "Surprise Medical Bills: New Protections for Consumers Take Effect in 2022," KFF, *available at*: https://www.kff.org/private-insurance/fact-sheet/surprise-medical-bills-new-protections-for-consumers-take-effect-in-2022/amp/.

[23] For example, New Jersey permits IDR entities to disaggregate claims involving multiple claim lines for those more than $2,000. *See* State of New Jersey, Department of Banking and Insurance, "Claims Payment: Claims Handling Appeals and the Program for Independent Claims Payment Arbitration (PICPA)," *available at*: https://www.state.nj.us/dobi/chap352/352appealqanda.html#14.

[24] For example, Virginia provides public information on the fees charged by its arbitrators, who charge a separate fee for batched determinations. *See* "Arbitrator Search," *available at*: https://scc.virginia.gov/balancebilling#/Arbitrators.

entities are only receiving payment for a small percentage of the disputes to which they are devoting significant time and resources.

In setting the certified IDR entity fee ranges for calendar year 2023, the Departments considered the anticipated time and resources needed for certified IDR entities to meet the requirements of the Federal IDR process, such as the time and resources needed for IDR entity certifications, making payment determinations (including determining whether the dispute belongs in the Federal IDR process), data reporting, and responding to audits. During calendar year 2022, certified IDR entities incurred more administrative burden than originally anticipated by the Departments. To account for this additional administrative burden in the upcoming calendar year, while also recognizing the need to keep the Federal IDR process from being cost prohibitive for disputing parties, the Departments have endeavored to strike a balance by increasing the range for permitted certified IDR entity fees for calendar year 2023 by a reasonable amount.

Accordingly, beginning January 1, 2023, certified IDR entities are permitted to charge a fixed certified IDR entity fee for single determinations within the range of **$200–$700**, unless otherwise approved by the Departments pursuant to Section V of this guidance. The Departments are of the view that this range will keep costs reasonable, thereby reducing the potential for excessive certified IDR entity fees that could result in inflated health care and insurance costs that could ultimately be passed on to consumers.

With regard to batched determinations, based on experience from calendar year 2022, the Departments are of the view that certified IDR entities incur increased workload based on the number of qualified IDR items or services (hereafter, "line items") within a batched determination. For example, it generally requires more work for the certified IDR entity to review a batched determination with 80 line items than one with 10 line items. The certified IDR entity must evaluate each line item within the batch to ensure it adheres to statutory and regulatory requirements and Federal IDR process guidance. Only when each line item is determined to meet these standards may the batch move forward in the process and be determined eligible for the Federal IDR process. If determined eligible, there are several further process steps that must occur before a payment determination can be made.

For calendar year 2023, if a certified IDR entity chooses to charge a different fixed certified IDR entity fee for batched determinations, that fee must be within a range of **$268–$938**, unless otherwise approved by the Departments under section V of this guidance. In addition, without the need to seek further approval, to account for the differential in the workload of batched determinations, a certified IDR entity may charge the following percentage of its approved certified IDR entity batched determination fee ("batching percentage") for batched determinations, based on the number of line items initially submitted in the batch:

- 2-20 line items: 100% of the approved batched determination fee
- 21-50 line items: 110% of the approved batched determination fee
- 51-80 line items: 120% of the approved batched determination fee
- 81 line items or more: 130% of the approved batched determination fee

The Departments are of the view that this approach to charging for batched determinations will ensure that a certified IDR entity is compensated based on the level of effort, costs are reasonable, the Federal IDR process is accessible, and IDR costs are clear to parties in advance of initiating the Federal IDR process in 2023. Further, for batched determinations, the fee range will not restrict the application of the batching percentages, as long as 100% of the batched determination fee is within the range of $268–$938. For example, if a certified IDR entity sets its batched determination fee for 2023 at $800, which is within the fee range of $268–$938, and is selected for a batched determination with 100 line items in calendar year 2023, the certified IDR entity would be permitted to charge $1,040 (130% of $800) as its batched determination fee because $800 is within the fee range, even though $1,040 exceeds the upper limit of the fee range. The batched dispute fees will be based on the number of line items in the initial submission of the batched dispute.

A certified IDR entity is not permitted to charge more than the approved certified IDR entity fee for the applicable year for any determination, except in accordance with batching percentages (unless the certified IDR entity receives written approval from the Departments to charge an IDR entity fee outside that range).[25] Therefore, to the extent a certified IDR entity seeks to pass incidental costs on to parties—for example, for service or processing fees—it must factor the costs of those fees into its certified IDR entity fee. Under no circumstances may a certified IDR entity charge a party for additional costs beyond the certified IDR entity fee and the administrative fee (which the certified IDR entity must remit to the Departments).

The fee ranges established for calendar year 2023 reflect the Departments' intent to minimize the costs of participating in the Federal IDR process in order to reduce the likelihood of these costs being passed on to consumers in the form of higher premiums, while balancing the need for the certified IDR entities to be compensated for the entirety of their work throughout the Federal IDR process. The Departments are of the view that these fee ranges will fund a robust Federal IDR process and keep the volume of disputed claims manageable.

The Departments will continue to review relevant data, such as the time and resources needed for certified IDR entities to make payment determinations, certified IDR entity reporting, and audits, as well as the volume of disputes and stakeholder feedback, and adjust the allowable certified IDR entity fee ranges for individual and batched determinations annually. Accordingly, the Departments will continue to publish guidance annually related to adjustments of these fee ranges.

IV. Process for Certified IDR Entities to Update their Fixed Fees within the Calendar Year 2023 Range

As noted in the interim final rules, a certified IDR entity may update its fees annually within the range established in guidance.[26] Similar to the process set forth in Section V of this guidance, certified IDR entities seeking to update their fees must submit their updated certified IDR entity fee for single determinations, batched determinations, or both, **to the Federal IDR email box[27] with the subject line "IDR Entity Fee Update – Within Range – 2023".** As specified above in

[25] 26 CFR 54.9816-8T(e)(2)(vii), 29 CFR 2590.716-8(e)(2)(vii), and 45 CFR 149.510(e)(2)(vii).
[26] *Id.*
[27] FederalIDRQuestions@cms.hhs.gov.

Section III of this guidance, certified IDR application of batching percentages is not considered an update in certified IDR entity fees, and therefore entities do not need to seek approval from the Departments to apply them.

Certified IDR entities wishing to update their fees for calendar year 2023 **must submit information on updated fees from November 7 through November 18, 2022.** As long as these fees are within the ranges set forth in Section III of this guidance, once confirmed by the Departments to the certified IDR entity, the new fees will become effective January 1, 2023.[28]

V. Process for IDR Entities Seeking Certification and Certified IDR Entities to Apply to Charge a Fixed Fee Beyond the Upper or Lower Bounds for Calendar Year 2023

As stated in Section I of this guidance, under the interim final rules, a certified IDR entity may not charge a certified IDR entity fee that is beyond the upper or lower limits for fees set forth in this guidance (other than through application of the batching percentages) unless the certified IDR entity requests, and can provide justification for, a higher or lower fee, and the Departments provide written approval for the certified IDR entity to charge a fee beyond the upper or lower limits for fees set forth in this guidance. An IDR entity seeking certification or a certified IDR entity can seek approval to charge a fee outside the permitted range at the time of certification and annually thereafter.

To request approval to charge a certified IDR entity fee outside the permitted range, the IDR entity seeking certification or certified IDR entity must provide a justification for the higher or lower fee. Specifically, the certified IDR entity **must submit a written proposal through the Federal IDR email box[29] with the subject line "IDR Entity Fee Update – Outside Range – 2023"** that includes:

(1) The alternative fixed fee the IDR entity seeking certification or certified IDR entity proposes as appropriate;
(2) A description of the circumstances that require the alternative fixed fee (this description could include, for example, a cost analysis showing the historical and anticipated volume of payment determinations the IDR entity seeking certification or certified IDR entity has conducted and expects to conduct, the historical and anticipated time and resources needed for the IDR entity seeking certification or certified IDR entity to meet and maintain compliance with applicable federal requirements, the number of personnel employed to make determinations, and the impact of inflation, market and geographic variations, and consistency of fees over time); and
(3) A description of how the alternative fixed fee will be used to mitigate the effects of these circumstances.

Certified IDR entities requesting to update their fees outside of the ranges set forth for calendar year 2023 **must submit their request for updated fees from November 7 through November 18, 2022**.

[28] The new rates will be effective for Federal IDR disputes initiated as of this date, irrespective of when the items or services at dispute were furnished.
[29] FederalIDRQuestions@cms.hhs.gov.

The Departments will review the justification submitted with an IDR entity's certification application, or the certified IDR entity's request, and issue written approval or denial of the request to charge fees beyond the permitted range in conjunction with an IDR entity's certification approval notice or following the certified IDR entity's request, as applicable.

Any certified IDR entity that has received written approval from the Departments to charge a certified IDR entity fee outside of the permitted ranges generally may not be selected by the Departments to make a determination in a situation in which the Departments randomly select a certified IDR entity on behalf of the parties. However, if there are insufficient certified IDR entities that charge a fee within the allowed range of certified IDR entity fees available to adjudicate the dispute, the Departments will select a certified IDR entity that has received approval to charge a fee outside of the allowed range of certified IDR entity fees.

VI. For Further Information Contact

For further information about the Federal IDR process or fee guidance, please contact FederalIDRQuestions@cms.hhs.gov.

EXHIBIT 9

February 13, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

RE: CY 2023 Federal Independent Dispute Resolution (IDR) Administrative Fees

Dear Secretaries Becerra, Walsh, and Yellen:

On behalf of the Emergency Department Practice Management Association (EDPMA) and American College of Emergency Physicians (ACEP), we are writing to express serious concerns about the impact that the increase in the 2023 Federal IDR administrative fee will have on emergency physician practices and the roadblock the Administration has put up, threatening provider access to a payment dispute resolution process that was codified by the U.S. Congress under the *No Surprises Act.* ***EDPMA and ACEP urge the Departments of Health and Human Services, Labor, and Treasury ("the Departments") to reinstate the originally announced $50 Federal IDR administrative fee for calendar year (CY) 2023.*** As the Departments should be aware, because of the mandates of the Emergency Medical Treatment and Active Labor Act (EMTALA), emergency physicians are often called upon to deliver services to patients presenting in the emergency department who have health insurance products under which emergency physicians are not contracted as in-network providers. The policies implemented by the Departments thus have a disproportionate impact on emergency medicine practices, including the $350 Federal IDR roadblock that the Departments swapped out at the end of 2022 for their previously announced amount of $50.

BACKGROUND

The *No Surprises Act* as enacted within the *Consolidated Appropriations Act, 2021*[1] authorizes the Departments to create a Federal IDR administrative fee to represent the costs incurred by the Departments (not the certified IDR entities) in administering the Federal IDR process. The *No Surprises Act* states, in relevant part:

> *ADMINISTRATIVE FEE.—*
> *''(A) IN GENERAL.—Each party to a determination under paragraph (5) to which an entity is selected under paragraph (3) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.*
> *''(B) AMOUNT OF FEE.—The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be* ***equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process***[2](emphasis added).

For CY 2022, the Departments set the IDR administrative fee at $50.[3] On October 31, 2022, the Center for Consumer Information and Insurance Oversight (CCIIO) announced that the Federal IDR administrative fee would remain $50 for CY 2023.[4] However, on December 23, 2022, CCIIO suddenly reversed course and released a memorandum stating that the 2023 administrative fee had been revised from $50 to $350.[5] ***This sevenfold increase in the non-refundable fee must be paid by disputing parties to access the Federal IDR process and is a substantial obstacle for physicians' ability to seek redress for unsubstantiated underpayments from health plans for services provided to insured patients seeking emergency care***.

2023 Administrative Fee Increase Rationale

In the December 23, 2022 memorandum, the Departments state that "there is a significant backlog of disputes pending eligibility determinations before certified IDR entities which has continued to grow since the publication of the prior 2023 guidance. To address this issue, the Departments have engaged a contractor and government staff to conduct pre-eligibility reviews, which include outreach and technical assistance in support of the certified IDR entities' eligibility determinations."

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[1] *Pub. L.* 116–260.

[2] 26 U.S.C. §9816(c)(8); 29 U.S.C. §1135e(c)(8); 42 U.S.C. §300gg-111(c)(8)

[3] CCIIO, Memorandum: *Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act* (September 30, 2021) (https://www.hhs.gov/guidance/document/calendar-year-2022-fee-guidance-federal-independent-dispute-resolution-process-under-no).

[4] CCIIO, Memorandum: *Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act* (October 21, 2022) (https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf)/

[5] CCIIO, Memorandum: *Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act: Change in Administrative Fee* (December 23, 2022) (https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf).

EDPMA and ACEP believe that the Departments have shifted the burden of certified IDR entity duties as articulated in Federal regulation onto disputing parties, by charging disputing parties for functions that certified IDR entities attested to provide as part of their certification. In the second interim final rule that the Departments issued to implement the *No Surprises Act*, the Departments explicitly lay out the functions that IDR entities must provide to the Departments in order to receive certification. Among other requirements, the Departments stated,

> *In order to be certified, an IDR entity must possess (directly or through contracts or other arrangements) and demonstrate sufficient arbitration and claims administration of health care services, managed care, billing, coding, medical, and legal expertise. With regard to medical expertise, where the payment determination depends on the patient acuity or the complexity of furnishing the qualified IDR item or service, or the level of training, experience, and quality and outcome measurements of the provider or facility that furnished the qualified IDR item or service, the IDR entity should have available medical expertise with the appropriate training and experience in the field of medicine involved in the qualified IDR item or service. Additionally,* ***the IDR entity must employ (directly or through contracts or other arrangements) sufficient personnel to make determinations within the 30 business days allowed for such determinations. To satisfy this standard, the written documentation the IDR entity submits must include a description of its organizational structure and capabilities, including an organizational chart and the credentials, responsibilities, and number of personnel employed to make determinations*** (emphasis added).[6]

Further, in the second interim final rule, the Departments explicitly state that considerations related to the ability of and resources needed by IDRs to make payment determinations is the province of certified IDR entity fees, *not* the administrative fee:

> *The Departments will also consider the anticipated time and resources needed for certified IDR entities to meet the requirements of these interim final rules, such as the time and resources needed to obtain certification, making payment determinations (****including determining whether the dispute belongs in the Federal IDR process****), data reporting, and audits. The Departments will also consider factors such as the anticipated volume of payment determinations under the Federal IDR process and adequacy of the Federal IDR process capacity to efficiently handle the volume of IDR initiations and payment determinations. The Departments will review and update the allowable fee range annually based on these factors and the impact of inflation and other cost increases. The Departments seek comment on these factors and any additional factors that should be considered* ***when determining the range for allowable certified IDR entity fees***.[7]

[6] 86 *Fed. Reg*. 56002 (October 7, 2021).
[7] 86 *Fed. Reg*. 56005 (October 7, 2021).

The Departments have directly contradicted themselves. Below, we discuss several solutions that we provide to the Departments as a means to alleviate what we believe were foreseeable pressures on the Federal IDR system. As a foundational matter, ***the Departments have already expressly stated that the costs it cites as a rationale for increasing the 2023 administrative fee should be carried by the certified IDR entities and, if appropriate, reflected in the certified IDR entity fees***. If the costs of making a payment determination are indeed higher, it makes perfect sense to reflect those costs in the certified IDR entity fee, where the prevailing party does not carry the costs that have been placed on the system by obfuscation of required disclosures, unsubstantiated challenges to Federal IDR eligibility, and an incentive to pay as little as possible in the hope that the provider gives up. Higher certified IDR entity fees will of course affect whether providers initiate Federal IDR for eligible claims under their existing cost-benefit analyses. However, ***it is wholly inappropriate for the Departments to erect a major obstacle to accessing Federal IDR, particularly when the Departments published in the Federal Register the expectations for certified IDR entities' abilities and the factors that go into calculating the range of allowable certified IDR entity fees***.

Ramifications of the $350 Federal IDR 2023 Administrative Fee

In emergency medicine, physicians deliver specific services in the emergency department setting that correspond to CPT codes describing emergency care evaluation and management (E/M) services. Physician practice reimbursement for these services varies by contract, ***we emphasize to the Departments that the total payment rate for an emergency E/M visit, even the highest level visit, is generally less than the $350 administrative fee***. This means that the amount-in-dispute for an emergency E/M visit will be ***even less*** than $350 administrative fee.

The *No Surprises Act* includes a mechanism called "batching" that, functioning properly, would allow providers to achieve economies-of-scale relative to the administrative fee by moving multiple claims through Federal IDR simultaneously as part of one payment determination request. However, the batching requirements have been implemented in a manner that has made it unnecessarily difficult to "batch" claims and achieve these economies-of-scale envisioned by the statute. For instance, while this was not discussed in the issuance of the federal regulations related to "batching," the Departments have issued guidance that states:

> For batched items or services, the certified IDR entity may select different offers, from either or both parties, when the QPAs for the qualified IDR items or services within the batch are different. For example, if a dispute batched multiple claims for Service A furnished by Provider B to individuals covered by Issuer C, with some individuals covered by plans in the individual market and others covered by plans in the large group market, there likely would be two different QPAs for the certified IDR entity to consider – one QPA for the services furnished to individuals enrolled in individual market coverage, and one QPA for individuals with large group market coverage. In these instances, the parties must provide the relevant information for each QPA, and the certified IDR entity must consider each QPA for each qualified IDR item or service separately. ***Note that items or services paid for by different self-insured group health plans are not allowed to be batched***[8] (emphasis added).

[8] Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities, p. 19 (October 2022) (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Federal-Independent-Dispute-Resolution-Process-Guidance-for-Certified-IDR-Entities.pdf)

Due to the inability to batch claims together by a health plan (e.g., *all* Blue Cross claims or *all* Aetna claims), non-contracted physicians are required to sort, for example, Blue Cross claims or Aetna claims by the employer that has contracted with those insurers to administer their health plan, even though this information is not readily available to physicians. This has divided up disputes that otherwise would be "batchable" into single payment determination requests – each of which now carries a $350 administrative fee, more than the likely amount in dispute for a single emergency E/M visit.

Through surveying its members, EDPMA found that, while the *No Surprises Act* is silent on a benchmark for the initial payment that health plans must make to providers for out-of-network services covered by the statute, health plans are, by and large, dispersing initial payments that are set at the Qualifying Payment Amount (QPA) reported by the health plan for that item or service. EDPMA and ACEP continue to believe that there are flaws in the QPA methodology and health plan compliance with that methodology. However, even if the QPA methodology were perfected and the health plans executed the calculations as precisely as possible, a $350 administrative fee has blessed the health plans with even more freedom to financially squeeze providers without consequence, given that the Departments have now made it economically irrational for providers to pursue dispute resolution. ***EDPMA and ACEP urge the Departments to immediately correct this flaw by rescinding the December 23, 2022 memorandum.***

Solutions

The *No Surprises Act* has brought needed financial security to patients by taking them out of the middle of disputes arising out of scenarios where the patient's insurance plan fails to fairly reimburse for services. This is particularly important for patients seeking emergency care given their inability to assess a provider's network status prior to seeking care. EDPMA and ACEP are appreciative that patients have this added security and understands that a statute of this magnitude and importance is complicated to implement. However, the pressures that have been placed on the Federal IDR system were not unknowable – and have been thoroughly documented for the Departments throughout the last year. EDPMA, ACEP, and other stakeholders have provided feedback to the Departments, alerting policymakers to the consequences of:

- Lack of provider access to insurance information (including whether it is a self-insured plan and whether it is employer-sponsored or who the employer is)
- Failure of health plans to disclose required information (e.g. the QPA or contact information)
- Lack of immediate clarity over whether state or federal law applies to a dispute
- Inordinate stress placed on IDR if below-market rate QPAs are generated (either by design by the Departments or by non-compliance by the health plans)
- Inordinate stress placed on IDR due to arduous batching rules and lack of information needed to appropriately batch under those rules.

We continue to offer ourselves as partners in implementing the *No Surprises Act* because this is an important statute for patient protection, and we are striving to get this right. However, ***the Departments cannot shift the burden of this enormous undertaking onto providers by way of an inordinate IDR administrative fee***. It is inappropriate even as articulated under the Departments' own language, it will lead to even more unduly consolidated health plan market control, and it will further destabilize safety net, emergency medicine practices. In order to address the issues cited by the Departments in the December 23, 2022 memorandum, ***EDPMA and ACEP urge the Departments to*** **rescind the December 23, 2022 memorandum, thus restoring the CY 2023 Federal IDR administrative fee of $50.** While we understand that there are certified IDR entity costs to administer these payment determinations, these costs are not the responsibility of providers. Rather, these should be accounted for in what the certified IDR entities communicated regarding their capacity as part of the certification process, the Departments' contracts with the certified IDR entities, and perhaps in setting the CY 2024 certified IDR entity fees (which are borne only by the non-prevailing IDR party), after increased Departmental transparency regarding the actual costs that led to the recalculation and an opportunity for public comment. We also refer the Departments to our January 23, 2023 letter in which ACEP and EDPMA provided in-depth recommendations that would address the issues cited by the Departments in the December 23, 2022 memorandum as prompting the need for a fee increase including mandating plan type disclosure and use of RARCs, modifying the QPA methodology to reflect market rates, moving open negotiation into the IDR portal, and modifying the batching rules to encourage fewer, larger batches.

We appreciate the opportunity to provide feedback. If you have any questions, please do not hesitate to contact the EDPMA Executive Director, Cathey Wise, at cathey.wise@edpma.org or Laura Wooster, ACEP's Senior Vice President of Advocacy and Practice Affairs at lwooster@acep.org.

Sincerely,

Don Powell, DO FACEP
Chairman
EDPMA

Christopher S. Kang, MD, FACEP
President
ACEP

EXHIBIT 10

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

January 19, 2023

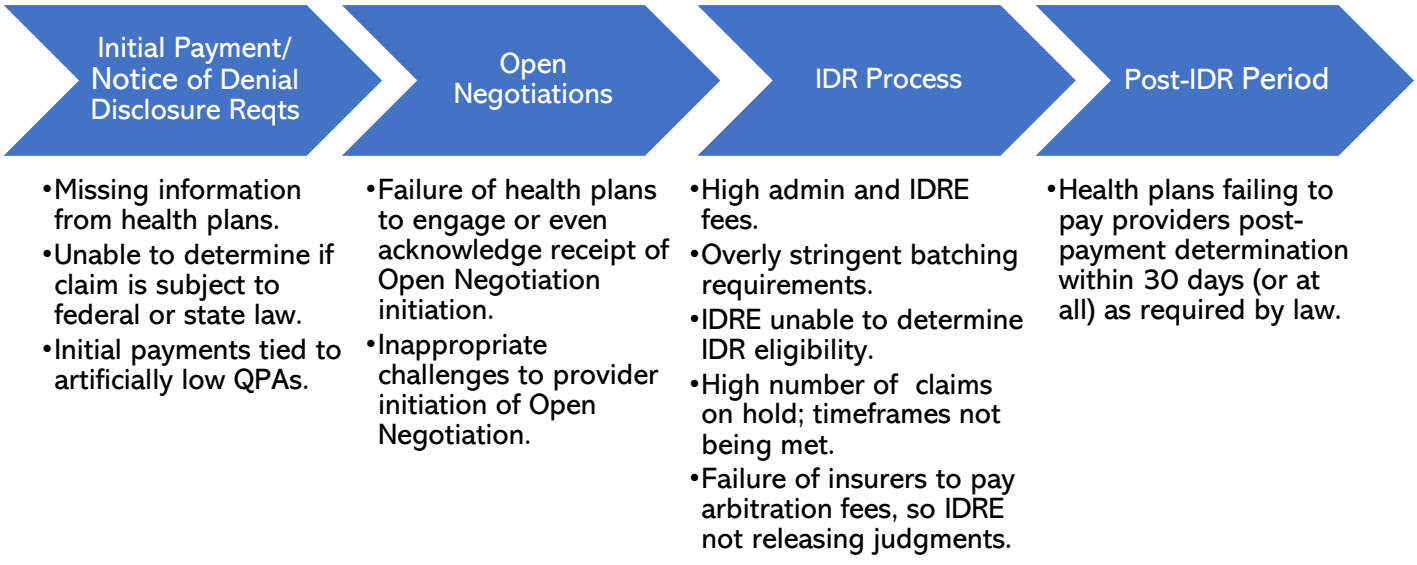
The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

Dear Secretaries Becerra, Walsh, and Yellen:

On behalf of our members, the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA) would like to thank the Departments of Health and Human Services (HHS), Labor, and Treasury (the Departments) for the opportunity to meet with members of their staff and other stakeholders on January 5, 2023 to discuss issues related to the implementation of the *No Surprises Act* and discuss potential solutions to the challenges our members are experiencing with the federal dispute resolution process. We found the discussion to be very productive, and we hope that we can continue to work collaboratively with the Departments and other stakeholders to find mutually beneficial ways to improve the process.

The figure below presents a high-level summary of the key issues that were discussed during the meeting.



As a follow-up, we are now providing additional input on some of these issues and more detailed recommendations for addressing them. ACEP and EDPMA's specific recommendations are broken out by the distinct phases of the dispute resolution process.

Before discussing our recommendations, we would like to first note that some of the difficulties with the process have been exacerbated by the unique aspects of how patient care billing works in emergency medicine. Despite the fact that these are universal realities in emergency care, we find they are often confused with the realities of scheduled, non-emergency care.

There is a great deal of variability in the amount of information that emergency medicine groups receive about an individual's insurance coverage at the time of treatment. Because of the dynamics and realities of acute, unscheduled patient care, emergency medicine providers often only receive limited information (or none at all) at the time they treat the patient in the emergency department (ED). This phenomenon is amplified by an important difference between scheduled care and emergency care due to the Emergency Medical Treatment & Labor Act (EMTALA). Emergency medicine groups do not collect billing or cost-sharing information prior to stabilizing the patient in accordance with the long-standing law, first enacted in the late 1980s.

In addition, in contrast to emergency care, insurance verification for pre-scheduled health care involves far more than the name of the insurance plan. With respect to scheduled health care, administrative staff not only verify first-level insurance information, but they also drill down to the patient's individual health plan type before the patient enters the exam room or treatment space. This type of information is critical and necessary not only for the payment process, but also for the federal dispute resolution process under the *No Surprises Act*. Administrative staff also pre-identify the correct co-pays, deductibles, and other pertinent benefit information, and, often, will require pre-payment of some or all patient-responsibility amounts, **all before health care is delivered**.

Emergency medicine practices, on the other hand, must wait until *after* the episode of care has occurred, and then wade through the morass of individual policy benefits, relying on costly and time-consuming administrative back-and-forth that may again involve the patient for more clarification (who often, will not know a sufficient level of detail, and must go back to the insurance plan, who *does* have the information). Therefore, requiring key information exchange between health insurers and providers proactively reduces administrative cost and keeps patients out of the middle.

The following table provides more detail and articulates a basis for ACEP and EDPMA's recommendations below, particularly around proactively communicating the health plan type and the *No Surprises Act* Remittance Advice Remark Codes (RARCs) and making accurate insurance information readily available to both providers and patients.

Step in the Emergency Encounter	Accompanying Data
1. A person presents to an emergency department (ED) believing they have an emergency medical condition (EMC). The hospital collects enough information from the patient so that care can be initiated. As mandated by the federal Emergency Medical Treatment and Labor Act (EMTALA) statute, a clinician performs a medical screening exam (MSE) – which may or may not include testing – to determine if an EMC exists.	Name, date of birth, allergies, etc. *This basic information is sufficient to initiate treatment, but insufficient for billing purposes.*

2. If the clinician reasonably believes an EMC exists, stabilizing treatment must be rendered to the patient. If the EMC can be stabilized and treated in the ED, the patient is discharged from the ED once that is complete (and, if necessary, any post-stabilization care will be addressed as appropriate). The hospital will collect more in-depth information from the patient prior to discharge from the ED.	Insurance coverage (if any), detailed contact information, demographics, employer, etc. *Note that patients often have outdated or inaccurate insurance cards or no information in hand at the time of their emergency, so emergency physician groups and billing companies may never have access to the patient's actual insurance card.* *In addition, certain health plan coverages in effect may not apply to this emergency (for example, auto insurance or workers' compensation is actually the payor for the claim). Due to EMTALA restrictions, the patient and the provider cannot definitively determine the health plan that is responsible for payment, the deductible amount, or co-insurance at the time care is rendered.*
3. If the patient requires further care to stabilize the EMC, the patient may be admitted to the hospital or transferred– in compliance with EMTALA mandates.	*Comprehensive billing information is gathered if the patient is admitted from the ED to the hospital but may <u>not</u> be gathered if the patient is transferred to another hospital (a higher level of care). These patients are often unstable. Financial discussions are inappropriate at the time of transfer; information must be obtained later.*
4. Following the patient's visit, the hospital shares patient information with the emergency physician group and/or billing company as part of a regular data transfer—usually daily.	*The physician group usually receives billing information routinely from the hospital, but its accuracy and thoroughness for ED patients is highly variable. This requires additional or more accurate data to supplement the initial data feed. Hospitals are subject to EMTALA and have the same limitations in their ability to gather data at the time of care as noted above.*
5. The physician group or billing company submits a claim to the patient's insurance company for the encounter.	*The physician group or billing company determines whether to submit a claim based on the best information available. The patient is re-contacted or directly billed if there is no information or if the information is inaccurate or incomplete.*
6. The insurance company responds to the physician or its billing group with an initial payment or denial, and an accompanying remittance.	*The health plan is responsible to remit timely payment under the* No Surprises Act*'s provisions. In order to do that, it must receive, evaluate, and process the claim, and remit timely payment. In doing so, it must also be able to identify the health plan type and other critical information. In service of reducing administrative burden, keeping patients out of the middle, reducing cost, and reducing reliance on IDR, EDPMA and ACEP strongly advocate for requiring and enforcing transparency and communication at the time of initial payment, including health plan type, RARCs, and claim adjustment reason codes (CARCs).*
7. If the patient's insurance coverage has a deductible that has not yet been met, the physician group or billing company sends a bill to the patient for their cost-sharing responsibility.	*Patient responsibility amounts are determined by the Qualifying Payment Amount (QPA) as set forth in the* No Surprises Act. *It is important that the QPA be identified (as required) at the time of initial payment.*

Overall, this process demonstrates how emergency care is substantially different due to EMTALA's requirements for provision of a medical assessment and stabilizing care without prior review of the patient's ability to pay (or health insurer's willingness to pay). As a result, the emergency care system has significant and unique dependency on payment and billing processes *after* care has been rendered.

With that context in mind, here are our additional recommendations related to the federal dispute resolution process:

Initial Payment and Notice of Denial Phase

Information Disclosures

As discussed in the meeting, in many cases, the provider does not receive all the information required to be disclosed by health insurers at the time of the initial payment or notice of denial. In some cases, the qualifying payment amount (QPA) for the item or service billed is not being clearly identified, and a certifying statement that affirms that the QPA was calculated properly and that it serves as the recognized amount for the purposes of calculating patient cost-sharing is missing. This lack of information makes it difficult for providers and eventually for certified IDR entities to determine whether a claim is eligible for the federal IDR process.

We have previously made recommendations about how to address the lack of information that providers are receiving from health insurers both during the initial payment and notice denial phase, and during the rest of the dispute resolution process. These recommendations were made with the intention of reducing the frequency on IDR, reducing administrative cost, and providing time- and cost-saving interventions early in the process. While our key recommendations are found below, we have also included a table in the ***Appendix*** that provides an overview of how our recommendations align with the major regulatory requirements of the dispute resolution process.

Recommendations

- **Mandate Plan Type Disclosure:** The Departments should require that the plan type be disclosed at the time of the initial payment or notice of denial, as this information is not available on a patient's insurance ID card (if that is even obtainable). Without knowing the type of plan early in the dispute resolution process, it will be extremely difficult for the provider to know whether the plan is a fully insured or self-insured plan, and whether it is therefore subject to the federal or state dispute resolution process.

- **Mandate Use of RARCs:** The Departments should require health insurer and issuer use of the Remittance Advice Remark Codes (RARCs) when providing the disclosures that regulation requires accompany the initial payment or notice of denial. Ensuring the use of the RARCs for all claims will also give providers the necessary information to assess patient responsibility amounts, keep patients out of the middle of the process, and reduce the need to initiate payment disputes for out-of-network services. Further, the RARCs will provide certified IDR entities with dispositive information about whether a particular claim is eligible for the federal IDR process.

QPAs and Initial Payments Being Artificially Low

During the January 5 meeting, ACEP and EDPMA emphasized some key points about the QPA and the initial payments:

- The QPA methodology finalized by the Departments is leading to artificially low QPAs that do not reflect market-rates. It was designed to limit cost-sharing liabilities and is not a market-based indicator of appropriate payment for an item or service.

- We are also hearing complaints that health insurers are miscalculating the QPA, leading to QPAs **even lower** than what proper adherence to the methodology would dictate. This combination of the QPA methodology *and* the miscalculations has led to QPAs that "don't even pass the laugh test"—those that are so low that they are even significantly below Medicare and Medicaid payment rates.

Recommendations

- **Increase Transparency Around Calculation of the QPA:** It is essential that the Departments require health insurers to disclose the methodology used to calculate the QPA for an out-of-network claim, so that providers are ensured it is calculated correctly and in line with the regulatory requirements. Currently, there is little to no recourse for providers who believe that the QPA is miscalculated. While they can submit a complaint, the initial payment they receive for that service is still, in most cases, based on an incorrectly calculated QPA. Currently, providers are restricted from requesting from health insurers specific information on how the QPA was calculated (i.e., to "check their math"), so requiring more transparency is the ONLY way to ensure that health insurers actually adhere to the methodology.

- **Scale up and Publicize Auditing of the QPA:** ACEP and EDPMA understand that the Departments have begun with their statutorily required audits of the QPA calculations. However, to enhance transparency, the Departments should scale up and publicly report on the results of these audits. That way, health insurers will be able to better understand the common mistakes that are being made when calculating the QPA and, hopefully, the number of miscalculations will decrease over time.

- **Modify the QPA Methodology to Ensure that the QPA Reflects Market Rates:** Our organizations have requested numerous modifications to the QPA methodology in previous comments. We continue to be especially concerned about the decision to use each contracted rate as a single data point when calculating a median contracted rate. The rate negotiated under a contract constitutes a single contracted rate regardless of the number of claims paid at that contracted rate**.** We request that the Departments base the rate on the total number of actual payments issued to individually contracted physicians. By basing the contract on claims rather than contracts, the QPA would more accurately reflect the actual negotiated rates between payors and providers. ***Health insurers should also be reminded that they are not required to tie the initial payment to the artificially low and potentially miscalculated QPA. The initial payment is supposed to represent a reasonable payment in full for the service that was delivered—and in many cases, the QPA, which was designed to keep patient cost-sharing low, does not reflect a reasonable payment.***

Open Negotiations Phase

There was ample discussion during the meeting about the lack of active negotiations during the Open Negotiations phase of the dispute resolution process. Our physician groups report that health insurers are sometimes not acknowledging receipt of the notice to initiate Open Negotiations and/or are not actively engaging in negotiations at any point during the 30-day period. The lack of engagement by health insurers to come to a resolution before

the IDR process is initiated is counter to the overall intent of the *No Surprises Act* to use the IDR process as a last resort-- and is a significant contributing factor toward the high number of disputes that advance to Federal IDR.

Some stakeholders did note that part of the reason why there may not be much engagement during this part of the dispute resolution process is the fact that both the statute and the regulations do not lay out a particular structure to Open Negotiations nor do they articulate any goals or parameters of the negotiations. Health insurers also reported that the notice of Open Negotiations was frequently going to the wrong contact person, so they had no way of tracking which claims had entered into the Open Negotiations Process.

Recommendation

- **Include the Open Negotiations Process in the IDR Portal:** The Departments should consider incorporating the Open Negotiations Process into the IDR portal. Doing so could help both health insurers and providers better track what claims are entering the dispute resolution process and when the 30-day Open Negotiations Process begins. There could also be a way to assign an identification number to specific items or services under dispute to better track them through the process. The updated portal could also clearly include the contact information, including the email addresses, for all the key contacts involved in the dispute. Finally, it would formalize the Open Negotiations Process and provide a more structured way for health insurers and providers to share information and try to resolve disputes before the IDR process. Therefore, it could track the level of engagement by both health insurers and providers and provide more data to the Departments about the level of compliance among the disputing parties to the statutory and regulatory requirements.

  If the Departments were to move in this direction, they must take the following into account:
  - *Administrative Complexity:* It is important that such a change is done in a manner that *reduces* administrative burden and does not create even more complexity.
  - *Terms of Open Negotiations NOT a Factor in the IDR Process:* If disputes go to the IDR phase of the dispute resolution process, the certified IDR entity should not be privy to the specific discussions that took place during Open Negotiations, including the amounts of any offers or counteroffers exchanged between the parties. The ONLY factor the certified IDR entity should take into account (or perhaps even be privy to) from Open Negotiations is the ***level of engagement*** of each party during that phase of the process.
  - *Batching Flexibility:* There are different rules around how claims can go through the Open Negotiations Process versus how they can be batched during the IDR process. If Open Negotiation is moved into the portal, we want to ensure that providers would continue to have the flexibility to decide how they want to batch certain claims at the beginning of the *IDR* process, rather than having to already make that decision at the start of Open Negotiations. Yet this could also offer providers an incentive and mechanism to enter some groups of claims into Open Negotiation organized according to the batching criteria, which could ease throughput pressure on certified IDR entities.

IDR Process and Beyond

Accessibility, Transparency, and Enforcement

Participants in the meeting discussed the results of the Department's first report on the IDR process that included data from the initial reporting period, April 15 to September 30, 2022. There was particular interest in understanding the geographic variation among the total number of initiated IDR claims and the number of claims determined to be ineligible for the IDR process—as most of the disputes were concentrated in a select few states.

Further, ACEP and EDPMA pointed out that the reason the majority of the initiating parties were large practice management companies, medical practices, or revenue management companies representing hundreds of individual groups was that many smaller groups simply did not have the resources or administrative capability to engage in the complex and administratively burdensome (and often fruitless) process. In fact, because of the high cost of the process and the fact that many IDR claims are currently on hold, some billing companies are instructing smaller groups not to use the process at all.

Finally, provider groups in the meeting noted the extremely concerning trend related to health insurers' failure to pay what they owe to the provider if a certified IDR entity finds in favor of the provider. ***Many health insurers are simply not paying the amount owed within the required 30-day period, if at all***, despite numerous attempts by providers to collect the payment they are entitled to under the terms of the arbitration. One group noted during the meeting that it has not received the amount owed to it in ***over 90 percent*** of the cases in which the certified IDR entity ruled in its favor (the eligibility rate and win rate was also over 90 percent, demonstrating a high level of reasonableness and good faith in utilizing the IDR process).

Recommendations

- **Reduce the IDR Fees in 2023:** The Departments should immediately rescind the significant increases in both the administrative fee and the fees that certified IDR entities can charge. These fees already create a financial barrier that prevents physician practices from participating, especially smaller and rural practices. These increases will further limit what types of claims go through the IDR process.

- **Make Enforcement and Auditing More Transparent:** The primary mechanism for addressing non-compliance with the *No Surprises Act* is on a case-by-case basis through the submission and resolution of individual complaints.

  We therefore recommend that the Departments release aggregated information about these cases, including:
  - The total number of cases
  - The total number of cases that are resolved
  - The total number of cases that are unresolved
  - The most common issues raised and how these issues were addressed
  - Best practices to avoid issues that are commonly leading to complaints

  This information should also be broken out by state to help provide more granular data and potentially answer some of the questions posed during the meeting about the possible reasons for geographic variation among IDR cases.

  Releasing all of this information will reduce the overall number of complaints and increase compliance of all *No Surprises Act* requirements. Further, analysis of these complaints could help determine which health insurers need to be audited. **Auditing is critical to ensuring that health insurers have an incentive to comply with the statutory and regulatory requirements.** The Departments should therefore publicly report auditing results, as well as best practices.

- **Enforce Required Payments:** Health insurers who are not paying what they owe to a provider after the IDR process is completed ***must be penalized and forced to compensate the provider the total amount owed plus interest.***

Batching Issues

During the meeting, multiple participants stated that the rules and requirements around batching are leading to significant confusion as well as an *increase* in the number of claims going through the IDR process (rather than the decrease batching was intended for). One of the major batching issues relates to "the same group health plan or health insurance issuer." This policy alone has created so much confusion that some providers are simply not even trying to batch self-insured claims. Further, these criteria require providers to know the employer of a product. This information is frankly not readily available to out-of-network providers, thus injecting a batching criterion that has thrown the entire system into disarray.

We believe that the statute was clear that all disputes (that otherwise met the batching requirements) from the same group health plan (or health insurance issuer) could be batched. The statute did *not* state that batching was limited to individual insurance products offered by a group health plan. Moreover, it is unworkable from the provider's perspective because in order for it to work, it relies on out-of-network providers organizing disputes based on information that they simply do not have.

Not having the plan type (as described earlier with regard to eligibility for IDR) also creates issues with batching, as providers do not know whether the health plan is a self-insured plan or the employer corresponding to the plan. Requiring health plans to provide the plan type at the time of the initial payment or notice of denial (one of our previous recommendations) would therefore also help reduce some of the errors in batching.

Having to put small batches through the IDR process has become even more concerning given the significant increase in IDR fees in 2023. Not only did the Departments announce a 40 percent increase to the maximum amounts that certified IDR entity fees could charge in 2023, but the Departments also just recently announced a 600 percent increase in the administrative (non-refundable) IDR fee that the Departments charge—from $50 to $350. With these increases, the financial burden of entering the IDR process will become even more cost-prohibitive for many physician groups who have limited infrastructure or resources. The high administrative fee of $350 specifically creates an artificial threshold for the IDR process—**a barrier that Congress explicitly omitted from the statute despite several proposals for thresholds offered along the way**. If claims are less than $350 and cannot be batched together to exceed this threshold, it is actually more expensive to enter the IDR process than to adjudicate a low payment to a claim, thereby limiting what types of claims can go through the IDR process, and unfairly providing insurers with further advantages in the process.

Recommendations

- **Modify Batching Rules to Have Fewer, Larger Batches Rather than More, Smaller Batches or Individual Disputes**: The Departments should take a careful look at all their batching requirements and ensure that they are 1) simple and easy to understand; and 2) do not require providers to have access to information that they do not have. This should at least include a modification to how batching is conducted for self-insured claims. In the alternative, the Departments must require that health insurers provide all information necessary to correctly batch claims in tandem with delivery of the initial payment.

Collection and Exchange of IDR Fees

Some stakeholders during the meeting raised the issue that it was difficult to transfer both the IDR administrative fee and the certified IDR entity fee to the certified IDR entity, as required. If the certified IDR entity does not receive the fees for both parties, the entity cannot render a decision—and this has contributed to some delays in the IDR process. One provider group said that certified IDR entities have different systems in place to electronically collect the fees (and noted that at the be process, one entity actually at one point had even required the use of PayPal to receive the fees).

Recommendation

- **Require Electronic Payment Uniformity Among Certified IDR Entities:** Certified IDR entities should have a uniform process in place to electronically collect all the IDR fees and refund the winning party the certified IDR entity fee. By creating a streamlined process of exchanging fees associated with the IDR process, there would be less interruptions to process and more adherence to the statutorily required timeframes.

Conclusion and Summary

We hope our letter sufficiently summarizes the major issues that providers are experiencing and provides more detail about the recommendations we discussed during the meeting. Overall, as stated throughout the letter, we recommend that the Departments ***immediately*** take the following steps:

Initial Payment and Notice of Denial Phase

- **Mandate Plan Type to Be Disclosed:** The Departments should require that the plan type be disclosed at the time of the initial payment or notice of denial.

- **Mandate Use of the RARCs:** The Departments should require health insurer use of the Remittance Advice Remark Codes (RARCs) when providing the disclosures that are required along with the initial payment or notice of denial

- **Increase Transparency around the Calculation of the QPA:** The Departments should require that health insurers demonstrate to providers that they are following the methodology outline in regulation and ensuring that QPAs are calculated correctly.

- **Scale up and Publicize Auditing of the QPA:** The Departments should scale up and publicly post the results of the ongoing QPA audits.

- **Modify the QPA methodology to ensure that the QPA reflects market-rates:** The Departments should modify the QPA methodology by basing the median contracted rate on the total number of actual payments issued to individually contracted physicians.

Open Negotiations Phase

- **Include the Open Negotiations Process in the IDR Portal:** The Departments should consider incorporating the Open Negotiations Process into the IDR portal. If the Department do pursue this

approach, there are a number of factors that ACEP and EDPMA believe the Departments must take into account when doing so.

IDR Process and Beyond

- **Reduce the IDR Fees in 2023:** The Departments should immediately rescind the significant increases in both the administrative fee and the fees that certified IDR entities can charge.

- **Make Enforcement and Auditing More Transparent:** The Departments should release information about the complaints they receive—broken out by state. Auditing is also critical to ensuring that health insurers have an incentive to comply with the statutory and regulatory requirements. The Departments should therefore publicly report auditing results, as well as best practices.

- **Enforce Required Payments:** Health insurers who are not paying what they owe to a provider after the IDR process is completed must be penalized and forced to compensate the provider the total amount owed plus interest.

- **Modify Batching Rules So That There Will be fewer LARGER Batches Rather Than More SMALLER Batches or Individual Disputes**: The Departments should take a careful look at all their batching requirements and ensure that they are 1) simple and easy to understand; and 2) do not require providers to have access to information that they do not have.

- **Require Electronic Payment Uniformity Among Certified IDR Entities:** Certified IDR entities should have a uniform process in place to collect all the IDR fees and refund the winning party the certified IDR entity fee.

We appreciate the opportunity to lay out our concerns and provide potential solutions to help improve the implementation of the *No Surprises Act*. If you have any questions, please contact Laura Wooster, ACEP's Senior Vice President of Advocacy and Practice Affairs at lwooster@acep.org, or Cathey Wise, EDPMA's Executive Director at cathey.wise@edpma.org.

Sincerely,

Christopher S. Kang, MD, FACEP
ACEP President

Don Powell, DO
Chair of the Board, EDPMA

Appendix: Information Needed for Federal Dispute Resolution Process

Major Regulatory Requirement	Regulatory Citation	Are Health Insurers Complying?	Recommendations
Disclosures Required at the time of the Initial Payment/Notice of Denial			
Qualified Payment Amount (QPA)	45 CFR § 149.140(d)(1)(i)	Rarely	• Mandate RARCs. • Publish audits of the QPA. • Require insurers to display the methodology used to calculate QPA. Information could include: ○ Number of contracts used to calculate the QPA; ○ Whether QPA was calculated using contracts with clinicians in same or similar specialty; ○ Geography used to calculate the QPA (i.e., Single MSA, all MSAs in a state, Census Division); ○ Percentage of total claims covered by contracts used to calculate QPA (in-network percentage); ○ Percentage of in-network claims attributable to each contract; ○ Whether plan or issuer's QPA calculations have had an audit result of anything other than "clean" within the last 3 years; ○ If the plan or issuer uses a standard fee schedule, the amount for the service as it

			appears on the fee schedule for the specific market; and ○ If plan or issuer uses contracts from a plan year other than January 31, 2019 to calculate the QPA.
Statement that the QPA is Calculated Accurately and Can be Used for Cost-Sharing: Statement certifying that, based on the determination of the plan or issuer: (1) the QPA applies for purposes of the recognized amount each QPA; and (2) the QPA shared with the provider or facility was determined in compliance with the methodology outlined in these interim final rules.	45 CFR § 149.140(d)(1)(iii)	Rarely	• Mandate RARCs. • Require health insurers to disclose the plan type.
Statement Regarding Initiation of Open Negotiations: A statement that if the provider wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider may contact the appropriate person or office to initiate open negotiation, and that if the 30-day negotiation period does not result in a determination, generally, the provider or facility may initiate the independent dispute resolution process within 4 days after the end of the open negotiation period. The plan or issuer must provide contact	45 CFR § 149.140(d)(1)(iv); 45 CFR §149.140(d)(1)(v)	Rarely	• Better enforcement of this requirement. • Include contact information as an element in combined Open Negotiations and IDR Portal.

information, including a telephone number and email address, for the appropriate office or person to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.			
Information about Contracted Rates not Based on FFS: Upon request of the provider, information about whether the QPA includes contracted rates that were not set on a fee-for-service basis.	45 CFR § 149.140(d)(2)(i)	Sometimes	• Better enforcement of this requirement.
Information about Cost-sharing Rates including Incentive Payments: Upon request, a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services involved that were excluded for purposes of calculating the QPA.	45 CFR § 149.140(d)(2)(iv)	Sometimes	• Better enforcement of this requirement.
Downcoding: If the QPA is based on a downcoded service code or modifier: • a statement that the service code or modifier billed by the provider or facility was downcoded;	45 CFR § 149.140(d)(1)(ii)	Sometimes	• Better enforcement of this requirement.

• An explanation of why the claim was downcoded, including a description of which service codes or modifiers were altered, added, or removed, if any; and • The amount that would have been the QPA had the service code or modifier not been downcoded.			
Open Negotiations			
Notice to Initiate Open Negotiations: To initiate the open negotiation period, a party must send a notice to the other party (open negotiation notice) that includes information outlined in 45 CFR § 149.510(b)(1)(ii).	45 CFR § 149.510(b)(1)	Rarely acknowledging receipt of the Open Negotiations notice or actively engaged in negotiations.	• Consider combining the Open Negotiations and IDR Portal in order to make sure Open Negotiations Process can be better tracked and actually help facilitate negotiations prior to the IDR process.
IDR Process and Beyond			
Notice of IDR Initiation: To initiate the Federal IDR process, a party must submit a written notice of IDR initiation to the other party and to the Secretary, using the standard form developed by the Secretary, during the 4-business-day period beginning on the 31st	45 CFR § 149.510(b)(2)	Since health insurers rarely provide this information at the time of initial payment or notice of denial, it is difficult for initiating parties (providers) to include all the required information.	• Better enforcement of previous requirement for health insurers to provide certain disclosures at the time of the initial payment/notice of denial.

business day after the start of the open negotiation period. The notice must include information outlined in 45 CFR § 149.510(b)(2)(iii).			
Batched items and services: Batched items and services may be submitted and considered jointly as part of one payment determination by a certified IDR entity only if the batched items and services meet the requirements listed in 45 CFR § 149.510(c)(3)(i).	45 CFR § 149.510(c)(3)(i)	The batching rules are difficult to adhere to and result in more, not less, batches.	• Modify batching rules so that there will be fewer larger batches rather than more smaller batches or individual disputes.
IDR Offer: Not later than 10 business days after the selection of the certified IDR entity, the plan or issuer and the provider, facility, or provider of air ambulance services must each submit to the certified IDR entity: an offer of an out-of-network rate expressed as both a dollar amount and the corresponding percentage of the qualifying payment amount represented by that dollar amount; information requested by the certified IDR entity relating to the offer; and additional information listed in 45 CFR § 149.510(c)(4)(i)(3).	45 CFR § 149.510(c)(4)(i)	In many cases, the offer submitted by the health insurer is close to the initial payment, which mirrors the QPA. It is difficult for providers to develop a counteroffer when there is limited transparency over how the QPA is calculated.	• Remind health insurers that the initial payment does not need to be based on the QPA. • Publicize audits of the QPA. • Require more transparency over how the QPA is calculated.

Payment Determination and Notification: Not later than 30 business days after the selection of the certified IDR entity, the certified IDR entity must select as the out-of-network rate for the qualified IDR item or service one of the offers as the out-of-network rate.	45 CFR § 149.510(c)(4)(ii)	Certified IDR entities rarely meet this 30-business-day timeline for making a payment determination.	• Reduce the backlog of claims and enforce the 30-day requirement.
Written Decision: The certified IDR entity must explain its determination in a written decision submitted to the parties and the Secretary that includes specific information outlined in 45 CFR § 149.510(c)(4)(vi)(B).	45 CFR § 149.510(c)(4)(vi)	Certified IDR entities meet this requirement, but sometimes do not fully explain how they came to their decision.	• Better transparency around how certified IDR entities render their decisions.
Payment by Losing Party: If applicable, the amount of the offer selected by the certified IDR entity (less the sum of the initial payment and any cost sharing paid or owed by the participant or beneficiary) must be paid directly to the provider, facility, or provider of air ambulance services not later than 30 calendar days after the determination by the certified IDR entity.	45 CFR § 149.510(c)(4)(ix)	Insurers rarely pay within 30-day period in cases where certified IDREs select the provider's offer.	• Penalize health insurers not paying what they owe to a provider after the IDR process is completed. • Compel health insurers to compensate the provider the total amount owed plus interest.
Costs of IDR Process: Each party must pay the predetermined certified IDR entity fee charged by the certified IDR entity to the	45 CFR § 149.510(d)	Sometimes Certified IDREs do not receive the IDR fees from health insurers.	• Certified IDR entities should have a uniform process in place to collect all the IDR fees and refund the winning party the certified IDR entity fee.

certified IDR entity at the time the parties submit their offers. Each party must, at the time the certified IDR entity is selected, pay to the certified IDR entity a non-refundable administrative fee due to the Secretary for participating in the Federal IDR process.		The high IDR fees are making it cost-prohibitive for many physician groups to participate in the IDR process.	• The Departments should immediately rescind the significant increases in both the administrative fee and the fees that certified IDR entities can charge.
Extension of Time Periods for Extenuating Circumstances: The time periods for the IDR may be extended in extenuating circumstances at the Secretary's discretion if certain conditions, found in 45 CFR § 149.510(g)(1).	45 CFR § 149.510(g)	The timelines are being extended routinely even in the absence of a formal extension request.	• Reduce the backlog of claims. • Enforce timelines mandated by statute and regulation.

EXHIBIT 11

April 25, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

RE: ***Feedback on the Independent Dispute Resolution (IDR) Portal***

Dear Secretaries Becerra, Walsh, and Yellen:

On behalf of our members, the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA) would like to lay out some issues emergency physicians have had obtaining the required information from plans and issuers as articulated under the *Requirements Related to Surprise Billing; Part I Interim Final Rule* (First IFR).[1] All of the information listed in the regulation is absolutely necessary for providers in order to accurately assess the patient responsibility amounts, keep patients out of the middle of easily

[1] Requirements Related to Surprise Billing; Part I. 86 FR. 36898-36899 (July 13, 2021).

addressable issues, sustain clinical practices, and eventually resolve any payment disputes for out-of-network services with efficiency for all parties involved.

As background, ACEP is the national medical society representing emergency medicine. Through continuing education, research, public education and advocacy, ACEP advances emergency care on behalf of its 40,000 emergency physician members, and the nearly 150 million Americans we treat on an annual basis. EDPMA is the nation's largest professional physician trade association focused on the sustainable delivery of high-quality, cost-effective care in the emergency department (ED), and its members handle over half of the visits to U.S. emergency departments each year. Together, ACEP and EDPMA members provide a large majority of emergency care in our country, including rural and urban settings, in all fifty states and the District of Columbia.

Overview of Regulatory Requirement

In the First IFR implementing the *No Surprises Act*, the Departments require that "plans and issuers make certain disclosures with each initial payment or notice of denial of payment, and that plans and issuers must provide additional information upon request of the provider or facility. This information must be provided in writing, either on paper or electronically, to a nonparticipating provider, emergency facility, or provider of air ambulance services, as applicable, when the QPA serves as the recognized amount."[2]

These required disclosures, which are specifically found in the First IFR[3], include the following:

- First, a plan or issuer must provide the Qualifying Payment Amount (QPA) for each item or service involved.

- Second, a plan or issuer must provide a statement certifying that, based on the determination of the plan or issuer: (1) the QPA applies for purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing), and (2) each QPA shared with the provider or facility was determined in compliance with the methodology outlined in these interim final rules.
    - The First IFR also requires a statement from the plan or issuer that the QPA applies for purposes of the recognized amount so that providers and facilities will understand that the plan or issuer has determined that neither an All-Payer Model Agreement nor a specified state law applies for purposes of calculating a participant's, beneficiary's, or enrollee's cost-sharing liability, but rather that cost sharing liability has been calculated using the QPA. The Departments expect that in most if not all cases where the QPA serves as the basis for determining the recognized amount, the federal IDR process will govern any dispute over payment instead of a specified state law or process. Therefore, this notice will also serve to

[2] 86 FR. 36898 (July 13, 2021).
[3] 86 FR. 36898-36899 (July 13, 2021).

direct providers or facilities to the federal IDR process if the parties cannot agree on an out-of-network rate.

- Third, a plan or issuer must provide a statement that if the provider or facility, as applicable, wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate open negotiation, and that if the 30-day open negotiation period does not result in a determination, generally, the provider or facility may initiate the IDR process within 4 days after the end of the open negotiation period. The plan or issuer must also provide contact information, including a telephone number and email address, for the appropriate office or person to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.

- In addition, upon request of the provider or facility, a plan or issuer must provide, in a timely manner, information about whether the QPA includes contracted rates that were not set on a fee-for-service basis for the specific items and services at issue and whether the QPA for those items and services was determined using underlying fee schedule rates or a derived amount. If a related service code was used to determine the QPA for a new service code, a plan or issuer must provide information to identify which related service code was used. Similarly, if an eligible database was used to determine the QPA, a plan or issuer must provide information to identify which database was used to determine the QPA.

- Finally, if applicable upon request, a plan or issuer must provide a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services involved that were excluded for purposes of calculating the QPA. Having information about whether the median contracted rate excludes these types of payment adjustments will better inform the open negotiation and IDR process.

Examples of Incomplete information

ACEP and EDPMA are extremely concerned that although these requirements have been very clearly spelled out for months in the First IFR, they are already not being met and therefore threaten the objectives of the *No Surprises Act.* As seen in the examples provided in Appendix 1, some issuers are not providing all the required information directly to providers with each initial payment or notice of denial of payment. Here are some overall issues our members are experiencing:

- **Issuers do not indicate that the QPA applies for purposes of the recognized amount**: As required by the *No Surprises Act*, when a state law or all-payer model does not apply, the cost-sharing amount for out-of-network services (called the "recognized amount"), should be based on the QPA. However, as seen from the Appendix 1 examples labelled "Unclear if patient responsibility tied to QPA," there is no statement or any other notification from the issuer that the QPA applies for purposes of the recognized amount. Since it is unclear whether the cost-sharing amount included in the remittance notice *is* the

recognized amount, our members are unable to verify whether that amount is accurate. **This lack of information can cause confusion for both providers and patients and can easily result in patients being billed the incorrect amount—which consequentially puts patients back in the middle of billing disputes.**

While the Centers for Medicare & Medicaid Services (CMS) recently released guidance for *No Surprises Act* Remittance Advice Remark Codes (RARCs) that would note that the cost-sharing amounts are calculated in concordance with the *No Surprises Act* requirements, the RARC codes are not mandatory and are not always being used. There are also RARC codes that identify whether the claim is subject to the federal process, but these also are not being included on remittance notices. The omission of the RARC codes is reflected in the Appendix 1 examples that are labelled "No Code (RARC) to notify claim is subject to the federal process**." Thus, without the RARC codes, and without a statement that the QPA applies for purposes of the recognized amount, it is also impossible to know whether the federal dispute resolution process applies to the claim instead of a specified state law or process.**

- **The QPA is NOT provided along with each initial payment or notice of denial.** The initial payment or denial, along with other information about the claim, are usually provided on an electronic remittance advice (ERA) or paper-based remittance notice. However, many issuers are not including the QPA on the ERA or paper-based remittance notice. We include such examples in Appendix 1 (labelled "No QPA"). Omission of the QPA from these remittance notices violates the regulatory requirement for the issuer to provide the QPA to the provider with each initial payment or notice of denial.

- **Most issuers are not providing contact information, including an email address, for the appropriate office or person with which to initiate open negotiations.** This information in many cases is not located on ERAs or paper-based remittance notices, and often cannot even be provided by issuers when our members contact them and specifically request it. Examples of missing contact information are included in Appendix 1 (labelled "No Email Contact for Initiation of Open Negotiation"). On the occasions that a phone number is at least included, without an email address, initiating open negotiation becomes administratively inefficient for all parties, adding costs to the system. Unlike a phone number, an email address also ensures a documented paper trail that will provide all parties with appropriate protection to demonstrate that the *No Surprises Act*'s many required timelines for open negotiation and the IDR process were adhered to.

Specific Requests

ACEP and EDPMA believe that the Departments should take the following actions to ensure that issuers are complying with the regulatory requirements around information sharing.

1. **Require Issuers to Include All Information in One Place: The Departments should require issuers to include all the required information listed in the First IFR in one place at the time of the initial payment or notice of denial—specifically in the ERAs or paper-based remittance notices.** Currently, there is no requirement for issuers to provide the information in a specific format or in a specific document. Creating and enforcing such a requirement may help address some of the issues we are experiencing and reduce administrative complexity.

2. **Require Information to Be Displayed in a Standardized Format:** In addition to requiring issuers to display all the information in one place**, the Departments should require the use of a standardized template in which to relay the information. The Departments could create such a standard template which includes all the required information in a clear and easily understood format.** Issuers then could then incorporate the standardized template into their ERAs or paper-based remittance notices to ensure that all required information is accurately transmitted to providers at the time of the initial payment or notice of denial.

3. **Require the use of the *No Surprises Act* RARCs**: As referenced above, CMS recently finalized new RARCs that are now optional for issuers to use to communicate information about claims to providers and facilities, subject to state law. **As part of the standardized template, the Departments should require the use of the RARCs.**

ACEP and EDPMA strongly believe that adopting these recommendations would help achieve many noteworthy goals that we both share: ensuring that patients are billed accurately and kept out of the middle of payment disputes; reducing administrative complexity and burden; and eliminating unnecessary costs in the health care system as both issuers and providers reduce the number of billing errors and the overall time it takes to properly review and adjudicate claims. Finally, having all the required information could help improve negotiations between the disputing parties, which potentially could help avoid having to rely on the IDR process to resolve disputes. We therefore respectfully request that the Departments duly and carefully consider our requests.

Lastly, ACEP and EDPMA would like to reiterate our previous request that the following information be made available in addition to the information already required to be disclosed by the First IFR:

- The type of plan that covers each claim and the dates that each plan has opted into and out of any state laws;
- The resolution pathway that each item or service lives under (i.e., "Specified State Law" or federal IDR process);
- The QPA(s) for the items and services *as billed by the provider* in cases where the initial payment or recognized amount is based off of a different service or level of service that the provider initially billed;

- The patient's copay, deductible, and coinsurance for each claim;
- Additional information that helps with the valuation of payment amounts should be routinely supplied in an easily accessible, machine-readable, downloadable format, including how the QPA(s) was calculated. Specific information includes:
    - The number of contracts used to calculate the QPA;
    - Whether the QPA was calculated using contracts with clinicians in the same or similar specialty;
    - The geography used to calculate the QPA (i.e., Single MSA, all MSAs in a state, Census Division);
    - Percentage of total claims covered by contracts used to calculate QPA (in-network percentage);
    - Percentage of in-network claims attributable to each contract;
    - Whether the plan or issuer's QPA calculations have had an audit result of anything other than "clean" within the last 3 years;
    - If the plan or issuer uses a standard fee schedule, the amount for the service as it appears on the fee schedule for the specific market; and,
    - If the plan or issuer uses contracts from a plan year other than January 31, 2019 to calculate the QPA.

By requiring issuers to provide this information in the initial response to the providers' claim—in addition to all the disclosures that the First IFR required—the Departments will facilitate clearer insight into how the QPA was calculated and reduce the potential for billing errors even further.

Thank you for the opportunity to provide our input on some of the issues our members are experiencing when it comes to receiving all the required information related to the QPA. If you have any questions, please contact Laura Wooster, ACEP's Senior Vice President of Advocacy and Practice Affairs at lwooster@acep.org, or Cathey Wise, EDPMA's Executive Director at cathey.wise@edpma.org.

Sincerely,

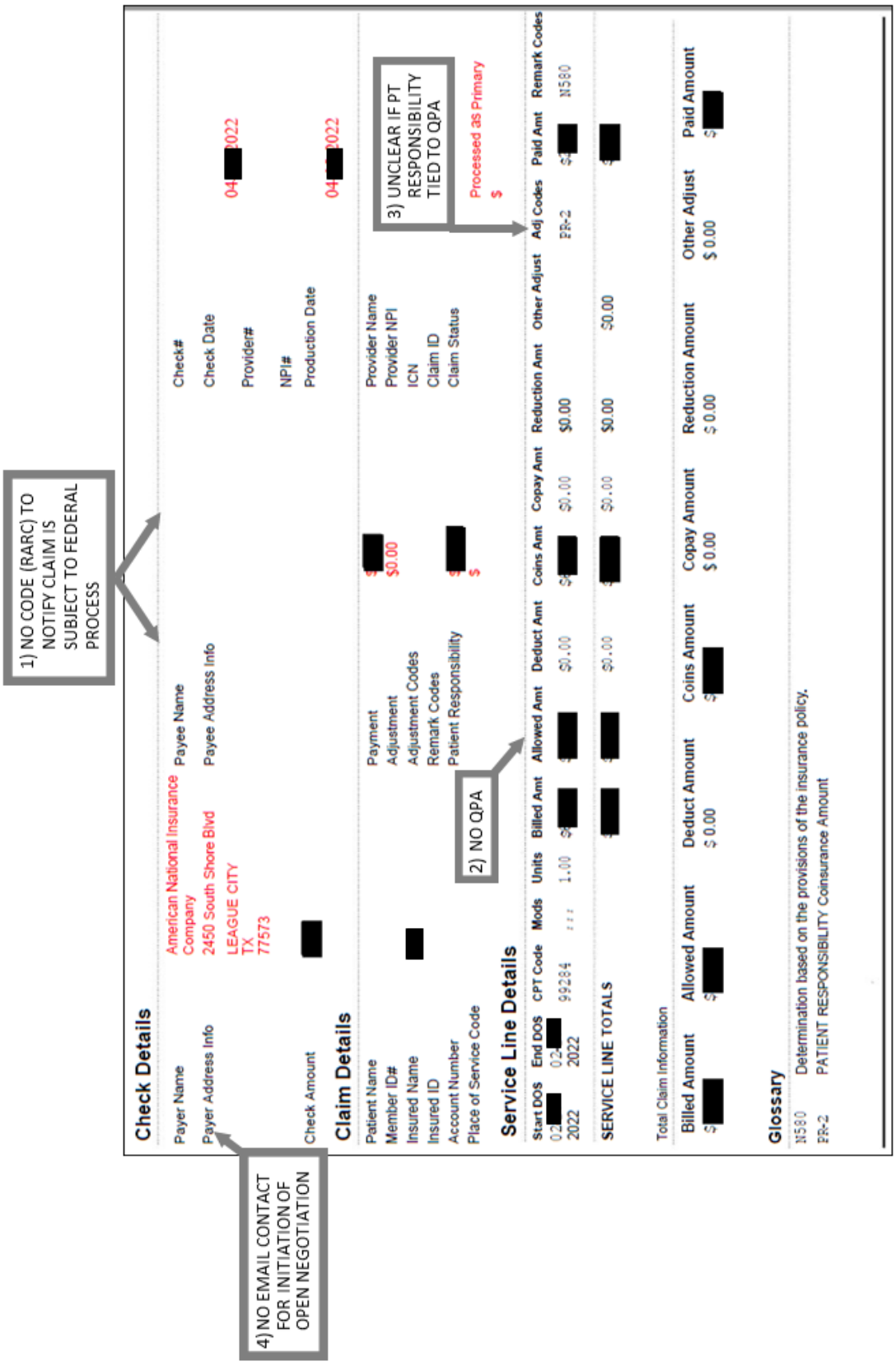
Gillian Schmitz, MD, FACEP

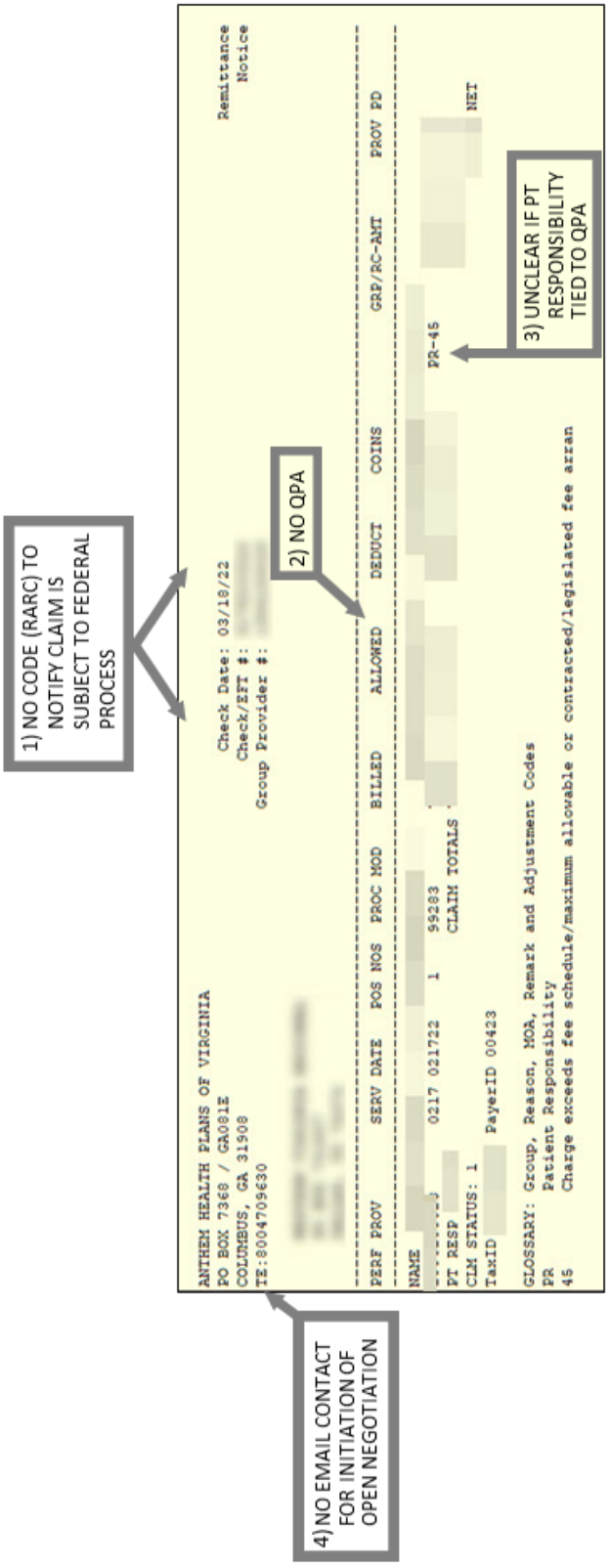
Gillian R. Schmitz, MD, FACEP
ACEP President

Don A Powell, DO

Don Powell, DO
Chair of the Board, EDPMA

Appendix 1


1) NO CODE (RARC) TO NOTIFY CLAIM IS SUBJECT TO FEDERAL PROCESS
4) NO EMAIL CONTACT FOR INITIATION OF OPEN NEGOTIATION
2) NO QPA
3) UNCLEAR IF PT RESPONSIBILITY TIED TO QPA
Check Details
Payer Name
American National Insurance Company
Payee Name
Check#
Payer Address Info
2450 South Shore Blvd
LEAGUE CITY
TX
77573
Payee Address Info
Check Date
Provider#
NPI#
Production Date
Check Amount
Claim Details
Patient Name
Member ID#
Insured Name
Insured ID
Account Number
Place of Service Code
Payment
Adjustment
Adjustment Codes
Remark Codes
Patient Responsibility
$0.00
Provider Name
Provider NPI
ICN
Claim ID
Claim Status
Processed as Primary
Service Line Details
Start DOS
End DOS
CPT Code
Mods
Units
Billed Amt
Allowed Amt
Deduct Amt
Coins Amt
Copay Amt
Reduction Amt
Other Adjust
Adj Codes
Paid Amt
Remark Codes
99284
1.00
$0.00
$0.00
$0.00
$0.00
PR-2
N580
SERVICE LINE TOTALS
$0.00
$0.00
$0.00
$0.00
Total Claim Information
Billed Amount
Allowed Amount
Deduct Amount
$ 0.00
Coins Amount
Copay Amount
$ 0.00
Reduction Amount
$ 0.00
Other Adjust
$ 0.00
Paid Amount
Glossary
N580 Determination based on the provisions of the insurance policy.
PR-2 PATIENT RESPONSIBILITY Coinsurance Amount


1) NO CODE (RARC) TO NOTIFY CLAIM IS SUBJECT TO FEDERAL PROCESS
2) NO QPA
3) UNCLEAR IF PT RESPONSIBILITY TIED TO QPA
4) NO EMAIL CONTACT FOR INITIATION OF OPEN NEGOTIATION
ANTHEM HEALTH PLANS OF VIRGINIA
PO BOX 7368 / GA081E
COLUMBUS, GA 31908
TE:8004709630
Remittance Notice
Check Date: 03/18/22
Check/EFT #:
Group Provider #:
PERF PROV SERV DATE POS NOS PROC MOD BILLED ALLOWED DEDUCT COINS GRP/RC-AMT PROV PD
NAME
0217 021722 1 99283
CLAIM TOTALS
PR-45
NET
PT RESP
CLM STATUS: 1
TaxID PayerID 00423
GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes
PR Patient Responsibility
45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arran

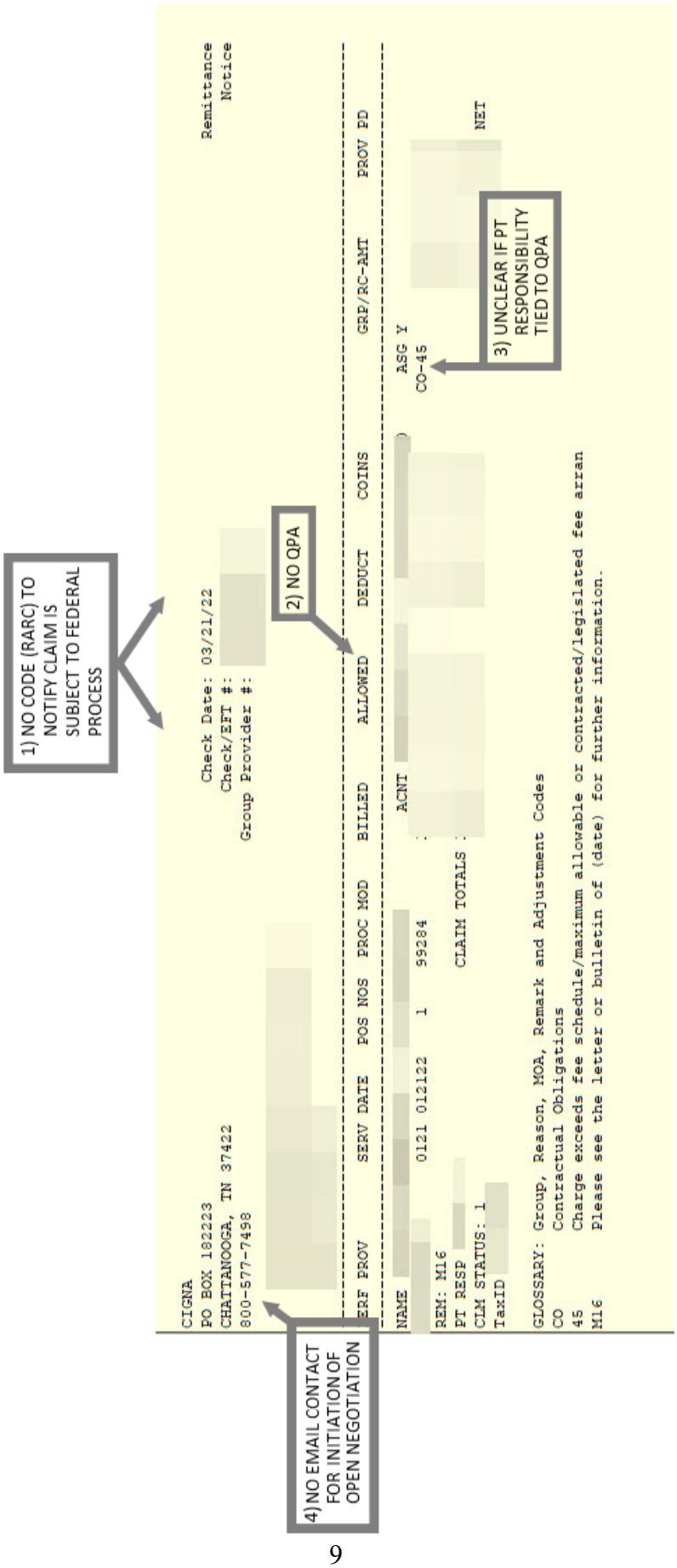

1) NO CODE (RARC) TO NOTIFY CLAIM IS SUBJECT TO FEDERAL PROCESS
2) NO QPA
3) UNCLEAR IF PT RESPONSIBILITY TIED TO QPA
4) NO EMAIL CONTACT FOR INITIATION OF OPEN NEGOTIATION
CIGNA
PO BOX 182223
CHATTANOOGA, TN 37422
800-577-7498
Remittance Notice
Check Date: 03/21/22
Check/EFT #:
Group Provider #:
SERV DATE POS NOS PROC MOD BILLED ALLOWED DEDUCT COINS GRP/RC-AMT PROV PD
ACNT
0121 012122 1 99284
CLAIM TOTALS
ASG Y
CO-45
NET
NAME
REM: M16
PT RESP
CLM STATUS: 1
TaxID
GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes
CO Contractual Obligations
45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arran
M16 Please see the letter or bulletin of (date) for further information.

EXHIBIT 12

PAGE: 1 CLINIC # 459746 (BPS01) GFS - JACKSONVILLE REPORT NO: CPX425.01

GREATWESTHEALTHCARE-CIGNA
8505 E. ORCHARD RD
GREENWOOD VILLAGE, CO 80111

PROVIDER REMITTANCE DATA
CIGNA 6405
CARRIER RUN DATE: 09/21/2022 PROVIDER: [redacted]

REPORT DATE: 09/21/2022
PRINT DATE: 09/21/2022
PRINT TIME: 07:54:51

[redacted]

REMITTANCE NOTICE
DATE: 09/21/2022
CHECK/EFT #: 600900675992

REND PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC	AMT	PROV PD
NAME [redacted] HIC [redacted]							ACNT [redacted]				ICN 222317369900	
[redacted]	0824 082422		1	99285		[redacted]	[redacted]	[redacted]	0.00	CO-45	[redacted]	[redacted]
REM: M16 N859												
										PR-187	[redacted]	
	0824 082422		1	93010		[redacted]		0.00	0.00	PI-4	[redacted]	[redacted]
REM: N519												
PT RESP	0.00	CLM STATUS 1		CLAIM TOTALS		[redacted]	[redacted]	[redacted]	0.00		[redacted]	[redacted]
BILL TYPE 231	DRG CD		ADJ TO TOTALS:		INTEREST	0.00		LATE FILING CHARGE	0.00		NET	[redacted]
[redacted]												
REM: M16 N859												
PT RESP	[redacted]	CLM STATUS 1		CLAIM TOTALS		[redacted]	[redacted]	0.00	[redacted]		[redacted]	[redacted]
BILL TYPE 231	DRG CD		ADJ TO TOTALS:		INTEREST	0.00		LATE FILING CHARGE	0.00		NET	[redacted]

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
	2	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	.00	[redacted]

GLOSSARY: CLAIM ADJUSTMENT REASON CODES

45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
1 Deductible Amount
187 Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)
4 The procedure code is inconsistent with the modifier used or a required modifier is missing
2 Coinsurance Amount

GLOSSARY: REMITTANCE ADVICE REMARK CODES

M16 Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.
N519 Invalid combination of HCPCS modifiers.

EXHIBIT 13

EDPMA 25 YEARS

Data Analysis

Qualifying Payment Amounts and Health Plan Compliance Under the No Surprises Act

The Emergency Department Practice Management Association (EDPMA) is a trade association focused on the sustainable delivery of high-quality, cost-effective patient care in emergency departments. Our members deliver or directly support health care for approximately half of the 146 million patients that annually visit U.S. emergency departments.

The Study

EDPMA surveyed its membership to report on issues related to the implementation of the No Surprises Act (NSA) since January 1, 2022. Specifically, EDPMA analyzed the out-of-network allowed amounts commercial health plans reimbursed for services and whether the Qualified Payment Amount (QPA) was disclosed to the provider as required by law. EDPMA also reviewed members' experiences of the Independent Dispute Resolution (IDR) process. We then conducted a subsequent survey to compare out-of-network allowable amounts in 2021 prior to the NSA to 2022 allowable amounts, after the NSA was implemented. The surveys found nearly universal payer non-compliance with even basic statutory requirements, payer-calculated QPAs that were inconsistent with actual in-network payments, and a clear regulatory failure to effectively enforce the law. This is a high-level summary of initial findings; additional details are forthcoming.

The Numbers

14,500 claims from 35 States
Date range: January – May 2022
59 local, regional, and national practices
Antitrust Safe Harbor status maintained[1]

The Findings

Health Plans routinely fail to comply with the NSA's statutory and regulatory QPA disclosure requirements.

91% of claims surveyed did NOT include an identified QPA as specifically required by law. There is no known enforcement related to this pervasive health plan non-compliance.

Post-NSA Out-of-Network Payments decreased 92% of the time, compared to Pre-NSA. The average decrease is 32% per ER visit.

EDPMA studied 2021 out-of-network data in nine states. Allowed amounts for Level 4 and Level 5 claims (which make up most ED visits) decreased 92% of the time. Of these claims, there was a 32% decrease in reimbursement levels for clinically identical services pre-NSA. This abrupt and dramatic reduction significantly risks how EDs deliver emergency care. Emergency Departments are relied upon to deliver half of the care for the uninsured and 30% of the care to Medicaid patients.

[1] Redacted data must be at least 3 months old; at least 5 data contributors per published dataset; no group contributing more than 25% of a data set; raw data only reviewed by a third-party independent consultant.

EDPMA 25 YEARS

Data Analysis

Qualifying Payment Amounts and Health Plan Compliance Under the No Surprises Act

The Independent Dispute Resolution volumes are driven by artificially low QPAs, payer intransigence, failure of Open Negotiation, health plan termination of in-network agreements, and CMS' refusal to implement common-sense recommendations.

Certified IDR Entities are attempting to process disputes at a much higher volume than estimated. The balanced law passed by Congress was significantly skewed by the NSA regulations, resulting in dramatically lower payments and more out-of-network claims. The QPA survey results suggest artificially low QPA calculations that are not reflective of a market-based payment rate. This could be due to the regulations establishing the QPA calculation methodology or due to health plans improperly applying the QPA methodology. These unsustainably low initial payments have created significant and unanticipated volumes of IDR initiations. The Tri-Departments reported in the first five months that providers initiated five times more disputes than the government anticipated for a full year.[2][3] Significant delays in resolutions (up to 6 months) drive substantial negative cash flow for emergency physician groups and result in additional threats to patient access to care.

When reported, the QPA consistently equals the allowed amount for provider payments.

While the statute avoided setting an initial payment benchmark and instituted no requirement that the paid amount equal the QPA, results find that health plans are commonly paying at a rate that equals the QPA at least 93% of the time. This finding highlights that health plans are misapplying the presumed credibility of QPAs as a payment standard, despite evidence that they do not accurately reflect in-network rates when the NSA specifically avoided the inclusion of a benchmark payment standard.[4]

EMTALA is now minimally funded, jeopardizing the Emergency Department Safety Net.

Poorly written rules and inattentive regulators have emboldened commercial payers to slash both in-and-out-of-network reimbursement for emergency care. These decisions have begun to erode funding for patients' guaranteed access to emergency care under EMTALA. This unsustainable model now heavily relies on hospitals that are also in distress. Without intervention, HHS' implementation of the No Surprises Act threatens to cripple our healthcare safety net.

Emergency Department staffing is in jeopardy.

Since the No Surprises Act, emergency medical groups are expected to lose almost $1 billion annually. If the current NSA implementation goes unchecked, this model will cripple emergency departments, risking access to emergency care. Emergency departments serving rural and underrepresented communities are especially at risk.

The Solutions

To ensure a sustainable healthcare safety net, emergency physicians must be fairly compensated in a timely manner for services already delivered, especially if those services are required under the federal EMTALA law, which provides both a guaranteed network for health plans and a safety net for patients.

Congressional Involvement

Congress should ensure that the bipartisan No Surprises Act not only keeps patients out of the middle of payment disputes but is implemented as intended. This includes aligned implementation policies for health plans and providers, efficient and cost-effective dispute resolution, appropriate transparency, and effective enforcement processes. Congress' continued assistance and involvement is key to achieving the agreed-upon goals of this landmark legislation.

[2] https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/federal-independent-dispute-resolution-process-status-update.pdf
[3] https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf
[4] The allowed amounts for emergency medicine services range from a weighted average of 126% to 145% of 2022 Medicare rates. These levels represent cuts of at LEAST 25% - 65% from pre-NSA average out-of-network reimbursement levels for emergency medicine.

EDPMA 25 YEARS

Data Analysis

Qualifying Payment Amounts and Health Plan Compliance Under the No Surprises Act

Rapid and Effective Enforcement

The Tri-Departments must uphold the NSA statute and ensure that ALL eligible claims clearly disclose the required QPA. Non-compliance with this and other provisions must be quickly and effectively enforced. EDPMA calls on the Tri-Departments to immediately begin robust audits of the QPAs and correct health plan non-compliance issues, including failing to report the QPA, and provide stakeholders with transparency into enforcement processes and results in real-time.

Accurate QPAs

The Tri-Departments must ensure QPAs are calculated as intended by law to reflect the patient's out-of-network financial responsibility and not the provider's out-of-network reimbursement. Audits should examine not just the payer's strict adherence to the methodology developed by the Departments, but whether the methodology itself results in QPAs that deviate materially from the true median of in-network reimbursement. Audits should be made public as they are completed; to arbitrarily withhold audit results until an "end of year report" during the first crucial years of implementation would be a significant dereliction of regulatory responsibility.

Require RARC Codes

Without RARC information from health plans, emergency medicine physicians cannot effectively navigate resolution processes when they receive inadequate or inappropriate payments for clinical services. EDPMA calls on the Tri-Departments to immediately mandate, not just "strongly recommend," that the most specific available RARC codes be communicated by the health plans at the time of initial payment in the mandated ANSI 835 remittance advice sent to physicians and hospitals.

Clarify RARC Codes

NSA-specific RARC codes are rarely communicated. When a RARC specific to the NSA is communicated, N830 is used in 93% of claims. This code informs the provider that the claim was processed EITHER under the federal OR a state balance billing law. In states with a Specified State Law, this code does NOT identify ERISA/non-ERISA claims or other characteristics that could place the claim under federal or state jurisdiction. To reduce the volume of unnecessary IDR claims, the Tri-Departments must require health plans to use the most specific NSA RARC from the list CMS developed earlier this year and a clear ERISA identifier in the ANSI 835. By mandating the use of an ERISA identifier and the most specific available RARC codes, the Tri-Departments will expedite the IDR process and reduce the unintentional submission of ineligible claims.

EMTALA Must Now Be Funded

Since 1987, the federal law EMTALA has required hospitals to provide clinical care to all patients without regard for their ability to pay. This requirement is significant and applies to almost all emergency care provided in US hospitals. However beneficial, EMTALA was never funded. Now, with commercial reimbursement plummeting due to the manner of implementation of the NSA, the previous equilibrium is significantly disrupted. EMTALA-required care, stand-by costs, uninsured care, and underinsured care have no offset in a system that requires care for all patients without a corresponding requirement of fair reimbursement. We must now step up to ensure that the healthcare safety net is sustainable and that patients can reliably receive emergency medical care. Without solutions, the patients we serve will be at a very real risk.

Contact **Cathey Wise** 703-506-3282 cathey.wise@edpma.org edpma.org

EXHIBIT 14

NEAL OPENING STATEMENT AT MARKUP OF SURPRISE MEDICAL BILLING, HOSPICE, AND HEALTH CARE INVESTMENT TRANSPARENCY LEGISLATION

Feb 12, 2020 | Press Release

(As prepared for delivery)

Good morning and welcome. Today, the Committee will mark up three important bills to protect patients and encourage more transparency in our nation's health care system.

First, we will consider H.R. 5821, the Helping Our Senior Population in Comfort Environments (HOSPICE) Act. This bill implements more oversight for Medicare hospice providers and greater transparency for enrollees to ensure patients receive the high-quality care they deserve at the end of life.

The Inspector General of the Department of Health and Human Services released two alarming reports in July that identified significant deficiencies in the quality of care delivered to Medicare hospice enrollees. Almost 90 percent of hospices had at least one care deficiency between 2012 and 2016. That is unacceptable. H.R. 5821 provides HHS with more tools to oversee hospices and to help poor-performing hospices improve. Thank you to Representatives Panetta and Reed for quickly coming together to introduce this important legislation.

Next we will consider H.R. 5825, the Transparency in Health Care Investments Act. This bill requires private equity firms that own and control medical care providers to report certain information. This transparency will shed sunlight on the impacts these investment activities may have on patient care and costs.

Increasingly, private equity firms are investing in areas such as emergency departments, ambulatory surgery centers, trauma units, nursing homes and hospitals, as well as health insurance companies. This reporting will enable policy makers and regulators to better understand private equity's effects on the health system.

Finally, we will consider H.R. 5826, the Consumer Protections Against Surprise Medical Bills Act of 2020. Ranking Member Brady and I worked together for many months to craft this bipartisan legislation that protects patients from unexpected medical bills for out-of-network services. At the outset, we agreed that any approach must first and foremost protect the patient from these surprise bills and provide incentives for providers and health plans to sort out payment disputes on their own.

The need to protect the patient is something I think we all agree on. But throughout this process we have asked what is the best approach? The doctors and insurance companies blame each other while the patient is caught in the middle.

I think the legislation we have before us today is the right approach – it protects the patient, but also recognizes the private market dynamics between insurance plans and providers.

There are two important provisions that I specifically want to highlight. First, we have included transitional assistance through the medical expense deduction which will provide some relief from surprise medical bills for patients during the time period between this proposal becoming law and it actually being implemented through the regulatory process.

Second, we have ensured that uninsured individuals are able to get a good faith estimate of their out-of-pocket expenses prior to a procedure – and in the event their final bill substantially differs from that estimate, they can access dispute resolution to help resolve the discrepancy.

Surprise medical bills cause tremendous emotional and financial distress for Americans when they are already in a particularly vulnerable state. This legislation ensures that such bills will be a thing of the past. It will remove the patient from any billing dispute, allowing them to focus on their health instead of worrying about the potential cost of their care.

We know that once the patient is removed from the billing dispute, health plans and providers are generally able to come to a resolution on their own. However, for those instances where resolution is elusive, this legislation provides a fair and balanced approach to settle plan-provider payment issues.

The first step is open negotiation, where the plan and provider exchange information in a way that I believe will help the parties understand what a reasonable offer is and get them to a resolution.

But if that exercise fails, the second step is a mediated resolution process. Ranking Member Brady and I have worked to craft a process where both the provider's offer and the plan's offer receive equal weight.

In addition, the resolution entity considers, but isn't bound by, the plan's median in-network rate. And likewise, the provider is not left in a position to disprove the adequacy of such a rate.

My concern with giving too much weight to such a benchmark rate is that we already know insurers are looking for any way they can to pay the least amount possible. They will work to push those rates down, regardless of what it means for community providers like physicians, hospitals, and our constituents who they employ.

With no federal network adequacy standards, plans can push rates down and drop providers from networks with no consequences, leaving patients holding the bag.

While this legislation doesn't take on network adequacy, it is something Congress must examine. Surprise bills would be much less common if insurer networks were more robust.

In addition, the legislation before us today does not yet address the "surprise" bills that come from insurance companies. These are bills, for example, when a patient received prior authorization only to find out later that the insurance company is going back on that agreement and sticking the patient with the bill.

I look forward to working with Ranking Member Brady and our committee colleagues on these two issues, among others, going forward. The problem of surprise medical billing is a complex issue that has real consequences for patients. The solution Congress finds will affect every part of our nation's health care system. As this measure moves along in the process, I intend to refine it, but I think we have a very good start before us today.

And I am not alone in that assessment. Many organizations are supportive of our work to protect the patients and allow a fair and balanced process between providers and insurance companies. These include consumer groups like AARP and Community Catalyst as well as the hospitals and doctors who provide care for our neighbors and are cornerstone of our communities – the Massachusetts Hospital Association, the Massachusetts Medical Society, the American Medical Association, the American Hospital Association, the Federation of American Hospitals, Catholic Health Association, America's Essential Hospitals, and National Alliance of Safety Net Hospitals.

With that, I will recognize Ranking Member Brady for the purpose of an opening statement.

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EXHIBIT 15

Congress of the United States
House of Representatives
Washington, DC 20515

November 5, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Dear Secretary Becerra, Secretary Yellen, and Secretary Walsh:

We write regarding the interim final rule (IFR) released on September 30 entitled "Requirements Related to Surprise Billing; Part II". The bipartisan No Surprises Act, passed by Congress in December 2020, was one of the most important patient protection bills in American history, but its success will depend on your departments following the letter of law in its implementation. We urge you to amend the IFR in order to align the law's implementation with the legislation Congress passed.

Congress passed the No Surprises Act after extensive bipartisan and bicameral deliberations to protect patients from surprise medical bills and create a balanced process to resolve payment disputes between insurance plans and health care providers. During these deliberations, multiple proposals were considered including a benchmark rate, an independent dispute resolution (IDR) process, and a hybrid. Following a comprehensive process that included hearings, markups, and extensive negotiations, Congress rejected a benchmark rate and determined the best path forward for patients was to authorize an open negotiation period coupled with a balanced IDR process.

The No Surprises Act specified an IDR process that takes patients out of the middle of payment disputes. It allows providers and payors to bring any relevant information to support their payment offers for consideration, except for billed charges and public payor information. Per this process, the certified IDR entity shall consider:

- Median in-network rates
- Provider training and quality of outcomes
- Market share of parties
- Patient acuity or complexity of services
- In the case that a provider is a facility: teaching status, case mix, and scope of services
- Demonstrations of previous good faith efforts to negotiate in-network rates
- Prior contract history between the two parties over the previous four years

The process laid out in the law expressly directs the certified IDR entity to consider each of these listed factors should they be submitted, capturing the unique circumstance of each billing dispute without causing any single piece of information to be the default one considered.

Unfortunately, the parameters of the IDR process in the IFR released on September 30 do not reflect the way the law was written, do not reflect a policy that could have passed Congress, and do not create a balanced process to settle payment disputes. The IFR directs IDR entities to begin with the assumption that the median in-network rate is the

appropriate payment amount prior to considering other factors. This directive establishes a de-facto benchmark rate, making the median in-network rate the default factor considered in the IDR process. This approach is contrary to statute and could incentivize insurance companies to set artificially low payment rates, which would narrow provider networks and jeopardize patient access to care – the exact opposite of the goal of the law. It could also have a broad impact on reimbursement for in-network services, which could exacerbate existing health disparities and patient access issues in rural and urban underserved communities.

We appreciate the complex nature of the patient protections that must be established and look forward to a final rule that accurately reflects Congress's multi-year bipartisan and bicameral work to pass this landmark legislation. Therefore, we urge you to revise the IFR to align with the law as written by specifying that the certified IDR entity should not default to the median in-network rate and should instead consider all of the factors outlined in the statute without disproportionately weighting one factor.

Thank you for your continued efforts on this important matter. We look forward to working with you to ensure the best outcomes for our patients and the health of our communities.

Sincerely,

Thomas R. Suozzi
Member of Congress

Brad R. Wenstrup, D.P.M.
Member of Congress

Raul Ruiz, M.D.
Member of Congress

Larry Bucshon, M.D.
Member of Congress

Additional Signatories

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André Carson
Earl L. "Buddy" Carter, R.Ph.
Liz Cheney
Judy Chu
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Randy Feenstra
A. Drew Ferguson, IV
Brian Fitzpatrick
Chuck Fleischmann

John Garamendi
Andrew R. Garbarino
Louie Gohmert
Jimmy Gomez
Josh Gottheimer
Mark E. Green, M.D.
Glenn Grothman
Michael Guest
Josh Harder
Andy Harris, M.D.
Brian Higgins
J. French Hill
Ashley Hinson
Chrissy Houlahan
Richard Hudson
Ronny L. Jackson, M.D
Sheila Jackson Lee
Chris Jacobs
Dusty Johnson
Eddie Bernice Johnson
Henry C. “Hank” Johnson Jr.
John Joyce, M.D.
John Katko
Mike Kelly
Daniel T. Kildee
Derek Kilmer
Young Kim
Ron Kind
Raja Krishnamoorthi
Darin LaHood
Doug LaMalfa
Conor Lamb
Doug Lamborn
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Grace Meng
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Jerrold Nadler
Grace F. Napolitano
Dan Newhouse
Eleanor Holmes Norton
Devin Nunes
Jimmy Panetta
Bill Pascrell, Jr.
Ed Perlmutter
Dean Phillips
Bill Posey
Tom Reed
Guy Reschenthaler
Tom Rice
David Rouzer
Lucille Roybal-Allard
Bobby L. Rush
Tim Ryan
Linda T. Sánchez
Bradley S. Schneider
David Schweikert
Austin Scott
David Scott
Pete Sessions
Terri A. Sewell
Brad Sherman
Mike Simpson
Albio Sires
Christopher H. Smith
Jason Smith
Lloyd Smucker
Elise Stefanik
Eric Swalwell
Van Taylor
Mike Thompson
Rashida Tlaib
Ritchie Torres
Michael R. Turner
Jefferson Van Drew, D.M.D.
Beth Van Duyne
Nydia M. Velázquez
Jackie Walorski
Daniel Webster
Bruce Westerman
Robert J. Wittman
Steve Womack
John Yarmuth
Don Young

CC: Daniel Barry, Acting General Counsel, U.S. Department of Health and Human Services
Laurie Schaffer, Principal Deputy General Counsel, U.S. Department of the Treasury
Peter Constantine, Associate Solicitor for Legal Counsel, U.S. Department of Labor
Lynn Eisenberg, General Counsel, U.S. Office of Personnel Management

EXHIBIT 16

QUANTIFICATION OF LEVEL 4 AND LEVEL 5 UNDERPAYMENTS: DRIVEN BY NSA PAYMENT LOGIC

PRE-NSA DATASET SAMPLE: 239,600 ER VISITS			NSA DATASET SAMPLE: 14,500 ER VISITS			NSA REDUCTIONS	
LEVEL 4 (99284)			**LEVEL 4 (99284)**			**LEVEL 4 (99284)**	
AVERAGE 2021 OON LEVEL 4 ALLOWANCE	MEDICARE NAT'L 2022 ALLOWANCE	2021 OON AVG LVL 4 AS % 2022 MED	AVERAGE 2022 OON LEVEL 4 ALLOWANCE	MEDICARE NAT'L 2022 ALLOWANCE	2021 OON AVG LVL 4 AS % 2022 MED	OUT-OF-NETWK LEVEL 4 AVG REDUCTION	OUT-OF-NETWK LEVEL 4 AVG DROP %
$413.92	$123.20	336%	$177.14	$123.20	144%	($236.78)	-57%
LEVEL 5 (99285)			**LEVEL 5 (99285)**			**LEVEL 5 (99285)**	
AVERAGE 2021 OON LEVEL 5 ALLOWANCE	MEDICARE NAT'L 2022 ALLOWANCE	2021 OON AVG LVL 4 AS % 2022 MED	AVERAGE 2022 OON LEVEL 5 ALLOWANCE	MEDICARE NAT'L 2022 ALLOWANCE	2021 OON AVG LVL 4 AS % 2022 MED	OUT-OF-NETWK LEVEL 5 AVG REDUCTION	OUT-OF-NETWK LEVEL 5 AVG DROP %
$592.50	$178.91	331%	$264.44	$178.91	148%	($328.06)	-55%

ANALYSIS OF 2023 FEE INCREASE IMPACT ON USING IDR FOR LEVELS 4 & 5 UNDERPAYMENTS

IDR ASSUMPTIONS:	2022	2023	
1. Average number of claims in batch:	1	1	
2. average time to produce & file batch:	1 hour	1 hour	
3. average cost to produce a batch (RCM Analyst @$25/hour) + (Coder @$25/hr)	$50.00	$50.00	A
4. filing fee	$50.00	$350.00	B
5. IDR Avg flat fee--1 claim--ASSUME LOSE 50% of the time (assume IDR flat fee of $500 for 1 claim--SEE NOTE 1)	$250.00	$250.00	C
6.total direct IDR cost	$350.00	$650.00	D (A+B+C)
LEVEL 4	**2022**	**2023**	
6.incremental IDR appeal--1 level 4 ($237 * 1)	$237.00	$237.00	E
7. ongoing net value of IDR win @50% of time--1 LEVEL 4	($113.00) (SYSTEMIC LOSS)	($413.00) (SYSTEMIC LOSS)	F (E-D)
LEVEL 5	**2022**	**2023**	
8.incremental IDR appeal--1 level 5 ($328*1)	$328.00	$328.00	G
9. ongoing net value of IDR win @50% of time--1 LEVEL 5	($22.00) (SYSTEMIC LOSS)	($322.00) (SYSTEMIC LOSS)	H (G-D)

NOTE 1--Under the "loser pays" rule, the average losing cost of 50% per average IDR single determination is used on an assumed 1 claim flat fee determination of $500; losing 50% of the time would mark the cost to $250.

EXHIBIT 17

December 01, 2021

Insurers Now Using "No Surprises Act" to Narrow Coverage Networks and Restrict Patient Access

ACR Considering All Available Options to Protect Patient Access and Stop Insurer Overreach

As the American College of Radiology® (ACR®) warned, insurers are now using the Biden administration's misinterpretation of the No Surprises Act, passed to protect patients during insurer-provider payment disputes for out of network care, to narrow medical networks and restrict patient access to their current providers.

This profit-driven move impacts access to all imaging (not just emergency care), including cancer screenings, use of which plummeted (https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/shifts-in-healthcare-demand-delivery-and-care-during-the-covid-19-era/iqvia-institute-reportcovid-19-impact-on-us-healthcare4292020.pdf?_=1598879241220)[1] (file:///C:/Users/kwalter/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/BPBBMOK9/12-01-21%20Insurers%20Narrow%20Networks%20-%20Surprise%20Billing_KRW%20(002)%20WT.docx#_ftn1) during the COVID-19 pandemic and may yet lead to increased cancer deaths (https://science.sciencemag.org/content/368/6497/1290.abstract). Scans to measure cancer treatment effectiveness and to diagnose and treat many other conditions are also impacted.

Blue Cross Blue Shield of North Carolina is the first insurer to tell providers (/-/media/ACR/Files/Advocacy/20211105-BCBSNC-rate-reduction-notice_Redacted.pdf) they may be considered an "outlier contract" scheduled for "termination" if they don't accept an immediate, drastic cut in reimbursement for services provided. Many providers — who already are reeling from the COVID-19 pandemic's economic impact — can't withstand this profit-driven move. However, the insurer says that the No Surprises Act allows them to take such action.

"Without regard for patient impact, insurers are trying to increase their already record profits by narrowing their provider networks," said Howard B. Fleishon, MD, MMM, FACR, chair of the American College of Radiology Board of Chancellors. "In addition to ongoing congressional advocacy, the ACR is considering all available options, including legal action, to ensure that the No Surprises Act is implemented as passed by Congress and protects patients' access to their chosen providers."

The recent surprise billing interim final rule (https://public-inspection.federalregister.gov/2021-21441.pdf) ignored the law's intent to set up a fair independent dispute resolution (IDR) process. The law stated that the qualified payment amount (QPA) be one of many equally weighted factors considered during payment disputes. Instead, the administration made the QPA — an unverified rate propagated by insurers — the primary factor in the IDR process. This sets an artificially low benchmark payment, which may not support wider access to care – particularly in underserved areas.

Health insurers' net incomes and profit margins have grown every year since 2015 (https://content.naic.org/sites/default/files/inline-files/2020-Annual-Health-Insurance-Industry-Analysis-Report.pdf). Insurers pocketed record profits in 2020 (https://www.nytimes.com/2020/08/05/health/covid-insurance-profits.html) – even as their costs dropped (https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/health-plan-cost-increases-return-to-pre-pandemic-levels.aspx). Meanwhile, insurance premiums continue to rise (https://www.kff.org/report-section/ehbs-2019-section-1-cost-of-health-insurance/) even as imaging costs have gone down

(https://www.neimanhpi.org/data_series/medicare-part-b-total-imaging-spending/#/graph/2006/2019/true). Record insurer profits have not led to reduced premiums for beneficiaries. There is no indication — nor proof — that insurer profit increases gained via No Surprises Act-related network restrictions would result in lower costs to patients.

“Efforts to implement the fair and equitable independent dispute resolution process, as stated in the law, do not impact patient protections in the No Surprises Act but would help ensure that patients continue to have access to their chosen providers,” said William T. Thorwarth, MD, FACR, CEO of the American College of Radiology.

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[1] (file:///C:/Users/kwalter/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/BPBBMOK9/12-01-21%20Insurers%20Narrow%20Networks%20-%20Surprise%20Billing_KRW%20(002)%20WT.docx#_ftnref1) Free registration required to download.

EXHIBIT 18

BlueCross BlueShield of North Carolina Abuses No Surprises Act Regulations to Manipulate the Market Before Law Takes Effect

Insurance company jeopardizing patient access to care through 'take it or leave it' ultimatums to in-network clinicians

CHICAGO – Today, the American Society of Anesthesiologists expressed grave concern about the strong-arm tactics of BlueCross BlueShield of North Carolina and its abuse of the new federal law designed to protect patients from out-of-network bills. The letters being sent to anesthesiology and other physician practices in the state threaten contract termination and the physicians' in-network status unless the physicians immediately agree to payment reductions ranging from 10 to over 30%. Implementation of the *No Surprises Act* is cited in the letters as the impetus for the reductions. The clear intent of the insurance company in taking this action is to improve its negotiating position against community physician practices in the dispute resolution process outlined in the recently released Interim Final Rule implementing the legislation.

The *No Surprises Act*, which was passed in December 2020, was designed to protect patients from surprise out-of-network bills. Although the law intended to resolve payment disputes through an impartial arbitration system, recent rules promulgated by the Departments of Health and Human Services, Labor, and Treasury will create a system that unfairly favors insurance companies. The evidence of this bias and this insurance company's intention to exploit the new rules is clearly demonstrated in the demand letters from BlueCross BlueShield of North Carolina weeks before the law even takes effect.

"Instead of expanding in-network access for patients, BlueCross BlueShield of North Carolina has demonstrated what we explained to Congress and the rule-making agencies would happen: insurance

companies will use their overwhelming market power and the *No Surprises Act*'s flawed rules to push more physicians out of insurance networks and fatten their own bottom line." said ASA President Randall M. Clark, M.D., FASA. "Insurance companies are threatening the ability of anesthesiologists to fully staff hospitals and other health care facilities. Left unchecked, actions like these of BlueCross BlueShield of North Carolina will ultimately compromise timely access to care for patients across the country."

ASA has previously called upon the U.S. Department of Justice to address these and other recent anticompetitive insurance company tactics.

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Founded in 1905, the American Society of Anesthesiologists (ASA) is an educational, research and scientific society with more than 54,000 members organized to raise and maintain the standards of the medical practice of anesthesiology. ASA is committed to ensuring physician anesthesiologists evaluate and supervise the medical care of patients before, during and after surgery to provide the highest quality and safest care every patient deserves.

For more information on the field of anesthesiology, visit the American Society of Anesthesiologists online at asahq.org. To learn more about the role physician anesthesiologists play in ensuring patient safety, visit asahq.org/madeforthismoment. Like ASA on Facebook and follow ASALifeline on Twitter.

# # #

BlueCross BlueShield of North Carolina

November 5, 2021

[redacted]

Re: Necessity to amend rate agreement, response needed before November 21, 2021.

Dear Provider:

[redacted] is likely aware of the passage of the federal "No Surprises Act" in December of 2020, with an impending effective date of January 1, 2021. Under this law, payments from health plans to out-of-network providers in many circumstances will be set at the "Qualifying Payment Amount" (QPA) which is generally calculated at the median in-network contracted rate for the same or similar specialty within the applicable geographic area. The law applies with respect to out-of-network emergency services, out-of-network professional services at a visit to an in-network facility, and air ambulance services. It applies to our commercial networks (non-Medicare Advantage, non-Medicaid). The QPA paid by health plan to the out-of-network provider constitutes payment in full unless certain limited exceptions apply for a given QPA. These exceptions include express prior patient disclosure and consent, or successful challenge in arbitration.

This new federal law allows a significant change to Blue Cross and Blue Shield of North Carolina's contracting approach with emergency service providers, hospital-based providers, and air ambulance services. Where previous state law could result in an obligation to pay at full charges if no contract is in place, the new law sets reasonable limits on payment at the median in-network rate. Where Blue Cross NC may have previously contracted at what we deemed an inflated rate that is at least somewhat lower than charges in order to avoid paying at full charge, we are now able to seek to contract at a rate more in line with what we consider to be a reasonable, market rate.

We have identified [redacted] as one of our outlier in-network providers with respect to rates. While the exact, final QPAs are not yet available pending upcoming finalization of the Rules to the No Surprises Act, the Interim Final Rules provide enough clarity to warrant a significant reduction in your contracted rate with Blue Cross NC. If we are unable to establish in-network rates more in line with a reasonable, market rate, our plan is to terminate agreements where the resulting out-of-network QPA would reduce medical expenses to the benefit of our customers' overall premiums.

Our ask of you at this point is as follows. We are seeking an immediate reduction in rates under our commercial agreement, as in interim step to the January 1, 2022 effective date of the No Surprises Act. This interim reduction will buy us breathing room to negotiate the final rates in light of the QPA amounts established in accordance with the upcoming Rules. With the interim reduction in place, we will not need to quickly terminate outlier contracts as a means of avoiding

payment levels after January 1, 2022 that are significantly higher than the default out-of-network QPA. Our reduction proposal, for a **December 15, 2021 effective date**, is **-15%**. We ask that you respond to this letter indicating your intention to agree, or providing a specific, comparable counterproposal. If we are able to reach agreement on the rate reduction we will quickly provide a simple rate amendment for your execution. If we are unable to reach agreement on the reduction, our intention is to proceed with identifying and executing on terminations of outlier contracts where the out-of-network QPA will result in significant savings to the benefit of our customers.

Thank you for your prompt attention to this request and your response before November 21, 2021. We hope and trust that we can update and maintain our ongoing partnership for January 1, 2022 and well beyond. If you have any questions, please contact Sr. Contract Manager, Colleen Thedieck, Colleen.Thedieck@bcbsnc.com at (984) 960-3749.

Sincerely,

Mark Werner
Vice President, Provider Networks

EXHIBIT 19

BECKER'S
PAYER ISSUES

4 disputes involving UnitedHealth, physician staffing firms

Morgan Haefner - Wednesday, July 22nd, 2020 Print | Email

TEXT

Here are four recent disputes involving UnitedHealth Group and physician staffing firms:

1. TeamHealth (Knoxville, Tenn.). UnitedHealth moved to end high-reimbursement in-network contracts with TeamHealth in 2019. The changes took effect between Oct. 15, 2019, and July 1, and affected contracts across 18 states. Earlier that year, UnitedHealth reduced TeamHealth's reimbursements for certain out-of-network claims by about 50 percent, prompting TeamHealth to sue UnitedHealth in eight states. According to Moody's Investors Service, the dispute could indirectly affect hospitals and other providers.

2. Mednax (Sunrise, Fla.). UnitedHealth plans to end its contracts with Mednax physicians in four states, beginning as early as March, the physician staffing group said in February. The contracts will end at staggered dates throughout the year from March 1 to Dec. 15. UnitedHealth said throughout the last few months it submitted proposals to Mednax that would reduce the amount it reimburses its physicians to a rate that was more consistent with what it pays other providers in Arkansas, Georgia, North Carolina and South Carolina. UnitedHealth said Mednax did not respond with counterproposals; however, Mednax said the firm "has engaged in numerous discussions with United regarding this matter. At no time were these discussions presented to Mednax as negotiations. Rather, United reinforced its unacceptable payment terms on a 'take it or leave it' basis."

3. U.S. Anesthesia Partners (Dallas). In March, Moody's Investors Service changed its outlook of U.S. Anesthesia Partners, a group of nearly 5,000 anesthesia providers, from stable to negative due to a contract termination from UnitedHealth. UnitedHealth canceled its in-network contracts with the provider group in Texas. The contract represents about 10 percent of U.S. Anesthesia Partners' annual revenues, and was expected to be terminated in April 2020.

4. Envision Healthcare (Nashville, Tenn.). UnitedHealthcare and Envision, one of the country's largest providers of emergency room services, agreed to extend their contract, effective January 2019. The agreement came after UnitedHealthcare argued Envision wrongfully sued the payer and by doing so broke an arbitration clause in their agreement. The insurer also called Envision's emergency room billing practices "egregious." In March 2018, Envision sued UnitedHealthcare for allegedly lowering contracted payments to Envision physicians and not allowing new Envision medical practices to join its network.

EXHIBIT 20

Gregory Lipson
Senior Vice President
Strategic Initiatives and Provider Contracting
Arizona Network Management

[redacted]

VIA CERTIFIED MAIL RETURN RECEIPT REQUESTED

[redacted]

Re: Notice of termination with Intent to Renegotiate – Cigna HealthCare of Arizona, Inc. Hospital Based and/or Hospitalists Provider Group Services Agreement – Cigna Commercial (group and individual) and Cigna Medicare Advantage participation

[redacted]

In accordance with the terms of the above-mentioned agreement between Cigna HealthCare of Arizona, Inc. and [redacted] dated [redacted] as amended ("Agreement"), this letter serves as 120 day prior written notice of termination of the Agreement for all lines of business, with intent to renegotiate. The termination is effective [redacted] unless Cigna rescinds the termination following the conclusion of negotiations.

Cigna's hope is that the parties can avoid termination by renegotiating certain unfavorable provisions in the Agreement. We value our relationship and look forward to working with you to reach mutually beneficial terms during our upcoming discussions.

Cigna Medicare Advantage appeal
This termination applies to the Arizona Medicare Advantage line of business. Group has the right to appeal the decision regarding termination of participation in Cigna Medicare Advantage for Arizona, for itself and its Represented Providers. If you wish to appeal and request a hearing, please send a written request via certified mail to the following address:

Cigna HealthCare of Arizona, Inc.
Cigna Medicare Advantage – Provider Appeals
Network Operations, ATTN: Director
25500 N. Norterra Drive
Phoenix, AZ 85085

The appeal request must be received by Cigna within 30 days of receipt of this notification. Upon receipt of a written appeal request from Group, we will contact you with details about the Medicare-required appeal and hearing procedures, including the process for submitting any additional information you wish to provide on behalf of Group and its Represented Providers. Cigna will convene a panel of peer physicians to review any such material.

Thank you for your cooperation during this process.

Sincerely,

Greg Lipson

Gregory Lipson
Senior Vice President
Strategic Initiatives and Provider Contracting
Arizona Network Management

cc: Arizona Network Management
Arizona Medical Management

EXHIBIT 21

UNITEDHEALTH GROUP

UnitedHealth Group Reports 2022 Results

- ***Revenues of $324.2 Billion Grew 13% Year-Over-Year, with Double-Digit Growth at both Optum and UnitedHealthcare***
- ***Cash Flows from Operations were $26.2 Billion or 1.3x Net Income***
- ***Full Year and Fourth Quarter Net Earnings were $21.18 and $5.03 Per Share***
- ***Full Year and Fourth Quarter Adjusted Net Earnings were $22.19 and $5.34 Per Share***

MINNETONKA, Minn. (January 13, 2023) – UnitedHealth Group (NYSE: UNH) reported full year and fourth quarter 2022 results reflecting broad-based growth at Optum and UnitedHealthcare.

“We expect the efforts by the people of our company that led to strong performance in 2022 will define 2023 as well, especially delivering balanced growth enterprise-wide, improving support for consumers and care providers, and investing to make high-quality care simpler, more accessible and affordable for everyone,” said Andrew Witty, chief executive officer of UnitedHealth Group.

UnitedHealth Group affirmed the 2023 growth and performance objectives established at its November 29th Investor Conference, including revenues of $357 billion to $360 billion, net earnings of $23.15 to $23.65 per share, adjusted net earnings of $24.40 to $24.90 per share and cash flows from operations of $27 billion to $28 billion.

UNITEDHEALTH GROUP

Quarterly and Annual Financial Performance

	Three Months Ended			Year Ended	
	December 31, 2022	**December 31, 2021**	**September 30, 2022**	**December 31, 2022**	**December 31, 2021**
Revenues	$82.8 billion	$73.7 billion	$80.9 billion	$324.2 billion	$287.6 billion
Earnings from Operations	$6.9 billion	$5.5 billion	$7.5 billion	$28.4 billion	$24.0 billion
Net Margin	5.8%	5.5%	6.5%	6.2%	6.0%

- UnitedHealth Group's 2022 revenues grew $36.6 billion or 13% year-over-year to $324.2 billion with double digit growth at both Optum and UnitedHealthcare, driven primarily by serving more people and by serving them more comprehensively.

- Full year 2022 earnings from operations were $28.4 billion, an increase of 19%, with strong contributions from Optum and UnitedHealthcare. Earnings per share grew 17% compared to last year.

- The medical care ratio at 82.0% for full year 2022 and 82.8% for the fourth quarter was consistent with the company's recent Investor Conference outlook. Days claims payable were 49.9 in the fourth quarter compared to 46.8 a year ago and 50.8 in third quarter 2022. Favorable medical reserve development was $620 million in the quarter.

- The full year 2022 operating cost ratio of 14.7% compared to 14.8% in 2021, with ongoing productivity gains offset by business mix and continued investments in growth initiatives.

- Cash flows from operations for the full year were $26.2 billion or 1.3-times net income. During 2022, the company returned approximately $13 billion to shareholders through dividends and share repurchases. Return on equity of 27.2% in 2022 reflected the company's strong overall growth and efficient capital structure.

UnitedHealthcare

UnitedHealthcare provides health care benefits globally, serving individuals and employers, and Medicare and Medicaid beneficiaries. UnitedHealthcare is dedicated to improving the value customers and consumers receive by improving health and wellness, enhancing the quality of care received, simplifying the health care experience and reducing the total cost of care.

Quarterly and Annual Financial Performance

	Three Months Ended			Year Ended	
	December 31, 2022	**December 31, 2021**	**September 30, 2022**	**December 31, 2022**	**December 31, 2021**
Revenues	$63.0 billion	$56.4 billion	$62.0 billion	$249.7 billion	$222.9 billion
Earnings from Operations	$2.9 billion	$2.1 billion	$3.8 billion	$14.4 billion	$12.0 billion
Operating Margin	4.7%	3.8%	6.1%	5.8%	5.4%

- UnitedHealthcare full year revenues of $249.7 billion grew $26.8 billion or 12% year-over-year, reflecting growth in the number of people served.

- Full year operating earnings were $14.4 billion compared to $12.0 billion last year, reflecting growth in people served and continued strong medical and operating cost management.

- People served domestically by UnitedHealthcare grew by over 1.2 million in 2022, led by the company's community-based and senior offerings. The number of consumers served with domestic commercial benefit offerings grew by 275,000 over the past nine months.

Optum

Optum's health services businesses serve the global health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers. Using market-leading information, analytics and technology to yield clinical insights, Optum helps improve overall health system performance: optimizing care quality, reducing care costs and improving the consumer experience.

Quarterly and Annual Financial Performance

	Three Months Ended			Year Ended	
	December 31, 2022	**December 31, 2021**	**September 30, 2022**	**December 31, 2022**	**December 31, 2021**
Revenues	$47.9 billion	$41.1 billion	$46.6 billion	$182.8 billion	$155.6 billion
Earnings from Operations	$4.0 billion	$3.4 billion	$3.7 billion	$14.1 billion	$12.0 billion
Operating Margin	8.3%	8.3%	7.9%	7.7%	7.7%

- Optum full year revenues of $182.8 billion grew $27.2 billion or 17% year-over-year, led by Optum Health, and full year operating earnings increased to $14.1 billion compared to $12.0 billion last year.

- Optum Health revenue per consumer served increased by 29% in 2022, driven by growth in patients served under value-based arrangements; expansion of care delivery services, including in-home, clinic-based, ambulatory surgery, behavioral and digital; and overall increasing acuity levels of the care that can be offered.

- Optum Insight's revenue backlog increased by $7.6 billion in 2022 to $30 billion, driven by the addition of Change Healthcare and growth in comprehensive managed services. In order to speed improved system performance and experiences for patients and care providers, Optum Insight is advancing its investment initiatives.

- Optum Rx revenue growth of 9% in 2022 reflects continued expansion of its pharmacy care services, adding clinical value to medications, including specialty and community-based pharmacies. Adjusted scripts grew to 1.44 billion compared to 1.37 billion last year.

About UnitedHealth Group

UnitedHealth Group (NYSE: UNH) is a health care and well-being company with a mission to help people live healthier lives and help make the health system work better for everyone through two distinct and complementary businesses. Optum delivers care aided by technology and data, empowering people, partners and providers with the guidance and tools they need to achieve better health. UnitedHealthcare offers a full range of health benefits, enabling affordable coverage, simplifying the health care experience and delivering access to high-quality care. Visit UnitedHealth Group at www.unitedhealthgroup.com and follow @UnitedHealthGrp on Twitter.

Earnings Conference Call

As previously announced, UnitedHealth Group will discuss the company's results, strategy and future outlook on a conference call with investors at 8:45 a.m. Eastern Time today. UnitedHealth Group will host a live webcast of this conference call from the Investor Relations page of the company's website (www.unitedhealthgroup.com). Following the call, a webcast replay will be on the Investor Relations page and at https://uhg.com/Replay through January 27, 2023. This earnings release and the Form 8-K dated January 13, 2023, can also be accessed from the Investor Relations page of the company's website.

Non-GAAP Financial Information

This news release presents non-GAAP financial information provided as a complement to the results provided in accordance with accounting principles generally accepted in the United States of America ("GAAP"). A reconciliation of the non-GAAP financial information to the most directly comparable GAAP financial measure is provided in the accompanying tables found at the end of this release.

Forward-Looking Statements

The statements, estimates, projections, guidance or outlook contained in this document include "forward-looking" statements which are intended to take advantage of the "safe harbor" provisions of the federal securities law. The words "believe," "expect," "intend," "estimate," "anticipate," "forecast," "outlook," "plan," "project," "should" and similar expressions identify forward-looking statements. These statements may contain information about financial prospects, economic conditions and trends and involve risks and uncertainties. Actual results could differ materially from those that management expects, depending on the outcome of certain factors including: risks associated with public health crises, large-scale medical emergencies and pandemics; our ability to effectively estimate, price for and manage medical costs; new or changes in existing health care laws or regulations, or their

enforcement or application; the DOJ's legal action relating to the risk adjustment submission matter; our ability to maintain and achieve improvement in quality scores impacting revenue; reductions in revenue or delays to cash flows received under government programs; changes in Medicare, the CMS star ratings program or the application of risk adjustment data validation audits; failure to maintain effective and efficient information systems or if our technology products do not operate as intended; cyberattacks, other privacy/data security incidents, or our failure to comply with related regulations; failure to protect proprietary rights to our databases, software and related products; risks and uncertainties associated with our businesses providing pharmacy care services; competitive pressures, including our ability to develop and deliver innovative products to health care payers and expand access to virtual care; changes in or challenges to our public sector contract awards; failure to develop and maintain satisfactory relationships with health care payers, physicians, hospitals and other service providers; failure to attract, develop, retain, and manage the succession of key employees and executives; the impact of potential changes in tax laws and regulations (including any increase in the U.S. income tax rate applicable to corporations); failure to achieve targeted operating cost productivity improvements; increases in costs and other liabilities associated with litigation, government investigations, audits or reviews; failure to manage successfully our strategic alliances or complete or receive anticipated benefits of strategic transactions; fluctuations in foreign currency exchange rates; downgrades in our credit ratings; our investment portfolio performance; impairment of our goodwill and intangible assets; and our ability to obtain sufficient funds from our regulated subsidiaries or from external financings to fund our obligations, maintain our debt to total capital ratio at targeted levels, maintain our quarterly dividend payment cycle, or continue repurchasing shares of our common stock. This above list is not exhaustive. We discuss these matters, and certain risks that may affect our business operations, financial condition and results of operations more fully in our filings with the SEC, including our reports on Forms 10-K, 10-Q and 8-K. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Actual results may vary materially from expectations expressed or implied in this document or any of our prior communications. You should not place undue reliance on forward-looking statements, which speak only as of the date they are made. We do not undertake to update or revise any forward-looking statements, except as required by law.

# # #

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UNITEDHEALTH GROUP
Earnings Release Schedules and Supplementary Information
Year Ended December 31, 2022

- Condensed Consolidated Statements of Operations
- Condensed Consolidated Balance Sheets
- Condensed Consolidated Statements of Cash Flows
- Supplemental Financial Information - Businesses
- Supplemental Financial Information - Business Metrics
- Reconciliation of Non-GAAP Financial Measure

UNITEDHEALTH GROUP
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
(in millions, except per share data)
(unaudited)

	Three Months Ended December 31,		Year Ended December 31,	
	2022	**2021**	**2022**	**2021**
Revenues				
Premiums	$64,700	$57,547	$257,157	$226,233
Products	9,398	8,961	37,424	34,437
Services	7,834	6,422	27,551	24,603
Investment and other income	855	813	2,030	2,324
Total revenues	82,787	73,743	324,162	287,597
Operating costs				
Medical costs	53,591	48,159	210,842	186,911
Operating costs	13,009	11,272	47,782	42,579
Cost of products sold	8,314	8,000	33,703	31,034
Depreciation and amortization	982	771	3,400	3,103
Total operating costs	75,896	68,202	295,727	263,627
Earnings from operations	6,891	5,541	28,435	23,970
Interest expense	(676)	(431)	(2,092)	(1,660)
Earnings before income taxes	6,215	5,110	26,343	22,310
Provision for income taxes	(1,307)	(919)	(5,704)	(4,578)
Net earnings	4,908	4,191	20,639	17,732
Earnings attributable to noncontrolling interests	(147)	(120)	(519)	(447)
Net earnings attributable to UnitedHealth Group common shareholders	$4,761	$4,071	$20,120	$17,285
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$5.03	$4.26	$21.18	$18.08
Adjusted earnings per share attributable to UnitedHealth Group common shareholders (a)	$5.34	$4.48	$22.19	$19.02
Diluted weighted-average common shares outstanding	947	955	950	956

(a) See page 6 for a reconciliation of the non-GAAP measure

UNITEDHEALTH GROUP
CONDENSED CONSOLIDATED BALANCE SHEETS
(in millions)
(unaudited)

	December 31, 2022	December 31, 2021
Assets		
Cash and short-term investments	$27,911	$23,907
Accounts receivable, net	17,681	14,216
Other current assets	23,477	23,635
Total current assets	69,069	61,758
Long-term investments	43,728	43,114
Other long-term assets	132,908	107,334
Total assets	$245,705	$212,206
Liabilities, redeemable noncontrolling interests and equity		
Medical costs payable	$29,056	$24,483
Short-term borrowings and current maturities of long-term debt	3,110	3,620
Other current liabilities	57,071	50,189
Total current liabilities	89,237	78,292
Long-term debt, less current maturities	54,513	42,383
Other long-term liabilities	15,608	15,052
Redeemable noncontrolling interests	4,897	1,434
Equity	81,450	75,045
Total liabilities, redeemable noncontrolling interests and equity	$245,705	$212,206

UNITEDHEALTH GROUP
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(in millions)
(unaudited)

	Year Ended December 31,	
	2022	**2021**
Operating Activities		
Net earnings	$20,639	$17,732
Noncash items:		
Depreciation and amortization	3,400	3,103
Deferred income taxes and other	(1,004)	(814)
Share-based compensation	925	800
Net changes in operating assets and liabilities	2,246	1,522
Cash flows from operating activities	26,206	22,343
Investing Activities		
Purchases of investments, net of sales and maturities	(6,837)	(1,843)
Purchases of property, equipment and capitalized software	(2,802)	(2,454)
Cash paid for acquisitions, net	(21,458)	(4,821)
Other, net	2,621	(1,254)
Cash flows used for investing activities	(28,476)	(10,372)
Financing Activities		
Common share repurchases	(7,000)	(5,000)
Dividends paid	(5,991)	(5,280)
Net change in short-term borrowings and long-term debt	12,536	2,481
Other, net	4,681	344
Cash flows from (used for) financing activities	4,226	(7,455)
Effect of exchange rate changes on cash and cash equivalents	34	(62)
Increase in cash and cash equivalents	1,990	4,454
Cash and cash equivalents, beginning of period	21,375	16,921
Cash and cash equivalents, end of period	$23,365	$21,375

UNITEDHEALTH GROUP
SUPPLEMENTAL FINANCIAL INFORMATION - BUSINESSES
(in millions, except percentages)
(unaudited)

	Three Months Ended December 31,		Year Ended December 31,	
	2022	**2021**	**2022**	**2021**
Revenues				
UnitedHealthcare	$63,046	$56,384	$249,741	$222,899
Optum	47,868	41,093	182,768	155,565
Eliminations	(28,127)	(23,734)	(108,347)	(90,867)
Total consolidated revenues	$82,787	$73,743	$324,162	$287,597
Earnings from Operations				
UnitedHealthcare	$2,932	$2,121	$14,379	$11,975
Optum (a)	3,959	3,420	14,056	11,995
Total consolidated earnings from operations	$6,891	$5,541	$28,435	$23,970
Operating Margin				
UnitedHealthcare	4.7%	3.8%	5.8%	5.4%
Optum	8.3%	8.3%	7.7%	7.7%
Consolidated operating margin	8.3%	7.5%	8.8%	8.3%
Revenues				
UnitedHealthcare Employer & Individual - Domestic	$16,281	$15,355	$63,599	$60,023
UnitedHealthcare Employer & Individual - Global	2,168	2,053	8,668	8,345
UnitedHealthcare Employer & Individual - Total	18,449	17,408	72,267	68,368
UnitedHealthcare Medicare & Retirement	28,051	24,843	113,671	100,552
UnitedHealthcare Community & State	16,546	14,133	63,803	53,979
Optum Health	$18,446	$14,550	$71,174	$54,065
Optum Insight	4,387	3,251	14,581	12,199
Optum Rx	25,854	23,849	99,773	91,314
Optum eliminations	(819)	(557)	(2,760)	(2,013)

(a) Earnings from operations for Optum for the three months and year ended December 31, 2022 included $1,692 and $6,032 for Optum Health; $895 and $3,588 for Optum Insight; and $1,372 and $4,436 for Optum Rx, respectively. Earnings from operations for Optum for the three months and year ended December 31, 2021 included $1,229 and $4,462 for Optum Health; $951 and $3,398 for Optum Insight; and $1,240 and $4,135 for Optum Rx, respectively.

UNITEDHEALTH GROUP
SUPPLEMENTAL FINANCIAL INFORMATION - BUSINESS METRICS

UNITEDHEALTHCARE CUSTOMER PROFILE
(in thousands)

People Served	December 31, 2022	September 30, 2022	December 31, 2021
Commercial - Domestic:			
Risk-based	8,045	8,055	7,985
Fee-based	18,640	18,500	18,595
Total Commercial - Domestic	26,685	26,555	26,580
Medicare Advantage	7,105	7,035	6,490
Medicaid	8,170	8,005	7,655
Medicare Supplement (Standardized)	4,375	4,370	4,395
Total Community and Senior	19,650	19,410	18,540
Total UnitedHealthcare - Domestic Medical	46,335	45,965	45,120
Commerical - Global	5,360	5,360	5,510
Total UnitedHealthcare - Medical	51,695	51,325	50,630
Supplemental Data			
Medicare Part D stand-alone	3,295	3,310	3,700

OPTUM PERFORMANCE METRICS

	December 31, 2022	September 30, 2022	December 31, 2021
Optum Health Consumers Served (in millions)	102	101	100
Optum Insight Contract Backlog (in billions)	$30.0	$24.1	$22.4
Optum Rx Quarterly Adjusted Scripts (in millions)	370	359	353

Note: UnitedHealth Group served 151 million unique individuals across all businesses at December 31, 2022.

UNITEDHEALTH GROUP
RECONCILIATION OF NON-GAAP FINANCIAL MEASURE
(in millions, except per share data)
(unaudited)

ADJUSTED NET EARNINGS PER SHARE[a]

	Three Months Ended December 31,		Year Ended December 31,		Projected Year Ended December 31,
	2022	2021	2022	2021	2023
GAAP net earnings attributable to UnitedHealth Group common shareholders	$4,761	$4,071	$20,120	$17,285	$21,700 - $22,300
Intangible amortization	396	280	1,292	1,184	~1,540
Tax effect of intangible amortization	(98)	(68)	(331)	(288)	~(380)
Adjusted net earnings attributable to UnitedHealth Group common shareholders	$5,059	$4,283	$21,081	$18,181	$22,850 - $23,450
GAAP diluted earnings per share	$5.03	$4.26	$21.18	$18.08	$23.15 - $23.65
Intangible amortization per share	0.42	0.29	1.36	1.24	~1.65
Tax effect per share of intangible amortization	(0.11)	(0.07)	(0.35)	(0.30)	~(0.40)
Adjusted diluted earnings per share	$5.34	$4.48	$22.19	$19.02	$24.40 - $24.90

(a) Adjusted net earnings per share is a non-GAAP financial measure. Non-GAAP financial measures should be considered in addition to, but not as a substitute for, or superior to, financial measures prepared in accordance with GAAP.

Adjusted net earnings per share excludes from the relevant GAAP metric, as applicable, intangible amortization and other items, if any, that do not relate to the Company's underlying business performance. Management believes that the use of adjusted net earnings per share provides investors and management useful information about the earnings impact of acquisition-related intangible asset amortization. As amortization fluctuates based on the size and timing of the Company's acquisition activity, management believes this exclusion provides a more useful comparison of the Company's underlying business performance and trends from period to period. While intangible assets contribute to the Company's revenue generation, the intangible amortization is not directly related. Therefore, the related revenues are included in adjusted earnings per share.