May 14, 2021

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

Dear Secretary Becerra:

On behalf of our members, the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA) are writing to supplement the letter we sent to the Departments of Health and Human Services (HHS), Labor, and Treasury (the Departments) regarding implementation of the *No Surprises Act*. Specifically, we are writing to provide technical comments on two important areas:

- Information Necessary to Accurately Bill Patients for Out-of-Network Emergency Services Under the *No Surprises Act*.
- Important Considerations Regarding the Timelines Included in the *No Surprises Act.*

It is critical that health care providers receive timely and accurate information from health plans to ensure that patients are not confused by any billing information they receive from either the health care provider or the health plans and that they are assessed the appropriate cost-sharing amount. Further, once the patient receives the bill from the health care provider, ACEP and EDPMA want to make sure that the Departments clearly lay out the timelines in regulation for the negotiation and independent dispute resolution (IDR) processes to ensure that they are consistent with the timelines included in the statute and that they promote timely and clear resolution. In all, we seek to enhance the patient protections and to optimize compliance with the law.

Claims and Billing Process Overview

To provide context for the specific technical recommendations for the *No Surprises Act* that follow, we first provide an overview of the claims and billing processes as they occur today when a patient receives emergency care. This overview is intended to provide an important backdrop for our comments and recommendations, so that the unique aspects of emergency care are firmly in mind as the *No Surprises Act* is implemented.

A person presents to an emergency department (ED) believing they have an emergency medical condition (EMC). 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 (as required by EMTALA). If the clinician reasonably believes an EMC exists, stabilizing treatment must be rendered to the patient. If the EMC can be stabilized in the ED, the patient will be discharged from the ED once that is complete (and, if necessary, any ensuing post-stabilization care will be addressed as appropriate). 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.

The requirements of EMTALA uniquely apply to patients being treated in EDs and essentially require medical assessment and stabilizing care without prior review of the patient's ability or health plan'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.

The activities of patient care are documented in the medical record and then translated into standardized language – Current Procedure Terminology (CPT) and International Classifications of Disease (ICD-10) for billing purposes.

This information is then used to populate a HCFA 1500 claim (for the clinician's services) or a UB-04 claim (for the facility's services). The HCFA 1500 is transmitted to the health plan following the emergency encounter usually within 10 to 15 days (it could be longer) via a standardized format called an American National Standards Institute (ANSI) 837 (837). The health plan then is supposed to adjudicate the claim and communicate information to the health care provider in a standardized format called an ANSI 835 (835) remittance (although compliance is unfortunately variable).

Health Insurance Portability and Accountability Act (HIPAA) transaction and code set (TCS) standards require that health plans use ANSI Claims Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) in their 835 electronic healthcare transactions:

- CARCs are utilized to identify the financial information regarding the claim decisions. As an example, the CARC "PI 242" describes a payor-initiated reduction as "services not provided by network/primary care providers." *This is critical information so that all parties involved clearly understand the determination a health plan has made about payment for services that were rendered.*
- The CARC codes PR 1, 2, or 3 reflects patient responsibility (PR) as follows: PR 1-deductible, PR 2-co-insurance and PR-3-co-payment. *This information is important so that patients understand why their health plan believes they owe an out-of-pocket payment and to distinguish these amounts from a balance bill. Health plans need to ensure that the*

patient responsibility amount is correct and should be responsible for correcting any errors.

- RARCs are utilized to identify a specific message as shown in the Remittance Advice Remark Code List. For example, the RARC "N830" describes "The charge for this service was processed by Federal/State Balance/Surprise billing regulation." *Currently, RARCs are important in order to identify state- versus federally-regulated plans. Going forward, these codes will need to be able to distinguish whether the health plan is subject to the state or federal processes established by the No Surprises Act.*

Here is an example of when a health plan follows the standardized format.

Information Necessary to Accurately Bill Patients for Out-of-Network Emergency Services Under the *No Surprises Act*

When a service has been delivered by an out-of-network health care provider, a claim will be submitted to the health plan, and under the *No Surprises* Act, the health plan must return an initial payment or denial within 30 days of the transmission of the claim.

For additional provisions of the *No Surprises Act* to be fulfilled, the health plan must furnish the health care provider with sufficient information to establish the patient's financial responsibility and to collect the appropriate patient cost-sharing component of the payment for the service that was rendered.

This specific information should be sent to the health care provider by the health plan along with the 835 remittance advice and the Explanation of Benefits (EOB) for the claim at the same time the initial payment or denial is made, and include the following:

1) **Type of Plan**

Detailed information about the type of plan, which should be found in ANSI codes. The information should include:

a. Whether it is an ERISA plan, and if so, whether the ERISA plan is participating in a state-based (i.e., opted-in) out-of-network/balance billing resolution process (ACEP and EDPMA had recommended in our first letter that all ERISA plans be subject to the federal processes established by the *No Surprises Act*.)
    i. We recommend the Departments request that ANSI create an additional descriptor within the N830 to describe if the federal or state surprise billing legislation is applicable.
b. Whether it is a non-grandfathered plan on the Federal Marketplace or grandfathered plan.
c. Whether it is a Medicare Advantage plan or Medicaid Managed Care plan.
d. Whether it is a group or individual plan.

As you know, existing laws provide for different sets of patient protections as well as a different reimbursement rate depending on the type of plan covering the claim, and providers will need to know that plan type in order to ensure compliance. For example, Medicaid managed care organizations and Medicare Advantage plans must follow certain laws that private plans do not, despite the fact that they are implemented by commercial payors and the commercial payor's name is on the plan. Further, the Affordable Care Act (ACA) extended patient protections, such as the Prudent Layperson (PLP) standard, to group and individual plans unless grandfathered in. Lastly, ERISA plans are generally governed by federal law instead of state law.

If the provider does not know the type of plan very early in the process, an applicable patient protection might inadvertently be violated, inappropriate payment could be requested from the patient, and unnecessary revenue cycle management administrative work that does not apply to the claim could be performed. Today, many health plans make it difficult for providers to determine the type of plan and the laws applicable to the claim—as is evident through clinicians' experiences with state laws on surprise medical billing.

Fortunately, this situation can be changed at little cost or disruption to the system. ACEP and EDPMA request that this information be embedded in the plan number, with each type of plan being given its own letter. For example:

- An ERISA plan could be identified with a plan number that ends with a "-E.
- A "-G" could identify a plan that is grandfathered from the ACA.

ACEP and EDPMA also recommend that this information should also be required to be clearly identified on the patient's insurance card or a similar, timely, easily accessible, updated, transparent, and accurate method. Finally, we request that the Departments strongly enforce this requirement and ensure that the information is provided in an industry standardized way, like the CARC or RARC.

2) **<u>Qualifying Payment Amount (QPA)</u>**

The *No Surprises Act* states that the QPA will serve as the "recognized amount" that is used to determine the patient's cost sharing responsibility. The QPA is also a factor that the independent dispute resolution (IDR) entity must consider for claims subject to the federal IDR process.

For the health care provider to have the appropriate information with which to accurately inform the patient of his or her cost-sharing responsibilities, the health plan must be required to communicate the QPA as part of the 835 remittance advice and EOB for the services included on the claim submitted by the provider.

For each QPA, the health plan should clearly indicate:

a. The billed service (i.e., CPT code for clinician services) to which the QPA applies to (ex. an ED evaluation and management level 4).
b. The geographic area from which the QPA was derived.
c. The insurance market from which the QPA was derived.
d. The specialty from which the QPA was derived (for example, clinicians with a specialty designation of emergency medicine are designated by the Centers for Medicare & Medicaid Services to have "specialty code" 93).
e. A contact method or reference link for the provider to find out more information about how the QPA was calculated. This information could also be incorporated into ANSI codes or found in the health plan's provider manual.

As an example, part of the 835 could read: "QPA: $300 (CPT 99284, Geozip: 124, insurance market: ERISA, specialty: 93)."

3) **Patient's Cost-Sharing Responsibility**

Health care providers must know the QPA that is used to determine the "recognized amount." In addition, health care providers must be empowered to accurately communicate to the patient his or her financial responsibility.

In order to do so, health plans must communicate to providers through ANSI codes:

a. What the cost-sharing structure is for the plan, based on the plan type (including what the deductible and coinsurance would have been if the services had been provided by an in-network provider).
b. Whether the patient has met his or her deductible and what coinsurance amount/ portion of the deductible is owed.
c. Based on a and b, what amount is owed by the patient. For example, the health plan could state, "in compliance with statute and regulation, based on the Recognized Amount of $300.00 and the described cost-sharing structure, the provider is entitled to collect $60.00 from the patient."

With this information, the provider has the appropriate level of documentation to send a bill to a patient for the correct cost sharing amount and answer any questions from the patient about how that amount was determined. The health plan should also be required to inform the provider what information regarding cost-sharing it communicated to the patient in order to ensure that the patient receives consistent and accurate information from both the provider and the health plan. **Without this, providers are unable to communicate to patients what their specific insurance coverage does or does not provide, and patients will continue to receive what they will perceive as "surprise" bills, despite the protections provided under the *No Surprises Act*.**

These historically required data elements – as well as suggested new data elements – are critical components in the 835, EOB, and insurance cards (or equivalent). Since they are important for transparency to patients and important for appropriate billing processes, we would recommend an affirmative mechanism that holds parties accountable to these requirements. Health care providers should also not be held liable if they improperly bill the patient based on inaccurate information that is provided by (or not available from) the health plan.

Important Considerations Regarding the Timelines in the *No Surprises Act.*

As stated above, the statute is clear when outlining what the health plan's initial obligation is once a provider sends a bill for a service – no later than 30 days after the bill is submitted, the health plan must issue an initial payment OR a notice of denial of payment. In addition, as we stated in our previous letter, **failure to make an initial payment or provide a notice of denial, within 30 days of the submission of the original claim should be deemed a *de facto* notice of denial.** By doing so, the important timelines in the *No Surprises Act* can progress affirmatively, and are not interrupted by any party's failure to participate or respond.

During the listening session hosted by the Departments on April 14, 2021, questions about the timeline with the Federal IDR process and how these might interact with plan/issuer appeals processes were raised. ACEP and EDPMA urge the Departments to ensure that the regulations reflect the following principles in this area:

- No plan or issuer may enact a process to mandate an appeals process or other mechanism for out-of-network providers that alters the *No Surprises Act* obligation for an initial payment or denial of payment of the submitted CPT code within 30 days of claim submission. If plans and providers agree to adjudicate a claim through a plan's or issuer's established appeals process, no event associated with that process shall alter the *No Surprises Act* timelines.

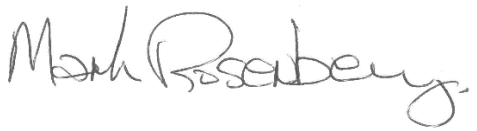
- Regardless of the nature of any dispute that makes its way through the IDR process, a payment determination by an arbiter has no bearing on enforcement of plan/issuer obligations under the Prudent Layperson (PLP) Standard or causes of action or complaints filed with appropriate authorities, including penalties and retroactive rescission of problematic policies. Implementation policies for the *No Surprises Act* should not eliminate the right of providers to pursue appropriate remedies, including legal or other mechanisms, particularly when those remedies are not under the intended purview of the *No Surprises Act*. Each party's rights under law – outside of the *No Surprises Act* – should be reserved.

ACEP and EDPMA urge the Departments to explicitly lay out these requirements in regulation to prevent any possible ambiguity around the health plan or issuer's initial

responsibilities and to avoid any situations that would cause the entire process of negotiation and prompt resolution to be delayed or to never be triggered at all.

Thank you for the opportunity to provide additional technical feedback. If you have any questions, please contact Laura Wooster, ACEP's Associate Executive Director of Public Affairs at lwooster@acep.org, or Elizabeth Mundinger, EDPMA's Executive Director at emundinger@edpma.org.

Sincerely,



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Bing Pao, MD, FACEP
Chair of the Board, EDPMA

CC: The Honorable Martin J. Walsh, Secretary of Labor
The Honorable Janet Yellen, Secretary of the Treasury