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United States Senate
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
WASHINGTON, DC 20510–6300

August 10, 2023

VIA ELECTRONIC TRANSMISSION

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

Dear Secretary Becerra:

Over the course of three years, Congressional leaders worked in a bipartisan, bicameral manner to end the practice of surprise medical billing. The successful agreement, now known as the No Surprises Act (P.L. 116-120, "the statute"), was crafted with precision, and was transmitted to the Department of Health and Human Services (HHS), Labor, and Treasury (collectively "the Departments") for execution. I write to reiterate my deep concern about how your agency has seen fit to interpret Congressional statute, and urge HHS to immediately remedy the issues outlined below.

The statute removed the patient from the middle of billing disputes and established a system in which an independent dispute resolution entity was allowed to make payment and value determinations on a wide variety of statutorily-defined criteria. Rather than implement the criteria as written in the statute, the Centers for Medicare and Medicaid Services (CMS) took artistic license, deviated from the criteria, and ultimately was ordered by the U.S. District Court to follow the statute as written – not once, but twice.[1] Similar legal challenges continue to plague the implementation of the statute. Disputes over the calculation of the qualifying payment amount (QPA) and the changing interpretation of "contracted rates," await a decision while other

[1] Texas Medical Association and Adam Corley v. United States Department of Health and Human Services et al., Texas Medical Association, et. al., v. United States Department of Health and Human Services, et al.

disputes around the drastic increase in administrative fee without sufficient justification have been recently vacated and remanded by the Court.[2,3]

The Department has approached these challenges as if they only impact the largest providers or the most sophisticated health plans. That is not true. Ultimately, the patient bears the adverse effects of the Department's unsuccessful implementation. Patients want to get their bill in a timely manner – and that process begins with the provider getting accurate remittance advice, which the Secretary enforces. Patients are harmed when providers stop providing services due to a lack of timely payment or the payment of inaccurate rates, both problems the Secretary could solve.[4] Patients are also ultimately denied the benefits of the No Surprises Act when the Department does not respond or produce feedback in response to complaints which assert payers, after losing at IDR, are turning to patients to recoup their lost costs.

These challenges join other obstacles in the implementation of the statute, namely the lack of consistent, standardized information flow between parties and the absence of timely payments once a payment determination has been made.[5] I am proud that in the first nine months of the statute's enactment, patients were protected from more than nine million surprise medical bills.[6] The challenges in implementation are not insurmountable, but will require the full engagement of the Department to address significant problems that have arisen due to HHS' flawed implementation of the statute. **In pursuit of this goal, please respond to the following questions on a question-by-question basis, by the close of business on Friday, September 15, 2023.** To furnish your timely response, please consult with the Department of Labor and Department of the Treasury as necessary.

The Qualifying Payment Amount (QPA)

1. Does the Department believe that the QPA is being calculated and communicated in a way that sufficiently meets the definition, instructions, and methodology listed in the statute?
2. Please provide the current definition, criterion, and methodology used to determine and calculate the QPA; any former definitions, criterion, and

[2] Texas Medical Association, Dr. Adam Corley, and Tyler Regional Hospital, LLC v. United States Department of Health and Human Services, Office of Personnel Management, Department of Labor, Department of the Treasury, Xavier Becerra *in his official capacity as the Secretary of Health and Human Services;* Kiran *Ahuja in her official capacity as the Director of the Office of Personnel Management*, Janet Yellen *in her official capacity as the Secretary of the Treasury*, and Martin J. *Walsh in his official capacity as the Secretary of Labor*

[3] Texas Medical Association, Dr. Adam Corley, Tyler Regional Hospital, LLC, Texas Radiological Society, and Houston Radiology Associated, v. United States Department of Health and Human Services, Office of Personnel Management, Department of Labor, Department of the Treasury, Centers for Medicare & Medicaid Services, *Xavier Becerra in his official capacity as the Secretary of Health and Human Services;* Kiran Ahuja *in her official capacity as the Director of the Office of Personnel Management*, Janet Yellen *in her official capacity as the Secretary of the Treasury*, Martin J. Walsh *in his official capacity as the Secretary of Labor*, and Chiquita Brooks-LaSure *in her official capacity as Administrator of the Centers for Medicare & Medicaid Services*

[4] https://www.axios.com/2023/08/03/insurers-refusing-pay-surprise-billing

[5] https://www.medpagetoday.com/opinion/second-opinions/104208

[6] https://ahiporg-production.s3.amazonaws.com/documents/202211_1P_Surprise_Billing.pdf

methodologies that the Department used to determine and calculate the QPA; and any guidances, bulletins, Frequently Asked Questions (FAQs), presentations, workshops, or other agency communications that provide information to providers, health plans, or payers in communicating the agency's instruction to determine or calculate the QPA.

3. Please provide the following:
    a. The Department's treatment of all statutory factors while calculating the QPA, including provider specialty, geographic region, services rendered, etc.
    b. Dates when the Department's calculation, instructions, criterion, or methodology surrounding the QPA was changed, and dates when this change was communicated publicly.
    c. Dates when the Department's guidance interpreting the instructions, methodology, criterion, or calculation of the QPA methodology changed, when subsequent communications were changed, and when these revisions were publicly communicated.
4. If Department staff consulted stakeholders before making the changes referenced in question 2, 3(a), 3(b), or 3(c), please provide the dates of stakeholder engagement (whether informal consultation, such as a phone call or email, or formal consultation, such as a meeting), and the participants (both internal and external) of these engagements.
5. With respect to the Department's definition of "contracted rate," please provide the following:
    a. The current definition and instructions provided to health plans or payers for determining a "contracted rate," and the required disclosure of such rate to providers. Please also provide citation for the definition and instructions.
    b. A description of how the Department's current definition and instructions in determining a "contracted rate" is derived from the statutory instructions on how to determine the QPA.
6. Please provide a description of changes made to the Department's interpretation or definition of "contracted rate," including:
    a. A timeline of changes made, beginning on January 1, 2021.
    b. The effective dates of each change, and their respective citations, as communicated to providers, health plans, and payers.
    c. For each change identified in 6(b) please provide whether the change was made through regulations, interim final rules, guidances, bulletins, FAQs, presentations, workshops, or other agency communications.
    d. An appropriate and relevant representative sampling of feedback solicited from a diverse set of stakeholders, including groups representing providers, health plans, and payers, by Department officials, as well as these stakeholder responses, prior to each change in the definition or interpretation of "contracted rate," as well as feedback given (whether solicited or unsolicited) to these changes.

7. With respect to the Department's change in interpretation and definition of a "contracted rate," please answer the following:
    a. Please provide the difference between "contracted rates" as defined and determined by the Interim Final Rule (IFR) released in July 2021 and the FAQ document released on August 19, 2022, including the footnote on the response to Question 14 of the FAQs.[7]
    b. Please provide the factors, including weight ascribed to each factor, associated feedback, and any other decision-making materials the agency contemplated when making the change as referenced in Question 7(a). Please ensure that this answer thoroughly elaborates on how the Department's understanding of the statutory definition changed from one definition to another.
    c. Please provide whether the Department believes that the FAQs referenced in Question 7(a), including the footnote on the response to Question 14 of the FAQs, carry the full weight of agency authority as providers, health plans, or payers contemplate adherence to the law. Please provide justification for this response.
    d. Please provide whether the Department believes providers, health plans, or payers are following (or, followed, should the Department have implemented a more current definition) the instructions given in the FAQs referenced in Question 7(a), including the footnote on the response to Question 14 of the FAQs. Please provide justification for this response.
    e. Whether the Department is aware of reports of noncompliance with the instructions given in the FAQs referenced in Question 7(a), including the footnote on the response to Question 14 of the FAQs. In justification for this response, please include instances where the Department has been made aware, corrective actions the Department has taken in response, and if successive reports of noncompliance have been made after the Department issued corrective actions.
8. As part of the change in interpretation and definition described in Question 7(a), please provide the following information:
    a. How many improperly calculated contracted rates (as defined as rates that the Department later stated were improper in its footnote to Question 14 in the referenced FAQ document) were included in QPA calculations between the release of the July 2021 IFR and the FAQ document in August 2022?
    b. Did the Department receive feedback on whether to adjudicate the improperly calculated contracted rates included in the QPA calculations referenced in Question 8(a)? If so, please describe the feedback and the Department's understanding of the feasibility of making the respective recommendations provided in the feedback. In your answer, please be specific in referencing your conversations (both formal solicitations or

[7] https://www.cms.gov/files/document/faqs-part-55.pdf

informal feedback), whether they were external (specifying the broad industry sector) or internal (specifying Department, agency, or other Administrative office).

9. Please provide the primary mechanism the Department has used to receive notification in the case of a QPA suspected of being calculated incorrectly and the primary mechanism the Department has used to receive requests to validate the accuracy of the QPA.
    a. If the Department has received such complaints or inquiries in regard to the QPA, including its calculation, please provide the number of complaints, a categorization of the complaints (such as the party filing the complaint), the number of complaints responded to, the violations of noncompliance found, the enforcement actions taken in response to those violations and the number of complaints filed in each category.
    b. Please provide information on how the Department has taken and is currently taking corrective action based on these complaints, including a representative sampling of examples (using de-identified information) detailing the complaint, the corrective action taken, the timeline, and the current practice (if applicable) by both parties involved.
10. Has the Department received complaints specifically in regards to how the QPA compares to other rates, such as rates with the Centers for Medicare and Medicaid Services (CMS) as part of participation in the Medicare or Medicaid programs ("Medicare rate" or "Medicaid rate")? If so, please provide the number of complaints and specify whether the complaint found the QPA for the item or service lower or higher than a similar Medicare or Medicaid rate for a similar item or service provided.
    a. Please provide information on how the Department has taken and is currently taking corrective action based on these complaints, including a representative sampling of examples (using de-identified information) detailing the complaint, the corrective action taken, the timeline, and the current practice (if applicable) by both parties involved.
11. Please provide the following information in regards to the statutory and regulatory requirements to communicate information about the QPA between provider, health plan, or payer ("parties").
    a. Each statutory and regulatory circumstance where information about the QPA must be shared between parties.
    b. What, if any, actions the Department is taking to ensure that the QPA is being communicated between parties. If communicated publicly, please include citations to these communications. If communicated directly to parties, please provide a diverse, representative sampling of de-identified vignettes to adequately show what actions the Department was asking parties to take, what challenges the Department was looking to address, the actions the parties took in response, and whether the parties' actions sufficiently met the Department's expectations.

c. De-identified vignettes for each statutory and regulatory circumstance where the Department has seen these requirements to communicate information about the QPA between parties met sufficiently.
d. Instances where the Department continues to seek new information in how to best address noncompliance with the requirement to share QPA information between parties.

Ensuring Timely and Accurate Payments

12. Does the Department believe that IDR entities, providers, plans, and payers are fulfilling their requirement to ensure payment in 30 calendar days after payment determination?
13. Please provide the most recent guidance as released to IDR entities, providers, plans, and payers in regards to their statutory requirement to ensure payment in 30 calendar days after payment determination.
    a. Instances where the Department has been notified of noncompliance with the statutory requirement to ensure payment in 30 calendar days after payment determination.
        i. A list of common challenges, as communicated by parties, in maintaining compliance with the statutory requirement to ensure payment in 30 calendar days after payment determination.
        ii. A description of how the Department was made aware of each such challenge.
        iii. What information, if any, has the Department requested from parties in order to understand what actions the Department may need to take to ensure parties are compliant with the statutory requirement to pay in 30 calendar days after IDR entity determination.
        iv. What actions, if any, the Department is taking to address these challenges. Please provide sufficient explanation as to each action the Department is taking to address these challenges (e.g. the goals of the communication, the actions communicated, etc).
        v. What evidence the Department has that demonstrates improvements in accurate and timely payments being made as a result of the actions taken by the Department.
    b. Instances where the Department attests to noncompliance with the statutory requirement to ensure payment in 30 calendar days after payment determination, but the Department believes there was no or few barriers to compliance (such as the barriers referenced in Question 13(a)(i)).
        i. A list of instances, categorized by party in noncompliance and any other common characterizations.
        ii. A description of how the Department was made aware of each such instance.

iii. Corrective actions the Department has taken to address these instances and whether there have been additional complaints made against the same party for similar instances of noncompliance.
iv. Documentation of information requested by the Department from parties in order to understand what actions might be needed by the Department in order to protect other parties from similar instances of noncompliance.
v. Actions the Department is presently taking to address these categories of noncompliance. These actions could include formal or informal engagement with IDR entities, providers, plans, or payers (e.g. public workshops, presentations, email conversations), as well as updating guidance to share enforcement actions. Please provide sufficient explanation as to each action the Department is taking to address these instances of noncompliance.

c. A summary of the Department's understanding of the challenges in maintaining compliance with the statutory requirement to ensure that payment is made within 30 calendar days of payment determination and how the Department intends to address these challenges.

14. Please provide summaries of conversations with IDR entities, providers, plans, and payers in regards to other instances of initial payments, final payments, initial payments recouped after the negotiation period, and final payments recouped after payment that have been highlighted as potentially being in noncompliance with the requirements under the statute. Please include:
    a. Detailed examples of potential noncompliance that have been highlighted as part of conversations with IDR entities, providers, plans, and payers.
    b. Information the Department has solicited from IDR entities, providers, plans, and payers in order to:
        i. Understand whether each highlighted instance of potential noncompliance is, in fact in noncompliance with statutory or regulatory requirements.
        ii. Determine whether each instance is in compliance or noncompliance with statutory or regulatory requirements.
        iii. Take further action in preventing future instances of similar noncompliance.
    c. Actions, and the timing of such actions, the Department has taken in order to:
        i. Bring parties into compliance (e.g. enforcement actions, informal guidance), and the parties' actions after these actions.

<u>Independent Dispute Resolution (IDR) Process</u>

15. Please list the common feedback and challenges shared by providers, plans, and payers with the Department in regard to the steps prior of the federal IDR process prior to initial payment or notice of denial of payment.

a. Please detail the feedback and challenges and how the Department has sought to mitigate them.
b. For challenges where a solution is outstanding, please provide the information requested and received by the Department to each party in order to seek a solution to the challenges.

16. Please list the common feedback and challenges shared by providers, plans, and payers with the Department in regard to the initial payment or notice of denial of payment.
    a. Please detail the feedback and challenges and how the Department has sought to mitigate them, including:
        i. Challenges in understanding whether a claim is eligible for the federal or a state (if applicable) arbitration process.
        ii. Challenges with the information provided as part of the initial payment or notice of denial of payment (e.g. the QPA) in understanding the specific party (whether specific provider or specific plan or payer) responsible for either initial payment or notice of denial of payment.
        iii. Transparency in the patient's specific health plan type and their remaining deductible for the coverage period.
    b. For challenges where a solution is outstanding, please provide information, if any, given to the Department as it relates to proposed solutions, such as:
        i. Usage of the most appropriate Remittance Advice Remark Codes (RARC) on claims to help determine whether a claim should be submitted to either federal or state (if applicable) arbitration process.
        ii. The feasibility of expanding the Department's portal to support and facilitate all communications, including the initial payment or notice of denial or payment, communications between all parties, and the final payment made.
        iii. Other solutions presented to decrease the number of ineligible claims submitted to the IDR process.
17. Please list the common feedback and challenges shared by providers, plans, and payers with the Department in regard to the open negotiation stage.
    a. Please detail the feedback and challenges and how the Department has sought to mitigate them, including:
        i. Challenges in identifying the point of contact (e.g. for a provider, plan, or payer to initiate negotiations).
        ii. Lack of engagement by the non-initiating party.
        iii. Feedback on the usage of different, non-federal portals during open negotiation.
        iv. Feedback on best practices for both parties when using the open negotiation stage, and strategies that have been communicated to

encourage the disputing parties to use these best practices in the open negotiation process.

v. Allegations of a lack of good faith efforts during the open negotiation stage, including the time allowed for open negotiations, such as the non-initiating party allowing the open negotiation period to close without engaging with the initiating party.

b. For challenges where a solution is outstanding, please provide the information requested and received by the Department to each party in order to seek a solution to the challenges.

18. Please list the common feedback and challenges shared by IDR entities, providers, plans, and payers with the Department in regard to the Federal IDR Process.
    a. Please detail the feedback and challenges and how the Department has sought to mitigate them, including:
        i. Delays in meeting timelines as outlined and specified by statute.
        ii. Lack of response regarding the status of a claim from both the Department and IDR entities.
        iii. Failure of IDR entities to utilize the most current guidance in rendering determinations.
        iv. Selection of a certified IDR entity, including preference displayed by IDR entities.
        v. Batching requirements.
        vi. Invoice and payment of fees, including the fees to the IDR entity and the Administrative fees.
        vii. Submission of information through the Department's portal.
    b. For challenges where a solution is outstanding, please provide the information requested and received by the Department to each party in order to seek a solution to the challenges.
19. Please list the common feedback and challenges shared by providers, plans, and payers with the Department in regard to the steps taken after the federal IDR process.
    a. Please detail the feedback provided by all parties regarding these challenges and how the Department has sought to mitigate them.
    b. For challenges where a solution is outstanding, please provide the information requested and received by the Department from each party in order to seek a solution to the challenges.
20. Please provide the additional information below as required by the statute:
    a. The length of time taken by each IDR entity in making a payment determination.
    b. The number, expressed as a total amount and percentage, of notifications where the offer selected by the IDR entity was the offer submitted by the plan or issuer and the number, expressed as a total amount and percentage,

of notifications where the QPA used for payment determination was the QPA submitted at the time of payment determination.

Batching Challenges

21. Has the Department received complaints or feedback regarding the current batching requirements?
    a. Please provide a representative sampling of the feedback and complaints received by the Department in regard to the current batching requirements, including all feedback and complaints from specialty providers regarding barriers imposed by the current batching requirements.
    b. Please provide the information requested and received by the Department in order to seek a solution to the challenges imposed by the current batching requirements as they relate to specialty and non-specialty practices.
    c. Please provide, in detail, how the Department is taking steps to mitigate the challenges regarding the current batching requirements in response to the complaints received, including how the Department is taking steps to increase efficiency and decrease administrative burden.
22. Has the Department considered implementing alternative batching requirements in order to support increased efficiency for claims entering the IDR process? Please detail them.

Administrative Fee

23. Please detail the methodology used as the Department calculated the increase in Administrative Fee. This methodology, and calculations in regards to the methodology, should reflect the change that went into effect in January 2023.
    a. How did the Department consider the impact that the increase in administrative fee could have on providers affected by the NSA, in particular those with low dollar value claims?
    b. How is the Department continuing to monitor this?
24. Please provide an explanation of instances where a decision of eligibility for the federal IDR process has been determined before the administrative fee is collected by the IDR entity. Please include:
    a. Whether the Department has made efforts to recover the required administrative fee in these instances.
    b. The percent of ineligible claims submitted to the federal IDR portal that paid the administrative fee during Q1 and Q2 of Calendar Year 2023.
    c. If the lack of payment of administrative fees for claims found ineligible contributed as a factor in the Department's decision to increase the administrative fee.
25. How much, as a percentage, of each administrative fee collected by IDR entities is remitted to the Department?

a. If the full amount is not being remitted to the Department, what actions are being taken to collect the full amount of the administrative fee?

26. Please provide an explanation detailing the accounting of the administrative fee during Q1 and Q2 of Calendar Year 2023, including:
    a. The total amount charged to parties who have submitted a claim to enter the IDR process.
    b. The total amount paid to the IDR entities by parties who have submitted a claim to the federal IDR process.
    c. The total amount of administrative fees remitted to the Department.
    d. The specific line items with accompanying amounts in which the Department is using the administrative fee to facilitate the federal IDR process.
    e. The total remaining balance of administrative fees collected by the Department.
27. Has the lack of timely payment of the administrative fees by the parties entering arbitration contributed to delays in the IDR process?
    a. What tools are the Department using to ensure that parties are paying in a timely manner as required by statute?
28. Due to the fees associated with participating in the federal IDR process, please detail the steps the Department has taken to address any economic disincentive to participate in the IDR process.
    a. What actions has the Department taken to ensure that all provider specialties have appropriate access to the federal IDR portal?
    b. How have the actions specified in 23(a) ensured that all provider specialties have sufficient access to participate in the federal IDR portal?

<u>Audits & Enforcement Authorities</u>

29. What enforcement authorities does the Department have as outlined by the statute?
    a. What additional enforcement authorities do you believe that you have outside of the No Surprises Act?
30. Please provide the following information in regards to audits required in implementation of the statute.
    a. Total number of audits required by statute for Calendar Year 2022, and how many were completed.
    b. Total number of audits required by statute for Calendar Year 2023, and how many have been started or completed.
    c. Detailed descriptions of the audit plans for Calendar Year 2024 in fulfillment of the statutory requirement.
31. For each audit conducted of health plans, please provide the following:
    a. The criteria sampled during the audits, the audit sample size, the size of the universe from which the sample was taken, and the statistical relevance of the sample size.

b. For each audit, please provide if the Department conducted the audit or provide the name of the specific third-party that conducted the audit.
c. The selection process for choosing health plans for the purposes of an audit.
    i. Are health plans that have received the most complaints selected for audit?
    ii. Are health plans that have utilized ghost rates in the calculation of the QPA selected for audit?

32. How did you determine that nine audits are sufficient to comply with the requirements of the statute, which details that not more than 25 audits can be conducted per plan year? Please provide documentation and rationale that the nine audits expected to be conducted as referenced in the July 2021 Interim Final Rules (IFR) is an adequate number to constitute a representative sample.[8]
    a. Please detail how the audits evaluate the calculation of the QPA methodology as outlined in statute and regulations.
        i. Please include how the audits are evaluating a health plan's contracted rates in comparison to similar contracted rates.
33. Please detail how the Department is evaluating the performance of contracted IDR entities.
34. Please provide information in regard to any barriers the Department might have in conducting these audits and providing this information to Congress.
35. Please provide the specific date when the audit reports will be made available to Congress as required by statute.

Additional Items

36. Through what process does the Department receive complaints regarding the implementation of the statute?
    a. To date, how many complaints have been received since the statute went into effect?
    b. What is the primary method in which these complaints are received?
    c. What percentage of complaints submitted have been responded to?
    d. Please provide the mean and median, in terms of number of days, regarding how quickly these complaints are resolved.
37. What feedback has the Department received in regards to the specific design and functionality of the federal IDR portal? Specifically, is the Department considering implementing specific changes to the federal IDR portal?
38. How many claims have been submitted to the IDR process thus far for Calendar Year 2023?
    a. Is this amount more or less than the expected total for 2023?

[8] https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i#p-608

b. Should this amount be less than the expected total, will the Department reduce the administrative fee?
c. Do you have an estimate for 2024?
    i. What is the basis for this estimate?

39. During Calendar Year 2022, how many HHS Full Time Employees (FTEs) and contractors provided support to IDR entities with pre-eligibility review and determinations? To date, during Calendar Year 2023, how many HHS FTEs and contractors have provided support to IDR entities with pre-eligibility review and determinations?
    a. What is the anticipated need of FTEs and contractors over the next year?
    b. How do you anticipate this will impact the administrative fee?
40. Please detail the outstanding items, as required by statute, in regards to Ground Ambulance Services. In addition, please address how the Department is addressing concerns of Ground Ambulance services being inappropriately included in the federal IDR process.
41. Please detail any arguments why the U.S. District Court for the Eastern District of Texas's decision in *Texas Medical Association, et al. v. United States Department of Health and Human Services*, vacating certain portions of the regulations surrounding the No Surprises Act, would require the Department to suspend the Federal IDR process, including the ability to initiate new disputes.

Sincerely,

Bill Cassidy, M.D.

Bill Cassidy, M.D.
Ranking Member
U.S. Senate HELP Committee

cc: The Honorable Julie A. Su, Acting Secretary, Department of Labor
The Honorable Janet Yellen, Secretary, Department of the Treasury