NAFEC Comments on Ways & Means Committee Hearing on "Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections"
September 25, 2023

Chairman Smith and Ranking Member Neal,

The National Association of Freestanding Emergency Centers (NAFEC) is appreciative that the Ways and Means Committee is providing much needed oversight into the disastrous implementation of the bipartisan No Surprises Act. As you know, the Committee played a critical role in fashioning a balanced approach that protects patients from "surprise medical bills" and also treats health care providers and health plans equitably through carefully crafted criteria for resolving disputes for payment to out-of-network providers.

NAFEC and the entire provider community has been shocked at how insurance companies are using the enactment of the No Surprises Act (NSA) as a pretext to slash provider reimbursement to pennies on the dollar, unreasonably delay payments, and flood the independent review process with easily resolved claims due to terribly inadequate payment. These actions threaten patient access to critical emergency care, causing some facilities to go out of business and putting many more on the brink of economic insolvency. While recent litigation has illuminated the flawed and biased implementation of the statute, it has also created disruptions in payments as the portal for independent dispute resolution has been frozen and FECs and other providers have an indefinite waiting time even if we ultimately prevail in those decisions.

NAFEC welcomed enactment of the NSA and explicitly requested that freestanding emergency centers, licensed by states to provide emergency medical care, be included in the patient protections and recognized for the first time in federal statute. Freestanding emergency centers (FECs) are emergency departments that are fully staffed 24/7 with emergency-trained ER physicians and nurses and have all the capabilities of a hospital-owned ER, including advanced imaging, lab, and pharmacy. FECs are also fully compliant with EMTALA laws. The only difference between FECs and hospital-owned ERs is ownership, not capability. FECs are able to treat patients within minutes and quickly stabilize them, avoiding unnecessary and costly inpatient admissions.

NAFEC's testimony specifically addresses:

- Payers' abuse of the independent dispute resolution (IDR) process to underpay emergency providers by offering preposterously low initial payments and qualifying payment amounts (QPAs).

- The lack of enforcement around payment timelines for payers processing and paying out reward amounts to providers after an IDR entity (IDRE) determination is made. Similarly, there is also no enforcement around IDRE fee refund timelines for the prevailing party.
- The egregious violation of a key patient protection provision in the NSA by reprocessing bills to include the IDR award amount for the provider after losing the IDR process, thus increasing the out-of-pocket (OOP) amount the *patient* owes.
- The inability of providers to effectively and efficiently batch claims due to strict requirements, thus contributing to the backlog of the IDR process.
- The urgent need for CMS to issue new rulemaking to fix the problems identified in the TMA lawsuits as well as the suggestions and issues made and identified in the Ways & Means hearing.
- The immediate need for the IDR portal to be reopened so that claims can continue to be adjudicated so that providers can continue to seek adequate payment.

Low Initial Payment Offers and Inaccurate Qualifying Payment Amounts (QPAs)

A fundamental problem with the implementation of the NSA is the flagrant abuse of the independent dispute resolution (IDR) process by payers, who are significantly undercutting freestanding emergency centers by offering absurdly low initial payments and QPAs, which do not reflect historical payments or our costs. These low initial payments from payers for the life-saving emergency care force providers to enter the long, drawn-out IDR process in order to attempt to recoup more adequate payment for critical care that has already been rendered to patients. These initial payments, as well as the QPAs that are also offered during the IDR process, are not representative of historical and customary payments made for services provided to insurers' enrollees, and are often well below the Medicare rate, which was explicitly abandoned by Congress in the development of the law for being too low and unreflective of commercial market rates. Additionally, CMS defied Congressional intent by prioritizing the QPA offered by payers as the main factor in IDR determination, rather than considered all of the factors that Congress had listed out in the law for equal consideration. CMS appears to have intentionally stacked the deck in favor of insurers, a point that has been validated by the courts in the various Texas Medical Association lawsuits on the implementation of the NSA[1,2,3,4].

During the rulemaking process, CMS implied that the administrative costs associated with an open negotiation period and the IDR process would deter plans from offering low rates that providers are unlikely to accept. Unfortunately, this assumption is far from reality as providers were forced to initiate 334,828 disputes through the IDR process between April 15, 2022 and

[1] Tex. Med. Ass'n, v. U. S. Dep't of Health and Human Servs., Case No. 6:21-cv-00425 (E.D. Tex. October 28, 2021) – TMA I
[2] Tex. Med. Ass'n, v. U. S. Dep't of Health and Human Servs., Case No. 6:21-cv-00425 (E.D. Tex. September 21, 2022) – TMA II
[3] Tex. Med. Ass'n, v. U. S. Dep't of Health and Human Servs., Case No. 6:22-cv-00450-JDK (E.D. Tex. November 30, 2022) – TMA III
[4] Tex. Med. Ass'n, v. U. S. Dep't of Health and Human Servs., Case No. 6:23-cv-00059-JDK (E.D. Tex. January 30, 2023) – TMA IV

March 31, 2023.[5] Yet, rather than address the root cause of these appeals to arbitration – inadequate payment, CMS massively (and illegally) hiked the administrative fees by 700 percent in order to deter providers from appealing thousands of lower dollar claims. It is evident that plans are not incentivized to offer adequate and appropriate initial payment amounts and are abusing the IDR process to delay fair and full payment to providers, which forces them into a financially untenable position and threatens their ability to provide vital emergency care.

Congress should compel CMS to revise the IDR process so that IDREs are considering all of the factors delineated in the statute, and not simply picking the offer that is closest to the QPA, which is typically not an accurate calculation to begin with. The courts ruled in the TMA II that preferring one of the six criteria is a clear violation of the statute and congressional intent.[6] Though CMS has since revised its rules around consideration of the QPA following its loss, the language still heavily favor the QPA factor and need further revising. CMS should require payers to offer the QPA as a **minimum** for the initial payment, then the IDREs can adjust final determinations based on other factors and information presented during the IDR process. However, to use the QPA as a starting point in provider reimbursement, CMS must ensure that the QPAs being used are accurate and that the data going into the calculation of the QPAs are applicable to the service and specific provider type being considered.

Payers have been artificially deflating QPA rates by forcing in-network providers to accept rate cuts in order to stay in-network and incorporating non-negotiated contracted rates (or "ghost rates") into QPA calculations. CMS must conduct transparent audits of payers' QPA calculations to ensure that they are appropriate to be used for reimbursing emergency care and penalties should be applied if payers continue to underpay providers.

Payment and Fee Refund Delays and Lack of Enforcement

Not only have payers capitalized on the lack of enforcement around QPAs and initial payment offers, but they also fail to abide by the 30-day timeline for final payments following the IDRE determinations. When an IDRE rules in favor of a provider, the payer has 30 calendar days to promptly pay the provider the amount owed. However, more than two years since NSA was enacted, CMS has yet to release regulations spelling out compliance and enforcement. As such, payers face no financial consequences for delaying (in some cases indefinitely) owed payments to providers. Providers carry the burden of initiating the IDR disputes on claims paid unfairly by payers and must provide detailed evidence supporting their case. In order for these claims to be considered for the IDR process, providers must file an open negotiation within 30 days of the EOB, file a dispute within 4 days of the expiration date, pay the invoice dispute, and submit an offer by the 10-day expiration date, with no extensions being granted unless there is an extenuating circumstance. If providers do not strictly follow all of these deadlines and

[5] Centers for Medicare and Medicaid Services. "Federal Independent Dispute Resolution Process – Status Update," April 27, 202. https://www.cms.gov/files/document/federal-idr-processstatus-update-april-2023.pdf
[6] [6] Tex. Med. Ass'n, v. U. S. Dep't of Health and Human Servs., Case No. 6:21-cv-00425 (E.D. Tex. September 21, 2022) – TMA II

requirements, then their case is rejected as ineligible for the process with no ability to appeal the decision. Meanwhile, payers have no financial pressure or incentive whatsoever to promptly pay claims owed to providers after the IDRE determination, as required by law and as instructed by the IDREs. Payers utilize the lack of enforcement around payment deadlines to delay payments in an attempt to further defund providers who refuse to accept their low reimbursement rates.

There must be an enforced standardization around IDRE determination payouts or the viability of many providers across the country – and the patients that depend on them for their emergency care -- will be further put at risk, which certainly appears to be the intention of payers who delay these required payouts. NAFEC recommends that CMS and the Departments use Texas' Prompt Payment law as a model for establishing payment deadlines and penalties to ensure prompt payment claims to providers throughout the IDR process. Under this law, health plans are required to pay, deny, or audit claims within 30-45 days (based on if it is an electric or paper claim) and cannot delay a claim without payment in this timeframe. For claims that are not correctly paid on time, a penalty is issued based on how late the claim is paid and the difference between the amount that the provider bills and the amount that is agreed upon by provider and payer for the service.[7,8] It is worth noting that nearly every state has laws in place around timelines and penalties for health claim payments, so it is puzzling why the Federal government has yet to implement a similar enforcement mechanism.[9] It is vital that CMS implement enforcement policies that ensure providers remain economically viable as they win IDR disputes and ensuring payment deadlines are adhered to by insurance companies is critical. Congress can compel such enforcement by withholding funding from the Department of Health and Human Services and Department of Labor for failure to enforce statutory deadlines prescribed by Congress in the NSA.

Similarly, there are major delays in IDRE fee refunds for the prevailing party in an IDRE determination, despite the 30-business day timeline laid out in regulation. CMS' March 2023 Federal IDR Process Guidance for Disputing Parties states that "*[t]he 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 of the certified IDR entity's determination.*"[10] However, this has not been the case as members have reported major delays in getting these fees refunded.

While we understand that the IDREs have been overwhelmed by the number of cases, it is important that these fees are refunded during the appropriate timeframe, as they are often a lifeline for providers who continue to be underpaid by insurers for their services. While the major payers, who have million to billion dollar margins to operate under, are able to withstand these cashflow delays, providers face increasing personnel and overhead costs and are in a less

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[7] Texas Department of Insurance. Prompt Pay FAQ

[8] Texas Medical Association. Summary of SB 418 Prompt Pay Legislation

[9] Anesthesia Business Consults. A Survey of State Prompt Pay Laws, Part I. Fall 2012

[10] Centers for Medicare and Medicaid Services. Federal Independent Dispute Resolution Process Guidance for Disputing Parties. March 2023. Page 28

stable financial position. We implore CMS to address these delays and ensure that IDREs are issuing timely and accurate fee refunds to the prevailing parties.

Patient Protection Violations

Payers have been egregiously violating patient protections that were explicitly built into the NSA and subsequent regulations, resulting in illegal and excessive patient out-of-pocket liability. Major payers have been improperly reprocessing claims after the IDRE determination to apply a higher patient OOP copayment by incorporating the reward amount that is owed to the provider by the payer. This occurs after the patient has already received their OOP bill and explanation of benefits for the original bill. Payers are carrying out this practice of intentionally harming patients fully knowing that they are in violation of the law, as explained in CMS' March 2023 IDR guidance for Disputing Parties where it is noted that "*[t]his determination of the OON rate does not change the participant's, beneficiary's, or enrollee's cost sharing, which is based on the recognized amount, or, in the case of air ambulance services, the lower of the QPA or billed charges."*[11]

This practice by payers is not only harmful to patients, who are once again being put into the middle of patient/provider surprise billing disputes (the entire reason for the NSA law in the first place) but is also a thinly veiled attempt to further drag out the IDR process by further delaying payments owed to providers. When payers attempt to reprocess claims to include the reward amounts in patient OOP expenses, providers are forced to file an appeal to reverse the insurance processing error, which is time consuming and further delays the claim from being paid out properly. This new payer tactic is simply another malicious tool in their toolbelt they can use to further encumber providers and the IDR process, as we once again point out that there is no enforcement of payment, or any penalties for payers after a final payment determination is made and the claim is not processed correctly.

To protect patients from further harm and increased OOP expenses, Congress must ensure that CMS take action to ensure that payers are not passing IDRE determination payments for providers onto patients. We recommend CMS issue a warning to payers and if the practice continues, CMS must issue penalties or some type of enforcement mechanism to ensure providers are not solely responsible for correcting these intentional billing inaccuracies.

Inability to Effectively Batch Claims

Lastly, we want to draw attention to the challenges around batching claims, which puts a huge burden on providers and makes the IDR process incredibly tedious and more overrun with claims. We highlighted the restrictive timelines that providers are expected to comply with if they want to submit a claim to the IDR process, and that timeline is even more challenging when having to go through thousands of claims to figure out which ones could be batched

[11] Centers for Medicare and Medicaid Services. Federal Independent Dispute Resolution Process Guidance for Disputing Parties. March 2023. Page 27

together. Batched claims require a strict criterion which forces providers to comb through the thousands of underpaid claims they receive from payers and figure out which ones are from the same insurer, have the same codes, and are within three days of each other. Once again, the burden is placed on the provider to do all this work while also meeting the tight deadlines allowed to meet IDR eligibility.

The restrictive batching rules were also part of the TMA IV lawsuit, and after losing the case CMS has been forced to vacate the batching rules until they can go through the required rulemaking process.[12] As CMS goes through this rule process, it would be prudent to modify the batching criteria so that it more closely aligns with how providers and insurers perform their billing, such as codes typically associated with specific episodes of care. If there was a more efficient way to effectively batch claims, then the IDREs could efficiently review more claims at one time. This would also reduce the number of administrative and IDRE fees that providers have to pay, which has been a barrier to entering the IDR process, particularly for smaller providers.

New NSA Rulemaking Needed Immediately

It is imperative for the health care system that CMS issue new rulemaking addressing the problems identified related to the IDR process. Providers and their practices are not able to subsist on the grossly undervalued reimbursement they are offered by payers for their services, and therefore patient access to care continues to be put in jeopardy. The TMA lawsuits and the Ways & Means hearing have identified the many flaws in CMS' implementation of the NSA, and pressure should be placed on the Administration to revise and rectify these rules as quickly as possible so they work as intended.

Reopen and Keep Open the IDR Portal After Litigation

We object to CMS's frequent shutdowns of the IDR process that follow successful litigation from the Texas Medical Association (TMA). As you know, this litigation takes months to go through the legal process before reaching a ruling, leaving plenty of time for CMS and the Departments to plan and prepare for their outcome. Yet, CMS has repeatedly shut down the IDR portal for long intervals, paralyzing the dispute resolution process for weeks or even months. It is inexcusable that CMS is closing the portal for IDR claims, which means providers are being punished by not being allowed to submit claims that they have been flagrantly underpaid. Only the insurance industry benefits when the CMS portal is suspended. FECs and other providers who must continue to provide care to patients and pay their staff and vendors are put in an impossible situation. CMS should reopen the IDR portal without further delay and increase staffing of the entire IDR process so that these claims can be properly and promptly processed.

Conclusion

[12] Tex. Med. Ass'n, v. U. S. Dep't of Health and Human Servs., Case No. 6:23-cv-00059-JDK (E.D. Tex. January 30, 2023) – TMA IV

NAFEC would like to once again thank the Committee for its attention on this important issue. CMS' handling of NSA implementation has been frustrating and devastating for providers and continues to threaten patient access to care. Providers are being driven out of business due to bureaucratic incompetence and malicious practices by payers. As concern over health care consolidation continues to grow, particularly in the provider space, we implore Congress and CMS to ensure policies are implemented to support small, independent providers and work to reverse these consolidation trends. We look forward to working with the Committee and the rest of Congress to implement meaningful change to ensure the NSA is being properly executed in a way that helps patients, rather than harms them.