November 8, 2022

The Honorable Chiquita Brooks La-Sure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dr. Ellen Montz
Deputy Administrator and Director
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Brooks La-Sure and Deputy Administrator and Director Montz:

On behalf of our members, the National Association of Freestanding Emergency Centers (NAFEC), we wish to thank the Centers for Medicare and Medicaid Services (CMS) for its work in implementing the No Surprises Act (NSA) and the revisions provided in the August 2022 "Requirements Related to Surprise Billing Final Rule" (87 FR 52618). However, we are deeply concerned that insurance companies are using the enactment of the NSA as a pretext to slash reimbursement to pennies on the dollar, unreasonably delay payments, and flood the independent review process with easily resolved claims. 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. In addition, though recent changes to the independent dispute resolution (IDR) process are appreciated, there are still substantial problems with how insurers process claims and significant flaws in the IDR process. We wish to share our experiences, provide concrete improvement recommendations, and support Congress' intent of the law and goal of the regulations.

Specifically, our issues and recommendations relate to the following:

1. A lack of federal enforcement of the law/regulations on QPAs and the IDR process
2. Inconsistency among the rulings by the certified independent dispute resolution entities (CIDREs) and conflicts of interest between the CIDRES and disputing parties

3. The absence of a standardized way to initiate the 30-day negotiation period with insurers and lack of confirmation and response from the insurers
4. Tight timelines, particularly for batching and filing claims, that put an unnecessary strain on providers and give advantages to insurers
5. A lack of response from CMS when issues and questions are submitted

We would like to request a meeting with your team and our leadership at your earliest convenience.

Background on freestanding emergency centers (FECs)

Freestanding emergency centers (FECs) are fully licensed emergency departments staffed by both emergency medicine-trained physicians and registered nurses. FECs operate 24 hours a day, seven days a week, with licensed pharmacies, clinical labs, and advanced imaging services on-site. These state licensed facilities adhere to the same standards and provide the same level of care as Hospital Based Emergency Rooms (HBERs), including state EMTALA regulations on treating all patients.

FECs are a relatively new provider model; the first FEC was licensed in 2010, and more than 200 are located in Texas. The primary difference between an FEC and a hospital off-campus emergency department is ownership, not capability. As you know, to expand provider capacity due to the COVID-19 pandemic, CMS deemed FECs eligible to be Medicare providers by enrolling temporarily as a Medicare-certified hospital.[1] This helped improve access to high-quality and convenient emergency services at a value to the Medicare program.[2] FECs are a major access point for emergency care and handle all types of emergency cases, including stroke, heart attacks, traumatic accidents, and COVID diagnosis and treatment.

Enforcement Issues Around QPAs and the IDR Process

Broadly, the IDR process lacks enforcement mechanisms, so insurers are able to draw out the process and abuse the system. Notably, the qualifying payment amounts (QPAs) that insurers are "allowing" need to be audited, proper timelines implemented, and appropriate documentation and information presented.

Insurers have capitalized on the lack of enforcement surrounding auditing QPAs by sending threatening letters to contracted in-network providers. In those letters, they demand providers accept 20 to 40% lower payment amounts than their contracted rates for all services or face being dropped from their network. This tactic attempts to drive down QPA rates to use them as a "historical" reference benchmark during arbitration while simultaneously forcing more providers out of network. This pushes more providers through the time-consuming and costly IDR process.

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[1] Center for Medicaid & Medicare Services (2020). Guidance for Licensed Independent Freestanding Emergency Departments (EDs) to Participate in Medicare and Medicaid During the COVID-19 Public Health Emergency.
[2] An actuarial analysis of emergency care Medicare claims by Dobson Davanzo found that FECs delivered emergency care 21.8% lower cost on a severity level standardized basis than hospitals.

Additionally, Insurers are offering ridiculously low QPAs, often paying below the Medicare rate, which was explicitly abandoned by Congress in the development of the statute for being too low and unreflective of commercial market rates. Insurers are not complying with requirements to pay the expected QPA on the first payment. These practices, and the many other tactics insurers are using to avoid fair and proper QPA payments, must be addressed.

We recommend that CMS provide concise and measurable timelines and goals for audits related to the QPA and IDR processes to ensure QPAs are calculated correctly, as defined in law. These calculations should exclude recent attempts by insurers to force providers to accept baseless and substantially lower QPAs. Additionally, CMS should deter this unlawful behavior by levying fines on insurers that fail to comply with clear expectations outlined in the statute. One way for CMS to resolve this problem is by requiring insurers to pay standardized minimum QPA rates based on historical payments made to providers over the last several years. These historical payments can be used as a baseline to ensure that initial payments are adequate and fair for providers. Additionally, it will eliminate ill-intended tactics by insurers to lower QPAs rates below what they paid prior to the NSA. To promote compliance, insurers who do not pay appropriate QPA on the first payment should face substantial fines.

Finally, while CMS stated in the August 2022 final rule that the Departments are committed to conducting audits, information or timelines for these audits is still unclear. This issue must be prioritized and addressed expeditiously.

CIDRE Inconsistency Issues and Conflicts of Interest

CMS currently has 13 CIDREs that can participate as arbiters of the IDR process.[3] The various entities, all of which charge different rates for their services, are inconsistent throughout the IDR process. They clearly need a better understanding of the rules. For example, some CIDREs claim that they cannot access the documentation shared in the portal. In contrast, others have no problem receiving and accessing documentation through the same portals. In addition, some CIDRES erroneously reject claims by stating they do not qualify for the IDR process, while others accept similar claims. Similarly, certain CIDREs only permit providers to dispute one CPT code per claim, which is misguided and impractical.

Additionally, there appear to be potential financial conflicts of interest (COI) with certain CIDREs and insurers, as many CIDREs have previously worked with/for insurers. These prior relationships inevitably lead to biased decisions in favor of the insurers during the arbitration process, which explains why there are often instances of insurers rejecting certain CIDREs and selecting different ones they know will rule in their favor.

To address the problems, we recommend that CMS correct inconsistencies and COIs between the different CIDREs. CMS should hold additional training for the CIDREs to explain the rules and promote a consistent and fair process. Providers should always be allowed to dispute an entire

[3] Center for Medicare and Medicaid Services. List of certified independent dispute resolution entities.

claim rather than only a single CPT code and follow a standardized, consistent dispute process. We recommend CMS randomly review cases by each CIDRE to ensure the IDR process is executed correctly. Additionally, CIDREs should be randomly assigned to cases by CMS, and the Agency should take steps to verify that there are no COIs between parties. It is simply not enough to have both parties assert that they do not have any COIs.

Lastly, CIDREs charge different fees for their arbitration services. These arbitration fees should be based on a standardized flat fee schedule rather than the wide range of fees currently charged for the same service. For example, one CIDRE, C2C Innovative Solutions, Inc., charges a $299 flat fee for single determinations (as opposed to batched determinations), while another CIDRE, EdiPhy Advisors, LLC, charges $500 for the same service. Rather than addressing these arbitrary price disparities, CMS recently announced new guidance allowing CIDREs to increase their fees in 2023. As a result, CIDREs can charge fees ranging from $268 to $938. CIDREs will also be allowed to charge additional fees based on the number of line items in batched claims.[4] These changes will exacerbate the existing fee disparities, discourage appeals and disproportionately impact small providers. Insurance companies can afford to pay these up-front fees. However, small facilities and provider groups who are already struggling with the meager insurance payments will find this incredibly burdensome, further endangering their ability to provide care.

Issues Initiating the 30-day Open Negotiation Period

Each insurance company has a different process providers must follow to initiate the 30-day open negotiation period. Each process is arduous and time-consuming, and frankly, often futile because the insurer does not respond, forcing parties to enter into the IDR process instead of resolving differences. Additionally, upon initiating the process with certain insurers, no verification is provided to the provider that the request was received. As such, providers cannot demonstrate that the 30-day open negotiation period has begun, resulting in the insurers inappropriately determining the beginning of the negotiation period.

The issue persists despite the August 2022 final rule which clarified that insurers cannot require providers to use plan-owned proprietary web systems to initiate an open negotiation period. Providers should be able to send a Department-issued standard notice of initiation of Open Negotiation[5], which would start the countdown on the 30-day open negotiation period. Unfortunately, insurers still require providers to use their portals and, in many cases, do not acknowledge receipt of the notice. CMS should mandate that insurers recognize and respond to these open negotiation notices, even if to uphold the original decision. CMS should also investigate insurers who require providers to use their portal and penalize insurers when they use it to delay the IDR process. If insurers are allowed to use portals, CMS must standardize how disputes on payment adequacy are sent through these portals. Each portal should require the

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[4] Centers for Medicare and Medicaid Services. Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act. October 31, 2022

[5] The Departments of the Treasury, Labor, Health and Human Services, and the Office of Personnel Management. Open Negotiation Notice. OMB Control No. 1210-0169

same information and be uniform across the various plans. Portals should also be required to automatically send confirmation notifications when a provider submits a request.

Timeline Issues

The current IDR rules encourage and incentivize insurers to force providers to partake in a tedious, timely, and costly process. Embedded in the process are challenging timelines for providers, including only being given four business days after the end of the open negotiation period to sort through claims and determine which ones to batch together based on the tedious criteria that make them eligible. With the recent radical changes in insurers behavior, thousands of claims now need to go through the IDR process each month. Four days is simply not enough time to figure out which ones should be batched together, especially considering that most of the claims that come through ultimately need to go through the IDR process.

Given the enormous volume of claims that need to be sorted, CMS should implement an additional five business days to allow providers to group files. Nine days total will help ease some of the administrative burdens that providers face under the IDR process. CIDREs are granted extensions that enable them to manage the volume of disputes they receive. Providers should be permitted similar grace periods.

In addition, the 30-day filing limit for open negotiations, beginning at the time the Explanation of Benefits (EOB) is issued, is very burdensome, especially for claims that first need to go through a corrected claims process, or an appeal process not related to the NSA. For example, if a carrier downcodes a claim, the timeline does not allow the provider to appeal the downcode prior to opening negotiations and initiating the IDR process. Once the 30-day time window is over, providers are not permitted to file open negotiation notices, even if the claim has yet to make its way through the initial appeal process.

CMS should allow providers additional time to file the open negotiation notices if an appeal must be submitted. CMS should also mandate that insurance companies respond to appeals and automatically open the IDR process if the insurer denies an appeal. A revised timeline could look like this:

- Allow providers 30 days from EOB to file an appeal or Corrected Claim IF NEEDED
- Allow insurance carriers 30 days to respond to appeal/corrected claim
- Allow providers 15-30 days to file IDR after the insurer's response

CMS Responsiveness Issues

The last issue we wish to raise relates to the lack of responsiveness from CMS when concerns are flagged through the FederalIDRQuestions@cms.hhs.gov email. CMS indicated they have 60 days to acknowledge a complaint/question, and following that period, they get an additional and separate time frame to respond. This timeline draws out the IDR process, benefiting insurers and choking cash flow to providers who rely on these payments to stay in business.

CMS must allocate additional resources to support the IDR process and resolve issues that are flagged in the system in a timely manner. CMS should also make the statutory timelines, as they believe accurate, available to the public and include:

1. acknowledging receipt of a complaint,
2. responding to the complaint,
3. notifying the insurer of their response/findings, and
4. any other relevant actions that the Agency takes.

Increased transparency will help identify bottlenecks in the process and benefit stakeholders.

Conclusion

NAFEC recognizes and appreciates the efforts made by CMS and the other Departments to develop a process to protect patients struggling with the cost of medical care and surprise bills. However, significant work needs to be done before the process can be deemed "fair" for all the parties involved. We implore the department to help resolve this brewing crisis before facilities and providers become insolvent and patient care is severely compromised. We hope our concrete recommendations aid the agency in resolving these substantive problems. Issues surrounding enforcement, QPA calculation and payments, CIDRE inconsistency and COIs, tedious barriers implemented by insurers to delay the IDR process, and impractical timelines levied on providers are all areas in which improvements must be made. In addition, CMS must be held accountable and make significant improvements in order for the IDR process to be effective and impartial.

We respectfully request your assistance in resolving these issues to ensure providers remain operational and patient access to care is not diminished across the country. Our leadership would like an opportunity to meet with your team at their earliest convenience. We hope to serve as a resource as you further refine the implementation of the No Surprises Act. If you have any questions or comments, please contact me at brad2@bradshields.com.

Sincerely,

Brad Shields
Executive Director
National Association of Freestanding Emergency Centers