May 14, 2021

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

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

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

Re: No Surprises Act

Dear Secretaries Becerra, Walsh and Yellen,

On behalf of our members, the National Association of Freestanding Emergency Centers ("NAFEC") has prepared some initial comments regarding implementation of the No Surprises Act ("Act"), which is found as Title I of Division BB of the Consolidated Appropriations Act of 2021 (Pub. L. 116-260).

Background on Freestanding Emergency Centers

NAFEC represents freestanding emergency centers ("Centers") in several states (often known as freestanding emergency rooms or freestanding emergency departments, as referred to in the Act). These Centers provide essential emergency care and are staffed 24 hours per day, 7 days per week by both Board Certified Emergency Physicians and mid-level practitioners (Nurse Practitioners and Physician Assistants), as well as emergency-trained Registered Nurses. The Centers maintain all medical equipment, supplies and other items required for emergencies, no

different from a hospital-based emergency room or hundreds of hospital-owned off-campus emergency departments located across the country. As such, these centers are highly regulated by the states in which they are licensed and comply with all state requirements, that are similar to the federal EMTALA statute and corresponding regulations,[1] which mandate screening of all patients presenting, and mandate treatment and stabilization of all patients presenting to the facility, with emergency medical conditions, regardless of their ability to pay. State licensure of freestanding emergency centers also requires freestanding emergency centers to comply with a panoply of health and safety regulations that equal or exceed emergency departments operated by hospitals. As an example, all freestanding emergency centers must have an ER physician on site at all times, while many hospitals may have only a primary care physician on site and some rural hospitals may only have a doctor on call but off premises.

The vast majority of these facilities have opened since 2010 and there are approximately 210 freestanding emergency centers [2] concentrated mostly in TX but also available in CO, SD and AZ. Freestanding emergency centers make up around one-third of all off-campus emergency departments, while the approximately 370 hospital owned off-campus emergency departments make up the remaining two-thirds. They improve access to emergency services, offer essential, high quality and more convenient emergency care, and significantly reduce patient wait times. Freestanding emergency centers offer a solution to both overcrowded emergency rooms in urban areas and create access in rural communities that may be limited. The Centers routinely care for patients with conditions similar to those found in a hospital-based emergency department, with approximately 95 percent of patients treated for moderate to high severity conditions. Importantly, they do not have the economic incentive to admit patients to fill empty hospital beds. Recently published peer-reviewed literature shows that freestanding emergency centers can lower health care costs. When comparing freestanding emergency centers to hospital-based ERs, Simon et al. observed a 20% lower admission rate for conditions such as chest pain, COPD, asthma, and congestive heart failure (CHF).[3]

We enclose our organization's Code of Conduct, to which our members are expected to adhere as a condition of membership. Among other things, the Code of Conduct prohibits billing excessive fees or charges. Excessive is defined as in excess of "what a reasonable third party would consider in excess of a reasonable charge or fee." The Code also requires compliance with state EMTALA-like standards, and direction of clearly non-emergent patients to non-

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[1] The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition. Historically, the Centers have not been subject to federal EMTALA standards as a result of not being recognized as Medicare-participating hospitals. During COVID-19, the Department of Health and Human Services issued waivers which would allow Centers to enroll (albeit temporarily) as hospitals participating in Medicare. As a result, those Centers have become subject to federal EMTALA standards.

[2] Medicare Payment Advisory Commission. Report to Congress: Medicare and Health Care Delivery System. Chapter 2: Using payment to ensure appropriate access to and use of hospital emergency department services. pg. 43 (June 2018). http://www.medpac.gov/docs/default-source/reports/jun18_ch2_medpacreport_sec.pdf?sfvrsn=0

[3] Simon EL, et al. Variation in hospital admission rates between a tertiary care and two freestanding emergency departments, American Journal of Emergency Medicine (2017).

emergency providers. Lastly, the Code of Conduct mandates transparency in billing, collection and marketing.

Protecting Patients on Their Cost-Sharing in Billing Disputes

NAFEC supports the statute's limitation of enrollee's cost-sharing to in-network cost-sharing for emergency medical services at a non-participating facility. Patients should not be required to pay more for receiving emergency care at an out-of-network emergency center (or other out-of-network provider) than they would be paying in an in-network emergency center (or other provider). Doing so undermines the "prudent layperson" standard, which assumes the patient will go to the most convenient emergency facility for their care and safety. In addition, EMTALA prohibits a provider from denying appropriate treatment in order to inquire about the individual's insurance status, which results in an inherent time lag between the provision of initial services and determination of whether the patient is insured and if the patient is in-network. Limiting patients' cost-sharing protects patients' pocketbooks and ensures they get expedient emergency care.

No Surprises Act's Recognition of State-Licensed Emergency Departments

We acknowledge and appreciate Congress' recognition of freestanding emergency centers as facilities in the Act. The statute recognizes that patients must be protected in all sites of care and that freestanding emergency centers, though a relatively new delivery model, should be part of the solution. Specifically, the statute applies patient protections and payment methodologies to ER departments "*geographically separate and distinct and licensed separately from a hospital under applicable state law; and provides any of the emergency services (as defined in subparagraph (C)(i)).*"[4] As such, this state licensure language distinguishes state-licensed freestanding Emergency departments from urgent care clinics and physician offices, as neither of those providers are licensed by states as facilities.[5] Emergency services and the state licenses under which the Centers operate include requirements that are substantially different from other treatment settings. When compared with clinics and physician offices, these requirements impose higher standards that must be recognized in rulemaking in all aspects, including reimbursement.

Freestanding emergency centers provide the same level of emergency services as are provided by hospitals, and in fact are mandated by state law to do so. There is no difference in capabilities of freestanding emergency centers and hospital-owned emergency departments. The difference is ownership, not ability. In contrast, urgent care centers are typically open for limited hours (e.g. 9 AM to 5 PM), often staffed by nurse practitioners or primary care physicians not trained in emergency care, and lack the diagnostic (e.g. CT scan) and lab capabilities of an emergency department.

[4] No Surprises Act Section 2(a)(2)(D)
[5] The Act sometimes refers to freestanding emergency departments, and it is clear that this includes freestanding emergency centers that are not provider-based or affiliated with hospitals.

During the recent and ongoing COVID pandemic, the Center for Medicare and Medicaid Services deemed freestanding emergency centers eligible to be Medicare providers to assist in meeting this public health emergency by enrolling temporarily as a Medicare-certified hospital to provide hospital services for the duration of the public health emergency.[6] Centers have responded by providing critically needed emergency services to the populations they serve, and they have demonstrated their capability and capacity to serve as Medicare participating providers, both during and after the pandemic, as a necessary and integral part of the health care system.

We make the following comments regarding what will be certain key components of the upcoming regulations that will affect particularly freestanding emergency centers:

A. Median Contracted Rate.

The regulations should not permit payors to set median contracted rates for Centers under the No Surprises Act that differ from those of hospital emergency facilities. Payors must take into account the resources and cost structure that go into the delivery of emergency care over a 24 hours per day, 7 days per week schedule. The median contracted rate must take into consideration the intensity of care, the cost of equipment and the required staffing that a freestanding emergency center must have in order to respond to emergency medical conditions of the same level of seriousness and acuity as those encountered by hospital emergency departments

Freestanding emergency centers are often out of network with many insurance plans, unlike other in-network facility providers. Many Centers are out of network because of the unwillingness of health plans to offer reimbursement rates appropriate for emergency services. Many plans treat Centers as urgent care or outpatient clinic settings rather than as licensed emergency facilities. The inability of the Centers to obtain adequate, mutually agreeable rates from insurance plans has given them no option but to remain out of network. Because of this out of network status, there is scant data from which to determine median contracted rates. The absence of adequate median contracted rates has been crippling to freestanding emergency centers, and impairs their ability to function effectively. The new regulations should, therefore, take into account the structure and regulatory requirements of a Center necessary to delivery emergency care to the public in establishing median contracted rates.

B. Recognized Amount.

We would also urge that the regulations require that the "recognized amount" be transparent and readily available to facilities and the public. This amount is used to determine the patient's cost-sharing responsibility. As required by the Act, this should be the amount that is allowed for an item or service by a non-participating facility. The Act should require the plans to disclose the amount of patient cost share under the plan for the type of health plan and for the CPT code that is billed.

[6] 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.

In some jurisdictions where Centers are authorized, including Texas, Centers are required to disclose to the public (including via their website(s)) detailed information about rates for the services the Centers provide. Any future rules implementing the Act should require a similar level of transparency by plans and payors.

C. Qualifications and Independence of IDR Entities.

We submit that the regulations should specify the qualifications and independence of the IDR entities. It is critical to the appropriate resolution of payment disputes that the IDR entities be both experienced in health care matters, and in particular emergency services coding and billing, and be independent of plans. We submit that an expertise in health care matters is needed for a complete understanding and appreciation of the complex services provided by freestanding emergency centers, as well as other providers covered by the No Surprises Act. We also submit that a complete absence of affiliation with plans is necessary to assure the neutrality that is both contemplated by the No Surprises Act, and vital in view of the finality of the IDR process.

D. IDR Fees.

We also believe that IDR fees should be reasonable, and not constitute barriers to the use of the IDR process. Texas, for example, provides a state-based IDR mediation system. Facilities have found that the fees associated with mediation have imposed meaningful barriers to the use of this system. In addition, plans have used the costs of mediation as a lever to extract concessions from providers. To some extent, this phenomenon will be mitigated by the federal provision that the non-prevailing party pays the prevailing party's costs of the IDR process. Nevertheless, high arbitration costs can be a significant impediment to legitimate contests of payment through the IDR process. We propose that the fees be set according to a reasonable schedule and range based on complexity and amounts at issue in order to not to constitute such an impediment to using the process.

E. Batching Claims in the IDR Process for Emergency Care.

The No Surprises Act provides for batching of claims in the IDR process for items and services related to the treatment of a similar condition. We submit that it is imperative that the regulations recognize a batching methodology that appropriately takes into account circumstances in which the service is emergency care. Emergency care is clinically quite different from elective or scheduled care, where a patient's condition is most often explicitly known in advance. As stated by the American College of Emergency Physicians and the Emergency Department Management Association's correspondence, "the routine practice of emergency care is characterized by a range of severity that patients present with, and a corresponding range of diagnostic, therapeutic, and decision-making intensity."[7] This is the essence of emergency care, mandated by federal and state EMTALA laws. Squeezing emergency care into elective procedure codes for batching would result in a severe and unnecessary administrative burden. Therefore, we strongly urge batching

[7] Letter of American College of Emergency Physicians and Emergency Department Practice Management Association to The Honorable Xavier Becerra, at 13 (March 24, 2021).

regulations that recognize the distinctive aspects of emergency care and allow separate batching of emergency care claims.

F. IDR Payment Determination Criteria.

The Act directs the IDR arbiter to equally consider numerous criteria in his or her determination. It is important to ensure this consideration is fair and balanced. We strongly urge that the regulations define the statutory criteria, and mandate equal consideration of all of the criteria identified in the law when addressed in the IDR process. Absent this, there could be a tendency to give certain factors greater weight than others without good reason. Congress purposefully chose to assign equal weight to each factor and this should be reflected and reinforced by the regulations.

We appreciate the opportunity submit our comments regarding the No Surprises Act.. If you have any questions, please do not hesitate to contact the undersigned, at brad2@bradshields.com.

Sincerely,

Brad Shields
Executive Director