March 24, 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) would like to provide some initial input as the Departments of Health and Human Services (HHS), Labor, and Treasury (the Departments) begin implementing the *No Surprises Act*—which was included in the *Consolidated Appropriations Act, 2021* (PL. 116-260).

As background, ACEP is the national medical society representing emergency medicine. Through continuing education, research, public education and advocacy, ACEP advances emergency care on behalf of its 40,000 emergency physician members, and the almost 150 million Americans we treat on an annual basis. EDPMA is the nation's largest professional physician trade association focused on the sustainable delivery of high-quality, cost-effective care in the emergency department (ED), and its members handle over half of the 146 million visits to U.S. emergency departments each year. Together, ACEP and EDPMA members provide a large majority of emergency care in our country, including rural and urban settings, in all fifty states.

ACEP and EDPMA have both strongly advocated for a comprehensive solution to addressing surprise medical billing (SMB), working with members of Congress to make sure that any such legislation would truly keep patients out of the middle of billing disputes, include fair payment mechanisms that ensure adequate reimbursement for out-of-network services, and promote a sustainable emergency care system. We believe that the *No Surprises Act* represents a reasonable solution to this issue, and we support the patient protections embedded in the law. We are appreciative that Congress promoted the process of open negotiation between payors and providers and included the back-stop of independent dispute resolution (IDR) to resolve lingering disputes between payors and providers. All of these provisions work together to keep our patients "out of the middle".

While the overall intent of the *No Surprises Act* is clear, there are numerous policies in the Act that must be further articulated and clarified in rulemaking by the Departments. Most of the provisions of the *No Surprises Act* become effective next year in 2022, and rulemaking will be conducted in stages this year. We understand that the first rule, with a statutory deadline of July 2021, relates to the definition of the "qualified payment amount" and methodology for calculating the median contracted rate. We understand that these issues are required to take precedence due to the rulemaking timeline, and our comments and solutions are designed to address this priority.

However, we want to ensure that our comments provide a comprehensive view of key points, dependencies, and downstream implications that are concurrently worthy of consideration as the Departments clarify critical terms during initial rule-writing. **Accordingly, our comments are directed to the important areas of the *No Surprises Act* that have unique and significant implications for emergency care.**

Below, we address six main topics:

Overview and Perspective: Unique aspects of emergency care

Before providing specific feedback, we offer an overarching perspective on the unique aspect of emergency care that frames our comments and suggested solutions.

We understand that the process of rule-writing rightfully seeks uniformity and efficiency for all patient care settings and specialties wherever possible, and we support uniform approaches and broad provisions wherever achievable. However, fundamental realities and ubiquitous differences in emergency care – especially differences uniquely required by longstanding federal law – must also be accommodated in the implementation of the *No Surprises Act.*

The process of providing emergency care includes requirements that are substantially different than other health care settings. These important differences not only protect patients but also create high standards and obligations for emergency physicians that must be acknowledged in rule-writing. Federal laws and provisions such as the Emergency Medical Treatment and Labor Act (EMTALA), the Prudent Layperson Standard, and others remain in full force and effect, and if well-considered, compliance with these laws can be properly expressed in implementation. However, if unacknowledged, we believe that there will be significant unintended consequences for the emergency care system, which is truly the nation's health care safety net. We believe there are efficient solutions that accommodate these unique realities, and we offer these accordingly.

Emergency medicine from both a clinical and reimbursement perspective is unique. Emergency care involves the acute diagnosis, treatment, and stabilization of diffuse and undifferentiated clinical conditions. For example, two of the most common patient presentations are "chest pain" and "abdominal pain." These initial presenting complaints have a large range of final diagnoses and require a large variety of patient-specific lab tests, radiology exams, and other interventions in order to reasonably ensure that no emergency medical condition has been missed, as is required by the federal law EMTALA. Treating patients based on their presenting systems is different from being able to assess and treat a patient in a scheduled, office-based setting with a previously determined diagnosis. Thus, the complicated and unpredictable nature of emergency care makes it extremely difficult to estimate ahead of time what services are going to be delivered during an individual patient encounter.

As emergency physicians, we are subject to EMTALA, which requires that we provide patients with emergency medical care regardless of their insurance status or ability to pay. ACEP and EDPMA strongly support the patient protections embedded within the EMTALA requirements, among which stipulate that a hospital may not place any signs in the ED regarding the prepayment of fees or payment of co-pays and deductibles. That is because doing so could lead to patients who are concerned about costs leaving prior to receiving a medical screening examination and stabilizing treatment, both of which are fundamental conditions for satisfying EMTALA, and the most foundational principles of these important patient protections enacted three decades ago. If emergency physicians were ever to attempt to collect cost-sharing payments prior to assessing and

stabilizing the patient, not only would that be a major EMTALA violation, but it could cause the patient's condition to deteriorate due to delaying the patient in receiving critical care.

The EMTALA requirements around the collection of cost-sharing payments not only influence how we as clinicians interact with patients—but they also impact how and when health plans determine the appropriate cost-sharing amount for the services rendered. Unlike scheduled care when the cost-sharing amount is known and collected up-front, we do not bill nor do we attempt to collect cost-sharing payments from patients for emergency care until after the health plan determines what the total allowable amount for the services will be—which is long after the patient has been discharged from our care and the ED.

In some cases, based solely on the diagnosis provided on the emergency physician's initial claim, health plans will dispute the type and/or level of emergency service rendered to the patient, and therefore make an initial adjudication that a lower level of service was rendered or should have been more appropriate. For example, if an emergency physician bills an ED evaluation and management (E/M) level 4 service, health plans may decide to "downgrade" the service, and instead set the total allowable amount (which determines patient cost-sharing) based on a level 3 service. A common scenario where this can occur is for a patient who presents to the ED with chest pain. The physician may have significant concern for heart attack, and only after hours of laboratory, radiology, and cardiac testing, may be able to thankfully diagnose that the patient did not have a heart attack or one of the other life-threatening conditions considered in the evaluation of a chief complaint of "chest pain". In this case the (relatively minor) final diagnosis does not reflect the potential seriousness of the patient's condition upon presentation nor the complexity of the encounter that followed. There is unfortunately a growing trend whereby some plans are adopting policies that downgrade the level of care based solely on the final diagnosis -- a violation of both the federal and state prudent layperson standards that recognize that the level of care called for is based on the patient's medical history and presenting symptoms, not the final diagnosis.

There are specific administrative and legal processes currently in place to adjudicate such downgraded claims or other disputes about the levels and/or types of services included on the claim. ***As reflected in a few sections in our comments below, it is vitally important that these existing processes are NOT affected by the new No Surprises Act requirements around payment for out-of-network services and that they themselves do not impact the carefully constructed timelines set by the statute for the initial payment/denial of claims and the negotiation and IDR processes.*** Thus, if a health plan disagrees with the levels and types of services included on the claim, we strongly believe the following should occur:

- The process for adjudicating the type of and/or level of service on the claim will be as it is today and remain separate from the payment and IDR processes included in the *No Surprises Act;* as such, it will not cause a delay or in any other way impact any of the *No Surprises Act*'s payment, negotiation, and IDR timelines.
- The "recognized amount," which is used to determine the patient's cost-sharing amount under the statute, should be based on the type of and/or level of service that is initially

included on the claim by the provider. The only exception should be in cases where the patient was incorrectly billed.
    - If the type of and/or level of service on a claim is ultimately changed and the patient's cost-sharing amount needs to be modified, any differential would be made up by the appropriate party (either the provider or health plan)—truly keeping the patient out of the middle of billing disputes.

- During the IDR process, the IDR entity should render its decision on the item or service that is reflected on the claim submitted by the provider. Thus, if an emergency physician initially billed an ED E/M level 4 service, the IDR entity should evaluate evidence and come up with an appropriate payment for a level 4 service—regardless of whether the level of service is ultimately changed by the health plan.

With this context and principles about emergency medicine in mind, please find our specific comments below.

A. Important Definitions

ACEP and EDPMA believe that the ways in which the following key terms are defined are critical to ensuring that emergency physicians and other clinicians are appropriately paid for services, both initially and ultimately through the IDR process if it is initiated.

1. Qualifying Payment Amount

The "qualifying payment amount," as defined in the *No Surprises Act*, is based off the median contracted rate recognized by the plan or issuer in 2019 and updated annually by a specific inflationary formula. ACEP and EDPMA appreciate that the law attempts to create an objective amount by directing the HHS Secretary to develop a methodology for setting the median contracted rate. However, without clear, definitive guidance, we fear that the reported amounts could be subject to manipulation or unwarranted variability in how they are calculated.

Therefore, we request that the Departments explicitly delineate the methodology for selecting the median. In all, for the 2022 base year and going forward, the qualifying payment amount—as mandated by statute—should reflect the ***total maximum amounts*** paid and be based on the total number of actual payments issued to individually contracted physicians in the same or similar ***given specialty*** as recognized by the carrier in the carrier's provider directory. Median contracted rates should be constructed for plans in the same geographic area, and ***within the same insurance market***.

When defining "the total maximum payment" that is used to set the median contracted rate, it is important that this amount truly encompasses all payments, including the direct contracted rate for the specific Current Procedural Terminology (CPT) code billed in addition to the pro-rata share of

any and all incentive or bonus payments. A contract for an item or service under which no claims were submitted should not be considered valid as part of the population from which the median is derived.

Furthermore, the Departments should pay particular attention to the phrase "same or similar specialty" in the statute. We believe when determining median contracted rates for emergency services, such as an ED E/M service, that health plans should only include data for a particular service when it is billed by a provider with the specialty designation of emergency medicine. Sometimes other providers bill ED E/M codes or other services that are typically provided in the ED setting. Including data from these encounters would inappropriately skew the health plan's calculations and also goes against the statute's requirement to base the qualifying payment amount off of the median contracted rate for the same or a similar item or service that is provided by a provider in the same or similar specialty.

Finally, we believe that in order to set accurate median contracted amounts for distinct items and services, only data from comparable health plans should be included. Private health plans in the individual and small group markets are inherently different from commercial Medicaid managed care plans and Medicare Advantage plans, and therefore should be kept separate for the purposes of conducting these calculations. Keeping them separate also aligns with the statutory requirement that median contracted rates be tied to all plans offered by an issuer within the *same insurance market*—as one could easily argue that Medicaid managed care plans, Medicare Advantage, and private plans are in different insurance markets since they each serve distinct segments of the population. Should these plan types all be conflated in determining the median contracted rate, patients' timely access to quality emergency care would over time become jeopardized.

2. Recognized Amount

Since the "recognized amount" is used to determine a patient's cost-sharing responsibility, ACEP and EDPMA believe it is critical that health plans make this amount transparent and easily available both to patients and clinicians. We agree that as laid out in the *No Surprises Act*, the recognized amount should be the amount that is allowed for an item or service furnished by a non-participating provider during a year a group health plan, group health insurance, or individual health insurance offered coverage. We also strongly urge the Departments to require that an insurer identify the type of health plan and disclose the amount of the patient cost share under the plan for the actual CPT code that is billed.

As stated above in our overarching comments on emergency care, the recognized amount should reflect the amount for the specific item or service on the claim as submitted by the provider—except for cases of fraud or a clerical error made by the provider billing the service. Thus, if a provider initially bills for an ED E/M level 4 service, the recognized amount should be based on that service.

In the event that the item or service ultimately changes (i.e. the ED E/M level 4 service is changed to a different level of service) and the patient's cost share needs to be subsequently modified, the appropriate party should be accountable for resolving the issue (i.e. the provider in cases where the patient is owed a partial refund, and the insurer in other cases)—appropriately leaving the patient out of the middle.

3. Initial Payment and Denial of Payment

Overall, ACEP and EDPMA believe that 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. ***Failure to make an initial payment nor provide a notice of denial, within 30 days of the submission of the original claim should be deemed a de facto notice of denial.***

Once the initial payment or notice of denial of payment is made, the timeline for initiating the negotiation process and subsequently the IDR process then begins. Thus, ***it is important to ensure that all these timelines continue uninterrupted no matter what other administrative actions or responses a health plan decides to take along the way, such as a change of status of the related claim.*** In order words, regardless of whether the health plan makes a payment or provides a denial of the submitted claim or makes any other administrative responses, no later than 30 days after the original claim was submitted, the provider should have the ability to initiate the 30-day open negotiation period with the plan. And then, as called for in the *No Surprises Act*, at the completion of the 30-day open negotiation period, either party then has the right to initiate the IDR process. ACEP and EDPMA urge the Departments to explicitly lay out these requirements in the rule in order to prevent any possible ambiguity around the health plan's initial responsibilities and to avoid any situations that would cause the entire process of negotiation and prompt resolution to never be triggered.

4. Audits of Plan Calculation

The *No Surprises Act* requires that an audit process be implemented in order to ensure that health plans and health insurance issuers offering group or individual health insurance coverage accurately determine the qualifying payment amount. ***ACEP and EDPMA believe that the audit process should be reflective of statistically valid samples of payments issued to an individual clinician or clinician in the same medical specialty. Further, as mandated by the statute, the annual 25 audit limit should not apply for audits that are performed as a result of complaints or based on information regarding non-compliance. The HHS Secretary could also consider making at least some of this information public.***

Finally, we feel that there should be penalties if payors do not comply with these audits. The following penalties are offered for consideration:

- Substantive monetary penalties per claim, such as civil monetary penalties—similar to those that the Centers for Medicare & Medicaid Services (CMS) levies on facilities and plans participating in the Medicare and Medicaid programs in accordance with Titles XVIII and XIX of the Social Security Act.
- Potential exclusion from participation in the federal Health Insurance Marketplace for repeated or prolonged non-compliance with an audit.

B. Federal/State Law Interaction

1. Definition of "Specified State Law"

The statute defines a "specified state law" as one that "provides for a method for determining the total amount payable . . ." In issuing regulations that will affect whether state or federal law applies to a claim submission, we believe the Departments should ensure clear and definitive patient protections, a clear method for determining the total amount payable, and consider supporting IDR for emergency care services whether via State or Federal law***. ACEP and EDPMA are concerned that if inappropriately implemented, vague or confusing state laws will fail to provide meaningful patient protections or a method for settling disputes, yet still prohibit access to the federal protections and the meaningful access to IDR that are afforded to disputes eligible for the federal process***. In considering our comments, we once again ask the Departments to consider that the *No Surprises Act* has already explicitly acknowledged the unique circumstances of emergency services by creating a separate section to address these characteristics.

State Law Exclusions

In determining whether there is a "specified state law," ***ACEP and EDPMA firmly believe that if emergency care is excluded from application of a state out-of-network billing law, the state shall be deemed to not have "a method for determining the total amount payable" for that item or service*** (even though it might have a method for determining the total amount payable for other items or services outside of emergency care). A clear policy should be developed to account for these circumstances; based on current state law experience there are two areas that this policy should account for in order to be effective:

- A category of services is explicitly excluded from application of the law (as emergency services are in certain state laws, for example in Indiana and, in most cases, in California).
- Where access to state law or dispute resolution processes is limited to cases above a monetary threshold (e.g., New Jersey) as limits can effectively exclude services, such as emergency care, whose codes are customarily reimbursed at dollar amounts lower than these thresholds. Similarly, laws based on assignment of benefits (e.g., Mississippi, Illinois) have limited applicability.

The intent of the *No Surprises Act* was to provide clear protections for patients and to ensure that there was some method of resolving reimbursement issues between plans and providers for all non-contracted services. If a state law does not govern all non-contracted services and the state law yet was allowed to preempt federal provisions for all services, the outcome would be a direct contradiction to the intent of the *No Surprises Act* and result in a misappropriation of the statutory provisions.

Limited or Partial Protections

- While we do not believe that the *No Surprises Act* contemplates that a "specified state law" would include states, such as North Carolina, with **only patient protections but no payment standard** (often referred to as having "limited" or "partial" patient protection), ***ACEP and EDPMA request that the Departments make clear that states with limited approaches to out-of-network services should not be deemed to have a "specified state law."*** Because there would be no "specified state law" in these instances, the provisions of the *No Surprises Act*, including the federal IDR process, would govern. This is an important provision that would help ensure that patients continue to have timely access to quality emergency care.

- As you develop regulations setting the parameters for which state laws have a "method for determining the total amount," ***ACEP and EDPMA believe it is paramount that the Departments distinguish between states that set an "initial payment" (which has the effect of ensuring that there is not a complete disruption in reimbursement for services rendered, but may not reflect the final payment) and those states that truly have a method for determining the total amount payable, which we believe involves some assessment of circumstances.*** We ask that the Departments clearly delineate that a state policy that simply dictates an initial payment amount without the mechanism for altering or appealing that amount (for example, Maryland and New Mexico) is explicitly not a "method for determining the total amount payable." We also suggest that, in making that differentiation, that the Departments utilize the framework of the *No Surprises Act* as a comparison point.

- We also believe that the Departments must address the reality that **unenforced, non-binding, or voluntary state laws and regulation** are states where there is *de facto* no method for determining the total amount payable and should be treated as such. For instance, our members with experiences in the State of Florida frequently report that insurance providers simply choose to ignore the IDR process that has been instituted. So, while the process exists on paper, , it has not proven to be a "method for determining the total amount" since payers are able to simply ignore it.

2. Treatment of ERISA Plans

The federal law is designed to provide protections for patients by limiting liability for out-of-network costs and increasing transparency in the process. We urge you to ensure the regulations bear that in mind as they are drafted and ensure that there is consistency in the rules that govern out-of-network services in a given state. Complicating this issue are practices by states that allowed for ERISA plans to "opt-in" to the state regulation of out-of-network services. Therefore, ***the Departments should implement provisions that, in states where there is a "specified state law," all ERISA plans are subject to the provisions of the No Surprises Act (i.e. the Federal IDR process) under the legal principle that states were only allowed to create ERISA opt-in provisions because of the (up until now) absence of Federal law on the matter***.

Without this policy, in states with a "specified state law" that allows ERISA plans to "opt-in" to being regulated by state rules, the Departments would create an environment in which patients and clinicians would be confused about which rules govern plans in their State, and the ERISA plans would be in the unfair position of being the only plans on the market to have a "choice" of which out-of-network rules to live by. Further, the plan can opt in or opt out at any time, leaving providers in the dark about whether a claim should be sent down the state or federal path, and significantly increasing administrative costs. In the event the Departments do not agree that all ERISA plans should be subject to the federal provisions and choose to allow for ERISA plans to "opt-in" to state regulation for out-of-network services, ACEP and EDPMA urge the Departments to implement a policy stating that any provision allowing for ERISA plans to "opt-in" to the State's out-of-network services regulation passed by a State after the signing of the enactment of the *No Surprises Act* (December 27, 2020) shall have no effect, as it is preempted by the *No Surprises Act,* and all ERISA plans in that state shall be subject to the *No Surprises Act*.

In addition, to achieve the goals of transparency and efficiency, ***ACEP and EDPMA urge the Departments to require that plans clearly delineate on the patient's insurance card and in the ANSI 835 remittance advice that the plan is ERISA, Medicaid MCO, grandfathered ACA plan, ACA plan, Medicare Managed Care, group, individual or otherwise.*** Further, we request that the Departments require for claims that are not electronic, that if a provider asks the plan the type of plan (ERISA, Medicaid MCO, grandfathered ACA plan, ACA plan, Medicare Managed Care, group, individual or otherwise), the plan shall provide the answer to the provider within 24 hours. This will ensure that the provider has the information needed to ensure they comply with applicable patient protections and utilize the correct dispute resolution process.

C. The Independent Dispute Resolution (IDR) Process

While ACEP and EDPMA understand that the *No Surprises Act* does not require promulgation of regulations related to the federal IDR process until December 27, 2021, we wanted to take the opportunity to bring focus to several recommendations that we believe will inform rulemaking on other provisions of the Act and serve as important concepts to consider as the agencies begin

rulemaking on the IDR process in earnest. Our comments below are ordered in chronological sequence of how the process of federal IDR is laid out in the *No Surprises Act*.

1. IDR Entity Certification Criteria

We believe that the certification of IDR entities is the first step to setting up a federal IDR system that functions as the law intended. ACEP and EDPMA urge the Departments to implement an IDR system that decreases system costs and efficiently administers the intended goals of the *No Surprises Act*. As our members have been participants in various state mechanisms set up for out-of-network IDR or arbitration, we have observed IDR entities with demonstrated variation in their efficiencies and productivity. As the HHS Secretary is given the authority to certify entities for participation in this process, such certification process should ensure an evaluation of the IDR entity's IT efficiencies and administrative costs.

IDR Entity Fees

ACEP and EDPMA believe it is imperative that the Departments ensure that the IDR entities available for selection are neither costly nor bureaucratic entities that create a cumbersome, costly federal IDR process. In Texas, for example, which provides a state-based mechanism to access IDR, providers have found the costs associated with arbitration to be a meaningful barrier to IDR access, and that payers used arbitration fees as a method for putting pressure on practices that are less able to withstand disruptions in cash flow. [1] We recognize that this is partially a byproduct of mediation fees being split by the parties under Texas law, no matter the outcome. While the *No Surprises Act* requires that the losing party is the only one subject to the IDR fees, thus better protecting from this dynamic, it demonstrates the importance of ensuring that IDR fees can't be used as a tool by certain parties to manipulate the system. Thus, the Secretary's certification process should ensure that the certified IDR entities in a given area are not *only* those with excessive fees.

IDR Entity Conflicts

ACEP and EDPMA believe another key component of instituting a process that supports the goals of the No Surprises Act is to promulgate selection criteria that ensure dispute party access to multiple organizations that are not only free from direct conflict with potential parties, but that are also free from a general bias toward either plans/issuers or providers. While the law provides restrictions on IDR entities from overseeing disputes that have a *direct conflict* with parties to the dispute, we are concerned that this does not account for *general IDR entity bias or conflict*. For instance, we do not believe that an entity that has a connection (even if not a direct "affiliate or subsidiary") with one payer should be allowed to serve on the list of potential IDR entities, even with the caveat that the entity would refuse to oversee a dispute regarding the exact payer with which it has the

[1] *See*, https://www.tdi.texas.gov/reports/documents/SB1264-preliminary-report.pdf (accessed March 23, 2021).

connection. Allowing for this IDR entity to be on the list does not address potential bias in the direction of one type of party in the dispute. We believe this should hold for entities with a general connection to provider organizations or provider professional or trade associations.

As well, while the statute provides that IDR entities may not be the employee or agent of a party or have a familial, financial, or professional relationship with the party, or otherwise have a conflict of interest with a party, the parties are of course not yet knowable at the time of IDR entity certification. Thus, the regulations should provide confidence that IDR entities with potential bias toward a particular type of party are not certified to be included in the list of eligible IDR entities.

2. Batching

While the HHS Secretary has the authority to "specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination by an entity," the statute goes on to also state that it can only be applied to items and services "furnished by the same provider or facility."

"Furnished by the Same Provider or Facility"

ACEP and EDPMA believe that the Secretary should promulgate regulations that implement a definition of providers that reflects the statutory language and real-world claims processing practices. As such, we believe that this should include allowing for batching of claims for TINs with multiple practitioners. This is consistent with the current Medicare approach to providers as a "Group Practice" (under the Quality Payment Program) and how other Medicare programs are structured (e.g., BPCI-Advanced addresses site-specific practices as TIN entities). In fact, with regard to the initial payment, the statute even states, "*the group health plan or health insurance issuer . . . not later than 30 calendar days after the bill for such services is transmitted by such provider or facility,* **sends to the provider or facility, as applicable, an initial payment or notice of denial of payment**." (emphasis added).

It would therefore be an unreasonable interpretation to suggest that this requires a departure from current business practice of reimbursing claims to the tax entity which submits the claim. We therefore believe it follows that "provider" could be the billing entity or the individual physician, and, as such, "provider" should be allowed to be the TIN submitting the claim for purposes of batching, if so chosen by the provider. Making this option available would reduce strain on the overall IDR process, reduce costs, and better reflect current real-world claims processing logistics. Further, emergency physicians provide a wide variety of services as compared to physicians in other specialties, so it is much more difficult for one individual person providing emergency care to have enough "similar" emergency claims to obtain the efficiencies provided for by batching.

Therefore, ***ACEP and EDPMA recommend that for purposes of the batching provisions, that the Departments implement a methodology that allows a nonparticipating provider to choose to batch claims eligible for IDR either in the name of the individual or in the name of the physician group, identified by its Federal Tax ID number, for which the nonparticipating provider is a member***.

"Related to the Treatment of a Similar Condition"

The statute provides for batching of claims in the IDR process for items and services "related to the treatment of a similar condition." As the agency contemplates policies for batching, ***ACEP and EDPMA believe is imperative that the Departments consider the goals of the legislation in light of the unique characteristics of the emergency department setting***. We do not believe that the law intended the implementation of a granular definition of "similar conditions" that prevents meaningful access to batching for emergency department providers. ***We recommend that the Departments make explicit provision that in the emergency physician context, the condition is in fact "emergency medical care" or "EMTALA-related care."*** As you know, emergency care is different than scheduled surgery or office visits where the patient's diagnosis or condition is most often explicitly known. Conversely, the routine practice of emergency medicine is characterized by a range of severity that patients present with, and a corresponding range of diagnostic, therapeutic, and decision-making intensity. This is the essence of "emergency medical care" which is bound by EMTALA, and results in the most common CPT codes (99281-99285). A contrary interpretation forcing emergency providers to limit IDR batching to granular, individual "conditions" would require a nearly endless series of adjudications, expense, and senseless administrative burden. We strongly encourage that this consideration – which is unique to emergency care – be given specific consideration in rule-writing.

3. Definition and Weighting of IDR Payment Determination Criteria

The *No Surprises Act* directs the arbiter to *equally* consider numerous criteria in rendering a determination, and it is important to ensure these are defined in regulation in a manner that ensures this equal weighting. ***ACEP and EDPMA urge the Departments to issue regulatory text that carefully defines the criteria in the IDR process that were laid out in the law, and reinforce that all criteria are equal in consideration in the IDR process***. We are concerned that without this, there could be drift toward preferences for certain criteria over time as a method for making the payment determination, when it is clear from the *No Surprises Act* text that Congress purposefully chose to assign equal weight to every criterion.

We also request that in implementing the IDR process that the agencies take into account the following considerations:

Qualifying Payment Amount

We recognize that in the IDR sections of the law that delineate the criteria for consideration, the language states that the qualifying payment amount should be considered "*for items or services that are **comparable** to the qualified IDR item or service*" (in addition to the other parameters, e.g., "furnished in the same geographic region"). We believe that the word "comparable" was incorporated in order to provide flexibility so that some number might be used, but that a "comparable" number should not be used when a more precise amount is available. Thus, we believe the qualifying payment amount considered should be the one for the most closely appropriate item or service available. ***ACEP and EDPMA urge the Departments to ensure that rule reflects that the qualifying payment amount selected for consideration as part of the IDR deliberations shall be the qualifying payment amount for the same item or service in dispute and that the qualifying payment amount for comparable items or services shall only be relied on in instances where the qualifying payment amount for the same item or service is not available.***

We firmly believe that by requiring the consideration of the qualifying payment amount in IDR, the statute intended for the arbiter to have a static data point as a reference in its deliberations. To allow additional median contracted rates into the deliberations when the exact median contracted rate for the item or service in dispute is available would run contrary to the inclusion of the provision in the first place.

Availability and Accuracy of Information

The availability of IDR in situations where disputes cannot be otherwise negotiated is a welcome component to the *No Surprises Act*. We request that the Secretary take the following considerations into account during rulemaking:

- The *No Surprises Act* requires parties to submit information "as requested by the certified IDR entity related to such offer." We believe it is reasonable to expect that IDR entities could request submission of information related to all of the potential criteria named in the statute. Whether the IDR entity request is related to the named criteria or some other information, we believe that the inclusion of the obligation of the party to comply is meant to ensure fair consideration of all *available* information. We urge the agencies to ensure that the naming of particular criteria or IDR requests for information do not create a disadvantage for a party that does not have access to information requested by the IDR entity or that one party has but the other does not (e.g., individual physician market share).
- We also request that the Secretary provide guidance on information on which an IDR entity can rely that is external to data submitted by the parties. While we do not suggest that this would be in all cases inappropriate, we are concerned that IDR entity reliance on flawed data or information obtained from unknown sources and

unvalidated for use in dispute resolution proceedings could undermine the intended process.

- Finally, given the "10-day deadline" for submission of the parties, we also request that the Secretary provide guidance on the ability of parties to provide additional information *after* the "10-day deadline" in order to complement or rebut information submitted by the opposing party. A system that encourages IDR entity reliance on incomplete or flawed data or information submitted by a party will not generate reliable outcomes.

Consideration of Additional Information

As we have discussed throughout this document, disputes between payers and providers in emergency care often relate to plans not agreeing with the type and/or level of emergency service that is included on the initial claim. As the Secretary considers the implementation of the federal IDR process, we believe it is important that the Secretary clearly articulate the extent to which these disputes will be addressed inside of IDR. We have stated our position regarding separate administrative and legal processes currently in place to adjudicate downgraded claims and other disputes about the levels and/or types of services included on the claim.

However, to the extent the Secretary believes these disputes are appropriate for IDR, we firmly believe that a long list of factors will then need to be added to the list of IDR entity considerations, including whether the insurer violated a statute, regulation, or guidance in making the initial payment and the impact on patients' access to care.

4. Unreasonable Plan Payments during Cooling-off Period

As dictated by the *No Surprises Act*, IDR payment determinations commence the 90-day "cooling off period." However, an IDR decision does not inform the initial payment for disputed claims incurred during the cooling off period. Given that the intent of the "cooling off period" (and other policies throughout the legislation) is to deter overreliance on IDR, it is important that the Departments focus on this component of the process to ensure that it does not become a vulnerability in achieving the goal of efficient and selective use of IDR.

For physician practices, managing cash flow is a key component of being able to ensure patient access to a sustainable service. It is a fact that during the "cooling off period," the health plans/issuers are the only entity with dominion over the amount of reimbursements paid to providers, whose hands are tied for the ensuing 90 days with respect to their ability to dispute subsequent payment amounts via IDR. Thus, health plans could technically make what are considered to be unreasonably low initial payments immediately following the IDR decision for the circumstance that was just adjudicated, with no threat of being taken to IDR in the short term, devastating provider or facility cash flow. The future risk of the provider initiating an IDR dispute could be outweighed by the benefits of the plan's increased access to cash. This introduces a

dynamic whereby plans/issuers are positioned to capitalize on access to cash while reimbursing providers at rates that are neglectful of practices' ability to remain viable because of unnecessary interruptions in cash flow.

As well, if payers were to act in this manner, it would run contrary to the clear intent of this provision: to deter overreliance on the IDR process for resolving payment disputes that already have a pattern of resolution. This is a concern recognized by Congress in drafting the *No Surprises Act* (the Secretary must report on whether plans have a "pattern or practice of routine denial, low payment, or down-coding of claims" during the "cooling off period"). The Secretary should ensure that the framework of the *No Surprises Act* and the inclusion of the "cooling off period" are not undermined by this vulnerability in the process.

As such, ACEP and EDPMA urge the Departments to enact protections for providers and facilities from unreasonable initial payments from plans during the required 90-day cooling off period. We look forward to continued conversation regarding potential solutions to prevent unnecessary cash flow disruptions and actions that could undermine the intent of the law, but emphasize that this is an important component of the federal IDR process to address to ensure that disputes held in the "cooling off period" do not unnecessarily move into IDR after the "cooling off period" ends.

5. Legal Options

As providers of emergency medicine, we urge you to consider the unique statutory requirements that apply to services furnished in the emergency department when implementing regulations about the federal IDR process and how this process interacts with those obligations that arise out of statute separate from the *No Surprises Act.*

Both EMTALA and the Prudent Layperson (PLP) standard place obligations on providers and insurers that the *No Surprises Act* did not intend to alter or address. It is for this reason that ACEP and EDPMA request that the Secretary make clear that disputes eligible for the federal IDR process should remain eligible for the federal IDR process irrespective of other claims and shall not be slowed down by those other obligations; simultaneously, legal options that are anchored in the EMTALA and PLP standard continue and existing processes for resolving those issues remain in place regardless of a federal IDR payment determination (with the full understanding that a payment amount dispute that receives a Federal IDR payment determination is final for that item or service). Likewise, if external processes regarding EMTALA or the PLP standard resolve that a new service or complexity of service should be considered, any new dispute regarding the payment determination for that new service is eligible for IDR.

In summary, we do not believe the *No Surprises Act* intended to supplant those other relevant statutes, however, we do not believe that disputes related to those other statutes should be used as method of manipulation over when parties can access the federal IDR process as intended by the *No Surprises Act*. Not only is this consistent with statutory intent, it recognizes the fact that arbiters

are not likely to have the medical and coding expertise needed to make these decisions in an efficient and accurate manner.

6. IDR Determination

Once an IDR determination is made, the non-prevailing party will need to make up the difference with the prevailing party within 30 days, as per the statute. If such a payment is not made by the end of the 30-day period, interest should apply. The Departments could consider setting the interest rate at the rate which HHS currently applies to overdue and delinquent debts, pursuant to 45 CFR Part 30—which is determined and fixed by the Secretary of the Treasury.

D. Administrative Processes

The *No Surprises Act* includes many new administrative processes, and ACEP and EDPMA request that you consider ways to limit their overall burden on clinicians.

1. Identification of Plan Type

We believe that clinicians will have a difficult time appropriately identifying eligible plan members by Explanation of Benefit (EOB) statement. Therefore, clinicians may not have all the necessary information regarding which out-of-network rules, laws, and standards – including patient protections – apply. A requirement to use the 830 Remittance Advice Remark Code (RARC) alone is insufficient to provide early enough and complete enough information).

Therefore, ACEP and EDPMA believe that the HHS Secretary should require plans to identify clearly on all Remittance Advice (RA)/ EOBs and ERAs (Electronic Remittance Advice) that a plan member is a beneficiary of an ERISA, Medicaid MCO, Medicare Managed Care, ACA, grandfathered ACA, group, or individual plan and subject to either the federal SMB process or the process used by the state of where the services were rendered, effective on or before January 1, 2022. Further, health plans should be held accountable for delivering an accurate and consistently identifiable electronic means via the RA/EOB/ERA for health care providers to verify the member's plan type.

In short, health plans should:

- Use a nationally uniform/standardized format to identify plan type on RA/EOB/ERA.
- Deliver plan type information electronically to provider via RA/EOB/ERA.
- Answer questions relating to plan type within 24 hours.
- Be subject to enforcement and penalties if the plans fail to comply with clearly identifying the applicable member plan type and delivering such information to the provider in accordance with the defined uniform format.

By implementing these requirements, the HHS Secretary would be significantly reducing overall clinician burden. Furthermore, these actions would limit any confusion about plan type that could cause clinicians to miss the deadline for initiating the IDR process or misidentify claims that are eligible for IDR (which could lead to higher administrative costs or a risk of inadvertent non-compliance). Finally, it would also reduce any potential errors around the appropriate cost-sharing amount for patients—thereby providing much-needed certainty and predictability to patients around expected costs (which is one of the key goals and laudable achievements of the No Surprises Act).

2. Timely Provider Enrollment

Provider enrollment timeframes vary greatly by payor and it may take up to 90 to 120 days for the payor to finalize. In instances where payor enrollment is required in conjunction with contracting/network participation, extended payor processing times may result in claims being released as out-of-network to avoid timely filing or revenue delays. ***Since delays in provider enrollment could impact the processing of out-of-network claims and the IDR process, it is essential to ensure that payors have timely, up-to-date provider enrollment systems. It is also essential that payors are held accountable for meeting network adequacy standards and receive penalties for non-compliance as appropriate.***

E. State All-payer Claims Databases (APCDs)

As articulated in the *No Surprises Act*, states may deploy a non-profit database not affiliated or subsidized by a health plan as part of their "specified state law" for determining "total payment." The database may be one that exists or is developed but in either case the health plans in that state including the ERISA plans shall be mandated to contribute data to the database that the state chooses. States may determine the formats, methods, accessibility and updates for health plans to initially supply data and to provide reasonable updates of that data to facilitate compliance with the *No Surprises Act*. ***State laws that rely on named databases, such as FAIR Health, should be considered a Specified State Law given that this is a "method for determining the total amount payable."***

It is critically important for the Departments to institute specific APCD reporting requirements in rulemaking. ACEP and EDPMA believe that these should include:

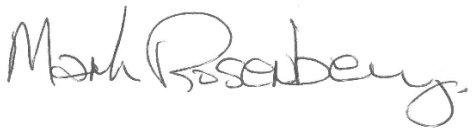
- A mandate that all health plans report data, including ERISA and state plans.
- Mandatory metric reporting of the number and percentage of PPO, exchange plans, HMO, Medicare Advantage, every other type of plan.
- Reporting of the percentage of insured (broken out by public versus private payor) and uninsured.

- Reporting by specific geo-zip regions to account for regional difference.
- Reporting every code by specialty taxonomy or site of service.

States may also allow the public to access the data. Completely restricting access to the data or allowing certain plans to opt out of reporting would jeopardize the usefulness and integrity of the data included in APCDs.

Thank you for the opportunity to provide initial 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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CC: The Honorable Martin J. Walsh, Secretary of Labor
The Honorable Janet Yellen, Secretary of the Treasury