December 6, 2021

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

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

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

RE: *Requirements Related to Surprise Billing; Part II; Interim Final Rules with Request for Comments (CMS-9908-IFC)*

Dear Secretaries Becerra, Walsh, and Yellen:

On behalf of our members, the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA) appreciate the opportunity to comment on the interim final rules with comment (IFC) released by the Departments of Health and Human Services (HHS), Treasury, and Labor (collectively referred to throughout as "the Departments") entitled *Requirements Related to Surprise Billing; Part II.*[1]

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 nearly 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 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.

[1] 86 *Fed. Reg.* 55,980 (October 7, 2021).

The comments included in this letter follow extensive comments that ACEP and EDPMA previously submitted after the release of IFC Part I. Throughout this letter, we highlight some of the key issues addressed in our IFC Part I comment letter that have gone unaddressed by the Departments since publication of IFC Part I. We emphasize that the issuance of IFC Part II without the response that stakeholders would have received if the Departments had engaged in full notice-and-comment rulemaking represents a fundamental disservice to sound policymaking and operational thoughtfulness related to these provisions. ***We again stress that the Departments' lack of transparency in rulemaking and failure to provide adequate details threaten to undermine our nation's health care system by lining the pockets of health insurance companies at the expense of patients and health care providers.***

Furthermore, our comments follow-up on the letter that we submitted on August 10, 2021 specifically related to the independent dispute resolution (IDR) process, as well on our initial response letter to the IFC Part II sent on November 11, 2021.

While we provide specific input on numerous policies in this IFC, we first want to highlight four main points that we expand upon further in our letter.

- **ACEP and EDPMA's Significant Objection to Flawed IDR Process***: As stated in our initial response letter to this IFC**, ACEP and EDPMA express our profound disappointment in the unwarranted weight and heightened prominence the Departments have given to the qualifying payment amount (QPA) in the IDR process. The approach taken by the Departments is inconsistent with the legislation ultimately passed into law by Congress that was intended to create a fair and unbiased process to resolve billing disputes.* Additionally, this is inconsistent with decisions Congress made by refusing to promote or pass other legislative proposals that would have produced the same or similar result promulgated by the Departments in this rule.

  The policy promulgated by the Departments threatens to undermine the statute, jeopardizes network adequacy, and distorts markets and negotiations. We are concerned that these effects could materialize even more swiftly in rural and socioeconomically disadvantaged regions. ACEP and EDPMA believe that the justification provided in the IFC for selecting this approach is significantly flawed and biased against providers—and we provide a rebuttal to each of the main arguments the Departments present. ***The Departments must enact changes to the IFC to ensure the No Surprises Act is implemented as intended by the clear statutory language that was passed by the full Congress in December of 2020.***

- **Missed Statutory Deadlines and Lack of Critical Information Needed for Implementation:** ACEP and EDPMA point out the major areas where the Departments have either not issued any guidance or have not provided enough information for providers to be able to fully understand and operationalize the requirements. We specifically highlight:
  - The mission-critical need to provide more clarity around how providers will know whether a state or the federal law will apply to a specific claim; and

- Our longstanding request that health plans provide much more information about the QPA to providers, including the QPA for the Current Procedural Terminology (CPT®) code(s) that was submitted by the provider on the claim if the health plans modified the service or code(s) present on the original claim.

Finally, with respect to the areas where the Departments have not yet provided any guidance or requirements, we note that they disproportionately focus on health plans—signaling that the Departments are showing a significant bias in terms of trying to shield health plans from taking on new requirements but have made no effort to reduce the administrative burden or the significant impact that the *No Surprises Act* requirements will have on providers and facilities.

- **Incongruent Timelines for Batched Services:** ACEP and EDPMA discuss issues regarding the various timelines in the *No Surprises Act* and regulation for batching services in the IDR process and request operational clarifications regarding the process. We provide an example of how the established timeline for allowing claims to be batched can unintentionally lead to some claims being separated from those that the statute contemplates being eligible for batching together -- thus forcing an unintended over-reliance on the IDR process and significantly threatening the viability of small provider practices due to delayed cash flow.

- **Good Faith Estimates (GFE) for Uninsured and Self-Pay Individuals:** ACEP and EDPMA fully support protections for the uninsured and efforts to increase transparency in the pricing and costs of health care items and services. While the GFE provisions seem only to apply to scheduled care—and not unscheduled emergency care—some of the language in the IFC, particularly the fact that patients can trigger the GFE requirements "upon request," could be construed by some as, in fact, applying to unscheduled care in the ED.

  Unlike scheduled medical care for a discrete clinical condition or well-described service, an emergency provider cannot know what medical condition a patient has, nor what will be required to diagnose or stabilize the condition. Furthermore, under EMTALA, patients are not allowed to receive information about costs prior to being stabilized. Doing so could potentially cause the patient to delay critical care. The last thing we want to do is put our patients in a position of making life-or-death health care decisions based on costs. Therefore, **we would like the Department to unequivocally state that the "upon request" GFE requirement does not apply to ED services due to the unique requirements of EMTALA and the essential characteristics of acute, unscheduled care.**

We provide additional information on these issues and other provisions of IFC Part II as well as request swift clarification through sub-regulatory or other guidance in certain areas that we believe are critically in need of additional detail prior to the January 1, 2022 applicability date of these provisions.

Sections of ACEP and EDPMA Response Letter

Missed Statutory Deadlines—Clear Bias in Favor of Reducing Burden on Health Plans

There are some major provisions in the *No Surprises Act* where the Departments have not met their rulemaking deadlines. These include:

- Plan/issuer obligations related to delivery of patient advanced explanation of benefits (advanced EOBs).
- Plan/issuer obligations related to accuracy of network directories.
- Plan/issuer obligations related to plan/insurance identification cards.

There is a clear, common thread here. While the Departments have subverted notice-and comment rulemaking through IFCs to ensure that obligations on providers and facilities are in place prior to January 1, 2022, the Departments did not do the same when implementing patient protections that require action by the insurance industry. The communication from health plans that would be required per the above provisions is absolutely necessary to the purpose and function of the *No Surprises Act* to ensure cost-sharing charges are accurate and access to care is maintained as the primary focus.

In some instances, this this one-sided implementation of transparency requirements will lead to absurd results. For example, the timeline in which the Departments are implementing this will cause providers to proffer a good faith estimate (GFE) to insured patients under the notice and consent provisions. But without implementing the requirement that plans and issuers *also* give an advanced EOB, the only cost information that the patients will see are the provider's expected

billed charges, but the patient will have no information or expectations about what the actual out of pocket cost will be under their terms of coverage or how far along they are in terms of meeting any deductible they might have. Not only is this not how the law is constructed, but this could deter patients from receiving medically necessary care, or, ironically, **even subject them to surprise bills** that could easily result from a lack of information on the extent of their insurer's coverage for that particular service and provider.

The lack of oversight for the health plans on these important requirements is inconsistent with the Departments' focus on transparency in these and other rules. This inaction, paired with the over-prioritization of the QPA outside of statutory direction, will lead to the implementation of a health care marketplace with much bias toward health plans, with little direct benefit to patients and employers. ***We urge the Departments to immediately correct course to avoid undermining the goals of the statute and the patient protections enacted under those provisions.***

Significant Lack of Clarity and Information Regarding Federal Dispute Resolution Process vs. Specified State Law Approach

In recognition of the fact that items and services are only eligible for the federal dispute resolution process in instances where a "Specified State Law" does not govern, ACEP and EDPMA cannot stress strongly enough how little information has been provided by state authorities prior to the January 1, 2022 start date to provide guidance on instances in which state law will apply or whether a provider has access to the federal process. There are major unanswered questions and states have not even provided a timeline as to when they expect to provide clarification. These include:

- How will providers and facilities determine the type of plan or coverage so that they can determine whether the plan is covered by state law?
- In ERISA opt-in states, how will a provider know whether an Employee Retirement Income Security Act (ERISA) plan has opted in (particularly given the Departments' lack of issuance of rules on plan ID cards prior to January 1, 2022)?
- In states with monetary thresholds to access dispute resolution, will the state provide clarification on how the provider will get confirmation that the dispute is covered by the state law to avoid missing Federal IDR timelines?
- Where a Specified State Law pertains to some specialty services but excludes other specialty services, will claims containing charges for both types of services have access to the state process (or federal process), or will the claim be "split"?
- For items and services furnished in a state with a Specified State Law, but provided by a provider based in another state or to a patient whose plan is based in another state, will claims for those services be under the jurisdiction of the state where services were provided in every circumstance?
- How will disputes over whether a claim is covered by Specified State Law be handled?

ACEP and EDPMA are concerned that the complexity of this system has been left with inadequate detail. While we understand that the *No Surprises Act* includes substantial deference to states, state law interaction with these Federal provisions is complex, begins in under a month, and has received little to no attention. ***We urge the Departments to facilitate actionable clarity on the***

implementation of these provisions at the state level as the patient protections and dispute resolution provisions of the No Surprises Act hinge on these details.

We request that the Departments consider a more well-developed process for identifying when a Specified State Law is in place, similar to what HHS put forth here in IFC Part II under the Patient Provider Dispute Resolution Process (PPDR) provisions. While the regulations implement the PPDR process, HHS provides that it will, for states that have a similar process meeting minimum standards, permit that those processes meet the requirements for the statute. To guarantee the patient protections afforded by the *No Surprises Act* are in place, HHS establishes "a process by which HHS will determine whether a state patient-provider dispute resolution process provides at least the same level of consumer protections as does the Federal process" and affirmatively will "communicate with the state and determine whether a state law provides for such a dispute resolution process, and ensure that such process meets or exceeds certain minimum Federal requirements." Further, HHS intends to carry out this process annually. We believe the Departments should conduct a formal, annual process for review of state laws for assessment of whether they meet the "Specified State Laws" standards to ensure the patient protections of the *No Surprises Act* are being met and to provide clarity regarding the appropriate venue for resolution of circumstance in which plans/issuers have likely issued inappropriate payment rates or inappropriate denials of payment.

Reducing Reliance on IDR Through Requiring Plan/Issuer Early Provision of Accurate, Complete Information

Plan/Issuer Communication Obligations

ACEP and EDPMA continue to be concerned that the process that the Departments put forward for the Federal IDR process falls short of fulfilling the goals of the *No Surprises Act*. We also believe that, **while IDR is a vitally important mechanism, it should be a venue of last resort.** Ensuring that timely, transparent, and accurate information is supplied efficiently during the initial time periods involving payment and open negotiation is critical to making sure that IDR is utilized in as few disputes as possible. ACEP and EDPMA believe that the current rules fail to require the delivery of this information, and we urge the Departments to take quick action to ensure that the information communicated throughout the *No Surprises Act* timeline be done so in a way that provides accurate information as completely and efficiently as possible so that parties can avoid IDR in as many instances as possible.

For as much attention as has been paid to the IDR details, we believe the 30-day open negotiation period is a key component that can support the parties in dispute and help to avoid overreliance on the IDR process. ***In order for the 30-day negotiation to fulfill its goal of providing an opportunity to avoid IDR, ACEP and EDPMA believe that the Departments must take immediate steps to ensure that at the time of the initial adjudication of the claim, or as part of the remittance communication that is issued in connection with payment or denial, plans/issuers are required to communicate the QPA for the Current Procedural Terminology (CPT®) code(s) as submitted by the provider on the claim, as well as other key pieces of information.*** It is particularly

important to specify information that relates to the differences between the billed amounts on the provider's claim and the plan/issuer's initial payment (or denial).

It is imperative that providers and facilities have this key information at the outset in order to optimize the 30-day open negotiation process and avoid engaging IDR wherever possible. For example, if the QPA for the CPT codes submitted by the provider are similar to the QPA for the CPT codes that the plan is paying, the provider may decide not to take the claim to IDR. However, if the QPA for the CPT codes submitted by the provider are unknown to the provider, the provider will not know whether it is worth their time and money to dispute the payment. Further, the provider may be willing to offer a lower reimbursement level during negotiations if the QPA for the CPT codes they submitted are lower than they expected.

We believe there should be an affirmative obligation on the plans to provide this information after the transmittal of a claim from a provider or facility. However, we also believe that transparency can be supported by making QPA information publicly available. Therefore, ACEP and EDPMA urge the Departments to require plans and issuers to publish their QPA calculations by CPT code in machine-readable files to increase the availability of information for purposes of claims processing and to reduce overreliance on the Federal IDR process.

Resolution of Disputes Under Federal Authority

Certification of IDR Entities

The Departments state in the IFC that an "individual, provider, facility, provider of air ambulance services, plan, or issuer may petition the denial of a certification of an IDR entity or a revocation of a certification of a certified IDR entity for failure to meet the requirements [for certified IDR entities] . . ." under statute and regulation. In IFC Part II, the Departments further state, petitioners submitting a petition for "denial of certification" will have "5 business days from the announcement that an IDR entity is seeking certification to submit the written petition" unless the Departments issue new guidance on a different timeline.

In implementing this section of the IFC, the Departments have not displayed nearly enough of the necessary information to properly assess possible IDR entities for certification. This is yet another example of the lack of transparency and lack of clarity regarding the new federal dispute resolution process.

On November 16, 2021, the Departments issued a notice of applicants with a petition deadline of November 22, 2021. This is the entirety of the information provided by the Departments:

- C2C Innovative Solutions, Inc. (https://www.c2cinc.com/)
- Federal Hearings and Appeals Services, Inc. (https://www.fhas.com/)[2]
- Island Peer Review Organization (https://ipro.org/)
- Maximus Federal Services, Inc. (https://maximus.com/federal)
- MCMC Services, LLC (https://www.mcmcllc.com/)

[2] This website provided was attempted to be accessed on Tuesday, November 16, 2021 several times throughout the day, lastly at 6:00 pm eastern time. In all instances, "**This site can't be reached**."

There is no information regarding:

- The jurisdictions in which these entities seek to operate;
- The capabilities the organizations will perform in order to meet the increased demand under Federal IDR;
- The medical expertise the entities have proposed to deliver, given the Federal scope of IDR and how that could differ from the states in which the entities operate now; and
- The entities' willingness to charge fees consistent with the IDR entity fee schedule included in IFC Part II.

Further, the document announcing the applicants did not even include a link to where a petition should be submitted. This is all in the context of a petition deadline of 5 business days. ***Quite simply, this is not a meaningful process.***

Open Negotiation

The Departments state that an "open negotiation period may be initiated by any party during the 30-business-day period beginning on the day the nonparticipating provider, facility, . . . receives either an initial payment or a notice of denial of payment for an item or service." ***We continue to believe the open negotiation timeline can be manipulated by health plans given the Department's language from IFC Part I.*** Under the *No Surprises Act*, health plans and issuers are required to send an initial payment or notice of denial "not later than 30 calendar days after the bill for such services is transmitted by such provider or facility." ***As stated in our response to IFC Part I, ACEP and EDPMA strongly believe that the Departments need to provide some additional safeguards and clarifications to ensure that all the processes and timelines outlined in the No Surprises Act run smoothly—particularly around the definition of "clean claim."***

First, we are very concerned that without a clear definition of clean claim, health plans or issuers will be able to label even accurate claims as "pending" without good reason, forcing patients to remain "in the middle" of a time-consuming dispute. That becomes critically important because it impacts that date on which the Open Negotiation timeline begins. Failure to clarify this issue and specify clear guidelines will leave providers inappropriately vulnerable. We continue to urge the Departments to ensure that the rule is amended to include a narrow definition of a "clean claim" where the claim is considered clean if it provides the identity of the patient, provider, and facility and the Current Procedural Terminology (CPT) and ICD-10 codes for the services rendered.

Second, we are concerned with the Departments' silence about the rights of providers and facilities under these timelines when a plan/issuer issues neither payment nor denial. ACEP and EDPMA urge the Departments to issue immediate guidance clarifying that if a provider or facility has received neither a payment nor a denial from a plan after 30 days of *transmitting the bill* (rather than determination of it as clean by the health plan) that the provider or facility is eligible to submit a Notice of Open Negotiation.

Regarding the Initiation of Open Negotiation, we appreciate that this process is largely dependent on the two parties to the dispute (and not the Departments nor a certified IDR entity). However, in the event the dispute is not resolved in Open Negotiation, the window in which to submit a Notice

of IDR Initiation is incredibly tight and highly contingent on the parties having a mutual understanding of the date on which the Open Negotiation period commences: "the 4-business-day period beginning on the 31st business day after the start of the open negotiation period."

Because of the importance of the date of the beginning of the open negotiation period, ACEP and EDPMA request that the Departments require the submission of the Open Negotiation Notice via the Federal IDR portal to receive a third-party timestamp on which both parties to the dispute can rely. We believe that this will be of minimal burden and will produce significant benefit in supporting the process outlined by the *No Surprises Act*.

Of note, the Departments are already requiring the use of the standard Open Negotiation notice and thus it will be easily receivable by the Federal IDR portal. Further, in the Departments' impact analysis of the rule, the Departments make the assumption that "25 percent of disputes will be resolved in open negotiation before entering the Federal IDR process." Conversely, this means that 75 percent of disputes will proceed to IDR. This volume requires precision when it comes to the timeline, particularly when this milestone is the trigger for a 4-business day requirement. We believe that the burden associated with submitting the Open Negotiation Notice via the Federal IDR portal will be minimal and clearly outweighed by avoidance of any confusion that results from differing opinions regarding the date of commencement of the Open Negotiation period. Finally, we believe that this would provide the Departments with useful information regarding the percentage of cases that are resolved in Open Negotiation, information to which it would otherwise not be privy. This will be important to assessing the effectiveness of the current regulations as well as the assumptions the Departments made as part of the impact analysis.

Initiation of the Federal IDR Process

The Departments have included the following provisions in IFC Part II:

- *Either party may initiate the Federal IDR process during the 4-business-day period beginning on the 31st business day after the start of the open negotiation period*
- *The initiating party must submit notice to the other party and to the Departments (standard Notice of IDR Initiation) through the Federal IDR portal*
- *The Notice of IDR Initiation must include specific information about the IDR items or services and the QPA (the first IFC requires health plans to provide the QPA to the provider along with each initial payment—so providers have this information if they are the initiating party).*

ACEP and EDPMA oppose a process that requires the provider or facility (when the initiating party) to submit the QPA as though the provider or facility is attesting to its accuracy. If the QPA is to be entered into this process, it should be submitted by the party that calculated it—the health plan or issuer. Asking providers and facilities to be responsible for attestation of the QPA ignores the Departments' statements that the QPA does not need the CPT code for the items or services as billed by the provider. ***ACEP and EDPMA firmly believe the Departments must place the obligation to submit the QPA on the party that is wholly and solely responsible for calculating the QPA and selecting the QPA. Under the guidance already issued, that party is always the plan or issuer.***

The Departments also state the following:

- *The initiating party will identify the preferred certified IDR entity in the Notice of IDR Initiation*
- *The party in receipt of the Notice of IDR Initiation may agree or object to the selection of the preferred certified IDR entity identified in the Notice of IDR Initiation*
- *If the non-initiating party fails to object within 3 business days of the date of initiation of the Federal IDR process, the preferred certified IDR entity identified in the Notice of IDR Initiation will be the selected certified IDR entity*
- *If the non-initiating party objects, the Departments state the party must timely notify the initiating party of the objection (including an explanation for objecting) and propose an alternative certified IDR entity to which the initiation party must agree or object. This must all be conducted within 3 business days of the initiation of the Federal IDR process.*
- *If the parties fail to agree, the Departments will select a certified IDR entity randomly from certified IDR entities, which selection will occur "not later than 6 business days after the date of the initiation of the Federal IDR process"*

ACEP and EDPMA request additional clarification on the process when the non-initiating party objects to the initiating party's certified IDR selection, and subsequently, the initiating party also objects to the non-initiating party's selection. We appreciate that the Departments state that the "initiating party must then agree or object to the alternative certified IDR entity." However, in the event the initiating party rejects the new selection, it is unclear whether the initiating party is allowed or required to make another selection or whether the matter proceeds directly to HHS for random selection of a certified IDR entity under the process laid out in the rules.

The Departments state that:

- *After the selection of the certified IDR entity, the selected certified IDR entity must review its selection to ensure it meets the conflict-of-interest requirement and attest to that* ***within 3 business days <u>of selection</u>***.
- *The certified IDR entity "must also review the information submitted by the parties to determine whether the Federal IDR process applies, including whether an All-Payer Model Agreement or specified state law applies." If the certified IDR entity determines that the Federal IDR process does not apply, the Departments have implemented that the certified IDR entity must notify the Departments and parties* ***within 3 business days <u>of making this determination</u>***.

ACEP and EDPMA request that the Departments require the certified IDR entity to make the determination that a dispute is eligible for the Federal IDR process <u>within 3 business days of selection</u>, the same timeline the Departments have implemented for the certified IDR entity conflict of interest attestation. "Within 3 business days of making the determination" puts no time certain on when this determination must be made. Given the lack of clarity being provided by states and the Departments over Specified State Laws and the cadence of the timelines under both federal and state laws, it is imperative that certified IDR entities are required to make these jurisdictional determinations quickly and efficiently.

Batched Items and Services

As part of IFC Part II, the Departments implement the *No Surprises Act* provisions that allow for batched determinations. In implementing these provisions, the Departments state that, in order to batch items and services:

- *Qualified IDR items and services must be billed by the same provider or group of providers or facility*

The Departments state that it is "the same provider or group of providers . . .if the items or services are billed with the same National Provider Identifier or Taxpayer Identification Number" or TIN. ACEP and EDPMA agree with the Departments interpretation that claims for qualified items and services can be batched if furnished by providers in the same group or at the individual NPI level.

The Departments also require the following elements for batching items or services:

- *The dispute must involve same group health plan or health insurance issuer*
- *The items or services must be the same or similar items or services, defined in IFC Part I as "those items and services that are billed under the same service code, or a comparable code under a different procedural code system"*
- *The items or services must have been furnished within the same 30-business-day period, or the 90-calendar-day suspension period (i.e. 90-day cooling off period for items and services that already completed IDR)*

ACEP and EDPMA believe that the some of the timelines and processes outlined in the statute and rule are confusing and need to be clarified. **In short, the timeline for batching is predicated in statue on a 30-business-day period following the *date of service*, while payment and IDR initiation are predicated on *claims submission/clean claim determination*.**

To explain in more detail and demonstrate the need for clarity in definitions and process, we have created the table below, which lays out an example scenario of similar services (labeled as A-I), that are furnished during a single 30-business-day period running from April 1, 2022 to May 14, 2022.

Each column represents a step in the process laid out in statute and in the IFC that must precede IDR – from the service being furnished, to a claim being determined as clean by the plan, through payment, open negotiation, and then notice of IDR initiation. As can be seen, although the payment or denial of a claim by a plan must happen within 30 calendar days of a claim being submitted, there will be great variability in the timing of that payment or denial within those 30 days due to variability in how long claims submission and clean claim determination will take. The various scenarios (1-5) listed below the table demonstrate how broad a range there can be in dates even while remaining within the timeline laid out in the regulation.

TABLE: Complexity of Potential Batching Timeline

		Variable Delay	Within 30 calendar days	Within 30 business days	After 30 business days	Within 4 business days
	I. Service	**II. Date Service Furnished**	**III. Clean Claim Determination**	**IV. Claim Paid**	**V. Notice of Open Negotiation**	**VI. End Open Negotiation**	**VII. Notice of IDR**
Batching of services furnished within 30 business days	**A**	1-Apr	6-Apr	13-Apr	25-May	6-Jul	12-Jul
	B	2-Apr	9-Apr	14-Apr	15-Apr	27-May	
	C	2-Apr	9-Apr	11-May	12-May	23-Jun	
	D	2-Apr	23-Apr	30-Apr	2-May	13-Jun	
	E	2-Apr	23-Apr	23-May	24-May	5-Jul	
	F	14-May	21-May	28-May	30-May	11-Jul	
	G	14-May	21-May	20-Jun	21-Jun	2-Aug	
	H	14-May	6-Jun	13-Jun	14-Jun	26-Jul	
	I	14-May	6-Jun	6-Jul	7-Jul	18-Aug	

Scenarios:

1. **A:** Timely claim processing both by provider and plan, with longest possible time between claim paid and notice of open negotiation by provider
2. **B, F:** Timely processing both by provider and plan. B-I: Notice of Open Negotiation given almost immediately.
3. **C, G:** Timely processing by provider, longer delay in payment by plan
4. **D, H:** Delay in claim submission by provider, timely payment by plan
5. **E, I:** Delayed claim submission by provider and payment by plan

ACEP and EDPMA therefore urge the Departments to make the following operational clarifications regarding the process in order to avoid confusion about the disposition of some claims relative to their pathway for resolution.

- ACEP and EDPMA seek clarification on the point at which an initiation of batching occurs. We are extremely concerned that the policies implemented by the Departments will prevent claims from being batched that the statute contemplated providers could group together for efficiency and reduced reliance on the Federal IDR process. The Open Negotiation Notice that must precede IDR does not specifically contemplate batching. It is not clear that this is the stage at which qualified items and services must be "batched." If they are batched at this point, it would align negotiations about these claims for similar services throughout the 30-business-day open negotiation period. However, in the table above, we illustrate that if batching occurs at the time of Notice of Open Negotiation, only claims A-E would have been paid by the time of the Notice of Open Negotiation, essentially excluding the claims from services furnished at the end of the 30-day period from an opportunity to be batched.

- Conversely, if batching occurs at the time of Notice of IDR, claims for all services furnished in this 30 business-day period may have undergone payment or denial by the time of Notice of IDR. However, it is unclear if claims for these similar services must have *all* completed the 30-business-day Open Negotiation in order to be eligible for batching. In the table above, In the table above, only claims for services A-F would be eligible for batching if completion of the Open Negotiation is a requirement. Clarification on the timing and eligibility requirements for batching is needed in order to ensure uniform claim processing.

- Since the underlying issue relates in part to clean claims, ACEP and EDPMA would again like to reiterate our strong urging for the Departments to clarify the definition of clean claim. The timing of the submission of the "clean claim" by the provider is not beholden to any clear timeline and therefor holds even greater potential to affect the timing of negotiation and thus IDR for services furnished within 30 business-days. It is common for health plans to delay agreeing that a claim submitted is "clean," despite submission of sufficient information for claim processing. This will inevitably lead to claims being "orphaned" from what should be a legitimate batching group, resulting in either (a) cash flow disruptions to a practice because the claim could end up held in the 90-calendar-day-suspension; or (b) detached from similar claims that would otherwise be able to be batched for Federal IDR, placing unnecessary repeated utilization on the Federal IDR process and costs on the parties.

Payment Determination: Offer Submissions

Regarding the offer submissions, the Departments state that:

- *The offer must be submitted not later than 10 business days after the selection of the certified IDR entity*.
- *The offer "must be expressed as both a dollar amount and the corresponding percentage of the QPA presented by that dollar amount."*
- *Where items and services are batched and have different QPAs, "the parties should provide these different QPAs and may provide different offers for these batched items and services, provided that the same offer should apply for all items and services with the same QPA"*

As stated previously, ACEP and EDPMA oppose forcing a party to a dispute to submit any information to a federally-governed entity as an expression of a number (i.e. percentage of QPA) that, in many cases, that party will believe is illegitimate (either as calculated or as selected) and is a number that is under the sole control of the plan or issuer involved in the dispute, without objective verification or required transparency to all affected parties. Requiring a provider or facility to submit their offer as a percentage of a number that was wholly calculated by the plan/issuer and unilaterally selected by the plan or issuer, is forcing providers and facilities to lend an air of legitimacy to what according to statute was meant to be only one of *many* factors for the arbiter to consider in making a payment determination. Forcing providers and facilities to repeat this information is heavy-handed and unnecessary.

Payment Determination: Selection of Offer

Overview

The Departments state that:

- *Not later than 30 business days after the selection of the certified IDR entity, the entity must select one of the offers submitted by the plan and the provider to be the out-of-network rate for the qualified IDR item or service.*
- *The Departments have stated that in selecting the offer, the certified IDR entity must presume that the QPA is an appropriate payment amount and select the offer closest to it, unless credible information submitted by either of the parties clearly demonstrates that the QPA is "materially different" from the appropriate out-of-network rate, based on additional circumstances. Information is defined as credible if upon critical analysis the information "is worthy of belief and is trustworthy."*
- *The Departments state that a "material difference" exists where there is substantial likelihood that a reasonable person with the training and qualifications of a certified IDR entity making a payment determination would consider the information important in determining the out of network rate and view the information as showing that the QPA is not the appropriate out-of-network rate under such additional circumstances.*

ACEP and EDPMA express our profound disappointment in the unwarranted weight and heightened prominence the Departments have given to the QPA in the Federal IDR process. This is further inflamed by the significantly elevated level of justification (i.e., "materially different standard") required to inform, advise, rebut, or revise the QPA using factors that were specifically included in the statute passed by Congress as mandatory considerations. The approach taken by the Departments is inconsistent with the legislation that was intended to create a fair and unbiased process to resolve billing disputes. The rule is egregiously unbalanced in favor of plans and issuers, who solely produce the QPA, have no functional requirements for transparency related to how they produce the QPA, and no requirement that the payment (or the QPA) even reflects the item or service on the claim that was submitted by the provider. ACEP and EDPMA are profoundly disappointed in this decision, which appears to be a clear attempt to produce an imbalanced system, biased against not only providers, but also seem to be directed at not just resolving payment disputes while keeping patients out of the middle as the law intended, but at expressly engineering payment rates for both in- and out-of-network care in local communities.

With respect to the Congressional intent of the law, ACEP and EDPMA point specifically to its legislative history. In Summer 2019, the Health, Education, Labor and Pensions Committee passed legislation that established a payment benchmark for all out-of-network care that was set at the plan's median in-network rate (S.1895). Similarly, the House Energy & Commerce Committee passed legislation (H.R. 2328) sponsored by Rep. Frank Pallone which also set the reimbursement standard at the plan's median in-network rate, and in a last-minute amendment provided an IDR process for only the highest cost services, those above a $1,250 threshold—putting it entirely out of reach for over 99 percent of emergency physician services. Neither of these bills were ever considered or passed by either the full House or the full Senate. Because there was significant bipartisan opposition to the payment standard and lack of any real dispute resolution process, these bills were never considered on the House or Senate floor.

In February 2020, the House Ways and Means Committee passed its own version of surprise billing legislation which was sponsored by the Committee Chair and Ranking Member. This bill did not establish a payment standard and, instead, created an independent dispute resolution where the arbiter considered all relevant information. This alternative had a great deal of bipartisan support.

The two factions were not able to reach a compromise until December 2020 when end-of-year legislation that was passed by both the House and Senate included compromise language. The compromise clearly provides that there is no payment standard, independent dispute resolution is available for all claims, and the arbiter is required to consider *equally* a list of factors. A press release from Rep. Pallone's committee staff announcing the compromise states *"If the parties choose to utilize the IDR process, both parties would each submit an offer to the independent arbiter. When choosing between the two offers the arbiter is required to consider the median in-network rate, information related to the training and experience of the provider, the market share of the parties, previous contracting history between the parties, complexity of the services provided, and any other information submitted by the parties."*

All in all, ACEP, EDPMA, and many others worked diligently with Congress to ensure the *No Surprises Act* strongly protects patients from surprise medical bills and also provides for a robust IDR process. The intent of the IDR process as passed into law by Congress is to facilitate a fair interaction between parties once patients are out of the middle of billing disputes. ***To achieve this goal, ACEP and EDPMA had specifically requested in our comments on the first IFC that the Departments avoid making the QPA the primary consideration of arbitration during the IDR process. As one can see from the legislative history above, this approach is how Congress intended it under the No Surprises Act, and is consistent with decisions previously made by Congress to avoid or nullify other approaches that would otherwise produce an imbalanced, non-market-driven, or bench-marking solution.***

However, what this rule puts forth is the total opposite. Under the IFC, certified IDR entities must presume that the QPA is an appropriate payment amount. While a certified IDR entity will still consider the other factors listed in the *No Surprises Act*, a party in the dispute must provide "credible information" to the entity related to those factors that clearly demonstrates that the QPA is "materially different" from the appropriate out-of-network rate. Otherwise, the certified IDR entity must select the offer closest to the QPA. These are evidentiary standards and process directives that have no basis in statute.

Consequences of Flawed IDR Policy

ACEP and EDPMA are deeply concerned that by requiring certified IDR entities to over-prioritize the QPA, the IFC as written undermines the entire dispute resolution process created and passed by Congress and produces an affirmative imbalance of legitimate market forces significantly in favor of health plans, without obligatory benefit to any other party. A true solution to surprise bills must acknowledge the role that insurance companies have in these billing disputes and recognize one of the root causes of the issue, which is narrow insurance networks. The Departments must also acknowledge that insurance companies specifically design different products on the basis of underlying networks, such as preferred provider organizations (PPOs), health maintenance organizations (HMOs), and others, which are inherently different by the nature of the breadth and number of providers included in each. It is not appropriate or accurate for the

Departments to assume that providers who are out-of-network are automatically at-fault; the Departments need only look at a single insurance provider to see differences in the provider networks among the plan's products to know that the health plans have had a hand in designing the narrowness or breadth of their networks.

The policy also threatens the viability of physician practices, particularly in small or rural communities, which could lead to *increased* provider consolidation, and even more pressure on hospitals in these essential localities. Note that rural hospital closures continue to rise, with a record-breaking 20 hospitals shutting down last year, threatening access to care for the 60 million Americans who live in these areas. Further, just since the publication of this IFC on September 30, 2021, numerous physician practices have already received unilaterally-initiated termination notices from insurance plans for long-standing in-network agreements, including agreements that currently protect patients in rural and underserved communities. Many of them even cite implementation of the new law as the reason for the changes. This is precisely the consequence that ACEP, EDPMA, and many other provider organizations cautioned the Departments to avoid.

Our members' direct experience – particularly in rural and underserved areas – is that there are substantial, market-driven reasons for rates of payment for services that work to the benefit of patients, hospitals, and communities, if patients are properly protected, and if those factors are allowed to work in a balanced manner. This rule inappropriately disrupts that balance in a manner that is not consistent with the statute passed by Congress.

ACEP and EDPMA are particularly disappointed with the justification provided by the Departments in the IFC for making the QPA the presumptive payment amount in the IDR process. We strongly believe that the specific arguments used by the Departments do NOT fairly and accurately describe the underlying language in the statute or the policies that the Departments implemented in IFC Part I regarding the QPA. Further, when describing the root cause of surprise medical billing, the Departments present an overall bias against health care providers and, more specifically, display a fundamental misunderstanding of how the Emergency Medical Treatment and Labor Act (EMTALA) requirements affect the incentives that health plans and emergency physicians have when negotiating contracts.

We believe that these misinterpretations and flawed assumptions have led the Departments to establish a policy that benefits health plans, including for-profit and publicly-traded health plans, at the expense of health care providers and the patients they serve. They also ignore distortions of market rates that have artificially lowered rates of in-network payment (and thus, median in-network rates) that providers have agreed to accept due to significant pressure by much larger, well-resourced health plans.

Given the numerous flaws and misinterpretations around the policy and the implications these errors hold for the NSA's implementation, ACEP and EDPMA break down the major arguments the Departments include in the IFC and point out some of the greatest areas of concern.

ACEP and EDPMA Rebuttal to Arguments Presented in IFC Justifying IDR Policy

1. **The Departments state that the QPA should be considered first since it represents a "reasonable market-based payment for relevant items and services."[3]**

ACEP and EDPMA strongly believe that the QPA does not represent a reasonable market-based payment for services. In IFC Part I, the Departments made it extremely clear that much of their decision-making process regarding the QPA was focused on the impact the rule would have in reducing patient cost-sharing amounts. To be clear, ACEP and EDPMA believe reducing the financial burden of health care on patients is a laudable goal. However, in utilizing the QPA to achieve this goal, which in and of itself was not problematic, the Departments did NOT ensure that the QPA would be an accurate representation of prevailing market rates for specific clinical services. The first IFC requires health plans to exclude risk sharing, bonuses, or penalties, and other incentive-based and retrospective payments or payment adjustments when calculating median contracted rates, which also artificially reflects lower rates of actual payment. In addition, the market rates are much more fairly represented by actual payments being made to providers for actual services rendered, not by a median of contracted rates, irrespective of the actual utilization of those contracts in the marketplace. We believe that this decision will lead to inaccurate QPAs that are significantly lower than the actual and prevailing payments, including the ultimate, full payments for applicable services. In some contracts, risk-sharing amounts can total 10 to 15 percent of total payments and the underlying fee schedule amount is adjusted downward to reflect the potential for earning such an incentive. Using this fee schedule amount as the QPA will deviate drastically from any representation of a prevailing market rate.

Another methodological flaw in creating a "market-based" approximation is the Departments' decision to set each contracted rate as a single data point when calculating a median contracted rate. Under the IFC Part I, the rate negotiated inside a contract constitutes a single contracted rate regardless of the number of claims that were paid at that contracted rate or the number of providers covered under that contract. In ACEP and EDPMA's comments on the first IFC, we had explicitly recommended a different approach to the Departments for calculating the median contacted rate. Specifically, we had requested that the Departments base the rate on the *total* number of actual payments issued to individually contracted physicians by that health plan. A true "market rate" would reflect the actual volume and frequency of payments on individual claims. Instead, under the method chosen and promulgated by the Departments, the "market rate" is purportedly the median of all rates acknowledged by the health plan/issuer, irrespective of their proportionate representation in the marketplace itself. The Departments' chosen approach is *not* representative of prevailing market conditions. It artificially sets a new standard that is determined by a payor's broad (or narrow) contracting experience irrespective of the frequency of use or applicability of those contracts in that market. In addition, the QPA as reflected is not subject to prior verification and validation, despite its centrality in the entire *No Surprises Act.* Then net effect is a significant imbalance in favor of health plans/issuers, contrary to the clear intention and language in the *No Surprises Act.*

[3] 86 Fed. Reg. 55,996 (October 7, 2021).

2. **The Departments state that the statutory text lists the QPA as the first factor that the certified IDR entity must consider in determining which offer to select. According to the Departments, this specific ordering makes the QPA the most important factor a certified IDR entity should consider.[4]**

While the *No Surprises Act* does list the QPA first, the statute does not in any way state that the QPA should be more important than the additional factors that are listed, let alone that the QPA should be a rate of payment that requires significant effort and disproportionate weight of evidence from the other factors or other evidence to refute. Rather, it simply states that, for the purposes of selecting an offer, the certified IDR entity "shall" consider the QPA AND information in a separate subparagraph. The information included in the separate subparagraph, which is not labeled in the statute as secondary in any way to the QPA, includes:

- The level of training, experience, and quality and outcome measurement;
- Market share held by the provider or facility or the plan or issuer;
- Patient acuity or the complexity of the service;
- Teaching status, case mix, and scope of services of the nonparticipating facility; and
- Previous contractual relationships (demonstrations of good faith efforts (or lack thereof) made by the providers or the health plan to enter into network agreements and contracted rates between the provider and the health plan.)

The statute could not be more clear in terms of what the certified IDR entity must and must not consider—and, through the plain reading of the statute, we strongly believe that Congress did not intend for any one factor to be the presumptive out-of-network payment amount. In addition, the Departments created and introduced a new, unexplainable statutory interpretation standard that would require Congress to consider the order in which they list *any* factors in *any* statute given that the Executive Branch now considers the first listed is the most important and everything that follows the first is of equal weight to each other, but of lesser weight than the first factor. This is non-sensical, and we question the validity of the entire policy given the lengths to which this Departments' provided rationale asks stakeholders to stretch the textual and statutory interpretation of plain language.

3. **Since the additional factors are secondary to the QPA, the Departments state that the certified IDR entity must select the offer closest to the QPA, unless the credible information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate, based on the additional circumstances with respect to the qualified IDR item or service.[5]**

The No Surprises Act does not require parties to use the additional factors solely as a means for proving why the QPA should not be the presumptive out-of-network payment amount. Rather, as plainly written, the statute allows for each factor to be considered independently, and the certified IDR entity must come to its decision after carefully considering the validity of all the information related to the factors that parties put forward.

[4] Ibid.
[5] Ibid.

4. **The Departments state that the *No Surprises Act* sets out detailed rules for calculating the QPA, suggesting that an accurate and clear calculation of the QPA is integral to the application of consumer cost-sharing and to the certified IDR entity's determination of the out-of-network rate. Further, the cost-sharing is based off of the QPA for services eligible for the Federal IDR process, indicating that the QPA is a reasonable out-of-network rate.[6]**

ACEP and EDPMA agree that the *No Surprises Act* does include detailed instructions about how to calculate the QPA, and that it is important to have accurate QPAs since they are used to determine a patient's cost-sharing amount and are one of the factors the certified IDR entity can evaluate. However, we do not believe that it is appropriate or logical to go a step further and argue that having specific rules around the QPA gives the QPA primacy in the IDR process, nor that this QPA as defined in the first IFR is a "reasonable out-of-network rate." The QPA is a new term and construct that was introduced by the *No Surprises Act.* Because the words "qualifying" and "payment" and "amount" did not appear in statute together prior to the enactment of the *No Surprises Act,* nor was QPA yet a term of art for which there was a universal understanding, it is only logical that Congress would have to create statutory text to explain this term in a way that it would not have to do so for words like, "training," or "expertise," or "market share," which are words and phrases for which the general public has near-universal understanding. To state that Congressional description of new terminology is a proxy for that term's importance in a list is illogical and quite frankly, confounding and inaccurate. And as with the previous section, would this create an additional new statutory interpretation standard requiring Congress to give primacy to any items that have more extensive definitions or legislative language devoted to them in statute?

In addition, it is misleading to assert that because cost-sharing is based off the QPA, the QPA is a "reasonable" out-of-network rate. As stated earlier, it was clear from the first IFC that the Departments' primary goal was keeping cost-sharing low --and, by doing so, the Departments ensured that the QPA would NOT be an accurate representation of prevailing market rates for specific clinical services. Further, the *No Surprises Act* goes to extreme lengths to make clear that patient financial obligations are detached from the ultimate payment amount, an explicit acknowledgement that the out-of-network rate would diverge from the QPA.

5. **The Departments state that health plans and issuers must "provide specific information on how the QPA is calculated to providers, ensuring that they (the providers) are aware of how this amount is calculated."[7]**

The Departments imply here that because health plans are required to provide information related to the QPA to providers, that the QPA is a transparent amount that both parties can fully understand. ACEP and EDPMA dispute this assertion for multiple reasons.

First, it is not accurate to state that health plans and issuers have to inform providers about how the QPA was calculated. While it is true that health plans and issuers are required to provide *information* about the QPA to providers, that information does NOT include many details about

[6] Ibid.
[7] Ibid.

the specific components of the QPA that can help providers understand how it was calculated. In IFC Part I, the Departments require health plans to provide the following information to providers along with each initial payment or notice of denial of payment:

- The QPA for each service involved.
- A statement certifying that each QPA was calculated based on the methodology outlined in the IFC.
- A statement that a provider or facility can initiate a 30-day negotiation for purposes of determining the amount of total payment and that if the 30-day open negotiation period does not result in a determination the provider or facility may initiate the IDR process within 4 days after the end of the open negotiation period. The plan must also provide contact information for the appropriate office or person to initiate open negotiations.
- **Upon request** (emphasis added) of the provider or facility, information about whether the QPA includes contracted rates that were not set on a fee-for-service basis, and if so, how the QPA was calculated.
- **Upon request** (emphasis added), a statement that the plan's contracted rates include incentive or other payments that were excluded for purposes of calculating the QPA.[8]

In ACEP and EDPMA's comments on the first IFC, we stated that the degree of disclosure regarding the QPA is severely deficient as a means for identifying potential abuses or for providing important context in both the negotiation and arbitration frameworks. We requested that health plans and issuers provide a significant amount of additional information, including details about how the QPA was specifically calculated. In addition to the disclosures already required under the rule, the following information should be made available by plans and issuers during the initial response to the provider's claim without providers having to additionally request it:

- The type of plan that covers each claim and the dates that each plan has opted into and out of any state laws;
- The resolution pathway that each item or service lives under (i.e., "Specified State Law" or federal IDR process);
- The QPA(s) for the items and services as billed by the provider: Given that these numbers will vary by insurance product, there could be multiple QPAs conveyed for the same CPT code on the same remittance communication from the plan/issuer, which could make it impossible for providers to evaluate the fairness, accuracy, and applicability of a QPA and assess the QPA relative to the initial payment amount made by the plan/issuer if it is not clear what the QPA is for the item or service as billed by the provider;
- The patient's copay, deductible, and coinsurance for each claim;
- Additional information that helps with the valuation of payment amounts should be routinely supplied in an easily accessible, machine-readable, downloadable format, including how the QPA(s) was calculated. Specific information includes:
    - The number of contracts used to calculate the QPA;
    - Whether the QPA was calculated using contracts with clinicians in the same or similar specialty;
    - The geography used to calculate the QPA (i.e., Single MSA, all MSAs in a state, Census Division);

[8] 86 Fed. Reg. 36,898-36,899 (July 13, 2021).

- Percentage of total claims covered by contracts used to calculate QPA (in-network percentage);
- Percentage of in-network claims attributable to each contract;
- Whether the plan or issuer's QPA calculations have had an audit result of anything other than "clean" within the last 3 years;
- If the plan or issuer uses a standard fee schedule, the amount for the service as it appears on the fee schedule for the specific market; and,
- If the plan or issuer uses contracts from a plan year other than January 31, 2019 to calculate the QPA.

Thus, under the current rules, the QPA still is not a transparent amount, as the individual components of the QPA that health plans and issuers use in their calculations do not need to be disclosed to health care providers. Without having detailed information about how the QPA is calculated, it will be extremely difficult for providers to present "credible information" about any of the other factors to the certified IDR entity to successfully dispute the validity of the QPA. Health plans and issuers will always have the advantage in negotiations, since only they have access to the underlying data and information that are used to determine QPAs. They can use those data to dispute any credible evidence that a health care provider tries to put forth during a dispute.

Another example of how the lack of transparency regarding the QPA can put providers at a significant disadvantage during the IDR process is with respect to downcoded claims. If claims are downcoded by payors, the level of service on the claim is unilaterally changed from what the provider documented and submitted as a claim to what the payor prefers. Emergency physicians commonly submit five ED evaluation and management (E/M) codes for payment (Current Procedural Terminology [CPT] codes 99281-99285). An example of a claim downcoded by a payor is the scenario where an emergency physician bills a CPT code 99285 (a level 5 service), but the payor "adjusts" the code on the claim to a CPT code 99283 (a level 3 service).

ACEP and EDPMA appreciate that in this second IFC, the Departments acknowledge that health plans downcode claims and that in these cases, a provider can argue that the QPA does not reflect the acuity of the service delivered during the IDR process.[9] However, in the example provided above where a health plan downcodes a claim from an ED E/M level 5 service to an ED E/M level 3 service—the QPA the health plan would put forth would be for an ED E/M level 3 service. Only the health plan has what would be the specific QPA for an ED E/M level 5 service, but they are not required to share it under the rules established by the Departments. Without this information, it would be extremely difficult for health providers to know what credible information they could provide to certified IDR entities. Further, a provider would not have the information needed to make an offer that was closest to the QPA for a ED E/M level 5 service. In ACEP and EDPMA's comments on the first IFC, we stated that it was extremely important for health plans to provide health care providers with the QPA for the billed service if the claim was downcoded and the QPA selected was based off of a different code. If providers do not have access to that information, it will be difficult or maybe even impossible for providers to be successful in the IDR process for downcoded claims.

[9] 86 Fed. Reg. 55,997-55,998 (October 7, 2021).

Due to this inherent advantage that health plans have in the IDR process for downcoded claims, along with the underlying goal to keep the QPA low for cost-sharing purposes**, health plans will now have even more of an incentive to downcode claims**.

6. **The Departments state that the QPA should reflect standard market rates arrived at through typical contract negotiations and should therefore be a reasonable out-of-network rate under most circumstances. The Departments state that the QPA is generally based on the median of contracted rates, and these contracted rates are established through negotiations between providers and facilities and plans and issuers.[10]**

The Departments state here that because QPAs are the median contracted rates for specific services that they therefore reflect standard market rates. In many cases, a contracted rate does NOT actually reflect the market rate in a particular geographic area. As explained earlier, contracted rates are impacted by a number of factors, including the market share of the health plan and the provider, the unique economic and clinical environment in communities and regions, and penalty and bonus structures that are built into contracts. Health care providers often agree to lower contracted rates in exchange for the reimbursement certainty and administrative efficiencies that come along with being in the health plan's network. In other words, given the complexity of contract negotiations and the various factors that impact the final contracted rates, it is misleading to definitively state that contracted rates represent ultimately reasonable, out-of-network rates.

7. **The Departments claim that anchoring the determination of the out-of-network rate to the QPA will increase the predictability of IDR outcomes, which may encourage parties to reach an agreement outside of the Federal IDR process to avoid the administrative costs and will aid in reducing prices that may have been inflated due to the practice of surprise billing prior to the *No Surprises Act*. In addition, the Departments state that anchoring the determination to the QPA will help limit the indirect impact on patients that would occur from higher out-of-network rates if plans and issuers were to pass higher costs on to individuals in the form of increases in premiums. [11]**

ACEP and EDPMA believe that this statement is representative of the inappropriate tone and bias that the Departments use throughout the rule, as they exclusively blame the underlying issue of surprise billing on providers and repeatedly state that providers choose to be out-of-network in order to charge higher prices at the expense of patients.[12] ***There are two parties in every contract negotiation, and the Departments do not appropriately acknowledge the role that health plans play in causing surprise bills***. There is very little, if any, acknowledgement of the frequent experience of providers of the heavy-handed and highly leveraged tactics of health plans/issuers that have narrowed networks, and kept providers out of networks. In reading the rule, one is left with the impression that providers are exclusively the only decision-maker in determining the composition of an insurer's network, and therefore to blame for these dynamics -- a position to which ACEP and EDPMA specifically and unequivocally object.

[10] 86 Fed. Reg. 55,996 (October 7, 2021).
[11] Ibid.
[12] 86 Fed. Reg. 56,046 and 56,047 (October 7, 2021).

These flawed arguments provided by the Department seem to consistently be leveled only against providers. We are perplexed at the Departments determined efforts to suggest that providers are the only actors in contract negotiations. Even if it is stipulated that providers are making business decisions as a result of negotiations, how can the Departments deem provider reactions to these market forces to be substantially and significantly illegitimate, while simultaneously inferring that somehow the market reactions of well-resourced insurance companies are substantially and significantly legitimate and have no deleterious effect on the costs of health care?

These assumptions are fundamentally flawed and have led the Departments to promulgate bad policy that will not even fix the problem that they are aiming to back into with a statute that was intended only to take patients out of the middle and to provide a fair process for resolving payment disputes between plans/issuers and providers/hospitals. This policy is significantly imbalanced, poses substantial risk going forward to patients and their access to care, and neither reflects the intent of Congress nor the plain language in the statute.

The IFC specifically calls out the role of emergency physicians and EMTALA—arguing that because of emergency physicians' legal obligation under EMTALA, and the inability of patients to make treatment decisions (including by selecting providers) in emergency settings, there are fewer incentives for emergency providers to contract with health plans.[13] In our experience, the EMTALA obligation actually causes *health plans* to be less likely to keep emergency providers in-network. The plans recognize that their policyholders are able to access emergency care regardless of insurance status or ability to pay, and therefore have no real incentive to enter into fair and mutually-agreeable contracted rates with emergency physicians. This is in sharp contrast to providers of many other specialties, who policyholders can research and seek out in advance based on network status.

Although ACEP and EDPMA strongly support the patient protections in the *No Surprises Act*, including the provision that limits cost-sharing for out-of-network emergency services to what patients would have paid if the service were delivered by an in-network provider—we believe that this provision will give health plans even *more* of an incentive to push emergency physicians out of network. Since the cost to patients is the same regardless of whether they received an in-network or out-of-network emergency service, patients will not choose health plans based on which emergency physicians in their area are in-network. Without this being a factor in the patient's decision-making process, health plans no longer need to have *any* emergency physician in-network to be attractive to potential enrollees.

This market dynamic is already playing out since this IFC was released, as EDPMA and ACEP already have members who have had longstanding contracts cancelled without notice or recourse after years of staying at the same reimbursement rate, forcing these emergency physician groups out-of-network. In addition, there have been communications that, in the view of health plans, there is no need to be in-network any longer, an alarming consequence of this imbalanced approach that will have far-reaching implications.

[13] 86 Fed. Reg. 56,046 (October 7, 2021).

Lastly, ACEP and EDPMA dispute the claim that this policy would "help limit the indirect impact on patients that would occur from higher out-of-network rates if plans and issuers were to pass higher costs on to individuals in the form of increases in premiums."[14] This statement implies that if health plans could lower costs, they would pass the savings along to their enrollees in the form of lower premiums. This is simply not true.

In 2020, health care costs to insurers significantly declined as individuals delayed seeking care due to the COVID-19 pandemic. Instead of passing those savings along to enrollees, the health plans instead fully absorbed those cost savings as profits. According to the Kaiser Family Foundation, insurer profits were higher in 2020 than they were in 2019[15]—yet we did not see any decline in premiums.

Even the Departments themselves do not know what effect their policies will have on premiums. In the IFC's Regulatory Impact Analysis, the Departments actually state that that "there is uncertainty around how premiums will ultimately be affected" and present conflicting evidence as to whether premiums will increase or decrease as a result of the policies included in the IFC. ACEP and EDPMA believe that it is irresponsible for the Departments to base a policy decision that appears to be based on an assertion that does not actually have any concrete evidence that supports it.

Overall Request

ACEP and EDPMA therefore call on the Departments to enact changes to the IFC that are necessary to ensure the No Surprises Act is implemented as intended by the clear statutory language and recently articulated by over a hundred and fifty Members of Congress. Specifically, the Departments must revise the IFC and issue immediate guidance to give certified IDR entities the discretion to consider all the allowable and relevant information submitted by the parties to determine a fair out-of-network payment to physicians, without creating a presumption that directs IDR entities to consider the offer closest to the QPA as the appropriate payment amount.

To be clear, our request for the Departments to modify the IFC would NOT delay the implementation of the critical patient protections embedded in the *No Surprises Act*. Rather, with patients protected, our concerns and specific request focus on ensuring fair payments to physicians and a balanced IDR process.

90-Day Cooling Off Period ("90-calendar-day suspension period")

As dictated by the *No Surprises Act,* IDR payment determinations commence the 90-day "cooling off period," now referred to in these rules as the "90-calendar-day suspension period." However, an IDR payment determination does not inform the initial payment for disputed claims during the suspension period. ***Given that the intent of the cooling off or suspension period (and other policies throughout the legislation) is to deter overreliance on IDR, ACEP and EDPMA***

[14] 86 Fed. Reg. 56,059 (October 7, 2021).
[15] Kaiser Family Foundation, "Health Insurer Financial Performance in 2020," 3 May 2021. https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-in-2020/

continue to be concerned that the Departments have not focused 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, especially small group/independent practices in rural and socioeconomically disadvantaged communities, 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 drastically and 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 for a protected period of 90 days after every IDR decision, while reimbursing providers at rates that neglect practices' ability to remain viable, due to fundamental interruptions in cash flow. This imbalance also introduces a dynamic that could drive parties again to IDR after 90 days to resolve these unreasonable payments, further putting pressure on what should be a last resort.

ACEP and EDPMA agree that the clear and reasonable intent of this provision is 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 continue to urge the Departments to enact protections for providers and facilities from unreasonable initial payments from plans during the 90-calendar-day suspension period. We believe this is an important component of the Federal IDR process that must be addressed to ensure that disputes held in the suspension period do not unnecessarily move into IDR after the suspension period ends, and we urge the Departments to address this void in the rules.

We also believe that this has become even more vital in light of provisions included in IFC Part I that would allow a plan/issuer to delay "initial payment" or "denial of payment" beyond "not later than 30 calendar days after the bill for such services is transmitted by such provider or facility" on the basis of whether it is a "clean claim." We believe that these are precisely the types of opportunities to manipulate the timeline that the *No Surprises Act* sought to avoid in its use of time certain terminology in the statutory language.

Because this uncertainty has been injected into the process by IFC Part I, we believe it is critical that the Departments create protections on the back end by enacting protections for providers and facilities from unreasonable initial payments during the required 90-calendar-day suspension period.

We would highlight that it is important that the Departments carry over its sentiment from IFC Part I that "[i]n the Departments' view, the statute's reference to an "initial" payment does not refer to a first installment" and that plans should be making what is reasonably expected to serve as the full initial payment. This is important not only for the financial viability of practices, but it also decreases the likelihood that disputes must access an IDR process for fair and reasonable treatment.

It is critical that the Departments consider this in the context of the 90-calendar-day suspension period when providers and facilities have no ability to use the IDR process to respond to unreasonable plan payments. Small practices and individual providers in particular will be particularly vulnerable to the ability of plans to complicate cash flow for claims held in the 90-calendar-day suspension period. At the very least, ACEP and EDPMA believe that the Departments should take immediate steps to create an explicit standard that they expect all parties to be acting in good faith, and apply clear, significant, timely, and fully enforced penalties to back up the Departments' expectations when that standard is not met.

Protections for the Uninsured: Good Faith Estimates (GFE) for Uninsured and Self-Pay Individuals

ACEP and EDPMA fully support protections for the uninsured and efforts to increase transparency in the pricing and costs of health care items and services. While the statutory language related to the disclosure of GFE to uninsured (or self-pay patients) expresses a clear intent for these provisions to apply to scheduled care, our comments focus on the requirements as they pertain to providers not when care is scheduled, but "upon request" by an uninsured (or self-pay) individual.

First, HHS leans on the existing definition of items or services, which are defined as "*all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees), provided or assessed in connection with the provision of health care*." This appears to provide no exception for emergency services under these provisions (if a GFE is requested by an uninsured or self-pay individual).

Second, HHS defines a health care provider in this context as "*a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, including a provider of air ambulance services*." There appears to be no exception for emergency care under this definition (if a GFE is requested by an uninsured or self-pay individual).

Third, HHS defines a "convening provider" or "convening facility" as "*the provider or facility who receives the initial request for a good faith estimate from an uninsured (or self-pay) individual and who is or, in the case of a request, would be responsible for scheduling the primary item or service*." While there is no explicit exception for emergency services, ACEP and EDPMA request explicit clarification that because there is no person or entity that "schedules" emergency services the way that other services can be "scheduled," that the Departments believe that there is no

"convening provider" or "convening physician" in the event of a "request" for a GFE to an emergency department or emergency department practitioner.

EDs across the country occasionally receive inquiries regarding anticipated costs for services that may be delivered in the emergency department. However, a typical patient, while appropriately curious about ultimate cost, may not be able to understand the medical, legal, and regulatory complexities involved, and may also be unable to articulate the clinical scenario that drives the requirements for high-quality clinical care inherent in the request.

In most cases, an accurate estimate of cost of diagnostic and therapeutic care is not possible in advance because a patient's condition is not specific enough, is clinically undifferentiated (versus fully diagnosed), and most importantly, differs significantly from scheduled care for a pre-diagnosed conditions that are not subject to the legal requirements of Emergency Medical Treatment and Labor Act (EMTALA).

EMTALA requires hospitals to provide a medical screening examination to every individual who "comes to the emergency department" seeking examination or treatment. The requirements of EMTALA are mandatory and are unaffected by in-network or out-of-network insurance status or payment considerations. In fact, EMTALA stipulates that a hospital may not place any signs in the emergency department regarding prepayment of fees or payment of co-pays and deductibles which can have the chilling effect of dissuading patients from seeking care. To do so could lead patients to leave prior to receiving a medical screening examination and stabilizing treatment without regard to financial means or insurance status, which is a fundamental condition for satisfying EMTALA. If a patient calls to request a GFE for emergency services, and we attempt to get pricing information to patients (i.e., verifying that they are uninsured for purposes of the GFE requirements), not only would this violate the spirit of EMTALA, but it could also potentially cause the patient's health to deteriorate since it could delay the patient from receiving needed care. The last thing we want to do is put our patients in a position of making life-or-death health care decisions based on costs.

While EDs and ED staff strive to provide patients with transparency in order to encourage appropriate access to care, for purposes of complying with federal regulation, ACEP and EDPMA believe it is imperative that HHS make a clear distinction in the requirements for emergency departments, including that the requirements (including the timelines) that apply "upon request" are not applicable in the emergency department or for an emergency department practitioner for a GFE by an uninsured or self-pay individual. Without clarification, state enforcement entities or HHS could construe the rules as written to apply to EDs and ED practitioners when a GFE is requested by an uninsured or self-pay individual, even though the recipient of the request would have no way to provide an accurate estimate in light of an appropriate assessment of the individual's health care needs and federal EMTALA requirements (including regarding inquiring about insurance status and other issues).

Thank you for the opportunity to provide feedback. If you have any questions, please contact Laura Wooster, ACEP's Senior Vice President of Advocacy and Practice Affairs at lwooster@acep.org, or Elizabeth Mundinger, EDPMA's Executive Director at emundinger@edpma.org.

Sincerely,

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