MEDICAL SOCIETY OF THE STATE OF NEW YORK
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Joseph Sellers, MD, President

May 28, 2021

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

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

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

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on the No Surprises Act

Dear Secretary Becerra, Secretary Yellen, Secretary Walsh and Administrator Brooks-LaSure:

I write to offer recommendations from the Medical Society of the State of New York (MSSNY) on key issues interpreting the No Surprises Act, which was passed into law as part of the Consolidated Appropriations Act, 2021 (P.L. 116-260) after a multi-year bipartisan and bicameral effort to protect patients and resolve payment disputes between insurance plans and healthcare providers in a balanced fashion. It is our understanding that, by July 1, 2021, agencies must establish through rulemaking the methodology a health insurer must use to determine the "qualifying payment amount" (QPA), the information to share with nonparticipating providers when making determinations; the applied geographic regions (consulting with the National Association of Insurance Commissioners); and the process to receive complaints. Please consider these comments.

QUALIFYING PAYMENT AMOUNTS

Markets

We urge that the federal regulations exclude Medicaid (both fee for service and MCOs), Medicare, and Medicare Advantage rates from calculations of the commercial QPAs so as to ensure appropriate data sets used in determining median in-network rates. In addition, federal regulations should include self-funded plans as part of the commercial QPAs, inasmuch as these plans are part of the markets sought to afford protections under the No Surprises Act. Furthermore, there should be transparency in how markets are determined in order to enable predictability of payment and enforcement.

To ensure the most precise calculations for QPAs, "geo-zips" should be used to define a particular geographic area for a QPA, given that even within metropolitan areas there can be wide variability as to the costs (rent, for example.) for practicing in that area that could affect payments. If the geographic areas cannot be defined by geo-zip", at the very least such regions should be calculated based upon the Market Geographic Rating Areas as recommended by the National Association of Insurance Commissioners. Where there is insufficient plan data to determine a QPA for a specific item or service, the plan should be required to use data from an independent claims database that includes data from the same geographic region (to the extent possible) and from the other plans in the same market (self-insured, fully insured, etc.).

Median Contracted Rate/QPA Calculation

The median contracted rate should be determined based on the contracted rate for *each* individual provider (each individual provider's rate is a single datapoint in a data set.). It is imperative that group contracts not be treated as a single datapoint in the data set used for the median calculation.

Moreover, to ensure accuracy for in-network rates used to establish the medians, it is essential to consider such rates by provider type (e.g., broken down by physician, NPs, CRNAs, etc.) and by specialty of the physician delivering the health care service (and subspecialty if possible). Education, level of training, and provider type are all important factors in contracting and determining in-network payment.

Furthermore, it is important that in-network rates used to establish medians be as specific as possible as to the type of item or service, down to the CPT family level, taking into consideration the "level of care" and other similar factors.

CMS should offer guidelines (and enforcement) on calculating the QPA for plans temporarily leaving and returning to the market, changes in a product's name, and other such actions that may be used to inappropriately alter the way the median in-network rate is calculated.

Transparency/Sharing Info with Providers

Insurers should be required to notify physicians of the recognized amount, and by default the QPA, when receiving cost-sharing totals (initial billing process) within 30 days. Furthermore, CMS should specify that additional information is to be shared when cost-sharing information is provided, including how the QPA/recognized amount was determined and what median in-network rate was used, the types of providers/specialties are included in the determination, and how the service was grouped (in terms of same or similar item or service).

Opportunity for Physician/Provider Complaints

Federal regulations should secure an opportunity and process for physicians to initiate a complaint associated with the initial payment amount (for example, if it is unreasonably low), whether initial payment is being paid directly to the physicians, and other similar issues associated with the initial billing process. Federal rules should provide clarity as to where physicians are to go to file a complaint for federally regulated plans.

Audit Process for QPA

The No Surprises Act requires that a process be established by which group health plans and health insurance issuers are audited by the Secretary or the State to ensure (a) compliance w/ requirement

of applying a qualifying payment amount and (b) qualifying payment amount satisfies payment amount. Specifically, we recommend that:

- Audits be conducted regularly as well as initiated because of complaints by physicians. Moreover, we would urge that the audits initiated as a result of complaints are not included in the required (maximum of 25 per insurer) audits under the statute.
- The audit process should include a comparison of QPA calculated using independent data (such as data from FAIR Health) to those being calculated by individual plan/product being audited to determine appropriateness/accurateness of plan's QPA.
- The audit results should be made publicly available.
- There should be fines or other remedies for noncompliance with audits.
- There needs to be a clear enforcement plan when payors are in violation of QPA calculation requirements.

INDEPENDENT DISPUTE RESOLUTION SYSTEM

New York's IDR system has worked exceptionally well in expeditiously resolving disputes at a relatively low cost, ensuring that physicians are not disincentivized from bringing disputes. This is tremendously important as one of the guiding principles in establishing New York law was preventing against indirect consequences relating to the availability of on-call specialty care in our hospital emergency departments. We are very concerned that a costly, complex IDR system will naturally favor deep-pocketed health insurance companies and would in effect create an incentive for health insurers to make underpayments to physicians when disputes arise.

New York is an example of a streamlined, efficient process, where the process only costs a few hundred dollars to submit a claim and does not require any in-person component. An online portal should be made available for submitting documents. A transparent IDR fee schedule should be publicly available. We very much want to ensure that a similar simple process is developed under the federal law.

Selection of IDR Entities and IDR Compliance

Like New York, IDR entities should be accredited and have physician medical directors to ensure appropriate health care expertise and fairness in resolving these disputes. The arbiters used by the IDR entities should have experience in medical coding and billing. Furthermore, IDR entities and arbiters should have no affiliation with any payer or provider organizations, and there should be transparency around the IDR entity selection process to ensure nonbiased entities and arbiters. Moreover, federal rules should follow New York's model by requiring that decisions be "made in consultation with a neutral and impartial licensed reviewing physician in active practice in the same or similar specialty as the physician providing the service that is subject to the dispute" (cite?).

A process should be in place for parties to issue complaints regarding an IDR entity (such as bias, not appropriately weighing factors, etc.). IDR decisions should be regularly audited to evaluate compliance with NSA IDR requirements and nonbiased nature of decision making.

Batching Claims

Federal rules should permit claims to be batched at the CPT code family level for the IDR process. Moreover, physicians in the same practice/group should be permitted to batch their claims for IDR and bring a single claim together.

Other Information to be Submitted to IDR Entity

We recognize that the physician's out-of-network rate, the "usual and customary" charge for the area and public program rates may not be submitted to the IDR to support either party's offers. However, we believe that these provisions do not prohibit the introduction of a range data from the Fair Health database that may affect the evaluation of a particular claim.

The No Surprises Act statutory language appears to expressly prohibit the billing physician's usual and customary charge as well as the amount the physician would have billed had relevant provisions of the No Surprises Act not applied (i.e., if the limits and protections of the No Surprises Act did not apply to the bill at issue). Specifically, the No Surprises Act language states:

> In determining which offer is the payment to be applied with respect to qualified IDR items and services furnished by the provider or facility, the certified IDR entity with respect to a determination shall not consider ***usual and customary charges or the amount that would have been billed by such provider or facility*** with respect to such items and services had the provisions of [this law] not applied."

(PHSA Section 2799A-1(c)(5)(D) (emphasis added)). The language on its face reads to limit what the particular provider's usual and customary charge would be, as well as what the provider would have billed absent the law. However, the statutory language does not clearly prohibit a provider from submitting – or the IDR from considering – generally applicable usual and customary rates from other physicians. Accordingly, the statute does not prohibit information from being offered for IDR consideration regarding ranges of charges in that particular geo-zip (for example, detailing what the charge for that geozip would be from 40^{th} – 60^{th} percentiles) as long as it does not refer to a single data point related to the particular physician's usual and customary charging practices or the charge the physician would have billed had the No Surprises Act not applied.

Moreover, physicians should be able to submit information to supplement any contracting history information, such as clarification as to why a contract terminated or was not entered into (e.g., lack of prompt payment, increasing administrative requirements, undesirable contract clauses).

Sharing Contracted Rates

Parties may submit contract information, potentially with other parties, to support their offers. Additional clarity is needed to ensure that providers can share contracted rates with IDR entity and if this information can be shared among all parties.

Weighing Factors During IDR Consideration

It is critically important that the IDR entity weigh all factors submitted by the parties equally. We are extremely concerned regarding undue weight being given to the QPA, especially given that it is based on data from a single payer. Overvaluing the QPA will lead to a more imbalanced system and provide a strong disincentive to providers to use the IDR and payers to offer fair contacts.

Ensure Accuracy of QPA as Part of IDR Submission

The IDR should have access to all information needed to ensure the accuracy of the QPA. The QPA submitted by plan should be validated as part of IDR process.

IDR Timelines

There is a need for physician education and resources on timelines leading up to IDR and during IDR. We hope CMS will create such resources for physicians and other providers.

Questions on IDR Scope

Should the plan deny coverage for a claim (either based on coverage or medical necessity), our reading of the statute is that such a denial removes the claim from the protections and requirements of the NSA. However, a health plan disputing aspects of the health care services that was delivered should be decided by the IDR process if some portion of the claim would be covered.

We further note that, it is imperative that regulators monitor denials in this context to ensure that plans are not using "denials" to circumvent the NSA process and shift costs onto patients and physicians.

Cooling Off Period after IDR

As mentioned above, access to a fair IDR system is imperative for making sure that our emergency departments have needed on-call specialty care. Therefore, the agencies must ensure a narrow definition of which entity is subject to the "cooling off period". To that end, federal rules should require that the "cooling off period" be applied at the product level, rather than at the plan or company level. Many large insurance companies have multiple products in a market. Most markets across the country are already dominated by one or two health insurers.

Furthermore, CMS should clarify that claims during the 90-day cooling off period can be batched (30-day batches) and potentially brought to IDR. Also, additional clarity is needed as to how statutory timelines apply to these claims.

We further recommend that federal regulators establish a process for physicians to easily file complaints (and appropriate remedies) regarding plan abuses during the 90-day cooling offer periods knowing that a claim cannot be brought (such as making low initial payments, application of cooling off period to other products, holding of claims, etc.)

APPLICABILITY OF STATE LAW

New York's surprise medical billing law, enacted in 2014, has been regularly lauded as an example of a successful comprehensive law that has protected consumers from surprise medical bills while also providing a balanced and simplified dispute resolution system for resolving physician-health plan and hospital-health plan disputes. To that end, a September 2019 report from the New York Department of Financial Services noted that its law had resulted in New York patients saving more than $400 million with respect to the receipt of emergency care services. Therefore, we appreciate that the No Surprises Act protects these comprehensive laws by including provisions that defer to a "specified state law" that establishes "a method for determining the total amount" that should be paid to an out-of-network physician by the insurer.

Given this documented success, we urge that the federal regulations specify that New York's and other comprehensive state laws should continue to be applicable to address disputes that arise under state-regulated health plans. In addition, federal rules should further clarify that these demonstrated

comprehensive and successful state laws can be applicable to resolve the disputes that arise from patients covered through self-insured health plans.

CONCLUSION

We greatly appreciated the opportunity to offer these comments. We are happy to discuss any of these comments, or any other questions or thoughts you or your teams may have. Thank you very much for your consideration of our recommendations.

Respectfully submitted,

Joseph Sellers, MD
MSSNY President