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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G 200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on the Interim Final Rule Implementing the No Surprises Act

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the Interim Final Regulation (IFR) to implement portions of the No Surprises Act (NSA). Overall, the Medical Society of the State of New York (MSSNY) supports the IFR insofar as it furthers a consumer protective agenda. Nevertheless, we have some concerns regarding the calculation of the Qualifying Payment Amount (QPA), information given to physicians about the QPA, and the notice and consent provisions. Most importantly, we urge you to consider in future regulations that the Independent Dispute Resolution (IDR) process will not impact consumer cost-sharing and should accurately reflect fair market conditions, including consideration of a broad range of information that is not pre-weighted such as data regarding other physicians' usual and customary charges.

The IFR's Pro-Consumer Choices

MSSNY supports choices reflected in the IFR that protect consumers from surprise bills from out-of-network physicians and other providers. First and foremost, we appreciate that the IFR as drafted includes certain components to the definition of QPA that keeps our patients' cost-sharing obligations artificially low. This will help consumers out-of-pocket expenses in surprise billing scenarios, especially those patients with high deductible plans. In addition, we are grateful that the IFR sets forth standardized notice and disclosure documents. The IFR further provides for a broader complaint process by which regulators will receive complaints regarding violations by health plans of all the consumer protections and balance billing requirements. Perhaps most importantly, we appreciate the IFR provisions to ensure enforcement of the "prudent layperson" standard and other protections impacting upon the delivery of emergency care, particularly given the actions of some health insurers which have sought to deny coverage for the emergency stabilizing care provided in hospital emergency departments.

Calculation of the QPA

While we support the consumer-oriented choices in the IFR, we have several concerns regarding how the Qualifying Payment amount (QPA) has been proposed to be determined. To begin with, we are troubled by the fact that the definition of "Median contracted rate" considers an individual contract as a datapoint in the median calculation, rather than individual physicians or other providers representing

datapoints. A contract with a group with 100 physicians will be considered equally with a contract with a group of 2 physicians. Moreover, the IFR fails to give weight to the number of claims/services provided under the contract. We are troubled that this definition will skew the QPA in favor of smaller contracts representing fewer physicians which will, in turn, likely have an arbitrary depressive impact on the QPA that does not truly represent the market.

We are also concerned with abusive tactics used by health insurers to process claims that will have the effect of depressing the QPA. Specifically, the IFR may encourage health insurers to "down-code" services, so that the QPA will be based on a down-coded claim, not the claim that was submitted for payment. Health insurers should calculate separate median contracted rates for CPT code modifiers that distinguish the professional services component from the technical component. Where a plan's contracted rates otherwise vary based on applying a modifier code, the plan or issuer must calculate a separate median contracted rate for each such service code-modifier combination.

We are further concerned that the IFR permits sponsors of self-insured group health plans to allow their Third Party Administrators (TPA) to determine the QPA for the sponsor by calculating the median using the contracted rates from all self-insured group health plans administered by the TPA. As a practical matter, we are concerned that TPAs and payers will be continuously able to calculate QPAs based on the most favorable "formula" for them using provider rates that may not be in their network.

Additionally, we are troubled by the likelihood that, where payment is not fully on an fee for service basis, the plan will calculate a median contracted rate using the underlying fee schedule rates, and not include bonus or other supplemental payments that are incorporated into the contract, This is one more way that the QPA calculation will misrepresent the median rate. Moreover, it could have the long-term impact of threatening movement toward APMs when plans are discouraged from offering fair underlying fee schedules.

Information Transmitted to Physicians About QPA

In addition to the above, we are concerned that the IFR only provides for minimal information to be provided to the physician from the plan about the calculation of the QPA/recognized amount and how patient cost-sharing is determined. Therefore, because physicians and hospitals have direct contact with the patient regarding cost-sharing, it is important that they have information related to the calculation of cost-sharing including:

- The method to calculate the in-network cost-sharing amount under the plan's terms
- Where the patient is in their deductible
- Where the patient is in their out-of-pocket maximum
- The Advanced Explanation of Benefits (AEOB)

As noted above, the physician should be provided all relevant data related to the calculation of the QPA:

- Whether the QPA is based on down-coding of the original claim, why the claim was down-coded, and what the QPA would be for the item or service had it not been down-coded.
- Information pertaining to the use of modifiers in calculating the QPA and what modifiers were used.
- Information pertaining to the use of bonuses and other supplemental payments paid to providers within the payers' networks.
- The number of contracts used to determine the median as well as the number of providers represented by those contracts.

- The types of specialties and subspecialists that have contracted rates included in the dataset used to determine the QPA.

Notice and Consent

We have several questions regarding the notice and consent provisions of the IFR. If notice and consent are provided/received, does the IFR require any payment to provider? Does the plan recognize assignment? We urge that, in these out of network situations, the plan should be required to recognize assignment and payment made directly to physician.

Regarding the Good faith estimate (GFE) with the notice and consent to be provided to the patient, there is further clarity needed how this will interact with the GFE submitted to the payer for the purposes of generating the advanced EOB? The GFE for notice and consent need only include the services to be provided by that provider. So, could the patient receive multiple GFEs? What will it mean for patients to receive a GFE from the physician (likely based on charges) and then an advanced EOB later with their cost-sharing with different numbers?. (Serves to potentially undercut patient-physician relationship, leave patient confused and dealing with different estimates, etc.). These intersecting scenarios need greater clarity.

We further have concerns that much of the information will be difficult for provider to obtain, especially given there is no existing contract with the patient's plan.

Audit Process

We are concerned that the IFR provides only a minimal outline of the audit process. Specifically, it includes a provision establishing HHS's existing enforcement procedures with respect to ensuring that a plan or coverage is in compliance with the requirement of determining and applying a QPA. However, it notes that it will set forth its enforcement mechanism through future notice and comment rulemaking. We reiterate that the audit process will be even more critical given the potential for abuse in calculating the QPA as noted above.

Initial Payments

There is greater clarity needed to address a number of situations that could impact the initial payment. The first such situation is where a plan suspects that notice and consent were not properly given and/or received, which the IFR provides that a plan can unilaterally adjust cost sharing and reprocess the claim. Our questions include: How will this communicated to the provider? How will this be communicated to the patient? What is the appeal process? Are NSA processes then available? We would argue that the burden should be on the plan to prove improper notice and consent prior to making an adjustments in cost-sharing.

Regarding the reference to a "clean claim", there is clarity needed on what information is needed to decide the claim for payment. What process will be used to transmit information on notice and consent? There is need for processes to prevent abuse by plans for denials/delays based on insufficient information

Regarding Claim Denials, there is clarity needed on the reasons for a denial that would still trigger the NSA processes. The example given is when the deductible is greater than the recognized amount. Our understanding is that a denial that stays within the NSA structure is essentially just a situation where the plan determines they have no additional financial responsibility for the claim given the patient's deductible or cost-sharing requirements. Clarity is needed that a QPA would still be provided

with denial, as well as all other information. Furthermore, clarity is needed regarding how an adverse benefit determination interacts with the NSA.

Impact on Access to Care

Protecting consumers is at the core of our shared interest. The concerns about the IFR raised above, particularly regarding the QPA calculation, pose a risk of negative impact on access to care. Many hospitals and other providers rely on out-of-network specialists to cover care, including emergency and urgent care as well as complicated procedures. This is particularly true for rural and urban areas with unmet needs. If the QPA is fundamentally unfair to physicians, we may see coverage and access to care issues particularly in hospital emergency departments as it may not be feasible for some out-of-network physicians to continue to take call for patients. This was a critical public health aim that the New York law sought to address. Access to care will be even more important in the upcoming regulations addressing the IDR process. It is therefore even more imperative that the IDR reflect market realities, particularly inasmuch as the IDR will not directly impact consumer cost sharing.

Next Steps

Given all of the concerns discussed above, particularly regarding the QPA, we urge you and your team to consider the following with respect to the IFR and especially the next round of regulations addressing the IDR process:

- **No Weighting**. The QPA should not be weighted more than any other factor by the IDR entity when picking a party's offer and that no directions are given to the IDR entity to do so.

- **Fair Datasets**. Payers and TPAs should not be given the option to pick their contract dataset.

- **Information Disclosure**. Health plans should be required provide the IDR entity information on the following, when applicable:

    - Whether the QPA is based on down-coding of the original claim, why the claim was down-coded, and what the QPA would be for the item or service had it not been down-coded.
    - Information pertaining to the use of modifier in calculating the QPA and what modifiers were used.
    - Information pertaining to the use of bonuses and other supplemental payments paid to providers within the payers' networks.
    - The number of contracts used to determine the median as well as the number of providers represented by each of those contracts
    - The types of specialties and subspecialists that have contracted rates included in the dataset used to determine the QPA.

- **Contracting History**. Information related to contracting history is extremely relevant and should be allowed to be considered.

- **Other Contracted Rates**. Physicians and other providers should be allowed to submit other contracted rates, including ranges of Usual and Customary Rate data for the area where the care is delivered recognizing that the provider's usual charge cannot be considered.

- **QPA Data to Physician**. The underlying data used by the health plan to determine QPA should be provided to the physician.

We greatly appreciate the opportunity to express our support and concerns with the IFR. And we are grateful to voice our concerns about future NSA regulations. MSSNY endorses the goal of this far-reaching law to provide greater protection and certainty for our patients when unexpected medical care is needed. We ask you to consider the potential unintended consequences to our health care system and access to care for our patients as these regulations are developed to ensure it is balanced. Thank you very much for your attention to our comments.

Sincerely,

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