



August 31, 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: *CMS-9909-IFC— Requirements Related to Surprise Billing; Part I; Interim Final Rules with Request for Comments*

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 I*.¹

¹ 86 Fed. Reg. 36,872 (July 13, 2021).

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 and the District of Columbia.

ACEP and EDPMA have long advocated strongly for a comprehensive solution to addressing surprise medical billing (SMB), working with members of Congress to make sure that any such legislation would truly keep patients out of the middle of billing disputes, include fair payment mechanisms that ensure adequate reimbursement for out-of-network services, and promote a sustainable emergency care system. We believe that the *No Surprises Act* represents a reasonable solution to this issue, and we support the patient protections embedded in the law.

The Departments have announced that the *No Surprises Act* will be implemented in stages, and this IFC represents the first of a set of regulations. We note that a second IFC is expected to be released shortly, which will focus mainly on the independent dispute resolution (IDR) process. ACEP and EDPMA sent a [letter](#) to the Departments on August 10, 2021 in anticipation of that second rule outlining our input on the IDR process and specific considerations that we hope the Departments will take under advisement as it finalizes the rule.

ACEP and EDPMA offer the following set of comments on the first IFC, broken up by the various sections of the rule. Our comments reflect the unique perspective of emergency medicine clinicians and their groups who provide acute, unscheduled emergency care. While we provide specific input on many of the interim final policies included in the rule, we first want to first highlight four key issues that we expand on further in the letter:

1. **Calculation of the Qualifying Payment Amount (QPA):** *ACEP and EDPMA are concerned that the methodology the Departments instituted for calculating QPAs will produce QPAs that do not accurately reflect market rates.* In our comments, we point out inconsistencies and flaws in particular aspects of the methodology, and by doing so, demonstrate why we believe that the QPA if so calculated will not be a fair nor representative metric in arriving at the final amount that is ultimately paid to the provider. *As a result of this, we encourage the Departments to ensure the QPA is not made the primary consideration of arbitration during the IDR process.*
2. **Specified State Law:** *ACEP and EDPMA urge the Departments to require that each state, prior to each calendar year, report to them whether or not it has a qualifying state law, and if so, for which items and services the state law applies. The Departments should maintain an inventory of state laws and make that information publicly available.* Transparency is key to avoiding confusion about whether state or federal law applies.

We also believe that the Departments should clarify that, when applying the federal three-part test to a state law, *it is the law of the state where the patient was located when services*

were rendered. The Departments should require plans to indicate whether the claim was processed under a state law or federal law using a process that we specify in our comments. There should also be a quick, inexpensive, and independent dispute resolution when there is a disagreement over whether the correct law was applied to the claim. Furthermore, the Departments should state that an item or service is not considered covered by state law unless it is covered under *all* circumstances. For example, if the state law only covers an item or service above or below a monetary threshold, federal law should apply.

In addition, we have concerns about allowing Employee Retirement Income Security Act (ERISA) plans to opt-in to state laws and believe that there should be strict limits on when they are allowed to do so—including requiring them to submit their data that is relevant to the state benchmark or state IDR factors into the database used in that state. *Finally, we do NOT think that the Departments should allow any health plans, clinicians, or health care facilities who are not subject to state law to opt in—especially on an episodic basis.*

3. **Information on the QPA that the Health Plan Must Share with Health Care Providers:** In the IFC, the Departments state that they seek to ensure transparent and meaningful disclosure about the calculation of the QPA while at the same time minimizing administrative burdens on health plans and issuers. *ACEP and EDPMA believe that the degree of disclosure regarding the calculation of the QPA is severely deficient as a means for identifying potential abuses or for providing important context in both the negotiation and arbitration frameworks.* In our comments, we list out additional information that should be made available by health plans and issuers without having to additionally request it during the initial response to the provider’s claim. *This level of transparency will help ensure that all statutory timelines are met.*

4. **Additional Plan Requirements Regarding Making Initial Payments or Providing a Notice of Denial:** Under the *No Surprises Act*, health plans and issuers are required to send “an initial payment or notice of denial of payment” not later than 30 calendar days after a nonparticipating provider or facility submits a bill. *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.’* We are very concerned that without a clear definition of clean claim, health plans or issuers will be able to pend accurate claims without good reason, forcing patients to remain “in the middle” of a time-consuming dispute. *Therefore, ACEP and EDPMA 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.*

We also point out other practices and policies that health plans and issuers use today to deny, pend, and downcode emergency claims based on diagnosis lists—all of which we believe violate the Prudent Layperson Standard (PLP). We **greatly appreciate and strongly support** the language included in the IFC that reinforces the PLP when a claim is denied based on diagnosis. However, we were disappointed that the IFC did not also mention downcoding based on diagnosis. *We ask that the Departments address this*

practice in the rule by explicitly and expressly prohibiting instances where plans downcode emergency claims based on diagnosis.

Sections of the IFC

- [Definitions](#)
- [Determination of the Cost-Sharing Amount and Out-of-Network Rate](#)
- [Specified State Law](#)
- [The Calculation of the Qualifying Payment Amount \(QPA\)](#)
- [The Information on the QPA that the Health Plan Must Share with Health Care Providers](#)
- [Audits](#)
- [Additional Plan Requirements Regarding Making Initial Payments or Providing a Notice of Denial](#)

Definitions

In the IFC, the Departments define numerous terms and request comments on their appropriateness and usability. A physician or health provider is defined in the IFC as one that is acting within the scope of practice of their license of certification under applicable state law. The terms “Emergency medical condition,” “emergency services,” and “to stabilize” generally have the meaning given to them by the Emergency Medical Treatment and Labor Act (EMTALA). As emergency physicians, we provide patients with emergency medical care regardless of their insurance status or ability to pay—and therefore strongly support the patient protections embedded within the EMTALA requirements.

The IFC definition of emergency services includes post-stabilization services provided after the patient is moved out of the ED and admitted to the hospital--unless certain conditions are met. The main condition is that the emergency physician or treating provider has determined that the patient is able to travel using non-emergency medical transportation to an available participating provider or facility located with a reasonable travel distance (taking into consideration the individual’s medical condition.) *ACEP and EDPMA acknowledge that the post-stabilization requirements in the IFC align with those included in the No Surprises Act. However, we do note that these requirements do not correspond to how emergency physicians typically treat and handle patients after they are stabilized. Therefore, additional guidance may be necessary in order for emergency physicians and hospitals to understand how to most appropriately comply with the requirements.*

Furthermore, we believe that the Departments need to evaluate the definition of “post-stabilization” in the context of a single emergency care “visit.” The Departments include a specific definition of “visit” in the IFC and seek comment on the scope of services that should be included in a single visit. Patients, especially those with mental illnesses, can remain in the ED for hours or even days due to the lack of available inpatient beds or space in other facilities where the patient could be transferred—a phenomenon known as “ED boarding.” Unfortunately, ED boarding has increased dramatically in this latest surge of the COVID-19 public health emergency. Since some patients who are stabilized have to remain in the ED (unless they can be discharged directly home) for hours or even days, it is unclear how to know exactly when a single emergency care visit ends.

Given this current state-of-affairs, it will be important for the Departments to issue additional guidance around their definitions of post-stabilization and visit.

The Departments also discuss the role that urgent care centers play in providing care to patients and seek comment on the degree to which people may be using urgent care centers in a similar way to how they use independent freestanding emergency departments (FSEDs). ACEP and EDPMA note that there are differences between the care that is typically provided in independent FSEDs versus the care delivered in urgent care centers. First, independent FSEDs are licensed and regulated by certain states to provide emergency care and are staffed 24 hours per day, 7 days per week by board certified emergency physicians and other emergency clinicians. The majority of urgent care centers are not licensed nor regulated by states, are not covered under EMTALA, are not required to be open 24 hours, 7 days a week, and are not generally staffed by emergency physicians and other emergency clinicians. Further, urgent care centers frequently must transfer patients with emergency and other more serious presentations to EDs due to a lack of appropriate staff, adequate diagnostics, pharmaceuticals, equipment, and available resources. Therefore, in many cases, urgent care centers are not providing true “emergency services” like hospital-based EDs and independent FSEDs do.

Determination of the Cost-Sharing Amount and Out-of-Network Rate

Out-of-network rate

Under the IFC, the health plan or issuer must make a total payment equal to one of the following amounts, less any cost-sharing paid by the patient: (1) an amount determined by an All-Payer Model Agreement; (2) if there is no such All-Payer Model Agreement, an amount determined by a specified state law; (3) in the absence of an All-Payer Model Agreement or specified state law, if the plan or issuer and the provider or facility have agreed on a payment amount, the agreed on amount; or (4) if none of those three conditions apply, and the parties enter into the IDR process and do not agree on a payment amount before the date when the IDR entity makes a determination of the amount, the amount determined by the IDR entity.

These requirements may result in circumstances where a plan or issuer must make payment prior to an individual meeting their deductible (i.e., high deductible plans). The rule provides the following example: if the recognized amount is \$1,000, but patient is in a high-deductible plan with \$1,500 deductible. The out-of-network rate winds up being \$1,500. The patient still only pays \$1,000 and the plan must pay \$500 (even though patient under current rules would have had to pay all \$1,500). ***ACEP and EDPMA support this policy as we believe that it helps protect patients in high-deductible plans from large cost-sharing obligations. We think the policy can play a critical part in achieving the goals of the No Surprises Act to help prevent patients from receiving a surprise medical bill.***

Specified State Laws

Definition of State Law and Determination of State vs. Federal Law

In the IFC, the Departments broadly interpret the statutory definition of a specified state law as,

“a state law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively.” According to the Departments, this definition not only means a mathematical formula for determining the out-of-network rate or a predetermined amount for an out-of-network service, but also a state law that requires or permits a plan and a provider or facility to negotiate, and then to engage in a state arbitration process to determine the out-of-network rate.

Further, in order for a state law to determine the recognized amount or out-of-network rate, the Departments lay out a “three-part test.” The law must include:

1. the plan involved (allowing for ERISA plans to opt-in if they are not otherwise subject to the state law)
2. the nonparticipating provider or nonparticipating emergency facility involved; and,
3. the item or service involved.

In instances where a state law does not satisfy all of these criteria, the state law would not be used to determine the recognized amount or out-of-network rate. The Departments do not think there would be numerous instances when it would be unclear whether state or federal law applies.

ACEP and EDPMA disagree with the Departments’ assessment that there will be few instances when it will be unclear whether federal or state law applies to the claim. Some state laws are extremely complicated, and it is not always clear if they have a method of determining the total amount payable for out-of-network services. Further, some states have laws that only set the cost-sharing amounts for out-of-network care, but not the out-of-network rate (and vice versa). In addition, some states have laws that only apply to specific claims in specific cases. For example, Indiana does have a state law governing processes around out-of-network billing, but it is not applicable to emergency services. **In these states with complex laws, relying on health plans to decide in each individual case whether the state law or federal law applies will result in significant confusion and will potentially open the door to cherry-picking.**

We understand that individual states will be responsible for enforcing these requirements and ensuring that their state law is applied appropriately. However, we strongly believe that there is a role for the federal government to play to make sure that health plans or issuers, clinicians, and facilities know when a state or the federal law applies. *We therefore urge the Departments to require that each state, prior to each calendar year, report to them whether or not it has a qualifying state law, and if so, for which items and services the state law applies. The Departments should maintain an inventory of state laws and make that information publicly available.*

This inventory will significantly reduce both confusion and disputes over whether a specified state law meets the federal requirements—and consequently, will ensure that fewer patients are dragged into any disputes. It may also prevent unnecessary use of IDR. Further, without such an official inventory, potential disputes regarding whether a state meets the “specified state law” will further lengthen and complicate the ultimate resolution of the reimbursement disputes. Under the *No Surprises Act*, clinicians already could wait more than six months for payment²—and these types

² Heller, et al. “Federal Out-of-Network Balance Billing Legislation: Context and Implications for Radiology Practices.” *Radiology* 2021; 000:1–6; available at: <https://doi.org/10.1148/radiol.2021210491>.

of “state versus federal” disputes could significantly lengthen that timeline. In addition, as the Departments finalize the inventory each year, we also ask that they consider for each state law whether or not applying it for emergency services would provide as much protection to patients as the federal law would.

Another clarification the Departments could institute to limit the confusion between whether state or federal law applies to a specific item or service (the third part of the three-part test) is to group all “emergency medical care” or “EMTALA-related care” together. In other words, all emergency services—defined as including ED evaluation and management (E/M) codes (CPT codes 99281-99285), critical care codes (CPT codes 99291 and 99292), other services that emergency physicians typically provide, or services conducted in place of service code 23—should all either apply to federal law or state law. We are concerned if state laws are allowed to only apply to some emergency services, it will become cost-prohibitive for small emergency physician groups to stay in business. Small emergency medicine groups do not have the capacity to separate out the services they provide and keep track of those that must follow state law requirements and those that must follow federal law requirements.

Similarly, ACEP and EDPMA urge the Departments to clarify that the term “item or service” includes all aspects of the claim, understanding that a claim oftentimes contains more than one service and their associated charges. Splitting up the claim and applying some services to the federal approach and others to the state approach would be inefficient, confusing, and ultimately unworkable. **We recommend that if an applicable specified state law does not apply to all items or services on a claim, that the charges for all items and services on that claim would be processed under federal law.**

We also urge the Departments to ensure that in situations where the item or service is not **specifically** covered by state law under **all** circumstances, that item or service **should not be considered covered by state law and instead is covered under the federal statute.** For instance, a state law should not be considered to cover an “item or service” if there is a monetary threshold for IDR on that item or service. Otherwise, the standard is easily manipulated. For example, in New York, the IDR process is only available for services over \$750. Therefore, services that are less than \$750 are not eligible for the IDR process, but services over that threshold ARE eligible for the IDR process. In New Jersey, where IDR is available based on the delta between the charge and the payment, the plan can forum shop and decide whether to go down the federal or state path by offering a payment rate that creates a delta that is just over or just under the \$1,000 threshold. **Therefore, when there is a monetary threshold (or any other similar restrictive criteria) in a state statute that precludes access to IDR for certain items or services, federal law should apply.**

Transparency is key to avoiding confusion about whether state or federal law applies. As discussed in the [“The Information on the QPA that the Health Plan Must Share with Health Care Providers”](#) section below, we believe the Departments should require health plans to designate in the “835 remittance documents” whether state or federal law applies to the item or service. This information should be provided along with the initial payment or denial, and no more than 30 days after receiving the claim. The 835 remittance is a standard format that health plans already are supposed to use to adjudicate the claim and communicate information to clinicians. We urge the

Departments to ensure that there are clear Claims Adjustment Reason Code (CARC) and Remittance Advice Remark Codes (RARC) that can be used to quickly and easily disclose this information to the clinician. If this information is not shared in a timely manner or is not accurate, the plan should be required to pay the clinician's billed charges and, in some cases, face penalties for non-compliance.

More specifically, currently there is already a Remark Code N830 which states, in part, "The charge[s] for this service was processed in accordance with Federal/State Balance/Surprise Billing. ... Payment amounts are eligible for dispute following any documented Federal/State appeal/grievance/arbitration process." At minimum, this remark code should now be divided into two remark codes, one for claims processed under the state law, and one for claims processed under the federal law. Therefore, the provider would have notice as to which law the plan applied to the claim and can thereby check the accuracy of the payment accordingly, and dispute the law applied if necessary.

Finally, we want to address situations when there could be disputes over whether state or federal law applies to the claim. If the clinician does not agree with the plan's designation of applicable law and the disagreement cannot be resolved within the 30-day negotiation period, there should be a simple, quick, inexpensive, and final resolution of the dispute and the decision should be made by an independent entity. We believe there should be an office at the HHS or the Department of Labor that determines which law applies to the claim within 10 days of receiving the dispute. Expedited decisions on "jurisdictional" issues are critical given the already extended NSA timeline for ultimate resolution of payment disputes. Having "jurisdictional" issues decided by the IDR arbitrator will further slow-down the resolution process and could cause "piecemeal" decisions that have no precedential impact.³ In order to prevent abuse of the system, the decision maker under this new office should have the authority to assess penalties when the losing entity has repeatedly identified the incorrect applicable law.

State law definition: Which State Law?

Another important issue related to specified state laws, which unfortunately the Departments do not directly address in the IFC, centers around emergency care provided in a state where the patient does not reside or the health plan or insurer does not offer in-network policies. ***ACEP and EDPMA urge the Departments to clarify that only one state law, if any, can apply to the claim and that must be the law of the state where the patient was located when services were rendered.*** If such clarification is not provided, there will be disputes over whether to apply one state law or another to the claim. These disputes could drag the patient along into the dispute for many months or years and could require the parties to spend a great deal of resources to simply determine which state has legal jurisdiction over the claim, if any. Applying the law of the state where the patient was located when services were rendered is consistent with current law. When a driver crosses state lines and is involved in a motor vehicle crash, the traffic laws of the state where the accident happened impact whether the driver is covered. Similarly, reimbursement for healthcare claims, including telehealth claims, are typically covered by the law of the state where the patient was located when the services were rendered. Currently, there are varying interpretations of when state laws on out-of-network billing apply, with some considering the state where the patient was

³ Ibid.

located when services were rendered, but others considering the state where the plan issuer is incorporated, the state where the patient lives, or the state where the provider's company is incorporated.

Clarifying which state laws applies in this situation would greatly benefit emergency physicians and the patients they serve by not only reducing confusion, but also eliminating the potential for health plans or issuers to engage in behavior that could increase the cost of care. Health plans understand that their beneficiaries may travel across state lines to receive care, and they take that fact into consideration when they draft their policies, set their prices, and voluntarily contract with beneficiaries. "Forum shopping" for purposes of the *No Surprises Act* by plans picking one state, then another and then another over time will cause confusion and decrease compliance as the physicians may apply one state's standard incorrectly not knowing that the plan is now covered by another state and may thwart the patient protections of the *No Surprises Act*.

ERISA Opt-in

In the IFC, the Departments state that the concept of "specified state law" still applies even to non-regulated state plans where the state allows plans (such as ERISA plans) to opt-in. In a previous [letter](#) to the Departments dated March 24, 2021, ACEP and EDPMA had expressed concern about allowing ERISA plans to opt in. Specifically, we believed that by doing so the Departments would create an environment in which patients and clinicians would be confused about which rules govern plans in their state, and the ERISA plans would be in the unfair position of being the only plans on the market to have a "choice" of which out-of-network rules to live by. Further, unless plans are required to opt in for a specified period of time, providers would be unable to transparently know whether to utilize the state or federal path, thus significantly increasing administrative costs, and often putting the patient back in the middle of billing disputes.

When ERISA plans are allowed to opt-in, there is also no assurance that a state's law will be enforced appropriately. For example, in Georgia, ERISA plans are allowed to opt in and are required to disclose the opt-in to clinicians. However, this disclosure is not being implemented or enforced and clinicians often do not know whether a plan has opted in or not. Further, health plans are remitting payments directly to patients and refusing to tell providers whether and how a claim has been adjudicated, forcing patients to remain in the middle of the reimbursement process by requiring that providers then seek payment directly from them.

If ERISA plans are allowed to opt in, there should be strict limits on when they are allowed to do so, and the process for opting in should be designed in such a way that limits confusion, discourages forum shopping, and keeps the patient out of the middle.

At minimum, the requirements for opting in should include the following:

- An ERISA plan must have a statistically significant number of claims in the state to opt in.
- An ERISA plan must provide to an all payer claims database (APCD) or other appropriate entity all data relevant to the state law's benchmarks or IDR factors before it can opt in.
- An ERISA plan that opts in should be subject to other relevant state laws, such as those regarding the state's prudent layperson standard and prompt payment requirements.

- Once an ERISA plan opts in, it should not be allowed to opt out. This would reduce confusion and discourage forum shopping. If an ERISA plan can opt out at any time, clinicians will not be able to reach a stage when it can rely on prior payments to estimate future reimbursement.

ERISA plans also must be required to disclose key information outlined in the “[The Information on the QPA that the Health Plan Must Share with Health Care Providers](#)” section below to clinicians within 30 days of receiving the claim, including the plan type for each state. Further, if this information is not disclosed to a clinician with initial payment or denial, and no later than 30 days after receiving the claim, ERISA plans should be liable for penalties and the time and money the clinician spent sending the claim down the wrong path.

Comment Solicitation on Other Issuers, Providers, or Facilities Opting In

The Departments also seek comment on whether health insurance issuers, health care clinicians, or health care facilities who are not subject to state law can opt into a program established under state law, including on an episodic basis. ***ACEP and EDPMA do NOT think that the Departments should allow any health plans, clinicians, or health care facilities who are not subject to state law to opt in—especially on an episodic basis.*** That would cause significant confusion and potential for gaming where stakeholders can pick and choose at different times which requirements (the state’s or the federal government’s) would most benefit them financially—perhaps at the expense of patients. If the Departments do in the future allow such a practice to occur, then we would strongly recommend that they institute the same requirements around opting in that we state above for ERISA plans.

The Calculation of the Qualifying Payment Amount (QPA)

Under the *No Surprises Act*, the QPA is used for two purposes: to determine cost-sharing requirements for patients in cases where an All-Payer Model or a specified state law does not apply, and as a factor that IDR entities can consider when selecting between the offer submitted by a plan and the offer submitted by a facility or provider in order to determine the total payment for emergency services.

In the IFC, the Departments only address one function of the QPA—to determine the cost-sharing amount in cases where an All-Payer Model or a specified state law does not apply. The primary goal of the *No Surprises Act* is to protect patients from unexpected medical bills and out-of-pocket costs. Therefore, in developing the IFC, ACEP and EDPMA believe that the Departments **very appropriately** 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. However, by doing so, the Departments ***did NOT ensure that the QPA would be an accurate representation of prevailing market rates for specific clinical services.*** In the various sections below, we discuss how the Departments’ approach to calculating the QPA will produce QPAs that do not reflect market rates.

As a result of this clear decision by the Departments, ACEP and EDPMA believe that the QPA will not be a fair and representative metric in arriving at the final amount that is ultimately paid to the provider. **ACEP and EDPMA encourage the Departments to remain consistent in this**

application when writing the rule related to the IDR process, adhere to Congressional intent, and avoid making the QPA the primary consideration of arbitration during the IDR process.

Median Contracted Rate

As defined in the law and the IFC, the median contracted rate means the median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the service is furnished, increased for inflation.

The median contracted rate is determined with respect to all group or individual health insurance coverage offered by the health insurance issuer that are offered in the same insurance market. In the IFC, the Departments set each contracted rate as a single data point when calculating a median contracted rate. The rate negotiated under a contract constitutes a single contracted rate regardless of the number of claims paid at that contracted rate.

In our March 24th [letter](#) to the Departments, ACEP and EDPMA had explicitly recommended a different approach to 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 basing the contract on individual claims rather than contracts, the QPA would more accurately reflect the actual negotiated rates between payors and providers. We continue to believe that this approach would not only better protect patients but accomplish numerous laudable goals of the *No Surprises Act*.

The Departments seem to be implementing a QPA calculation methodology that they believe will result in lower cost-sharing for patients. They contend that a methodology that considers the volume of claims associated with each contract “*would likely put upward pressure on the QPA.*” **However, the Departments provide no evidence to support this conclusion. ACEP and EDPMA question the empirical basis for the conclusion reached by the Departments that larger groups and facilities necessarily negotiate higher rates.** Local prevailing market rates reflect the negotiated and agreed upon rate based upon a number of factors including the nature of the local geographic region (rural vs. urban), the type of facility (academic vs. community) and many other factors. A much more certain outcome of this approach is that **the QPA will not be representative of prevailing market conditions and 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 the market.**

We also request a clarification to the QPA calculation methodology. Specifically, we believe that it is the intent of the Departments to prohibit plans and issuers from arbitrarily excluding contracts from their QPA calculations, based on the following: “*the amount negotiated under each contract is treated as a separate amount.*” **The Departments should clarify that health plans and issuers must include any and all contracts for providers contracted under that specialty when calculating the QPA for a given service, provider, and geography.** In addition, we recommend that the Departments establish a threshold of number of claims paid under a contract that was in place on January 31, 2019 in order for the contract to be included in the calculation of the QPA. Health plans and issuers should not have discretion in “choosing” which contracts to include in

their calculation. If any contract is excluded, the health plan or issuer should be required to disclose such exclusion, as well as the rationale within the rule for such exclusion.

Insurance Market

In the IFC, the Departments define the term “insurance market” to mean one of the following: the individual market, small group market, or large group market. The relevant insurance market is determined irrespective of the state. More limited forms of coverage, such as excepted benefits, short-term, limited-duration insurance, and account-based plans, including health reimbursement arrangements, are not included. The Departments also clarify that any plan or coverage that is not a “group health plan” or “group or individual health insurance coverage” offered by a “health insurance issuer,” such as a Medicare Advantage or Medicaid managed care organization plan, must also not be included in any insurance market for purposes of determining the QPA. **ACEP and EDPMA strongly support this decision to exclude Medicare Advantage or Medicaid managed care organization plans from the QPA calculations.** These plans and their associated rates are inherently different from private health plans and their rates—and therefore should not be included in the calculation. Further, ACEP and EDPMA believe that to the extent that a contracted rate is actually a flat rate used across a mix of Medicaid, Medicare, and commercial products, it should not be used for the calculation of the QPA.

Same or Similar Item or Service

The term “same or similar item or service” means a health care item or service billed under the same service code, or a comparable code under a different procedural code system. In the IFC, the Departments state that a service code can include a CPT, HCPCS, or DRG code. However, the Departments DO NOT explicitly state whether the same or similar service must be on the specific CPT code on the claim. As described in the [“Additional Plan Requirements Regarding Making Initial Payments or Providing a Notice of Denial”](#) section below, downcoding is a significant issue facing emergency medicine. If health plans are allowed to base the QPA on a different CPT code than the one included on the claim, plans will likely continue to engage in this harmful practice—which will result in more lengthy and costly appeals and administrative processes.

We therefore request that the Departments require the plan or issuer to calculate the QPA based on the CPT code(s) submitted by the clinician. The Departments should clarify that the plans must calculate the QPA and offer initial payment based upon the service(s) provided and codes submitted as documented by the provider. We also request that the Departments clarify that any disagreement over the proper level of services provided be resolved through existing administrative processes as they currently are today as long as they do not interfere with the statutory timeline requirements of the *No Surprises Act*.

As described in our August 11th [letter](#) and in the [“The Information on the QPA that the Health Plan Must Share with Health Care Providers”](#) section below, if the Departments do allow health plans to base the QPA on a different CPT code(s) than what was submitted on the claim—and health plans do select such a QPA for a given service—we request that health plans also be required to provide clinicians with the QPA that is actually based on the exact CPT code(s) submitted on the claim to be used for the negotiation and IDR processes.

Provider in the Same or Similar Specialty

The IFC does not require health plans to calculate the median contracted rate for each specialty that provides a service. Instead, it provides plans the flexibility necessary to calculate the median contracted rate, relying on their contracting practices with participating providers. The Departments considered requiring a plan to calculate separate median contracted rates for every provider specialty but concluded that this approach would put too much burden on health plans, and lead to more instances in which the plan would not have sufficient information to calculate the QPAs using its contracted rates.

ACEP and EDPMA believe health plans and issuers should be required to assess the specialty of a clinician based on the usual business practice that was in place on January 31, 2019. Further, health plans and issuers should be required to offer a transparent, plain language disclosure on the method by which the clinician's specialty was determined and do so at the same time and on the same correspondence in which the QPA is communicated to the clinician. Health plans and issuers that did not have a manner for determining a provider's specialty on January 31, 2019 should be required to establish a method for doing so, which must then be disclosed to the provider accordingly. Further the health plan or issuer should be prohibited from changing the method by which it determines a clinician's specialty during a plan year.

The Departments give considerable deference to plans in determining whether a contracted rate is reflective of a given clinician's specialty. The rule states that "*plans and issuers should be required to calculate median contracted rates separately by provider specialty only where the plan or issuer otherwise varies its contracted rates based on provider specialty.*" We consider it likely that a health plan or issuer and a clinician may differ as to whether the amount of a negotiated rate is reflective of the clinician's specialty or some other negotiating factor.

Often, a contract between a clinician and plan or issuer contains a complete fee schedule of codes, most of which a given clinician has little to no expectation of ever billing. When contracting, the plan or issuer does not necessarily present a different fee schedule based on the specialty of the clinician, rather, the difference in contracted rate is the product of negotiation between the parties.

For example, an emergency medicine physician is likely to focus on negotiating the reimbursement rate for CPT codes 99281 – 99285 since these codes comprise the majority of clinical services they provide, while simply accepting the standard contract rate for other codes for which they provide very few, or no services. Conversely, a physician specializing in Family Medicine may simply accept the standard fee schedule rates for codes 99281 – 99285 while focusing reimbursement negotiations on codes more relevant to his or her practice. Despite this, it is not necessarily the case that the health plan or issuer varies their contracted rates for these codes based on the clinician's specialty. **The Departments therefore should require the health plan or issuer to calculate the QPA based on the contracted rate of clinicians of the same or similar specialty and the codes that are billed for that specialty, as directed by the statute.**

Geographic Regions

The *No Surprises Act* directs the Departments, in consultation with the National Association of

Insurance Commissioners (NAIC), to establish through rulemaking the geographic regions to be applied when determining the QPA, taking into account access to services in rural and underserved areas. NAIC recommended that geographic regions correspond to the applicable rating area used for purposes of the individual market and small group market rating rules, while allowing states the flexibility to establish alternative geographic regions. After consultation with the NAIC, the Departments are establishing geographic regions that reflect differences in health care costs based on whether care is provided in urban or rural areas. These geographic regions take into account access to services in rural and underserved areas, including health professional shortage areas.

A geographic region is defined as one region for each metropolitan statistical area (MSA) in a state and one region consisting of all other portions of the state. If a plan or issuer does not have sufficient information to calculate the median of contracted rates for a service provided in an MSA, the plan or issuer must consider all MSAs in the state to be a single region when calculating the median of contracted rates for the service provided in that MSA.

ACEP and EDPMA believe that Departments established this methodology as a way to achieve their stated goal of avoiding the use of alternative methodologies for calculating the QPA. In order to pursue a primary methodology that relies sparingly on an alternative methodology, the Departments defined “Geographic Regions” in a way that would almost always result in an established plan being able to calculate a QPA *at some geographic level*. We note however, that any QPA calculation that utilizes either of the expanded geographic regions (i.e., all MSAs within a state or Census Division) are inherently less representative of actual contracted rates within the original site of service’s geography.

It is important that clinicians, negotiators, and arbiters be aware of the geographic level at which a QPA was calculated, as well as the inherent variability in accuracy associated with each geographic level. We recommend that the Departments develop standardized disclosures to accompany any QPA advising in transparent, plain language the geographic level at which the QPA has been calculated and that health plans be required to provide this disclosure with the reporting of the QPA to the provider. These disclosures should state that each degree of separation from the original geography reduce the applicability of the QPA to real world rates within the site of service’s geography.

Non-Fee-for-Service Contractual Arrangements

The *No Surprises Act* requires that the QPA take into account payments that are made by a health plan that are not on a fee-for-service basis. However, in the case of these alternative payment models, the IFC requires health plans to calculate a median contracted rate for each service using the underlying fee schedule rates for the relevant services, if underlying fee schedule rates are available. If there is no underlying fee schedule rate for a service, the plan must calculate the median contracted rate using a derived amount. The Departments believe that this approach will minimize the number of instances in which a health plan would not have sufficient information to calculate a median contracted rates and ensures that arrangements that pay for value over service volume are reflected in the QPA. When calculating median contracted rates, the IFC requires health plans to exclude risk sharing, bonus, or penalty, and other incentive-based and retrospective payments or payment adjustments.

ACEP and EDPMA oppose this methodology, and we believe it lacks accountability and will lead to inaccurate QPAs that are significantly lower than the actual prevailing market rate and full payment for the applicable service. 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 an incentive. Therefore, allowing a derived amount while excluding risk-sharing amounts and other adjustments may act as a financial penalty to those clinicians who have previously participated in alternative payment models and other value-based contracts. We would instead encourage the Departments to consider an approach that requires a health plan or issuer to calculate the aggregate award or penalty applied to a given contract in the plan year that included January 31, 2019 and use such award or penalty in its QPA calculations.

Cases with Insufficient Information

In general, ACEP and EDPMA support the alternative process to determine the QPA in cases where a group health plan or health insurance issuer offering group or individual health insurance coverage lacks sufficient information to calculate the median of contracted rates in 2019, as well as for newly covered services in the first coverage year after 2019. We agree with the Departments that the overall goal should be to minimize the instances that an alternative methodology is used.

ACEP also supports the requirement that, with respect to plans that have three contracted rates after 2019, that the contracted rates account for at least 25 percent of the total number of claims paid for that service for that year with respect to all plans offered by the issuer in the same insurance market. ACEP agrees that this threshold is needed to account for the potential that some health plans or issuers engage in selective contracting practices that artificially change the median contracted rate. However, we also believe that contracting practices were already affected by anticipated surprise medical billing legislation in 2019, and that determination of a sufficient data should take those selective contracting practices into consideration. **Therefore, we request that the 25 percent threshold apply in all cases, even for health plans or issuers that have three contracted rates in 2019.**

Eligible databases

If insufficient information exists, the *No Surprises Act* directs the plan to determine the QPA through use of any database that is determined to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility.

ACEP and EDPMA opposes the policy to categorically include all State all payer claims databases (APCDs). As stated in a [letter](#) to the State All Payer Claims Databases Advisory Committee on July 22, 2021, we believe that APCDs should meet certain requirements around data submission in order to qualify.

These include:

- ***Calendar Year Submission:*** All health plans submitting data to State APCDs should be required to report data for full calendar years and not for any periods of time shorter than

that. When a State APCD is used as part of a program related to the calculation of payment in relation to surprise medical billing, all participating health plans must submit full and complete data sets for any reference year utilized in the program.

- ***Required Data Elements:*** All health plans reporting to State APCDs should be required to include all additional payments, including quality incentive and other value-based payments, which combined with a base fee schedule, would accurately reflect the full amount of payment for a given service.
 - As part of the required data element set required under a State APCD, plans should be required to include the following data elements in each submission:
 - The allowed amount for each service;
 - The patient’s cost-sharing responsibility for the service;
 - The health plan’s payment to the provider for the service;
 - The physician/non-physician provider specialty taxonomy; and,
 - The modifier linked to the CPT code and payment.
- ***Segregation of Payer Type:*** If a State APCD is used to analyze or evaluate commercial health plan payments, then it must solely utilize data from commercial health plans and not from any government payers. Furthermore, if a State APCD collects data from government plans, including Medicare Advantage or Medicaid Managed Care Organization (MCO) plans, the data should be compiled separately and kept segregated from commercial health plan data for the purposes of analyzing or evaluating payments.
- ***Transparency:*** To ensure transparency, State APCDs must clearly present data in a way that will make it easy for appropriate users to interpret. State APCDs should also be required to identify what data elements health plans are required to report on and methodologies utilized in aggregation and analysis of the data. By making it clear which data elements are or are not included in a particular State APCD, stakeholders will be able to compare the data that are available across State APCDs and understand which State APCDs include more comprehensive sets of data.

We believe that only APCDs that meet these requirements should be used to determine the QPA in cases where insufficient information exists.

New Service Code

A “new service code” means a code that was created or substantially revised in a year after 2019. In situations in which a plan or issuer is billed for a covered service using a new service code, the plan or issuer must first identify a reasonably related service code that existed in the immediate preceding year. The Departments seek comment on whether additional rules are needed regarding how plans should be required to identify a reasonably related service code.

The Departments also believe that it is reasonable to use Medicare payment rates to approximate the relative cost of two different but reasonably related service codes. If Medicare has not established a payment rate, the plan must calculate the QPA by first calculating the ratio of the rate that the plan or issuer reimburses for a service billed under the new service code compared to

the rate that the plan reimburses for service under the related service code (the relativity ratio), and then multiplying the relativity ratio by the QPA for service billed under the related service code. Once the plan or an eligible database has sufficient information to calculate a QPA, the QPA for a new service code would be calculated using the median contracted rate of the plan, or the median of the in-network allowed amounts in the eligible database.

ACEP and EDPMA agree that it is appropriate to use the Medicare physician fee schedule (PFS) to approximate the relative values of different services. The Departments could also consider limiting the definition of a “new service code” to those codes that undergo valuation or revaluation by the AMA/Specialty Society RVS Update Committee (RUC). This Committee, which has been providing recommendations to the Centers for Medicare & Medicaid Services (CMS) for nearly 30 years, uses a process of surveying the specialists who use any code(s) under consideration to appropriately value any new or substantially revised codes. In the RUC process, substantially revised codes are those for whom 1) the description of the item or service is significantly changed or 2) those codes that are determined to be inaccurately valued. Alternatively, it's important to demonstrate what codes would resultantly not be included in this definition of substantially revised codes. For example, service code description edits that are not significant enough to warrant revaluation (i.e., editorial changes) would not be revalued by the RUC and appropriately would not be considered “new service codes.” Similarly, we would not consider all codes as "new service codes" after each (re)valuation process, even though all codes have a very slight change in their RVU value as a budget-neutrality effect after each (re)valuation of a code or code set being considered. Only the code or code set that was considered for (re)valuation would be eligible for “new service code” status.

The Medicare PFS and RUC process could also be used for valuing a new or substantially revised code to determine the reasonably related service code, rather than having the plan or issuer choose a reasonably related service code, which has significant opportunity for bias and misvalue. In the RUC process of placing value on a new code or a substantially revised code, a service code is clearly identified that is most closely valued to the code under consideration. This is done by a submission of reference codes for consideration by the involved specialty or specialties and then review and approval or revision by a multi-specialty committee. This list of reference codes is then considered by a nation-wide survey sent to physicians who are anticipated to utilize the code being considered, through which they give feedback on the anticipated work and time needed for the new or revised code. The RUC then uses this data to select the most closely valued reference service code. Given this time-tested and successful process already utilized by CMS, the RUC-determined most closely valued reference code could be used as the reasonably related service code rather than having the plan or issuer choose a reasonably related service code.

The Information on the QPA that the Health Plan Must Share with Health Care Providers

In the IFC, the Departments state that they seek to ensure transparent and meaningful disclosure about the calculation of the QPA while at the same time minimizing administrative burdens on health plans and issuers.

With each initial payment or notice of denial of payment, health plans and issuers must provide:

- The QPA for each service involved.

- A statement certifying that: (1) the QPA applies for purposes of the recognized amount and (2) each QPA was calculated based on the methodology outlined in this IFR and that neither an All-Payer Model Agreement nor a specified state law applies.
- 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 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, a statement that the plan’s contracted rates include incentive or other payments that were excluded for purposes of calculating the QPA.

The Departments seek comment on these disclosure requirements.

ACEP and EDPMA believe that the degree of disclosure regarding the calculation of the QPA is severely deficient as a means for identifying potential abuses or for providing important context in both the negotiation and arbitration frameworks. While it is critical that the health plan or issuer provide the QPA amount to the out-of-network provider at the time of initial payment or denial, this represents the bare minimum of information that should be provided in such cases. 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);
 - 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.

By requiring that plans provide this information in the initial response to the providers’ claim, the Departments will facilitate clearer insight into how the QPA was calculated. Further, this level of transparency will help ensure that all statutory timelines are met. ***Any delay in obtaining this information through follow-up is also more likely to lead to costly arbitration rather than a resolution being achieved during the negotiation period, as the provider will not have full transparency of information in order to determine if the QPA reflects a fair market reimbursement rate for the specific claim(s) provided and may have to initiate open negotiations prior to receiving the requested information in order to preserve their right to access dispute resolution.***

In addition, as discussed in our May 14, 2021 [letter](#), we believe the American National Standards Institute (ANSI) 835 and Explanation of Benefits (EOB) are the most appropriate tools for ensuring that key information is disclosed by the plan to the provider. However, health plans must be required to provide the 835 and EOB when paying or denying the claim and not later than 30 days after receiving a clean claim (in the case of a plan denying a claim through inaction). In order to ensure that plans actually comply with this transparency requirement, there must be a strong financial disincentive for violations. We recommend that, if a health plan or issuer does not provide a complete 835 within 30 days, the health plan or issuer must reimburse the provider for the billed amount on the claim AND be subject to financial penalties payable to the provider as well as civil monetary penalties. Moreover, the health plan or issuer should be liable for all costs expended by the provider in reliance on inaccurate information in the 835. Without strict enforcement of the transparency requirements, we are gravely concerned that the *No Surprises Act* may not achieve its intended purpose of protecting patients.

Audits

The *No Surprises Act* directs the Departments to establish via rulemaking a process to ensure health plans are in compliance with the application of QPAs and that the QPA reflects the year involved. HHS has stated that the agency will only exercise enforcement authority over issuers in a state if the HHS Secretary makes a determination that the state is failing to enforce a provision. The Department of Labor and the Treasury Department generally have primary enforcement authority over private sector employment-based group health plans. The IRS has jurisdiction over certain church plans. HHS also has primary enforcement authority over non-federal governmental plans, such as those sponsored by state and local government employers.

It is our understanding that the Departments intend to more fully address QPA compliance audits in future rulemaking. In this future rulemaking, ACEP and EDPMA recommend that the Departments create standards of auditing that all federal agencies and states would be required to meet in order to demonstrate that they were exercising appropriate oversight of the program. By creating clear and transparent standards of auditing, the Departments will create a consistency in

application of the rule which all stakeholders could refer to should a concern arise as to whether the state was meeting the standards required by the Departments. We would encourage the Departments to clarify that the statutory maximum of 25 annual audits applies only to audits performed by federal entities, and further, audits that occur as a result of complaints **will not count toward the annual maximum amount.**

We would also encourage the Departments to perform additional follow-up audits on plans affiliated with a plan or issuer that received an audit finding other than “clean,” and that these audits should continue until several clean audits of the offending plans have been achieved. For the purposes of negotiation and arbitration, it is also crucial that audit findings of anything other than “clean” be disclosed proactively to out-of-network clinicians at the time of initial payment or denial.

In addition, the degree of engagement in enforcement and audit activity varies significantly by state. The rule references HHS’ authority to enforce Parts A and D of Title XXVII of the Public Health Service Act when the Secretary has determined that the state is failing to do so. We would encourage HHS to utilize this authority where appropriate, especially during the first several years of implementation of the *No Surprises Act*.

In the IFC, the Departments also establish a process for receiving complaints against health plans for any of the consumer protection and balance billing requirements that it violates. The Departments state they are pursuing a “no wrong door” approach to patient reporting of noncompliance with *No Surprises Act* protections. **We applaud this approach** and believe the patient experience should be prioritized throughout the *No Surprises Act* rulemaking process. We encourage the Departments to take a similar “no wrong door” approach to reports of noncompliance on the part of health plans and issuers.

Additional Plan Requirements Regarding Making Initial Payments or Providing a Notice of Denial

Clean Claim

Under the *No Surprises Act*, health plans and issuers are required to send “an initial payment or notice of denial of payment” not later than 30 calendar days after a nonparticipating provider or facility submits a bill. In the IFC, the Departments encourage providers and facilities to include information about whether the surprise billing protections apply to the service on the claim form itself and to make it a “**clean claim.**” The Departments state that they may specify additional standards if the Departments become aware of instances of abuse and gaming where health plans or issuers are unduly delaying making an initial payment or sending a notice of denial to providers on the basis that the provider has not submitted a clean claim. The Departments solicit comment on whether any additional standards are necessary to prevent abusive claims payment practices.

ACEP and EDPMA strongly believe that the Departments need to provide some additional safeguards and clarifications to ensure that all the processes outlined in the No Surprises Act run smoothly. The Act clearly states that a health plan or issuer must either make an initial payment or deny a claim “*not later than 30 calendar days after the bill for such services is transmitted by*

such provider or facility.” This language indicates that Congress intended to ensure prompt payment and did not intend to allow plans to indiscriminately slow payment down by pending (suspending or delaying payment on) an accurate claim where the claim form is fully and accurately filled out with requests for additional information that confirm the claim’s accuracy. Prompt adjudication of the claim is necessary to ensure patients understand their cost-sharing responsibility and are taken out of the middle of disputes between the plan and the provider.

It is important to keep in mind that the claims process is built on the foundation that providers will provide the basic claim information and accurately code a claim. To ensure this foundation, laws pose significant financial penalties on those who commit fraud and detailed coding guidelines ensure consistency. Therefore, claim forms do not require the submission of in-depth clinical information, they simply identify of the patient, provider, facility and the CPT and ICD-10 codes for the services rendered.

We are very concerned that health plans or issuers will be able to pend accurate claims without good reason, dragging patients into a time-consuming dispute. It would also open the *No Surprises Act* IDR process up to health plan manipulation. Since emergency physician groups are dependent on regular cash flow, and health plans or issuers could indiscriminately pend claims until the provider agrees to a lower level of reimbursement.

In the rare case where there is good reason to question the accuracy of a claim, the system always allows for resolution. The health plan or issuer can conduct a medical review either before initial payment or during the negotiation period. If after medical review the parties agree that the claim was not accurate, the parties can negotiate lower reimbursement during the negotiation period. There is no need to keep the patient in the middle of the payment dispute or slow down the path to IDR by allowing health plans or issuers to indiscriminately demand confirmation of accurate claims before the IDR clock is initiated. The health plan or issuer also can conduct pre- and post-payment reviews when needed.

Therefore, ACEP and EDPMA 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 CPT and ICD-10 codes for the services rendered. If a broader definition of a clean claim is utilized:

- **Patients would remain in the middle with no specification of their cost-sharing financial responsibility for a long period of time due to disputes over the accuracy of a claim, and**
- **Health plans or issuers could manipulate providers into accepting underpayment.**

The Prudent Layperson Standard

In the IFC, the Departments discuss an important patient protection that ACEP and EDPMA believe needs to be fully enforced to ensure that the *No Surprises Act* is successfully implemented. The “prudent layperson” (PLP) standard, first established under the Balanced Budget Act of 1997, allows people who reasonably think they are having an emergency to come to the ED without worrying about whether the services they receive will be covered by their insurance. This law states that payers must cover any medical condition “manifesting itself by acute symptoms of

sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the individual (or a pregnant woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part.” The PLP originally applied to all of Medicare and to Medicaid managed care plans, and then was extended under the Affordable Care Act (ACA) to all plans other than plans that are grandfathered from the ACA. Furthermore, 48 states (all except Mississippi and Wyoming) have passed their own laws making some kind of PLP standard mandatory in their state, an additional layer of protection to the federal law.

The PLP protects patients’ access to care and ensures providers of emergency care get reimbursed without any undue administrative burden. ***Under both the Obama and Trump administrations, CMS clearly stated that a claim cannot be denied and payment cannot be modified based on diagnosis.*** In 2016, the Obama Administration issued the Medicaid Managed Care Rule which stated “*The final determination of coverage and payment must be made taking into account the presenting symptoms rather than the final diagnosis. The purpose of this rule is to ensure that enrollees have unfettered access to health care for emergency medical conditions, and that providers of emergency services receive payment for those claims meeting that definition without having to navigate through unreasonable administrative burdens*” (emphasis added).⁴ In a March 15, 2018 response letter to EDPMA, former CMS Administrator Seema Verma reiterated that “Whenever a payer... denies coverage **or modifies a claim for payment**, the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation, must be focused on the presenting symptoms (and not on the final diagnosis), and must make take into account that the decision to seek emergency services was made by a prudent layperson (rather than a medical professional)” (emphasis added). ACEP and EDPMA wholeheartedly agree with this guidance.

Over the last few years, commercial insurers have been adopting practices and policies that deny, pend, and downcode emergency claims based on diagnosis lists to the detriment of both patients and providers. Because of this reliance on diagnosis (rather than symptoms), ***all of these practices violate the PLP.*** [Appendix 1](#) includes recent examples of these policies. One such example is a recent Cigna policy announced August 14, 2021 that states that, effective November 14, 2021, “emergency room E/M CPT codes 99284 and 99285 will be reimbursed consistent with the appropriate CPT code 99283 when a single noncomplex diagnosis code is used.” This practice, known as downcoding, is described below.

Downcoding Emergency Claims Based on Diagnosis

ACEP and EDPMA greatly appreciate and strongly support the language included in the IFC that reenforces the PLP when a claim is denied based on diagnosis. The Departments highlight some of the practices health plans have taken recently that violate the PLP and unequivocally state that these are inconsistent with the emergency services requirements of the *No Surprises Act* and the *Affordable Care Act*.

⁴ 81 Fed. Reg. 27,749 (May 6, 2016)

While we wholeheartedly endorse this language, we were disappointed that the IFC did not mention downcoding based on diagnosis. If claims are downcoded by payors, the services are still covered by the payors (rather than denied), but 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).

When health plans and issuers downcode claims, they state that the diagnosis “conflicts with” the level of emergency care. However, the measurement of service (or CPT) in emergency care is not a reflection of a final diagnosis, but rather the work and risk in making that diagnosis. Medical complexity in emergency care is based on all of the patient’s presenting symptoms, the patient’s medical history, and the patient’s comorbidities – not the diagnosis. Those factors often require a physician to conduct a thorough and appropriate evaluation, including diagnostic testing, and utilize a high level of medical expertise to determine if the patient is suffering from an emergency medical condition, regardless of the final diagnosis(es) determined at the conclusion of the evaluation. If a health plan or issuer disputes the level of care, it must do a medical review before it has the information needed to downcode the claim. When the health plan downcodes the claim without reviewing the medical record first, it has not examined the information that is relevant to determining the correct level of care.

By downcoding claims, health plans are also disregarding current coding requirements. There are clear documentation standards and guidelines that dictate what level of service a provider can submit on a claim. Professional services are described in claims using the universally accepted CPT and the supplementary HCPCS codes. Decades ago, HHS named CPT and HCPCS codes as the sole code sets for describing physician services, among other services, tests, and procedures. In addition to published detailed descriptions of services named by these codes, the CPT Editorial Panel releases updated and detailed guidelines regarding the elements of services that must be present to meet requirements for assignment of a particular code to a service. Strict adherence to the above-mentioned coding guidelines is ensured by front-end quality assurance processes and on the back-end by thorough auditing and corporate compliance processes with financial and legal implications for noncompliance by the provider.

Most claims billed by emergency physicians are actually coded by professional coders who have a significant amount of training, expertise, and ongoing education. With respect to training and ongoing education, there is a standard practice in place for coders to have certification, including from the American Health Information Management Association or the American Association of Procedural Coding. There is also maintenance of certification including continuing education from CPT or CMS. Finally, coders receive and are responsible for education from regional Medicare Administrative Contractors (MACs).

Billing companies also undergo annual internal audits of all processes, including coding practices, as recommended by the Office of the Inspector General (OIG) within HHS. In addition, they perform voluntary audits of their coding team by external parties as well. Standard practice among

billing companies is to accept no less than 95 percent accuracy proven by these internal and external coding audits.

Moreover, all providers, both those that use professional coders and the minority that do not, are subject to strict oversight by CMS via contracted services performed by the MACs, Recovery Audit Contractors (RACs), and Zone Program Integrity Contractors (ZPICs). These contractors review claims data, analyze for variance in CPT submission, and gather additional data to determine if there are patterns of overpayment or underpayment. In response to the audit findings, providers can be subject to more intense global claim review, withholding of future payments based upon claim-by-claim review, recoupment of fees already paid to providers, and civil or even criminal charges brought by the OIG. Relatedly, private payors oftentimes also perform their own global audits of submitted claims and may refer providers for additional education or regulatory action as deemed appropriate. Lastly, patients can trigger an audit as well by contacting the above parties about any concerns they have with services billed for by providers.

Thus, ACEP and EDPMA strongly oppose the unilateral, payor-driven practice of downcoding based on no evidence other than the diagnosis and believe that there are strong standards and enforcement mechanisms already in place to ensure accurate and appropriate coding by clinicians. We ask that the Departments address this practice in the rule by explicitly and expressly prohibiting instances where plans downcode emergency claims based solely on diagnosis.

Pending Emergency Claims Based on Diagnosis

As discussed above, when a claim form is fully and accurately filled out, claims should not be pended based on final diagnosis or otherwise. If the plan has good reason to believe the claim is inaccurate, it can certainly do a medical review before initial payment or during the 30-day negotiation period if it wants to confirm that the accuracy of the claim. Since so many health plans pend emergency claims based just on diagnosis, ACEP and EDPMA urge the Departments to clarify that claims cannot be pended based on diagnosis alone.

Initial Payment

In the Departments' view, the statute's reference to an "initial" payment does not refer to a first installment—but should be the plans best effort to make a full payment. The IFC does not require plans to make any specific amount of minimum initial payment. The Departments seek comment on whether to set a minimum payment rate or methodology for a minimum initial payment in future rulemaking, and if so, what that rate or methodology should be.

ACEP and EDPMA commend the Departments for their guidance regarding the initial payment made by a health plan or issuer to an out-of-network provider or facility. Requiring health plans or issuers to make an initial payment that they reasonably expect the provider or facility to accept as payment in full should theoretically reduce the overall incidence of arbitration and therefore avoid unnecessary administrative cost and burden to the health care system. We are concerned, however, that health plans and issuers may not abide by the Departments' guidance in good faith when issuing an initial payment. We worry that some health plans or issuers may instead offer low initial payments that will be used to create cash flow pressure and exert leverage on smaller

provider groups in order to compel acceptance of unfavorable contracts. We therefore recommend that the Departments include in the complaint and audit processes a study of whether plans are compliant with the recommendation that the initial payment reflects a full payment for services provided.

We also strongly oppose establishing a minimum initial payment. Since the initial payment is supposed to reflect the health plan’s good faith effort to make a *full* payment, there is no need to set a minimum payment (assuming that policy is properly enforced). Doing so would create a de facto payment amount for each service, thereby inherently establishing a rate-setting methodology—which Congress expressly attempted to avoid when it drafted the *No Surprises Act*.

IDR vs Traditional Appeals Process

The Departments provide some clarifications on the type of disputes that can go through a health plan’s traditional appeals process, and which can go through the *No Surprises Act* negotiations and IDR process. Overall, when the patient’s cost-sharing is involved, it can go through the health plan’s traditional appeals process. When the patient is not involved, and the dispute just involves the payment between the plan and the provider, it can go through the *No Surprises Act* negotiation and IDR processes. The Departments acknowledge that there may be instances where an enrollee appeals their cost-sharing amount through the claims and appeals process concurrently with a provider’s challenge to a payment amount through the IDR process.

ACEP and EDPMA generally support this approach, as the Departments are appropriately considering how best to keep patients out of the middle of billing disputes. However, as discussed previously, we believe the Departments need to clearly define a “clean claim” and state that claims cannot be pended indiscriminately by the health plan based on diagnosis or other unwarranted reason. Allowing health plans to use these tactics to tie up claims would cause patients to be held hostage during the months, or perhaps years, that the claim is pending. If a health plan or issuer has good reason to believe that a claim is fraudulent and wants to review the medical record, it can certainly do so during the 30 days prior to initial payment or the 30-day negotiation period after initial payment.

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 Munding, EDPMA’s Executive Director at emunding@edpma.org.

Sincerely,



Mark S. Rosenberg, DO, MBA, FACEP
ACEP President



Bing Pao, MD, FACEP
Chair of the Board, EDPMA

Appendix 1: Examples of Payor Policies that Have Led to Payment Denials and Downcoding

Commercial Policies that Violate the Prudent Layperson Standard

1. **Cigna Emergency Department (ED) Policy:** This policy downcodes Level 4 and Level 5 emergency visits based on diagnosis.
2. **UHC ED Facility Fee Policy 2021:** This policy denies certain emergency claims before reviewing the presenting symptoms in the medical record. The policy was delayed until the end of the COVID-19 public health emergency.
3. **UHC ED Professional Fee Policy 2020 and 2021:** https://www.edpma.org/downloads/UHC_April1Policy.pdf. This UHC policy downcodes level 5 emergency claims based on an E/M protocol which bases reimbursement on diagnosis. This policy was delayed in 2020, rescheduled in 2021, and delayed again in 2021.
4. **Moda 2021:** [5/5/21 EDPMA/ACEP Letter to Moda Health re: Policy that Violates PLP](#). This Moda policy proposes to routinely downcode Level 4 and Level 5 emergency visits based on diagnosis.
5. **Anthem 2021:** https://www.edpma.org/downloads/Bulletin_ERBilling.PDF further described in [2/25/21 Anthem Response to EDPMA's 2/22/21 letter on E/M Policy](#). This Anthem policy allows Anthem to deny, pend, or downcode level 4 and 5 emergency claims from some providers based on diagnoses.
6. **Paramount 2019:** https://edpma.org/wp-content/uploads/2021/02/pg0396_emergency_room_professional_services.pdf. This Paramount policy bases emergency reimbursement on diagnoses.
7. **MS BCBS ED Policy 2018:** [December 12, 2018 Professional Emergency Room Policy](#). This policy aligns ED E/M visit code level 1-5 with final diagnosis.
8. **FL BCBS ED E/M Policy 2017:** [August 2017 Florida Blue Bulletin with Update](#). This policy denies and downcodes level 4 and 5 emergency claims based on diagnosis code.
9. **Aetna ER Policy 2016:** https://www.edpma.org/downloads/AetnaPolicy_Level5.pdf. This Aetna policy downcoded level 5 emergency claims to a level 4 based on diagnosis. The policy was replaced in 2017.

Medicaid Policies that Violate the Prudent Layperson Standard

1. **Centene National Policy 2017** (<https://edpma.org/wp-content/uploads/2021/02/2017-Centene-ER-Leveling-Policy.pdf>) Centene has Medicaid MCO plans in 30 states and the policy downcodes level 5's and 4's to a 3 based on diagnosis.
2. **Medicaid Kansas-** In January 2018, Kansas Medicaid released a [bulletin](#) retroactively reversing its policy of reducing emergency reimbursement using diagnosis lists (after CMS weighed in).
3. **Medicaid Virginia—July 2020:** [VAMA Policy](#)
4. **Medicaid Indiana—April 2020:** [INMA Policy](#)
5. **Medicaid Iowa—August 2018:** [IAMA Policy](#)

C. **PLP quotes from CMS under various administrations:** [Key CMS PLP Quotes](#)