



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

To: The Honorable Xavier Becerra, Secretary, U.S. Department of Health and Human Services
The Honorable Martin Walsh, Secretary, U.S. Department of Labor
The Honorable Janet Yellen, Secretary, U.S. Department of the Treasury

From: Massachusetts Medical Society

Re: Requirements Related to Surprise Billing; Part II (File Code: RIN 1210-AB00; CMS-9908-IFC)

Date: December 6, 2021

On behalf of our 25,000 physician, resident, and medical student members, the Massachusetts Medical Society (MMS) appreciates the opportunity to provide comments on the implementation of the *No Surprises Act* and the Interim Final Rule (IFR) on “Requirements Related to Surprise Billing; Part II” (File Code: RIN 1210-AB00; CMS-9908-IFC).

The MMS has long held the position that patients should be protected and held harmless from surprise medical bills. The MMS was closely involved with our Congressional leaders working to draft the *No Surprises Act*, and we appreciated that the resulting bill aimed to protect patients, while taking into consideration the concerns of physicians and hospitals. We appreciate that the Interim Final Rules (IFRs) released by CMS in July and September also include strong patient protections. While the intent of both the legislation and rulemaking is clear—to protect patients from surprise medical bills—additional clarity would help providers prepare and navigate the provisions when they go into effect next year.

In addition, we have serious concerns that the Independent Dispute Resolution (IDR) process outlined in the IFR Part II regulations is not consistent with either the statutory requirements of or Congress’ intent in drafting the *No Surprises Act* law. We recognize that the IFR released in late September is final and will go into effect; however, we believe that your departments—Department of Health and Human Services (HHS), the Department of Labor (DOL), and Department of the Treasury (USDT)—should strengthen the law with the below, outlined recommendations. Furthermore, there are provisions outlined in the IFR that could have unintended consequences, undermining patient access to care and creating unnecessary confusion when interacting with existing state laws, and we urge the agencies to consider this additional feedback for future rulemaking.

These recommendations are a result of a working group of state and national medical societies, led by the American Medical Association (AMA).

Good Faith Estimate and Protections for the Uninsured

The IFR Part II outlines the process by which providers will need to provide a Good Faith Estimate (GFE) to certain patients and the required elements to be included as part of the GFE. The GFE is a notification of expected charges for a scheduled or requested service, including those that are reasonably expected to be provided in conjunction with the care, and it is considered part of medical record.

When scheduling care, or upon request, a provider must determine if a patient has and is planning to use health insurance coverage. If the patient has coverage, the provider will send the GFE to the plan to generate an Advanced Explanation of Benefits (AEOB). This part of the rule has been delayed and will not be implemented on January 1, 2022. **Overall, we appreciate that the Departments delayed implementation of the GFE requirements related to the AEOB for insured patients.** The delay will give us additional time to work with our members and other stakeholders in the physician community to best advise the Departments on the implementation of this portion of the rule. The extra time will also help ensure that solutions for implementation do not create additional cost and waste in the healthcare system, while ensuring our patients receive meaningful price information prior to their care. That being said, delaying this portion of the law has led to some confusion in how the state and federal laws will interact in Massachusetts—the state law is described in more detail below.

While the AEOB process is not explained in this IFR, the rule does detail the process by which a GFE is to be provided to patients who are uninsured or self-pay. If the patient is uninsured or self-pay, a GFE will be prepared by the provider and be provided directly to the patient. The Departments are offering enforcement discretion for the first year for the provisions related to the GFE for uninsured or self-pay patients, recognizing that it will take time for providers to implement these processes. **The Massachusetts Medical Society appreciates this enforcement discretion. However, the MMS has serious concerns about the burden placed on providers due to the GFE process outlined in the IFR, especially the burden on the convening provider and the impact these burdens will have on physician practices as the Departments eventually move to enforce these requirements.** Below, we detail concerns with the process as outlined and make recommendations to improve the rule:

I. Broad Definitions and Scope

Notably, the IFR establishes definitions that are broader in scope for “provider” and “facility” than other sections of the rule (including broader definitions than the notice and consent provisions from the IFR Part I). As written, these provisions apply to a wide range of providers and health care facilities, and extra burden is placed on the “convening” provider or facility to provide the GFE. Some important definitions include:

- Good Faith Estimate: “a notification of expected charges for a scheduled or requested item or service, including items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service, provided by a convening provider, convening facility, co-provider, or co-facility”
- Health Care Facility: “an institution (such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) in any state in which state or applicable local law provides for the licensing of such an institution, that is licensed as such an institution pursuant to such law or is approved by the agency of such state or locality responsible for licensing such institution as meeting the standards established for such licensing”
- Health Care Provider: “a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law, including a provider of air ambulance services”
- Items or Services: “all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees), provided or assessed in connection with the provision of health care”
- Convening Health Care Provider or Convening Health Care Facility: “the provider or facility who receives the initial request for a good faith estimate from an uninsured (or

self-pay) individual and who is or, in the case of a request, would be responsible for scheduling the primary item or service”

- Co-Health Care Provider or Co-Facility: “a provider or facility other than a convening provider or a convening facility that furnishes items or services that are customarily provided in conjunction with a primary item or service”

Additional clarity is needed on the intended scope of the GFE requirements, including to which types of services and items they apply (e.g., are office-based care, primary care services, and emergency services included?). As currently written in the IFR, the definitions imply that the provisions will apply to a wide range of providers and facilities. The MMS has concerns about the potentially broad application of this provision—as mentioned above, this scope is much broader than the related notice and consent requirements and other sections of this IFR and the previous rulemaking. This will place undue administrative burden on providers, particularly smaller, independent practices that do not have extensive resources to track down and develop the required information for the GFE.

Furthermore, per the rule, the provider must inform a patient when scheduling that they have the right to request a GFE; however, the rule also suggests that any conversation about costs is meant to trigger a GFE. This means that a patient may request a GFE to compare costs and make a decision about from where they will seek care, or whether they will submit a claim to insurance or self-pay. (These individuals would be considered self-pay for purposes of the requirement on the provider or facility to provide a GFE.)

The MMS supports patients receiving meaningful and actionable cost information before their care, but we have concerns about unintended consequences. For example, because any conversation about costs triggers a GFE, it could mean that some patients receive GFEs when they did not want them or prefer to use other price transparency tools offered by the provider. There is no automated way to make requests and communicate costs between convening and co-providers, so this will lead to providers investing significant time and resources developing GFEs for patients they may not see. **It is important to consider that the definitions and scope of this section of the rule may add additional cost and waste to the health care system.**

II. Requirements for Convening Providers; Managing Co-provider Information

As discussed above, the convening provider or facility is responsible for determining if the patient is uninsured or self-pay, must notify the patient that a GFE is available upon scheduling, and will provide the GFE to the uninsured or self-pay patient. As part of developing the GFE, the convening provider or facility is responsible for contacting all applicable co-providers and co-facilitators no later than 1 business day after the request for the GFE is received (or the primary item or service is scheduled). The convening provider or facility is also responsible for requesting submission of expected charges from all applicable co-providers and co-facilities. **The MMS is concerned about the time and resources that will be required and the administrative burden placed on convening providers needing to track down information from co-providers. Furthermore, there is no easy, automated process to allow a provider to determine who the co-providers will be when scheduling care—nor is there an easy way to contact those providers for a cost estimate.** With no automated process, this will cause disruptions to staff workflows and put enormous pressure on staff time and resources tracking down this information. This requirement has the potential to force providers into hiring staff to primarily create GFEs for patients.

Additional clarity is needed on what happens when a co-provider is delayed in providing cost information to the convening provider or when the convening provider is unable to determine within the deadlines who the co-providers will be. We appreciate that the Departments acknowledged the potential challenges of providing GFEs in the IFR, particularly in situations involving co-providers or co-facilities. The enforcement discretion provided in the rule will certainly help providers adjust to the new policies; however, we urge the departments to recognize in enforcement decisions when providers have made a reasonable attempt to provide the necessary information to patients.

III. Elements of GFE for Uninsured; Concerns with Provider Access to Information

The GFE must include several elements, including:

- Patient name/date of birth;
- Description of the service and the date primary services are scheduled;
- Itemized list of services, grouped by provider or facility, reasonably expected to be provided—including those in conjunction with the primary services for that period of care;
- Applicable diagnosis codes, service codes, and charges associated with each service;
- Name, NPI, and TIN of each provider and states and facility location where care will be provided;
- List of services that the convening provider/facility anticipates will require separate scheduling;
- Disclaimer that there may be additional services that the convening provider/facility recommends as part of the course of care that must be scheduled separately and not reflected;
- Disclaimer that the information is only an estimate;
- Disclaimer that informs patient about the right to initiate the dispute resolution process; and
- Disclaimer that the GFE is not a contract.

As highlighted above, **the GFE must include a wide range of information, and the MMS is concerned that some of that information may not be readily available to the convening provider**. Furthermore, it is unreasonable to require convening providers to provide information that they do not easily have access to or would have difficulty obtaining. For example, it will be difficult for providers to obtain the NPI or TIN for co-facilities or accurate diagnosis and service codes for outside facilities or ancillary providers. In addition, using a surgery as an example, a surgeon can expect to use services like anesthesia and radiology at a hospital or other facility, but likely won't know which individuals will provide those services when the GFE is developed. This makes it extremely difficult for the convening provider to prepare an accurate GFE when several other co-facilities or co-providers are involved in the item or service. Therefore, we urge the Departments to limit the information that convening providers are required to provide from the co-facilities and co-providers. One solution would be to only require convening providers to provide a list of the additional services patients can expect in conjunction with the primary service.

IV. Timing Concerns

The convening provider or convening facility is responsible for providing the GFE to uninsured (or self-pay) patient within 3 business days upon request. Information on scheduled care must be furnished within 1 business day of scheduling care that is to be provided in 3 business days; and within 3 business days of scheduling care to be provided in at least 10 business days. When a GFE is provided initially in response to a request and then the item or service is subsequently

scheduled, a new GFE must be provided to the uninsured (or self-pay) individual under the established timelines.

The MMS understands that this timeline was established in the *No Surprises Act* and the Departments have limited flexibility in changing the timeline. However, it is important to note that **this timeline will be very difficult for convening providers to meet (particularly without an automated tool or standardized method to rapidly generate a GFE)**. This is particularly challenging given the ongoing workforce challenges threatening the sustainability of physician practices. Workforce shortages are increasing the cost and effort to maintain an adequate clinical and office staff, and physician offices are struggling to keep up with their day-to-day responsibilities. For example, it is already difficult for physician offices to maintain staff, since many front office staff, medical assistants, registered nurses, or technicians are finding jobs elsewhere that have lower health risk or less stress. The added administrative burden created by confusing and challenging timelines in this rule could be incredibly problematic for physician practices.

We are concerned that the timeframes outlined in this section may have the impact of delaying care. Providers may need to push back scheduled care to meet the timelines required to send a GFE to the patient. The timeline is also confusing, as it conflicts with the timeline established in the IFR Part I for the notice and consent provisions, which also require a GFE. We are worried these two sets of conflicting timelines will confuse providers and lead to additional administrative burden. We urge to the Departments to develop and make available educational materials for physicians and other providers on these requirements.

V. **Interaction with Massachusetts Notice Law**

The MMS would also urge the Departments to provide additional clarity on whether the requirements outlined in this section of the IFR are intended to preempt state law, as this is not clear in the rule as written. For example, Massachusetts is implementing a state Notice law that requires much of the same information be shared with the patient as the GFE requirements in the IFR. However, the state law differs greatly in the timeline required to share this information. There are also stringent penalties placed on providers who do not comply with the state timeline. This will create significant confusion for providers when trying to follow both the state and federal laws at the same time. For example, if a provider follows the process and timeline as outlined in the IFR Part II, they run the risk of missing state-required deadlines and could face penalties of up to \$2500 for each instance of non-compliance. We are worried about the administrative burden our Massachusetts providers are now facing when trying to reconcile the two competing laws and the financial cost if a provider (in good faith) follows the federal timeline over the state timeline.

VI. **GFE as Related to Future Rulemaking on AEOB**

The concerns outlined above on about the GFE for the uninsured or self-pay are even more important considering how they might relate to the GFE needed to initiate the AEOB. **We urge the Departments to move away from the concept of a convening provider or facility when eventually implementing provisions related to the AEOB.** It is unnecessary and extremely difficult to put one single provider in charge of collecting cost estimates, particularly when insurers will have all of the relevant information needed to generate the AEOB. If the Departments implement a required step for the AEOB where co-providers are required to send cost estimates to a convening provider before they go to the plan (instead of that information being sent directly to the plan), it has the potential to significantly delay care.

VII. Patient-Provider Dispute Resolution Process

The IFR established a patient-provider dispute resolution process, accessed when charges to an uninsured or self-pay patient are substantially in excess of the GFE—“substantially in excess” is defined as at least \$400 more than the GFE. While we appreciate and support the patient protections established with this provision (for example, that a patient’s bill can’t be moved to collections while a dispute is pending), **we seek further clarification on the process.** For example, when there are multiple providers (a convening provider and co-providers), it is unclear whether the cost is considered substantially in excess of the GFE if the cumulative, total cost is \$400 over the cost of care, but no one provider’s cost exceeds that \$400 threshold. If that is the case, how does the dispute process work when there are multiple providers involved?

In addition, **we urge the Departments to consider revising the threshold for entering the dispute resolution process from \$400 to a percentage of care in excess of the GFE instead.** A threshold example to consider could be 15% more than the GFE. This type of system would require less adjustment over time as costs change. We also urge the Departments to consider a requirement that the disputed GFE must be a GFE provided once care is scheduled—this reflects the concern that some information is not available before care is scheduled and the GFE may be more accurate once the care is scheduled.

IDR Process and Payment Determinations

The IFR Part II explains the process and requirements for the Independent Dispute Resolution (IDR) process—the process by which to resolve payment disputes between providers and insurers. While we appreciate some clarification provided by the Departments in this part of the rule—like clarification around the initial payment and the open negotiation period—we are very concerned that the section on payment determinations does not reflect the text of the *No Surprises Act* nor congressional intent. Our concerns, recommendations, and considerations on the IDR process provisions are outlined in more detail below.

I. Initial Payment

The IFR clarifies that any initial payment should be an amount that the plan or issuer reasonably intends to be payment in full based on the relevant facts and circumstances. The MMS appreciates this clarification, but **urges the Departments to require that this initial payment also be the health plan’s offer to the IDR entity (should the process continue to that point).** This is important to ensure that plans do not make unreasonably low initial payments, which could force some providers into the IDR process unnecessarily. That being said, it should be made clear that, while this initial payment should be considered payment in full from the plan’s perspective, it does not mean that the payment amount should be presumed correct if the provider disagrees and initiates the IDR process.

II. Open Negotiations

The MMS appreciated the clarification in the IFR that the statutory 30-day open negotiations period will be measured in business days, rather than calendar days. This will provide an appropriate amount of time for the parties to engage in payment negotiations.

III. Initiating IDR

Per the IFR, either party can initiate the IDR process during the four-business-day period after the end of the open negotiations period. The initiating party is required to submit a notice of IDR initiation to the other party and to the Departments through a portal (that same day). Should the restrictions on the IDR entity’s decision making (discussed below) remain, we

believe providers will be the ones primarily initiating the IDR process (as opposed to the payer)—and **we are concerned that the information required for the notice of IDR initiation will be challenging for providers to provide.** Much of the information required will not be easily accessible for providers. For example, it is not clear whether providers would know the Qualifying Payment Amount (QPA) at the time the IDR process is initiated. Also, they may not know the amount of cost-sharing allowed for the patient under the plan. This information will be best sought from the payers—we ask that the Departments require this information to be submitted by the plan to ensure the process is accurate and efficient. We also ask that the Departments consider requiring additional information to be submitted by the plans to the IDR entity upon receiving the notice. This could include the original claim and the QPA associated with the original claim if the original claim has been modified, downcoded, or otherwise changed. We also urge the Departments to implement a provision that would allow for potential delays to the initiation of the IDR process if there were extenuating circumstances. The Departments could set a maximum allowance for extra days (e.g., five business days) if the parties both agree to the delay.

IV. **Selecting an IDR Entity (IDRE), Certification, and Reporting**

As outlined in the IFR, the two parties are to jointly select the IDRE within three business days following the date of initiation. If the parties fail to agree on the IDRE, the initiating party must provide notification in one business day through the IDR portal and the Departments will randomly select an IDRE within six days of initiation. If the non-initiating party believes the IDR process is not applicable and/or state laws apply, they can provide notice via the IDR portal. Based on information requested by the IDRE, the IDRE will determine whether the process is applicable within three business days. **The MMS is concerned that this is the first time in the IDR process that a formal determination as to the applicability of federal law is made, and this is late in the process for physicians to find out that they are not pursuing the right process** (this could be 60 or more days after the initial payment). **We are also concerned that the IDRE will not be knowledgeable about every state law to be able to determine whether a state law applies.** Therefore, we urge the Departments to provide more clarity on this provision and to also consider whether it might be more appropriate for the IDRE to perform a final check prior to entering the IDR and have the plan make their determination as to the applicability of the federal law at the time of the initial payment. This would help prevent one of the parties from challenging the use of federal law at the time of the IDR. We also ask that the Departments provide clarity on how providers can dispute a determination of applicability of federal law.

Moreover, the MMS appreciates the Departments' certification requirements outlined in the IFR. The measures outlined in the rule are appropriate to ensure that the IDREs have no conflicts of interest or biases. We also urge the Departments to monitor IDRE decisions over time to look for any biases that may be apparent through their decision making.

In addition, the IFR requires that the IDRE must report certain data to the Departments on the IDR process within 30 business days of the end of each month. **We are concerned that the reporting requirements rely heavily on the QPA (and explaining determinations that deviate from the QPA)** rather than reporting on data that is not influenced by the QPA. As mentioned in [the MMS' past comments on the IFR Part I](#), we are concerned that the QPA does not accurately reflect the market. The IFR process also requires reporting on provider practice size to determine if smaller providers are able to access the IDR process and to analyze integration of providers. We appreciate that the Departments are prioritizing the impact of the IDR process on physicians (particularly independent practices) in their reporting and analysis.

We

would be interested to learn how other related data on the impact might be collected, as well as how named physicians and other provider information will be protected if this data is made public.

V. **IDR Process Cost**

When the IDRE is selected, the parties must pay an administrative fee to the Departments (\$50 in 2022) and a fee at the time the offers are submitted—on average the IDRE fees will be approximately \$400. IDRE fees and administrative fees can be viewed in the IDR portal when engaging in the IDRE selection process, and there will be annual guidance from Departments on range of allowed fees—which the MMS appreciates. However, **we are concerned that the fee structure, as paying prior to the IDR process is a much tougher ask for a small practice than a large insurance company.** With the IDR process favoring plans as the prevailing party (described below), this will only disincentivize physician participation in the process. This further emphasizes the need for a balanced IDR process.

In addition, for batched claims, the party with fewest determinations in its favor is considered the non-prevailing party and responsible for the IDRE fee. If each party prevails in an equal number of determinations, the fee is split evenly between the parties. **The MMS urges the Departments to consider a structure based on the parties' percentage of "wins" instead of having the party with the least "wins" pay the entire fee.** For example, if the IDRE picks the physician's offer in 60 percent of the batched claims, the physician would be responsible for 40 percent of the fee. This structure could be fairer and more efficient.

VI. **Batching of Claims**

We appreciate that the IFR allows for the batching of multiple claims, including batching qualified claims during the 90-day cooling-off period together. This will create efficiencies in the IDR process. We ask the Departments to consider additional scenarios where claims could be batched together, like when a payer is using a common payment methodology across claims, but the claims don't meet other batching requirements. We also ask for more clarity on the moment in time when batching occurs and what claims are allowed for batching—for example, when the IDR is initiated, claims eligible for batching could be in different stages (paid, in open-negotiation, some not submitted). We also appreciate the consistency provided by the Departments by defining "such item or service" in the cooling-off period context as "same or similar item or service" as defined in the IFR Part I.

VII. **Payment Determination**

a. Submitting Offers to the IDRE

Along with each party's offer, the information required to be submitted to the IDRE must include:

- The party's offer expressed as both a dollar amount and percentage of the QPA;
- Information requested by IDR entity;
- For providers, the size of their practices;
- For plans, information on the coverage areas, geographic regions, and other limited information for purposes of QPA calculation; and
- Any additional information (excluding prohibited information) to support an offer.

We have serious concerns about the provision that the offer by each party be expressed as a percentage of the QPA. As outlined in our previous comments to the Departments on the IFR Part I, we believe that the QPA (and related methodology) as

outlined in the first rule does not accurately reflect the market. Furthermore, this requirement creates a bias toward the QPA as the reasonable amount for payment. This is also biased towards the plans because the payers more readily have all the information needed to develop and base their offer around the QPA, while physicians are going into the IDR process having little information on the QPA calculation. This could present even more of a problem if the plan has downcoded or modified an original claim, and the two parties are using two different rates from which to base their comparisons.

In addition, physicians use the cost of providing care as the basis for their fee schedules, not a plan's median contracted rate. Requiring providers to compare offers to each plan's QPA does not create consistency. For example, one plan could have a QPA of \$90 for a service while another has a QPA of \$70—if the physician charges \$100 for a service, that offer will appear very different as a percentage of the two QPAs. This could lead to different IDR decisions for the same offer for the same service. **Therefore, we strongly urge the Departments to change the requirement that the parties' offers be submitted as a percentage of the QPA.**

We also urge the Departments to require the plans to provide more information on the calculation of the QPA along with their offer to the IDR entity. Some information the Departments could consider requiring are the types of providers included in the QPA calculation, how many individual providers were represented by each contract, and the types of services as part of the calculation.

b. Written Decision by IDRE

In the IFR, the Departments require that the IDRE provide a written decision at the end of each IDR process. If the IDRE doesn't choose the offer closest to the QPA, the IDRE must give a detailed explanation of the additional considerations made, the credibility of information submitted, and the basis for their determination that they should deviate from the QPA as the appropriate out-of-network amount. **We are concerned that this report and the emphasis on the QPA provides an incentive for IDREs to pick the party's offer that is closest to the QPA**—with the offer closest to the QPA, they will avoid needing to create such a detailed report to justify their decision and an administrative hassle.

c. Departments' Standard for Decision-making by IDRE and Interpretation of Statute

In the IFR, the Departments establish a standard for decision making by the IDRE which is materially different from the statutory language and does not align with Congressional intent. As outlined in the IFR, the IDRE is required to begin with the presumption that the QPA is the appropriate out-of-network rate (when deciding which offer to select) and they must select the offer closest to the QPA—unless there is credible information submitted by the parties which demonstrates that the QPA is not an appropriate out-of-network rate. The *No Surprises Act* statute established that the parties may provide additional information to the IDRE to support their offer. In addition, the statute highlights several factors that are relevant and “shall” be considered by the IDRE when determining an out-of-network payment. However, contrary to the statutory language, the Departments significantly limit how these factors may be used by the IDR entity in the IFR. Thus, the Departments disregarded the process established by Congress to ensure payments were fair and are essentially anchoring the IDR's decision to the QPA. Thus, the Departments' process is predetermining the outcome of the IDR process.

By deviating from the *No Surprises Act* text and Congressional intent to establish a process where the QPA is so heavily weighted in the IDRE's decision making, the Departments have exceeded their statutory authority. This will have long-term negative consequences on patients, providers, and the health insurance market—and will undoubtedly lead to consolidation in the health care marketplace. Therefore, **we strongly urge the Departments to revise the process in a subsequent, final rule, removing the provisions that create a presumption that the QPA is the appropriate out-of-network rate.**

Furthermore, the MMS disagrees with the Departments' listed rationale for favoring the QPA. The Departments explain that part of their decision to set the QPA as the presumptive out-of-network payment was because of the attention and detail paid to the description of the QPA in statute. This is mainly because the QPA was a new, novel concept that needed to be clearly defined by the law. The other items suggested as factors for consideration were known concepts and self-explanatory, not needing detailed descriptions. Nowhere in the statute does Congress ask the Departments to weigh in on how the QPA and other factors should be used by the IDR entity in making a determination. In fact, Congress explicitly states that additional factors related to the offer "shall" be considered by the IDRE. Assigning relative weights to the factors to be considered is specifically and intentionally absent from the statute, and the Departments are exceeding their authority by creating this presumption toward the QPA. Moreover, Congress outlines specific factors that shall not be considered by the IDRE. By outlining factors that Congress did not wish to be considered and those that they wanted included, it shows that Congress concluded the items to be included were all equally important to the IDRE's decision making.

To underscore congressional intent many members of Congress who were part of the negotiations of the final bill text have written letters to the Departments outlining their intent. For example, Ways and Means Chairman Richard Neal, a member of our Massachusetts Congressional Delegation who we communicated with on the legislation, was a key drafter of the final *No Surprises Act* text. He made it clear in a [recent letter to the Departments](#) that Congress did not intend for the QPA to be the presumptive out-of-network payment. A [letter from over 150 members of Congress](#) also relayed the same sentiment. We urge the Departments listen to these fellow policymakers in Congress who are expressing concerns with the IFR and consider revising the IFR language to allow all factors to be considered equally.

d. Negative Implications for Patient Access to Care

The IDR process as outlined by the Departments will significantly harm patient access to care in the future. **The process in the IFR incentivizes plans to offer lower payment rates to providers, which will ultimately lead to consolidation in the health care marketplace and narrower provider networks.** Patients will then have less choice and options for their care. To explain it further, there will be less demand for in-network care, which will reduce the insurers' incentive to engage in meaningful contract negotiations with physicians. Physicians who attempt negotiations will be given take-it-or-leave-it contracts with rates at or below the QPA. In fact, we are already seeing this happen in North Carolina, where the largest commercial market insurer in the state is using this IFR (specifically citing the IFR in their letters to providers) to drastically slash contract rates. It will be less important to plans whether they have hospital-based physicians in-network or not. Provider networks for in-network patients will narrow as the plans drop in-network contracts, impacting patients outside of the surprise medical billing protections, potentially

decreasing access to care for those patients. Additionally, patients will be getting much less for their premiums with these more limited networks. In addition, these lower rates—and the administrative burden caused by this rule—will drive provider consolidation, with physicians joining health care systems and closing their independent practices. The narrower provider networks and consolidation will only exacerbate existing health disparities and inequity—and will have a significant impact on rural and historically underserved communities. In addition, this will have an impact on innovation—with fewer resources, providers will need to make choices about whether they can take on any additional risk (i.e. Alternative Payment Models or value-based care) and invest in new technologies.

Congress knew that the IDR process needed to have sufficient checks on health plans and a balanced IDR process that allowed providers to make their case for a fair out-of-network payment. The IDR process instituted by Congress would have helped encourage plans to come to the negotiating table and settle payments in the open negotiations process. By implementing an IDR process that predetermines the outcome at the QPA level (or below), plans no longer are incentivized to negotiate and the necessary checks and balances are removed. As mentioned above, this has already happened in North Carolina—this action is likely to continue in other states if the Departments do not change the IFR so that the QPA is not set as the presumptive out-of-network payment rate.

e. Changes Needed if Current Process Remains

We strongly urge the Departments to revise the IDR process' reliance on the QPA as the appropriate out-of-network amount—however, if this process remains, there are some additional changes needed to promote a fairer process. First, **the plans will need to provide additional information to providers about the QPA upfront.** Moreover, without knowing the QPA information for the original claim from the plans, providers will not be able to submit credible information to refute the modified or downcoded claims. We urge the Departments to require that this information be sent by the plan to the provider immediately upon receiving notice that the IDR was initiated, and before the deadline to submit offers to the IDRE. We also seek clarification that other factors supporting a party's offer can be submitted by providers, including confidentially submitting contracted rates with other plans to support their offer.

As always, the Massachusetts Medical Society appreciates the opportunity to provide comments and work with the Departments on our shared goal of providing the highest quality health care to patients. The MMS' comments and recommendations are guided by our policies, our membership, and our commitment to providing quality, equitable care to all patients. Should you have any questions, please contact Alexandria Icenhower, Federal Relations Manager, at aicenhower@mms.org or 781-434-7215.