

December 6, 2021

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

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

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

RE: Requirements Related to Surprise Billing; Part II (CMS–9908–IFC)

Dear Secretaries Becerra, Walsh and Yellen:

The 21 undersigned surgical organizations appreciate the opportunity to comment on the “Requirements Related to Surprise Billing; Part II” interim final rules with comment (IFR) implementing certain provisions of the No Surprises Act issued by the Office of Personnel Management; Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; and Centers for Medicare & Medicaid Services, Department of Health and Human Services (collectively referred to as the “Departments” in this letter).

Overarching Comments

The undersigned surgical organizations support the overall goals of the No Surprises Act and the protection of patients from surprise medical bills. We are not requesting a rollback or delay of these patient protections. Instead, our comments below address fair payments for physicians for services provided to patients covered by a health insurance plan, concerns with aspects of implementation that stray significantly from the plain language of the statute, and an undue increase in administrative burden on providers.

Our most significant concerns relate to the many instances woven throughout the rule where the IFR favors plans and issuers over providers, which could reduce physician networks and jeopardize access to care for patients. We are also concerned about the longer-term implications

of this IFR on both in- and out-of-network physicians as they negotiate payor contracts, as well as the potential consequence of narrowed networks. We have heard anecdotally from our members that plans are already implementing aggressive contracting changes, citing the No Surprises Act as a rationale. The No Surprises Act bans balance billing for out-of-network services and includes an impartial payment dispute resolution process. While the law requires all factors to be considered equally in arbitration, the overemphasis on the qualifying payment amount (QPA) establishes a presumption that the median in-network rate, calculated by insurance companies, is the appropriate payment rate. Thus, the IFR ignores years of bipartisan and bicameral negotiations and misreads both the plain language of the statute and Congressional intent,¹ heavily benefiting insurers over physicians.

We are also deeply concerned about the lack of feasibility of the good faith estimate (GFE) requirements. The requirements on convening providers are especially burdensome, given the complexity of care today, the policy's timelines, the lack of a standardized methodology to easily generate GFEs, and the fact that convening providers might not have access to all the information they are required to provide.

We urge the Departments to consider the comments below to ensure fair payment for physicians, include essential checks and balances on the provider-insurer contracting process, and minimize regulatory burden to preserve a strong physician workforce for the future.

Federal Independent Dispute Resolution (IDR) Process

Open Negotiation & Initiation of the Federal IDR Process

Initial Payment

The Departments refer to the July 2021 interim final rules to clarify that the 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 prior to the beginning of any open negotiations or initiation of the Federal IDR process. **We agree that the initial payment should be an amount that the plan or issuer intends to be payment in full, and we urge the Departments to require that the initial payment should be the plan's or issuer's offer amount for IDR as well.** This is an important requirement to ensure that plans and issuers do not make unreasonably low initial payments, particularly during the 90-calendar-day suspension period where providers have no recourse against plans for insufficient payments, which could force some providers unnecessarily into the IDR process. **However, the mere fact that the initial payment should be considered**

¹ Congressional authors of the No Surprises Act have made clear that they wrote this law with the intent that the IDR entities must equally weight and consider many factors. See, e.g., (1) Joint statement from the Committees on Ways and Means, Energy and Commerce, and Education and Labor Committees (available at <https://gop-waysandmeans.house.gov/protecting-patients-from-surprise-medical-bills/>); (2) Letter from Senate Health, Education, Labor and Pensions Committee members Senators Margaret Wood Hassan and Bill Cassidy, MD (available at https://www.cassidy.senate.gov/imo/media/doc/SMB%20Letter%20Final_4_29_21.pdf); (3) Letter from House Ways and Means Committee leaders Representatives Richard E. Neal and Kevin Brady (available at <https://www.mcdermottplus.com/wp-content/uploads/2021/10/surprise-billing-regs-Neal-Brady-letter.pdf>); and (5) Letter from 152 bipartisan members of the U.S. House of Representatives (available at https://wenstrup.house.gov/uploadedfiles/2021.11.05_no_surprises_act_letter.pdf).

payment in full from the plan’s perspective does not mean that this payment amount should be presumed correct if the provider disagrees and ultimately initiates the IDR process.

Open Negotiation

The Departments state that the Notice of Open Negotiation must be delivered within 30 business days of the initial payment or notice of denial, and the 30-business day open negotiation period begins on the day on which the open negotiation notice is first sent by a party. The No Surprises Act does not always specify whether references to “days” are business days or calendar days. **We appreciate the Departments’ clarification that this open negotiation period is 30 business days.**

However, we continue to remain concerned with the Departments’ divergence from statute as it relates to the timeline. As already stated, the open negotiation notice must be delivered within 30 business days of the initial payment or notice of denial. The statute states that the initial payment or notice of denial must be provided “not later than 30 calendar days after the bill for such services is **transmitted by such provider or facility,**” creating an identifiable moment in time that the process starts that avoids manipulation by any party. Yet, in the first IFR, the Departments state that the 30-day payment or denial requirement is 30 days from the day that the plan has determined that it is a “clean claim.” This introduces a dynamic whereby plans can unilaterally control the timeline and deny providers and facilities their access to open negotiation by stalling the date by which payment or denial must be made. The No Surprises Act went to great lengths to ensure that the moments in time were certain and not subject to manipulation. Because the Departments have injected this uncertainty into the process by disregarding statutory direction that the 30 days begin when the facility **transmits** a bill, we **request that providers and facilities can initiate open negotiation after 30 days from when the bill was transmitted when plans have not yet provided an initial payment or notice of denial in to ensure that plans cannot manipulate the resolution timelines established under statute.** Furthermore, we urge the Departments to require that the Notice of Open Negotiation be submitted to the Federal IDR portal, providing a time stamp that will allow all parties to know exactly when the notice was delivered.

Initiation of Federal IDR Process

Either party may initiate IDR in the 4-business-day period after the end of the open negotiation period. To initiate the Federal IDR process, the initiating party must submit to the other party and to the Departments a Notice of IDR Initiation through the Federal IDR portal. The Notice of IDR Initiation must include:

1. Information sufficient to identify the qualified IDR items or services (and whether the services are batched), including the dates and location of the items or services, the type of qualified IDR items or services, corresponding service and place-of-service codes, the amount of cost-sharing allowed and the amount of the initial payment made by the plan or issuer for the qualified IDR items or services, if applicable;

2. The names and contact information of the parties involved, including email addresses, phone numbers, and mailing addresses;
3. The state where the qualified IDR items or services were furnished;
4. The commencement date of the open negotiation period;
5. The initiating party's preferred certified IDR entity;
6. An attestation that the items or services are qualified IDR items and services within the scope of the Federal IDR process;
7. The qualifying payment amount (QPA);
8. Information about the QPA as described in regulation; and
9. General information describing the Federal IDR process.

We note that providers might not have access to some of the required information as part of the Notice of IDR Initiation. For example, providers might not know the amount of cost-sharing allowed for the patient under the plan. It is also unclear whether the providers would know the QPA at the time of initiation of the IDR process. **Generally speaking, providers should not be required to include information at any point in the IDR process that they would not already have as part of routine patient billing under the plan. Further, providers should not be required to submit information (i.e., the QPA) that is under the complete control of the plans and issuers, both in its calculation and selection.**

We also suggest that the Departments allow the parties to initiate the Federal IDR process if certain extenuating circumstances make it impossible to meet the deadline. At the very least, we recommend some additional maximum number of days to initiate the IDR process if the parties are mutually agreeable to such an extension.

Federal IDR Process

Selecting an IDR Entity

The Departments state that the certified IDR entity must review the information submitted by the parties to determine whether the Federal IDR process applies, including whether an All-Payer Model Agreement or specified state law applies. If the certified IDR entity determines that the Federal IDR process does not apply, the certified IDR entity must notify the Departments and parties within 3 business days of making this determination. We request clarification on the Departments' requirement that the IDR entity must determine whether the Federal IDR process applies. **It is not appropriate that the Federal IDR entities are granted the ability to determine whether state law applies.** This would necessitate that every IDR entity be knowledgeable about every state law.

Rather, it appears that the intent of this provision could be that the Federal IDR entity performs a final check prior to entering IDR to confirm a decision already made by another entity. Given the lack of clarity, we request further explanation of this requirement. In addition, to the extent that a certified IDR entity performs this "final check" that the Federal IDR process is the appropriate venue for dispute resolution, we request that the entity conduct this analysis within 3 business days of being selected. The regulations as written only require that the certified IDR entity notify parties within 3 business days of making the determination, but provides no guidance on when

the certified IDR entities must make this determination. Given the expected confusion surrounding whether state or federal law applies and timelines under state law for their processes, parties must be notified as quickly as possible so that timelines under state law are not missed if that is the appropriate resolution venue. **The Departments should undertake a comprehensive state-by-state analysis to determine whether the state law or federal law applies. This information, which should be periodically updated, could then be published on the Departments' websites.**

Costs of IDR Process

In the case of batched items or services, the party with the fewest determinations in its favor is considered the non-prevailing party and is responsible for paying the certified IDR entity fee. If each party prevails on an equal number of determinations, the fee is split evenly. Requiring the party with the fewest determinations in its favor to be responsible for paying the certified IDR entity fee could be a disincentive to batch claims. **Instead, we urge the Departments to establish a fee based on the percentage of favorable determinations.** For example, if one party receives an unfavorable determination for 40 percent of the batched claims, then that non-prevailing party should pay 40 percent of the certified IDR entity fee.

Batched Items and Services

We appreciate the ability to batch multiple claims as described in the IFR, including claims arising during the cooling-off period into a single batch. The Departments appear to have struck the right balance to facilitate an equitable consideration of multiple claims within a single IDR review. We also ask for clarification on the moment in time in which batching occurs. At the moment of IDR initiation, claims that are potentially eligible for batching could be in different stages (some paid, some not yet submitted, and some in open negotiation). We ask for clarification on which claims may or may not be batched.

Payment Determination

Submission of Offers

Not later than 10 days after the date of selection of the certified IDR entity, the plan or issuer and nonparticipating provider, nonparticipating emergency facility, or provider of air ambulance services must each submit to the certified IDR entity an offer for a payment amount for such qualified item or service. We reiterate our recommendation that **the initial payment made by the health plan or issuer should be *de facto* their offer amount for IDR.**

The Departments state that the offer must be expressed as both a dollar amount and the corresponding percentage of the QPA represented by that dollar amount (in order to facilitate certified IDR entity reporting of the offer as a percentage of QPA). As we highlighted in the introduction, this rule places an overemphasis on the role of the QPA in the IDR process. **The requirement that the parties must submit the offer as both a dollar amount and a corresponding percentage of the QPA is another example of the Departments conferring unnecessary weight to the QPA.** It is also unclear at what point providers will learn the QPA

for their claim during the open negotiation process and forcing providers to lend credence to the QPA by communicating their offer as a percentage of the QPA is unnecessary and unfortunate.

Where items and services are batched and have different QPAs, the Departments state that parties should provide these different QPAs and may establish different offers for these batched items and services, provided that the same offer should apply for all items and services with the same QPA. **We support this policy as allowing the batching of claims with different QPAs, and different offers for the different QPAs, which will allow for additional administrative ease and reduced fees, with the caveat, as stated above, that the requirement to provide QPA-related information should rest solely on plans and issuers.**

Submission of Additional Information

At the time of submission, the Departments state that the providers must also indicate the size of their practices and facilities (i.e., for providers fewer than 20 employees, 20 to 50 employees, 51 to 100 employees, 101 to 500 employees, or more than 500 employees; facilities must similarly report but the step begins with 50 or fewer employees), which the certified IDR entities will use to meet reporting requirements. **We request clarification on why the Departments require information on the size of the providers' practices and facilities and what relevancy the number of employees (as opposed to providers) has on an IDR determination.**

Selection of Offer

Standard for Decision-making

Not later than 30 business days after the selection of the certified IDR entity, the certified IDR entity must select one of the offers submitted by the plan or issuer and the provider or facility to be the out-of-network rate for the qualified IDR item or service. The Departments state that in selecting the offer, the certified IDR entity must presume that the QPA is an appropriate payment amount but must also consider additional circumstances only if the parties submit the information. The Departments also state that to be considered by the certified IDR entity, information submitted by the parties must be "credible" and relate to the offer submitted by either party and must not include information on the prohibited factors.

The Departments direct that the certified IDR entities must select the offer closest to the QPA, after considering the QPA, additional information requested by the certified IDR entity from the parties, and all of the "credible" information that the parties submit that is consistent with the requirements in the regulation unless the credible information submitted by the parties clearly demonstrates that the QPA is "materially different" from the appropriate out-of-network rate. If the certified IDR entity determines that the "credible" information demonstrates that the QPA and appropriate out-of-network rate are "materially different" or when the offers are equally distant from the QPA but in opposing directions, the Departments state that the certified IDR entity must select the offer that the certified IDR entity determines best represents the value of the items or services, which could be either party's offer. The Departments state that they will provide additional guidance to certified IDR entities as necessary to clarify how the allowable factors should be considered.

We fundamentally disagree with the Departments’ interpretation of this section of the No Surprises Act. We urge the Departments to revise the IFR to conform to the statutory language, which allows an IDR entity the discretion to conduct a *de nova* review of the payment offer and consider all the relevant information submitted by the parties to determine a fair out-of-network payment to physicians, without creating a presumption that directs an IDR entity to consider the offer closest to the QPA as the appropriate payment amount.

After extensive bipartisan and bicameral deliberations, Congress passed the No Surprises Act to protect patients from surprise medical bills and create a balanced process to resolve payment disputes between plans and issuers and health care providers. To this end, the statute is quite clear that the IDR entity *shall* consider a variety of factors, including not just the QPA but also the following:

- Level of training, experience, and quality and outcomes measurements of the provider that furnished such item or service;
- Market share of parties;
- Patient acuity or complexity of furnishing the item or service;
- Teaching status, case mix, and scope of services of the nonparticipating facility;
- Demonstrations of good faith efforts (or lack thereof) to enter into network agreements; and
- Prior contract history between the provider and the plan during the previous 4 plan years.

Nowhere in the statute is language creating a “rebuttable presumption” that requires IDR entities to give outsized weight to a single statutory factor — the QPA. In fact, as defined by the statute and outlined in the first IFR, “Requirements Related to Surprise Billing; Part I,” the primary purpose of the QPA is to determine the patient’s cost-sharing amount for out-of-network care. **While the QPA is relevant, it is merely one of several factors, each of which must all be considered equally by the IDR entity.** The process laid out in the law expressly directs the certified IDR entity to consider each of the above-listed factors to capture the unique circumstance of each billing dispute without causing any single piece of information to be the default one considered. Furthermore, in the IFR, the Departments intimate that information related to these additional factors will only be considered if it is deemed “credible.” Once again, the Departments interject terminology that does not exist in the statute, and which might limit the consideration of factors other than the QPA by the IDR entity. We take issue with this qualification and urge the Departments to direct the IDR entities to consider **all factors relevant to the payment offer, without qualification and without comparison to the QPA, as consistent with the plain text of the statute.**

Moreover, directing the IDR entity to presume the QPA is the correct payment amount is tantamount to establishing a federal payment benchmark for commercial rates — something that Congress specifically crafted legislative language to avoid when it negotiated the final parameters of the No Surprises Act. If unchanged, the approach taken in this IFR will incentivize health plans to establish artificially low payment rates, which would narrow provider networks and jeopardize patient access to care — the exact opposite of the law’s goal and Congressional

intent. It could also have a broad impact on payment rates for in-network services, which is outside the scope of a law meant to govern *out-of-network* payment rates. Already, we have evidence that health plans are weaponizing the law and related regulations to force providers into take-it-or-leave-it contracts at significantly reduced rates.²

Downcoded claims

If a plan or issuer has altered the service code or modifier(s) for a submitted claim and applies a QPA that uses a different service code or modifier(s) than the service code or modifier(s) submitted by the provider or facility, the provider or facility could submit credible information to the certified IDR entity demonstrating that the QPA applied by the plan or issuer to the claim is based on a service code or modifier that did not properly encompass patient acuity, the complexity of furnishing the qualified IDR item or service. We appreciate the Departments' acknowledgment that plans or issuers sometimes alter the service code or modifier(s) for submitted claims. In these instances, plans or issuers would apply a QPA that is different from the QPA that would have applied to the service code or modifier(s) submitted by the provider or facility. We also appreciate that the Departments will allow the provider or facility to submit credible information demonstrating that the QPA applied was not appropriate. **For providers and facilities to provide such credible information, the Departments should require plans and issuers to indicate that a different QPA is being used (i.e., that the claim has been “downcoded”) and share with providers and facilities the QPA that would have applied to the service code and modifier(s) originally submitted by the provider or facility.**

90-Day Cooling Off Period (or “90-Calendar-Day Suspension Period”)

When a certified IDR entity makes a determination, the party that submitted the initial Notice of IDR Initiation may not submit a subsequent Notice of IDR Initiation involving the same other party, with respect to a claim that is the same as or similar to a qualified IDR item or service that was subject of the initial determination, during the 90-calendar-day period following the initial determination. Services provided during the 90-day period are eligible for IDR and may be included in the same batch following the end of that period. After the end of the 90-day period, either party can initiate the IDR process for claims affected by the suspension, and the party must submit the Notice of IDR Initiation within 30 business days following the end of the cooling-off period (as opposed to the standard 4-business-day period following the end of the open negotiation period). The 30-business-day period begins on the day after the last day of the 90-calendar-day period. **We appreciate the opportunity for parties to batch claims during this period. We request clarification that no open negotiation is required for claims batched during the 90-day cooling-off period.** We also request clarification as to whether the payment determination for the claims held in the 90-day cooling off period would trigger *another* 90-day-cooling off period or whether that payment determination would represent the resolution of the full set of circumstances under consideration as triggered by the initial payment determination.

² See, for example, reports of letters sent by Blue Cross Blue Shield of North Carolina to anesthesiologists and other physician practices in that state threatening contract terminations and the physicians' in-network status unless the physicians immediately agree to payment reductions ranging from 10 to over 30%. Implementation of the No Surprises Act is cited in the letters as the impetus for the reductions. (Available at <https://www.asahq.org/about-asa/newsroom/news-releases/2021/11/bcbs-abuses-no-surprises-act-regulations>)

Protections for the Uninsured

GFEs for Uninsured and Self-Pay Individuals

Upon scheduling an item or service to be furnished, the No Surprises Act requires that providers and facilities provide a notification of the GFE of the expected charges for furnishing such item or service (including any item or service that is reasonably expected to be provided in conjunction with such scheduled or requested item or service or reasonably expected to be so provided by another provider or facility), with the expected billing and diagnostic codes for any such item or service. If an individual is not enrolled in a certain type of plan or coverage or is not seeking to file a claim, the No Surprises Act requires providers and facilities to furnish the GFE to the individual. The Department of Health and Human Services (HHS) acknowledges that it could take time to establish processes to meet these requirements for GFEs provided to uninsured (or self-pay) individuals from January 1, 2022, through December 31, 2022. Therefore, HHS will exercise its enforcement discretion in situations where a GFE provided to an uninsured (or self-insured) individual does not include expected charges from co-providers or co-facilities.

We appreciate HHS' acknowledgment of the challenges of providing GFEs, particularly in situations involving co-providers or co-facilities. **Therefore, we support the plan to exercise enforcement discretion and urge HHS to err on the side of the providers who make a reasonable attempt to provide the necessary information to patients.** Nevertheless, we have some outstanding concerns about the ability of surgeons to comply with the requirements of this section of the IFR, as outlined below.

Definitions

Convening Health Care Provider or Convening Health Care Facility is defined as the provider or facility who receives the initial request for a GFE 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.

“Good Faith Estimate” is defined as 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.

In many situations, surgeons are likely to be the convening provider and serve as the patient's point of entry for services rendered at an outside facility (e.g., hospital or ambulatory surgery center) and by ancillary providers (e.g., anesthesiologists, radiologists, and pathologists). As such, the responsibility to prepare the GFE will fall on the shoulders of the surgeons and their practices.

Requirements for Convening Providers

To determine whether the GFE requirement applies, HHS requires that the convening provider or facility inquire and determine if the individual meets the definition of an uninsured (or self-pay) individual. HHS also requires that the convening provider or facility must inform uninsured (or self-pay) individuals that GFEs of expected charges are available to uninsured (or self-pay) individuals upon scheduling an item or service or upon request. HHS requires that the convening provider or facility contact all applicable co-providers and co-facilities no later than 1 business day after the request for the GFE is received or after the primary item or service is scheduled, and request submission of expected charges for items and services that meet the requirements for co-providers and co-facilities.

Regarding the timing requirements, HHS requires that the GFE must be provided according to the following parameters:

- For an individual who schedules at least 3 business days before the date the item or service is furnished, the GFE must be provided no later than 1 business day after the scheduling.
- For an item or service scheduled at least 10 business days before the date the item or service is furnished, the GFE must be provided no later than 3 business days after the scheduling or request.
- If a provider or facility included in the GFE is no longer available, the convening provider or convening facility must issue an uninsured (or self-pay) individual with a new GFE no later than 1 business day before the item or service is scheduled to be furnished. However, if any changes are made less than 1 business day before the item or service is scheduled to be furnished, the replacement provider or replacement facility must accept the GFE as their expected charges for the items or services being furnished that were provided by the original provider or facility represented in the GFE.
- When a GFE is provided in response to a request and then is subsequently scheduled, a new GFE must be provided to the uninsured (or self-pay) individual under the established timelines.

This timeline is set forth in the No Surprises Act, so we understand that the Departments have limited flexibility in its implementation beyond the enforcement discretion already provided. But we note that the timing set forth will be extremely challenging for convening providers without some sort of tool or standardized method to quickly generate GFEs.

Content of the GFE for an Uninsured (or Self-Pay) Individual

The GFE must include wide-ranging information, some of which may not be readily available to the convening provider — particularly if that individual is a surgeon in private practice. Generally speaking, surgeons can readily include the following information in the GFE:

- Patient name and date of birth;
- Description of the primary item or service in clear and understandable language;

- Itemized list of items or services, grouped by each type of provider or facility, reasonably expected to be provided for the primary item or service, and items or services reasonably expected to be furnished in conjunction with the primary item or service, for that period of care, including:
 - Those items or services reasonably expected to be furnished by the convening provider or convening facility, and
 - Those items or services expected to be furnished by co-providers or co-facilities;
- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service **that are within the direct purview of the convening surgeon (more on this below)**;
- Name, NPI, and TIN of each provider or facility represented in the GFE **(subject to the clarification/limitation below)** and the state(s) and office or facility location(s) where the items or services are expected to be furnished by such provider or facility;
- List of items or services that the convening provider or convening facility anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service;
- A disclaimer that informs the uninsured (or self-pay) individual that there may be additional items or services the convening provider or convening facility recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the GFE;
- A disclaimer that informs the uninsured (or self-pay) individual that the information provided in the GFE is only an estimate of items or services reasonably expected to be furnished at the time the GFE is issued to the uninsured (or self-pay) individual and that actual items, services, or charges may differ from the GFE;
- A disclaimer that informs the uninsured (or self-pay) individual of their right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess of the expected charges included in the GFE;
- A disclaimer that the GFE is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the GFE;
- In instances where a convening provider or convening facility anticipates that certain items or services will need to be separately scheduled (such as those items or services typical of the standard of care), the convening provider or facility must include a separate list of items or services that the convening provider or facility anticipates will require separate scheduling and that are expected to occur either prior to or following the expected period of care for the primary item or service. Additionally, the GFE must include a disclaimer directly above this list that notifies the uninsured (or self-pay) individual that: (1) separate GFEs will be issued to an uninsured (or self-pay) individual upon scheduling of the listed items or services or upon request; and (2) for items or services included in this list, information such as diagnosis codes, service codes, expected charges, and provider or facility identifiers may not be included as that information will be provided in separate GFEs upon scheduling of such items or services or upon request; and (3) include instructions for how an uninsured (or self-pay) individual can obtain GFEs for such items or services.

However, it is unreasonable to require certain convening providers to provide information for which they do not have access or when it would add a significant burden to the convening provider. For example, while surgeons may know the name of the facility in which patients' surgeries will be provided, it will be difficult for them to ascertain the NPI and TIN of facilities. Similarly, surgeons may expect to use anesthesia, radiology, pathology and other ancillary services at hospitals and other facilities but will not likely know which individuals will provide those ancillary services when the GFE is prepared. It will also be challenging for convening surgeons to provide accurate diagnosis and service codes for outside facilities and ancillary providers. Likewise, it will be impossible for convening surgeons to accurately estimate expected charges for those providers not directly controlled by the convening surgeon. **Thus, in situations where patients require care from more than one provider, in addition to their own information, the convening provider should only be responsible for providing a list of additional services that patients can expect in such a format that will allow the patient to obtain GFEs from any additional co-providers.**

Patient-Provider Dispute Resolution

The No Surprises Act requires the Secretary of HHS to create a process for an uninsured (or self-pay) individual who received a GFE of expected charges to seek a determination from a selected dispute resolution (SDR) entity for the amount to be paid to the provider or facility. The individual can only seek a determination from the SDR if (a) if they are furnished the item or service for which they received the GFE; and (b) if the charges are "substantially in excess" of the GFE, defined as at least \$400 more than the total amount of expected charges for the provider or facility listed on the GFE. **We request clarification from HHS on whether a patient can seek a determination from the SDR entity if the cumulative costs are over \$400 when no single provider's costs are significantly above what would be expected. Also, we recommend that the threshold for entering the SDR process should be based on a percentage of the costs rather than a flat \$400.** For example, if the final costs are a specific percentage above the GFE, then the SDR process can be initiated. **Finally, in circumstances where a replacement GFE is provided upon scheduling after a GFE was issued "upon request," we request that HHS provide clarification that determining eligibility for the PPDR must be premised on the most up-to-date "scheduled care" GFE and not any GFE that the patient requests prior to scheduling.**

Conclusion

On behalf of our surgeons and the patients they serve, we appreciate the opportunity to provide our thoughts and recommendations regarding this second installment of regulations related to the No Surprises Act. We look forward to our ongoing dialogue with the Departments on this and future rulemaking. If you have any questions or need additional information, do not hesitate to contact us.

Thank you for considering our comments.

Sincerely,

American College of Surgeons
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American Orthopaedic Foot & Ankle Society
American Pediatric Surgical Association
The American Society of Breast Surgeons
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society for Metabolic and Bariatric Surgery
American Society of Plastic Surgeons
American Society for Surgery of the Hand
American Urological Association
Congress of Neurological Surgeons
Society of American Gastrointestinal and Endoscopic Surgeons
Society for Vascular Surgery
The Society of Thoracic Surgeons