

September 7, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-9909-IFC Requirements Related to Surprise Billing: Part I

Dear Administrator Brooks-LaSure:

The American College of Radiology (ACR), representing nearly 40,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to comment on the first Interim Final Rule with Comment (IFC) issued by the Internal Revenue Service, Department of the Treasury, Department of Labor and the Department of Health and Human Services on implementation of the No Surprises Act (NSA), included in the Consolidated Appropriations Act of 2021.

The ACR shares the administration's patient-centered goal of ending "surprise medical billing" (SMB), while also addressing payer network adequacy issues that often lead to such problems. Specifically, the ACR strongly supports the NSA "hold harmless" provisions, removing patients from reimbursement disputes between insurers and providers. In addition, the ACR appreciates the NSA's balanced approach with respect to insurance companies and medical practices. The law was designed to give neither side unbalanced leverage in network contract negotiations, and in fact, is intended to promote good-faith negotiations and network contracting.

To promote a sustainable healthcare system, it is imperative that fair payment mechanisms exist to ensure adequate reimbursement for out-of-network services. The NSA represents a reasonable solution to this issue. The ACR is particularly supportive of the open negotiation between payers and providers, including independent dispute resolution (IDR) to resolve lingering disputes. The ACR would like to offer comments on the calculation of the Qualifying Payment Amount and its implications.

The "Qualifying Payment Amount" (QPA) is defined in the Act as initially benchmarked at the median contracted rate recognized by the plan or insurer on January 31, 2019 and then updated for inflation annually. The QPA has dual roles in the NSA; it is one of many equally-weighted criteria to be used in IDR determination, and it is used to calculate patient cost sharing amounts for such services furnished by nonparticipating emergency facilities and nonparticipating providers at participating facilities when there is

no applicable All-Payer Model Agreement or amount determined by a specified state law. Given this second role of the QPA, it is logical when developing the QPA calculation methodology that the goal is to limit the financial burden on patients. The ACR understands this approach to limiting the cost-sharing amounts for patients who receive unexpected out-of-network care.

That said, the ACR would like to acknowledge that the QPA calculation methodology as outlined in the IFC does not represent “real world” median contracted rates. The primary issue with the calculation methodology is the treatment of a contract as a datapoint in the median calculation, rather than individual claims representing datapoints. There is no weight given to the number of claims or services provided under a contract. As a result, there is potential skewing of the QPA calculation downward. As an example, an insurance company may have contracts for a service with medical practices that rarely (if ever) perform that service. Since those medical practices do not depend on that service for a meaningful fraction of their revenue, it is likely that they accepted an insurer favorable rate, and instead focused the negotiation on services of greater importance to their practice. It is conceivable that in some regions, the number of contracts for an unbilled or rarely billed service is greater than the number of contracts for a frequently billed service. Defining the median at the contract level, regardless of how often that service was billed, will thus artificially reduce the calculated rate.

The ACR is also concerned that the QPA calculation does not include bonus or other supplemental payments, such as when providers participate in alternative payment models or have built-in incentives. Failure to incorporate such payments into the QPA calculation both misrepresents the median rate and could have the long-term impact of threatening movement toward value-based payment arrangements.

The ACR strongly believes that the QPA should not be used as the primary factor in the IDR process. While the ACR understands the rationale behind the QPA calculation methodology, given this approach, it is even more important that the NSA’s original intent be followed. The law states that the IDR entities “shall consider” the following when making a determination:

1. Offers by both parties
2. QPA (for the same service in the same geographic region)
3. Circumstances, including training, experience, quality and outcomes measurements
4. Market shares of parties
5. Acuity of patients/complexity of cases
6. Teaching status, case mix, scope of services of facility
7. Good faith efforts by parties to contract and contracting rate history from the last four years.

When drafting the NSA, Congress clearly intended to avoid favoring insurance companies or medical practices. As part of that balance, they selected an arbitration-based approach, as opposed to a benchmark, and established a list of IDR criteria with no one factor predominating. Bipartisan letters written by the three major committees of jurisdiction (Senate Health, Education, Labor and Pensions; House Ways and Means; House Energy and Commerce) confirm this intent. The authors of these letters include lawmakers deeply involved in drafting the language of the Act. For example, the bipartisan Senate HELP letter states that, “we wrote this law with the intent that arbiters give each arbitration factor equal weight and consideration.”

We are concerned that attempts to establish the QPA as the primary factor in IDR determination would convert a balanced, arbitration-based law into a benchmark-style law that favors insurers at the expense of patients and providers. While the vast majority of radiologists practice in-network and do not engage in out of network billing, the ACR is concerned that the NSA could be used to reduce network contracting and lower in network payment rates, impacting patient’s access to medical imaging. If the QPA is established as the primary criteria in IDR, it would have an unintended second order effect on insurer/provider contract negotiations. If the QPA is given disproportionate weight in IDR, insurers will have less incentive to negotiate in good-faith with medical practices and maintain a robust group of in-network providers that are paid at market rates. The result would be less network contracting, with more providers and patients pushed out of network. This is antithetical to the goals of the NSA.

In summary, the ACR fully supports the intent of the NSA to eliminate “surprise” medical bills for patients. However, it is imperative that fair payment mechanisms ensure adequate reimbursement for out-of-network services in order to promote a sustainable healthcare system. The NSA was crafted in a balanced manner, avoiding favoring insurers or providers. While the ACR understands the rationale behind the methodology used to calculate the QPA, the calculation does not reflect the real-world business environment. It is therefore even more important that future rulemaking support the NSA’s balanced, arbitration-based approach with equal weighting of all IDR criteria. The College appreciates the Departments’ efforts to support this intent and engage with both providers and payers to ensure continued patient access to high quality healthcare.

Thank you for the opportunity to provide feedback on the first IFC. The ACR looks forward to continuing to engage and offer comments during the continued rulemaking process. If you have any questions, please contact Kathryn Keysor, ACR Senior Director, Economics and Health Policy at kkeysor@acr.org.

Sincerely,



William T. Thorwarth Jr. MD FACR
Chief Executive Officer