The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

August 20, 2021

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: No Surprises Act Interim Final Rule

Dear Administrator Brooks-LaSure,

The American College of Obstetricians and Gynecologists (ACOG), representing more than 60,000 obstetrician-gynecologists and partners in women's health, appreciates the opportunity to offer feedback on the interim final rule (IFR) of the No Surprises Act (NSA), as part of the Consolidated Appropriations Act of 2021. As physicians dedicated to providing quality care to women, ACOG is concerned that implementation of the NSA may threaten the financial sustainability of obstetrician-gynecologist practices and limit access to critical health care for women of all ages.

ACOG supports protecting patients from receiving unanticipated medical bills from out-of-network providers or others as a result of a coverage gap. ACOG appreciates the steps this legislation takes to protect patients from surprise medical bills, including coverage of emergency services, or a change in anesthesia care. It is also critically important that implementation of the NSA treat physicians equitably to their payer counterparts. While this rule tackles many important components of the NSA, further clarity on how obstetrician-gynecologists can properly understand and implement the provisions of the law that have yet to be discussed well ahead of the January 1, 2022 effective date is imperative.

As distinguished in the law, the qualifying payment amount (QPA) is calculated by the median contracted rate recognized by the plan or issuer in 2019 and is updated annually through a specific formula taking inflation into consideration. Given the far-reaching impact of these QPAs and their attachment to patient's cost-sharing, ensuring the sound methodology behind the median contracted rate and the subsequent QPA is of prime importance. The mix of payers in this space is vast and varied, and such a methodology must take these factors into consideration. ACOG has significant concerns over the payers' unilateral ability to set median contracted rates without input by physicians or facilities. In the IFR, providers are automatically disclosed very little information around the payer's QPA for a given service, having to resort to requesting additional information on how the QPA was calculated by the payer. This allows for little input by providers on items with direct impact of the median contracted rate and QPA, such as similarity of services. This is especially concerning when payers work to set median contracted rates for services with insufficient information, new services codes, or codes that have been significantly changed. Without physician input, these rates could be set without expert recommendation or utilize undesirable data, leading to further burden on providers to initiate and see through a 30-day

open negotiation period. **ACOG recommends requiring payers to involve physicians and/or facilities in the ratesetting and QPA calculation process prior to services being billed.**

The IFR also notes that physicians and facilities must include good faith estimates of charges a patient would expect to receive if they consent to forgo NSA protections, information on prior authorization, and in-network providers that could provide the care or service in place of the provider in question. Additionally, this information must be provided within 72 hours of an appointment or within 3 hours of an appointment made within the last 72 hours. This information is critical for patients to make informed decisions on the care they receive; however, this also places unreasonable administrative burdens on the physician to provide this information to the patient within the expected timeframe. Much of this information should be provided by the payer, who knows the in-network providers and options available to the patient. Therefore, **ACOG recommends that payers provide critical information about physician and facility availability, estimates of charges and prior authorization requirements to patients and providers**.

Furthermore, implementation of the law should ensure that payers are appropriately accountable. Payers must maintain accurate and up-to-date lists of their in-network providers to ensure that patients can avoid the financial consequences of unknowingly receiving care from an out-of-network provider. In circumstances of inadequate networks or physician availability, payers must make accommodations for their beneficiaries, especially when care was delivered by an out-of-network clinician unknown to the patient. Additionally, when implementing the requirements surrounding advanced cost estimates, it is imperative that the responsibility be appropriately borne by payers and the utmost attention be given to avoid increasing the administrative burden on physicians.

ACOG looks forward to the opportunity to review the upcoming regulations set forth on the independent dispute resolution process in the coming months. Thank you for your time and consideration. If you have questions or concerns, please contact Erin Lambie Alston, ACOG's Policy Strategist, at elambie@acog.org.

Sincerely,

Lisa Satterfield, MS, MPH
Senior Director, Health Economics & Practice Management