



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

November 30, 2021

The Honorable 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: [Requirements Related to Surprise Billing; Part II \[CMS-9908-IFC\]](#)**

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 second 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.

The first iteration of regulations set forth earlier in 2021 established calculations of the qualifying payment amount (QPA), the interaction of state and federal surprise billing requirements, the patient notice and consent processes, disclosure of balance billing protections, and complaint processes. This second round of regulations surrounding the NSA legislation implements the following components: the open negotiations and independent dispute resolution (IDR) processes between providers and health plans, expansion of the scope of the federal external review process to cover adverse benefit determinations, good faith estimate (GFE) requirements and the dispute resolution process for uninsured or self-pay patients. Please see our detailed comments below on specific provisions covered in this IFR.

**Independent Dispute Resolution (IDR) Process**

*Initiation*

Once the open negotiation period has concluded without agreements by either party, the parties must formally initiate the federal IDR process as outlined in the rule. As part of this initiation, physicians and/or facilities are required to submit several points of information regarding the items and/or services

in question including amount of cost sharing allowed. In many cases, this information is not readily available to physicians and would be more easily accessed by their payer counterparts, such as the QPA and amount of cost-sharing allowed. Furthermore, given the very short turnaround time of four business days to provide this information and thus initiate the federal IDR process, it is imperative that further barriers are not established. **ACOG requests that physicians seeking to initiate the IDR process are only required to submit the information they have access to, and that the regulation is further modified to place the primary responsibility of submitting the necessary information on the payers.**

#### *Batched Items and Services*

In the rule, the Departments have established that similar items and/or services billed by the same provider/group of providers to the same payer within a specified timeframe can be batched for further efficiency in the federal IDR process. The Departments are soliciting comments on this approach and if other alterations should be made. **ACOG appreciates the Departments' decision to allow for batching of services and items as appropriate and requests this provision is retained in further iterations of the regulations.**

#### *Payment Determination*

The Departments specify that the certified IDR entity will presume the payment option closest to the QPA is the appropriate payment amount unless credible information provided by either party dictates otherwise. ACOG recognizes the importance the Departments have placed on the QPA in the federal IDR process, but the assertion that the QPA should reflect standard market rates through their basis on median contracted rates, thus automatically assuming it is the appropriate payment amount, is shortsighted. The Departments note that doing so will increase the predictability of IDR outcomes and encourage providers to avoid administrative costs by reaching agreements on payments outside of the IDR process. However, this sentiment does not consider the barriers such a process can place on physicians and smaller practices. Physicians seeking to engage in the IDR process are bearing the costs associated with the items and services that have not been paid for and will be required to pay an additional \$500 to see through the IDR process. Presuming the QPA as the appropriate payment amount from the outset suggests the IDR is unnecessary and discourages physicians and practices from engaging in the process entirely. As such, **ACOG strongly recommends that the Departments reevaluate the presumption that the QPA is the appropriate payment amount and return to the statutory intention of the original legislation where the QPA is a single factor amongst others that the certified IDR entities will assess in their final payment determinations.**

#### **Protections for Uninsured and Self-Pay Patients**

##### *Good Faith Estimates*

Per the rule, uninsured or self-pay patients are entitled to receive clear and understandable documentation of the expected costs associated with the care that they are considering or are scheduled to receive. The anticipated charges informing the good faith estimate (GFE) are to be provided by the physicians and/or facilities who are expected to furnish the items or services to be billed to the patient. However, the exact information on GFEs and expected charges for a specific item or service would need to be gathered from other providers that would be involved in the services being provided. Doing this would instill a tremendous burden on the physician that is managing the care of the patient. Additionally, the physician is often not initially aware of which specific providers will be involved (i.e., anesthesiologist, radiologist, pathologist) in the furnishing of services, the specific services which

may be required, and the costs associated with such services. This creates a substantial amount of work for physicians and could be impractical to provide ahead of services for an uninsured or self-pay surgical patient. As such, **ACOG recommends the Departments identify a more appropriate and efficient method of retrieving GFEs for services being furnished for uninsured or self-pay patients.**

Furthermore, there continues to be confusion around who exactly the “convening provider” is expected to be in these circumstances. The rule defines the convening provider 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.” Specifically, the Departments decided against utilizing the “treating health care provider” as many physicians and facilities participating in a patient’s care are both considered the “treating health care provider.” However, it remains unclear from the rule’s language on how to quickly and effectively determine who is the convening provider. Without doing this, physicians and facilities run the risk of delaying the information gathering process associated with the GFE, further burdening the true convening provider. **ACOG requests that the Departments consider the convening provider the facility or location of the procedure, and further clarify and provider examples.**

#### *Patient-Provider Dispute Resolution*

Within the rule’s discussion of the patient-provider dispute resolution process, it is noted that charges “substantially in excess” will refer to an amount of at least \$400 more than the expected charges listed in the GFE. The Departments also noted that there was consideration of establishing a percentage-based threshold of excess total expected charges from the GFE but decided against implementing this due to the variations in dollar threshold based on the magnitude of expected charges detailed in the GFE. We understand these concerns regarding establishing a percentage-based threshold but have concerns about establishing a flat rate of \$400. Doing so results in large inequities for disputes representing a minimal percentage of the total expected charges. Additionally, in many cases, items and services may vary greatly from the furnished GFE as a result of changes required at the point of surgery due to the discovery of a more severe condition or an emergent need. Therefore, **ACOG requests the Departments reconsider implementing a \$400 flat rate in favor of a percentage-based threshold of total excess charges from the GFE.**

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](mailto:elambie@acog.org).

Sincerely,



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