VIA FEDERAL REGISTER PORTAL
Internal Revenue Service
Department of the Treasury

Employee Benefits Security Administration
Department of Labor

Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: OMB Control Number, 1210-0169

Sound Physicians ("Sound") is a leading physician partner to hospitals, health plans, physician groups, and post-acute providers seeking to transform outcomes for acute episodes of care. Sound has been a leader in the industry for 20 years and operates in 44 states across the country. Sound's operations continue to grow as the need for physicians continues. Sound's service lines are emergency medicine, hospital medicine, critical care, anesthesiology, and telehealth. Sound works with hospitals and provider groups to ensure that all patients in Sound's service areas have access to physicians and other providers. As a leader in the industry, Sound has contracts with a majority of payors.

The advent of the No Surprises Act has directly impacted Sound's ability to provide lifesaving care as payors have largely seen the Act as an opportunity to lower reimbursement rates to in- and out-of-network providers. Unlike other in- or out-of-network providers in the healthcare industry, Sound's providers are unable to pick their patients based on their insurance reimbursements.

The Independent Dispute Resolution ("IDR") process is one way that providers are able to advocate for their rates. However, the Final Rule fails to completely address Sound's and other similarly situated providers' questions and concerns.

Sound is therefore providing these comments on the Final Rule and the No Surprises Act IDR process:

- Batching Requirements Create Expensive Delays and are Cost Prohibitive

Sound has entered into a substantial number of contracts with payors and provides services to tens of thousands of patients across the country. While Sound is primarily in-network with most payors, there are several states in which Sound has not been able to obtain a contract or where the contract has been terminated. Since the passage of the No Surprises Act and the implementation of the IDR process, Sound has been submitting claims through the Federal portal. Recent guidance regarding batching of these claims is proving to be a substantial hurdle to submitting these claims, as evidenced by the startling statistics published by the Departments for the first quarter submissions pertaining to batching and rejected claims. The 21,000 claims that have been challenged and the 7,000 rejected batches compared to the 1,200 determinations is not promising.

We first note the issue with "same or similar" codes. In the emergency department, there are only a select few codes that are being billed based on the intensity of the visit: 99281; 99282; 99283; 99284; 99285. Many of the IDR entities are interpreting this to mean the *exact same* CPT code and rejecting batches that include several codes at once. This is inconsistent with the statute and practically speaking makes it difficult in situations where codes like 93010 are billed with codes like 99284 and 99285. Insurance companies and IDR entities seem eager to find reasons to throw out IDR requests due to alleged improper batching. **We encourage the Departments to issue guidance to the IDR entities that allows and encourages batches to include similar claims so that fewer batches need to be submitted.** The issues are the same and these batches would allow IDR entities to make a determination that affects more claims at once, enhancing the efficiency of an already strained system. Indeed, all stakeholders, including the IDR entities, payors, and providers would benefit from these efficiencies.

Second, the Departments' requirement that providers submit claims by individual plan and contemplated funding source is problematic. This requirement is overly burdensome on providers and inconsistent with the intent of the NSA statute. In the Final Rule and other guidance published by the Departments, payors have been directed to provide information on remittance advice including information about downcoding, the Qualified Payment Amount (QPA), and the proper party to contact to initiate the IDR process. However, the information about funding source is not included as information that payors must provide. To date, only one payor has made this information available. All providers—not just Sound—face this same challenge when batching claims. Making matters even worse, many payors are not engaging in the good faith negotiation process or providing additional information when specifically requested. The entire batch is then being rejected by the IDR entities, creating additional work for Sound to resubmit all of the claims—even ones that were properly batched. **We encourage the Departments to issue guidance clarifying the information required for complete batch submissions so that inefficient claims processing may be avoided.**

Third, we have learned that IDR entities have started requiring that claims be batched by date of service rather than date of adjudication. Certain payors have required that Sound register all of their physicians as out of network prior to accepting claims electronically. This process took several months to complete. As a result, all of the claims that were late in adjudicating through no fault of Sound, have to be batched separately. **We encourage the Departments to revise this guidance regarding the claims eligible to be submitted in a batch to provide more flexibility to the provider.**

These issues combine to create an administrative nightmare inconsistent with the intent of the statute. Sound is being forced to batch claims in such small quantities that it cannot meaningfully address the low rates initially paid because of the costs associated with these arbitration submissions. These unnecessary roadblocks collectively work to impede and discourage Sound's and other providers' ability to meaningfully participate in the IDR process. At a minimum, flexibilities in these batching requirements should be granted during this initial implementation stage where the learning curve and the payment delays caused by the new system have created stressful financial situations. Especially for batching issues, IDR entities should not be administratively closing the submission and requiring the provider to start the entire submission over again. Clear guidance has been

issued that only claims that do not meet the requirements are removed from consideration, however in practice, this is not happening.[1]

- IDR Process Should Promote Transparency

Sound has been actively working to gather the relevant data that IDR entities can consider to support Sound's position during arbitration. This data supports Sound receiving a out of network rates that are greater than the QPA, however the IDR entity still sided with the payor. When Sound requested information about the payor's submission, they were told that the IDR entity was not permitted to share the other party's documentation. If the goal of No Surprises Act and IDR process is to get to a point where both parties work together to compromise, sharing those position papers and documentation is essential so we can understand the rationale. Further, the IDR entities may unfairly give more weight to payor data than is justified. Sound puts forth a significant amount of work in their submissions and remain frustrated by the lack of transparency behind payor rates and behavior during this process.

Sound recommends that the Departments require IDR entities share submitted data with either party upon request.

- Current Quantity of IDR Entities Not Capable of Supporting System

Sound has been submitting claims to good faith negotiation and arbitration under the federal IDR process since the portal first opened in April. A substantial number of those submissions are still pending despite the statutory time frame for issuing a determination having elapsed. In recent weeks, at least three IDR entities have stopped accepting new submissions. Given that these rules have placed a major burden on the provider to go through such an arduous process to get fair reimbursement from payors, the lengthy delays and systemic issues that continue to plague this process are frustrating, but also damaging to Sound's ability to render care due to substantially decreased reimbursement. The insufficient number of IDR entities is problematic because Sound and other providers have fewer options to select for their arbitrations. It also means that any new submissions, of which there are likely tens of thousands as indicated by preliminary data published by the Departments, will be pushed further down the list for a final determination.

Sound recommends that the Departments contemplate an alternative solution to resolving these disputes and increasing access to arbitrators as well as immediate updates to the submission portal to ensure that providers and payors maintain appropriate choices for the determination and so that claims can be processed in the statutorily directed timeframes. Sound recommends that payors be required to negotiate during the mandated open negotiation period to alleviate workload requirements on the IDR entities and limit the costs associated with dispute submission. The Departments also should implement guidance requiring the payor to pay all administration costs associated with the IDR process, irrespective of the arbiter's final decision, where the payor fails to negotiate during the mandated open negotiation period.

[1] U.S. Dep't Health and Human Services, U.S. Dep't of Labor, U.S. Dep't of the Treasury, Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities, August 2022, (available at https://www.cms.gov/files/document/TA-certified-independent-dispute-resolution-entities-August-2022.pdf).

- QPA is Not an Accurate Reflection of the Appropriate Price to Pay for Out of Network Services

While Sound appreciates that the Final Rule directs arbiters to consider all of the statutorily enumerated factors and not presume that the QPA is the presumptive amount, we remain concerned that the QPA, and not an independent data set, remains such a key factor in the IDR determination. IDR entities continue to look at the QPA as holding substantial weight and credibility when making determinations. This amount, while required to be listed first, is also a subjective figure that needs heavy scrutiny. Fair Health, while not always a perfect answer, provides a transparent baseline to payors, providers, and other consumers.

The continued reliance on the QPA is creating substantial issues in contracting, as payors are leveraging the industry's lack of balance billing to decrease provider rates during contract negotiations. Despite inflation, the rising cost of labor, and the increased need for physicians in general, many payors are coming into contract negotiations and offering less than the original contract. While Sound agrees that patients do not need to be in the middle of these types of negotiations, payors have minimal incentive to increase provider reimbursement. Many providers, still reeling from the economic impact from the recent pandemic, cannot withstand this added blow.

The Final Rule and some of the accompanying sub-regulatory guidance clarified how providers should be calculating the QPA for certain specialties, but this continues to circumvent the issue of contracted amount compared to paid amount**.**

Sound recommends that the Departments revise existing regulations to ensure that the QPA cannot be manipulated by payors. Given that providers have no recourse to dispute these payments other than file for IDR, it is imperative that the Departments conduct routine audits of the data that is making up the QPAs. With the number of submissions that have been received in the federal portal, we are concerned that resources are not being properly allocated to conduct these types of investigations. Payors must be held accountable for artificially low payments.

- Double Counting Guidance Continues to Prejudice Providers

Payors set their rates arbitrarily. Directing IDR entities to avoid double counting may further incentivize these entities to discredit the information that providers submit, even though the rules instruct them to consider all of the eligible information. As previously discussed, the QPA is a median contracted amount that does not consider paid claims, and payors are able to drop outlier contracts that, in their view, negatively impact their QPA. This amount is arbitrary and does not contemplate all of the work that providers like Sound factor into what it costs to render these services.

Sound recommends that the Departments issue guidance that encourages the IDR entities to fairly consider all information submitted from the provider while recognizing the payors' financial incentives to keep their costs low.

- All Data Should Be Permissible

Providers lack clear guidance on permissible information. Including a prohibition on certain types of data can be misleading and makes it more difficult for providers to provide high quality support for their position coming into the arbitration. All data should be permissible and left to the IDR entity to make the fact determination about the appropriate rate. Including information about data that will be excluded from the final determination does not make sense. The arbiters are capable of determining how to credit the information supplied by the provider and the payor. Sound is currently experiencing situations where IDR entities continue to over-value payor data despite valuable information being submitted in support of higher rates. Charge data and federal payor data is highly relevant, and many providers benchmark their own rates according to Medicare rates. States with their own dispute resolution processes accept a wide variety of data and allow the arbiter to make those determinations. Given that the Final Rule directs the arbiter to consider factors such as double counting when making determinations as it relates to the QPA, the arbiters can make their own determination about whether charge data, or usual and customary data is relevant for the final award.

Sound recommends that the Departments issue guidance to IDR entities and allow them to consider all information that a provider submits and make their own determinations regarding the final award.

- Payors Still Requiring Use of Portal Contrary to Final Rule

The Final Rule included clear guidance regarding the use of payor-specific portals to submit good faith negotiations. However, some payors are still requiring that claims be submitted through their own electronic portals, or suggesting the only way to follow up on a claim is by utilizing those portals. While we recognize certain streamlining functions that payors are intending to deploy, Sound functions in many states and with many payors, and payors' continued reliance on their internal processes creates additional barriers to following claims through the IDR process and is clearly contrary to the Final Rule.

Sound recommends that the Departments issue stricter guidance regarding non-compliance and enforce punishments of plans that fail to accommodate alternative methods of claim submission.

- Payors Failing to Engage in Open Negotiations

Over the previous four months, Sound has submitted numerous batches of claims to payors in several states. Only one of these payors has been responsive at all to the good faith negotiation attempt. The process should enable providers like Sound to avoid taking these claims to arbitration. But if the payors do not even come to the table, the system will continue to work inefficiently. Providers like Sound are often seeking additional information about the claims when they submit to the good faith negotiation. When the payors fail to engage, Sound is unable to properly batch the claims for the arbitration process, which creates extra delays to obtaining final resolution and additional administrative reasons for claims to be rejected due to missed timing for filing in the federal portal. Payors need incentives, or as mentioned above, repercussions for their failure, to come to the table and negotiate. As it currently stands, payors are almost encouraged to wait out the claims that are submitted to arbitration before they provide any data or otherwise meaningfully engage. Requiring payors who fail to meaningfully engage during the open-negotiations period to pay all administrative costs of the IDR process irrespective of the final outcome should encourage payors to participate in the process as intended,

while also improving efficiencies and alleviating the backlog of pending disputes and overall strain on the current system.

While the negotiation history is relevant information for the arbiter, Sound recommends that the Departments issue guidance requiring payors to negotiate these claims prior to submission and or issue penalties to payors for refusing to negotiate.

- Written Determinations May Not Provide Necessary Feedback

Sound appreciates the new requirement for written determinations for each adjudicated batch of claims and expects that this requirement will be beneficial for future submissions. However, given the backlogging of IDR claims, we have concerns about whether the IDR entities will be able to provide meaningful comments to providers regarding why submissions led to certain results. The Final Rule indicated that a template letter would be released to the IDR entities soon**.**

Sound recommends that the Departments consider requiring these written determinations include a tailored response to each submission that goes beyond a check box.

- Downcoding Claims Needs Further Guidance

Downcoding is particularly problematic in emergency department claims. Providers do not have visibility when payers downcode claims because a Remittance Advice Remark Code (RARC) is not typically used to identify this practice. While we recognize the Departments attempted to address this issue by including some additional disclosure requirements, the practice in general remains. Further clarification is needed in this disclosure component to ensure transparency at all levels of this process if this practice is allowed to continue. Downcoding becomes increasingly problematic under the new framework for challenging out-of-network rates given the statutory timeframes. The CPT code billed in emergency care is not a reflection of a final diagnosis, but rather the work that went into making that diagnosis. Medical complexity in emergency care is based on all of the patient's presenting symptoms, the patient's medical history, and the patient's comorbidities. Physicians conduct a thorough and appropriate evaluation, including diagnostic testing, and utilize a high level of medical expertise to determine if the patient is suffering from an emergency medical condition, regardless of the final diagnosis. When the payor downcodes the claim without reviewing the medical record first, it has not examined the information that is relevant to determining the correct level of care.

Sound requests that the Departments require the payors to calculate the QPA based on the CPT code(s) submitted by the clinician. The Departments should clarify that the plans must calculate the QPA and offer initial payment based upon the service(s) provided and codes submitted as documented by the provider. We also request that the Departments clarify that any disagreement over the proper level of services provided be resolved through existing administrative processes.

- Information Needed in Flat Files to Eliminate Administrative Burdens

Payors are placing much of the information regarding what entity to contact and information about the claim in the claim remittance advice. Given the substantial volume of claims that providers like Sound have to process,

streamlined data is necessary to minimize the administrative barriers. Sound needs information about the payor, federal or state process, specific plan information, and funding source in a flat file from the payer such as an 835 file.

Sound recommends that the Departments issue subsequent guidance to payors regarding the places and formats that they need to make their information available.

Conclusion

Sound continues to support policies that relieve patients of the financial burdens of unexpected surprise medical bills, and we appreciate the efforts that Congress and the Departments have made to pull individual consumers from the middle of a battle between sophisticated industry players. The NSA and its implementing regulations must be evaluated as to both the short-term value they bring to patients and long-term burdens on the health care system overall. In this case, the implementing regulations continue to disproportionately favor payors over providers in ways not contemplated or intended by policy makers or the actual language of the NSA. Accordingly, we urge the Departments to revise the above policies and procedures to more appropriately align with the statutory text and based on the actual experience of Sound and the broader provider community since the NSA's implementation on January 1, 2022.

Thank you,

Kelly Searle
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