September 26, 2022

The Honorable Janet Yellen
Secretary
United States Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Xavier Becerra
Secretary
United States Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Martin J. Walsh
Secretary
United States Department of Labor
200 Constitution Ave NW
Washington, DC 20210

Re: RIN 1545-BQ01 and 1545-BQ02: Requirements Related to Surprise Billing
RIN 1210-AB99 and 1210-AC00
RIN 0938-AU62 and RIN 0938-AU63

Dear Secretaries Yellen, Becerra and Walsh:

On August 26, 2022, the Department of the Treasury, on behalf of itself, the Department of Labor, and the Department of Health and Human Services (hereinafter the “Departments”), published in the Federal Register the final rules for the requirements related to surprise medical billing. The final rules contain disclosure requirements for the Qualifying Payment Amount ("QPA") and the Independent Dispute Resolution ("IDR") process, as required by Section 102 and the relevant portions of Section 105, specific to air ambulances, of the No Surprises Act ("NSA"), Consolidated Appropriations Act, 2021 (Pub. L. 116-260), and as revised in light of subsequent federal court decisions. PHI Health, LLC ("PHI") filed comments to the information collection requirements ("ICR") as contained in the July 2021 and October 2021 interim final rules ("IFR"), and such comments, to the extent they relate to ICR and were not included in the final rules, are incorporated herein by reference.

PHI notes that the preamble to the final rules states that further regulatory guidance will be forthcoming. We look forward to participating in that process with the Departments. PHI recognizes the hard work of the staff of the Departments in implementing the No Surprises Act, thereby providing greater clarity for air ambulance providers in the future, but is concerned that the final rules as drafted fail to meet the requirements of the NSA and of the Paperwork Reduction Act. Today, I am writing on behalf of the 1,187 medical and aviation professionals serving PHI Health's patients nationwide to discuss the final rules, and how they should be revised and improved to ensure the sustainability of essential air medical services throughout the United States.

The additional paperwork burdens imposed by the issues discussed herein with the final rules should be read in the context of the extremely detailed data submission requirements of the proposed rules for section 106 of the NSA, and the relative compliance burdens placed heavily on air ambulance companies and lightly on issuers and plans therein. See Part II.F. of the Supplemental Information, 86 Fed. Reg. 51737-9 (September 16, 2021). When combined with the paperwork requirements of section 106, we appreciate the Department's acknowledgement of the magnitude of the burden the final rules' paperwork. It is our experience that the burdens to obtain compliance with the NSA and reimbursement for services by insurers and IDR entities is onerous and diminishes PHI's ability to serve its patients. Dividing the requirements of the NSA into separate rules does not diminish the overall paperwork burden.

Summary

PHI, as one of the leading air ambulance providers in the United States, is concerned that these NSA final rules will lead to diminished capacity for providing air ambulance services nationwide, jeopardizing patient access to emergency air ambulance services, especially in rural and underserved areas. Inherent in the Paperwork Reduction Act requirements is the goal of efficient provision of services by the private sector and efficient performance of the functions of the Departments for the benefit of the public. See 44 USC § 3501(1) and (2). However, because of flaws in the final rules, and in the interim final rules that are still in effect, the compliance burden on PHI and other providers with the NSA is substantially greater than estimated by the Departments in the final rules. Moreover, the lack of compliance with the NSA by insurers and IDR entities is imposing a much greater burden on PHI and other providers of air ambulance services. These additional costs and the inherent diversion of personnel to address them is one of the

underlying causes of diminished patient access to emergency air ambulance services, along with the lack of appropriate reimbursement payments for PHI's services by immensely profitable health insurers. To prevent erosion of the nation's air ambulance capabilities to provide emergency care because of an IDR process biased in favor of insurers, and the lack of enforcement to ensure that insurers and IDR entities meet their NSA obligations, PHI calls upon the Departments to 1) revise the final rules and IFRs as discussed herein; and 2) enforce compliance by insurers with such rules, and thus ensure that critically ill patients do not suffer from the lack of air ambulance services.

Discussion

The Paperwork Reduction Act provides in 44 USC § 3506(b)(1) that each agency shall manage information resources to reduce information collection burdens on the public and increase program efficiency and effectiveness. The final rules request comments on:

1. Whether the collection of information is necessary for the proper performance of the functions of the Departments, including whether the information will have practical utility;
2. If the information will be processed in a timely manner;
3. The accuracy of the Departments' estimates of the burden and cost of the collection of information, including the validity of the methodology and assumptions used;
4. Ways to enhance the quality, utility, and clarity of the information collection; and,
5. Ways to minimize the burden of the collection of information on those who are to respond, including the use of automated collection techniques or other forms of information technology.

Part A. The Failure of IDR Entities and Insurers to Comply Puts Additional Paperwork Demands on PHI

In evaluating these PRA requirements, PHI can show that the lack of compliance with the NSA by issuers and plans and by IDR entities imposes additional paperwork burdens on PHI beyond the Departments' estimates by forcing it to take additional steps beyond mere submission of a claim to obtain payment for it services and providing the details of additional circumstances. These burdens can be illustrated by the following examples of the lack of compliance by insurers and IDR

entities:

1. **IDR Entities Requiring that a Single Air Transport Be Adjudicated in Two Separate IDRs.** Emergency air ambulance transports have two HCPCS codes for each transport: one is a flat fee,[1] while the other is a mileage rate, which applies to every "loaded" mile flown with a patient onboard.[2] Nearly every single emergency air ambulance transport will be billed using both codes.[3] Since March, PHI has been initiating *one* IDR for each transport, and has submitted *one* offer that refers to both codes. More than a dozen of those IDRs have resulted in final determinations on the merits, without PHI hearing any objection from the payor or the IDR entity.

    a. Starting recently, however, several IDR entities have spontaneously "closed" PHI's IDRs, on the ground of being "incorrectly batched." Here is the reason given by one typical example received last week:

    b. After initial review, C2C Innovative Solutions, Inc. (C2C) has closed DISP-08735 due to one or more of the claims in this dispute being incorrectly batched. The claims were determined to be incorrectly batched due to: **Different service codes.**

    c. The IDR entity then instructed PHI to "submit each of these" two service codes as a separate "single claim dispute" within four business days. PHI has no choice but to comply, on pain of losing the IDR.

    d. PHI respectfully submits that this new practice is contrary to the statutory and regulatory text and purpose and substantially increases the IDR paperwork. The statute authorizes an IDR "for qualified IDR ambulance services," 26 U.S.C. § 9817(b)(5), and defines "air ambulance service" as "medical transport by helicopter or airplane." 26 U.S.C. § 9817(c)(1). Similarly, the regulations define a "Qualified IDR item or service," to mean (among other things) "air ambulance services furnished by a [] provider of air ambulance

[1] A0430 (for fixed-wing vehicles), and A0431 (for rotary vehicles).

[2] A0435 (for fixed-wing vehicles), and A0436 (for rotary vehicles).

[3] The only exception would be the rare case in which the air ambulance is dispatched to the patient, but then does not actually transport the patient—in that case, there would be no milage code billed, because the aircraft did not fly any "loaded" miles.

services," and allows PHI to seek payment for such services. 45 CFR § 149.510(a)(2)(xii). When PHI provides "air ambulance services" to a patient, it has thus performed a single "qualified IDR item or service," which should be the subject of a *single* IDR.

e. PHI's interpretation also makes practical sense. When PHI submits a claim for its services, it submits *one* claim (containing both codes). Payors similarly send *one* initial payment or denial, and send *one* Explanation of Benefits (EOB) (again, containing both codes). Although the QPAs for each code are obviously different, the other relevant factors, in the IDR process, are *identical*: e.g., the patient acuity, the ambulance vehicle type, and the provider training are all the same because both codes refer to just one single transport, by one aircraft with one flight crew.

f. If allowed to continue, this new practice will quickly *double* the amount of air ambulance IDRs and the amount of IDR paperwork. That will significantly increase costs for providers, payors, IDR entities, and CMS itself, and will likely also lead to further delays in the IDR process. This new practice might also result in conflicting IDR determinations, in which one IDR entity accepts the payor's offer for the flat-fee code, and another IDR entity accepts the provider's offer for the mileage code, even though both codes refer to the same transport, for the same patient, by the same vehicle and flight crew.

2. **IDR Entities Improperly Placing Disputes on Hold Without Authority.** PHI has had a growing number of cases where the IDR Entity placed a dispute on hold. PHI has asked the IDR entities for 1) information regarding why the hold was issued and 2) the authority under which the IDR entity purports to act. The IDR entities have generally not responded to these written requests. The IDR entities have not cited any provision of the regulations which give them unilateral authority to place a dispute on hold, and there is no clear mechanism for PHI to contest these entirely unexplained holds. PHI cannot proceed with IDR until the hold is lifted, but PHI cannot get the hold lifted without an explanation of why it was instituted in the first place or clear procedures for how to do so.

3. **IDR Entities Improperly Closing Disputes.** IDR entities have recently been "closing" disputes without notice, explanation and/or opportunity to respond. The IDR entities have often been unresponsive or unhelpful when PHI has raised its objection to close a dispute in writing. To the extent that insurers are raising objections, the insurers' submissions are generally not shared with

PHI. Some IDRs have even been closed as untimely, even though CMS has expressly granted extensions for those IDRs (and PHI has transmitted these extensions to the IDR entities). As with holds, there is no clear mechanism to challenge such determinations.

4. **IDR Entities (or Insurers) Invoking Inapplicable State Laws to Close IDRs or Place Them on Hold.** For a large number of claims, insurers or IDR entities have begun erroneously informing PHI that IDR is not applicable. Typically, these insurers cite various provisions of state law, (in)applicable state "all-payer model agreements," and enforcement letters between state officials and CMS regarding which provisions of the NSA a state will (or will not) enforce. However, these provisions, agreements, or letters do not apply to PHI's air ambulance services. To date, PHI has not received any objection from an insurer that cites an applicable state law or all-payer model agreement or enforcement letter which covers PHI's air ambulance services.

5. **"Cooling off period" uncertainty. We do not have information on plan/issuer for which to reference for a cooling off period.** Providers (like PHI) often do not know the identity of the group health plan or the specific health insurance issuer at issue. Most of PHI's transports are emergencies, which means PHI has access to the patient for only a short period of time, during an extreme crisis in which there is little to no opportunity to obtain insurance information. And health insurance issuers and administrators of group health plans often do not provide this information to PHI during the claims process. Indeed, in PHI's experience so far, PHI has on several occasions gone through the entire IDR process—through the final determination—without ever being told the name of the specific group health plan or insurance company.

    a. Without knowing the identity of patient's group health plan or health insurance issuer, PHI is unable to determine whether the 90-day "cooling off" period applies. That provision forbids PHI from submitting a notification of IDR "involving the same other party" within 90 days after an IDR determination. *See* 45 C.F.R. § 149.510(c)(vii).[4] PHI cannot apply this

[4] "(B) Suspension of certain subsequent IDR requests. In the case of a determination made by a certified IDR entity under paragraph (c)(4)(ii) of this section, the party that submitted the initial notification under paragraph (b)(2) of this section may not submit a subsequent notification involving the same other party with respect to a claim for the same or similar item or service that was the subject of the initial notification during the 90–calendar-day period following the determination."

provision because PHI rarely learns the name of the "other party". For the same reason, PHI is unable to "batch" its IDR submissions.[5]

b. Because PHI is unable to determine whether the 90-day cooling off period applies, PHI has no choice but to continue to apply the standard deadlines. PHI is concerned, however, that the payor may invoke the 90-day cooling off period. Specifically, the payor may lodge an objection with the IDR entity (without telling PHI what that objection is) protesting that there was an IDR determination regarding that payor and PHI within the last 90 days. In response to such an objection, the IDR entity might find that PHI's IDR submission is ineligible,[6] without PHI every being told what the problem is. PHI will then be in the truly untenable position of having to guess at what the payor's objection was, to *guess* at why the IDR entity has found the dispute not "eligible," and then to guess (wildly) at when the 90-day "cooling off" period might end. All this on pain of PHI's claim being found untimely if PHI does not re-initiate IDR during the 30-day window following the end of the 90-day period that PHI can only guess at.

6. **Insurers continue to delay payments, sometimes more than 30 days.** Insurers refuse to acknowledge sufficient information to make determinations, despite PHI answering their requests for additional information. This loophole allows for payment delays and prevents PHI from initiating open negotiations (and possible IDR). PHI has repeatedly suggested a process for initiating the open negotiation period so that insurers cannot ignore claims, *viz.,* require insurers to acknowledge a claim submission and request any needed additional information within ten days and make a determination of such submission within ten additional days.

7. **Some insurers have unilaterally demanded a refund on disputed services, utilizing recoupment against payments**. Although combining payment for batched claims promotes efficiency, insurers should not be permitted to

[5] "Batched" services "may be submitted and considered jointly as part of one payment determination." 45 C.F.R. § 149.510(c)(v)(3). However, batching is only available if "payment … would be made by the same plan or issuer" for all services in the batch. *Id.* (3)(i)(B).

[6] A "qualified IDR … service" is defined to mean a service that "is not an item or service for which a notification under paragraph (b)(2) of this section is submitted during the 90–calendar-day period under paragraph (c)(4)(vi)(B) of this section." 45 C.F.R. § 149.510(a)(2)(xii).

unilaterally and retroactively adjust future payments to recoup funds that are a result of the NSA IDR process.

In each of these cases, PHI has been forced to engage in additional paperwork to ensure it is properly compensated for providing emergency services, usually without success. Insurers and IDR entities routinely ignore our entreaties to follow the NSA and to treat PHI fairly for providing emergency services. Note that Part III.D.6. of the Supplemental Information, 86 Fed. Reg. 56008 (October 7, 2021), of the Interim Final Rule Part II states that: "Departments will monitor the implementation of the Federal IDR process, as well as the petition process, to determine whether certified IDR entities are abiding by the applicable requirements." PHI urges the Departments to take action on the above issues to ensure IDR entities (and insurers) are fulfilling their regulatory obligations and not putting additional paperwork burdens on air ambulance providers, including PHI, to resolve payment disputes. The Departments should require IDR entities to give notice of any preliminary, non-merits rulings, such as putting a claim on hold. IDR entities should then identify the opposing party and provide an appropriate and fair process for the resolution of non-merits rulings.

Part B. The New Presumption of QPA Validity in the Final Rules Puts Additional Paperwork Burdens on Air Ambulance Providers

The final rules also impose additional paperwork burdens on PHI in excess of the work estimated therein by requiring it to take additional steps beyond the submission of a claim to obtain payment for services and detailing additional circumstances, because the final rules include a new presumption of QPA validity. These new burdens require PHI to submit additional information to show that the additional circumstances listed in section 105(b)(5)(C)(ii) of the No Surprises Act are not already “accounted for” in the QPA and that these additional circumstances “relate to” PHI’s “offer.” *See* 45 C.F.R. § 149.520(b)(3). The new QPA presumption also increases paperwork burdens on the IDR entity, which must prepare an additional written explanation of why it concludes that any non-QPA factors that it considers were not “accounted for” by the QPA. That paperwork requirement is particularly onerous because the IDR entity receives very little information about the rates that were used to calculate the QPA. Without knowing what went into the QPA, it is difficult to determine what has been excluded.

Moreover, the QPA is not a valid measure of the appropriate payment for air ambulance services. The QPA as used in the IDR in the final rules remains a house built on sand. The QPA:

1. includes air ambulance contracted rates that were agreed to by providers that do not provide air ambulance services, even though such providers are indifferent to whatever amount the insurer includes in their contract for air ambulance services.
2. fails to recognize that the median contracted rate can be manipulated by health insurers to drive the qualified payment amount down by pushing out providers, thus lowering health insurers' reimbursements;
3. fails to include single contract agreements in determining a median contracted rate, despite such contracts representing what air ambulances and insurers have historically agreed upon for payment of air ambulance services, and expanding the available data for accurate pricing of reimbursements;
4. fails to account for the fact that air ambulance services are provided by for-profit and non-profit organizations, and the degree to which a provider may be subsidized by health system cost allocations, charitable contributions, or tax support. The presence of these subsidies allows such subsidized providers to charge lower prices and accept lower contracted reimbursement amounts, thus skewing the data for the median contracted rate down; and

As we have repeatedly stated in prior comments, the QPA is being gamed by insurers; such gaming includes excluding air ambulances from in-network agreements while including rates agreed to by providers that do not operate air ambulances. Further distortion results from excluding single contracts from consideration, as well as the inclusion of median contracted rates that are agreed to by hospitals that agree to provide air ambulance services at a loss, in exchange for more lucrative in-hospital services, such as cardiac services and cancer treatments.

The final rule, by presuming that the QPA is correct and that additional circumstances are already accounted for in the QPA, ignores these manipulations of the QPA by insurers. Overcoming the new QPA presumption puts additional paperwork burdens upon PHI and other air ambulance providers. The focus of the final rule should instead be on the insurers, who should have to show their work on paper and thus prove that the QPA is correct and is not subject to any of the distorting factors listed above.

Part C. Adverse Benefit Denials Increase the Paperwork Burden on Air Ambulance Providers

The Departments state in Part One of the NSA IFRs that medical necessity denials will be considered as Adverse Benefit Determinations ("ABD"), which may be appealed through an insurer's claims and appeals process rather than Notices of Denial of Payment, which can be contested through the IDR process. See section III.B.1.i., 86 Fed. Reg. 36901 and 45 C.F.R. § 149.30 (July 13, 2021). Unfortunately, health insurers make it a practice to routinely and perfunctorily deny air ambulance claims for lack of medical necessity to avoid or delay paying claims.

Because of repeated, baseless claims denials for lack of medical necessity, PHI must devote additional staff time and effort to assist our patients in navigating the claims appeals processes created by insurers. Resolution of these appeals may take months, along with volumes of additional paperwork, while patients worry about the financial responsibility they may face if their insurer denies coverage for emergency air ambulance services. The Departments' proposed regulations to treat such denials as ABDs will subvert the intent of Congress to remove patients from disputes between air ambulance providers and insurance payers. This error must be corrected. As noted in our September 3, 2021 comment on Part One of the IDR, this is not for lack of money. Health insurers remain immensely profitable, but they put those profits ahead of emergent patient care by leaving air ambulances out of network and undercompensating air ambulance providers for their services.

Conclusion

PHI Health urges the Departments to reconsider and correct these deficiencies in the final rule, to minimize the paperwork burden on air ambulance providers, and so that all factors in the IDR process are considered equally in a balanced, fair and independent arbitration process, as Congress intended, and the statute plainly requires. The Departments should remove the presumption that additional circumstances are included in the QPA and require disclosure by insurers about the rates included in their QPAs. Finally, the Departments should enforce the NSA, the interim rules to the extent not superseded by the final rules, and the final rules to and to prevent the abuses outlined above with the minimum of paperwork required from providers. In doing so, the Departments will act to sustain the provision of emergency air ambulance services for the protection of the health of rural and underserved populations throughout the United States.

Sincerely,

Christopher Hall
Director, Government Affairs & Industry Relations
PHI Health, LLC.