

September 7, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

RE: File Code CMS-9909-IF
Department of Health and Human Services: Requirements Related to Surprise Billing; Part I
[RIN 0938–AU63]

Dear Administrator Brooks-LaSure:

On behalf of our physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to offer comments on the July 12, 2021, Interim Final Rule (IFR): Requirements Related to Surprise Billing; Part I, implementing provisions of the No Surprises Act (NSA), signed into law as part of the Consolidated Appropriations Act of 2021.

First and foremost, we thank the Centers for Medicare & Medicaid Services (CMS) for establishing important patient protections in the IFR. For example, strengthening the prudent layperson standard for accessing emergency medical care will help ensure that many patients are not forced to make unimaginable choices between seeking emergency care or facing financial hardships. Additionally, recognizing the impact of unanticipated out-of-network care on those with high deductible plans and limiting cost-sharing in those situations will prove important for many patients. Moreover, the IFR takes important steps toward establishing streamlined complaint processes with aggressive response timelines to help ensure the NSA is working effectively for the individuals it was meant to protect.

While the IFR puts in place these and other important reforms, there are provisions of the IFR with which the AMA has serious concerns. The following comments focus on components of the IFR that the AMA believes must be corrected or clarified in future rulemaking.

Qualifying Payment Amount (QPA)

The AMA appreciates efforts by the Departments¹ to ensure that cost-sharing remains minimal for patients in all situations, including those associated with surprise medical billing, and we believe that the method that CMS has determined will be used to calculate the QPA does that.

However, ultimately, we believe it is in all stakeholders' best interest to ensure that the calculation that purports to represent a median in-network commercial rate for provider payments in this process is truly reflective of the market. The QPA, under the method outlined in the IFR, does not meet that standard.

¹ Department of the Treasury, Department of Labor, and Department of Health and Human Services.

We suggest that the impact of a nonrepresentative QPA is significant to health insurance markets and the ability of physicians, especially smaller physician practices, to engage in fair contracting with large insurance companies (i.e., payers and plans).

It is already difficult for independent physician practices to negotiate fair contracts when payers regularly have significant market power (see AMA's [Competition in Health Insurance](#)). If the process used to arbitrate out-of-network payments—payments for those who have not been approached to participate in a network, dropped from a network, or have found that conditions are not conducive to fair contracting—is largely considered skewed to favor plans, and plans are always able to prevail, it becomes nearly impossible for many physicians to engage in meaningful negotiations with plans.

In other words, when the perception or the reality of the independent dispute resolution (IDR) structure is that it works in favor of the plans and is not a legitimate option to pursue a fair out-of-network resolution, it is a race to the bottom for contracted rates. Plans may offer lower and lower rates knowing that physician practices have two choices—accept the rates in a contract or accept them as out-of-network payment (i.e., the initial payment under the NSA). The Biden Administration has expressed its concern about consolidation in the health care market. For many practices, in order to keep their doors open, physicians will have to consolidate, join a health care system, and abandon independent practice models. **Therefore, keeping the IDR process fair and accessible must be a priority in order to protect independent physician practices.**

If a flawed QPA is held up to the IDR entity as the median in-network commercial rate and considered an important tool in determining a fair payment to the out-of-network provider, the IDR process will not be considered fair and accessible. As such, **the AMA urges the Departments take steps to ensure that the QPA is considered by the IDR in context, does not play an oversized role in the IDR entity's decision making, and is approached with the understanding that the QPA was not designed to always represent a median commercial in-network rate.**

Specific Concerns with QPA Methodology

The AMA is concerned with several components of the methodology used to calculate the QPA for the reasons listed below.

Median Contracted Rate

The AMA believes that the QPA is likely to be skewed lower as a result of the way in which contracts are treated in the calculation. The IFR requires that each contract represent a single datapoint in the median calculation rather than individual providers being represented as datapoints. The result is that large contracts and small contracts are weighted equally, potentially skewing the QPA to favor smaller contracts representing fewer physicians.

For example, an insurer in a geographic region may have contracts with three radiology groups. One of the groups has two physicians, one of the groups has three physicians, and one of the groups has 50 physicians. The median will be determined by lining up the three contracts and picking the middle rate. In this scenario, it is likely that the median contracted rate will just reflect in-network rates for five of the 55 radiologists in that area. In other words, in using each contracted rate as a datapoint, rather than each contracted physician's rate, it is very possible that the QPA will essentially be discounting contracts that represent the majority of physicians in an area.

Insurance Market

Under the definition of “insurance market” in the IFR, sponsors of self-insured group plans have the option of calculating their QPA based on their plan or allowing their third-party administrator (TPA) to determine the QPA by calculating the median using the contracted rates from all self-insured group health plans administered by the TPA. **The result of providing sponsors this option is that TPAs and sponsors may continuously calculate QPAs based on the most favorable “formula” for them, i.e., the method for calculation that results in the lowest QPA.**

Same or Similar Item or Service

The method used to determine “same or similar service” under the IFR fails to account for downcoding of a claim by the plan, suggesting that the QPA would be based on the downcoded service and not the claim as originally submitted for payment. **Failure to recognize the original claim and allow the QPA to be based on a code level unilaterally determined by the plan seems to be a provision both ripe for abuse and likely to result in consistently lower QPAs at the plan’s discretion.**

Treatment of Alternative Payment Models

The IFR allows plans to disregard the impact of alternative payments, and specifically bonus and other incentive-based payments, in the calculation of the QPA. Where payment is not fully on a fee-for-service basis, the plan is directed to calculate a median contracted rate using the underlying fee schedule rates, if available. If bonus or other supplemental payments are incorporated into the contract, the median is calculated based on the base fee schedule. **The failure to incorporate such payments into the QPA calculation misrepresents the true median rate that providers are receiving for their services under these contracts.**

Databases

The IFR clarifies that state all payer claims databases (APCDs) are categorically eligible databases to be used when a plan does not have sufficient information to determine a QPA. The AMA strongly supports the development and funding of APCDs, and we are grateful that the NSA took steps to ensure their continued success and growth. **However, given that many state APCDs lack data from self-funded group health plans, and some may have insufficient data on in-network amounts for the relevant items and services furnished in the applicable geographic region by commercial plans (excluding Medicaid and Medicare), the AMA has concerns that some APCDs may not be able to provide data for the calculation of a QPA that accurately reflects the market.**

Steps Needed to Address QPA in IDR Process

Given the above stated concerns about the method used to calculate the QPA under the IFR, the AMA does not believe that, in most situations, the QPA will serve as a meaningful tool for arbiters to help determine a fair payment amount. Because the QPA must statutorily be provided to the IDR entity, it is extremely important that additional information be communicated to the IDR entity in order to put the QPA in context and helps arbiters to determine its usefulness. The AMA appreciates that the Departments took steps in the IFR to recognize that certain factors, such as incentive-based payments, are relevant to the open negotiation and IDR processes.

We urge the Departments to recognize that the following information is also relevant to the open negotiations and IDR processes and should always be provided to the IDR entity and provider *without a requirement that it be requested*:

- Directions that the QPA is not to be weighted more than any other submitted information by the IDR entity when picking a party's offer.
- A disclaimer that the QPA has been calculated for the purposes of determining patient cost-sharing and may not necessarily reflect a true median of contracted commercial rates in that market for that item or service.
- If applicable, clarification that the QPA is based on a downcoded claim as determined by the insurer, information on why the claim was downcoded, and what the QPA would be for the item or service had it not been downcoded.
- Information pertaining to the use of any modifier in calculating the QPA and what modifiers were used.
- Information pertaining to the use of alternative payment models, bonuses and other supplemental payments paid to providers within the payers' networks.
- The number of contracts used to determine the median as well as the number of providers represented by each of those contracts, individually.
- The types of specialists and subspecialists that have contracted rates included in the dataset used to determine the QPA.

Information on the physician's contracted rates with other health plans will also help provide context for the QPA and is very relevant to the IDR entity's deliberations. **Should a physician make a determination to submit such information, we ask that the Departments develop a pathway for doing so that protects the confidentiality of such information.** Our understanding is that some states, including California, have processes in place to allow submission of such confidential information to an arbiter under their current state laws and we would urge the Departments to look to these states for guidance.

Information Transmitted to the Physician about Patient Cost-Sharing

Under the initial requirements for this process as outlined in the IFR, it seems providers will receive very little information from the plan to help them determine the patient's cost-sharing. **Because physicians and hospitals have direct contact with the patient regarding cost-sharing, it is important that they have information related to the calculation of cost-sharing including:**

- The method to calculate the in-network cost-sharing amount under the plan's terms;
- Where the patient is in their deductible;
- Where the patient is in their out-of-pocket maximum; and
- The advanced explanation of benefits (EOB) at such time as it is implemented.

Initial Payments

The AMA appreciates that the IFR clarifies that the initial payment is meant to reflect the amount the plan reasonably expects to pay for the service. **To ensure this is the case, and to reduce the use of the IDR process, we suggest the Departments require that the plan's initial payment be the same as its offer in IDR, should IDR be pursued.**

While the statute does not contemplate a minimum payment amount, the Departments seek comment in the IFR on whether they should establish a set initial payment. Given the years of congressional debate that led to this outcome, **the AMA opposes a payment standard, especially one based on Medicare or in-network rates, recognizing the impact this would have on contract negotiations and the long-term sustainability of independent physician practices.**

Medicare rates simply do not reflect the costs of providing care, especially in the commercial market where the population varies greatly. Medicare physician payments have not kept up with inflation over the past decade. According to data from the Medicare Trustees, Medicare physician pay has barely changed for nearly two decades, increasing just seven percent from 2001 to 2020, or just 0.3 percent per year on average. In comparison, the cost of running a medical practice increased 37 percent between 2001 and 2020, or 1.7 percent per year.

Likewise, in-network rates should not serve as a payment standard for out-of-network care, as they are reached through negotiation during the contracting process and physicians agree to significantly discount their fees in exchange for contracted benefits, such as increased patient volume, being listed in the plan's provider directory, and prompt payment of claims. **Setting out-of-network payments at those discounted rates would only serve to create unsustainable downward pressure on in-network physician payments.**

Additionally, the NSA requires that plans send an initial payment or denial to the physician within 30 days of the claim being submitted, and the IFR clarifies that the clock begins on the date the plan receives all the information necessary to determine payment, i.e., a "clean claim." We anticipate the potential for significant delays as a result of noncontracted physicians' unfamiliarity with each plan's specific claim coding, documentation, and submission requirements, which frequently vary. As such, **the AMA urges the Departments to require transparency and clear communication from plans to providers on the exact information that is needed to correct the claim in the first rejection.** Additionally, we share the Departments' interest in ensuring that this requirement is not used to delay or deny claims or prolong the NSA processes for resolving out-of-network payments. We ask that the Departments closely monitor such activity and provide a process for providers to submit complaints about possible abuses.

Specified State Law

The AMA appreciates the IFR's clarification that a specified state law is both a state law that sets a predetermined amount, as well as law that requires or permits a plan and a provider to negotiate and then to engage in a state arbitration process to determine the out-of-network rate. As such, it seems many state laws will continue to apply to plans regulated in a particular state after implementation of the NSA. The AMA has supported this preemption structure; however, we recognize the complexity associated with implementation and continued compliance, especially for physician practices who will be navigating state and federal rules.

A major concern for the AMA and our state and specialty medical association partners is being able to clearly ascertain which state laws qualify under the NSA as specified state laws. While certain state laws seem to clearly meet the standard laid out in the IFR, other states that may not require an initial payment or set a threshold for application of their law creates some ambiguity. We understand CMS is pursuing clarification from state regulators as to both their intention in enforcing the NSA and their interpretation as to whether their state law is a specified state law. We look forward to such clarification from state regulators and we ask for additional clarification from CMS when available.

Another major concern for the AMA is physicians being able to clearly identify which set of rules apply to a claim when a specified state law is also in place. We think it is impossible to overstate the potential for physician confusion in navigating two regulatory structures, potentially even within the same episode of care depending on the scope of a state law. At a minimum, **the AMA urges the Departments to require plans to clearly communicate which law they are using in remittance advice and other initial communications.**

Moreover, there is flexibility provided in the IFR that allows plans to continue to opt-in to state laws when states allow it. Currently, it is required that a plan fully opt-in for all services, and not episodically. **We strongly encourage the Departments to maintain that requirement to minimize confusion and the cherry-picking of state laws that are most beneficial to a plan for certain claims.**

Recognizing the potentially serious implications for physicians who fail to abide by the correct law, we encourage significant and long-term flexibility for those physicians acting in good faith.

Notice and Consent Process

The AMA appreciates the further clarification provided in the IFR on the notice and consent provisions in the NSA. Additionally, we appreciate efforts by CMS to standardize the process and reduce confusion with a standard form.

However, for physicians, there are still several components of this process that we believe could be clarified and improved in order to ensure that patients get the information they need to make informed decisions without placing unnecessary administrative burden on physician practices.

First, we suggest that if notice and consent are provided and received, the Department should still require payments directly to the provider in those situations where the patient seeks out-of-network coverage for their care. The common practice of plans sending out-of-network payments to patients who are then responsible for making full payments on the cost-of-care to the provider can be confusing, time-consuming, and administratively burdensome on the patient and provider. We believe it is in the spirit of the statute to remove the patient from the middle of payment as much as possible and requiring direct payments to providers in these scenarios would further that goal.

Second, the AMA appreciates that the Departments provide some leeway in terms of information that must be submitted to the patients with the notice and consent documents, recognizing that physicians, especially physicians who are not contracted with the patient's plan and do not have an existing relationship, are not able to easily obtain detailed information regarding utilization management and other care restrictions in the timeframes required. (In fact, contracted physicians with existing relationships often have great difficulty obtaining utilization management information from health plans.) Requiring that detailed utilization management information be included in the notice and consent could have the impact of delaying care as notice and consent documents are held up while the physician waits on a response from the health plan regarding prior authorization information. It also has the potential to create unnecessary administrative waste if the patient ultimately decides not to receive care from that provider.

We have similar concerns regarding cost-sharing information and agree that an estimate of the physician's charges is the extent of cost information that a nonparticipating physician can reasonably be expected to provide to a patient. Requiring the physician, especially one who is unfamiliar with the patient's plan, to estimate any patient cost-sharing is unreliable, confusing, and likely duplicative, as the patient will be receiving an advanced EOB from the plan prior to care (to be fleshed out in future rulemaking). As the

IFR notes, patients may revoke consent at any time, so a more reliable cost-sharing estimate, that potentially includes information regarding utilization management as well, from the plan prior to care will still factor into the patient's ultimate decision to receive out-of-network care. **The AMA urges CMS to maintain the flexibility in the IFR in terms of the physician providing this information to a patient.**

Unfortunately, under this section, the IFR takes steps to shift network adequacy responsibilities onto providers, rather than onto the plans. For example, the IFR clarifies that the notice and consent exception is only available to physicians if there is a participating provider available at the facility. While we agree that it is difficult to give consent if no other options exist, this requirement creates a scenario where the nonparticipating provider is penalized for an inadequate network (a network where no participating providers are available at a participating facility) rather than the plan. **We agree that patients should not be responsible when a plan's network is inadequate, but we disagree that a physician should have to enter the NSA surprise billing process to resolve the plan's deficit.**

Additionally, the AMA has concerns with what appears to be authority given to health plans to determine if notice and consent were properly given and received. Under the IFR, if a plan knows or reasonably should know that notice and consent were not properly and timely given and received, the plan is instructed to reprocess the claim. The AMA seeks greater clarity on how this decision is communicated to the provider and if there is a process for challenging or appealing this determination. **The AMA suggests that plans should not be provided this quasi-regulatory role to determine proper notice and consent.**

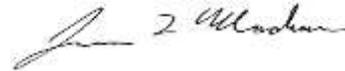
Finally, while in most situations it will be appropriate, the AMA is concerned that there may be instances where the three-hour timeframe related to same day care could have the impact of delaying needed services. This could be particularly relevant to post-stabilization care in a facility where care is needed quickly, or coordination of providers and availability of resources may not align with these timeframes. **The AMA urges CMS to consider options for exceptions to this requirement to ensure timely care.**

Conclusion

The AMA appreciates the opportunity to provide comments on this IFR. The AMA has worked closely with state medical associations and national medical specialty societies to develop many of the recommendations contained in this letter and we look forward to working with CMS to ensure physicians receive the resources and clarity they need to effectively implement the patient protections in this new law.

If you have any questions, please contact Shannon Curtis, Assistant Director of Federal Affairs, at shannon.curtis@ama-assn.org or 202-789-8510.

Sincerely,



James L. Madara, MD

cc: Department of Treasury [RIN 1545-BQ04]
Department of Labor [RIN 1210-AB99]