

June 14, 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: AMA Input on Qualifying Payment Amount and Related Calculations in the No Surprises Act

Dear Administrator Brooks-LaSure:

On behalf of our physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to offer input on the implementation of the No Surprises Act (NSA), which was signed into law as part of the Consolidated Appropriations Act of 2021 and addresses surprise medical billing at a national level.

On May 21, the AMA submitted comments related to the implementation and calculation of the Qualifying Payment Amount (QPA) under the NSA, as well as the QPA audit process due to the statutory guidelines. The following comments focus on the implementation of the Independent Dispute Resolution (IDR) Process, the Notice and Consent requirements and the determination of a Specified State Law. The AMA has worked to build consensus on these issues among many of the state medical associations and the national medical specialty societies, particularly those impacted by the provisions covered in this letter. The recommendations below largely reflect such work.

I. Independent Dispute Resolution (IDR) Process

The IDR process is a critical component of the NSA in terms of promoting a fair payment amount for provided care. While the statutory language offers an outline for this process, the AMA believes there are many components of the IDR process where clarification is much needed.

Certification and Selection of IDR Entities

The NSA directs the Secretary to create a process for certifying and recertifying the IDR entities and identifies several initial requirements that an IDR entity must meet. These requirements are laudably directed at ensuring the IDR entity's qualification, independence, and impartiality. The AMA recommends additional considerations for the Centers for Medicare & Medicaid Services (CMS) as you develop the IDR certifying process:

- IDR entities should have experience and expertise in medical coding and billing.

- IDR entities should be accredited if possible. While accreditation is never a replacement for regulation and enforcement of such regulation, it is often a useful supplement.
- IDR entities and arbiters should have no affiliation with any payer or provider organizations, and there should be transparency around the IDR entity selection process to ensure nonbiased entities and arbiters.

The statute also requires that parties be able to petition for denial or withdrawal of an IDR entity's certification for failure to adhere to the requirements. Greater clarity is needed as to how this process would work and what documentation is needed. The AMA encourages CMS to make this process as streamlined and administratively simple as possible to ensure that parties without significant resources (e.g., small physician practices) are able to report problems. Additionally, to supplement this process, the AMA recommends that IDR decisions be regularly audited to evaluate compliance with NSA IDR requirements and ensure the nonbiased nature of decision-making.

Batching

The AMA appreciates the ability of physicians to batch items or services for the IDR process, i.e., have multiple IDR-eligible items or services jointly considered as part of a single determination by the IDR entity. Batching creates a more efficient and cost-effective process for both physicians and payers.

The statute identifies four criteria that must be met for items or services to be batched, and the AMA respectfully recommends the following clarifications to ensure the efficiency this process was designed to achieve.

1. Providers tied to a single Taxpayer Identification Number (TIN) should be permitted to batch items and services for IDR together.
2. Items or services should be permitted to be batched at the Current Procedural Terminology® (CPT®) family level, as well as with other codes related to the episode(s) of care.
3. Given that health plans often have multiple products, clarification is needed as to what is meant in the statute by "same group health plan or health insurance issuer."
4. CMS should use the flexibility provided to the Secretary in the NSA to expand the 30-day batching period. This is especially relevant for low-volume items or services, longer episodes of care, and complications or hardships experienced by the physician in accessing the IDR process, including poor access to internet, unanticipated delays by the IDR entity, delays that result from appeals processes outside of the scope of the NSA/IDR process, etc.

Treatment of Factors to be Considered by the IDR Entity

The NSA requires that the parties submit their offers for payment amount and any additional information requested by the IDR entity to the entity within 10 days of IDR selection. The statute also requires that the IDR entity consider the QPA and any other factors that either party submits to support their offer with specific exceptions, including the level of training, experience and quality and outcome measurements; the market share held by either party; the acuity of the patients or the complexity of the care; the teaching status, case mix and scope of services of the facility; and demonstrations of good faith efforts, or lack thereof, to contract.

While some stakeholders have suggested certain factors (e.g., the QPA) should always be "weighted" more than others by the IDR entity, it is clear that Congress did not intend to instruct the IDR entity to

give more weight or importance to one factor over another. The statutory language provides that an IDR entity *shall* consider both the: (1) QPA; and (2) information on any of those circumstances identified above, information requested by the IDR entity, and any additional information submitted by the parties. Nothing in the language identifies a particular factor as weightier than another or more important to the IDR entity's decision, and such suggestions are simply an attempt to negate years of careful Congressional deliberations and to rewrite the statute.

Every factor identified in the statute (and more) is relevant to payment determinations. For example, the IDR process will likely be used most frequently to resolve payment for items or services that are unique or unusual, for which an insurer's initial payment is insufficient. Such outlier items and services may be provided by a physician with highly specialized skills or for a patient with an unusually complex case – relevant factors in determining payment for the care. Requiring that the arbiter, who should have expertise in medical billing and coding, hold up the QPA as the most important factor in such a situation is undercutting both the expertise of the arbiter and the independence of the IDR process. We urge CMS to refrain from directing the IDR entities from being required to weigh certain factors over others.

Submitting Information to IDR

As mentioned above, the statute identifies several factors the IDR entity must consider when making a determination of payment for an item or service. As parties to the IDR consider if and how to best submit information on such conditions, the AMA asks that CMS provide guidance or examples of how such information might be most effectively communicated. For example:

- Parties submitting market share information could use the AMA's Competition in Health Insurance study as a resource.¹
- When establishing the complexity of case or the patient acuity, is it best to submit medical records, or would other resources be more appropriate?
- When showing previous contracting efforts, information on why a contract was terminated, evidence of poor business practices or increasing administrative requirements by the plan, delayed credentialing, etc., should be considered relevant information to submit. We also recommend that the ability to access in-network services at the facility and other network adequacy issues are relevant.

Such guidance would increase the efficiency, as well as the uniformity and consistency of the IDR process.

Additional Information to be Submitted to IDR Entity

The NSA allows for additional information to be submitted by the parties to support their respective offers. To the most appropriate extent possible, we ask that CMS ensure that parties to the IDR process be able to view each other's submissions.

We recognize that the usual and customary charge, the physician's out-of-network rate, and public program rates may not be submitted to the IDR to support either party's offers. While the AMA did not support all of these exclusions and finds that the physician's out-of-network rates are relevant to the IDR's decision, we also recognize that Congress did not agree.

¹ <https://www.ama-assn.org/system/files/2020-10/competition-health-insurance-us-markets.pdf>

As CMS works to implement these provisions, we urge you not to expand these exclusions to limit relevant information and data from being submitted to the IDR. For example, providers should be able to submit a range of aggregated charge data, as well as a range of allowables, from payers in the region to support their offer.

In addition, contract information with other plans or providers may be relevant to the IDR entity's decision and should be allowed to support a party's offer. However, additional clarity is needed to ensure that parties can share contracted rates with IDR entities and if this information can be shared among all parties or, alternatively, how it will be kept confidential.

Finally, we urge CMS to require that the IDR entities have access to all the information needed to validate and ensure the accuracy of the QPA.

IDR Process and Timeline

Every effort should be made to make the IDR process as administratively simple and inexpensive as possible in order to ensure that all parties, including small physician practices, practices in rural areas, and under-resourced parties have the same opportunities to use the system.

The AMA recommends that the New York State's IDR process, as established under its state surprise billing law, is an example of a streamlined, efficient process. The New York State process uses an online portal for submitting documents and does not require any in-person component for participation. We urge CMS to look at New York's process when creating the regulations to implement the NSA.

Additionally, we also ask that CMS make the IDR fee schedule publicly available and easily accessible.

In terms of the IDR timeline, we urge CMS to clarify that all reference to "days" in the statutory timelines are *business* days. While quick, we think that the timelines in the statute for submitting information to the IDR are workable and reasonable, as long as the clock is not ticking during nonbusiness days and holidays. We also think there is a need for education and resources on timelines leading up to and during IDR process. We hope CMS will create such resources for physicians and other providers and the AMA would be happy to work with you to do so.

Finally, we believe it is important to clarify whether the timelines for the next steps in the NSA process that lead up to and include the IDR process still apply if a health plan does not abide by the timelines related to the initial payment or notice of denial.

IDR Cooling-Off Period

Following a decision by the IDR entity, the NSA establishes a 90-day "cooling off" period for the IDR-initiating party. During this time, the initiating party may not submit a subsequent request involving the "same other party" and the same item or service.

As CMS determines exactly how this cooling-off period should be operationalized, the AMA urges you to apply this period at the product level, rather than at the plan or company level. Many large insurance companies have multiple products in a market and applying this restriction too broadly could have a negative financial impact on many practices, specifically smaller ones, while also creating a backlog of claims in the IDR system.

We also recommend that CMS clarify that items or services provided during the 90-day cooling off period can be batched (in 30-day batches) and potentially brought to IDR. Also, additional clarity is needed as to how statutory timelines apply to these claims.

Finally, while recognizing that an initial and final report on the impact of the cooling-off period must be completed within two years and four years, respectively, the AMA recommends that there should be a process for providers to issue complaints about plan abuses during the 90-day cooling offer period (e.g., low initial payments, application of cooling off period to other products, holding of claims, inappropriate downcoding, etc.).

Scope of IDR Process

The AMA is concerned about ambiguity in the scope of the IDR process specifically as it relates to initial denials based on medical necessity. The statute identifies “a notice of denial of payment” as a triggering event for the processes leading up to and included the IDR process. However, the AMA urges CMS, the Department of Labor, and the Department of Treasury to clarify that the IDR process is not the appropriate process to determine medical necessity.

The AMA believes this is consistent with Congressional intent, given the structure of the IDR process and the factors that the statute identifies for consideration by the IDR entity. There is nothing in the statute that requires the IDR entity to be familiar or have expertise in the clinical practice of medicine. Furthermore, the statute’s factors for consideration by the IDR entity are largely relevant to payment and contracting, and do not include a review of medical literature, suggesting that Congress did not intend for medical necessity determinations to be made through IDR.

As such, the AMA asks that the agencies limit the types of notices of payment denials that are eligible for the IDR process by excluding those denials that are eligible for external review under state or federal law. As an example, the agencies should disqualify those adverse determinations that involve medical judgment and are eligible for review under the Federal external review process under 45 C.F.R. § 147.136(d)(1) from using the IDR process to resolve the question of medical necessity.

Additionally, we urge the tri-agencies to clarify the appropriate course of action for patients, physicians, and payers when a denial is made based on a coverage determination (e.g., the payer denies the service or items based on noncoverage or patient ineligibility). The denials could arguably also be inappropriate for resolution in an IDR process, although payment for such services must also ultimately be determined. Therefore, greater clarity is needed.

Finally, we urge CMS to monitor the frequency or any increase in denials of unanticipated out-of-network care and take action should it be determined that abuse is taking place.

II. Notice and Consent

The NSA establishes notice and consent requirements for benefits provided by an out-of-network physician or other health care provider at an in-network facility, with certain exceptions. The AMA believes that further clarification is needed as CMS implements this section of the NSA with the goal of improving transparency and preventing administrative burden.

Services and Providers Exempt from Notice and Consent Option

The NSA states that the notice and consent exception to the statute’s surprise billing restrictions cannot be applied to items and services related to emergency medicine, anesthesiology, pathology, radiology, neonatology; items and services provided by assistant surgeons, hospitalists and intensivists; diagnostic services; items and services provided by an out-of-network provider if no participating provider is available at the facility; and items and services provided by other specialty practitioners as the Secretary determines (i.e., “ancillary services”).

As CMS considers this section, the AMA recommends that the list of “ancillary” services not be expanded at this time and that language in the statute is added to clarify that notice and consent may not be applied to any item or service “furnished as a result of unforeseen, urgent medical needs that arise at the time such covered item or service is furnished” is a sufficient “catch all” for any unanticipated medical bills.

Additionally, the AMA urges CMS to consider identifying the ancillary services not by specialists but by type of service provided, as some of the physicians providing the specialized care identified in the statute may provide advanced scheduled care as well. For example, an anesthesiologist may see patients for scheduled pain management services unrelated to a surgical or other interventional procedure. Such care should fall under that notice and consent exception.

Notice and Consent Form and Information

Given that many states have existing notice and consent requirements in place for out-of-network care, the AMA recommends that CMS work directly with those states to (1) determine best practices for obtaining notice and consent and (2) ensure that stakeholders are not burdened by duplicative requirements that can result in administrative waste. Additionally, as CMS works to develop any forms that may be used for notice and consent purposes, the AMA suggests that feedback from stakeholders would be helpful in that process.

Finally, as CMS establishes notice and consent requirements, we urge you to consider that many physicians may or may not have access to some of the information identified in the statute, especially as there is not a contract between the physician and the health plan. For example, it may be difficult for a physician to obtain information about prior authorization or other care management limitations on the service prior to care in the timeframe required. Such information is best and most efficiently obtained from the health plan.

Post Stabilization Consent

Following stabilization, the AMA recognizes that consent must be obtained to continue providing care at an out-of-network payment level to a patient. The AMA recommends that generally, the determination of whether a patient is able to provide consent should remain between the physician and patient. CMS could offer guidance to physicians and other health care providers in these situations and the AMA would welcome the opportunity to work with CMS on such guidance.

III. Specified State Laws

Many states policymakers have taken action to address surprise medical billing in their health insurance markets and the NSA determined that a state law that both protect patients from surprise medical bills and

“provides for a method of determining the total amount payable” is a “specified state law” and should preempt the federal requirements on surprise medical billing for those state regulated plans. As the agency develops regulation and guidance on this issue, the AMA recommends the following to assist physicians, patients, and all stakeholders in determining the required processes to follow to resolve a surprise medical bill.

Defining a Specified State Law

The AMA urges CMS to ensure that specified state laws are only those state laws that provide for thorough patient protections and a clear and accessible method for determining a fair payment amount. Those state laws that do not meet both requirements should not be recognized as specified state laws under the NSA.

Additionally, we ask that CMS clarify the appropriate processes for when a state law, that would otherwise be considered a specified state law, has a narrower scope than the federal law in terms of providers or services covered. For example, some state laws may apply only to emergency services or some state laws may apply only to a particular group of specialists. The AMA recommends that in such situations the federal law could fill in the “gaps” in the state law, but without clear and concise guidance, confusion is inevitable.

Clarity and Guidance for Stakeholders

For those states with existing state laws, guidance on how to determine whether or not the state law meets the NSA’s criteria for a specified state law is critical. The AMA urges CMS to provide concise criteria for determining a state law’s status, as well as information on whether CMS and the tri-agencies will recognize a state as having a specified state law. Ideally, such a determination should be done in consultation with state regulators, who will be responsible for enforcement, and other local stakeholders. Such information should be posted publicly on the CMS website.

Once such a determination is made, patients, providers, and health plans will need to be able to clearly identify which law governs a claim. We recommend that CMS work in collaboration with state regulators, health care providers and health plans to establish methods for easily accessing such information, such as providing such information on the patient’s insurance card or making it available on the plan’s website for that product. We also ask that regulators provide leniency to physicians and other providers who may accidentally attempt to use the wrong process for resolving a dispute.

Additionally, it is important that state policymakers have clarity on what is needed in a state law to preempt the federal statute if they decide to legislate surprise medical billing for their health insurance market.

Finally, we ask that CMS provide additional clarity on the role of state regulators in enforcing the surprise billing provisions of the NSA, and where patients and physicians can take complaints and seek resolution, in both states with a specified state law and those without.

IV. Next Steps

The AMA appreciates the opportunity to provide input on the implementation of the NSA, and as mentioned above, will continue to work with state medical associations and national medical specialty

The Honorable Chiquita Brooks-LaSure

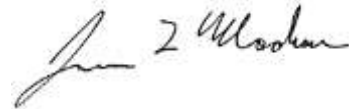
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societies to develop recommendations on the many provisions of the law. We look forward to sharing future comments on the remaining provisions.

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,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is written in a cursive style with a large initial "J" and "M".

James L. Madara, MD