

May 21, 2021

Elizabeth Richter
Acting 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 Acting Administrator Richter:

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 the federal level.

The AMA continues to support the protection of patients from the financial strain and impact of unanticipated medical bills that arise when patients reasonably believe the care they received would be covered by their health insurer. In these cases, we believe that patients should be responsible only for cost-sharing amounts they would otherwise have been subject to if the care had been provided in-network, and these costs should count toward their in-network out-of-pocket maximums and annual deductibles. While the intent of the NSA is to address this and other issues related to surprise medical billing, we believe that more clarity is needed for our members to be equipped to properly navigate the provisions contained in the law once it goes into effect on January 1, 2022.

The AMA is aware that the first set of regulations, with a statutory deadline of July 1, 2021, relate to the definition of the “Qualified Payment Amount” (QPA) and methodology for calculating the median contracted rate and will take precedence due to the rulemaking timeline. We are therefore focusing our comments on these issues and will provide subsequent comments in the coming weeks on additional regulatory requirements contained in the statute.

Broadly, the QPA is defined in the NSA as the health plan’s median contracted rate for that service in a geographic area for 2019 with inflationary increases. Below we suggest ways in which the Department of Health and Human Services (HHS), along with the Department of Labor (DOL) and the Department of the Treasury (DOT), could provide greater clarity, reliability, and compliance in terms of the QPA as the NSA is implemented.

Please see our detailed comments below on the following topics related to the QPA:

- I. Markets and Geographic Areas Used to Determine Median Contracted Rate as a Component of the QPA

- II. Calculating the Median Contracted Rate and the QPA
- III. Information Related to the QPA and Recognized Amount to be Shared with Providers During the Initial Billing Process
- IV. Audit Process for Compliance with QPA Requirements and Application

I. Markets and Geographic Areas Used to Determine Median Contracted Rate as a Component of the QPA

The QPA, as defined by the NSA, is calculated by the median contracted rate recognized by the plan or issuer in 2019 and updated annually by a specific inflationary formula. The median contracted rate should be calculated using rates from the same market. As described below, the AMA believes there are several factors that should go into defining a market, all of which should be communicated clearly to the physician by the health plan during the initial billing process. This is particularly important as the recognized payment amount, the amount that is used to determine the patient's cost-sharing, is based on the QPA and in turn, the median contracted rate.

First, the statute differentiates appropriately between the individual market, the large group market, and the small group market and requires that geographic regions be applied to narrow the contracted rates used in the calculation. The AMA suggests that geozips¹ are the most appropriate tool to define these geographic areas to ensure the rates better reflect the cost of providing care in an area.

Second, the AMA urges HHS to ensure that Medicaid fee-for-service, Medicaid managed care, Medicare, and Medicare Advantage rates are excluded from calculating the median contracted rates, as these products are not part of the commercial markets within the scope of the NSA and, therefore, would skew the data sets.

Finally, we urge HHS to clearly identify the threshold for a health plan to have sufficient data to calculate a QPA in a market. When such threshold is not met for a particular item or service, the plan should be required to use data from an independent claims database, such as Fair Health or other databases maintained by non-profit organizations, from the same geographic region, and from other plans in the same market to calculate the QPA.

II. Calculating the Median Contracted Rate and the QPA

The AMA believes it is critically important that HHS establishes a clear, publicly available methodology for calculating the QPA to ensure predictability, reproducibility, and compliance. In developing this calculation, the AMA recommends the following:

- Plans should use the total maximum amounts paid to physicians and other providers, including any co-insurance paid by the patient because cost-sharing and other co-insurance may vary based on the specific plan or where patients are in their deductibles;
- The median contracted rate should be determined based on the contracted rate for each individual physician or provider. In other words, group contracts should not be treated as a single datapoint in the data set used for the median calculation;

¹ A geozip is a geographic area usually defined by the first three digits of U.S. zip codes and may include areas defined by one three-digit zip code or a group of three-digit zip codes.

- Contracted rates used to calculate a median for an item or service should be limited to only those provided by physicians or other providers in the same specialty. Education, level of training, and provider type are all important factors in contracting and determining payment;
- Contracted rates used to calculate a median for an item or service should be as specific as possible as to the type of item or service, down to the Current Procedural Terminology® (CPT®) family level, taking into consideration the “level of care” and other similar factors;
- The median contracted rate and the QPA should be calculated based on the level of the claim submitted, without reflecting any downcoding by the payer, and should not incorporate modifiers that reduce payment amounts; and
- HHS should consider using an outlier methodology that excludes \$0 paid on claims, as well as inappropriately low payments, that may result in inappropriate skewing of the median.

Additionally, when determining the median contracted rate, it is important that the methodology requires plans to incorporate alternative payment models and contracting incentives that are relevant to payment rates but may not be reflected in base fee schedules. Attached is a brief summary of just of few of the many alternative payment models that may impact the median contracted rate. We would be happy to further discuss how payment under these models could be reflected in the QPA.

III. Information Related to the QPA and Recognized Amount to be Shared with Providers During the Initial Billing Process

As mentioned above, it is important that physicians be made aware of the recognized amount, and the QPA, during the initial billing period. Specifically, in an effort to ensure transparency at all points in the NSA payment process, physicians should receive information identifying:

- How the QPA was calculated, including whether the plan had sufficient claims to use internal data or accessed outside independent data to do the calculation;
- What median contracted rate was used to calculate the QPA;
- The types of providers that were included in calculating the median;
- What same or similar services were included in the calculation;
- The geographic area that was used; and
- The health insurer market that was used.

Additionally, though not specific to the recognized amount or QPA, the AMA recommends that physicians also be provided with co-insurance information for the patient at the same time they are provided the recognized amount and cost-sharing total. Such information should include the patient’s deductible amount, where the patient is in their deductible, and how their cost-sharing is structured. This will be important for physicians who need to effectively communicate to patients why they are receiving a bill and the justification for the billed amount.

IV. Audit Process for Compliance with QPA Requirements and Application

The NSA requires that HHS, along with DOL and DOT, establish a process through regulation under which health plans are audited by the Secretary or the State to ensure compliance with the calculation and application of the QPA requirements. As the Tri-Agencies move forward with drafting these audit regulations, the AMA recommends that the following be considered:

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- Ensure that audits initiated as a result of complaints are separate and not included or “counted” in the yearly audit requirements under the statute;
- Require that the audit process include a comparison of the health plan’s QPA to one that is calculated using independent data to determine the appropriateness and accurateness of a health plan’s QPA; and
- Make the audit results publicly available.

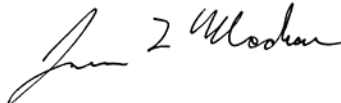
The AMA also believes there is a need for a mechanism, whether through fines or other remedies, to ensure compliance with audits, as well as a clear enforcement plan when health plans are in violation of QPA calculation requirements.

Next Steps

The AMA appreciates the opportunity to offer input on the implementation of the QPA and other related requirements under the NSA. The AMA has worked closely with state medical associations and national medical specialty societies to develop the recommendations contained in this letter. As previously mentioned, we anticipate offering additional consensus recommendations on other NSA provisions including the independent dispute resolution (IDR) process, the definition of a “specified state law,” the NSA state preemption provisions, and notice and consent requirements of the statute.

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 "Jim L. Madara". The signature is written in a cursive, flowing style.

James L. Madara, MD

Attachment

Examples of Alternative Payment Models (APMs):

Payment for a High-Value Service. A physician practice would be paid for delivering one or more desirable services that are not currently billable, and the physician would take accountability for controlling the use of other, avoidable services for their patients.

Condition-Based Payment for Physician Services. A physician practice would have the flexibility to use the diagnostic or treatment options that address a patient's condition most efficiently and effectively without concern that using lower-cost options would harm the operating margins of the physician's practice.

Multi-Physician Bundled Payment. Two or more physician practices that are providing complementary diagnostic or treatment services to a patient would have the flexibility to redesign those services in ways that would enable high-quality care to be delivered as efficiently as possible.

Physician-Facility Procedure Bundle. A physician who delivers a procedure at a hospital or other facility would have the flexibility to choose the most appropriate facility for the treatment and to work with the facility to deliver the procedure in the most efficient and high-quality way.

Warranted Payment for Physician Services. A physician would have the flexibility and accountability to deliver care with as few complications as possible.

Episode Payment for a Procedure. A physician who is delivering a particular procedure could work collaboratively with the other providers delivering services related to the procedure (e.g., the facility where the procedure is performed, other physicians who are involved in the procedure, physicians and facilities who are involved in the patient's recovery or in treating complications of the procedure, etc.) to improve outcomes and control the total spending associated with the procedure.

Condition-Based Payment. A physician practice would have the flexibility to use the diagnosis or treatment options that address a particular health condition (or combination of conditions) most efficiently and effectively and to work collaboratively with other providers that deliver services for the patient's condition in order to improve outcomes and control the total spending associated with care for the condition.