MASSACHUSETTS MEDICAL SOCIETY
Every physician matters, each patient counts.

To: The Honorable Chiquita Brooks-LaSure, Administrator, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services

From: Massachusetts Medical Society

Re: *No Surprises Act* Implementation – Input on Independent Dispute Resolution (IDR) Process and Advanced Explanation of Benefits (AEOB)/Good Faith Estimate (GFE)

Date: September 2, 2021

On behalf of our 25,000 physician, resident, and medical student members, the Massachusetts Medical Society (MMS) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the implementation of the *No Surprises Act*. This letter focuses primarily on the independent dispute resolution (IDR) process due to be released in the coming weeks. A previous letter to CMS outlined considerations for the Qualifying Payment Amount (QPA), and a forthcoming comment letter will respond to the provisions outlined in the first Interim Final Rule (IFR) which was released in early July.

As mentioned in past correspondence, the MMS was closely involved with our Congressional leaders working to draft the *No Surprises Act*, and we appreciated that the resulting compromise bill aimed to protect patients, while taking into consideration the concerns of physicians and hospitals. While the intent of the legislation to protect patients from surprise medical bills is clear and the statute provides a general outline for the IDR process, additional clarity on the details of implementation of the IDR process would help providers prepare and navigate the provisions when they go into effect next year. The IDR process is a critical component to promote fair payment for care. As you build out plans for implementation, the below areas could be expanded and strengthened by the Department of Health and Human Services (HHS), the Department of Labor (DOL), and Department of the Treasury (USDT) for additional clarification. These recommendations are a result of a working group of state and national medical societies, spearheaded by the American Medical Association (AMA):

Independent Dispute Resolution (IDR) Process

I. Selection of IDR Entities and Certification

The *No Surprises Act* legislation directs the HHS Secretary to establish a process to certify IDR entities, including requirements they must meet in order to ensure their qualifications and impartiality. We ask that CMS consider instituting the following, additional qualifications for IDR entities:

- Experience in medical billing and coding;
- Are accredited, when possible; and
- Have no affiliation with any payer or provider organizations.

In addition, we suggest that there is transparency in the IDR entity selection and certificiation process. Furthermore, the statute outlines that there will be a process to petition for denial or withdrawal of an IDR entity's certification, and there should be more clarity provided around this process. This process should be administratively simple so all parties involved are able to navigate it, including parties with fewer resources (small

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physician practices). We also recommend regular audits on this process to ensure IDR entities' independence.

II. Batching of Claims

As identified in the statute, physicians will have the ability to batch items or services during the IDR process—in other words, multiple IDR-eligible items or services can be considered together as part of an IDR entity's single determination. The MMS appreciates the allowance for batching, as it will create a more efficient IDR process for all parties involved. While the statute identifies criteria for batching, we recommend additional areas for clarificiation and inclusion in the final regulation:

- Claims for items or services should be permitted to be batched for the IDR process at the Current Procedural Terminology® (CPT®) code family level, as well as with other codes related to the episode(s) of care.
- Providers in the same practice/group Taxpayer Identification Number (TIN) should be permitted to batch their claims for IDR and bring a single claim together.
- Clarification on what is meant by "same group health plan or health insurance issuer" as outlined in statute, given that health plans often have multiple products.
- CMS should consider expanding the time period for batching beyond 30-days. This would be helpful for circumstances where there are longer episodes of care, low-volume items or services, or hardships or complications experienced by the physician in accessing the IDR process.

III. Treatment of IDR Factors

The statute requires the IDR entity to consider the QPA along with a wide range of factors submitted by the parties to support their offer (to include provider level of training and quality outcomes, the market share held by either party, complexity of care, scope of services, and demonstrations of previous good faith efforts to negotiate in-network rates and prior contract history between the two parties, among other factors). The parties are required to submit their offers for payment amount and other additional information requested by the IDR entity within 10 days of IDR selection. It was clear by Congress that they did not intend for the IDR entity to give more weight to any one factor over another. Therefore, the MMS recommends that CMS clarify in the final rule that:

- The IDR entity should weigh all factors submitted by the parties equally.
- Undue weight should not be given to the QPA. This is especially important given that it is based on data from a single payer and overvaluing the QPA could lead to an imbalanced system.

Each factor identified in the statute (and others in addition to those explicitly outlined in the statute) are relevant and critical to determing fair payment. For instance, the IDR process will likely be used to resolve payment disputes for unique items or services—these outlier services or items may be because of an unusually complex case by a physician with highly specialized skills, where considering additional information would be crucial.

IV. Submitting Information to IDR

As mentioned above, parties can submit a range of information to the IDR entity.

- We urge CMS to provide guidance and specific examples of how best to communicate various factors, as this will help the parties consider how to effectively submit information.
- In addition, we ask that CMS ensure, to the most appropriate extent possible, the parties in the IDR process are able to view the submission by the other parties.

We ask that CMS not further limit the types of information that can be shared (from the exclusions already outlined in statute). For example, a range of aggregated charge data from payers in the region and/or contract information with other plans or providers may be relevant to an IDR entity's decision and should be allowed to be submitted. Additional clarity is needed to ensure that all parties can share contracted rates with the IDR entities—and whether that information can be shared among all parties or how it will be kept confidential.

V. IDR Process and Timeline

We appreciate that Congress outlined a high-level IDR process and general timelines in the statute, though there are many areas that need further clarification and information. In regards to the IDR process, we urge CMS to put measures in place to make the process as straightforward and transparent as possible. For example:

- The IDR process should be administratively simple and inexpensive. A costly and complex IDR process would create an unfair system that favors health plans and could create incentives for lower initial payments to physicians. Some suggestions that could aid in creating a simple, fair process include:
    - Using an online portal for submitting documents
    - Not require any in-person component
    - For an example of a streamlined, efficient process, CMS should look to the process that the state of New York recently implemented for their surprise billing law. This could be a model for CMS, as their process uses an online portal and does not require an in-person participation component.
- The IDR fee schedule should be transparent, publicly available, and easily accessible.

For the IDR timeline, we recommend the following:

- There is a need for education and resources on timelines leading up to and during the IDR process. We hope CMS will create such resources for physicians and other parties involved in the IDR process.
- All references to "days" in the timelines should be clarified to mean *business* days. This is not clear in the current statute. While the timelines in the current statute are very tight, we believe it could be met so long as the timeline is not factoring in nonworking days.
- Further information is needed to clarify whether the timelines for the subsequent IDR process steps still apply if a health plan does not abide by the timelines related to the initial payment or notice of denial.

VI. Cooling Off Period

Established in statute, there is a 90-day "cooling off period" following the IDR entity's decision where the initiating party cannot submit a subsequent request involving the same party or same item of service. As CMS determines how to operationalize this cooling off period, the MMS recommends CMS consider the following:

- The required "cooling off period" should be applied 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 too broadly could lead to a backlog of IDR claims and have a significant negative impact on smaller physician practices.
- We urge CMS to clarify that claims made during the 90-day cooling off period can be batched (30-day batches) and potentially brought to IDR. Further clarification is needed on how the timelines in statute apply to these claims.

- The statute requires future reports on the effectiveness of the cooling off period. However, we recommend CMS develop a process in the interim for providers to submit complaints about potential plan abuses occurring during the 90-day cooling off period (this could include low initial payments, application of the cooling off period to other products, holding of claims, etc.)

VII. IDR Scope

We urge CMS to clarify that the IDR process is not the appropriate process to determine medical necessity. We ask that the agencies exclude from IDR the denials that are eligible for external review under state or federal law, limiting the types of payment denials that are eligible for the IDR process. 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. 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.

Advanced Explanation of Benefits (AEOB) and Good Faith Estimate (GFE)

The MMS supports transparency in the health care system and believes that transparency can help patients make informed decisions on their care and lead to lower health care costs for patients. The advanced explanation of benefits (AEOB) outlined in statute will be helpful in achieving this transparency. To ensure that stakeholders involved have the necessary resources and information to communicate patients' costs effectively and efficiently, we recommend the following:

- Based on the statute, a physician must submit to a health plan a good faith estimate (GFE) of charges (for insured patients) to trigger creation of an AEOB. This GFE must be provided within a tight timeframe (one business day if care is scheduled three to ten days in advance, and three business days if care is scheduled more than ten days in advance). Given these tight timeframes, we urge CMS to limit the GFE requirements to only the information that is reasonably within the physician's ability to quickly and easily obtain and is necessary to generating an AEOB.
- Currently, there are no requirements that the AEOB be transmitted to the physicians and other health care providers submitting a GFE. We ask CMS to establish this as a requirement. For example, the patient may have questions after receiving the AEOB about the cost and care information and will likely approach their physicians to answer these questions. Physicians and hospitals should be equipped to answer these questions, and the AEOB is needed to support informed conversations.
- There is also no standard format for providers to submit the GFE to health plans and for the plans to send the AEOB to providers and patients. To ensure consistency, compliance, and administrative simplification, we recommend that CMS work with stakeholders to develop a HIPAA-mandated administrative electronic standard to ensure uniform exchange of this information.

As always, the Massachusetts Medical Society appreciates the opportunity to provide comments and work with CMS on our shared goal of providing the highest quality health care to patients. The MMS' comments and recommendations are guided by our policies, our membership, and our commitment to providing quality, equitable care to all patients. Should you have any questions, please contact Alexandria Icenhower, Federal Relations Manager, at aicenhower@mms.org or 781-434-7215.