



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: Requirements Related to Surprise Billing; Part I (File Code: CMS–9909–IFC)

Date: September 7, 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* and the Interim Final Rule on “Requirements Related to Surprise Billing; Part I” (File Code: CMS–9909–IFC).

The MMS has long held the position that patients should be protected and held harmless from surprise medical bills. The MMS was closely involved with our Congressional leaders working to draft the *No Surprises Act*, and we appreciated that the resulting bill aimed to protect patients, while taking into consideration the concerns of physicians and hospitals.

Moreover, we appreciate that the Interim Final Rule (IFR) released by CMS in July includes strong patient protections. In particular, we support the following provisions:

- Enforcement of the prudent layperson standard and other protections related to emergency services will help ensure that many patients are not forced to choose between seeking emergency care or facing financial hardship.
- Patients will have a lower cost-sharing amount as a result of the qualifying payment amount (QPA) calculations.
- There is limited cost-sharing for those with high deductible health plans in surprise billing scenarios (without violation of IRS regulations).
- Standardized example notice and consent and disclosure documents are provided.
- The rule develops a broad complaint process by which the agencies will receive complaints regarding potential violations by insurance plans of the consumer protection and balance billing requirements.
- While the IFR does not outline a time period for filing a complaint, the rule explains that federal agencies will respond to complaints within 60 days.

While the intent of both the legislation and the IFR—to protect patients from surprise medical bills—is clear, additional clarity on certain details would help providers prepare and navigate the provisions when they go into effect next year. We recognize that the IFR released in early July is final and will go into effect; however, 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). We also offer some feedback on provisions in the IFR that could have unintended consequences, and we urge the agencies to consider this additional feedback for future rulemaking. These recommendations are a result of a working group of state and national medical societies, spearheaded by the American Medical Association (AMA).

Qualifying Payment Amount (QPA)

While we appreciate that the QPA calculation would ensure that patients have a lower cost-sharing amount, we are concerned that the QPA calculation methodology outlined in the IFR would not properly or accurately reflect the market. A QPA that is not representative of the market could have significant, negative impacts to health insurance markets and the ability of physician practices (particularly smaller, independent practices) to engage in fair contracting with large health insurance payers and plans. Furthermore, we urge the agencies (HHS, USDT, and DOL) to ensure that the QPA does not play an oversized role in the independent dispute resolution (IDR) entity's decision making process and it is considered in context, with the understanding that it will not always represent a median commercial in-network rate. These concerns, along with proposed recommendations, are outlined in more detail below.

I. QPA Methodology

a. Median Contracted Rate

As mentioned above, the MMS is concerned that the QPA is likely to be skewed—and thus, unrepresentative of the market—because of the manner in which contracts are treated in the QPA calculation. The QPA methodology outlined in the IFR explains that each contract represents a single datapoint in calculating the median, rather than individual providers representing the datapoints. Moreover, no weight is given to the number of claims or services provided under the contract in calculating the median contracted rate. Therefore, large contracts (representing many physicians under one contract) and small contracts (representing a small number of physicians) will be weighted equally under this calculation. This will skew the median contracted rate lower to favor the smaller contracts representing few physicians. Explained differently, by using each contracted rate as a datapoint, instead of each contracted physician's rate, it is likely that the QPA will discount contracts representing the majority of physicians in an area.

b. Insurance Markets

In the IFR, sponsors of self-insured group health plans can calculate their QPA based on their plan or they have the option of allowing their third-party administrator (TPA) to determine the QPA for the sponsor by calculating the median using the contracted rates from all self-insured group health plans administered by the TPA. We are concerned that this could have the impact of TPAs and payers continuously calculating QPAs based on the most favorable “formula” for them using provider rates that may not be in their network—in other words, the calculation method that results in the lowest QPA.

c. Same or Similar Item of Service

The MMS is concerned that the “same or similar item of service” definition in the IFR does not recognize how downcoding will be treated for the QPA. Based on the explanations in the IFR, it seems as if the QPA will be based on the downcoded claim instead of the original claim that was submitted for payment. We urge the departments to clarify the language to ensure the original claim submitted for payment is recognized. Without this protection, plans would have unilateral ability to downcode claims, consistently reducing the QPA at their discretion.

d. Treatment of Alternative Payment Models

The MMS urges CMS to incorporate language requiring plans to include alternative payments, particularly bonus or other incentive payments, into their calculation of

the QPA. Currently, the rule allows plans to disregard these alternative payments. In alternative payment models, where payment is not fully on a fee-for-service basis, plans are directed to calculate the 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. By not incorporating these payments into the QPA calculation, it could misrepresent the actual median rate that providers are receiving under these contracts.

e. Databases

As outlined in the IFR, state all payer claims databases (APCDs) are eligible databases to be used when a plan does not have sufficient information to determine the QPA. However, the IFR does not clarify criteria to determine whether an APCD can be considered to have sufficient data (and whether an APCD can be used in a market where they don't have sufficient data). For example, many state APCDs lack data from self-funded group health plans. We support the development of APCDs, but are concerned current APCDs may not be able to provide data for a QPA calculation that reflects the market.

II. Information Transmitted to the Physician about the QPA/Patient Cost-Sharing

Based on the process outlined in the IFR, plans are required to share little information with providers to help them determine a patient's cost-sharing amount. The MMS urges CMS to clarify the information that providers will receive from the plans. Physicians and hospitals have direct contact with the patient in discussing the cost-sharing amount, so it will be important that they have relevant information, 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 (AEOB) at such time as it is implemented.

III. Treatment of QPA as Part of the IDR Process

As mentioned above, the MMS is concerned that the QPA will often not reflect the true market rate for services rendered. Under statute, the QPA must be provided to the IDR entity. However, it will be important that additional information is submitted to the IDR entity to provide necessary context about the QPA. As mentioned in a previous letter to CMS, it will be important that the IDR entity consider a wide range of factors during the IDR process and no factor is weighted more heavily than any other factor (including no extra weight given to the QPA). We appreciate that the IFR mentioned other factors, like incentive-based payments, as relevant to the IDR process negotiations. The MMS urges the agencies (HHS, USDT, DOL) to recognize in the regulatory framework that the following information (as captured in comments by the AMA) should be required to be provided to the IDR entity and provider (without a requirement that it must 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.

We also recognize that information on the physician's contracted rates with other health plans could also give additional context for the QPA deliberations, should a physician make the determination to submit that information. We ask the agencies to develop a process for physicians to submit this information to the IDR entity directly that would maintain the confidentiality of this information. We urge the agencies to look at California's surprise billing laws for a state example of allowing submission of confidential information.

Initial Payments

The IFR requested additional information on the initial payment. Please find our suggestions below:

I. Plan's Initial Payment Should be Same as IDR Offer

We appreciate that the IFR explained that the initial payment is meant to reflect the amount that the plan reasonably expects to pay for the service. We suggest that the IFR be clarified to require that the plan's initial payments be the same as the plan's offer for IDR (should IDR be pursued)—this will ensure that the initial offer is reasonable.

II. Negative Impact of an Initial Payment Standard or Minimum Payment

The IFR seeks comments on whether the agencies should establish a set initial payment amount. The statute is clear that it does not establish a minimum payment amount, and we would urge the agencies to not propose a payment standard. The MMS has serious concerns about a payment standard, particularly one based on Medicare or in-network rates. This could have serious negative implications for contract negotiations and the long-term sustainability of independent physician practices. For example, Medicare physician payment rates have fallen way behind inflation over the past decade and do not accurately reflect the cost of providing care. For in-network rates, physicians often discount their fees significantly in exchange for contracted benefits, like increased patient volume, inclusion in the plan directory, and prompt payment of claims. An out-of-network payment standard using those rates would put downward pressure on in-network payments and be unsustainable for independent practices.

III. Transparency on Plan's Required Information

The statute outlines that plans are required to send either the initial payment or denial to the physician within 30 days of the claim being submitted. However, the IFR clarifies that this begins when the plan receives a "clean claim" or all of the necessary information to determine payment. Noncontracted physicians will likely be unfamiliar with each plan's varying requirements for coding, documentation, and submissions. To reduce delays and increase efficiencies in the process, we ask that the regulatory framework be clarified to require transparency from the plans to clearly communicate to providers the exact information that is needed to correct claims in the first rejection. Furthermore, we ask the agencies to ensure this requirement is not used to delay the process for resolving payment

disputes by closely monitoring the process and providing a method for providers to submit complaints.

Specified State Law

The IFR clarifies that a “specified state law” is both a state law that sets a predetermined payment amount and a law that requires or permits a plan and a provider to negotiate and then to engage in a state arbitration process. However, we recognize the complexity associated with implementation and continued compliance, especially for those navigating state and federal rules.

I. State by State Analysis

While Massachusetts does not currently have a state law on out-of-network billing that fulfills the statutory definition, we understand from our colleagues in other states and from national medical societies that there is much confusion around what is considered a specified state law. Additional clarification from CMS, including a state-by-state analysis of the relevant laws, updated regularly by CMS, would be helpful in better understanding which laws take precedence. Furthermore, the Massachusetts legislature is currently in the process of determining whether to defer to the federal law or adopt a separate, state out-of-network billing law. Regardless of the outcome at the state level, it will be important that physicians in our state understand the requirements, and clear guidelines from CMS would aid in their understanding of the law.

II. Communications by the Plan

We are also concerned that the prevalence of varying sets of laws at the state and federal level will be confusing to physicians in identifying which set of rules apply to a claim. There is potential for much confusion among physicians navigating two regulatory structures, in some cases in the same episode of care. We ask that CMS and the other agencies require plans to be transparent and communicate which law they are using in remittance advice and other initial communications. In addition, plans can opt-in to state laws when states allow it. We ask that the agencies maintain the requirement that a plan is required to opt-in fully for all services, and not episodically. Without this requirement, plans may conveniently choose only the state laws that are beneficial to them for certain claims, and it could increase confusion.

III. Enforcement and Flexibility

The rule doesn't identify which entity in each state will be expected to enforce the rule (if the state is the one enforcing it). Information on which regulatory entity in each state will be enforcing the law would be useful to physicians. In addition, we ask that CMS and the other agencies allow for an opportunity for corrections without penalty for physicians who are acting in good faith but use the wrong process. Recognizing that there are serious implications for physicians who fail to abide by the correct law, we ask for flexibility for physicians acting in good faith.

Notice and Consent

We appreciate that the IFR provides information on the notice and consent provisions as outlined in the *No Surprises Act*. We also appreciate that CMS has taken clear efforts to standardize the process, reduce confusion, and promote administrative simplification by providing an example standardized form. However, there are several components of the notice and consent process that could use further clarification.

I. Recognizing Assignment/Payment to Physician

It is unclear in the rule whether plans are required to deliver any payment directly to the provider and whether the plans will recognize assignment if notice and consent are provided and received. In the scenario where notice and consent is received and the patient seeks out-of-network coverage for their care, we urge CMS to require plans to recognize assignment and make payments directly to the provider. This would also be an important patient protection. The practice of plans sending out-of-network payments to patients who are then responsible for making full payments on the cost-of-care can be confusing and time-consuming for patients. Removing patients from the middle of such payments would help reduce administrative burdens for patients and physicians.

II. Obtaining the Necessary Information

We appreciate that the rule provides some flexibility in the types of information that must be submitted to patients by providers along with notice and consent documents, recognizing that not all of the information is easily obtainable by physicians. For example, detailed information on utilization management and other care restrictions would be difficult and time-consuming for physicians to receive from the health plans and could delay notice and consent documents. In addition, it will be difficult for nonparticipating physicians to reasonably and reliably estimate a patient's cost-sharing information. Since the patient will also be receiving an advanced explanation of benefits (AEOB) from the plan prior to care, requiring this information from the physician could be duplicative (the AEOB is to be explained in future rulemaking). We ask that CMS maintain flexibility in the notice and consent information required by physicians.

III. Network Adequacy and Plan Authority

The rule clarifies that the notice and consent exception is only available to physicians if there is not a participating provider available at the facility. We agree that patients should not be responsible in this scenario and that it is difficult to give consent if no other options exist. However, this rule seems to shift network adequacy responsibilities onto providers rather than the health plans. Under this scenario, nonparticipating providers are penalized for a plan's inadequate networks (networks where no participating providers are at a participating facility). A physician should not have to enter the surprise billing process to resolve the plan's deficit, and there should be more network adequacy responsibilities placed on the plans. In addition, we would like greater clarity on the provision that the health plan is instructed to reprocess a claim if the plan knows/reasonably should know that notice and consent were not properly given. This would appear to give authority to plans to determine if notice and consent were properly given and received. We ask CMS to provide additional clarity on how this would be communicated to the provider and if there will be a process to challenge this determination.

IV. Timeframes and Interaction with AEOB

Clarification in future rulemaking will be needed to understand how the notice and consent timeframes align with the timeframes outlined in statute for the advanced explanation of benefits (AEOB). We are concerned that potentially different timelines for the good faith estimates required in the notice and consent and AEOB processes could create confusion. In addition, when a patient is provided the notice on the same day care is provided, providers and facilities are required to provide the notice no later than three hours prior. While this timeframe should be appropriate in most instances, we ask CMS to consider establishing exceptions to this requirement for instances where care is needed more quickly (post-

stabilization) than the three-hour requirement might allow or when provider coordination and availability of resources may not align with this timeframe.

V. Interaction with State Law

Lastly, further clarification is needed on how the federal notice and consent requirements outlined in the IFR interact with state notice laws. For example, Massachusetts' law requires providers to give notice to patients regarding the provider's network status. The state's law does not, however, require patient consent to be obtained. Additionally, Massachusetts does not require that a standardized form be used to provide this notice. The state requirements for notice also differ from the federal law on how far in advance of the service the notice must be given. While there has been significant discussion and clarification about how the state and federal laws interact for payment dispute-related provisions, further information is needed on the interaction of state and federal notice and consent laws, specifically which law takes precedence in various scenarios. In the example of the Massachusetts law, the timeline for notice is more restrictive, but the lack of required consent is less stringent, leading to questions of which law should be applied in various situations. Based on the information in the rulemaking about the notice and consent form, it appears that Massachusetts providers who fall under either of the below two categories would be required to provide the completed federal form (under the timeline outlined in federal rulemaking) to patients:

- A nonparticipating provider or nonparticipating emergency facility when furnishing certain post-stabilization services, or
- A nonparticipating provider (or facility on behalf of the provider) when furnishing non-emergency services (other than ancillary services) at certain participating health care facilities.

Additional clarity would help to reduce confusion and administrative burden for Massachusetts physicians (and providers in other states) trying to navigate multiple, conflicting regulations.

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.