

September 3, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9909-IFC
Baltimore, MD 21244-8016

Subject: Requirements Related to Surprise Billing; Part I (CMS-9909-IFC)

Dear Administrator Brooks-LaSure:

On behalf of over 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we are pleased to share our feedback on the Requirements Related to Surprise Billing; Part I Interim Final Rule (IFR) (CMS-9909-IFC), published in the Federal Register on July 13, 2021.

The intent of the No Surprises Act (NSA), to ensure that patients are removed from the middle of out-of-network (OoN) billing disputes between insurers and healthcare practitioners, is one that the AAOS supports with much enthusiasm. We recognize that the sanctity of the physician-patient relationship is based on a foundation of trust and communication. When our patients receive exceptionally expensive medical bills for care provided in emergent situations, we are concerned that their physical healing may come at the cost of their financial well-being. As we discussed in our letter sent prior to rulemaking, it is our hope that the Departments of Health and Human Services, Labor, and Treasury (the Agencies) remain cognizant of the market failure that created this surprise billing problem in the first place. While patients typically can choose physicians and facilities within their own insurance network for elective care, it is sometimes impossible to avoid out-of-network practitioners and facilities.

In addition, ancillary clinicians contract separately with insurance companies from principal physicians and can be out-of-network even if the principal physician is contracted with the patient's health insurance network. To the extent that HHS and CMS have legal authority, AAOS supports incorporating specific, quantitative standards that require insurance networks to maintain a minimum number of active primary and specialty physicians, accurate updated physician directories, and provide transparent out-of-network payment options for patients. We believe these remedies are essential for preventing surprise medical bills, ensuring access to care, and decreasing physician burden.

We applaud the Agencies in their work to fulfill the consumer safeguards set forth by the NSA as it relates to lower cost-sharing for patients and the enforcement of standards meant to ensure continued access to quality care. However, AAOS is concerned by a number of the proposals detailed in this interim final rule. Below we will share our thoughts and suggestions:

Qualifying Payment Amount

Although AAOS strongly supports a healthcare system that does not leave patients who receive emergency care bankrupt, we are deeply concerned by the potential use of the median contracted rate as the primary datapoint to determine the qualifying payment amount (QPA) under the Independent Dispute Resolution (IDR) process. As was stipulated in the NSA, the median contracted rate was intended to be *just one of several equally weighted factors in the arbitration process*. In the present iteration of the IFR, the number of claims or services in a single contract will not be considered in this process. This may result in a false equivalency between large and small contracts with poor representation of the true median.

Furthermore, AAOS is disappointed that the IFR fails to adequately account for the value focused payment structure in Alternative Payment Models. As early adopters and leaders in the shift to value-based care, orthopaedic surgeons have incomparably invested in providing the highest quality musculoskeletal care in the most cost efficient format. To ignore this work by excluding bonus or supplemental payments from the calculation of the median contracted rate would be a chilling factor in further adoption and greater risk assumption by physician leaders.

While we appreciate that the agencies incorporated our suggestion to use All-Payer Claims Databases (APCDs) as a source when plans have insufficient data to calculate the QPA, we request further clarity on (1) what factors will be used to decide when an APCD has sufficient data and (2) under what circumstances the APCD will be used in the QPA determination for self-funded plans. To ameliorate potential skewing of the data, AAOS supports transparency from the plan by requesting that they provide the following information to the IDR entity and provider in all disputes:

- The total number of contracts used to calculate the median, as well as the total number of physicians represented by the contracts
- The types of specialists and subspecialists whose contracted rates are included in the dataset used to calculate the QPA
- Data pertinent to the APM arrangement and what payments, if any, were excluded from the calculation
- Statement from the plan declaring whether a claim was down-coded, and if so, why. Additionally, in cases where the claim is down-coded, the physician should have access to what the QPA calculation would have been based on the originally submitted claim.

To clarify, *AAOS does not support taking the above actions at the expense of the patient*. Rather, we suggest that the Agencies create a secondary QPA to be used in the IDR process separate from

responsibilities related to patient cost-sharing. In this way, we believe that patients will benefit from accessing affordable care and also ensuring that physicians are suitably reimbursed from insurers for the work they perform. Under this proposal, we also suggest that the second QPA calculated for the purposes of the IDR process be based on the 2019 rate and adjusted for inflation using the same formula proposed for the presently finalized QPA.

Toward that end, we ask that the process for accepting or denying claims for initial payment also be expounded upon. For example, will the onus be on the plan to provide evidence of inadequate notice and consent? If the claim is denied, what information will the physician have regarding when the IDR process will be initiated? Finally, we request that there be standardized processes for submitting and processing 'clean claims.' It would be inappropriate to require physician practices to spend time preparing such detailed claims only to have insurers opaquely determine what is denied or delayed.

Notice and Consent

AAOS strongly supports the retainment of an OoN balance billing option when appropriate notice and consent is given. In nonemergent situations, balance billing should be permitted only if the patient is adequately informed about the likelihood of out-of-network care. The patient should have every opportunity to seek care from their provider of choice regardless of network status in order to preserve choice and competition. Toward that end, we are pleased to see that the notice and consent process as written in the IFR makes an effort to empower patients with the cost information required to make informed medical and financial decisions. However, we urge the Agencies to simplify the notice and consent process to ensure that patients receive only the information they need (for example, the Advanced Explanation of Benefits) prior to scheduling nonemergent care.

Similarly, the overlapping and inconsistent requirements regarding the timelines for providers to share the Good Faith Estimate and Advanced Explanation of Benefits are bound to create confusion for patients and inevitably lead to increased burden for physicians and their practices. Instead of a duplicitous process that may lead to artificial deadlines and slow access to care, we ask that the Agencies create a streamlined process to ensure that patients are aware of and understand the cost the physician reasonably anticipates they will be responsible for when undergoing treatment. Specifically, we are concerned that physicians will have no choice but to spend their limited time tracking down each patient's prior authorization, list of all providers who will be involved with the care team, and the patient's individual cost-sharing to produce an accurate Good Faith Estimate.

Specified State Law

The need for the Agencies to make clear how the federal provisions will interact with existing or forthcoming state-level unanticipated billing laws cannot be overstated. Significant questions remain regarding the opt-in process, and the interplay between state-level thresholds for surprise billing consumer protections and this federal process. Most pressing is the need to clarify which pathway physicians should take when there are multiple IDR processes available. Furthermore, in determining the parameters of what is defined as a specified state law, the Agencies must ensure both consumer

protections against true “surprise” bills and a transparent process for payment determination. Given the patchwork landscape of state laws, we request that the Agencies provide state-by-state guidance.

The issues with state law also trace back to the overarching discrepancies in the narrow networks created and reinforced by insurers. In a scenario where plans pay in-network contracted rates that are reasonable and worthy of the expertise and skill that physicians bring to their patients, the need for balance billing and subsequent dispute resolution would be immaterial. With this in mind, AAOS encourages the Agencies to focus greater attention on the promotion of a fair, competitive, and transparent insurance market in which physicians are sufficiently reimbursed for the care they provide and where patients are not subject to puzzling cost-sharing arrangements.

Thank you for your time and attention to the concerns of the American Association of Orthopaedic Surgeons (AAOS) on the substantial changes made in the Part I Interim Final Rule on Surprise Billing. The AAOS looks forward to working closely with the Agencies on further iterations of this rule, and to enhancing the care of musculoskeletal patients in the United States. Should you have questions on any of the above comments, please do not hesitate to contact Shreyasi Deb, PhD, MBA, AAOS Office of Government Relations at deb@aaos.org.

Sincerely,



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President, AAOS

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