



Advancing High Performance Health

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December 6, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: RIN 1210-AB00

Dear Administrator Brooks-LaSure:

On behalf of the AMGA, I want to express our appreciation for the opportunity to comment on the “Requirements Related to Surprise Billing; Part II.” This interim final rule with comment (IFC) implements aspects of the No Surprises Act, which was enacted as part of the Consolidated Appropriations Act of 2021. The regulation governs the federal independent dispute resolution (IDR) process, which payers and providers may use to resolve disagreements over the appropriate out-of-network rates for select emergency services and items and services provided by nonparticipating providers at in-network facilities. AMGA has serious concerns with how the regulation effectively precludes an actual negotiation from occurring and instead appears to favor a predetermined outcome.

Founded in 1950, AMGA represents more than 450 multispecialty medical groups and integrated delivery systems, representing approximately 177,000 physicians who care for one in three Americans. Our member medical groups work diligently to provide innovative, high-quality, cost-effective, patient-centered medical care.

AMGA is pleased to offer these recommendations for your consideration.

Key Recommendations

AMGA strongly encourages the agencies to revise this IFC so the IDR process does not effectively default to the median in-network rate by disproportionately weighing one factor at the expense of the other considerations included in the statute.

AMGA recommends that the agencies pause implementation of the Good Faith Estimate (GFE) requirement and work with stakeholders to create a process that does not create a burden for providers and ensures patients receive accurate information.

Rule Should Not Default to Qualifying Payment Amount

The No Surprises Act includes an IDR process to prevent patients from being involved in payment disputes between providers and payers.

The No Surprises Act instructs arbitrators to consider several factors:

1. The “qualifying payment amount” (QPA), which is generally the insurer’s median in-network rate for similar services in that geographic region as of 2019, inflated forward by the Consumer Price Index for All Urban Consumers (CPI-U);
2. Demonstrations of good faith efforts (or lack thereof) to reach a network agreement and any contracted rates between the two parties during the previous four years;
3. Market shares of both parties;
4. Patient acuity; and
5. The level of training, experience, and quality of the clinician, or the teaching status, case mix, and scope of services offered by the facility.

While the law includes several factors for the IDR entity to consider as part of the process, the IFC effectively dismisses most of these factors in favor of the QPA. The IFC indicates that the IDR entity “must look first” to the QPA and then move to other considerations. The regulation goes on to indicate the statute provides “limited guidance” on how these additional factors should be considered. AMGA contends this is a misinterpretation of the law, and 150 members of the U.S. House of Representatives agree that the regulation does not reflect congressional intent.

In a Nov. 5, 2021 letter to Sec. Xavier Becerra, Sec. Janet Yellen, and Sec. Martin Walsh, the members of Congress note the law “expressly directs the certified IDR entity to consider each of these listed factors should they be submitted, capturing the unique circumstance of each billing dispute without causing any single piece of information to be the default one considered.” The letter continues:

Unfortunately, the parameters of the IDR process in the IFR released on September 30 do not reflect the way the law was written, do not reflect a policy that could have passed Congress, and do not create a balanced process to settle payment disputes. The IFR directs IDR entities to begin with the assumption that the median in-network rate is the appropriate payment amount prior to considering other factors. This directive establishes a de-facto benchmark rate, making the median in-network rate the default factor considered in the IDR process. This approach is contrary to the statute ...”

AMGA shares the concerns raised in the letter and believes this approach undermines congressional intent. In addition, by unduly favoring the QPA, the IDR process could encourage payers to artificially lower payment rates, knowing that the IRD process would effectively default to the QPA. AMGA recommends that the agencies revise the IRD process so that the arbitration process allows for a fair consideration of all the relevant factors.

Good Faith Estimate

The rule includes a requirement that providers offer a good faith estimate (GFE) of the cost of items and services provided to uninsured or self-pay patients. Regulations are pending for GFEs

for patients with health coverage. While supportive of price transparency, AMGA is concerned that the GFEs provided to uninsured and self-pay patients may cause more confusion. In addition, our members report that responding to requests for GFEs threatens to overwhelm an already stressed administrative and nonclinical staff.

For example, for the GFE to be useful the patients will need to be specific and accurate about all the services they are requesting. It is unreasonable to assume patients will have the knowledge needed to provide the information for non-clinical staff to cypher through tens of thousands of CPT and diagnosis codes for a meaningful estimate. We understand the GFE must note additional services may be scheduled separately, and will not be captured on the GFE. In addition, the GFE is not a contract, but rather only an estimate. All of this will likely create confusion and additional frustration for patients, which is exactly the opposite of what the No Surprise Act intended. Additionally, the “convening provider” must provide the GFE to the patient within three business days of receiving the initial request for the estimate. There can be multiple different providers submitting multiple different CPT codes for what they layperson would consider a single procedure. It will be administratively difficult to coordinate with the various potential providers, which would be necessary for a reliable GFE within the designated period.

The rule notes that the agencies will undertake additional rulemaking on providing GFEs for patients with health insurance coverage. AMGA recommends that the agencies pause implementation of this requirement. Instead, the agencies should work with stakeholders through the regular rulemaking and comment process to develop a procedure that offers clear, accurate, and timely information for all patients.

We thank CMS for consideration of our comments. Should you have questions, please do not hesitate to contact AMGA's Darryl M. Drevna, senior director for regulatory affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,

A handwritten signature in cursive script that reads "Jerry Penso".

Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer, AMGA