AAOS
American Association of Orthopaedic Surgeons

December 3, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9908-IFC
P.O. Box 8010
Baltimore, MD 21244-8010

Subject: Requirements Related to Surprise Billing; Part II (CMS-9908-IFC)

Dear Administrator Brooks-LaSure:

On behalf of over 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), and the orthopaedic specialty and state orthopaedic societies that agreed to sign on, we are pleased to share our feedback on the Requirements Related to Surprise Billing; Part II Interim Final Rule (CMS-9908-IFC), published in the Federal Register on October 7, 2021.

For more than two years, AAOS worked across the legislative and regulatory arena[1] to ensure that patients are removed from the middle of out-of-network (OoN) payment disputes between insurers and physicians. We are pleased that the rule maintains strong patient protections from balance billing in emergent situations, and non-emergent situations where notice and consent is not given. AAOS members place the physician-patient connection at the forefront of their practice, and we believe this protection will maintain the sanctity of that relationship. However, the AAOS is alarmed by the deviation from congressional intent as evidenced in the language of the Requirements Related to Surprise Billing Part II IFC.

The language of the No Surprises Act (2020) clearly states that several factors must be ***equally considered*** by the arbiter during the Independent Dispute Resolution (IDR) process. These include the following:

- "Median in-network rates
- Provider training and quality of outcomes
- Market share of parties
- Patient acuity or complexity of services
- In the case that a provider is a facility: teaching status, case mix, and scope of services

[1] AAOS Comments on Surprise Billing IFC Part I; AAOS Letter to Congress (December 2020)

- Demonstrations of previous good faith efforts to negotiate in-network rates
- Prior contract history between the two parties over the previous four years"

The law was deliberately written with the intention of providing a fair and comprehensive process for physicians and insurers to settle OoN payment disputes in a way that protects patients. By considering each of the above factors ***equally***, the law is intended to develop a system that examines all aspects which impact payment.

Unfortunately, the Departments of Health and Human Services (HHS), Labor, and Treasury ("the Departments") and the Office of Personnel Management (OPM) have instead ignored both the resounding petitions from the physician community and congressional intent to create a balanced IDR process. Turning their backs on the health care leaders who have been at the forefront of medicine through frequent iterations of health system reinvention and who now bear the brunt of the ongoing COVID-19 pandemic, the Departments have permitted commercial insurers to move away from a good faith negotiating process. This rule grants them a system for IDR that will in practice tip the scale of disputes in their favor by making the insurer-formulated Qualifying Payment Amount (QPA)—calculated as the median in-network rate—the primary factor for consideration in IDR and the presumptive appropriate payment amount. Not only is this a significant departure from congressional intent, it conveys to physicians that the government is willing to emphasize cost-saving measures targeting front-line physicians above patient safety and access when it comes to solving the issues that concern the health care system.

Most frequently, the reason that providers are OoN is not due to their own unwillingness to negotiate for in-network contracts with insurers. Instead, insurers offer contracts at rates which are untenable to cover the true costs of care. It is under these circumstances where the market has failed to create a level-playing field for clinicians of all specialties to participate in-network with plans that require a minimum number of active primary and specialty physicians. This rule creates an ad-hoc system of benchmarking that guarantees every patient in-network cost-sharing and in-network payment to physicians, while shutting physicians out of an IDR process that accounts for their work and expertise in a meaningful way. It is difficult to imagine this type of government overreach acceptable in other industries.

We strongly urge the Departments to update the IFC to reflect the statutory language and intent of the law. It is imperative to the continued practice of medicine in the United States that these consumer protections ensure ***both*** patients' access to care and the financial health of their physicians. Moreover, we are concerned by the manner in which the administration appropriated the intent of the No Surprises Act and used the interim final rulemaking process to insert regulations that fulfill directives of Executive Order 14036, issued on July 9, 2021 "Promoting Competition in the American Economy in order to promote the interests of American workers, businesses, and consumers." This may conflate the intent of the NSA to provide transparency among the in- and out-of-network costs under applicable state law with the earlier directives regarding price transparency requirements.

In addition to the concerns addressed above, we would like to express our thoughts on the following areas of the IFC:

Independent Dispute Resolution Process

The rule states that the initial payment made by the insurer to the provider should be an amount that the plan reasonably intends to pay the provider. This will be the amount that the Departments assume will be the plan's full payment. However, we are concerned by the lack of guardrails to ensure that the plans will be required to make the initial payment in an amount that would cover the true cost of care. In the open negotiation process, we welcome the clarification regarding the use of business days and calendar days for the respective processes. To facilitate a streamlined negotiation process, we request that the original claim from the physician be included in the open negotiation notice.

Although we appreciate the clear timelines and parameters for the Notice of IDR, we are concerned that the four (4) business-day time frame for initiating IDR following the end of the open negotiation period may not account for circumstances beyond the control of the physician to meet this deadline. Chiefly, we believe that this may detract from patient care and result in additional time spent wading through burdensome administrative processes. In cases where the deadline is not met, we request that the Departments evaluate a process for initiating IDR where certain extenuating circumstances are considered. Examples of extenuating circumstances range from simple challenges such as scheduling conflicts that preclude the physician from initiating the process, to complex and uncontrollable circumstances such as natural disasters or persistent but infrequent surges in COVID-19 cases. Though we request that the Departments consider extending the timeline for initiating the IDR process, AAOS remains committed to ensuring that the rule's patient protections and access to care are not delayed.

For the content items included in the Notice of IDR, we believe that the Departments' required items to include are a comprehensive list that should assist the entity in understanding the nature of the claim (or claims, if batched). Yet, to provide the fullest window into the dispute, we believe that it would be prudent to require a copy of the original claim to highlight the acuity of services provided and original charges.

As is stated in the IFC, there are strict criteria for groups to become certified IDR entities. We are appreciative of the thought that has been given to ensure that these entities are conflict-free and provide truly *independent* arbitration. We similarly appreciate that the parties to arbitration will have the opportunity to jointly choose the entity, before the process is deferred to the Departments to select. Yet, we believe that just three (3) business days to do so may not be enough time to determine the appropriate IDR entity. This could lead to the selection of an entity which may not be the most suitable to oversee and make a payment determination. Moreover, the notion that the IDR entity will be the one to adjudicate disputes of applicable state law concerns us. For example, the rule omits language explaining how a physician party to the IDR process may dispute the applicability for federal or state law. Moreover, AAOS requests that the Departments create a process for monitoring the balance of dispute resolutions at the respective IDR entities. For example, if an entity is consistently more favorable to one side or the other there should be a transparent process for disclosing this.

Should any given entity clearly and consistently favor one party over the other, we ask that the Departments consider remedies for ensuring parity.

We earlier requested that the process for batching claims be simplified to ensure that there was not additional burden created for the submission of claims for same or similar services, as well as services that are billed as part of a bundled payment arrangement. AAOS values the Departments' recognition of the need for this. Furthermore, we appreciate that the claims for services which are provided during the 90-day cooling off period will be permitted to be subsequently submitted together in a single batch.

Good Faith Estimate

AAOS supports the implementation of a price transparent health care market for patients. Although we believe that the good faith estimate (GFE) is an important tool in the cadre of options for making cost information accessible to patients, we are concerned that the IFC's provisions related to providing a patient the good faith estimate may become the default tool for achieving broader price transparency initiatives. Instead of directing patients to cost estimator tools that may have already been developed as a result of prior rules regarding price transparency, the GFE requirement for self-pay patients may become one avenue for patients to shop providers instead of directing them to publicly available estimator tools that are already available. While our members are willing to ensure that self-pay and uninsured patients have access to care in a transparent manner, the provisions outlined here will likely act as the precursor to the requirements for the forthcoming Advanced Explanation of Benefits (AEOB) that will be required for all patients seeking care, regardless of insurance status.

With this in mind, we request that the Departments consider the unintended consequences that the burdens of these requirements may have on physician practices, particularly those that are smaller. Given the brief timeline to provide the GFE to patients once they request it, we are concerned that this strain will negatively impact the already limited resources of small practices. This runs counter to the initiatives of Executive Order 14036, which advocates for changes to bolster competition in the health care industry. The burdens of the IFC may have the opposite effect by forcing physicians, who had been leading independent practices, into consolidation to account for the greater overhead costs stemming from these requirements.

In the rule, the Departments offer knee surgery as an exemplary procedure for which the GFE would include the following items and instructions: "the actual knee surgery (such as surgeon professional fees, assistant surgeon's professional fees, anesthesiologist professional fees, facility fees, prescription drugs, and durable medical equipment fees); "all items or services that are reasonably expected to be provided from admission through discharge as part of that scheduled knee surgery, from all physicians, facilities, or providers be included in the GFE"; "a provider or facility would furnish separate good faith estimates upon scheduling or upon request for any items or services that are necessary prior to or following provision of the primary item or service beyond the period of care."; "examples could include certain pre-operative or post-operative items or services that are not typically

scheduled during the period of care for the knee surgery, such as certain laboratory tests or post-discharge physical therapy."

AAOS is concerned that the Departments presume the orthopaedic surgeon will be considered the convening provider in the above example as well as for the myriad other orthopaedic procedures. While our members are eager to participate in programs that increase patient access and preserve strong consumer protections, we think the extent of the burden on the convening provider will prove detrimental to patient access and contribute further to the burnout that physicians are facing from the dual challenges of the pandemic and the cumulating prior authorization requirements being imposed on patients and physicians by commercial insurers.

We are likewise concerned that the broad definitions of health care facility may extend the GFE and forthcoming AEOB requirements to many more groups than are required under the rules to provide notice and consent for out-of-network care. This expansion to facilities including hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgical centers, rural health centers, federally qualified health centers, laboratories, and imaging centers will have long-reaching impacts and a potential ripple effect on the efficiency with which appointments can be scheduled and care can be provided. Should this broad definition be maintained, we ask that the Departments consider alternative opportunities to standardize the process for the GFE as well as reduce other forms of administrative burden that detract from critical time physicians have available to spend with patients.

Provider Patient Dispute Resolution

AAOS appreciates the additional patient protections offered by the provider-patient dispute resolution process for uninsured and self-pay patients. We support the Departments' conscientiousness as it relates to the fees associated with the process and ensuring that it is accessible to all patients who receive an OoN bill that is in excess of $400 of the GFE. Yet, we request additional clarity on the role of individual provider costs versus cumulative costs exceeding the $400 limit. Would an individual physician be subject to the dispute resolution process if their individual cost exceeded the GFE by $200, but the total exceeded $400? Particularly in the surgical field, where unanticipated changes can arise once the surgery has commenced, we request clarity on this process and a streamlined approach for resolving charges when the cumulative cost is what exceeds the substantially in excess threshold.

Finally, we ask that the Departments consider the burdens this process may disproportionately have on the underrepresented communities it is, in part, intended to serve. We applaud the efforts that the Centers for Medicare and Medicaid Services (CMS) have made in 2021 to collect feedback on creating an equitable health care landscape for future optimization of Medicare quality programs. The provider-patient dispute resolution process is another opportunity to ensure access to quality care for the millions of Americans who fall into the abyss of under- or uninsured. While the monetary threshold to access the provider-patient dispute resolution process was carefully considered, the time patients will have to spend going through the process may prove prohibitive or exclusionary. We ask that the Departments consider allocating additional resources to patients seeking resolution through

provider-patient dispute resolution process by considering and perhaps leveraging the role of patient advocates and other resources intended to assist patients in accessing care.

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 II Interim Final Rule on Surprise Billing. The AAOS looks forward to working closely with the Departments on further refining 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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Alabama Orthopaedic Society
American Association of Hip and Knee Surgeons
American Orthopaedic Foot & Ankle Society
American Orthopaedic Society for Sports Medicine
American Shoulder and Elbow Surgeons
American Society for Surgery of the Hand
Arizona Orthopaedic Society
Arkansas Orthopaedic Society
Arthroscopy Association of North America
California Orthopaedic Association
Cervical Spine Research Society
Connecticut Orthopaedic Society
Delaware Society of Orthopaedic Surgeons

Florida Orthopaedic Society
Georgia Orthopaedic Society
Iowa Orthopaedic Society
Kansas Orthopaedic Society
Limb Lengthening and Reconstruction Society
Maine Society of Orthopaedic Surgeons
Maryland Orthopaedic Association
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Michigan Orthopaedic Society
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North Carolina Orthopaedic Association
North Dakota Orthopaedic Society
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