



December 3, 2021

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Martin Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Submitted online via www.regulations.gov

Re: CMS-9908-IFC— Requirements Related to Surprise Billing; Part II; Interim Final Rules with Request for Comments (RIN 1210-AB00)

Dear Secretaries Yellen, Walsh and Becerra:

On behalf of the American Association of Oral and Maxillofacial Surgeons (AAOMS), which represents more than 9,000 oral and maxillofacial surgeons (OMSs) in the United States, thank you for the opportunity to comment on the interim final rule (IFR) entitled, "Requirements Related to Surprise Billing; Part II," as published in the *Federal Register* on September 30, 2021.

OMSs – many of whom are part of small practices – are also an integral part of hospital systems, providing emergency department coverage, serving as essential members of trauma teams throughout the country and performing complex procedures at hospitals. AAOMS supports efforts to prevent patients from being unfairly surprised by an out-of-network bill, while ensuring that providers have the opportunity to be reimbursed at a fair and reasonable rate.

The No Surprises Act (NSA) is representative of significant bipartisan and bicameral efforts aimed at mitigating unanticipated financial hardships for those patients who inadvertently receive out-of-network care. AAOMS is supportive of many of the provisions in the final version of the law.

Also, we would like to thank the Centers for Medicare & Medicaid Services (CMS) for delaying the implementation of the provision of Good Faith Estimates (GFEs) for insured patients beyond January 1, 2022, recognizing the significant administrative and logistical challenges this poses for both providers and insurers. We appreciate the cooperation between both entities in addressing significant issues related to the current healthcare landscape. Clearly, it will take time for all relevant stakeholders to come together to create meaningful pathways and protocols to allow for seamless integration of patient care and insurance reimbursement.

While the NSA puts into place important reforms necessary to protect patients from surprise medical bills, there are several implementing provisions in this IFR that AAOMS finds concerning and are outlined in this letter.

Presumption of QPA as an appropriate out-of-network rate is contrary to Congressional intent

AAOMS supports a standardized and consistent provider-insurer payment negotiation process and agrees that such a process is necessary to ensure fair payment for services. It is our position, however, that the IFR's interpretation of the statute's independent dispute resolution (IDR) process, namely the assertion that the qualifying payment amount (QPA) is to be the primary factor against which all out-of-network rates will be referenced, is a departure from intent of the legislation and unfair to the provider of service.

The IDR process was borne of substantial bipartisan effort to establish a balanced system in which payment proposals would take into consideration several key factors, characterizing the uniqueness of each patient encounter and the various treatment options provided to optimize the patients' treatment and recovery. It has been noted that the calculation of the QPA must be both consistent and transparent. However, presupposing that the QPA is both reasonable and representative of the market in question, and requiring compelling evidence for any deviation from the QPA, places an undue burden on the out-of-network provider. This effectively imposes upon the out-of-network provider the burdens of participation, namely the presumption of a network rate, without the benefit of participation, namely inclusion in the insurer's network to reach the insurer's subscribers. That is, the in-network allowance (QPA) is often discounted and offered to participating providers in return for inclusion in the insurer's network provider listing; the listing serves as a patient referral source to participating providers. If the in-network allowance (QPA) is applied to the out-of-network provider, the provider will have to comply with the discounted rate of the in-network provider without the benefit of the network listing.

Furthermore, implementation of the law as such significantly restricts what information providers may present to substantiate their request for review, further diminishing the likelihood of providers, especially those in small practice settings, engaging in the IDR process at all. Therefore, we ask the Departments to revise the IFR to give certified IDR entities the discretion to consider all the allowable and relevant information submitted by the parties, without creating a presumption that directs IDR entities to consider the offer closest to the QPA as the appropriate payment amount.

Placing the responsibility of network status of ancillary providers on the office-based primary provider is impracticable

AAOMS agrees that the provision of a GFE for scheduled or requested services is an integral component of the patient protections against surprise medical bills set forth under the NSA; however, we believe the inclusion of co-providers/co-facilities in the responsibility of the convening provider presents unique challenges for office-based providers that perform surgeries in ambulatory surgical centers (ASCs), hospital outpatient facilities or inpatient hospitals, as OMSs routinely do.

In the case of nonemergency surgical services, the OMS is often subject to the scheduling constraints and the limited availability of specialty-specific equipment and supplies in facilities in which they have privileges. As such, it is uncommon for any ancillary providers (e.g., anesthesiologists, radiologists or hospitalists) to have their procedures predetermined at the time of scheduling (this includes their network status and fees for service). Similarly, the insurance and network information is often not communicated to the OMS in advance of the procedure nor are the procedures predetermined. As a result, procedures are often performed prior to predetermination of insurance coverage. Often the patients' medical condition necessitates immediate management to prevent further deterioration of the patient's condition and the OMS is not adequately compensated for the specialty care provided

We request the IFR be amended to specify that the primary surgical provider – such as the OMS in the above example – only be required to provide notification on their own network status at the time the patient makes the appointment and be allowed to direct the patient to the facility for the network status of other potential providers involved in the patient's care. By amending the IFR as such, should the facility not comply with the rule's notification requirements and the patient receives care from an out-of-network provider such as anesthesiologist or pathologist, then the facility is penalized but the primary surgical provider is not.

Clarification is needed to further define the term “health care facility” and assure the language regarding office-based settings is excluded from the definition

AAOMS reemphasizes its request to ensure the definition of “health care facility” does not include office-based settings. We agree that the specific settings mentioned in the bill – such as hospitals, critical access hospitals, ASCs – are appropriate to include in the definition; however, in the case of office-based providers, patients are informed in advance as to whether the provider is in their network and the patient is able to decide whether they wish to incur any additional costs by seeking treatment from an out-of-network provider. As such, AAOMS requests the IFR be clarified to ensure the definition of “health care facility” not be misinterpreted to include physician and/or dental office-based settings.

Thank you for your consideration of these comments. Please contact Patricia Serpico, AAOMS Director of Health Policy, Quality & Reimbursement, with any questions at 800-822-6637, ext. 4394 or pserpico@aaoms.org.

Sincerely,

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