May 7, 2021

Association of
American Medical Colleges
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399
T 202 828 0400
www.aamc.org

The Honorable Xavier Becerra
Secretary
Department of Health and Services
Humbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, DC 20220

Re: Implementation of the No Surprises Act (part of the Consolidated Appropriations Act, 2021, (Pub.L. 116-260) Division BB – Private Health Insurance and Public Health Provisions)

Dear Secretaries Becerra, Yellen, and Walsh:

On behalf of the Association of American Medical Colleges (AAMC or the Association), we are writing to provide initial input as the Departments of Health and Human Services (HHS), Labor, and Treasury (the Departments) begin to implement the No Surprises Act (the Act), which was included in the Consolidated Appropriations Act, 2021.

The AAMC is a not-for-profit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and their more than 179,000 full-time faculty members, 92,000 medical students, 140,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

AAMC and our members support safeguards that protect patients from surprise medical bills and promote transparency. Many AAMC members already have made substantial investments in working to achieve this goal. Most have dedicated staff to assist patients in navigating the complex health insurance system and educate them as it relates to their benefits and cost-sharing liabilities. Some have developed online calculators to provide estimates of the costs for scheduled services.

Teaching hospitals often are where individuals go when experiencing an emergency or emergent complex care issue—either by choice or because the teaching hospital is where the ambulance takes them—and it is a time when patients are at their most vulnerable. We are pleased that the Act prohibits balance billing and holds patients harmless by only requiring them to pay the in-network cost sharing amount for out-of-network emergency care, and care provided by ancillary providers. We appreciate the establishment of an independent dispute resolution (IDR) process to resolve any disputes between payors and providers about payment amounts, and that the process will take into account the unique qualities of teaching hospitals and the patients they serve.

However, we are concerned with the tight implementation timeline and urge the Departments to consider delaying implementation to provide sufficient time to implement many of the system changes that both providers and insurers will have to make to allow for a seamless transition. The short timelines for hospitals, physicians, and health plans to communicate good faith estimates and Advanced Explanation of Benefits (EOBs) will be challenging. Communication channels between providers and plans will have to be adapted to allow for HIPAA compliant bi-directional exchanges of information. For providers to comply with these requirements, the Departments must establish a standard transaction set that is incorporated into electronic medical record (EMR) systems, requiring EMR vendors to make changes. Complying with these new requirements can be further complicated by the complex structures and relationships between physician practices and hospitals. **Given the complexity of implementation, we recommend that the Departments delay the implementation date by one year; if that is not possible, then the enforcement date should be no sooner than January 1, 2023.**

Many provisions in the No Surprises Act require clarification through rulemaking. In this communication we provide initial input based on feedback from our members to aid in the development of the proposed rules. We anticipate that once the proposed rules are issued and available for comment we will provide further feedback. Below we provide initial recommendations for your consideration as you develop guidance and proposed regulations implementing the law.

The AAMC's key recommendations include the following:

- ***Qualifying Payment Amount***: The qualifying payment amount (QPA) should account for the uniqueness of teaching hospitals and their patient population, as well as their associated providers who furnish care. The Departments should consider the following factors when calculating the QPA: the higher level of patient acuity at teaching hospitals; payment adjustments that support teaching hospitals' educational mission; comparable rates for similar facilities; and uncompensated care payments. Medicare and Medicaid reimbursement rates should be excluded from the QPA calculation.

- ***Notice and Consent:*** Out-of-network providers should only be responsible for the notice and consent requirements for the items and services they will provide. The Departments should provide language or a template that should be included in the notice and consent documents to ensure compliance.

- ***Notice and Consent: Post Stabilization***: The Departments must clarify the definition of "post stabilization" and the interaction between current federal laws, such as the Emergency Medical and Active Labor Treatment Act (EMTALA) and the No Surprises Act.

- ***Interaction with State Law and Regulations****:* The Departments should clarify the circumstances when federal or state law governs. The Departments should implement policies stating all self-funded plans are subject to the provisions of the No Surprises Act to ensure consistency. To assist in determining whether state or federal law applies, plans should be required to inform providers of the type of plan a patient is enrolled in upon a provider's initial query for eligibility and coverage and/or require the patient's insurance card to identify the type of plan.

- ***Independent Dispute Resolution Timelines*****:** Time frames associated with the negotiation and IDR process should be extended. The Departments should allow health plans and providers to jointly request a 30-day extension for the negotiation period, and allow providers and health plans a minimum of 30 days to trigger the IDR process and 30 days to submit their offer and any supporting materials**.**

- ***Independent Dispute Resolution Factors*****:** When making a payment determination, the Act requires arbiters to consider the qualifying payment amount, and if requested, information on the level of training, experience, quality and outcomes of the provider, the market share held by the provider, patient acuity, teaching status, case mix, scope of services and contracting rate history over the last 4 years of the provider. In addition to these factors, we recommend that the arbiters also include the provider's median in-network rate for the same service, the provider's uncompensated care percentage, and the provider's payer mix in their consideration. Flexibility should be allowed in batching items and services.

- ***Good Faith Estimates Delay:*** Implementation of the good faith estimate provision and the Advanced Explanation of Benefits requirement should be delayed until a plan for harmonizing the multiple price transparency programs is developed.

- ***Good Faith Estimates: Standardized Format***. Before requiring providers to comply with the good faith estimate requirements, the Departments should develop a standardized transaction set to allow for bi-directional exchange of information as it relates to good faith estimates and Advanced EOBs, and coordinate with EMR vendors to ensure they have sufficient time to include the standardized format in their systems.

- ***Scope of Good Faith Estimates:*** The regulations should clarify that providers are only required to provide a good faith estimate when there is a scheduled appointment **and** the patient requests the good faith estimate. In addition, the regulations should clarify that good faith estimates are required only for items or services provided at the time of the scheduled service and only for services that the provider is responsible for directly billing to the plan.

OVERVIEW: ACADEMIC MEDICAL CENTERS

It is vitally important that the regulations implementing the No Surprises Act address the complexity of services provided, and populations treated by teaching hospitals and teaching physicians. In addition to patient protections from out-of-network bills, it is critical to ensure that patients continue to have access to services provided by teaching hospitals and teaching physicians. AAMC member teaching hospitals, because of their expert faculty physicians, health care teams, and cutting-edge medical technology, provide care for complex patients and often care for patients for who are unable to receive care elsewhere. For example, our teaching hospitals, while comprising only 5% of all hospitals, provide 25% of the nation's medical and surgical intensive care beds, 36% of cardiac intensive care beds, 61% of pediatric intensive care beds, and are home to 69% of all Level 1 Trauma Centers. Our members are well-established and respected regional referral centers and centers for tertiary care. Their communities know that their emergency rooms are open to anyone in need, with experts in medical specialties available 24/7. As a result, major teaching hospitals often are sites for emergency treatment as they house such services as trauma centers, burn units, and inpatient psychiatric services.

Teaching physicians who work at teaching hospitals and academic medical centers provide care in what are among the largest physician group practices in the country, often described as "faculty practice plans" because many of these physicians have faculty appointments at affiliated medical schools and supervise medical residents and students as part of their daily work. They are typically organized into large multi-specialty group practices that deliver care to the most medically complex and vulnerable patient populations, many of whom require highly specialized care. Faculty practices often have a single tax identification number (TIN) that includes many specialties and subspecialties. Recent data shows that faculty practice plans range in size from a low of 128 individual national provider identifiers (NPIs) to a high of 4,319 NPIs, with a mean of 989 and a median of 816. Often care is multidisciplinary and team-based. In addition to patient care, faculty practices support the educational development of residents and medical students who will become tomorrow's physicians. In addition to primary care, teaching physicians provide critical other services for their local communities, including a large percentage of tertiary, quaternary, and specialty referral care. Given the expertise of physicians who work in faculty practices, it is not unusual for the practices to serve a patient population that is regional if not national.

CALCULATION OF THE QUALIFYING PAYMENT AMOUNT (QPA)

QPA Must Account for Highly Specialized Care Provided at Teaching Hospitals

As part of the prohibition on balance billing, the Act directs health plans to determine a patient's cost sharing amount based on the "recognized amount." The recognized amount is defined in the Act in three ways: (1) as the amount required under a state's surprise billing law, if applicable; (2) what is required under a state's all-payer model, if applicable; or, (3) the "qualifying payment amount." The QPA will be used to calculate a patient's cost sharing amount when furnished care from a non-participating provider.

Beginning January 1, 2022, a health plan or health insurance issuer will also base the reimbursement for items and services furnished by that non-participating provider on the QPA. The Act describes the QPA as the median of the insurer's contracted rates as of January 31, 2019 and trended forward. The QPA is determined using historical rates between the plan and the provider. If historical rates are unavailable, an independent database of historical payment rates for such items and services become the basis for the QPA. The Act notes that these rates will be based on rates for similar or the same items and services by specialty. The rates must reflect contracts in the same insurance market – *e.g.*, individual or group insurance markets – and the geographic region in which the services were provided. The QPA is also referenced in the IDR process as a factor an arbiter must consider when selecting between a health plan's and a provider's offer for reimbursement.

We believe the QPA must account for the uniqueness of teaching hospitals and their associated providers who furnish specialized care. The nation's teaching hospitals deliver highly specialized items and services that are often unavailable at other institutions. In many communities, these services, such as trauma centers, burn units, and neonatal services, may only be available at teaching hospitals. Further, the patients cared for by these providers are medically complex and often cannot access care elsewhere. Most insurers, including Medicare and Medicaid, recognize the important role and value that teaching hospitals play in the health care system and the need for higher reimbursement at these facilities to ensure specialty and sub-specialty care provided is maintained. This highly specialized care is recognized by payers through higher reimbursement rates These higher rates must be considered when calculating the median rates that will ultimately define the QPA.

When developing the methodology to calculate the QPA for teaching hospitals and their associated providers, several factors must be considered to accurately compensate for the items and services furnished. The statute notes that plans or issuers must account for payments that are not made on a fee-for-service basis. **We urge the Departments to consider the following factors when determining the methodology for calculating the QPA:**

- **The higher level of patient acuity seen at teaching hospitals as compared with other facilities**. Patient acuity, in both the inpatient and outpatient settings, generally is higher at teaching hospitals than at other hospitals.
- **Payment adjustments that support teaching hospitals' educational mission to train the next generation of physicians and allied health professionals.** Medicare and other payers have recognized the need to support this mission as evidenced by including payment adjustments such as graduate medical education payments.
- **Comparable rates to determine the median rate are captured from similar facilities and providers.** The items and services furnished at teaching hospitals can be very different than "similar services" provided at other facilities. Comparing reimbursement rates from very different providers will not accurately reflect median rates at teaching hospitals.
- **Exclusion of Medicare and Medicaid payments.** Medicare and Medicaid substantially under reimburse for services provided. These programs median rates should be excluded from the calculation of the QPA as consistent with the IDR process.

- **Inclusion of uncompensated care payments made to hospitals.** Teaching hospitals care for a high number of uninsured and underinsured individuals which should also be factored into the QPA. Payers have recognized this through higher reimbursement for safety-net hospitals.
- **Define geographic areas by either metropolitan statistical areas (MSAs) or the insurance rating area to accurately capture median rates.** Geographic location should be considered when comparing rates.

Require Transparency of the Methodology and Data Used to Calculate the QPA

Health plans should be required to be transparent in how they calculate the QPA and make the information publicly available, including information on the methodology and data used to calculate the QPA. Provider reimbursement may be based on different forms. For example, some plans pay hospitals at discharge based on diagnosis related groups (DRGs), while others reimburse based on per diem, fee-for-service, capitated or value-based models, or by other methdolologies. Notably, many contract terms between providers and insurers are not directly reflected in a provider's reimbursement. Contracts often contain terms that include expectations around volume, easing of certain administrative requirements, or shared savings for better outcomes in exchange for lower reimbursement rates. The QPA calculation should reflect factors accounting for these contract differences and base the QPA on the median payment rate for a service offered broadly (*e.g.*, through preferred provider organizations) within the same geographic regions for similar types of providers.

NOTICE AND CONSENT

Beginning January 1, 2022, out-of-network providers will be prohibited from balance billing patients for covered emergency services and certain non-emergency services provided at in-network facilities unless certain conditions are met. For these services, patients' cost sharing would be limited to the plan's in-network cost sharing for the covered services.

However, the Act provides that an out-of-network provider may balance bill for items and services associated with non-emergency services if certain notice and consent requirements are met. The notice and consent process may not be used for some services, including emergency services, certain ancillary services, and items or services that are delivered because of an adverse event that arises during a procedure for which notice and consent was received.

Under the requirements, the patient must receive written notice and consent within 72 hours of the item or service being furnished, or at the time the appointment is made, depending on when the item or service was scheduled. The notice can be in paper or electronic form based on patient preference and must contain the following information: notification that the provider is out-of-network for their health plan; a good faith estimate of the charges for the items and services; a list of in-network providers at the facility (if the facility is in-network) to which the patient can be referred; information on any prior authorization or other care management requirements; and a clear statement that consent is optional and the patient can instead choose to seek care from an in-network provider. The notice must be available in the 15 most common languages spoken in the provider's area. The notice and consent form must include a space to

obtain the patient's signature agreeing that they were provided with appropriate notice, including a cost estimate, as well as the date on which notice was provided and consent obtained.

Out-of-Network Providers Should Only Be Responsible for the Notice and Consent for the Items and Services They Will Provide

The requirement to obtain notice and comment for all out-of-network items and services could be burdensome for some providers. Therefore, we ask the Departments to clarify that providers should only be responsible for obtaining notice and consent for the items and services they will furnish.

Flexibility Is Essential When Defining "unforeseen, urgent medical needs"

The Act states that the notice and consent process will not cover items and services that are furnished "as a result of unforeseen, urgent medical needs that arise at the time such covered item or service is furnished." When defining "unforeseen, urgent medical needs" we urge the Departments to acknowledge that the occurrence of some adverse events can be totally unrelated to the medical intervention. For example, a patient may experience a heart attack which is due to their cardiac history rather than to the intervention. Additionally, if a patient unexpectedly requires intensive postoperative care, such as the need for intravenous medications, these "unforeseen" events should be not be considered "adverse." Moreover, to avoid undue burden on providers, and as a recognition that in medical care unexpected events can happen, providers should not be expected to capture all potential postoperative sequelae to ensure that the required treatment is not "unforeseen."

The Departments Should Provide A Template for Notice and Consent Language

The Act does not specify the language that must be used by an out-of-network provider to obtain notice and consent. We ask the Departments to provide language or a template that should be included in the notice and comment documents to ensure compliance. However, providers should have flexibility to incorporate this information into forms that best meet the needs of their patient population.

Ancillary Services List Should Not Be Expanded

Out-of-network providers that obtain notice and consent from the patient for out-of-network items and services may balance bill the patient. However, the Act specifies that certain out-of-network ancillary services are excluded from obtaining notice and consent and therefore are prohibited from balance billing the patient for these ancillary services furnished. The Act also allows the Departments to expand the list of ancillary services for which there is a prohibition against obtaining notice and consent for out-of-network services. Ancillary services are an important part of delivering health care and additional services should not be added to the list without stakeholder input.

POST-STABILIZATION SERVICES AND NOTICE AND CONSENT

When a patient receives emergency services from an out-of-network facility or provider, the Act requires that once a patient has been stabilized, the patient should be moved to an in-network facility. The patient would be permitted to stay in the out-of-network facility if they are informed that they are in an out-of-network facility and give consent to remain at the facility. In other words, unless the patient is transferred or consents to stay in the out-of-network facility, the patient cannot be balance billed for services provided after stabilization.

The Act notes that a medical screening exam is to be furnished as required under EMTALA[1] when a patient comes to an emergency department. EMTALA also requires that if a patient has a medical emergency or is in active labor the patient must be stabilized before transferring unless the hospital is unable to stabilize a patient within its capability, or upon patient request. These decisions are based on the facility's capacity to treat the patient which includes having available physicians with the necessary expertise. We ask the Departments to clarify how EMTALA and other federal laws and provisions will interact with the Act to ensure that hospitals can comply with all relevant requirements.

Clarify Post-Stabilization Services

The Act defines emergency services to include those furnished after a patient has been stabilized and as part of outpatient observation or an inpatient or outpatient stay as part of the emergency visit. We ask the Departments to clarify that the definition of post-stabilization services includes all services from the time the treating physician determines the patient is stable through discharge or transfer to another facility.

The Act notes that post stabilization transfer would occur when a provider determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation. We believe that the determination of whether a patient is clinically stable to be discharged or requires transfer to another facility rests solely with the treating physician. The Departments should be clear that health plans do not have a role in making the clinical decisions about whether a patient is stable.

Hospitals should be held harmless when they are unable to transfer patients to another facility, including post-acute facilities, in a timely manner after stabilization due to the lack of bed availability at the facility to which the patient should be transferred. Health plans should not be allowed to deny coverage of post-stabilization services because out-of-network hospitals are unable to transfer patients to an in-network facility due to circumstances beyond their control. Health plans should be required to assist the hospital and patient to secure a bed in an in-network facility and should not be able to deny finding or authorizing placement at an in-network hospital to the point where transfer is no longer relevant because the patient no longer requires inpatient post-acute care.

The Act allows for an out-of-network hospital to balance bill a patient if the patient consents to continue to be treated by the out-of-network hospital. Teaching hospitals routinely provide specialized services that cannot be furnished in other hospitals, including Level 1 Trauma

[1] Emergency Medical Treatment and Labor Act.

Centers. These trauma centers receive all patients that require their specialized care, regardless of their ability to pay. Some health plans exclude teaching hospitals from their networks for many reasons, including the perception that their costs are higher relative to other hospitals. However, there are few Level 1 Trauma Centers in the country, with some states only having one. If a patient cannot realistically be transferred to another facility because of the need for specialized care, out-of-network hospitals should not be limited to in-network rates.

INTERACTION WITH EXISTING STATE LAW AND REGULATIONS

Clarify How the No Surprises Act Interacts with State Law

Many states have enacted laws to prevent balance billing and the Act defers to state law where applicable. As the Departments propose regulations to implement the Act, it is imperative that attention be given to clarifying when state or federal law applies. The intent of the No Surprises Act is to provide clear protections for patients and to ensure that there is a method available to resolve reimbursement issues between plans and providers for all non-contracted services. Without clear direction as to whether a state or federal standard applies there is likely to be significant confusion for both patients and providers. There will also be operational challenges to implementing state and federal policies that are not consistent. Therefore, it must be made clear to providers whether for the purposes of the balance billing provisions of the No Surprises Act an insurance product is regulated by state law or federal law.

In addition, the Departments should address whether self-funded plans will be held to federal or state law as it relates to balance billing requirements. Most self-funded plans are regulated by ERISA rather than by state law. However, some states allow self-funded plans to opt-in to the state's consumer protections. Allowing self-funded plans to choose (*e.g.*, opt-in, opt-out) between state and federal consumer protections would be confusing and impose significant burden on providers. To ensure consistency with patient protections and out-of-network claims the Departments should implement policies stating that all self-funded plans will be subject to the provisions of the No Surprises Act.

It is necessary for providers to know the type of plan in which a patient is enrolled when determining whether state or federal patient protections and balance billing requirements apply. Therefore, the Departments should require health plans to provide information on the type of plan upon a provider's initial query for eligibility and coverage and/or require the patient's insurance card to identify the type of plan. This requirement will be a first step in assisting providers in complying with state and federal balance billing requirements, including consumer protections, the QPA, and the IDR process.

INDEPENDENT DISPUTE RESOLUTION

The AAMC supports the independent resolution process to resolve disputes about payment between health care providers and insurers. It is crucial for the Departments to establish rules that ensure that the IDR process is fair, unbiased, results in appropriate payment amounts, efficient, and that cost of the IDR process is not a barrier. Below are specific recommendations regarding the IDR process.

Time frames Associated With the Negotiation and IDR Process Should Be Extended

The Act includes specific time frames for negotiation and the IDR process. If a provider is not satisfied with the initial payment from the plan, the provider and insurer may begin a 30-day open negotiation period during which they can agree upon the payment amount. If the provider and health plan are unable to come to an agreement during the 30-day open negotiation period, either party may trigger the IDR process within 4 days of the conclusion of the open negotiation period. After triggering the IDR process, the health plan and the provider have three business days to jointly select the IDR entity, and within 10 days of selection of the IDR entity each party must submit an offer for reimbursement and supporting materials. The party that submitted the notification to initiate the IDR process may not submit another case for the same item or service involving the same other party for a 90-day period after the initial notification (referred to as the "lockout period"). We have concerns with such limited time frames, especially in cases where the provider would like to "batch claims." Recognizing that these timelines may not be feasible, the statute grants the Departments the flexibility to adjust the timelines, and we urge the Departments to exercise that discretion.

Payment negotiations between health plans and providers regarding out-of-network services provided are complicated as there are many factors to consider, such as the acuity of the patient, quality/outcomes, case mix of the provider, and market payment rates. Therefore, the 30-day time frame may not be sufficient for providers and plans to conclude these negotiations. While the Act does allow negotiations to continue during the IDR process, once the process is triggered, a fee must be paid to the arbiter. **We recommend that the Departments allow health plans and providers to jointly request a 30-day extension for the negotiation period.**

The AAMC also requests that the Departments consider extending the 4-day window to trigger the IDR process and the 10-day time frame for submitting an offer for reimbursement and documentation. Providers need to consider many factors when deciding whether to trigger the IDR process, including the amount of payment received, claims that may be batched, availability of supporting documentation, and the cost of arbitration. **Using the flexibility granted by Congress, we recommend that the Departments allow providers and health plans a minimum of 30 days to trigger the IDR process and 30 days to submit their offer and any supporting materials.** Allowing this extended time frame will reduce unnecessary administrative expense for plans and providers and benefit patients.

The AAMC is concerned that the 90-day lockout period could cause cash flow problems for providers, and we urge the Department to change it to 30 days. While we recognize that the goal of the 90-day lockout period is to encourage settlement of claims and reduce arbitration, we believe that changing the other time frames for negotiation and IDR as we recommend, will reduce the likelihood of pursuing arbitration.

Arbiters Must Consider All Relevant Factors as Part of IDR process

AAMC supports the provision in the Act that requires payment arbiters to consider a number of factors when making a payment determination, including the qualifying payment amount for the

item or service (*i.e.*, the health plan's median in-network rate for the same service in the same geographic region), and if requested, information on the level of training, experience, quality and outcomes of the provider, the market share held by the provider, patient acuity, teaching status, case mix, scope of services and contracting rate history over the last 4 years of the provider. **In addition to the factors identified in the Act, we recommend that the arbiters include in their consideration the provider's median in-network rate for the same service, the amount of the provider's uncompensated care, and the provider's payer mix.** In addition, the arbiter should ensure that payment rates are inclusive of all forms of reimbursement, such as shared savings and quality bonuses from value-based program participation. The Departments should issue regulations that support the importance of the arbiter considering **all** relevant information related to these factors when determining payment rates.

For teaching hospitals and teaching physicians, rates are likely to be different when compared to community providers due to higher patient complexity, and the infrastructure needed to support the research, education, clinical, and community and global health missions. These teaching hospitals and physicians deliver care to the most complex and vulnerable patient populations, many of whom require highly specialized care which often is not available elsewhere. It is essential for arbiters to recognize the important role and value that teaching hospitals play in the health care system and the need for reimbursement to reflect the resources required to provide and maintain these services, including the availability of specialty and subspecialty care. Therefore, we appreciate that the Act includes consideration of teaching status in determining the payment rate.

We support the provision in the Act requiring that the IDR process not consider providers' charges or rates paid by public programs, such as Medicare, Medicaid, the Children's Health Insurance Program, or TRICARE. **The AAMC recommends that the Departments clarify that rates paid by Medicare Advantage Organizations and Medicaid managed care plans, which are also considered public programs, also are excluded.**

Standards Should be Set to Ensure that Parties are Not Disadvantaged by Requests for Information From the Arbiter or Use of Invalid Information

The Act also requires parties to submit information related to the offer "as requested by the certified IDR entity." We recognize that it is possible that the IDR entity may request information on all of the factors named in the statute. We recommend that the Departments ensure that a party is not put at a disadvantage during the process if that party does not have access to some of the information requested. **In addition to the information submitted by the parties to the dispute we request that the Departments provide guidance on other types of information that an IDR entity can use to make its decision.** It will be important to ensure that the IDR entity does not rely on data or information obtained from unreliable sources that may not be valid.

Allow Flexibility In Batching of Items and Services

We support the provision in the Act that allows providers to batch together for consideration during the IDR process claims submitted within a 30-day period that are furnished by: the "same

provider or facility" under the "same plan" and for the "treatment of similar conditions." Batching will reduce administrative costs for all parties and accelerate payments to providers. **When defining, the "same provider or facility", the AAMC recommends that the regulations clarify that the claims may be batched at the TIN level or the individual provider level. For physician group practices, this would mean that claims for multiple clinicians that submit claims as part of the group practice under the same TIN may be batched**. This would be consistent with the approach that is used under the Medicare Quality Payment Program to measure performance and determine payment adjustments for physician practices. This would also reduce burden and costs associated with the IDR process.

With regard to the requirement that items and services be "related to the treatment of similar conditions" we urge the Departments not to define the "similar conditions" on a granular level. For some services, such as specific surgical procedures, the services that could be batched may be apparent. However, for other services, such as emergency medical care, the items and services that should be batched could include a broader range of services. **We urge flexibility in how providers can define the scope of claims included in the batches to minimize burden on all the parties.**

Ensure IDR Entities Have Appropriate Expertise

The AAMC urges the Departments to ensure that any entity certified as an IDR entity understands the complexities of the health care system. The entity must ensure that the decisions made are fair to both parties, and that appropriate criteria is used to make decisions that are standardized and uniform. The entity should be staffed with individuals who have expertise in managed care contracting, revenue cycle, and experience with arbitration. IDR staff should also have expertise in the complexities of contracting, including knowledge of narrow networks, shared savings programs, and other payment models. They should have an understanding of the distinction between different settings of care (such as teaching hospitals as compared to community hospitals) and the unique services provided by various physician specialties and subspecialties.

Exercise Oversight of IDR Process

It will be essential for the Departments to exercise oversight over the arbitration process to ensure that arbiters have relevant medical and legal expertise and are unbiased, that the process results in fair payment amounts for the parties involved and does not cause an undue administrative burden or high costs.

TRANSPARENCY REQUIREMENTS: GOOD FAITH ESTIMATE

The Act includes new price transparency requirements that apply to providers and health plans. Under the statute, providers are required to share good faith estimates of the "expected charges" for scheduled services with the health plan (for insured patients) or the individual (for uninsured patients). Providers must transmit the good faith estimate at least 3 business days before the services are furnished and no later than one business day after the service is scheduled. For services scheduled more than 10 business days later, the provider needs to furnish the

information within three business days of the patient requesting an estimate or scheduling a service. In addition, health plans are required to provide their enrollees with "advanced explanations of benefits" for scheduled services. The Advanced EOB would include the good faith estimate of charges submitted by the provider, the contracted negotiated rate, the amount the health plan would pay, and the patient's obligations for payment.

The AAMC supports price transparency for patients regarding their financial responsibility. Our nation's teaching hospitals have already risen to this call by developing price transparency tools at their institutions, which allow patients to access their coverage and cost-sharing information as it applies to the services they are seeking at hospitals. We have several recommendations regarding the price transparency requirements.

Delay Implementation of Good Faith Estimate to Allow Time to Harmonize Price Transparency Requirements in Programs

The good faith requirement duplicates price transparency requirements that are already in effect for hospitals and health plans, and therefore may increase administrative costs for hospitals and health plans without improving transparency for patients. Effective January 1, 2021, hospitals are required to post standard charges for at least 300 "shoppable" services. Many hospitals have placed price estimation tools on their website to provide this information. Hospitals are also required to publicly post online, in a machine-readable format, price information for all items and services offered by that hospital. Similarly, beginning January 1, 2022 health plans must provide detailed price information in machine-readable files to the public, and in 2023 will be required to make personalized out-of-pocket cost information for 500 shoppable services available on the Internet. We urge the Departments to streamline and harmonize the requirements under these price transparency programs. To avoid patient confusion, it is important that providers and health plans provide consistent information to their patients about the charges and costs associated with providing items and services. **We recommend that implementation of the good faith estimate provision and the Advanced EOB requirement be delayed until a plan for harmonizing these multiple price transparency programs is determined.**

Define Scope of Price Transparency Requirements

The Act requires that the health care provider provide a notification (in clear and understandable language) of the good faith estimate of the expected charges for furnishing the item or service with the expected billing and diagnostic codes. Specifically, the statute requires providers to include "…expected charges for furnishing such item or service (including any item or service that is reasonably expected to be provided in conjunction with such scheduled item or service and such an item or service reasonably expected to be so provided by another health care provider or health care facility), with the expected billing and diagnostic codes for any such item of service." The title of the section (2799B-6 of the PHSA) is "Provision of Information Upon Request for Scheduled Appointments." **Based on this title, we recommend that the regulations clarify that providers are only required to provide a good faith estimate when there is a scheduled appointment <u>and</u> the patient requests the good faith estimate**.

Providing a good faith estimate for scheduled services when the patient does not request it would be unnecessary and a significant administrative burden on providers. Teaching hospitals and teaching physicians provide a large volume of patient visits, surgeries, procedures, and ancillary services. It would be very difficult to produce good faith estimates for **all** the services that they provide (especially in the timelines set), to transmit them to health plans, and then for the plans to get the Advanced EOBs timely to their enrollees. If providers were required to provide good faith estimates for all services, this would result in unnecessary cost to the system and divert important resources away from patient care. Instead, we recommend that providers inform patients of their right to make a request. It also is not unusual that an estimate from a provider differs from the estimate provided by the plan. This would cause confusion for both the patient and the provider. **The Departments should require that health plans provide the Advanced EOB to providers at the same time that it is provided to patients.**

In addition, we request that the rules clarify that "in conjunction with" refers to the obligation to furnish good faith estimates for items or services provided at the time of the scheduled service. We do not believe Congress intended for providers to include estimates for items or services, such as post-acute care, that are provided after the scheduled service. In addition, we ask that the regulations clarify that providers are responsible for providing the good faith estimate only for items and services that they directly bill to the plan. It would be challenging for providers to furnish estimates for items and services from other providers that they do not employ or own. For example, it is common for patients to receive physical therapy services from private physical therapist outpatient practices after orthopedic surgery. Teaching hospitals do not typically own these physical therapy practices, and therefore would find it difficult to provide the patient with an estimate of the charges for physical therapy.

Establish a Standard Format for Submission of the "Good Faith Estimate"

To streamline the process for submitting good faith estimates, the AAMC urges the Departments to develop a HIPAA compliant standard electronic claims transaction format that providers can use to transmit the good faith estimate to the health plans. Before requiring providers to comply with the good faith estimate requirements, the Departments should develop a standard transactions format, coordinate with EMR vendors to ensure that they have sufficient time to include the standard transaction format in their systems, and ensure that the health plans are able to accept the transaction. Without a standardized format, it would be extremely difficult for providers to comply with the requirement to furnish good faith estimates, especially in the time frames set forth.

Good Faith Estimate by Health Plans Should be Used For Advanced EOB Purposes Only

We urge the Departments to create regulations that ensure that the good faith estimates furnished by providers to plans are used for the purpose of creating the Advanced EOBs and prohibit their use for making determinations related to the medical necessity of services relies on clinical judgment. The Act requires providers to include "expected charges for the item or service (including any item or services reasonably expected to be provided in conjunction….)". While the provider furnishes its best estimate of services that will be provided, it is possible that other items or services that deviate from those initially expected will be needed,

requiring changes to the services and codes that were included in the good faith estimate. For example, unforeseen medical needs may arise at the time that the service is provided that require the provider to proceed with a different course of treatment.

TRANSPARENCY REQUIREMENTS: PROVIDER DIRECTORIES

Effective January 1, 2022, health plans are required to ensure provider directories are current and accurate. The plan must regularly verify provider contract status and have updates at least once every 90 days. Effective January 1, 2022 providers must have a process in place to ensure timely provision of directory information to the health plan, including information at the beginning of a network agreement, when the provider terminates an agreement, or when there are any material changes (*e.g.*, practice location change). If a patient receives and relies on incorrect information from a plan about a provider's network status prior to the visit, the plan may not impose cost-sharing greater than the in-network rates.

The AAMC believes that it is essential for plans to maintain provider directories that are regularly updated to ensure accuracy. We further urge the Departments to require plans to have up-to-date systems and processes in place to ensure that providers are enrolled in a timely manner. Lengthy processing times for enrollment can result in claims being considered "out-of-network" when they should not be. Since faculty practices typically consist of around 1000 clinicians from multiple specialties, these practices need to make updates to physician enrollment in the plan on a frequent basis as new physicians join the group practice and others depart. In the past, faculty practices have encountered problems with timely enrollment processing with some plans.

CONCLUSION

Thank you for the opportunity to provide input as you develop regulations that protect patients from surprise medical bills and ensure appropriate payment to providers. We would be happy to work with you on any of the issues discussed above or other topics that involve the academic health center community. If you have questions regarding our comments, please feel free to contact Gayle Lee at galee@aamc.org and Mary Mullaney at mmullaney@aamc.org.

Sincerely,

Janis M. Orlowski, M.D., M.A.C.P.
Chief Health Care Officer, AAMC

cc: Mary Mullaney, AAMC
Gayle Lee, AAMC