AMERICAN ACADEMY OF NEUROLOGY®

201 Chicago Avenue
Minneapolis, Minnesota 55415

Tel: (612) 928-6100
Fax: (612) 454-2744

AAN.com

November 23, 2021

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

The Honorable Martin J. 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, NW
Washington, DC 20220

RE: Requirements Related to Surprise Billing; Part II [CMS-9908-IFC]

Dear Secretaries Becerra, Walsh, and Yellen:

The American Academy of Neurology (AAN) is the world's largest neurology specialty society representing more than 36,000 neurologists and clinical neuroscience professionals. The AAN is dedicated to promoting the highest quality patient-centered neurologic care. A neurologist is a physician with specialized training in diagnosing, treating, and managing disorders of the brain and nervous system. These disorders affect one in six people and include conditions such as multiple sclerosis, Alzheimer's disease, Parkinson's disease, headache, stroke, migraine, epilepsy, traumatic brain injury, ALS, and spinal muscular atrophy.

Surprise Billing and Independent Dispute Resolution (IDR) Process

Patients have been burdened by the practice of surprise medical billing for far too long. This rule, implementing the newly enacted federal protections against surprise billing under the No Surprises Act, is important because it provides a regulatory framework to ensure that

patients are shielded from surprise medical bills under many of the circumstances in which these bills most commonly occur. We commend the Departments' work to quickly issue the surprise billing rules so that stakeholders can implement the processes necessary to protect patients.

We concur with the Departments that the IDR entity certification requirements included in the rule will help ensure the integrity of the Federal IDR process. A failure to meet appropriate standards puts at risk the ability of providers to avail themselves of an equitable and efficient process.

We agree with the listed criteria in the rule outlining details that will be considered for certification. Specifically, the rule explains that an IDR entity can become a certified IDR entity by providing written documentation demonstrating that they meet eligibility criteria, including having sufficient expertise and staffing to conduct determinations on a timely basis, being free of conflicts of interest, being accredited by a nationally recognized and relevant accrediting body (such as URAC) or otherwise ensuring that IDR entity personnel possess the requisite training to conduct payment determinations. This ensures that policies and procedures are in place to maintain confidentiality of individually identifiable health information, providing a fixed fee for single determinations and a separate fee for batched determinations, having a procedure in place to retain certified IDR entity fees and retain and remit administrative fees, meeting appropriate indicators of fiscal integrity and stability, evidencing its ability to collect and transmit the information required to be reported to the Departments, and properly carrying out the requirements of the Federal IDR process in accordance with the law.

The rule also establishes a process for members of the public, providers, and others to petition for the denial or revocation of certification of an IDR entity. Petitioners submitting a petition for denial of certification will have five business days from the announcement that an IDR entity is seeking certification to submit the written petition. We believe this five-day period may need to expand even longer to ensure interested parties have adequate time to submit their requests. We also believe there may be challenges in how the public will understand the nuances between certified and non-certified IDR entities. We suggest perhaps a list of approved IDR entites could be created and carefully communicated to patients.

The ability to deny an IDR entity certification is another important tool of the Departments. We appreciate and agree with the illustrative examples laid out in this rule. For instance, in one hypothetical situation, the Departments described an IDR entity that has knowingly committed or participated in fraudulent or abusive activities. In another situation, an IDR entity may submit information as a part of the certification process that demonstrates that the IDR entity cannot fulfill the responsibilities required of certified IDR entities. In these cases, and many others, it is critical to protect the interests of patients by denying certification.

Furthermore, the Departments are establishing a Federal IDR portal to administer the Federal IDR process. The Departments explain this portal is intended to maximize

efficiency and reduce burden. We greatly appreciate this commitment to reducing burdens on both providers. However, in our many years of experience with federal websites, they are sometimes poorly designed, filled with broken links and unusable content. We strongly urge the Departments to invest the necessary resources to build a properly working portal to ensure providers are not unnecessarily burdened.

The Departments also explain that it may take time for providers and facilities to develop systems and processes for providing and receiving the required information from others. Therefore, for good faith estimates provided to uninsured (or self-pay) individuals from January 1, 2022, through December 31, 2022, HHS will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured (or self-pay) individual does not include expected charges from other providers and facilities that are involved in the individual's care. We commend HHS for utilizing its enforcement discretion and encourage the agency to maximize the use of this policy, where appropriate.

Additionally, we believe that more time may be needed for providers and payers to choose a resolution entity. Three days may simply not be enough time and could be burdensome for both providers and payers. The same applies to the four day limit on triggering the dispute resolution process. Where possible, we encourage the Departments to add flexibility to these date limits.

The rule further states that the independent dispute regulator, after receiving offers from the payer and provider, must choose the payment amount closest to the qualifying payment amount (QPA) unless one party submits documentation that clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate. We encourage the Departments to consider other factors where appropriate, such as public reimbursement rates, the amount the provider would have billed if the law banning surprise billing did not apply, or usual and customary charges.

The AAN has some concerns that the rule, as written, may not implement the No Surprises Act law in line with congressional intent. Congress wanted an equitable and balanced system to resolve disputes with no single factor given preference over others. However, this rule makes the QPA a substantial factor in IDR arbitration. This will tend to favor payment rates developed by insurance companies. This could disincentivize insurers from offering fair contracts to physicians and reduce patient access to care.

Finally, the QPA should already reflect service codes and modifiers so factors such as patient acuity and case complexity will likely only be relied on in rare instances where the QPA did not reflect this context. IDR entities should be encouraged when necessary, however, to conclude that the QPA does not fully account for patient acuity or complexity if the parties disagree on the appropriate service code or modifier. We believe this will allow IDR entities to resolve disputes over downcoding by selecting the offer that best represents the value of the qualified IDR item or service.

Conclusion

The regulations implementing the IDR process are incredibly important to patients and their providers. We hope the Departments will consider our feedback outlined above to better improve the IDR process so that it is less burdensome on providers. Additionally, a failure of an IDR entity to meet appropriate standards will significantly hinder providers' ability to avail themselves of an equitable and efficient process. Please contact Daniel Spirn, Senior Regulatory Counsel, at dspirn@aan.com or Max Linder, Government Relations Manager, at mlinder@aan.com with any questions or requests for additional information.

Sincerely,

Orly Avitzur, MD, MBA, FAAN
President, American Academy of Neurology