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June 13, 2023

CMS, Office of Strategic Operations and Regulatory Affairs,
Division of Regulations Development
Attention: Document Identifier/OMB Control Number: CMS-10853
Room C4–26–05,
7500 Security Boulevard,
Baltimore, Maryland 21244–1850

Submitted online via www.regulations.gov

Re: CMS–10853 Patient Provider Dispute Resolution Requirements Related to Surprise Billing: Part II Proposed Collection with Request for Comments

Dear Sir/Madam:

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 Proposed Collection of information on the "Patient Provider Dispute Resolution Requirements Related to Surprise Billing: Part II," as published in the *Federal Register* on May 2, 2023.

OMSs — many of whom are part of small practices — are an integral part of both outpatient and hospital-based care teams, providing high-quality dental and oral healthcare services across various treatment settings. 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.

Our Association remains committed to consumer protection and education, ensuring patients have the tools and resources available to understand the costs of care. We understand that the provision of good faith estimates (GFE) to uninsured (or self-pay) individuals, as well as the patient-provider dispute resolution (PPDR) process are integral components of the patient protections against surprise medical bills set forth under the No Surprises Act; however, AAOMS believes that certain regulatory provisions warrant the Agency's reconsideration both in terms of consistency of implementation and feasibility for healthcare providers as the utilization of arbitration processes under the No Surprises Act continues to increase.

Payment determinations for unforeseen circumstances not included in the good faith estimate unfairly penalize providers

An integral part of the patient-provider dispute resolution process, regulation requires both providers and facilities to submit "credible" information to select dispute resolution entities to allow for informed payment determinations to be made in the event total billed charges exceed the expected charges included in the good faith estimate.

When the select dispute resolution (SDR) entity or arbitrator determines the information submitted by the provider or facility supports that the difference between the billed charge and the expected charge reflects the costs of a medically necessary item or service and is based on unforeseen circumstances that could not have reasonably been anticipated, the arbitrator must determine the amount to be paid by the patient. According to regulation, for items or services furnished by the provider that were not included in the original estimate of expected charges, the payment amount is determined as the lesser of either 1.) the billed charge or 2.) the median payment for the same or similar service in the geographic area as reflected in an independent claims database. However, if the arbitrator determines the information submitted fails to demonstrate that the billed charge reflects the cost of a medically necessary item or service that was, in fact, unforeseen the payment amount is determined to be $0.

In general, healthcare practitioners strive to provide the most appropriate care based on their expertise and clinical judgement. Although, even the most diligent clinician may encounter an unexpected issue that must be addressed at the time a procedure is furnished. As currently implemented, the PPDR process requires a provider to accept/receive a payment amount less than the charged amount for the unforeseen items and services not included in the good faith estimate, even when such charges are substantiated by credible information. **The failure of the PPDR process to recognize the billed amount as the appropriate payment amount, when warranted unfairly penalizes providers for the treatment of unforeseen medical circumstances.**

The median payment amount should not be the standard applied under the patient-provider dispute resolution process

As noted above, HHS has implemented a methodology under the patient-provider dispute resolution process that bases the payment amount on either the lesser of the billed charge or the median payment for the same or similar service in the geographic area as reflected in an independent claims database, in certain circumstances.

HHS is of the view that the median payment amount is a reasonable payment amount. The methodology used, according to HHS is the same as was established to calculate the qualifying payment amount (QPA), which HHS considers a fair market rate for an item or service by group health plans and health insurance issuers offering group or individual health insurance coverage. In the October 2021 interim final rule, HHS states that utilizing the same methodology regarding median rates as applied to the QPA and payment amounts

applied to the patient-provider dispute resolution process creates an equivalent standard that may be applied in all instances in which the regulation refers to median rates. HHS also believes this methodology sets additional guardrails to protect patients from "excessive" medical bills, even in the event of unforeseen circumstances.

However, AAOMS believes the median payment rate for healthcare services in a geographic area does not necessarily represent the market value of those services. Rather, the median payment rate reflects the midpoint at which payments are distributed among providers in a specific area. This is influenced by various factors including payer contracts, varied reimbursement methodologies, negotiated rates and contract provisions, as well as regulatory policies. Market value, on the other hand, represents the price that willing buyers and sellers agree upon in an open and competitive market. It considers factors such as supply and demand dynamics, the quality and uniqueness of services, provider expertise, patient preferences and other market forces. While the median payment rate can provide some insight into the prevailing reimbursement rates in an area, it does not capture the full complexity of market dynamics.

Actual market value may vary based on factors such as provider reputation, patient volume, service quality, geographic location and local competition. Further, payment rates for healthcare services can be influenced by negotiations between payers and providers, government regulations, fee schedules and other factors that may not align with market forces. Therefore, using the median payment rate alone may not accurately reflect the market value of healthcare services in a geographic area. **While AAOMS understands and appreciates the consumer protections established under the federal surprise billing regulations, we generally disagree with HHS that the median payment rate as defined is reflective of fair market pricing for healthcare items and services, nor that it reflects a reasonable payment amount.**

Further, the equivalent standard that HHS has set across median payment rates assumes that the established methodology yields a fair market, appropriate rate. However, in relation to the QPA and its role in payment determinations under the federal independent dispute resolution (IDR) process, this has been called into question. In response to district court rulings in 2022 and 2023, CMS has revised certain regulatory provisions and guidance governing the federal IDR process, including clarifying that the QPA or the median in-network amount may not be presumed as the appropriate out-of-network rate for items and services covered by the No Surprises Act. Updating policy under the patient-provider dispute resolution process to require payment be equal to the billed amount if the physician provides credible information for medically necessary and unforeseen care would be consistent with the changes made under the federal IDR process. As such, **AAOMS encourages HHS to consider updating the methodology for payment determinations under the PPDR to align with the federal IDR process. Specifically, we ask that HHS consider allowing the final payment amount for medically necessary services due to unforeseen circumstances to be equal to that of the total billed charges, when warranted.**

The credibility standard under the patient-provider dispute process is ambiguous

AAOMS wishes to note that the ambiguous definition of "credible" — for the purposes of payment determinations under the PPDR process — may prove challenging both for providers and arbitrators as the utilization of the arbitration process continues to increase. According to HHS, information is defined as credible if "upon critical analysis the information is worthy of belief and consists of trustworthy information." Although it is common to require healthcare providers to justify treatment decisions within the scope of medical necessity, AAOMS believes that additional guidance on what may be considered "credible information" when determining whether additional care or increased complexity of services are medically necessary and due to unforeseen circumstances may aid providers in the submission of appropriate documentation under the PPDR process. As such, **AAOMS encourages HHS to consider issuing guidance to allow a determination of the type of information that meets the credibility standard in relation to the patient-provider dispute resolution process.**

The definition of "substantially in excess" remains challenging

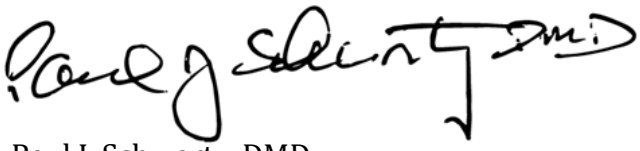
Under the requirements for the patient-provider dispute resolution process, a good faith estimate for an uninsured (or self-pay) patient is eligible for payment dispute resolution when the total billed charges from a provider or facility are deemed substantially in excess of, or at least $400 more than, the expected charges included in the good faith estimate.

From a clinical standpoint, even a straightforward procedure or slight change in medically necessary care may exceed the $400 threshold. Further, unforeseen interventions that are within the scope of accepted patient care protocols could easily trigger a $400 increase in treatment costs. Absent a more appropriate threshold at which the dispute process may be initiated, this could lead to the routine over-estimation of charges as a way of avoiding the patient-provider dispute resolution process in its entirety. For example, providers may feel they must include all potential clinical scenarios and associated treatments in the good faith estimate, even if they may be unlikely to occur. Such practices could have the reverse effect on the perceived cost of care, limiting accessibility and ultimately delaying patient care.

HHS has indicated that setting a higher dollar amount or using a percentage of total billed charges as the threshold may create access issues for certain patients in utilizing the patient-provider dispute resolution process. While we acknowledge that raising the threshold to a higher dollar amount may create undue limitations, AAOMS believes that using a flat $400 rate for the dispute threshold does not recognize the complex nature of many medical, dental and surgical items and services. Therefore, **AAOMS encourages HHS to reconsider what is defined as "substantially in excess" regarding the total billed charges by a provider or facility in relation to the expected estimate of charges. For example, HHS may consider utilizing the greater of either $400 over the expected charges presented in the good faith estimate *or* a predetermined percentage of the total billed charges as the threshold to trigger the patient-provider dispute resolution process.**

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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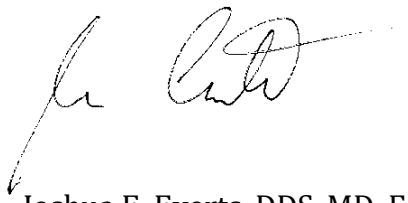

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