



March 28, 2022

Centers for Medicare and Medicaid Services  
Attention: Administrator, Ms. Chiquita Brooks-LaSure

Submitted online via [www.reginfo.gov/public/do/PRAMain](http://www.reginfo.gov/public/do/PRAMain)

Re: CMS-10780 Requirements Related to Surprise Billing: Qualifying Payment Amount, Notice and Consent, Disclosure on Patient Protections Against Balance Billing, and State Law Opt-in Submission for OMB Review with Request for Comments (OMB control number: 0938-1401)

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 “Requirements Related to Surprise Billing: Qualifying Payment Amount, Notice and Consent, Disclosure on Patient Protections Against Balance Billing, and State Law Opt-in,” as published in the *Federal Register* on March 4, 2022.

First, we would like to thank the Centers for Medicare & Medicaid Services (CMS) for recognizing the substantial administrative burden newly placed on providers under the No Surprises Act (NSA), as well as the steps taken thus far to mitigate it. AAOMS supports the efforts of the Department of the Treasury, Department of Labor and Department of Health and Human Services (the Departments) to ensure more affordable and accessible health care, while ensuring providers still have a seat at the decision-making table.

OMSs are an integral part of our country’s hospital systems, providing emergency department coverage and serving as essential members of trauma teams. Yet, most OMSs are primarily office-based, functioning within the constraints of smaller practices. Site of service differentials between large health care organizations and small group practices include both economies of scale and staffing limitations. This presents unique challenges for OMSs making good faith efforts to comply with newly implemented provisions as they simultaneously work to regain pre-pandemic caseloads. As such, AAOMS wishes to elucidate a few key points for further consideration.

### Qualifying Payment Amount (QPA)

AAOMS appreciates the granularity with which the process of calculating the QPA has been delineated and agree that there must be a consistent and transparent methodology for determining out-of-network payment rates for items and services falling within the scope of the NSA. We also strongly support the Departments' efforts to ensure that cost-sharing remains minimal for individuals in as many situations as possible, allowing access to affordable care when choice of provider or health care facility is not an option. There is, however, a basic tenant of the QPA methodology that we find concerning, particularly for smaller, independent provider practices, as OMS offices often are.

Unquestionably, the QPA as currently defined is not reflective of the true market value for health care items and services as, ultimately, the contracted rates with which the QPA is calculated are not. Contracted rates are established through negotiation between providers and insurers, with an agreement to significantly decrease charged rates in exchange for the benefits of being a contracted provider. At best, market share differentials have made it difficult for small provider-owned and operated practices to negotiate fair contracts with insurers on a regular basis. The presumption that the QPA is representative of fair and reasonable reimbursement will only bring severe downward pressure on in-network providers, making network contracting a mute issue.

It has been brought to AAOMS' attention that this is already happening. In some states, top insurers are engaging in threatening renegotiation tactics, forcing the hand of contracted providers to accept egregiously lower payment rates that claim to be more in line with the QPA or be dropped from the network. Such business practices concerning contracted providers begs the question of how pathways such as open negotiation and arbitration will be handled with non-contracted providers. It must be acknowledged that this represents an untenable situation for both contracted and non-contracted providers, with little-to-no limitations being placed on insurers to prevent such actions. Although the independent dispute resolution (IDR) process allows non-contracted providers to challenge the out-of-network payment amount, it should be noted that the lowering of contracted rates across the board is not an issue that can be resolved through the arbitration process as outlined.

It is foreseeable that this will lead to consolidation within the health care market. The increased administrative processes that are required to ensure compliance with many of the provisions set forth under the NSA, combined with decreasing reimbursement, will leave independent provider practices, including OMS offices, with little choice but to abandon independent practice models.

As an alternative, providers may elect not to furnish certain types of procedures or services as they continue to be faced with unreasonable and untenable reimbursement rates that do not equate to the level of skill, training or associated risk involved with treatment. Many OMS procedures have historically been undervalued by insurers, notwithstanding the methodology of the QPA. It is not unreasonable to assume that this may also deter OMSs from providing emergency on-call services, whose expertise is vital throughout emergency departments and trauma centers. Either way, decreased availability of oral health specialists performing highly specialized procedures may ultimately work to limit access to care for those individuals in need of specialized treatment. At a time when oral healthcare is increasingly being viewed as an integral part of the care continuum, this could have far-reaching ramifications for the health care delivery system.

Affordable healthcare services mean little if there are no providers able or willing to render those services because the reimbursement is not equitable to the risk involved.

To be clear, the issue at hand is not one of profit margins. Nor does it become one of charging patients more money for, as the NSA dictates, patient cost-sharing will largely not be affected by the payment received by the provider. The issue is one of recognition for the training and skill uniquely OMS services represent and the right for OMSs to receive fair and reasonable reimbursement for those services. Ultimately, it is about the sustainability and financial viability of the independent practice to continue to serve the needs of its patients.

### Notice and Consent

AAOMS recognizes the significance of the information presented as part of the notice and consent requirements and agrees such information is necessary for individuals to make fully informed decisions about their care and who provides it. We also appreciate the development of a standardized form to help reduce confusion and ease some administrative burden for providers and facilities.

AAOMS appreciates the clarification CMS has since provided that the NSA's ban on balance billing for non-emergency services applies only to plan covered services; however, we would like to reiterate our request for clarification on a few key aspects of the inapplicability of the notice and consent exception.

In reference to **§ 149.420 Balance billing in cases of non-emergency services performed by nonparticipating providers at certain participating health care facilities**, the NSA has broadened the definition of ancillary services to include "items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at *such* facility." It has been noted that the carve-out in (b)(1)(iv) under which ancillary services are defined, refers to "such" facility rather than "the" facility, while the subsection (a) uses "the" facility in reference to the facility in which the non-participating provider is providing the service. This raises the question as to whether the intent of (b)(1)(iv) is to prohibit invoking the notice and consent provisions when there is no participating provider providing such services in any similar participating facility, rather than requiring there be a participating provider in the very same participating facility. Given the intent of the NSA, it is our interpretation that the prohibition of the notice and consent exception would apply in instances where there is no participating provider in any accessible participating facility to furnish the items or services, as this would leave the individual with no true choice in terms of provider.

However, information presented as part of CMS' No Surprises Act Training Series on Jan. 26, 2022, referenced ancillary services as "items or services of an out-of-network provider if there is no in-network provider who can provide the item or service at *the* facility," leading AAOMS to question the broader interpretation of the definition, with the provision applying only to the facility in which the individual is physically treated. As such, AAOMS seeks further clarification on the definition of ancillary services, as it is imperative for those OMSs furnishing items and services at health care facilities.

With respect to certain post-stabilization services, the prohibition of the notice and consent exception applies unless specific criteria are met, one of which being that the individual is stable enough to be transferred by nonmedical or nonemergency medical transport to an available

participating provider or participating facility located within a reasonable travel distance. It is AAOMS's interpretation that, once stabilized, a non-participating provider may seek consent to balance bill the patient or refer the patient to another participating provider or participating facility within a reasonable distance, *only* if there is a participating provider nearby to refer them to. If our interpretation is correct, in the absence of a provider participating with the individual's network located within a reasonable distance, a non-participating provider would be prohibited from the notice and consent exception and thus prohibited from billing the individual more than in-network cost-sharing amounts.

In addition, the standard notice and consent documents indicate that, for post-stabilization services furnished by an out-of-network provider in an in-network emergency facility, a list of any participating providers at the facility who are able to furnish the items or services described in the notice is to be included. Since it is not indicated whether the other participating providers listed should be of the same specialty, AAOMS interprets this to mean that a participating provider of a different specialty other than that of the non-participating provider supplying the notice and consent to the individual - if able to provide the item or service as described in the notice - may be referred to render the item or service over the non-participating provider. This would have ramifications for non-participating OMSs furnishing items or services at a health care facility at which participating plastic surgeons or ENTs were also available. Thus, AAOMS would like further clarification as to our interpretation of this scenario.

#### Disclosure on Patient Protections Against Balance Billing

AAOMS remains committed to consumer protection and education, ensuring patients have the tools and resources available to understand their rights and options for care. We acknowledge and agree that the required disclosure information, provided in easily understandable language and in highly accessible ways, will help facilitate the dissemination of newly established protections to the broader patient population and open new pathways of communication between providers, facilities and patients.

The content of the disclosure has been outlined to include all applicable state laws and/or requirements that factor into surprise billing protections. While this is incredibly important and necessary for patients, it has tasked providers with navigating a complex patchwork of state and federal legislation to determine how they interact and what rights and prohibitions need to be disclosed. Thus far, HHS has encouraged states to develop model language that would aid providers in doing so; however, the requirements, thus far, have pertained solely to providers and facilities. Although we agree that state-level model language and disclosures would not and should not supplant expert legal guidance, placing a greater impetus on states to take on a collaborative role would only help to ensure provider compliance, especially for smaller provider-owned and operated facilities navigating both state and federal balance billing frameworks.

Through previous rulemaking, HHS has sought comment on the location of the posted disclosure information, particularly whether the posting of such information could be in a location other than what would be deemed "prominent" or "central." We believe there are some instances in which it may be inappropriate or misleading for the disclosure information to be posted in a such a way. OMSs treat patients in a variety of care settings, which includes furnishing items or services at health care facilities that fall within the purview of the federal surprise billing protections; however, the pathway to care predominantly initiates through the provider's office. As specified under the NSA, not all items and services or care settings fall within the scope of federal regulation

thus, posting the disclosure information in a prominent or central location within an OMS office could lead patients to incorrectly assume surprise billing protections exist where they do not.

As such, it is the viewpoint of AAOMS that disclosure information should be displayed in the location in which the OMS typically provides the treatment plan with their patients, discussing options, risk, cost and insurance coverage. That location is typically chairside in the examination room. Posting disclosure information in an examination room would not detract from the significance of the disclosure but rather aid in the facilitation of meaningful and transparent provider-patient interaction on financially and procedurally impactful laws and prohibitions. Such placement may not be deemed "prominent" or "central," yet it would help avoid unnecessary confusion for those patients not impacted by the NSA due to the nature of their care, insurance coverage and/or site of service.

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

Sincerely,

A handwritten signature in cursive script that reads "James David Johnson, Jr. DDS".

James David Johnson, Jr. DDS  
AAOMS President

A handwritten signature in cursive script that reads "John J. Hillgen IV".

John J. Hillgen, IV, DMD, MBA  
Chair, AAOMS Committee on Healthcare Policy, Coding & Reimbursement