



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

To: The Honorable Chiquita Brooks-LaSure, Administrator, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services

From: Massachusetts Medical Society

Re: No Surprises Act Implementation – Input on Qualifying Payment Amount and Related Calculations

Date: June 24, 2021

On behalf of our 25,000 physician, resident, and medical student members, the Massachusetts Medical Society (MMS) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the implementation of the *No Surprises Act*. As we are aware of the varying deadlines for the agency to develop plans for implementation of the legislation, this letter focuses on just the first part of the process, the Qualifying Payment Amount (QPA), due to be released on July 1, 2021. Subsequent letters will address additional parts of the law, like the independent dispute resolution (IDR) process, Notice and Consent provisions and specified state law.

The MMS has long held the position that patients should be protected and held harmless from surprise medical bills. We were closely involved with our Congressional leaders working to draft the *No Surprises Act*, and we appreciated that the resulting compromise bill aimed to protect patients, while taking into consideration the concerns of physicians and hospitals. While the intent of the legislation to protect patients from surprise medical bills is clear, additional clarity on the details of implementation would help providers prepare and navigate the provisions when they go into effect next year.

In particular, we welcome the opportunity to provide you with our comments on the QPA and its related calculations. In the *No Surprises Act*, the QPA is defined as the median contracted rate recognized by a health plan for a service in a geographic area in 2019 and updated annually with an inflation increase formula. As you build out plans for implementation, the below four areas could be expanded and strengthened by the Department of Health and Human Services (HHS), the Department of Labor (DOL), and Department of the Treasury (USDT) for additional clarification. These recommendations are a result of a working group of state and national medical societies, spearheaded by the American Medical Association (AMA):

I. Markets and Geographic Areas Used to Determine QPA Median Contracted Rate

As mentioned above, the median contracted rate, as defined by the *No Surprises Act*, should be calculated using rates from the same market or geographic area. However, that market or geographic area can be defined in many ways. The MMS believes there should be transparency in how markets are determined to allow for predictability of payment and enforcement. This definition will be particularly important because the recognized payment amount, the amount that is used to determine the patient's cost-sharing, is based on the QPA (and, therefore, the median contracted rate). As outlined below, we recommend several factors that should go into the market definition:

- The law requires that geographic regions be applied to narrow the contracted rates used in the calculation. When calculating the QPA, geozips would be the ideal category used to define the market or geographic area. A geozip is a geographic area usually defined by the first three digits of U.S. zip codes and may include areas defined by one three-digit zip code or a group of three-digit zip codes. Using a geozip, as compared to using a larger market area, would help to ensure that the rates accurately reflect the cost of providing care in that area.
- MMS urges HHS to exclude Medicaid fee-for-service, Medicaid managed care, Medicare, and Medicare Advantage rates from calculations of the commercial QPAs in order to ensure appropriate data sets used in determining median in-network rates. Including these products in the rate could skew the data sets used and are outside the scope of the *No Surprises Act* as it relates to commercial markets.
- MMS urges HHS to identify and define the threshold for sufficient data needed to determine the QPA. If there is insufficient plan data to calculate a QPA for a specific item or service, we believe the plan should be required to use data from an independent claims database that includes data from the same geographic region and from the other plans in the same market to calculate the QPA. This could include FAIR Health or other databases maintained by non-profit organizations.

Furthermore, to increase transparency, these market factors should be communicated clearly to the physician by the health plan during the initial billing process.

II. QPA and Median Contracted Rate Calculations

The MMS urges HHS to develop a clear, transparent methodology for calculating the QPA and median contracted rate. The methodology should be publicly available to allow for providers to predict and replicate the calculations and to ensure compliance with the framework. The MMS supports the below recommendations as outlined by the AMA in their comment letter:

- Plans should use the total maximum amounts paid to physicians and other providers, including any co-insurance paid by the patient because cost-sharing and other co-insurance may vary based on the specific plan or where patients are in their deductibles;
- The median contracted rate should be determined based on the contracted rate for each individual physician or provider. In other words, group contracts should not be treated as a single datapoint in the data set used for the median calculation;
- Contracted rates used to calculate a median for an item or service should be limited to only those provided by physicians or other providers in the same specialty. Education, level of training, and provider type are all important factors in contracting and determining payment;
- Contracted rates used to calculate a median for an item or service should be as specific as possible as to the type of item or service, down to the Current Procedural Terminology® (CPT®) family level, taking into consideration the “level of care” and other similar factors;
- The median contracted rate and the QPA should be calculated based on the level of the claim submitted, without reflecting any downcoding by the payer, and should not incorporate modifiers that reduce payment amounts; and
- HHS should consider using an outlier methodology that excludes \$0 paid on claims, as well as inappropriately low payments, that may result in inappropriate skewing of the median.

In addition, it will be important for the methodology to incorporate alternative payment models and contracting incentives that may not be reflected in base fee schedules, but are relevant to payment rates.

III. QPA and Recognized Amount Information to be Shared with Providers During the Initial Billing Process

To ensure transparency, predictability, and compliance, it is important that physicians are made aware of the recognized amount and QPA during the initial billing process when they are receiving the cost-sharing totals (within 30 days). The MMS urges CMS to specify the additional information that should be shared, including:

- How the QPA and recognized amount was determined;
- What median in-network rate was used;
- The types of providers and/or specialties that are included in the determination;
- How the service was grouped (in terms of same or similar item or service);
- The geographic area that was used; and
- The health insurer market that was used.

In addition, specific cost sharing information should be provided to the physicians, so it may be communicated to the patient, including:

- The cost-sharing structure for the patient's plan;
- Whether the patient has met their deductible or the amount still owed; and
- The cost-sharing total for the service provided.

IV. Audit Process for Compliance with QPA Requirements and Application

The *No Surprises Act* requires that HHS, DOL, and USDT, establish an audit process under which group health plans and health insurance issuers are audited through either a state or federal process. This audit process would ensure the health plans' compliance with the QPA calculation and other requirements. To that end, MMS recommends the following:

- The audits initiated as a result of complaints should be separate and not included or "counted" in the required yearly audits under the statute.
- The audit process should include a comparison of the QPA calculated using independent data (such as data from FAIR Health) to those being calculated by the individual plan or product being audited to determine the accurateness of the plan's QPA.
- Audit results should be made publicly available, and audits should be conducted regularly.

The MMS also encourages HHS to establish a clear enforcement plan—to include fines or other remedies for noncompliance—for instances where payors are in violation of QPA calculation requirements. This could include when plans base their QPA on downcoded payment amounts and not on the level of claim submitted.

As always, the Massachusetts Medical Society appreciates the opportunity to provide comments and work with CMS on our shared goal of providing the highest quality health care to patients. The MMS' comments and recommendations are guided by our policies, our membership, and our commitment to providing quality, equitable care to all patients. Should you have any questions, please contact Alexandria Icenhower, Federal Relations Manager, at aicenhower@mms.org or 781-434-7215.