



December 3, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: RIN 1210-AB00; Requirements Related to Surprise Billing; Part II

Dear Administrator Brooks-LaSure:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 133,500 family physicians and medical students across the country, I write in response to the interim final rule (IFR) published in the September 30 version of the *Federal Register*.

Patient Protections

The AAFP strongly [supports](#) the patient protections established in this IFR and through previous rulemaking. We have long advocated to protect patients from unanticipated medical bills and other high health care costs. Family physicians see firsthand how patient cost-sharing requirements and unanticipated medical bills can cause patients to forgo needed services and lead to preventable illness. We are encouraged that these additional protections will improve equitable access to care for patients.

Good Faith Estimates for Uninsured (or Self-pay) Individuals

The IFR requires physician practices and facilities to inquire about each patients' health insurance status or whether they are seeking to have a claim submitted to their insurance for the care they are seeking. The practice or facility must provide a good faith estimate (GFE) of expected charges for items and services to an uninsured or self-pay individual. Uninsured or self-pay individuals are defined as an individual who:

- Does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, federal health care program; or
- Has benefits for such items/services under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a health benefits plan under chapter 89 of title 5, United States Code, but does not seek to have a claim submitted to their plan, issuer, or carrier for the item or service.

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The GFE must include expected charges for the items or services that are reasonably expected to be provided together with the primary item or service, including items or services that may be provided by other clinicians and facilities. These requirements go into effect on January 1, 2022.

The AAFP agrees that providing a GFE to uninsured or self-pay patients will improve patients' understanding of the costs of their care and may help avert some unexpected medical bills. The GFE will help inform patients about the estimated cost of their care and help them decide which treatment options or other health care services they want to receive.

Implications for Direct Primary Care Practices

We interpret this requirement to apply to [Direct Primary Care](#) (DPC) practices. Practices that use the DPC model typically charge patients a flat monthly or annual fee, under terms of a contract, in exchange for access to a broad range of primary care and medical administrative services. Patients pay their physician or practice directly in the form of periodic payments instead of the practice billing a patient's insurer. Based on the definition of a self-pay patient, we believe the GFE requirement will apply to DPC practices when interacting with patients.

The AAFP is concerned that the GFE requirement is both unnecessary and burdensome for DPC practices, given they have contracted with a patient to provide specific services for an agreed upon fee. Most practices publicly post their prices online, and some states even require DPC practices to meet various price transparency requirements. The IFR specifies that the GFE must be separate of a contract, meaning that DPC practices will have to provide patients with a separate estimate of their costs each time they furnish primary care services even though the patient will have signed a contract and agreed to the flat payments required by the DPC practice. Further, DPC practices already alert patients when they require services that are not included in the agreed upon flat fee. **As such, we recommend HHS clarify in future regulations that DPC practices are exempt from the GFE requirement in the final rule when:**

- **all of the items and services that are reasonably expected to be provided are already included in the flat fee paid by the patient *or***
- **in the event additional services are reasonably expected to be provided that are not included in the flat fee, but the patient opts to submit a claim to their insurer for those services.**

In other words, the GFE requirement should only apply to DPC practices when there is a reasonable expectation that the primary service, and/or related items and services, are not included under the flat fee *and* the patient opts to pay entirely out of pocket for those additional services.

The AAFP also recommends that HHS include specific considerations for DPC practices when developing subregulatory guidance or informational materials on these regulations, such as FAQs. Such guidance could help DPC practices recognize when they need to provide GFE to patients and what additional administrative processes they will need to implement to be in compliance with these requirements.

Burden and Enforcement Discretion

The AAFP is concerned that the requirement for physician practices to provide individuals with a list of expected charges from other clinicians and facilities will be burdensome for primary care practices

and challenging to operationalize. This is particularly true for uninsured or self-pay patients, since practices cannot seek out-of-pocket estimates from the patient's health plan. Practices do not have ready access to charge amounts from hospitals, labs, imaging centers, and other physician practices, making it nearly impossible to meet this requirement.

HHS notes in the IFR that it will exercise its enforcement discretion in situations where a GFE is provided to an uninsured (or self-pay) individual but does not include expected charges from other providers and facilities that are involved in the individual's care. HHS will exercise enforcement discretion in these situations through December 31, 2022. The AAFP thanks HHS for recognizing the time and resources required to come into compliance with these requirements and exercising enforcement discretion accordingly. However, we are concerned that most primary care practices will not be able to implement the systems needed to meet this requirement in the next year.

We urge HHS to monitor the feasibility of this requirement over the next several months and consider extending the commitment to exercise enforcement discretion and/or removing the requirement for practices to estimate charges from other clinicians or facilities in subsequent regulations.

Patient-Provider Dispute Resolution

The IFR establishes a patient-provider dispute resolution process to determine a payment amount when an uninsured (or self-pay) individual receives a GFE and then is billed for an amount "substantially in excess" of the GFE. A patient's bill will be determined eligible for the patient-provider dispute resolution process if the patient received a GFE, if the process is initiated within 120 calendar days of the patient receiving the bill, and if the bill is substantially in excess of the GFE. HHS has defined "substantially in excess" as the billed charges being at least \$400 more than the GFE for any provider or facility listed on the GFE. The AAFP believes these eligibility criteria and the definition of "substantially in excess" provide appropriate protection for uninsured and self-pay patients without imposing undue burden on physician practices. **We recommend against reducing the threshold for billed charges to be "substantially within excess" to any value lower than \$400 more than the GFE.**

Independent Dispute Resolution

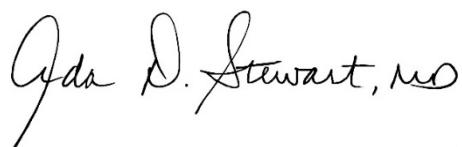
The IFR outlines the federal dispute resolutions process that out-of-network physicians and other clinicians, facilities, plans, and issuers may use to determine the out-of-network rate for applicable items and services as defined by the previous IFR. This IFR states that, when making a payment determination, certified independent dispute resolution entities must begin with the presumption that the qualifying payment amount (QPA) is the appropriate out-of-network amount. The QPA is generally the plan or issuer's median contracted rate for the same or similar service in the specific geographic area. If a party submits additional information that is allowed under the statute, then the certified independent dispute resolution entity must consider this information if it is credible. For the independent dispute resolution entity to deviate from the offer closest to the QPA, any information submitted must clearly demonstrate that the value of the item or service is materially different from the QPA. **The AAFP is concerned that the directive to presume that the QPA is an appropriate out-of-network amount will unfairly skew the IDR process and may have negative implications, particularly for independent primary care practices, in the long term.**

We note that family physicians and other primary care clinicians are generally in-network and do not frequently bill out-of-network services. However, a skewed IDR process that restricts physicians' ability to make their case for a reasonable out-of-network payment removes a critical remaining incentive for insurers to negotiate fair contracts with physicians. We agree with the analysis that *insurers* will likely pay many in-network physicians much less in the coming years as they negotiate contracts (and renegotiate current contracts) under the QPA's ceiling. This will put an additional financial strain on many independent practices that are working to make ends meet and pay their staff, many just regaining their footing lost over the last 18 months due to the pandemic. While financial strain often forces independent practices to close, others make tough decisions to accept outside funding, join hospital systems, or consolidate with other provider groups. These pandemic-related challenges have already accelerated hospital acquisitions of physician practices and physicians' departure from independent practice.¹ Evidence indicates these outcomes may actually worsen equitable access to quality, lower-cost care. Both of these trends have been shown to increase prices for health care services and increase insurance premiums.² Consolidation disproportionately harms low-income communities, worsens health disparities, and reduces access to essential services in rural areas.^{3,4}

To avoid these unintended consequences, strengthen independent physician practices, and ensure these regulations are in-line with congressional intent, **we ask that you revise the most recent IFR to conform with the No Surprises Act statutory language to allow an IDR entity the discretion to consider all the relevant information submitted by the parties to determine a fair out-of-network payment to physicians, without creating a rebuttable presumption that directs an IDR entity to consider the offer closest to the QPA as the appropriate payment amount.**

Thank you for the opportunity to provide comments on the IFR. Please contact Meredith Yinger, Senior Regulatory Strategist, at myinger@aaafp.org or 202-235-5126 with any questions about our comments.

Sincerely,

A handwritten signature in black ink that reads "Ada D. Stewart, MD". The signature is written in a cursive, flowing style.

Ada D. Stewart, MD, FAAFP
Board Chair, American Academy of Family Physicians

cc: Department of Treasury
Department of Labor

¹ COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019-2020. Physicians Advocacy Institute. June 2021. Available at: http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Revised-6-8-21_PAI-Physician-Employment-Study-2021-FINAL.pdf

² Scheffler RM, Arnold DR, and Whaley CM. Consolidation Trends in California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices. September 2018. Health Affairs. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0472>

³ Yerramilli P, May FP, Kerry VB. Reducing Health Disparities Requires Financing People-Centered Primary Care. *JAMA Health Forum*. 2021;2(2):e201573. Available at: <https://jamanetwork.com/journals/jama-health-forum/article-abstract/2776056>

⁴ O'Hanlon CE, et al. Access, Quality, and Financial Performance of Rural Hospitals Following Health System Affiliation. December 2019. Health Affairs. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00918>