AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

Comment Summary: FY 2022 Surprise Billing

On September 7th, AHPA submitted comments in response to the interim final rule "*CMS-2021-0117 Surprise Billing Interim Final Rule; Part 1*." Below are some of the key positions taken by AHPA in our response to the Centers for Medicare and Medicaid Services (CMS). To review AHPA's comment letter, click here.

Ban on Balance Billing

Policy: The rule prohibits out-of-network non-participating providers, facilities and providers of air ambulance services from balance billing patients for emergency services and for professional non-emergency services when delivered at an in-network health care facility.

Position: Supported.

- Sought clarification from CMS on whether the balance billing protections also apply to patients enrolled in plans with out-of-network coverage.
- Recommended that CMS clarify that limiting payments for emergency services is also inconsistent with the prudent layperson standard established by the ACA.

Policy: The rule seeks comments on whether to include urgent care centers in the definition of health care facility, including those that are not licensed as facilities under state law.

Position: **Did not support.**

- Opposed to including urgent care centers within the definition of what constitutes a health care facility because this would fundamentally change their function, which is not to provide emergent care. It could also impact urgent care centers' licensure requirements.

Patient Consent for Certain Out-of-Network Providers

Policy: The protections that limit cost-sharing and prohibit balance billing do not apply to certain non-emergency services or certain post-stabilization services if the out-of-network provider gives the patient a written notice and obtains the patient's consent to receive out-of-network services. CMS sought comment over which guidelines may be needed to determine when an individual is in condition to receive the written notice and provide consent.

Position: Did not support.

- AHPA does not believe that CMS should provide specific guidance on when a patient would not be medically able to receive the written notice and provide consent.
- Recommended allowing flexibility in the required timelines for providing notice and consent, particularly for patients seeking non-emergency care from out-of-network providers at in-network facilities

Qualifying Payment Amounts (QPA)

Proposal: The No Surprises Act requires that CMS establish a methodology for calculating the QPA, which will be used to determine a patient's cost-sharing amount for out-of-network services.

Position: No position, provided recommendations and sought clarification.

- Recommended that CMS use medical inflation as opposed to the CPI-U to adjust the QPA.
- Stated that using the median contracted rates for the QPA calculation would result in rates that are significantly lower than average commercial rates.

- Recommended adopting additional safeguards to protect patients and providers from inaccurate QPA calculations.
- Recommended that CMS postpone finalizing the QPA methodology until the regulation defining the IDR process is released.
- Recommended that CMS include a statement within its final rule clearly stating that the QPA should not be used as a payment benchmark or as a primary consideration for final payment determination in the IDR process.

Complaint Process

Policy: Establish an oversight system with a new complaint department that seeks to provide patients with an avenue to share grievances. While the rule did not include a time period upon which a complaint must be filed, it sought comments on whether one should be established.

Position: **No position and provided recommendation**

- Recommended that CMS impose a statute of limitation that, at a minimum, reflects the document retention requirements which are set at seven years.