AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

September 7, 2021

The Honorable Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: Docket No. CMS–2021–0117, Surprise Billing Interim Final Rule; Part 1; Center for Medicare and Medicaid Services Interim Final Rule and Request for Comments

Dear Ms. Brooks-LaSure:

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment, along with other federal agencies, on the Center for Medicare and Medicaid Services (CMS) Surprise Billing Interim Final Rule; Part 1. Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include 94 hospitals and more than 600 other health care facilities across the nation. AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to urban areas of California. With such diverse facilities, populations served and geographic locations, we strive to provide objective and sound policy recommendations that work well for health care as a whole.

AHPA supports the ban on balance billing stipulated by the No Surprises Act and implemented through this interim final rule. We want to thank CMS for working towards taking patients out of the middle and allowing them to focus on what is truly important – their health. We do take this opportunity to offer comments and recommendations on the following issue areas within the Surprise Billing Interim Final Rule; Part 1:

- Ban on Balance Billing
- Patient Consent for Certain Out-of-Network Providers
- Clean Claims

- Qualifying Payment Amounts (QPA)
- Complaint Process

Ban on Balance Billing

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. The prohibition does not apply to scheduled services when both the facility and the provider are out-of-network. It also does not apply to certain out-of-network services for which patient consent to receive care out-of-network is obtained.

AHPA seeks clarification from CMS on whether the balance billing protections also apply to patients enrolled in plans with out-of-network coverage. In these instances, would a notice of patient consent also be needed before treatment can be rendered for non-emergency services or post-stabilization services?

Post-Stabilization Services

The No Surprises Act added new sections to the Public Health Services (PHS) Act prohibiting balance billing for emergency care services and certain post-stabilization services. In the rule, post-stabilization services are considered emergency services unless the following conditions are met:

- The attending emergency physician or treating provider determines that the patient can travel to an in-network facility using non-medical or non-emergency transportation.
- The attending physician determines that the individual is medically able to provide informed consent to be treated at a different, in-network provider or facility.
- The in-network facility is within a reasonable travel distance for the patient to travel to.

AHPA believes that CMS needs to consider instances when an in-network facility will *not* accept a patient for post-stabilization services despite the patient's consent to receive care at the in-

network facility. Currently, there are many instances in which, when trying to refer a patient to an in-network facility for post-stabilization services, the other facility will not accept the patient. In these situations, the patient may be pressured to accept the post-stabilization services from the out-of-network facility. **We ask that CMS clarify whether the balance billing protection applies in these situations.**

Prudent Layperson Standard

CMS states that they are aware that some plans and issuers currently deny coverage of certain services provided in the emergency department of a hospital. The rule states that these policies are inconsistent with the requirements of the No Surprises Act, as well as the prudent layperson standard established by the Affordable Care Act.[1]

While AHPA appreciates CMS making this clarification, we believe that it fails to address situations in which health insurers do not restrict coverage but reduce payment to health providers for emergency services. For example, a payer may cover a patient's visit to the emergency department but then reimburse the provider at the same rate as an urgent care clinical service. This practice, while not restricting patient access, places a significant financial burden on health providers. **AHPA recommends that CMS clarify that limiting payments for emergency services is also inconsistent with the prudent layperson standard established by the ACA.**

Urgent Care Centers

The No Surprises Act defines a health care facility as each of the following with respect to non-emergency services: (1) A hospital; (2) a hospital outpatient department; (3) a critical access hospital; (4) an ambulatory surgical center; or (5) any other facility, specified by the Departments, that provides items or services for which coverage is provided under a health plan. The rule seeks comments on whether to include urgent care centers in the definition of health

[1] The Prudent Layperson Standard defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in placing the patient's health in serious jeopardy.

care facility, including those that are not licensed as facilities under state law. Under this policy, urgent care centers would be subject to the balance billing prohibitions. The rule states that "it is possible that individuals may be using urgent care centers (regardless of how they are licensed) in a similar way to how they use independent freestanding emergency departments, in which case it may be appropriate to designate urgent care centers as health care facilities."

AHPA is 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. We are concerned that this policy could lead to urgent care centers being subjected to new regulations and licensure requirements, which would increase the financial burden on these facilities. Additionally, states such as Florida have laws that require providers to post signage indicating that the services provided in a free-standing emergency department are billed at the same rate as hospital emergency departments and are not urgent care services. The policy being considered would therefore conflict with these state laws and cause additional confusion among patients.

Patient Consent for Certain Out-of-Network Providers

As stipulated by the rule, 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 seeks comment over which guidelines may be needed to determine when an individual is in condition to receive the written notice and provide consent (e.g., whether standards are needed to account for individuals who are experiencing severe pain, intoxication, incapacitation, or dementia after being stabilized).

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. This determination should be left to the discretion of the attending physician and the conditions provided above (e.g., severe pain, intoxication, dementia) should serve only as examples of when a patient may be unable to provide consent. We believe that this recommended policy aligns with

the provision allowing the attending physician to determine whether the patient's medical condition is stable enough for the patient to travel to an in-network facility.

Notice of Consent

The rule requires that out-of-network health providers alert the health plan when the notice of consent process was used and share the signed consent form. The consent form should include good faith estimates of out-of-network costs and information on care limitations, such as whether the plan requires prior authorization. The information must be provided separately from other documents and staff must be present or available to answer questions. The compliance date to meet this deadline is January 1, 2022.

AHPA encourages CMS to adopt a standard process for sharing the signed notice with health plans as this would help ensure consistency and minimize the burden of alternate forms of transmission. Having a standard process would ensure that this exchange of information happens seamlessly while eliminating confusion between the payer and health provider.

AHPA recommends 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. Should patients wish to continue their care with the out-of-network provider through subsequent visits, it is unreasonably burdensome to expect both the provider and patient to progress through the notice and consent process for each clinical interaction. The Departments should consider incorporating additional fields on the required notice and consent forms in which patients acknowledge the ongoing higher costs of continuing to seek out-of-network care with their preferred provider.

Additionally, AHPA believes that it is important to take health care providers out of the financial compensation equation as much as possible so that their focus is on patient care. While we strongly support the need to inform patients of their out-of-network status and how that would increase out-of-pocket costs, the provision of any additional financial information should rest with the health insurer. Currently, the information provided by health insurers within

the Eligibility and Benefit Response (271) transaction is often very limited and lacks information regarding prior-authorization requirements and other care limitations. Payers also sometimes have different benefit tiers within a health plan and that information is often not contained within the 271 transaction. It is our belief that since this information is held by a patient's health insurer, it would be best for that information to be provided directly by the health insurer. This is consistent with the approach taken by the NOTICE Act, which requires patients to be informed of their observation status. The form used to implement this requirement, the Medicare Outpatient Observation Notice (MOON), instructs patients to contact their health insurer for additional financial information. We believe that this policy results in patients receiving more comprehensive and accurate information about their coverage benefits.

Additionally, health plan in- and out-of-network determinations are nuanced; exclusions for specific specialty drug services at in-network facilities are an example of this. This will make it difficult for in-network facilities to accurately convey which providers would be in- or out-of-network for specific services for any given patient that comes to the emergency department. Plans and issuers can quickly, efficiently and accurately convey the necessary information, and we believe that the responsibility to direct patients to in-network providers, facilities and services should fall on the payer rather than the provider.

AHPA also recommends that CMS delay the implementation date for these requirements by at least another year. The January 1, 2022 deadline does not provide adequate time for health providers to change their processes, educate health care personnel about the new requirements and identify how to address potential challenges. Moreover, the resurgence of the COVID-19 Delta variant has put a massive strain on hospitals.

Requirements Regarding Initial Payments (Clean Claim)

The interim final rule requires payers to send out-of-network providers an initial payment or notice of denial of payment within 30 calendar days after a bill is submitted. The rule specifies that the 30-calendar day period generally begins on the date the plan or issuer receives the information necessary to decide a claim for payment for such services.

AHPA is concerned that without appropriate safeguards payers could abuse these clean claim requirements. **We urge CMS to conduct oversight of the timeframes taken by health insurers from the initial claim submission to the final payment and investigate plans with patterns of long delays between the two.** Without adequate oversight, payers can abuse clean claim requirements and delay payment to out-of-network providers.

AHPA also recommends that CMS abstain from creating any payment benchmark for the clean claim. Doing so would run contrary to Congressional intent and could result in such benchmark becoming the de facto payment for out-of-network claims.

Qualifying Payment Amounts (QPA)

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. The interim final rule specifies that cost-sharing amounts for services furnished by out-of-network emergency facilities and out-of-network providers at in-network facilities must be calculated based on one of the following amounts:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- If there is no All-Payer Model Agreement, an amount determined by a specified state law; or
- If there is no such applicable All-Payer Model Agreement or specified state law, the lesser of the billed charge or the plans or issuer's median contracted rate, referred to as the QPA.

While AHPA understands that the methodology proposed by CMS was designed to keep the QPA low and therefore diminish a patient's financial liability for out-of-network services, we want to address some of our concerns on the impact that this could have on providers.

Methodology for calculating the QPA

For a given item or service, the QPA is the *median* of the commercial health plan contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation. According to the rule, the plan or issuer will be required to adjust the QPA by increasing the median contracted rate by the percentage increase in the consumer price index (CPI-U) for all urban consumers over 2019. The rule also directs plans to calculate different QPAs for emergency services based on the type of facility "if the plan or issuer has contracted rates that vary based on facility type for a service code." The accompanying preamble text discusses only two different types of facilities: freestanding emergency departments and hospital emergency departments.

AHPA recommends that CMS use medical inflation as opposed to the CPI-U to adjust the QPA. To guarantee adequate compensation for services rendered, CMS needs to ensure that the inflation adjustment will represent the actual inflation for hospital services and items. We also urge the agency to consider incorporating other data points, such as single case agreements and other facility characteristics. AHPA is concerned that the failure to account for other facility characteristics, such as whether a hospital is a teaching hospital or a safety-net hospital, may result in payments that do not adequately capture the additional cost of providing care at different facilities. This is particularly important if payer-provider negotiations go to arbitration, as the IDR entities are directed by statute to consider the QPA when making rate setting determinations.

Additionally, it is our belief that using the median contracted rates for the QPA calculation would result in rates that are significantly lower than average commercial rates. We recommend considering the use of an independent, not-for-profit entity, such as FAIR Health, for calculating the QPAs. FAIR Health has a database that maintains the average billed charges for providers by geographic regions. Using FAIR Health to establish the QPA calculations would allow all parties to go to an impartial source to calculate the non-par payment, providing more transparency to the process.

If CMS decides to proceed with the finalized policy, we recommend adopting additional safeguards to protect patients and providers from inaccurate QPA calculations. This should include requiring health plans and issuers to compensate patients for any excess cost-sharing based on an inaccurate QPA. In addition, the IDR process must have a mechanism for revisiting decisions that took into account a QPA that was later found to be inaccurately calculated.

QPA Relationship with the IDR

The lack of regulatory guidance on how the implementation of the IDR process will function and how the QPA calculation will impact said process means that, at this time, we cannot accurately grasp the concept in its entirety. **AHPA therefore recommends that CMS postpone finalizing the QPA methodology until the regulation defining the IDR process is released**. Doing so will allow commentators to fully understand the relationship between the IDR and QPA and confidently provide comments to the departments.

AHPA is concerned that the QPA calculation will be utilized as a payment benchmark in the arbitration process or as a primary consideration for final payment determinations. Given that the proposed QPA methodology will likely be substantially below a commercially reasonable rate, using it as a benchmark or primary consideration in the IDR process would unfairly reduce the monetary compensation a provider receives. It would also considerably disadvantage hospitals during negotiations, impacting existing networks. **To address this concern, we recommend 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.**

Information to be Shared about QPAs

The No Surprises Act directs CMS to specify the information that a plan or issuer must share with an out-of-network provider when determining the QPA. This includes a statement certifying that:

- The QPA applies for purposes of the recognized amount; and

- Each QPA shared with the provider or facility was determined in compliance with the methodology outlined in these interim final rules.

AHPA believes that the information payers are required to convey to providers regarding the QPA is insufficient. A statement from a payer stating that they are compliant with the regulations does not provide any transparency on how the QPA calculation was conducted. Providers will have no way of knowing if payers truly calculated the QPA according to the rules set forth. **AHPA therefore recommends that CMS implement substantial oversight to make sure that the QPA process is not manipulated by payers.**

Complaint Process

The interim final rule establishes an oversight system with a new complaint department that seeks to provide patients with an avenue to share grievances. While the rule does not include a time period upon which a complaint must be filed, it seeks comments on whether one should be established. Specifically, whether a patient should be required to file a complaint within a given time period and if so, what time period should be used.

AHPA recommends that CMS impose a statute of limitation that, at a minimum, reflects the document retention requirements. The failure to create a statute of limitation places an unreasonable burden on providers as current document retention practices are set at seven years.

Conclusion

AHPA welcomes the opportunity to discuss further any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact me at Carlyle.Walton@AdventistHealthPolicy.org or Susana Molina, Director of Public Policy, at Susana.MolinaRamos@AdventHealth.com.

Sincerely,

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President
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