National Alliance of Safety-Net Hospitals

September 7, 2021

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-9909-IFC

Subject: 5 CFR Part 890, RIN 3206-A030, Department of Treasury, Internal Revenue Service, 26 CFR Part 54 [TD9951], RIN 1545-BQ04; Department of Labor, Employee Benefits Security Administration, 29 CFR Part 2590, RIN 1210-AB99; Department of Health and Human Services, 45 CFR Parts 144, 147, 149, and 156 [CMS-9909-IFC], RIN 0938-AU63: Requirements Related to Surprise Billing; Part 1

To Whom it May Concern:

I am writing on behalf of the National Alliance of Safety-Net Hospitals to convey to the Department of Treasury, Department of Labor, and Department of Health and Human Services (to be referred to hereafter as "the Departments") and their agencies our views on the Requirements Related to Surprise Billing, Part 1, interim final rule with request for comments, that was published in the *Federal Register* on July 13, 2021 (Vol. 86, No. 131, pp. 36872-36985).

The Interplay of Federal and State Regulation and Oversight

In general, the law and regulations apply to all forms of comprehensive group and individual market commercial coverage except in instances in which states already have their own surprise medical billing protections in place for state-regulated plans. The interaction between federal requirements and state law is very important and very complicated. NASH urges the Departments to identify more clearly when state laws rather than federal laws apply. Such guidance should include a crosswalk of state law and the federal provisions. Until this crosswalk is introduced and all involved parties have a clearer understanding of the requirements, we urge enforcement discretion over matters involving which jurisdiction prevails.

The Scope of the No Surprises Act

The regulation applies balance billing protections to patients enrolled in most forms of comprehensive, commercial health coverage but not to public coverage programs, such as Medicare and Medicaid, or to limited coverage benefit plans, health-sharing ministries, and short-term limited duration plans. In general NASH supports this, with a few exceptions.

We disagree with the application of No Surprises Act protections to plans that do not contract with any providers to deliver benefits in-network but rely instead on an out-of-network reference pricing. Such

quasi-insurance products harm both patients and providers. We urge the Departments not to implement policies that will facilitate the growth of such limited plans and believe the regulation, in its current form, could do exactly that.

We also are concerned about when the regulation takes effect. The regulation states that it applies to plan years beginning on or after January 1, 2022. NASH is concerned that providers will not know immediately whether such protections apply to individual patients because they will have no idea when the plan year of their patients begins. With this in mind, we ask that the final regulation clarify how these requirements will be implemented when plan coverage years start after January 1, 2022.

How the Regulation Addresses Balance Billing Practices

Balance Billing: Scope of Services Subject to the Ban

NASH supports a ban on balance billing for emergency services and certain scheduled professional services. NASH is concerned about how the inclusion of post-stabilization services in the definition of "emergency services" would be implemented under this regulation. The regulation describes the period of post-stabilization services as extending until the patient is transferred to an in-network facility or when the patient consents to be balance-billed. We request that the final rule also clarify when the period of post-stabilization would end when patients are directly discharged from the hospital without transfer or consent to be balance billed. NASH also requests that the final rule include a provision that requires payers to work in a timely fashion with providers to transfer stabilized out-of-network patients to in-network facilities. We believe a regulation that effectively tackles the challenge of surprise medical bills must address this long-time, persistent problem by specifically defining what constitutes timely action by the insurer.

The Post-Stabilization Period

The rule calls for the treating provider or physician to make the final determination on when a post-stabilization patient can give consent for out-of-network care. The rule defines the factors that the treating provider must consider, and among those factors is cultural challenges and contextual factors faced by the patient. Because so many safety-net hospitals serve diverse communities NASH appreciates the Departments' recognition of the importance of cultural factors and supports their decision to vest this responsibility with the treating provider but asks that the final rule provide additional guidance on how to interpret this new requirement to consider how cultural or contextual factors influence informed decision-making.

Timely Provision of Notice of Potential Out-of-Network Billing

The statute requires that the notice include information about any limitations payers may put on patients' coverage, such as prior authorization. The rule urges providers to include specific information in the actual notice document regarding the patient's health plan care limitation policies. Recognizing that getting this specific health plan policy information may prove challenging, the Departments permit providers to adopt a general default statement that informs patients that such limitations may apply. NASH agrees that providers should be required to use the default statement because they cannot definitively speak to insurers' policies.

The statute also requires that the provider notify an individual within 72 hours of a scheduled appointment regarding such items or services that may be out-of-network (or at the time of scheduling if the service is within 72 hours), subject to certain limits and qualifications. NASH agrees with the Departments' limit

on using the same-day notice and consent process in instances where the patient's condition would not lead to a delay that could compromise patient care and asks that the Departments clarify this in the final regulation.

The Requirement That Providers Give Patients Good-Faith Estimates of Potential Costs

The statute requires that a notice to inform patients of their potential out-of-pocket costs if they continue with care from an out-of-network provider include a good-faith estimate of the cost of services. This regulation, however, offers no guidance on how providers should calculate good-faith estimates; that information will be shared with stakeholders in a future regulation. We cannot conceive of responsibly providing such estimates without further guidance, which suggests that delaying enforcement of the No Surprises Act until a reasonable period after rule-making is complete would be appropriate. NASH prefers to withhold further comment on this subject until we have a complete understanding of the requirements for good-faith estimates.

Application of the Notice and Consent Process in Non-Emergency Settings

The complex nature of hospital care makes it challenging for providers to know with certainty when consent would be required for a patient to assume financial responsibility for out-of-network care. For example, our interpretation of the regulation is that it does not apply to scheduled, non-emergency services when both the facility and the treating providers, including ancillary, are out-of-network. NASH supports this interpretation and asks the Departments to confirm this interpretation in the final regulation or in further guidance.

We also believe that out-of-network providers identified as "ancillary" providers in the law and regulation should be able to use the notice and consent process for balance-billing purposes in certain contexts. To continue protecting patients from surprises, the regulations could permit this use of balance billing by ancillary providers only when there is sufficient time to obtain the patient's consent. Any ancillary provider who is not known at the time of scheduling and who was not included in the notice and consent forms would not be permitted to balance bill.

Information Exchange Between Providers and Payers

The regulation requires providers to alert patients' insurers when the notice and consent process has been used and to share the signed consent form. For post-stabilization patients, the provider or facility also must notify the insurer of whether all the conditions for notice and consent specific to post-stabilization patients have been met. Neither the regulation nor the separately issued standard form, however, offer any guidance on how the signed notice or consent documents should be transmitted to the insurer. NASH urges the Departments to adopt a single, standard process for transmitting these forms to ensure consistency and minimize the burden of multiple forms of transmission. We also urge the Departments to expedite the adoption of standard electronic transactions for the exchange of this information between the provider and insurer and that they modify the standard form to reflect these transaction standards.

Accessible Languages

The rule requires that providers provide notice and consent for balance billing in the top 15 languages in a state or geographic region where the facility in question is located. Because community safety-net hospitals typically serve diverse communities, NASH supports this proposal but encourages CMS to provide these translations to ensure standard notice language for as much of the country as possible while substantially reducing the administrative burden on providers.

Determining Patient Cost-Sharing

NASH supports the approach taken in the No Surprises Act of establishing a methodology for determining patient cost-sharing that does not rely on a final determination between the provider and the payer. We appreciate that the patient's cost-sharing will count toward any in-network deductible or out-of-pocket maximums under the plan.

Methodology for Calculating the QPA

Under the statutes and this rule, patient cost-sharing is based on an amount determined by an applicable All-payer Model Agreement; the amount determined under applicable state law; and the qualifying payment amount, or QPA, or the billed amount if less than the QPA. The No Surprises Act created the QPA for two purposes: to calculate patient cost-sharing and to serve as one of the factors for consideration by the arbiter in the independent dispute resolution (IDR) process, which will be established in a future regulation.

It appears as if the Departments structured this methodology to drive the QPA as low as possible – for example, by not calculating a separate QPA for providers with higher input prices. While we appreciate and support the desire to reduce patient cost-sharing, this decision could affect more than just patient cost-sharing.

The regulations direct 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. This approach ignores the substantial differences between types of hospitals and again underscores why the QPA would be inappropriate as either the initial payment to the provider or as a substantial factor for consideration in the IDR process. As such, we again urge the Departments to clarify that the QPA is not intended to serve as the provider's or facility's reimbursement unless agreed to by the provider or facility and to not weight the QPA more heavily than other factors in the IDR process. Absent these clarifications, we ask the Departments to revisit this policy and require plans and issuers only to use rates for like facilities in the calculation of a median rate based on characteristics of the facility, including a hospital's trauma level, whether they are teaching hospitals, disproportionate share providers, and/or trauma centers.

An inappropriately low QPA could have a substantial impact on access to care if it is given a prominent role in the IDR process because if plans learn that they can generally reimburse providers less through the IDR process (because the low QPA is given controlling weight by the arbiter) they will have less incentive to negotiate with providers to build robust provider networks. To that end, we urge the Departments to release the regulations governing the IDR process as quickly as possible and solicit anew comments on the QPA methodology once stakeholders have a complete understanding of its use. In addition, we urge the Departments to recognize that the objective of driving down patient cost-sharing may be at odds with achieving fair and reasonable reimbursement for providers. NASH has several concerns about the calculation of the QPA

The Question of How Best to Calculate Median Rates

While the statute calls for using median rates in the calculation of the QPA, NASH disagrees with how the Departments intend to implement this. The Departments call for collecting all plans of a given payer, listing their contracted rates for a given service from highest to lowest, and using the median in that list to calculate a median rate. Such an approach, NASH believes, gives too much weight to rates that may be

included in contracts but rarely – if ever – used. A useful median needs to be based on the frequency with which those rates are paid. A better approach is to use a weighted median for calculating the QPA. In addition to better accounting for the frequency of a negotiated rate's use, a weighted median could conceivably reduce the number of cases where a plan might have too few contracted rates to calculate a median, and using a weighted median would also enable the Departments to include single case agreements in the calculation with less concern about skewing the results.

The Question of How Best to Trend Forward Cost Growth

The statute defines the QPA as the insurer's median in-network rate for 2019 trended forward and the regulation calls for using CPI-U, the *Consumer Price Index* for All Urban Consumers, for this purpose. Indexing the QPA based on CPI-U poses a serious problem because CPI-U does not keep pace with the growth in health care expenditures. This failure to reflect real cost growth will result in the QPA lagging actual rates paid for services delivered in the current period, which could prove harmful to community safety-net hospitals. As the Departments consider their rulemaking regarding the IDR process and the extent to which the QPA should be considered as part of that, we urge them to recognize that the indexing of the QPA to CPI-U will quickly undermine any value it may currently have as a measure of market prices for services.

Provider Payments

The regulation requires that insurers either make an initial payment to providers within 30 calendar days of receiving a clean claim for covered services or issue a notice of denial of payment. It is understood at this point that the initial payment may not be the final payment and that final reimbursement will be determined based on one of several methodologies.

Initial Payments From Insurers to Providers

Congress considered and clearly rejected setting benchmark rates for payments by plans to providers. NASH appreciates that the Departments have followed this guidance and have not proposed benchmark rates and urges them to continue not to do so. However, we believe that the initial payment needs to be at minimum a commercially reasonable rate. Safety-net hospitals want to do everything they can to avoid lengthy and costly arbitration through an IDR. Many operate on very thin margins. We encourage the agencies to ensure that the initial payment is a reasonable amount. If the number of claims denials that are subsequently overturned in the provider's favor during the appeals process is any indication, some payers will not hesitate to engage in protracted administrative adjudication that increases costs without adding value to the health care system. We believe that requiring a commercially reasonable initial payment could pre-emptively thwart such actions.

How the QPA is to Be Used

The regulation describes how the QPA is to be calculated but does not present the full extent of how it will be used. Without that broader understanding we are not in a position to perform a complete assessment of the methodology and express either our support for or our disagreement with that methodology. Nevertheless, we can already anticipate how some of the decisions made in this first IFC and provisions required by statute will reduce the extent to which the QPA should be "considered" in the IDR process.

First, the Departments explicitly structured this methodology to derive a QPA that reflects cost factors they believe should be used to determine cost-sharing and explicitly ignored cost factors they thought could potentially be relevant in payer-provider rate negotiations. This results in an intentionally low QPA, especially for teaching hospitals, disproportionate share hospitals and trauma centers.

Second, the use of CPI-U to index the median rates from 2019 to the current period will result in a QPA that does not keep pace with the rate of growth of medical costs relative to average consumer costs.

This low QPA could have a substantial impact on reimbursement to safety net hospitals if it is given a prominent role in the IDR process. To that end, we urge the Departments to release the regulations governing the IDR process as quickly as possible and solicit anew comments on the QPA methodology after stakeholders have a complete understanding of its use.

We further recommend that the Departments clarify in the regulations that the QPA is not required to be used by payers as the initial payment (instead requiring insurers to pay a commercially reasonable rate) and that the QPA not be overly weighted in the IDR process. We cannot comment further until we learn more about the IDR process and can understand its potential impact.

NASH's Request: Delay Implementation of This Regulation

A theme that recurs throughout this letter is that as we respond to what the Departments have proposed, NASH recognizes that we are responding to what is only a partial proposal. Too many aspects of the federal government's eventual approach to regulating health care providers and payers under the No Surprises Act have not been determined and have not been shared with stakeholders. This lack of critical information signals that this process is moving too fast and is not yet ready to move forward. As we submit this letter we have less than four months to plan to implement and then actually to implement major changes in how we do business – without knowing the full scope of the changes required of us. We do not know whether forthcoming details will be as important as they currently appear to be, nor, conversely, do we know whether areas of current concern will end up being as consequential as we currently anticipate. This speaks to the need to slow down this process to give payers and providers a reasonable opportunity to develop a clear understanding of the totality of how the Departments envision implementing the No Surprises Act and what we need to do to comply with these new requirements. Ideally, the entire implementation process should be put on hold until all of the regulations are out and all of the processes and changes have been presented and explained and everyone involved has had a reasonable opportunity to comment on them, raise concerns, ask questions, and seek formal, written clarification and guidance. At the least, if implementation must begin on January 1, 2022, NASH urges the Departments to exercise enforcement discretion until 2023.

We also would like to remind regulators that for the past 18 months hospitals have been almost completely consumed by their response to the greatest health care challenge of our time: the COVID-19 pandemic. All hospitals have been affected by COVID-19. We have been required to work in new and different and often very costly ways under extraordinary conditions, often without the support of the financial and human resources to which we have grown accustomed. Doing so has been especially challenging for community safety-net hospitals, which typically lack the financial resources of most hospitals; serve diverse, disadvantaged communities greatly affected by the social determinants of health and generations of health inequities; and have in many places been disproportionately affected by the spread of the virus. The timing for introducing a major new administrative responsibility for community safety-net hospitals could not possibly be worse. Our optimism about the possibility of seeing light at the end of the COVID tunnel as summer approached has disappeared as we head toward fall and witness the

virus's resurgence. Now is not the timing to distract us from our mission of helping our communities survive this most extraordinary challenge.

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NASH appreciates the Departments' consideration of our views on the Requirements Related to Surprise Billing, Part 1, interim final rule with request for comments and welcomes any questions you may have about those views or any other aspects of the implementation of the No Surprises Act.
Sincerely,

Ellen J. Kugler
Executive Director