American Hospital Association™
Advancing Health in America

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October 18, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: CMS-9907-P: Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement, Proposed Rule (Vol. 86, No. 177) September 16, 2021

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the proposed rule related to enforcement of the No Surprises Act (NSA). **Oversight and enforcement of the NSA will be of critical importance to ensure patients benefit from these new protections and to prevent widespread, negative consequences of any misapplication of the policy.**

The NSA established critical new patient protections against balance billing in certain out-of-network scenarios. The statute included new mechanisms for calculating a patient's cost-sharing liability in these scenarios, as well as a framework for determining provider reimbursement. Each of these provisions introduces new requirements on providers, facilities, health plans and issuers, some of which are dependent on new information flows and complicated mathematical calculations. A misunderstanding or misapplication of the policy could result in patients being improperly billed the wrong amounts, as well as health plans and issuers failing to appropriately reimburse providers for care.

There are a number of provisions in the NSA that will require close oversight. These include whether plans/issuers correctly calculate the qualifying payment amount ("QPA" or, generally speaking, the plan's or issuer's median in-network rate); whether they

delay patient billing by inappropriately rejecting claims as not “clean;” whether they make appropriate initial payments to providers/facilities; whether they ensure timely patient transfers where appropriate; and whether they maintain appropriate access to in-network providers. Robust oversight of health plans and issuers will be particularly important if the independent dispute resolution (IDR) process is implemented as constructed in the recent interim final regulations issued Sept. 30, 2021. Specifically, in directing IDR entities to start with the presumption that the QPA is the appropriate out-of-network rate the process skews decisions in favor of plans and insurers as to make the IDR process effectively meaningless as a backstop to inappropriate reimbursement. Therefore, the government will need robust oversight and enforcement of health plans and issuers to ensure that they are not abusing the NSA provisions in ways that harm patients or the providers who care for them. Additional comments on our deep concerns with the IDR process will be shared in separate comments on the interim final rule.

Oversight and enforcement of the NSA is intended to be a shared responsibility of both the federal and state governments. This is true regardless of whether a state has a surprise medical billing law. This shared oversight will bring its own challenges, including who is “on first” and how to ensure parity in oversight and enforcement in different jurisdictions.

This regulation in part focuses on NSA enforcement. Specifically, the regulations as proposed would clarify the role of states in oversight and enforcement, establish oversight and enforcement processes regarding provider and facility compliance with the NSA, and update existing processes for health plan oversight to include enforcement of NSA requirements.

The AHA appreciates the opportunity to provide the following comments on the proposed approach to provider oversight and enforcement.

Need for Additional Guidance Prior to Enforcement

The NSA requires substantial changes in how providers, facilities, plans, and issuers operate. Providers and facilities will need to change workflows, update technology and establish and implement new patient communication processes. We urge the Centers for Medicare & Medicaid Services (CMS) to assist providers and facilities in this work and give time for these changes to take effect before beginning enforcement.

There are several examples of where additional information is needed to assist providers in appropriately implementing these policies. For example, there are still a number of open questions related to the application of state or federal balanced billing protections. Whether state or federal law (or both) apply depends on the circumstances of the case. Generally, state law applies to state-regulated products (e.g., fully insured individual and group market), and federal law applies to products that are primarily regulated at the federal level (e.g., self-insured/ERISA, FEHBP). However, in some states, a federally-regulated plan may opt into the state process. In addition, if the state

law is less protective than the federal law, the federal law may “wrap around” the state law to provide comprehensive protection. An example of this is when a patient receives both emergency and post-stabilization services and the state law only provides protections for the emergency services. In that instance, the state law protections apply for the emergency services, and the federal law applies to the remainder of the care (up to the limits in federal law and regulations). When a patient enters the hospital, either for an emergency or scheduled service, a new process will need to flag which, if any, polices apply to that patient based on their insurance coverage. This will impact the information given to them on their rights and responsibilities prior to care, as well as the amount that they are ultimately billed for their care. However, there is no way to determine which policy (federal or state) applies at this time due to both technology and policy constraints.

First, the technology that is currently used to check a patient’s insurance coverage (the eligibility transaction standard) does not indicate the type of coverage in the standard response. Without knowing the type of coverage, hospitals and health systems will not know whether state, federal, or no balance billing policies apply. This becomes more complicated in states that allow federally regulated plans to opt into a state process. **Clarity around which policy is applicable is needed for providers to be sure they are applying the correct policy before the policies are enforced.**

Another example of a new workflow challenge comes when an out-of-network provider seeks patient consent to balance bill. The law requires the notice to include a list of in-network providers at the facility that are able to furnish the services. However, a provider will not know definitively which providers may be in-network and/or covered for a particular service. That is a function of a patient’s coverage. The only way for a provider to obtain that information is to reference the plan's or issuer’s provider directory or contact the plan/issuer directly. Relying on health plan provider directories will not guarantee accurate information as such directories are notorious for containing errors. In addition, there are nuances to how plan provider directories list facilities and providers. For example, the facility could be listed as in-network in the plan directory, but the plan chooses to exclude coverage for certain provider services performed at the facility, such as outpatient surgery, laboratory and diagnostic services, and specialty drug therapies. These health plan coverage nuances would make it nearly impossible for the in-network provider to know with any certainty whether the service would be covered if delivered by the “in-network” providers listed in the directory. Alternatively, contacting the health plan manually each time would add considerable burden and add costs for both providers and health plans/issuers.

There are a number of other areas where open questions remain and yet, these policies go into effect in less than three months. The administration has previously acknowledged that it intends to use discretion in oversight and enforcement for several NSA provisions given the newness of the law and the lack of adequate time to issue all of the necessary regulations. **We urge CMS to continue to focus its efforts on**

implementation support through the release of guidance, standards and technical assistance before turning to investigation and enforcement.

Clarity in Roles of Federal and State Governments

One area with substantial lack of clarity is the role of federal and state governments regarding oversight and enforcement. The law and regulations establish states as the primary regulators (with the federal government as a backstop) but there is currently little information from states on whether they plan to enforce the requirements or defer to the federal government, and if a state does intend to enforce, what that process will look like. Providers need to know whether the state or the federal government will be enforcing each requirement and what that process will entail before enforcement begins.

Importance of Alignment across Provider/Plan Oversight and Enforcement

In the proposed rule, HHS proposes an oversight and enforcement process for providers and facilities that appears intended to mirror the process for oversight and enforcement of health plan and issuer requirements. As a general principle, we support parity and fairness in oversight and enforcement policies across providers and plans/issuers. We ask, however, for alignment not just in the processes, but also in prioritization of issues for oversight and enforcement. We are concerned that health plan/issuer bad behavior can more easily go unnoticed or uninvestigated as their requirements primarily are related to interactions with providers and not patients. However, their actions have direct consequences for patients. Incorrect calculations of the QPA by plans/issuers, lack of timely responses by plans/issuers to requests for patient transfers and plan/issuer delays in remitting cost-sharing information to providers, for example, can all negatively impact patients. We urge the departments to prioritize these areas for oversight.

Oversight Timeline

In the preamble, HHS lays out its proposed oversight timeline. HHS indicates that providers typically will be given 14 days to respond to a notice of possible violation. Compiling the relevant information and responding along this timeline will be challenging, particularly for smaller hospitals with fewer resources to respond to such inquiries. We ask that HHS consider extending this timeline to 30 days for issues that do not warrant a rapid response. We note that existing policies give health plans 30 days for response; instead of aligning at 14 days, we encourage HHS to adopt a 30-day timeline for both providers/facilities and plans/issuers.

Hospitals and health systems fully support protecting patients from any surprise medical bills resulting from gaps in their coverage, and we are pleased to work with the departments on implementation of this important law. Please contact me if you have

questions or feel free to have a member of your team contact Ariel Levin, AHA's senior associate director for policy, at alevin@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President