



# AMERICA'S ESSENTIAL HOSPITALS

September 7, 2021

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue SW  
Washington, DC 20201

## **CMS-9909-IFC: Requirements Related to Surprise Billing: Part 1**

Dear Administrator Brooks-LaSure:

America's Essential Hospitals appreciates the opportunity to submit comments on the above-captioned interim final rule (IFR) related to balance billing, or surprise billing. While we strongly support protecting patients from payment negotiations between private insurance plans and providers, we are concerned that several provisions in this rule will increase administrative burden on essential hospitals.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all. Filling a vital role in their communities, our more than 300 member hospitals provide a disproportionate share of the nation's uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Our members provide state-of-the-art, patient-centered care while operating on margins a third that of other hospitals—2.9 percent on average compared with 8.8 percent for all hospitals nationwide.<sup>1</sup>

Essential hospitals are committed to serving all people, regardless of income or insurance status. Their patients face sociodemographic challenges to accessing health care, including poverty, homelessness, language barriers, and low health literacy. Ten million people in communities served by essential hospitals have limited access to healthy food, and nearly 24 million live below the poverty line.<sup>2</sup> Essential hospitals are uniquely situated to target these social determinants of health and are committed to serving these patients. These circumstances, however, compound essential hospitals' challenges and strain their resources, requiring flexibility to ensure they are not unfairly disadvantaged for serving marginalized patients and can continue to provide vital services in their communities.

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<sup>1</sup> Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey*. America's Essential Hospitals. May 2021. <https://essentialdata.info>. Accessed August 13, 2021.

<sup>2</sup> Ibid.

We are pleased to see provisions in this IFR to protect patients from payment negotiations between private insurance plans and providers. While our members' patients are mostly uninsured or publicly insured, 20 percent of inpatient visits and 29 percent of outpatient visits at essential hospitals in 2019 were covered by commercial insurance.<sup>3</sup>

However, we are concerned this IFR neglects to account for the unique position of essential hospitals in their communities and the additional costs and burdens associated with implementation. We urge the Department of Health and Human Services (HHS) to consider the steps outlined below as it finalizes and implements this rule.

**1. HHS should take steps to address qualifying payment amount calculations and contracting issues for providers serving a safety net role.**

Essential hospitals provide high-acuity care, such as level I trauma, burn, and neonatal care. In some cases, they are the only hospital in their community with the resources and experience to provide such services. Essential hospitals also serve patients who are medically complex and face socioeconomic barriers to health and health care. Our member hospitals provide wraparound services—case management, transportation, nutrition support, legal services, language access, and patient navigation, among others—to meet these needs.

Given the provision of these services and their patient mix, costs at essential hospitals tend to be higher. In many markets, these factors lead to essential hospitals facing inadequate reimbursement from private insurers or exclusion from provider networks altogether. With this in mind, we are concerned the methodologies in this IFR will disadvantage essential hospitals through the determination of the qualifying payment amount (QPA).

First, and as described below, we believe the QPA will be skewed lower because adequate rates are not included in the calculation. Second, due to the QPA skewing lower, payers will have no incentive to pay essential hospitals adequate rates during contract negotiations or to include them in provider networks. Essential hospitals then might be forced to accept inadequate rates to be included in payers' networks, or be out-of-network and rely on the QPA or future independent dispute resolution (IDR) process for payment.

a. HHS should further analyze factors that will skew the QPA downward, resulting in inadequate payments.

The QPA will be calculated using the payer's median contracted rate for the same or similar services offered by a similar provider or facility type in the same insurance market. However, if a payer has chosen not to contract with essential hospitals or other similar providers, their rates will not be included in the QPA calculation, likely skewing the calculation downward.

Essential hospitals provide services, equipment and technology, as well as wraparound services, that may not be provided by other hospitals in the area—this robust care and advanced equipment requires additional resources and adequate payment rates to maintain. When essential hospitals are not included in a payer's network, the costs for these additional services are not accounted for in the QPA calculation. Similarly, if a payer has contracted with these providers at inadequate rates, this rate will be included in the calculation of the QPA and skew the QPA lower.

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<sup>3</sup> Ibid.

For 2022, the median contracted rate will be indexed to calculate the QPA and increased by the percentage increase of the urban consumer price index (CPI-U) over 2019, 2020, and 2021. For 2023 and beyond, the QPA will be determined by increasing the QPA for the service from the previous year by the annual CPI-U. However, the CPI-U tends to trail the CPI for medical care, which will further lower payments below adequate rates.

Both methodologies will underpay essential hospitals and exacerbate their financial challenges. **We ask HHS to reexamine QPA methodologies to better account for inadequately reimbursed services provided by essential hospitals.**

- b. HHS should ensure QPA methodologies do not incentivize payers to exclude essential hospital from their networks.

Given our concern that the QPA methodologies will skew the amount downward, we believe payers will have no incentive to contract with essential hospitals, despite the vital services these hospitals provide. Payers will be able to defer to a QPA in negotiations as a fallback rate if providers will not accept the payer's offered rate, even if it is inadequate to cover the costs to provide a given service. Providers will then have to accept this lower rate or rely on the IDR process should the provider remain out-of-network for that payer.

Consider this scenario: an essential hospital that is interested in becoming an in-network provider in the 2023 plan year but has not contracted with the payer in the past. The payer already has several in-network hospitals in this community and has established QPAs for several similar services. The payer can use the established QPAs for these services as a reference amount, knowing that if this essential hospital remains out-of-network and a beneficiary uses their services, the payer can offer this amount for payment, regardless of the actual cost of the service or adequacy of the payment. The established QPA in this scenario does not account for additional vital services the beneficiary might receive at the essential hospital that are not available at other, in-network hospitals. So in negotiations for the 2023 plan year, the essential hospital may try to contract for adequate payment rates, but the payer knows that if the essential hospital does not accept their offered rate, the hospital will have to accept the established the QPA as an out-of-network provider or enter the IDR process in an attempt to receive an adequate payment.

When essential hospitals are not paid adequate rates, it jeopardizes the services on which patients rely. As mentioned above, many essential hospitals offer services that no other hospital in their area can offer—our members operate a third of the nation's level 1 trauma centers and house almost 40 percent of burn care beds and a quarter of pediatric intensive care unit beds.<sup>4</sup> Further, many patients of essential hospitals need services to support their medical treatment, such as case management, transportation, nutrition support, legal services, language access and patient navigation. Reimbursement methodologies that do not account for these services put these vital offerings at risk, which can undermine the patient's medical treatment and health.

**HHS must reevaluate this methodology and its impact on providers serving a safety net role, as well as network adequacy for services covered under this IFR. Further, the agency should address these issues as the agency develops the rule for the IDR process.**

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<sup>4</sup> Ibid.

## **2. HHS must ensure all stakeholders share in notice-and-consent responsibilities and burdens.**

This IFR places the responsibilities of educating and informing patients about their benefits, as well as the administrative and financial burden of implementing these requirements, on providers. We believe these responsibilities should be shared among all stakeholders.

### a. HHS must place some responsibility of educating beneficiaries on insurers.

We appreciate how this IFR aims to help patients make informed decisions about their care and to protect them from coercion. However, the IFR puts most, if not all, of the responsibility on providers. We believe all stakeholders—hospitals, clinicians, insurers, and others—must be involved in educating patients about their health care coverage and individual out-of-pocket costs.

When post-stabilization services are provided by an out-of-network emergency facility or provider or non-emergency services are provided by an out-of-network provider at an in-network facility, a patient must receive this information to be billed at the out-of-network rate:

- notice that the provider or facility is out of network;
- a clear statement that consent is optional and the patient can seek care from an in-network provider;
- a good faith estimate of the amount the patient may be charged, even if the provider intends to bill the plan or coverage directly;
- if a service is offered by an out-of-network provider at an in-network facility, patients must receive a list of in-network providers who could perform the service; and
- information regarding prior authorization.

These requirements place the responsibility solely on the provider, relying on information from patients and insurers to be accurate and up to date. Specifically, it requires patients or their representatives to have the correct insurance information at the time of service and payer systems to be up-to-date with provider and service coverage information when hospital staff is running real-time eligibility checks. The reality of determining out-of-network services by service type for each patient in real time will place significant administrative burden on scheduling, registration, and billing departments.

### **HHS should mandate and provide guidance on the role and responsibility of payers in educating beneficiaries on which services and providers are in-network and out-of-network.**

### b. HHS should balance the administrative burden of implementing notice-and-consent requirements among stakeholders.

The notice-and-consent requirements in the IFR place the costs of implementation on providers. Providers will have to train staff in multiple departments and make modifications to their medical and billing systems to enable patients to waive balance billing protections and comply with federal and, in some locations, state law. The administrative burden of implementation and compliance should not fall solely on providers.

This burden will have a disproportionate impact on essential hospitals with slim financial margins. The cost of implementing these requirements will jeopardize other needed investments, such as changes to quality metrics and technology updates. Further, essential

hospital staff still are battling COVID-19. The pandemic required large and swift changes to policies and procedures to all hospital departments and systems. The treatment of COVID-19 patients and the implementation of these changes has taken a heavy toll on hospital finances and staff. Placing the burden of implementing additional compliance requirements on hospitals now, during the pandemic, is untenable.

**HHS must balance the role of payers and providers in implementing and financing notice-and-consent requirements in this IFR.**

Additionally, HHS is requiring the standard notice-and-consent form be available in the 15 most common languages in the geographic region of the provider. Given the expense to translate these forms and HHS' intention for all providers to adopt the use of the HHS form, **we recommend that HHS translate these forms.** This will be more efficient and will reduce cost to providers.

**3. More guidance is needed on the interaction of federal and state balance billing laws.**

Essential hospitals in states with existing surprise billing laws will have to invest significant time and financial resources in understanding the interaction between federal and state laws, as well as incorporate those laws into real-time care decisions. This will require a deeper analysis of both the federal and state laws and integration of their requirements into scheduling, registration, electronic medical record, and billing systems to comply with all applicable regulations. Special attention will be necessary when the state law applies to some parts of the patient encounter while the federal law applies to others, and it will require integration of both federal and state notice-and-compliance laws and procedures as discussed above. Subsequent system modification will be expensive, as will staff training to correctly implement these laws.

Further complicating matters, several of our member hospitals provide services in multiple states. Their service areas are more fluid than state lines; patients may receive care at several in-network facilities while receiving services from an out-of-network provider, irrespective of the location of the facility or the provider. Hospitals will have to navigate complex federal and state laws to stay in compliance, which will require additional financial investments. More guidance is needed to address these complexities, as well as application of state laws to out-of-state telehealth consults.

**HHS must provide more guidance on the interaction between federal and state balance billing laws and provide technical assistance and financial resources to help hospitals operationalize these requirements.**

**4. Implementation should be delayed until after the COVID-19 public health emergency.**

Finally, we are concerned about the January 1, 2022, start date. We appreciate the delay of the good faith estimate and advanced explanation of benefits requirements outlined in the frequently asked questions document published August 20, 2021.<sup>5</sup> However, given the timing of this IFR release and comment period and the two additional interim rules expected later this

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<sup>5</sup> *FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49.* Department of Labor. <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/our-activities/resource-center/faqs/aca-part-49.pdf>. Accessed August 31, 2021.

year, there is very little time for our members to develop, implement, and train their staff on new policies and procedures related to surprise billing protections. Further, hospitals are overrun with COVID-19 patients due to the delta variant; their staff and resources are thinning. Implementing this rule during the COVID-19 public health emergency (PHE) would further deplete already limited hospital resources, taking them away from patient care and other aspects of COVID-19 PHE compliance. **We ask that you delay the implementation and compliance deadlines to six months after the COVID-19 PHE ends.**

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or [eomalley@essentialhospitals.org](mailto:eomalley@essentialhospitals.org).

Sincerely,

Bruce Siegel, MD, MPH  
President and CEO