September 7, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

The Honorable Janet Yellen
Secretary
Department of the Treasury

The Honorable Kiran Ahuja
Director
Office of Personnel Management

Submitted electronically to: http://www.regulations.gov

Re: CMS-9909-IFC; Requirements Related to Surprise Billing; Part I.

Dear Administrator Brooks-LaSure, Secretary Yellen and Director Ahuja:

On behalf of the Premier healthcare alliance serving approximately 4,400 hospitals and health systems, hundreds of thousands of clinicians and 225,000 other provider organizations, we appreciate the opportunity to submit comments on the surprise billing interim final rules. With integrated data and analytics, collaboratives, supply chain solutions, and consulting and other services, Premier enables better care and outcomes at a lower cost. Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Premier maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our hospitals and health systems, their employed physicians and independent physicians aligned with them.

Premier supported the passage of the *No Surprises Act* as a solution to protect Americans from unexpected medical bills. We continue to believe that patients should be held financially harmless when they unknowingly receive care from an out-of-network provider, particularly during a medical emergency. We appreciate that both the surprise billing legislation and these interim final rules provide opportunities for payers and providers to negotiate mutually agreeable solutions when out-of-network charges occur.

Premier and our members are at the forefront of implementing and advocating for the movement to value-based payment models. These models depend on providers and payers working collaboratively to drive higher quality, more cost-effective healthcare. **When providers and payers work together to control the total cost of care, patients are less likely to be charged higher rates for out-of-network or emergency care.** These initial interim final rules provide a meaningful step towards patient protections; however, in the absence of rulemaking on the Independent Dispute Resolution (IDR) process we cannot fully comment on all policies. Below we offer comments on the interim final rule policies and highlight opportunities to continue to strengthen the movement to value within the surprise billing regulations.

SCOPE OF THE NEW SURPRISE BILLING PROTECTIONS

The *No Surprises Act* established protections from surprise medical bills for patients receiving emergency services from out-of-network providers or facilities, or non-emergency services from out-of-network providers at in-network facilities. These interim final rules codify that if a group health plan or issuer of

individual or group coverage covers emergency services, cost sharing for out-of-network emergency services must not be greater than the amounts would be if the provider and facility were in-network. Additionally, if the plan or issuer covers services performed by out-of-network providers at in-network facilities the same limitations on cost sharing apply, unless a notice and consent process is followed and patients waive protections. The interim final rules also codify an expanded definition of emergency services that includes post-stabilization services in certain instances.

Emergency Services

The Departments note that some payers review diagnosis codes documented on a claim for emergency services and *deny coverage* if the diagnosis does not qualify as an emergency medical condition based solely on the final diagnosis. The Departments indicate that plans and issuers must cover emergency medical services without limiting what constitutes a medical emergency based on diagnosis codes, timing of symptom onset or other arbitrary criteria. **Premier supports this approach.** Providers and patients rely on the statutory framework of the "prudent layperson" standard for emergency medical conditions, and all parties must work from the same standard to achieve equitable access to clinically appropriate care.

Post-Stabilization Services

The *No Surprises Act* defines emergency services to include any covered items or services furnished after a patient is stabilized, with respect to the visit in which emergency services are furnished. The interim final rules codify this definition and provide criteria by which providers may determine that a patient is stable enough that surprise billing protections for emergency services no longer apply. These criteria include the individual's ability to travel to an in-network provider or facility located within a reasonable distance by non-medical or non-emergency medical means. Under certain circumstances patients may also waive continued protections from higher out-of-network bills through a notice and consent process, if the treating provider believes that the individual is in a condition to receive such information.

The Departments seek comment on the definition of reasonable travel distance, and whether specific standards or examples should be provided for what constitutes an "unreasonable travel burden." The Departments also solicit comments on whether specific guidelines are needed to determine when an individual is in a condition to receive the written notice and provide consent. **Premier supports the Departments' prioritizing the medical discretion of treating providers in these interim final rules.** We recognize that a complete picture of an individual's medical condition and ability to travel involves accounting for social risk factors, such as financial hardship or lack of available public transportation infrastructure. We also recognize that the treating provider is best suited to determine the physical, emotional and social context for seeking notice and consent. **Premier urges the Departments to continue to empower providers to use their experience and expertise on a case-by-case basis,** rather than instituting a regulatory definition of reasonable travel distance, strict guidelines for what constitutes an individual's condition to receive notice and consent, or other inflexible standards.

DETERMINATION OF THE COST-SHARING AMOUNT AND PAYMENT AMOUNT TO PROVIDERS AND FACILITIES

The *No Surprises Act* requires that patient cost-sharing amounts for out-of-network emergency services and non-emergency services furnished by out-of-network providers at in-network facilities cannot exceed in-network cost-sharing rates. The statute specifies that cost-sharing should be calculated as if total

charges were equal to a recognized amount, defined as 1) rates set by CMS All-Payer Model Agreements, or 2) rates determined by State law, or 3) the lesser amount of the billed amount or the qualifying payment amount (QPA), in that order. The intent is to shelter patients from any ongoing ratesetting negotiations between payers and providers by requiring plans or issuers to use the recognized amount to calculate cost sharing, rather than the amount the out-of-network provider or facility is ultimately paid.

To determine payment rates for out-of-network providers, the *No Surprises Act* and the interim final rules require that the plan or issuer make a total payment equal to one of the following amounts, less any cost sharing: 1) Rates set by CMS All-Payer Model Agreements, or 2) rates determined by State law, 3) rates agreed upon by the provider and payer, or 4) the rate set by the IDR entity, in that order. The QPA will be a factor in the IDR arbitration determinations.

The QPA is defined in statute as the median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service and provider specialty in a given geographic region, adjusted for inflation. The interim final rules specify the methodology for calculating the "median contracted rate"—including which rates may be included in the calculation. Premier's comments and recommendations for further refining this methodology are discussed below.

Interactions with State Law

The Departments note the complex landscape that providers and payers face as they navigate existing state balance billing protections and the new federal legislation. Factors such as whether a plan or issuer has "opted in" to applicable state laws, differences between state and federal legal requirements for payer-provider negotiations, and different requirements across state lines may cause confusion and unintentional noncompliance. State approaches towards enforcement are also highly variable, and if states are not fully aware of the instances in which state rather than federal protections apply, patients may still face surprise medical bills.

Significant administrative burden and compliance concerns fall on providers and facilities. For example, providers must determine whether a given patient's self-insured employer has opted into a state's regulatory scheme. Hospitals must decide whether to follow state or federal policy when states define the post stabilization period differently than these interim final rules. Hospital systems operating across multiple states face additional layers of complexity.

We are concerned that payers and providers are ill-equipped to navigate these challenging complexities. **Premier strongly urges the Departments to disseminate additional state-by-state guidance, and to commit to a dedicated technical assistance effort.** Interactions between state and federal legislation, regulations and case law will vary by state. Rapid and involved technical assistance on a state-by-state basis is necessary to help payers and providers manage compliance and to prevent slowdowns in the implementation of the regulations.

All-Payer Model Agreements

The interim final rules specify that the recognized amount that serves as the basis for cost-sharing and out-of-network rate setting calculations should be based on CMS All-Payer Model Agreement rates when available. **We applaud the Departments' commitment to All-Payer Models, which require collaboration by payers, providers and states and promote value through lower healthcare costs and improved quality of care.** State-wide All-Payer Models are one approach to shifting large swaths of payers and providers onto a path from volume to value. The Maryland All-Payer Model, for example, has evolved from its previous iteration as a fee-for-service ratesetting model to its current iteration that tests

annual global budgets to slow hospital cost growth. As value-based models, All-Payer Models also inherently reduce opportunities for surprise bills as providers are moving toward comprehensive budgets across a patient population, rather than relying on fee-for-service charges.

Calculating Median Contracted Rates

The interim rules exclude a number of valuable datapoints, such as single case agreements and additional facility costs associated with teaching hospitals, that would more fully reflect the negotiated rates that providers and payers have worked cooperatively to establish in a given market. **It is essential to include in the QPA calculations complete data that is fully representative of contracted rates to ensure providers are paid fairly.** This is of particular importance in the event that payer-provider negotiations go to arbitration, as the IDR entities are directed by statute to consider the QPA when making ratesetting determinations.

Single Case Agreements

The interim final rules exclude single case agreements from the QPA median contracted rate calculation. In contrast, the Departments note that it is reasonable for patients to expect in-network cost-sharing rates for services delivered at a facility with a single case agreement in place for their care, and thus surprise billing consumer protections would apply for single case agreements. We agree that services provided at a facility under a single case agreement should be considered by the patient and the Departments as in-network services. These agreements effectively extend the plans' network under special circumstances. It is inconsistent to exclude single case agreement rates from the QPA, while at the same time treating them as in-network for the purpose of applying balance billing protections. **Further, this policy disregards the good-faith negotiation efforts of payers and providers to achieve mutually agreeable, adequate reimbursement for specialized care.**

The Departments posit that the term "contracted rate" refers solely to rates negotiated with providers and facilities that participate in the payer's network. However, **we recommend that the Departments include single case rates in the calculation of median contracted rates**.

Third Party Administrators

Throughout the interim final rules, the Departments acknowledge the role that third party administrators (TPAs) play in administering benefits for health plans. **Premier supports the policy that allows the plan sponsor to use TPAs to calculate the QPA, using the contracted rates from all self-insured group health plans administered by the TPA for a given item or service, provider or facility type, and geographic region.** We agree that this approach will likely result in fewer instances of insufficient information to calculate a median contracted rate, alleviating administrative burden and costs.

Facility of the Same or Similar Facility Type

The interim final rules require that median contracted rates be calculated separately for services provided in hospital-based versus independent freestanding emergency departments. The Departments also seek comment regarding whether urgent care centers or retail clinics should be designated as "health care facilities" under these interim final rules, thereby ensuring that rates for these providers are included in median contracted rate calculations for the QPA.

The Departments note that independent freestanding emergency departments may have significantly different case-mix and level of patient acuity compared to hospital-based emergency departments. We concur that the differences in case-mix and level of patient acuity may directly impact payment, and thus

will impact the calculation of the QPA. Assuming that urgent care centers and retail clinics would be considered freestanding emergency departments, the inclusion of these providers would create an even larger discrepancy between the patient characteristics of hospital-based and freestanding emergency departments.

Premier supports calculating separate median contracted rates for independent, freestanding emergency departments and hospital-based emergency departments. This approach will help prevent inadequate reimbursement when the QPA is considered during IDR arbitration. However, we are concerned that failure to account for other facility characteristics, such as whether a hospital is an academic medical center or a safety net hospital, may result in inadequate payment that is misaligned with the cost of care. Commercial payer rates are highly variable across hospitals, even within an individual metropolitan area. Medicare fee-for-service rates often serve as a de facto floor for ratesetting negotiations with private payers. Medicare makes add-on payments to compensate safety net hospitals for uncompensated care and teaching hospitals for the additional costs of running medical education programs. Calculating median contracted rates across all hospital-based emergency departments, rather than calculating separate rates for safety net and other high-cost facilities, will likely result in inappropriately lower rates for these hospitals, should IDR arbitration be evoked. Furthermore, knowing that IDR arbitrators must consider median contracted rates, safety net and teaching hospitals would be disincentivized from utilizing the arbitration process that the *No Surprises Act* created to level the playing field between payers and providers in out-of-network ratesetting disputes.

Premier urges the Departments to revise the QPA methodology to consider additional facility characteristics beyond whether an emergency department is hospital-based or freestanding to ensure hospitals and health systems have equal opportunity for adequate reimbursement should they pursue IDR arbitration. If the Departments pursue inclusion of urgent care centers or retail clinics, we ask that the Departments use separate QPA calculations in consideration of the significant population and payment differences between these types of facilities and other types of emergency departments.

The Departments also seek comment on the impact of healthcare consolidation on contracted rates and the QPA. We believe hospital consolidation is being viewed through the lens of yesterday's business model—fragmented, duplicative and wasteful healthcare that does not meet the needs of a patient. With a goal of shifting to more patient-centric care while lowering costs and achieving higher quality, the nature of healthcare competition is changing. We are transitioning from competition among providers seeking to generate volume of services to competition between integrated provider networks designed to deliver affordable, high-value care. Some of these high-value networks are being organized by physicians, others by insurers, and others by health systems. To truly consider the impact of consolidation among any healthcare entity (e.g., health system, insurer, provider group) on the QPA or contracted rates, we must first understand the broader evolving market dynamics.

Non-Fee-for-Service Contractual Arrangements

The *No Surprises Act* requires that any rulemaking to establish the QPA methodology must take into account non-fee-for-service payments made by plans or issuers. The interim final rules further require that QPA calculations include rates derived from value-based arrangements such as capitated arrangements, shared savings arrangements and bundled payments. The Departments note that value-based arrangements use underlying fee-for-service schedules and require that this information be included in the QPA calculation. The Departments further cite their belief that this approach ensures that arrangements that pay for value over volume are reflected in the QPA. Additionally, the rule excludes from the QPA retrospective payment adjustments such as shared savings payments and quality bonuses paid to providers. **This approach does not recognize the nature of value-based arrangements and**

ultimately discourages the movement to value.

First, the Departments' assertion that plans or issuers use underlying fee schedules for most value-based arrangements is incorrect. Providers and payers have been partnering to implement these arrangements for well over a decade. While earlier iterations of value-based arrangements are often based on an underlying fee schedule, later iterations often use agreed upon budgets updated based on patient risk profiles and overall healthcare spending trends. Ultimately, payers and providers participating in advanced value-based arrangement have abandoned fee-for-service. **Requiring these payers to use an underlying fee schedule to meet the requirements of calculating the QPA creates unnecessary burden.**

Second, the inclusion of underlying fee schedules for value-based arrangements will artificially lower the QPA. The value-based arrangements using an underlying fee schedule typically include significant discounts on payment, with the opportunity to earn retrospective payment adjustments based on overall cost and quality performance. We understand that it is not feasible to include retrospective payment adjustments as these payments occur long after the services are rendered. However, exclusion of this information artificially lowers the payment amount for the purposes of the QPA.

Finally, we believe that patients in value-based arrangements are already shielded from unexpected medical bills because the payer and providers have agreed to a payment arrangement. The *No Surprises Act* is a direct response to the faults of fee-for-service payment. Rather than retrofitting value-based arrangements to fee-for-service, the Departments should take every step possible to recognize that these agreements are in the best interest of patients and reflect collaboration between payers and providers. Specifically, we recommend that the Departments:

- **Remove value-based arrangements from inclusion in the QPA determination.** As discussed, many value-based arrangements no longer have underlying fee schedules, and those that do incorporate discounts that have the impact of artificially lowering the QPA.
- **Give preference to the existing value-based arrangement when resolving disputes that involve a value-based arrangement.** While we believe that value-based arrangements avoid surprise medical bills, in the rare instance of a dispute, the value-based arrangement should be considered as a part of the rubric for cost-sharing and out-of-network rate calculations provided in the interim final rules. For example, the payment in the value-based arrangement should be considered before the lesser of the amount billed by the provider or facility or the QPA when determining patient cost sharing. Similarly, the value-based arrangement must be considered alongside the rates agreed upon by the provider and payer when determining the provider payment.

Cases with Insufficient Information

In the absence of sufficient data to calculate the median contracted rate, the No Surprises Act allows the plan or issuer to use a database to calculate the QPA as long as the database is free from conflicts of interest and provides sufficient information. The interim final rules further establish that State all-payer claims databases are eligible for use provided they meet certain conflict-of-interest requirements and are able to distinguish between commercial and public payer rates.

In order to assure transparency and a level playing field, **we encourage the Departments to put additional conditions on the use of third-party databases for QPA calculations**. **Providers should have equal access to data from third-party databases** upon request, ensuring that payers and providers have the same information as they negotiate out-of-network rates. Providers should also be allowed to challenge the data source used, as it should be incumbent on the plan or issuer to provide sufficient evidence that the third-party database is unbiased and complete.

The Departments also seek comment on whether databases owned or controlled by TPAs present a conflict of interest. **Premier recommends that the Departments allow the use of TPA databases as long as the general criteria for third-party databases are met and a sufficient level of transparency can be achieved for providers**. Allowing TPAs to use their own databases provides an efficient means for calculating the QPA, negating the need for TPAs to contract with outside databases, which would inject additional costs and delays into the process.

We urge the Departments to consider alternative ways to address cases of insufficient information, such as utilizing rates from expanded service areas, as long as payers or TPAs can demonstrate that such service areas are comparable. This methodology would allow the consideration of additional datapoints without having to fully vet a new third-party entity.

Information to be Shared about the QPA

Premier supports requiring that certain information pertaining to QPA calculations be shared with providers. Disclosure of the information used to calculate the QPA will ensure transparency in the out-of-network ratesetting process. The Departments seek comment on whether a specific definition or standard is needed to ensure that information provided to providers upon request is disclosed in a timely manner. **We recommend that plans or issuers be required to respond to provider requests for additional information within 10 days.** This will give providers time to review and consider the information during the 30-day negotiation period**. We also recommend that plans or issuers must provide all rates that factor into the QPA calculation, along with a statement verifying whether such rates include any value-based payment adjustments.** We believe that sharing such information directly aligns with the Administration's ongoing commitments to increasing price transparency, as well as empowering providers as equal partners in ratesetting negotiations.

Notice and Consent Exception to Prohibition on Balance Billing

In limited circumstances the interim final rules allow for the use of a notice and consent process to waive patient protections against balance billing. Those circumstances are limited to (1) post-stabilization when provided by out-of-network providers and facilities under certain conditions and (2) out-of-network providers furnishing items and services at in-network facilities. The notice and consent process is intended to both protect patients from surprise medical bills and retain patient rights to choose their providers.

Implementation of the notice and consent process under the interim final rules will impose significant additional administrative burdens on providers. For example, for post-stabilization patients at in-network facilities, the process requires providers and facilities to give patients a list of alternative in-network providers at the facility that may furnish the services. To comply with this requirement, providers must rely on the accuracy of any given payer's provider directory or contact the payer directly to confirm information. Providers should not be held responsible for potentially incorrect health plan directory information. Additionally, health plan in- and out-of-network determinations are nuanced, for example exclusions for specific specialty drug services at in-network facilities. 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.**

Additionally, Premier recommends allowing additional 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.

CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the Surprise Billing interim final rule. If you have any questions regarding our comments or need more information, please contact Aisha Pittman, vice president, policy, at aisha_pittman@premierinc.com or 202.879.8013.

Sincerely,

Blair Childs
Senior Vice President, Public Affairs
Premier healthcare alliance