MISSOURI HOSPITAL ASSOCIATION

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September 3, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9099-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Requirements Related to Surprise Billing; Part 1 (CMS-9099-IFC)

Dear Ms. Brooks-LaSure:

On behalf of its 142 member hospitals, the Missouri Hospital Association offers the following comments in response to the multi-departmental interim final rule with request for comment related to surprise billing.

INTERACTION BETWEEN FEDERAL AND STATE LAW

The federal surprise billing regulations provide a baseline level of protection to the patient. However, the underlying federal statute defers to state law on surprise billing in certain circumstances. The proposed federal regulations reflect these intergovernmental issues but do not always clearly identify when federal or state standards would apply. For example, Missouri law has surprise billing patient protections and an independent arbitration process. It applies to an out-of-network practitioner's treatment of a patient whose encounter began with emergency care at an in-network facility. The Missouri law's protections continue until the patient's discharge. In this case, federal regulation defers to state law regarding the practitioner, but the facility would be subject to federal law and regulations because the Missouri surprise billing law does not apply to facilities. Complicating the issue, the federal regulations require that the good faith estimate include all services provided during post-stabilization care. In this case, various components of state and federal law may apply to the same patient episode of care. Due to this type of overlapping interaction between federal and state law, MHA urges the departments to establish clear guidelines as to when federal or state law applies.

OPERATIONALIZING THE REGULATION REQUIREMENTS

The surprise billing regulations are extensive and complex. MHA applauds the departments' use of discretionary authority to delay the enforcement of certain surprise billing requirements, as announced on August 20. For those requirements that will be enforced on January 1, 2022, hospitals will need time to operationalize the various components, including public notifications, notice and exception processes, coordination between the hospital and practitioners, and

development of systems to provide coding and charges for good faith estimates. MHA urges the departments to further use their discretionary authority to delay enforcement of such requirements. This would grant enough time for stakeholders to collaborate with regulators to address implementation barriers. MHA recommends that the departments create a technical advisory group to provide operational recommendations.

GOOD FAITH ESTIMATES

The statute requires that good faith estimates are to be included within the patient notice and consent documentation. MHA supports the requirement for each provider to manage their own patient notice and consent; however, for post-stabilization services, the regulation requires that the facility gather the good faith estimates from all treating providers. The regulation also requires that the good faith estimate should include the diagnostic coding that would accompany the service. The providers serving patients within a facility are often independent practitioners who charge, code and bill separately from the facility. In such cases, the facility does not know what the charges and coding will be for each provider treating the patient in a post-discharge setting. The requirement to have hospitals gather this information and use it to present a good faith estimate is an undue and onerous burden. MHA urges the departments to amend the regulations to allow each provider to obtain their own patient waiver and provide their own good faith estimate, including post-stabilization services.

REFERENCE-BASED PRICING

Hospitals across the country have grappled with insurers that utilize a reference-based pricing scheme to undermine the fair market negotiation processes. When reference-based pricing schemes are used, the insurer often has no in-network hospital contracts for members to utilize. In place of networks, reference-based pricing companies unilaterally decide what an appropriate payment should be for the service. Such policies do nothing more than shift risk and cost onto the patient while reimbursing hospitals an arbitrary rate that often does not cover the cost of treatment. Within the new regulations, patients enrolled in plans that utilize the out-of-network reference-based pricing scheme would be protected from surprise billing. MHA is concerned that including reference-based pricing products under the surprise billing protections will create an incentive to adopt such schemes. MHA urges the departments to exclude reference-based insurance coverage from the scope of the surprise billing protections.

PRIOR AUTHORZATIONS FOR PATIENT TRANSFERS

The surprise billing law provides protections to patients receiving out-of-network emergency and post-stabilization services, and the law grants that post-stabilization can extend until the patient is transferred to an in-network facility. Many commercial plans require hospitals to obtain prior authorizations for transfer to other facilities. Hospitals often report problematic and opaque processes and delays in obtaining decisions. Essentially, plans can use the prior authorization

process to their advantage, offloading unreimbursed cost and delaying care. MHA urges the departments to require clear standards and prompt prior authorization decisions to ensure timely transfers to an in-network provider.

Thank you for the opportunity to comment and for your consideration of these issues.

Sincerely,

Daniel Landon
Senior Vice President of Governmental Relations

Andrew Wheeler
Vice President of Federal Finance

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