Illinois Health and Hospital Association

October 12, 2021

Xavier Becerra
Secretary
Department of Health and Human Services

Laurie Bodenheimer
Associate Director
Healthcare and Insurance
Office of Personnel Management

Douglas W. O'Donnell
Deputy Commissioner
Services and Enforcement
Internal Revenue Service

Ali Khawar
Assistant Secretary
Employee Benefits Security
Admininstration
Department of Labor

Mark J. Mazur
Acting Assistant Secretary
Tax Policy
Department of the Treasury

Re: Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement (CMS-9907-P)

Dear Mr. Becerra, Ms. Bodenheimer, Mr. O'Donnell, Mr. Khawar and Mr. Mazur:

On behalf of our more than 200 member hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement proposed rule. IHA values the opportunity to engage the Office of Personnel Management, Internal Revenue Service, and U.S. Departments of Health and Human Services, Labor and Treasury (the departments) in developing enforcement practices that ensure health plan/issuer (i.e., payers) and provider/facility (i.e., providers) compliance with No Surprises Act (NSA) requirements. Illinois hospitals have long supported protecting patients from surprise medical bills, and Illinois Public Act 96-1523[1](215 ILCS 5/356z.3a)[2] bans balance billing for out-of-network anesthesiology, emergency, neonatology, pathology and radiology services provided at in-network hospitals or ambulatory surgery centers. Ensuring appropriate and equitable enforcement of both Illinois' surprise billing legislation and the NSA is crucial to realizing the patient protections envisioned by Congress.

[1] https://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=096-1523
[2] https://www.ilga.gov/legislation/ilcs/ilcs4.asp?DocName=021500050HArt%2E+XX&ActID=1249&ChapterID=22&SeqStart=99300000&SeqEnd=114800000

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IHA appreciates that the departments are quickly producing technically complex regulatory guidance to meet the congressionally mandated NSA implementation date of Jan. 1, 2022. However, as demonstrated by announced delayed enforcement of advanced explanations of benefits and good faith estimates for insured patients, the industry is generally unprepared to implement many aspects of the NSA in the timeframe allotted by Congress. Our members continue to deal with surges in COVID-19 as they try to build back from the lost revenues and coronavirus-related expenses experienced over the last 20 months. Hospitals and health systems are also facing the same employment challenges burdening other sectors of the economy, resulting in limited staffing resources that may affect a provider's ability to implement NSA requirements. Further, the departments recently released new, extensive guidance on integral pieces of the NSA, including the independent dispute resolution process, which are still under review and directly affected by this proposed rule. For these reasons, and others described below, **we strongly urge the departments to defer enforcement of the NSA until all implementing regulations are finalized and stakeholders have had sufficient opportunity to implement, evaluate, and revise NSA-related processes and documents.**

Enforcement Responsibilities

This proposed rule creates two parallel enforcement processes. While the proposed rule makes clear that states are the primary enforcers of Public Health Services (PHS) Act provisions, including NSA requirements, it also outlines scenarios in which the Centers for Medicare & Medicaid Services (CMS) becomes the primary enforcer for both payers and providers. Specifically, if a state notifies CMS that it has not enacted legislation to enforce PHS requirements, or the state fails to substantially enforce PHS requirements, CMS becomes the primary enforcer. It is our understanding that states must indicate whether they intend to act as primary enforcers of PHS requirements, and we have not heard whether Illinois, or other states, intend to act as primary enforcers at this time. **Without clear guidance around which entity, the state or CMS, will act as primary enforcer of NSA requirements, providers and payers are unable to dedicate appropriate resources to properly execute surprise billing requirements because they will not know which set of rules to follow. This is particularly true in states like Illinois that have already enacted surprise billing legislation.**

Additionally, while the NSA provides protections that are more expansive than Illinois Public Act 96-1523, there is some overlap in the items, services and provider types covered by the two laws making it difficult for stakeholders to know which law applies to a particular situation. Further, states only have enforcement jurisdiction over certain types of health plans. Thus, in states like Illinois, there will be two parallel enforcement processes running simultaneously as certain services and health plans will fall under CMS' jurisdiction and others under the state's. The departments might address part of this confusion with a technical fix. Specifically, when providers initiate an eligibility and benefits transaction with a payer to confirm patient enrollment and the cost-sharing amount, the payer does not communicate the type of plan the patient has, meaning whether the plan is an ERISA plan, fully self-funded, etc. In our comments on CMS-9909-IFC, we suggested the departments require payers to make the necessary

changes to communicate which process providers should follow for negotiation and arbitration, perhaps via a remittance advice or a notice of denial. Once again, **we request the departments establish appropriate oversight of payers to ensure they communicate accurate plan information to providers in a uniform and timely manner. Additionally, we request the departments provide clear guidance on how state and federal enforcement entities should work together to protect patients from surprise medical bills.**

Finally, we are concerned that state and federal oversight bodies may not be fully prepared to enforce NSA requirements under the PHS Act by Jan. 1, 2022. State and federal governments are not immune to the challenges presented over the last 20 months during the ongoing COVID-19 pandemic, and we are concerned that oversight bodies may be unprepared to expand current PHS enforcement responsibilities to include providers as well. Specifically, we suspect stable, dedicated enforcement at the state level against providers and payers will not occur before the state agency promulgates regulations which will likely not occur before the implementation date. Guaranteeing appropriate equitable oversight may require the departments to delay enforcement activities and conduct workgroups with government, payer and provider stakeholders to ensure understanding of enforcement processes and adequate staffing, technological capabilities, and financial resources. **To that end, we urge the departments to ensure that state and federal oversight bodies have the resources necessary to apply equal enforcement of reported violations and conduct random audits for both payers and providers. We also request the departments complete the rulemaking process for all aspects of the NSA, and provide education and technical assistance to stakeholders, including state agencies, to ensure uniform implementation and execution of NSA provisions. Such actions will ensure the best possible experience for patients in particular, who will ultimately suffer the most from noncompliance related to confusing timelines and inconsistent requirements.**

<u>Investigation Process and Notification</u>

IHA appreciates the alignment between payer and provider enforcement processes outlined by the departments. Providing consistent enforcement across stakeholders mitigates confusion and provides a clear process for compliance with corrective action plans and other enforcement actions. However, the proposed change to 45 CFR 150.307(b) to modify the timeframe responsible entities have to respond to an investigation specified by CMS, which suggests a time period of 14 days for both payers and providers, may present challenges. Many Illinois hospitals expressed concern with the anticipated 14-day response period, as a notice from CMS would go through several levels of review internally and potentially need to go through outside counsel before a hospital can respond. Such review processes are in addition to time spent by the hospital investigating allegations of noncompliance, gathering supporting documentation, and formulating a response. Thus, **we request the departments rethink this proposed change, and instead keep the 30-day response timeframe in the federal code.**

We also ask the departments to provide additional examples of what would qualify for an extension to the response timeframe. Specifically, **it is reasonable that providers would need additional time to collect relevant data and documentation, and we ask the departments to specify this as a potentially legitimate reason to request and grant an extension.**

Finally**, we ask that CMS ensure adequate enforcement over payers' calculation of the qualifying payment amount (QPA).** We are concerned that absent adequate oversight of the QPA, there may be situations where providers inadvertently violate NSA requirements, particularly as it pertains to the amount of patient cost sharing. We are confident that CMS will do everything in its power to protect patients under the NSA; however, **the current lack of transparency around QPA calculations as described in CMS-9909-IFC is concerning, and we urge the departments to increase transparency and required methodological communication around the calculation of QPAs as part of their robust enforcement processes.**

Mr. Becerra, Ms. Bodenheimer, Mr. O'Donnell, Mr. Khawar and Mr. Mazur, thank you again for the opportunity to comment on this proposed rule.

Sincerely,

A.J. Wilhelmi,
President & CEO
Illinois Health and Hospital Association