



Charles N. Kahn III
President and CEO

June 15, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Martin Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Dear Secretaries Becerra, Yellen, and Walsh:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, D.C and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH and our members strongly support the *No Surprises Act*, which first and foremost protects patients from surprise medical bills by holding the patient to in-network cost-sharing in circumstances where the patient has no reasonable control over the network status of the providers administering care. In drafting and enacting the *No Surprises Act*, Congress also importantly preserved the role of health plan/provider payment negotiations while creating a process to fairly resolve payment disputes. It is imperative that the implementing regulations and dispute resolution process advance and actively maintain that fairness so as not to inappropriately advantage health plans at the expense of patients and their health care providers.

The *No Surprises Act* contains numerous new policies and processes that will require significant engagement across the health care sector and outlines an ambitious and multipronged implementation timeline. We look forward to working with you and your Departments on implementation of the *No Surprises Act* and offer the below initial recommendations based on input from our member hospitals and health systems on three areas: 1) regulatory process and implementation timelines; 2) determination of the “qualifying payment amount” (QPA); and 3) notice and consent process for certain out-of-network care.

We continue to seek input from our members regarding other policies in the *No Surprises Act*, including the independent dispute resolution process (IDR) and advance explanation of benefits (EOB), and look forward to future engagement with you on those issues.

Regulatory Process and Implementation Timelines

As noted above, the *No Surprises Act* outlines an ambitious implementation timeline for numerous new policies and the creation of an entirely new dispute resolution process. The myriad of implementation issues to consider and decisions to make – coupled with the potential impact of these policies on health plan/provider relationships and operations – means it is vital that your Departments provide ample opportunity for stakeholder input on any proposed regulations before they are implemented. This includes full notice and comment rulemaking for each implementing regulation as well as adequate time of at least a few months for stakeholders to operationalize the final rules before the *No Surprises Act* takes effect January 1, 2022.

Qualifying Payment Amount (QPA)

The *No Surprises Act* created the qualifying payment amount (QPA), from which the patient’s cost-sharing is determined and which is one of the factors considered in the IDR process. In developing the regulations implementing the QPA methodology and transparency requirements, the FAH urges your Departments to ensure the QPA does not become a de facto benchmark payment used by health plans to under-reimburse for services and/or create an incentive to drop in-network health care providers. The FAH offers the following recommendations on various aspects of the QPA:

Geographic Area

The FAH urges the Departments to define geographic region as either the metropolitan statistical areas (MSAs) or insurance rating areas and to ensure that such definition appropriately delineates between rural vs. urban areas.

Calculation Inputs

To protect against misuse and in keeping with the language of the *No Surprises Act*, it is imperative that only comparable rates are included as inputs in the QPA calculation and that inappropriate and/or noncomparable rates are not permitted in the methodology. For example, the calculation should not include denied claims or rates from narrow networks or exclusive plans (e.g., HMOs, EPOs). Such plans are by their nature exclusionary and should not be considered as meeting the threshold type of plan from which rates can be used in the QPA calculation. In addition, the calculation should not include any public payer rates such as

Medicare Advantage, Medicaid managed care, CHIP, Tricare, or worker's compensation. Public payer rates are not permitted to be considered under the IDR process and thus building them into the QPA, which can be considered in the IDR process, is not permissible under the statute.

The QPA calculation should include the total maximum payment between a plan and the in-network providers, including incentive and/or bonus payments. It should also include an add-on percentage to account for the fact that in-network rates are by their nature a discounted rate in exchange for patient volume, which does not exist in out-of-network situations. The add-on percentage also is critical to compensate providers for the increased cost of providing out-of-network emergency services, which are particularly unpredictable and require additional staffing to be available, regardless of utilization. In addition, the methodology should account for the type of facility and the acuity of the patient. For example, if the out-of-network facility is a high-acuity hospital, the rates used to calculate the QPA should only be drawn from other high-acuity facilities. Similarly, calculating the QPA for a Level 3 out-of-network service should only draw on Level 3 rates. The FAH is concerned that without specifically delineating the inputs into the methodology in this way, health plans will be incentivized to drop from their networks facilities with busy and high-acuity Emergency Departments.

Similar Service

As part of including apples to apples rates in the QPA calculation, the *No Surprises Act* sets forth that the in-network, contracted rates should be for the "same or similar specialty." As noted above, the FAH believes it is vital that only comparable rates are included in the QPA calculation and urges the Departments to ensure such fairness in the implementing regulations. As the term "specialty" is usually applied to physicians, not facilities, the FAH recommends that "service line" and acuity are the more appropriate distinctions for facility care. The NICU, Trauma, and Emergency Department are all different services lines (or specialties at the facility level) that contain a number of services and acuity levels within each category. Determining the median for facility care should be based on the service line and the acuity, for example, comparing NICU Level 1 to other NICU Level 1 rates and NICU Level 3 to other NICU Level 3 rates. A NICU Level 1 rate should not be used in the QPA calculation for a NICU Level 3 service, as that would inappropriately dilute the calculation and potentially the payment rate to the provider.

The FAH further recommends that the Departments convene a workgroup of expert stakeholders from the health plan and health provider communities to further explore and define "same or similar specialty," especially as it relates to facility-level care.

Calculation Transparency

As the QPA is poised to have a potentially significant impact on health care provider reimbursement, it is vital that health insurers are transparent regarding the QPA methodology and calculation. This includes the inputs into the calculation such as the number of rates, each specific rate, and each specific facility. Health plans should be required to transmit this information to out-of-network providers when communicating the patient cost-sharing amount, including it on the explanation of benefits (EOB) / explanation of payment (EOP), and be required to put the methodology on their websites. Such detailed information is necessary for

providers to model the QPA and ensure the appropriate facilities were included in the calculation.

In addition, plans should be required to tell the provider on the EOB/EOP the type of plan in which the patient is enrolled (e.g., ERISA plan vs. state-regulated plan), including the financially responsible payor if it is an entity other than the plan itself, such as an employer or delegated entity, and that information should also be included on the patient's insurance card. It is often very difficult for health care providers to identify the patient's plan based on the insurance card or the EOB/EOP, and providers currently waste time and resources trying to locate that information. The *No Surprises Act's* overlay of federal surprise billing requirements onto existing state requirements makes this information necessary for determining whether to follow federal or state law, and providers should not have to hunt for it.

Notice and Consent

The *No Surprises Act* preserves patient choice to select or maintain an out-of-network health care provider through a notice and consent process for certain out-of-network services, such as surgery by an out-of-network clinician and/or post-stabilization services at an out-of-network facility.

There are several issues to consider as you work to implement these notice and consent provisions, including when a patient is stable and able to give consent after an emergency service, overlap of any federal requirements with existing state requirements, and the format and language used in the notice itself.

Post-stabilization services should include all services from the time the patient is stable through when the patient is either discharged or transferred from the out-of-network facility. For these services, the FAH urges you and your Departments to adopt policies that reinforce the health care provider as the determiner of whether a patient is stable. As there is no black and white line for determining when an individual patient is stable and able to give consent to receiving out-of-network services, it is imperative that the patient's treating health care provider continue to be the one to make that decision based on the clinical needs and presentation of the patient. The patient's health insurance provider should not have a role in such determination. The insurer does have an important role, however, in working with providers if and when a patient is both able and desires to transfer to another, in-network facility. Implementing regulations should require health plans to promptly engage with providers in such instances to arrange for a timely transfer, including identifying appropriate in-network facilities and arranging for and covering the transportation. If the health plan fails to timely undertake these actions, the plan should be required to reimburse the out-of-network facility's charges for providing continued services while holding the enrollee (the patient) to his or her in-network cost-sharing responsibility.

Also vital to operationalizing this notice and consent process is minimizing patient confusion and provider burden and allowing for exceptions when providers are unable to comply with the requirements. Providers across the country are already complying with various state notice and consent laws and regulations, and we are concerned about the addition of an overlapping, duplicative, or potentially conflicting federal requirement. As such, the FAH recommends you adopt and implement a policy that deems health care providers in compliance

with federal law if they are in compliance with state notice and consent requirements in the state in which they are providing the services, including regarding the 15 languages in the local area into which the notice and consent must be translated. Along with such deeming, we also recommend the implementing regulations focus on key information or language to include in the existing notice and consent documents providers give to patients rather than a new standardized federal form. Focusing on the information that should be conveyed rather than a specific form or format will give providers the flexibility to comply with both state and federal requirements with one form, thus minimizing operational burden and patient confusion. We also strongly believe there must be an exceptions process for providers that cannot comply with the notice and consent requirements due to extraordinary circumstances, such as a public health emergency and/or natural disaster.

The FAH also strongly urges the Departments to make implementing regulations very clear that facilities are *not* responsible for any part of the notice and consent process for out-of-network clinicians or other providers not directly employed or contracted by the facility. In such instances, the need for the notice and consent arises because the clinician or other provider is out of the patient's network and thus only that clinician/provider is in a position to provide the necessary information to the patient and appropriately and effectively manage that relationship.

The FAH appreciates the opportunity to weigh in on these initial areas for implementation under the *No Surprises Act*. We look forward to continued engagement with you to protect patients from surprise medical bills and ensure a fair and operationally feasible process for payments to out-of-network providers. Should you have any questions or follow up, please do not hesitate to reach out to me or a member of my staff at 202-624-1534.

Sincerely,

