



Charles N. Kahn III
President and CEO

October 18, 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

Re: Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement; CMS—9907—IFC; 86 Fed. Reg. 51,730 (September 16, 2021)

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, DC 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. These tax-paying hospitals account for nearly 20% of U.S. hospitals and serve their communities proudly while providing high-quality health care to their patients.

The FAH appreciates the opportunity to submit comments to the Office of Personnel Management, Department of the Treasury, Department of Labor, and Department of Health and Human Services (HHS) (collectively, the Departments), regarding their proposed rule, *Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider*

Enforcement (Proposed Rule), published in the Federal Register (86 Fed. Reg. 51,730) on September 16, 2021. The FAH and its members strongly support the *No Surprises Act*, which first and foremost ensures that patients have in-network coverage and cost-sharing obligations in circumstances where the patient has no reasonable control over the network status of the facility or health care providers administering care. Surprise medical bills—including those that result from improper payer denials or limitations on coverage—burden our health care delivery system and should be eliminated in a manner that preserves market negotiation of network rates between health plans and providers, consistent with Congress’s intent. The following comments address the portions of the Proposed Rule concerning the imposition of civil monetary penalties (CMPs) on facilities and providers other than air ambulance providers.

The FAH requests that HHS revise proposed 45 C.F.R. § 150.513(e)(1) to clarify that a provider or facility will not be subject to a CMP for an unknowing violation provided that the provider or facility takes appropriate action to rectify the violation within 30 days of acquiring the requisite knowledge of the improper bill. At present, the regulation indicates that the 30-day period runs from the date of the violation, but the Proposed Rule does not explicitly set the date of violation as the date upon which the provider or facility becomes aware of that violation. In adopting this statutory exception at section 2799B-4(b)(4) of the PHS Act, Congress recognized that it would be inappropriate to impose a CMP on a facility or provider that neither knew nor should have known of the violation at the time of billing and promptly rectifies the violation upon learning of the violation. Clarifying the Proposed Rule to specify that the 30-day period runs from the date the provider acquires such knowledge would be consistent with the provisions of existing 45 C.F.R. § 150.341. Under this regulation, health insurance issuers and plans are immunized from CMPs during the period where no responsible entity “knew, or exercising reasonable diligence would have known, of the failure” and have a 30-day period to correct the failure, running from the date the entity knew or, exercising reasonable diligence, would have known of the failure. Similarly, we urge HHS to revise “within 30 days of the violation” to read “within 30 days of the first day that the provider or facility knew, or exercising reasonable diligence would have known, that the bill was in violation of part 149 of this subchapter.”

In addition, the FAH recommends the creation of a presumption that a facility or provider neither knew nor should have known of the improper balance bill when the facility or provider acts in conformity with the issuer’s or plan’s explanation of benefits (EOB).

Providers and facilities should be permitted to reasonably rely on the information provided by the plan or issuer in the EOB when billing patients, and it would be inappropriate for providers and facilities to face CMPs when the improper bill resulted from reliance on (mis)information contained in an EOB and corrective action is taken promptly once the error comes to light. As such, it should be presumed that a provider’s due diligence does not necessitate independent investigation beyond review of the issuer’s or plan’s EOB. Moreover, reliance on the EOB should be treated as a significant factor that implicates the nature of violations and circumstances under which they were presented and the degree of culpability of the provider or a facility under proposed § 150.513(b)(1) and (2) and should be explicitly acknowledged as a mitigating circumstance under § 150.513(c).

The FAH urges the Departments to eliminate subsection (a) of proposed 45 C.F.R. § 150.521 concerning collateral estoppel. Subsection 150.521(a) proposes to bind a provider or facility in any future proceeding under Part 150 following a final decision pertaining to the provider or facility's liability for a violation, providing that the provider or facility was a party and had an opportunity to be heard. The Proposed Rule does not present any rationale or statutory support for including this provision, and it does not appear to be required by the PHS Act or referenced provisions of the Social Security Act. Moreover, proposed § 150.521(a) improperly omits many of the elements required for the application of collateral estoppel, including the requirement that the same issue be implicated in both proceedings and that the issue was actually litigated and actually and necessarily decided in the first action. In fact, subsection (a) does not even use the term "issue" or any similar term. It is also unclear why HHS included this provision with respect to CMP proceedings against providers and facilities when no similar provision is found in the portions of Part 150 pertaining to CMP proceedings against issuers and health plans. Therefore, the FAH requests that subsection (a) be deleted from proposed § 150.521, leaving only the language required in section 2799B-4(b)(1), which references section 1128A(c)(3) of the Social Security Act.

Finally, the FAH requests that the Departments adopt a corollary to proposed 45 C.F.R. § 150.525 that would be applicable to health insurance issuers and plans. Where a penalty against an issuer or plan becomes final, it is appropriate to notify the appropriate State regulatory agencies (namely, the State Department of Insurance or similar agency, and, in appropriate cases, the State Attorney General, among others). Although proposed § 150.525 is included by virtue of the reference to section 1128A(h) of the Social Security Act in section 2799B-4(b)(1) of the PHS Act, there does not appear to be any policy rationale against mirroring this requirement in subpart C of 45 C.F.R. Part 150.

If you have any questions or wish to speak further, please do not hesitate to reach out to me or a member of my staff at 202-624-1534.

Sincerely,

