



August 24, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Administrator Brooks-LaSure,

On behalf of the American College of Physicians (ACP), I am writing to express our support for the bipartisan efforts to protect health care consumers from the growing problem of “surprise billing” released in the Centers for Medicare and Medicaid Services (CMS) interim final rule with comment period on July 13, 2021.

The American College of Physicians is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 161,000 internal medicine physician specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness that attempts to eliminate billing practices that often leave patients with unexpected, high out-of-pocket costs in connection with care provided in situations they cannot reasonably avoid. We appreciate the rule on this issue and believe that this is a positive step forward in addressing this problem. We are pleased to provide ACP’s perspective and suggestions on certain provisions where we have established policy and where it impacts our patients and the care we provide as internists.

Overview

Surprise billing—unexpected bills patients receive due to receiving care from an out-of-network physician or facility—or unexpected in-network service charges can be a financial burden on patients and contribute to medical/consumer debt. Medical debt is a growing concern, even for those who are insured. Reports of high and unanticipated “surprise” medical bills, especially in emergency situations for patients who do have health insurance coverage and are being treated at in-network facilities, have resulted in calls for the federal government to take both legislative and regulatory action.

This Interim Final Rule with Comment period (IFC) aims to protect individuals from surprise medical bills for emergency services, air ambulance services provided by out-of-network provider organizations, and non-emergency services provided by out-of-network provider organizations at in-network facilities in certain circumstances.

If a plan or coverage provides or covers any benefits for emergency services, this IFC requires emergency services to be covered:

- Without any prior authorization (i.e., approval beforehand);

- Regardless of whether the “provider” is an in-network “provider” or an in-network emergency facility; and
- Regardless of any other term or condition of the plan or coverage other than the exclusion or coordination of benefits or a permitted affiliation or waiting period.

The IFC also limits cost-sharing for out-of-network services subject to these protections to no higher than in-network levels, requires such cost-sharing to count toward any in-network deductibles and out-of-pocket maximums, and prohibits balance billing. These limitations apply to out-of-network emergency services, air ambulance services furnished by out-of-network “providers”, and certain non-emergency services furnished by out-of-network “providers” at certain in-network facilities, including hospitals and ambulatory surgical centers.

ACP Comments

ACP’s guiding policy on surprise medical bills is outlined in its position paper entitled, “[Improving Health Care Efficacy and Efficiency Through Increased Transparency](#).” Specifically:

“ACP supports efforts to provide greater protections for patients from unexpected out-of-network health care costs, particularly for costs incurred during an emergency or medical situation in which out-of-network clinicians provide additional services without the patient’s prior knowledge. While the College reaffirms the right of physicians to establish their fees and to choose whether or not to participate as an in-network provider, ACP supports establishing processes to reduce the risk for “surprise” bills for out-of-network services for which a patient was unable to obtain estimates for services before receipt of care or was not given the option to select an in-network clinician. Health plans also have an affirmative obligation to pay fairly and appropriately for services provided in and out of network, and regulators should ensure network adequacy in all fields, including emergency care.”

Additionally, patients do not have the clinical expertise to diagnose their condition and determine whether or not they need an ambulance, especially in a perceived emergency where minutes could mean the difference between life or death. Because ambulatory services are often delivered out-of-network, this could result in surprise medical bills for patients needing those services. We are pleased to see that CMS made the patient protections in this IFC applicable to ambulatory services, particularly in the case of emergency situations. **ACP supports the decision of CMS to provide protections for patients from surprise bills in situations where they need an ambulance, especially in a perceived emergency.**

Cost-Sharing Amounts

This IFC specifies that patient cost-sharing amounts for emergency services provided by out-of-network emergency facilities and out-of-network “providers”, and certain non-emergency services furnished by out-of-network “providers” at certain in-network facilities, must be calculated based on one of the following amounts:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- If there is no such applicable All-Payer Model Agreement, an amount determined under a specified state law; or

- If neither of the above applies, the lesser amount of either the billed charge or the qualifying payment amount is generally the plan’s or issuer’s median contracted rate.

Similarly, cost-sharing amounts for air ambulance services provided by out-of-network “providers” must be calculated using the lesser of the billed charge or the plan’s or issuer’s qualifying payment amount, and the cost-sharing requirement must be the same as if an in-network air ambulance provider provided services.

The Departments intend to issue regulations soon regarding IDR entities and the IDR process.

ACP Comments

ACP agrees with the approach CMS has outlined that emergency services provided by out-of-network emergency facilities and out-of-network provider organizations, and certain non-emergency services furnished by out-of-network provider organizations at certain in-network facilities, must be calculated based on a recognized amount which is generally the lesser of the “Qualifying Payment Amount” (QPA) – the plans median in-network rate for the item or service, or an all-payer model agreement between CMS and the state.

When a plan determines that the QPA is the recognized amount, additional details about the QPA must be provided, including the plan contact information to initiate the 30-day negotiation period for the total plan payment. If an agreement cannot be met, Independent Dispute Resolution (IDR) may be initiated. **ACP encourages CMS to include in the IDR process described in future sub-regulatory guidance that health plans have an affirmative obligation to pay fairly and appropriately for services provided in and out of network.**

Further, ACP encourages regulators to ensure network adequacy in all fields. How network adequacy and the fair payment of services for physicians may contribute to the increase in patients receiving out-of-network care should also be examined to ensure an appropriate number of available in-network physicians, especially in the emergency setting. **Further consideration of proposals to ensure levels of network adequacy is needed.**

Balance Billing

Under this IFC, surprise billing for items and services covered by the rule generally is not allowed. Further, the total amount to be paid to a clinician or facility, including any cost-sharing, is to be based on:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- If there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law;
- If there is no such applicable All-Payer Model Agreement or specified state law, an amount agreed upon by the plan or issuer and the “provider” or facility; or
- An independent dispute resolution (IDR) entity determines an amount if none of the three conditions apply.

In limited cases, a clinician or facility can notify a person regarding potential out-of-network care and obtain the individual's consent for that out-of-network care and extra costs. However, this exception does not apply in certain situations when surprise bills are likely to happen, such as for specified ancillary services connected to non-emergency care, such as anesthesiology or radiology services provided at an in-network health care facility.

Additionally, this IFC requires certain health care clinicians and facilities to make publicly available, post on a public website, and provide to individuals a one-page notice about:

- The requirements and prohibitions applicable to the “provider” or facility under Public Health Service Act section 2799B-1 and 2799B-2 and their implementing regulations;
- Any applicable state balance billing limitations or prohibitions; and
- How to contact appropriate state and federal agencies if someone believes the “provider” or facility has violated the requirements described in the notice.

ACP Comments

ACP believes and supports increased transparency in all sectors of the health care system, and that action should be taken to increase protection for patients who face unexpected or surprise bills through no fault of their own. Creating databases that provide reliable and complete information on the prices and out-of-pocket costs of services, such as all-payer claims databases, in addition to quality information, can help optimize the potential benefits of transparency in the health care system. Addressing price, cost, and quality-level transparency issues can support a more efficient and effective health care marketplace with the potential for reduced costs and improved outcomes.

The IFC prohibits balance billing by out-of-network emergency and facility-based provider organizations, as so defined in the interim rule. It also requires that patients receiving scheduled care be given notice at the time of scheduling about the provider organization's network status and any potential charges they could be liable for if treated by an out-of-network provider organization. If a patient does not sign a consent form acknowledging that the provider organization is out-of-network, the patient cannot be balance billed. ACP supports establishing ways to hold patients harmless for “surprise” bills for out-of-network services for which a patient was unable to obtain estimates for services prior to receipt of care or was not given the option to select an in-network clinician. **ACP believes health plans and health care facilities should clearly communicate to a consumer whether a provider organization or clinician is in-network or out-of-network and the estimated out-of-pocket payment responsibilities of the consumer.**

Conclusion

ACP believes this IFC is a step in the right direction in providing protections for patients from surprise billing. As the health care system undergoes multiple transitions—an increase of insured consumers, a shift to paying for the quality of service over quantity, and an influx of data from multiple sources—health care price transparency has emerged as a vital component to address costs for patients and maintaining a health care system accountable to those it serves. By tailoring tools and data to individuals, health care price transparency can work to mend the fragmentation of health care through

access to meaningful information for consumers, physicians, and payers. From a broader perspective, health care price transparency can support collaborative efforts at the state and federal level to optimize the potential of data sharing and potentially reduce costs to the health care system.

Thank you for this opportunity to comment on CMS' Interim Final Rule with Comment period (IFC) aimed to protect individuals from surprise medical bills, and other federal programs for Calendar Year 2022 and beyond. We are confident these recommended changes would improve the strength of these proposals and help promote access to affordable care for Medicare patients while supporting physicians to deliver innovative care and protect the integrity of the Medicare trust funds. We appreciate the opportunity to offer our feedback and look forward to continuing to work with the Agency to implement policies that support and improve the practice of internal medicine. Please contact Brian Outland, Director, Regulatory Affairs, for the American College of Physicians, at boutland@acponline.org or 202-261-4544 with comments or questions about the content of this letter.

Sincerely,

A handwritten signature in black ink, appearing to read "William Fox". The signature is fluid and cursive, with the first name "William" and the last name "Fox" clearly distinguishable.

William Fox, MD, FACP
Chair, Medical Practice and Quality Committee
American College of Physicians