National Rural Health Association

December 03, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G Washington, D.C. 20201

RE: Requirements Related to Surprise Billing: Part II

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS), Office of Personnel Management (OPM), Internal Revenue Service (IRS), Department of the Treasury (Treasury), Department of Labor (DoL), and the Department of Health and Human Services (HHS) interim final rule (IFR) related to surprise billing. We appreciate your continued commitment to the more than 60 million Americans residing in rural areas and look forward to our continued collaboration to improve health care access, outcomes, and quality.

NRHA is a non-profit membership organization with more than 21,000 members nation-wide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care infrastructure, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

We appreciate the agencies continued emphasis on narrowing the gap between rural patients and providers. This letter outlines suggestions for which NRHA believes this interim final rule can be strengthened. We look forward to our continued collaboration in ensuring Americans living in rural areas have access to critical health services in their local communities and rural providers receive the equitable reimbursement they deserve.

As we mentioned in NRHA's response to the Requirements Related to Surprise Billing; Part I, NRHA applauds the agencies work to remove the patient from billing disputes between providers and insurers, ultimately reducing their out-of-pocket liability. **However, NRHA is concerned that the methodology used to establish the qualifying payment amount (QPA) [established in Part I IFR], coupled with regulations outlined in the Part II IFR, will make it more difficult for providers to receive fair, adequate payment for out-of-network services, particularly in rural areas.**

QPA Does Not Reflect Rural Reality

NRHA continues to have concerns that the QPA will not truly be reflective of the realities in rural communities. In the Part I IFR, the agencies outlined how the QPA will be determined. In part,

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this will be reliant on data provided by providers and health plans. As outlined in our Part I comments, NRHA is concerned that the regulation will require already strained rural providers to be subject to additional price transparency regulations to set up the QPA. Further, given the strain already being placed on the rural workforce, NRHA is concerned that rural providers will struggle to comply with this data meaning the QPA may be potentially crafted with greater emphasis on the data coming from health plans. The IFR places the burden on the rural provider to show why a different rate should apply. NRHA urges the agencies implement this rule in a manner that does not put rural providers at a distinct disadvantage in negotiating with health plans.

Independent Air Ambulance Providers

Further, air ambulance services in rural areas will particularly be hindered. NRHA believes the way the two rules have been written provide little incentive for health plans to offer fair contracted rates, only further hindering providers, particularly independent air ambulance providers, ability to receive fair payment for services. As we described in our Part I comments, NRHA believes the Part II IFR continues to treat independent air ambulance providers and hospital-based air ambulance providers the same, even though they have drastically different cost structures. In fact, more than 70 percent of air ambulance transport is provided via independent air ambulance providers, and that percentage is even higher in rural communities. NRHA believes if independent air ambulance providers were forced to accept the same rates as hospital-based providers, they would not be able to sustain their operations and ultimately rural patients would lose access to needed services. Hospital-based providers can accept lower reimbursement rates for transports because they are able to recoup the air ambulance costs through other services. In contrast, independent air ambulance providers are entirely dependent on transport reimbursement and will receive payment amount significantly below fair market value. NRHA urges the agencies to revisit the July 13, 2021, Part I IFR to establish a QPA methodology that differentiates between independent and hospital-based air ambulance providers at the risk of reducing access to air ambulance services in rural areas of the country for Medicare beneficiaries.

IDR Process Favors Payers Over Providers

NRHA has concerns that the independent dispute resolution (IDR) process favors insurance companies rather than providers, particularly those in rural areas. When the No Surprises Act passed Congress in 2020, NRHA was excited for rural patients to be held harmless from surprise medical bills and the process to determine financial resolve. However, that process should not be implemented at the expense of rural providers. NRHA is particularly concerned that the IDR process is heavily reliant on the QPA being the presumptive, appropriate amount, and will not ultimately be reflective of the realities facing rural providers. By instructing arbiters in billing disputes to consider the benchmark QPA– the median rate the insurer pays to in-network providers for similar services in the area – before weighing other payment variables, IFR unfairly burdens providers and results in smaller and more rural providers being pushed out of network.

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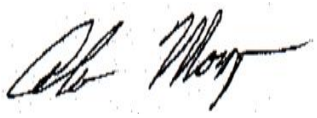
At a minimum, NRHA urges CMS to adjust the weight given to the QPA during the IDR process to ensure continued Medicare beneficiary access to these critical services.

Requirements Related to Surprise Billing; Part I, and the No Surprises Act, specifically outlined the patient's cost sharing liability as: an amount determined by an applicable All-Payer Model Agreement; if no All-Payer Model Agreement, then an amount defined under state law; or, if there is no All-Payer Model Agreement or state law determination, the QPA. If an agreement cannot be met with the three conditions mentioned for out-of-network services, then the IDR process may be initiated. However, NRHA is concerned with the IFR outlining that the IDR entity (IDRE) shall choose the offer closest to the QPA, unless it can be supported by sufficient data. In particular, we have concerns that the QPA may not represent the historical fair market, and placing added emphasis on this number will have a distinct disadvantage on providers, especially independent air ambulance providers and health care providers serving rural communities. **NRHA encourages the agencies to reassess their rulemaking to not place such emphasis on the QPA.** Instead, NRHA encourages the agencies to instruct the IDRE to evaluate all supplemental information provided by both parties without having the instructed pre-conceived notion that the QPA is the adequate, fair amount. Possible additional factors include: the acuity of the care provided, the provider's case mix and scope of services, and the respective market share of the provider and health plan.

Thank you for the chance to offer comments on this interim final rule and for your consideration of our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality and access to care. If you would like additional information, please contact Josh Jorgensen at jjorgensen@ruralhelath.us.

Sincerely,



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