December 2, 2021

Laurie Bodenheimer
Associate Director
Healthcare and Insurance
Office of Personnel Management

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

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

Ali Khawar
Assistant Secretary
Employee Benefits Security Administration
Department of Labor

Xavier Becerra
Secretary
Department of Health and Human Services

Re: CMS-9908-IFC; Requirements Related to Surprise Billing II

Submitted electronically via http://www.regulations.gov

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

Trinity Health appreciates the opportunity to comment on surprise billing policies set forth in CMS-9908-IFC. Our comments and recommendations reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 115,000 colleagues and nearly 26,000 physicians and clinicians caring for diverse communities across 25 states. Nationally recognized for care and experience, the Trinity Health system includes 88 hospitals, 131 continuing care locations, the second largest PACE program in the country, 125 urgent care locations and many other health and well-being services. Based in Livonia, Michigan, its annual operating revenue is $20.2 billion with $1.2 billion returned to its communities in the form of charity care and other community benefit programs.

Trinity Health has 17 Clinically Integrated Networks (CINs) that are accountable for approximately 1.5 million lives across the country through alternative payment models. Our health care system participates in 14 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes 5 markets partnering in one national MSSP Enhanced Track ACO, Trinity Health Integrated Care. We also have 3 markets partnering as a Next Generation ACO and 2 participating in CPC+. In addition, we have 31 hospitals participating in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative, and 2 hospitals in the Comprehensive Care for Joint Replacement (CJR) program. Our work—and experience

in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts.

Trinity Health strongly supports protecting patients from surprise medical bills that result from gaps in their insurance coverage. In our comments below, we urge the departments to modify certain provisions of the rule that are inconsistent with statute and Congressional intent and unfairly tip the scales toward payers.

Surprise medical bills are just one instance of a number of problematic payer policies impacting patients. For example, while surprise medical bills may result from gaps in provider networks, payers have implemented a number of policies that restrict patient access to care and create other forms of unexpected bills. Specifically, payers restrict access to care through confusing and burdensome utilization management requirements, such as prior authorization, and delay or deny payments to providers. In addition, payers deny payment using medical necessity, which interferes with providers determining what is medically necessary and appropriate care for patients. Denials of claims is prevalent across all payers and has been increasing over time. These denied claims result in delayed payment, unnecessary patient debt, increased administrative burden and added waste to the nation's health care system.

Administrative burden associated with denials increases cost for Trinity Health by $15 million each month. From our data:

- 8-10% of total hospital encounters incur a payer denial on first submission.
- Denials for subsequent claim submissions and secondary payor submissions consistently range 12-15% for all encounters.
- 80-95% of denied claims are undertaken with a corrective action to respond and resolve, including re-submission, correction, or appeal efforts—highlighting concerns that patients and providers were initially denied services and payments that should have been provided.
- Attempting to overturn clinical denials through the arduous appeal process is successful 55-65% of the time yet creates increased burden that often includes engaging physician involvement for peer-to-peer reviews.

While we encounter these issues with both commercial and Medicare Advantage (MA) payers, the 2018 study[1] by the Government Accountability Office (GAO) flagged widespread and consistent problems related to denials of care and payment in MA and recommended that CMS take a number of steps to stop the inappropriate denials. **We urge the Departments to implement GAO recommendations and do a similar study for commercial plans.**

Examples of plan abuse to reduce or delay payment to providers include:

- Adopting the Sepsis 3 criteria to recode DRG classifications and reducing reimbursement to providers which is inconsistent with the CMS quality measure and denies reimbursement for services provided to treat early stage sepsis treatment.
- Extending the definition of medical necessity to include location or place of service and financial considerations with the argument that services did not need to be performed in certain types of facilities—thus interfering with the ability of providers who are actually providing direct care to the patient to determine what is appropriate treatment and care.
- Implementing policies contrary to EMTALA by denying payment when patient presents to ED for certain conditions.

[1] Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials, 2018, Report (OEI-09-16-00410), https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp

Trinity Health urges oversight of timeframes from initial claim submission to final payment, which should include investigations of plans with patterns of long delays.

Independent Dispute Resolution (IDR)

Overreliance on the Qualified Payment Amount (QPA)

In drafting the No Surprises Act, Congress sought to create a balanced, fair IDR process for payment disputes between payers and providers. The final statutory language laid out all factors that arbiters should consider during the "baseball style" IDR process, in *addition* to the QPA, including:

- The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service.
- The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.
- The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.
- The teaching status, case mix, and scope of services of the participating facility that furnished such item or service.
- Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

The interim final rule issued by the departments direct the arbiter to begin with the presumption that the QPA is an appropriate out of network rate (thereby prioritizing the QPA in the IDR process) and only consider other factors if the supportive evidence meets a “credible information” standard and clearly demonstrates that the QPA is “materially different” from the appropriate out-of-network rate.

Trinity Health is incredibly concerned by the IDR process outlined in the rule as it creates a higher bar for the other factors required for consideration by Congress. We urge the departments to rescind this rule and reissue regulations that align with statute and give arbiters deference to use their expertise to weight factors according to the situation. Overweighting the QPA is inconsistent with statute and an inappropriate policy that heavily biases the IDR process toward plans. Further, the process as outlined eliminates an important check on payers, tipping the scale for provider/payer negotiations. Knowing that there is no way for providers to prevail at arbitration means that payers will be even more emboldened to continue their problematic policies, resulting in payers squeezing already vulnerable providers and/or implementing more problematic policies for patients.

Further, Trinity Health is concerned the IDR process as outlined in the interim final rule will impact network access for patients as it creates a disincentive for payers to maintain comprehensive networks. If a provider cannot agree to the terms the payer brings to a negotiation, the payer can terminate their contract knowing that their members can still get access to many critical services under these protections. The result will be incomplete provider networks that can have real consequences for patient access to care not protected by the No Surprises Act.

Process

The IDR process as outlined is a complicated process with a reliance on federal portals. **Trinity Health strongly recommends the departments allow discretion in timelines as the process gets off the ground and ensures a functional federal portal that is user friendly. In addition, the departments should establish contingency plans in the event the federal portal encounters unforeseen challenges.**

Batching of Claims
Providers and facilities can batch similar claims in a single IDR request, subject to certain conditions. All of the following conditions must be met to batch claims: the items and services must use similar procedural codes and have been billed by the same provider, group of providers or facilities; billed to the same plan or issuer; and occurred within 30-business days or within the 90-day “cooling off” period between IDR requests for same or similar services.

Limiting batching to claims that are for the same items or services will significantly reduce the potential efficiencies gained from batching. **Trinity Health recommends the departments allow for broader discretion in the batching of claims, as this would disincentivize plans and issuers from adopting inappropriate out-of-network payment methodologies that would trigger the IDR process and create efficiency by reducing the number of requests submitted through the IDR process for resolution.**

Conclusion
Trinity Health strongly supports protecting patients from unexpected medical bills and we are available to discuss our comments. If you have any questions, please feel free to contact me at jennifer.nading@trinity-health.org or 202-909-0390

Sincerely,

/s/

Jennifer Nading
Director, Medicare and Medicaid Policy and Regulatory Affairs
Trinity Health