AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

September 7, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
Attention: CMS-9909-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

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

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

Delivered Electronically

Re: Comments on Requirements Related to Surprise Billing; Part I (CMS–9909–IFC)

Dear Secretaries Becerra, Walsh, and Yellen:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to comment on the Requirements Related to Surprise Billing; Part I Interim Final Rule (IFR) published in the Federal Register on July 13, 2021 (CMS-09909-IFC). We strongly support the No Surprises Act's (NSA) patient protections against unexpected medical bills and the ability of health plans and providers to work together to determine appropriate reimbursement for out-of-network care. We look forward to working with the Administration as it continues its implementation of the provisions of the NSA.

AMRPA is a national trade association representing more than 650 freestanding Inpatient Rehabilitation Hospitals and units of general hospitals (IRH/Us, referred to by the Department of Health and Human Services as "inpatient rehabilitation facilities," or "IRFs"). Our members focus on the care and functional recovery of some our nation's most vulnerable patients, including patients recovering from traumatic brain injury, stroke, and traumatic spinal cord injury. Importantly, the COVID-19 pandemic has and continues to demonstrate the distinct value of IRF care for post-acute care (PAC) patients, as AMRPA members have been able to capably care for higher acuity patients while maintaining the same high rates of discharge to home and community and other vital quality metrics.

Our comments on the initial NSA regulations focus on the following areas:

- Unique Context of Inpatient Rehabilitation Medicine
- Scope of Ancillary Services and Notice and Consent Waivers
- Qualifying Payment Amount
- Initial Payment Amount

- Independent Dispute Resolution Process

We look forward to continuing to work with the Administration on these issues as well as the additional regulations that will need to be promulgated before the NSA requirements go into effect.

Unique Context of Inpatient Rehabilitation Medicine

We recognize and support that the NSA seeks broad protections for patients, especially in cases where patients cannot chose their provider. To help provide additional context and guidance for the Departments as they promulgate the NSA regulations, AMRPA members wish to convey the unique context of inpatient rehabilitation medicine that may impact how the regulations and protections work in practice.

IRFs play a crucial role in the care, treatment, and recovery of individuals with disabling injuries and illnesses, such as stroke, brain and spinal cord injuries, respiratory disease, cancer, joint replacement, and many others. To provide high quality care, our members take an integrated team approach to treatment. The rehabilitation team is led by a licensed physician with specialized training and experience in inpatient rehabilitation. Other team members include rehabilitation nurses, physical therapists, occupational therapists, speech-language pathologists, psychologists and neuropsychologists, cognitive therapists, social workers/case managers, and dietitians. Depending on the patient's needs, prosthetists, orthotists, recreation therapists, and other clinicians may also be part of the rehabilitation team.

The nature of many IRF patients' conditions may pose problems for implementation of the NSA. Many IRF patients are ill enough that they require inpatient care, but also well enough that they are able to be transported to obtain non-emergency services from providers who do not have privileges on the medical staff of the IRF and are unable or unwilling to visit the patient in our hospital. For example, an IRF patient may need to see a neuro-ophthalmologist to be assessed for eye trauma that was incurred at the time of their injury, but deferred while life-saving treatments were prioritized. This examination and assessment typically is not available within a specialized hospital like an IRF, and normally is conducted in the physician's office setting. The ophthalmologist would bill the patient for an outpatient visit, even though the patient was currently an IRF inpatient, and it would not be the economic responsibility of the IRF to pay for that care.

In some cases, IRF patients need to be sent to an emergency department for emergency services. After they are stabilized, these patients return to the IRF for continued care. While the IFR contemplates and addresses post-stabilization care, we are unsure whether the NSA rules extend to post-stabilization IRF services.

We ask that the Departments clarify how the NSA would apply to, and how to ensure that patients are aware of, the unique context of receiving out-of-network care when they are still an inpatient of another facility or unit.

AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Scope of Ancillary Services and Notice and Consent Waivers

Under the NSA, a patient can knowingly and voluntarily agree to use certain types of out-of-network providers, and be billed the out-of-network rate in limited circumstances, when notice and consent is provided. Providers, however, cannot request a consent waiver if the provider furnishes ancillary services that a patient typically does not select.

Ancillary services are defined under the rule to include emergency medicine, anesthesiology, pathology, and radiology; care provided by assistant surgeons, hospitalists, and intensivists; and diagnostic services (including radiology and laboratory services). The IFR considered including rehabilitative services in the definition of ancillary services and has asked for comment on which, if any, additional ancillary services should be included in the definition.

AMRPA agrees with the initial scope of ancillary services provided in the IFR and believes rehabilitation services should not be included in this regulatory definition. Unlike the other ancillary services defined by the rule, rehabilitation services are integrated into the delivery of care in IRFs to improve patient daily functioning and well-being. In contrast, ancillary care typically refers to the range of services provided to support the work of the main care provider. Due to the interdisciplinary nature of medical rehabilitation care, no component can be considered incidental or ancillary; each is critical to make the whole greater than the sum of the parts. AMRPA strongly believes that rehabilitation services do not fit within the term "ancillary" and were not within the scope contemplated by the NSA to be ineligible for the notice and consent waiver process.

In addition to the scope of the notice and consent waivers, we urge the Departments to carefully design the notice and consent process. Otherwise, we are concerned that this new policy will result in patients receiving conflicting information and will result in implementation challenges for providers. Under the IFR, the notice and consent forms must be given to the patient separately from other documents and must be given at least 72 hours in advance of a scheduled appointment. If the appointment occurs less than 72 hours after scheduling, notice and consent can be given on the same day as the appointment was made and must be given at least 3 hours in advance of the appointment itself.

There are several common scenarios in rehabilitation care that require AMRPA members to schedule same-day appointments for out-patient services to provide the necessary and best care for their patients. Often, patients present with conditions that require urgent appointments for physical therapy services. As an example, a typical acute low-back pain patient who is seen in a walk-in clinic or emergency room and must be seen immediately by a physical therapist to receive cold therapy and be instructed in body mechanics. These types of same-day appointments serve an important purpose, as they can increase patient access to care by making patient visits more efficient and reducing transportation burden. The hospital that is the host for the IRF unit typically provides these services, so while it is not the IRF providing the service, we are the functional entity that provides the care.

Unlike with routine physical therapy services, these urgent needs may not allow enough time to comply with the notice and consent timeframes. Patients may also need to urgently see a rehabilitation physician who may not be in-network and who may not be employed by the IRF itself. Accordingly, we urge the Departments to provide additional flexibilities for the notice and consent processes for these complex situations.

In addition, AMRPA members provide care to patients who often have significant cognitive impairments, including speech difficulties or the inability to speak. The Departments should consider patients who cannot respond within the timeframe due to these disabilities and may not have an authorized representative available to aid in the notice and consent process.

Qualifying Payment Amount

Under the NSA, patient cost-sharing is equal to the "recognized amount" for such services. The recognized amount is based on state model or law. If neither apply, then it is the lesser of the billed charge or the "qualifying payment amount" (QPA). The QPA is generally defined as the median contracted rate in 2019 for the same or similar item or service, by a similar provider, in the same geographic region, and will be updated by an inflationary factor. Payers are generally responsible for calculating the QPA using their data.

The IFR outlines information that the payer must disclose regarding the QPA. Upon request of the provider, a payer must provide information about whether the QPA includes contracted rates that were not set on a fee-for-service basis and whether the QPA was determined using underlying fee schedule rates or a derived amount.

While the regulations generally outline the data used to calculate the QPA, there remains significant payer discretion on the sources of data, what data inputs to include or exclude, and the exact methodology for calculating the median. We are concerned that the proposed process gives too much power and discretion to payers. We urge the Departments to ensure that there are sufficient safeguards and monitoring of the payment calculation process. To give providers an ability to monitor the QPA determinations, we recommend that payers also be required to provide the methodology used to determine a particular calculation upon provider request.

Initial Payment Amount

The NSA and IFR require payers to make an initial payment (or send a notice of denial of payment) within 30 calendar days after the provider or facility submits a clean claim, as determined by the payer. The initial payment should reflect the amount that the payer intends to be payment in full and must be made even where the patient has not satisfied their deductible. If the provider accepts the initial payment amount (plus the patient's cost sharing), this amount will be treated as the "out-of-network rate."

We are concerned that, under the proposed payment system, payers will have an incentive to offer providers a low, insufficient initial payment amount. We urge the Departments to consider including a safety net in these payment calculations to protect against abuse and manipulation.

AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

For example, the final rule could set forth a minimum payment amount that is equal to the Medicare payment rate for the service. We recommend that the final rule develop a definition of a "reasonable offer" for the initial payment amount that would protect against underpayments to providers.

Independent Dispute Resolution Process

As the Departments continue to develop the structure of the Independent Dispute Resolution (IDR) process, including what information should be included in the arbiter's determination, timeline for decisions, batching of claims, and qualifications of arbiters, we urge the Departments to consider the burdens the IDR process could place on providers.

When a payment dispute arises, we are concerned that many providers – particularly small practice groups and individual practices – will not have the time nor the energy to compete with large insurers that have more resources at their disposal. As a result, these providers may effectively be forced to accept underpayments simply because they do not have the resources to challenge the payments within the IDR process. We urge the Departments to make the IDR process as simple and efficient for providers as possible. Otherwise, we fear that many providers will often have to accept underpayments by default.

Oversight of the IDR process is crucial to ensuring that the process leads to fair and timely results for participating parties and does not result in unnecessary administrative burden or cost. To that end, AMRPA asks the Departments to implement a continuous oversight process, which includes monitoring IDR decisions, to ensure there is no systematic arbiter bias.

Closing

We appreciate the Departments' engagement with AMRPA as our members navigate the NSA implementation process. We look forward to continuing our long-standing collaboration as the Departments refine and finalize policies, including those in this IFR and future NSA rule-makings.

Please let us know if we can provide any technical assistance or further information on our recommendations. If you have any questions, please do not hesitate to reach out to Kate Beller, AMRPA Executive Vice President for Policy Development and Government Relations (202-207-1132, kbeller@amrpa.org).

Sincerely,

Anthony Cuzzola
Chair, AMRPA Board of Directors

VP/Administrator, JFK Johnson Rehabilitation Institute

Mark Tarr
Chair, AMRPA Regulatory and Legislative Policy Committee
President and Chief Executive Officer, Encompass Health