September 7, 2021

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9909-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted via regulations.gov

RE: CMS-9909-IFC- Requirements Related to Surprise Billing; Part I

Dear Administrator LaSure:

Thank you for the opportunity to submit comments on the Requirements Related to Surprise Billing; Part I issued by issued by the Office of Personnel Management and the Departments of Health and Human Services ("HHS"), Labor, and the Treasury (collectively, the "Departments").

Community Catalyst is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with local, state and national advocates to leverage and build power so all people can influence decisions that affect their health. Health systems will not be accountable to people without a fully engaged and organized community voice. That's why we work every day to ensure people's interests are represented wherever important decisions about health and health care are made: in communities, state houses and on Capitol Hill.

We offer comments on the above Interim Final Rule implementing the No Surprises Act (NSA) to supplement other comments we have submitted: on June 30, 2021, in anticipation of federal rulemaking to implement the No Surprises Act (https://www.communitycatalyst.org/resources/comment-letters/document/No-Surprises-Act-Recommendations.pdf) and as one of the signers to a consumer and patient group letter submitted on September 7, 2021. The comments below highlight areas of particular concern to Community Catalyst and reflect our broader mission to organize and sustain a powerful community voice to ensure that all individuals and communities can influence the local, state and national decisions that affect their health.

Nationally, one in five people (23 percent) report having unpaid medical bills.[1] Ample evidence shows that surprise medical bills are one of the key factors contributing to medical debt.[2] Although medical debt affects people across socioeconomic and demographic backgrounds, people from historically oppressed and excluded populations – those who are Black, Latinx, Asian, Pacific Islander or Indigenous – incur substantial medical debt[3] and experience long-lasting financial consequences compared with their white counterparts.[4] Also disproportionately affected by medical debt are immigrants, people with disabilities, women, LGBTQ+ people, people with low-income or no health insurance. It is therefore critical that all solutions that aim to end surprise medical bills are developed through a racial justice and health equity lens. In applying this crucial lens, we call your attention, in particular, to the IFR provisions governing disclosure of balance billing protections, notice and consent to waive protections, and the complaints process. If not done right and with an eye toward the potential for a disparate impact on particular populations, implementation of the NSA may exacerbate inequities that put some individuals at far greater risk of medical debt.

We also want to offer comment on the health care settings and circumstances to which the NSA protections apply. We urge the Departments to take a more expansive view of facilities, recognizing that patients are receiving both emergency and non-emergency care in many different settings. Patients are often unaware of the distinctions among the various types of health care providers and the potential billing consequences of choosing, for example, an urgent care center, instead of a free-standing emergency department. One approach to more broadly defining health care facilities to which the NSA protections apply would be to include any and all in-network facilities where a physician or provider may bill independent of the facility, which would include urgent care centers as well as labs, imaging facilities, rehabilitation and physical therapy clinics, behavioral health and substance use disorder treatment facilities and potentially other facilities. Doing so is consistent with Congress' intent to provide comprehensive protections for surprise billing.

In our view, this is the strongest approach to hold consumers harmless from surprise bills arising from inadvertently and unknowingly receiving care from an out-of-network provider or facility, particularly give the rapidly changing landscape of health care facilities, including urgent care centers, retail clinics, and free-standing emergency departments. However, based on our research, we believe the Departments must encourage and work with states to better align federal and state policy with regard to the definition and licensing of facilities in this evolving and growing landscape. Our research has found that most states do not issue facility licenses for

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[1] Judy T. Lin, Christopher Bumcrot, Tippy Ulicny, Gary Mottola, Gerri Walsh, Robert Ganem, Christine Kieffer, Annamaria Lusardi. The State of U.S. Financial Capability: The 2018 National Financial Capability Study. Finra Investor Education Foundation, June 2019. https://www.usfinancialcapability.org/downloads/NFCS_2018_Report_Natl_Findings.pdf.

[2] Lindsey Bomnin and Stephanie Gosk. "Surprise medical bills lead to liens on homes and crippling debt." *NBC News*, March 19, 2019. https://www.nbcnews.com/health/health-news/surprise-medical-bills-lead-liens-homes-crippling-debt-n984371

[3] Neil Bennett, Jonathan Eggleston, Laryssa Mykyta and Briana Sullivan. 19% of U.S. Households Could Not Afford to Pay for Medical Care Right Away. U.S. Census Bureau, April 7, 2021. https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html.

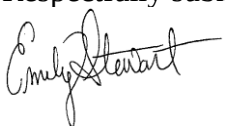
[4] Brianna Wells. Solving The Medical Debt Crisis. The Greenlining Institute, March 2021. https://greenlining.org/wp-content/uploads/2021/03/Greenlining-Medical-Debt-Crisis-Report-2021.pdf.

urgent care centers or retail health clinics.[5] Rather, these entities are generally operated under either an individual physician's license or, in the case of those affiliated with a hospital, under that hospital's license, thereby avoiding targeted oversight from state departments of health. Strengthened state licensing and regulation of urgent care centers and retail clinics is necessary to help ensure equitable distribution of these facilities and equal access for all consumers, including those who are uninsured or who rely on Medicaid.

We are also concerned that neither the statute nor the IFR defines hospital outpatient department within the definition of facilities. Leaving this term undefined will lead to confusion and uncertainty for consumers about when they can depend on the law's protections. It will also surely result in balance billing in circumstances and settings Congress intended to capture in the prohibition on surprise bills. We therefore recommend that the Departments define "hospital outpatient department" and to do so as broadly as possible, in order to meet Congressional intent to ban balance billing in all settings where consumers do not knowingly choose to receive out-of-network care.

Thank you for your consideration of these comments. We stand ready to work with the Departments to implement this historic and far-reaching consumer protection in an equitable and effective manner. If you have any questions, please contact Quynh Chi Nguyen at qnguyen@communitycatalyst.org.

Respectfully submitted,



Emily Stewart
Executive Director

[5] Community Catalyst and National Health Law Center. Making "Convenient Care" The Right Care For All: Improving State Oversight of Urgent Care Centers and Retail Health Clinics. https://www.communitycatalyst.org/resources/tools/convenient-care-report/pdf/Urgent-Care-Center-BriefAppendix-2.pdf