Texas Hospital Association

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September 7, 2021

Kari DiCecco
Internal Revenue Service
Department of the Treasury
Office of Associate Chief Counsel
c/o
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Via electronic submission to: http://www.regulations.gov

Re: CMS-9909-IFC

Dear Ms. DiCecco:

On behalf of our more than 470 member hospitals, the Texas Hospital Association is pleased to submit comments to the Centers for Medicare & Medicaid Services regarding CMS-9909-IFC (surprise medical billing). Protecting consumers from surprise medical bills is a priority for Texas hospitals. THA was a firm supporter of a surprise billing ban in Texas (S.B. 1264), which passed into law in 2019. THA's comments reflect experience from operational issues in implementing the surprise medical billing ban in Texas.

Diagnosis as a Factor for Emergency Care

Prohibiting health benefit plan issuers from denying payment for emergency care based on the ultimate diagnosis is paramount to preserving the health and safety of Americans and an important aspect of preventing surprise medical bills, because receiving emergency care services is one of several conditions invoking the surprise billing ban. Federal law prohibits health insurance plans that cover emergency care from requiring prior authorization for care provided in an emergency department of a hospital, regardless of whether the care is provided in- or out-of-network.[1] In addition, the Emergency Medical Treatment & Labor Act (EMTALA) prohibits a hospital from seeking, or directing an individual to seek, insurer authorization for screening or stabilization services until after the hospital has provided a medical screening examination and initiated stabilizing treatment.[2] For Medicaid managed care, under Texas law, "A health care MCO is prohibited from requiring an authorization for emergency services or for services to determine if an emergency condition exists."[3] Despite a clear prohibition on using prior authorization for lifesaving emergency care, health plans nationwide—including in Texas—have implemented policies tantamount to prior authorization for emergency care. These policies utilize features such as automatic payment for certain diagnosis but full medical record requests for other diagnoses in order for hospitals to obtain

[1] 29 CFR § 2590.715-2719A(b).
[2] 42 CFR 489.24(d)(4).
[3] 1 Tex. Admin. Code § 353.4(c)(2)(D).

payment after providing care in their emergency departments. Not only do these policies cause issues for prior authorization, they also condition payment on a patient's ultimate diagnosis, which runs contrary to the "prudent layperson standard." The prudent layperson standard defines emergency care subject to EMTALA and its treatment and reimbursement protections, defined under Texas law[4] below:

> "[E]mergency care" means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
> (1) placing the person's health in serious jeopardy;
> (2) serious impairment to bodily functions;
> (3) serious dysfunction of a bodily organ or part;
> (4) serious disfigurement; or
> (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

In a January 7 letter[5] to the health plans of Texas, Texas Department of Insurance Commissioner Kent Sullivan wrote, "Claim denials based on a failure to meet the prudent layperson standard for emergency care must be based on a review of the patient's presenting symptoms, not on the later diagnosis code." Moreover, a recent federal case[6] from the Eleventh Circuit Court of Appeals found a patient's "ultimate diagnosis" to be "irrelevant" as to whether the patient presented with an emergent condition under the prudent layperson standard. It is fundamental that the prudent layperson standard looks at a patient's health based on the patient's presenting symptoms, rather than their diagnosis. Despite this guidance, some health insurance plans have interpreted the definition of emergency care to include the patient's final diagnosis, rather than simply the presenting symptoms.

The preamble to the proposed rule includes a similar discussion:

> These interim final rules make clear that if a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, the plan or issuer must cover emergency services without limiting what constitutes an emergency medical condition (as defined in these interim final rules) solely on the basis of diagnosis codes. When a plan or issuer denies coverage, in whole or in part, for a claim for payment of a service rendered in the emergency department of a hospital or independent freestanding emergency department, including services rendered during observation or surgical services, the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation and be focused on the presenting symptoms (and not solely on the final diagnosis). This determination must take into account that the legal standard

[4] Tex. Ins. Code § 1301.155; Tex. Ins. Code § 843.002; Tex. Ins. Code § 4201.002.
[5] https://www.tdi.texas.gov/medical-billing/letter-to-health-plans.html
[6] Am. Coll. of Emergency Physicians v. Blue Cross & Blue Shield of Georgia, 20-11511, 2020 WL 6165852, at *1 (11th Cir. Oct. 22, 2020).

> regarding the decision to seek emergency services is based on whether a prudent layperson (rather than a medical professional) would reasonably consider the situation to be an emergency. In covering emergency services, plans and issuers must also ensure that they do not restrict the coverage of emergency services by imposing a time limit between the onset of symptoms and the presentation of the participant, beneficiary, or enrollee at the emergency department. Similarly, plans and issuers also may not restrict the coverage of emergency services because the patient did not experience a sudden onset of the condition.

This well-intentioned discussion; however, does not correspond to the language in the proposed rule which would only prevent a payor from "constituting" a medical emergency "*solely* on the basis of diagnosis codes" (emphasis added).[7] Diagnosis has not, and should not, be a factor in determining whether the prudent layperson standard for emergency care is satisfied. Using a diagnosis to retroactively define an emergency condition disregards the resources, time and clinical decision making required to screen and stabilize patients under EMTALA. However, most important, these policies can dissuade patients from seeking care when they believe they have an emergency condition. For example, if a patient comes to an emergency room with chest pain, the emergency physician will evaluate a patient and order tests to determine whether the patient is having a myocardial infarction, or something less severe. If the patient is suffering from a myocardial infarction, then the physician has a chance to save a patient's life. However, if the plan conditions payment on the diagnosis and the physician ultimately determines the patient is suffering from a less severe medical condition and not a heart attack, then the providers and the hospital are not fairly compensated for their efforts and the patient may very well be left with the unpaid balance. Because of the disagreement between the provider and the payor, there is underlying uncertainty as to whether emergency care was actually rendered and whether the balance billing prohibition applies. This is contrary to EMTALA and the intent of the prudent layperson standard.

THA proposes to remove the word "solely" from the language in all three proposed sections of the code[8] to read as follows: "Without limiting what constitutes an emergency medical condition (as defined in paragraph (c)(1) of this section) ~~solely~~ on the basis of diagnosis codes."

Post-Stabilization Services

THA appreciates the inclusion of post-stabilization services in the definition of emergency care subject to the balance billing prohibition because it creates a bright line rule resulting in a significant increase in fairness among the payor, the provider and the patient. The preamble of the proposed rule states that:

> [E]mergency services include any additional items and services that are covered under a plan or coverage and furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items and services are furnished) after a participant, beneficiary, or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the other emergency services are furnished. Such additional items and services (referred to in this preamble as post-stabilization services) are considered emergency services subject to surprise billing protections . . . .

[7] Proposed 26 C.F.R. § 54.9816-4T(b)(4); 29 C.F.R. § 2590.716-4(b)(4); 45 C.F.R. § 149.110(b)(4).
[8] *Id.*

The text of the proposed rule aligns with the purpose of the preamble, stating:

> Inclusion of additional services.—(A) Subject to paragraph (c)(2)(ii)(B) of this section, items and services—
> (1) For which benefits are provided or covered under the plan; and
> (2) That are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant or beneficiary is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in paragraph (c)(2)(i) of this section are furnished.[9]

Including post-stabilization services as part and parcel of the surprise billing prohibition removes unhealthy discourse between plans and payors as to when an emergency condition is "stabilized" and is simply better for patients. If payors and providers cannot agree on when an emergency condition ends, there is an inherent inefficiency in the payment system.

Thank you for your consideration of these comments. We look forward to working with you on these issues. Should you have any questions, please do not hesitate to contact me at cduncan@tha.org or 512/465-1539

Respectfully submitted,

Cameron Duncan
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Texas Hospital Association

[9] Proposed 26 C.F.R. § 54.9816-4T(c)(ii)(2); 29 C.F.R. § 2590.716-4(c)(ii)(2); 45 C.F.R. § 149.110(c)(ii)(2).