



September 7, 2021

The Honorable Elizabeth Richter
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9909-IFC
7500 Security Boulevard
Baltimore, MD 21244-8016

RE: Requirements Related to Surprise Billing Part 1

Dear Acting Administrator Richter:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the proposed rule on the requirements for the No Surprises Act as enacted in statute by Public Law 116-260.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 218,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

ASHA appreciates CMS's efforts to protect consumers from unexpected and exorbitant medical bills. ASHA's comments focus on the interim final policies proposed by the Office of Personnel Management (OPM), Internal Revenue Service (IRS), and the Department of Health and Human Services for the No Surprises Act.

Methodology for Calculating the Qualifying Payment Amount (Section VI. D.)

ASHA supports the proposed mechanism to assign value to patient cases that lack sufficient information to determine an average cost for their services.

However, ASHA is concerned that there is no mention of Current Procedural Terminology (CPT®) Category III codes or temporary codes for emerging technology. While many of these codes are not eligible for reimbursement, payers have the flexibility to provide coverage and determine pricing, as needed. Not mentioning these codes may precipitate inconsistent pricing practices among payers that adversely impact consumers. Therefore, ASHA encourages CMS to add explicit language related to the application of this rule to codes that would fall under "new technology" or CPT Category III.

Inclusion of Audiology and Speech-Language Pathology as "Ancillary Services"

ASHA recommends clarifying the broad applicability of the proposed rule across covered provider types including audiology and speech-language pathology. One way to accomplish this would be for CMS to establish a comprehensive list of provider types and/or services or clarify that the rules, absent explicit exclusions, apply to all covered provider types as 'ancillary services' as defined at Section 149.420(b)(1).

ASHA acknowledges that this rule focuses solely on facility-based and hospital outpatient providers. However, it is critical to have a parallel rule for freestanding private practices because

it is equally important for patients in freestanding private practice settings to have equivalent notice if their scheduled provider is out of network. The responsibilities should be clarified in writing to protect both the patient and provider. ASHA is concerned that the lack of this language will lead to patient dissatisfaction and significant billing concerns for the practice impacted.

Timing Requirements for Disclosure/Allowing for Patient Choice

ASHA appreciates the inclusion of specific language to the required timing of disclosure to the patient and what satisfies sufficient disclosure or opportunity for patient choice requirements. The rule fails to mention a policy applicable to requirements in place for outpatient services not connected to a facility. Since many audiologists and speech-language pathologists provide outpatient services, ASHA maintains that it is necessary to include explicit language for both inpatient and outpatient scenarios.

In an outpatient setting, it is possible that a patient may seek care in a multispecialty practice where a specific type of provider (e.g., ear, nose and throat specialist) is in the patient's network, but the therapy provider (e.g., audiologist) may be out-of-network. ASHA recommends that CMS issue guidance to these practices on necessary protocols to put into place to prevent noncoverage of a certain portion of a patient's care.

While Section 149.420(c)B(2) of the rule presents the required timeframe of notice and consent procedures, ASHA recommends that CMS clarify that the *72-hours* and the *3-hours* expectation represent a minimum timeframe and—following a best practices perspective—providers should give notice upon scheduling or as soon as possible.

In regard to ensuring voluntary consent, ASHA urges CMS to provide more details on the type of coercive behavior that would violate patient protections. In addition, ASHA recommends that patients have an in-network option in scenarios when they choose to waive their out-of-network billing protections. Without an in-network option, the patients' choice to waive their protections may not be voluntary at all.

Conclusion

ASHA supports eliminating surprise billing and most of the provisions within this proposed rule. The proposed rule allows for patients to continue to drive their own care; thereby, empowering them to be informed consumers. It protects both patients and providers, allowing patients more notice and control of their financial responsibilities. The rule may also reduce provider burden related to paperwork, billing, and potential litigation.

ASHA appreciates the opportunity to submit these comments for your consideration. If you or your staff have any questions, please contact Jacob Manthey, ASHA's director of health care policy for private health plans and reimbursement, at jmanthey@asha.org.

Sincerely,



A. Lynn Williams, PhD, CCC-SLP
2021 ASHA President