Virginia College of Emergency Physicians

MSV MEDICAL SOCIETY OF VIRGINIA

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION
An alliance of hospitals and health delivery systems

Emergency Department EDPMA Practice Management Association

SENT VIA FEDERAL EXPRESS AND ELECTRONIC MAIL

July 13, 2021

The Honorable Xavier Becerra (Xavier.Becerra@hhs.gov)
Secretary, U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Chiquita Brooks-LaSure (Chiquita.Brooks-LaSure@hhs.gov)
Administrator, Centers for Medicare and Medicaid Services U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Virginia DMAS State Plan Amendment on ED Utilization – No Surprises Act Provisions

Dear Secretary Becerra and Administrator Brooks-LaSure:

We previously wrote to you on June 21, 2021, regarding our inquiries on two Virginia Department of Medical Assistance Services (DMAS) programs to automatically downcode emergency department ("ED") visits for "potentially avoidable" emergency care services based on the final principal diagnosis code (the "Downcoding Provision"). We are writing now to bring to your attention provisions of the recently released interim final rule promulgating regulations for the No Surprises Act, which includes provision that are relevant to our previous inquiry.

On July 1, 2021, the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury (collectively, the Departments), along with the Office of Personnel Management (OPM) released an interim final rule with comment period (the "IFC"), entitled "Requirements Related to Surprise Billing; Part I." This rulemaking related to Title I (the No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021, and establishes new protections from surprise billing and excessive cost-sharing for consumers receiving health care items and services.

Of interest, the IFC includes lengthy discussion of policy concerns related to the prudent layperson standard, which is central to our position that the Downcoding Provision is unlawful and inappropriate. Beginning at p. 29 of the pre-print document CMS-9909-IFC, the IFC establishes that for purposes of the regulations, the definition of emergency medical condition is consistent with the prudent layperson standard included in the Emergency Medical Treatment and Active Labor Act (EMTALA):

> The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in EMTALA, including (1) placing the health of the individual (or, with respect to a pregnant woman,

> the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. This definition includes mental health conditions and substance use disorders.

IFC at pp. 29-30.

The IFC then highlights that the Departments are aware that some plans and issuers currently deny coverage of certain services provided in the emergency department of a hospital by determining whether an episode of care involves an emergency medical condition *based solely on final diagnosis codes* – the exact practice used in the Downcoding Provision. The IFC unequivocally states:

> These practices are inconsistent with the emergency services requirements of the No Surprises Act and the ACA. This is true even if the process for complete consideration of the claim following an initial denial is not designated as a formal appeal. Instead, the determination of whether the prudent layperson standard is met must be made on a case-by-case basis before an initial denial of an emergency services claim.

IFC at p. 30.

To address this impropriety, the interim final rule makes 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 solely on the basis of diagnosis codes*. This provision is expressly included at 45 C.F.R. § 149.110(b)(4) and 29 C.F.R. § 2590.716-4(b)(4) of the regulations.

The IFC goes on to state that:

> 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 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.

IFC at pp. 30-31 (emphasis added).

As explained in detail in our previous correspondence, DMAS's SPA 20-0012, Emergency Room Claims for the Downcoding Provision automatically reduces payment for any claim with a final principal diagnosis appearing on a list of almost 800 different diagnosis codes. Beyond our continued assertion that the Downcoding Provision violates existing federal statutes and regulations, it is in clear conflict with the policy adopted by the Departments that no claim for payment of a service rendered in the emergency department of a hospital or independent freestanding emergency department can be denied, in whole or in part, based solely on the final diagnosis. This determination must be based on all pertinent documentation and be focused on the presenting symptoms and must take into account that the legal standard regarding the

decision to seek emergency services is based on whether a prudent person would reasonably consider the situation to be an emergency. The Downcoding Provision has the exact opposite effect.

On behalf of the members of our associations, we again urge CMS to reject SPA 20-0012 for the Downcoding Provision. We believe the Downcoding Provision violates applicable federal law, regulations, and CMS guidance for reasons described at length in our correspondence and should be rejected on these grounds alone. Now, the release of the interim final rule and provisions submitted above provide even further basis for rejecting the Downcoding Provision. Any policy based on the prudent layperson standard that applies to group health plans, health insurance issuers, carriers under the Federal Employees Health Benefits (FEHB) Program should surely apply the Medicaid program and enrollees as well.

Thank you again for your attention to this important matter and please do not hesitate to contact us. We would welcome the opportunity to further discuss our concerns with you.

Sincerely,

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Enclosures

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