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RE: Requirements Related to Surprise Billing; Part II,
CMS–9908–IFC: RIN 0938–AU62, Vol. 86, No. 192/Thursday, October 7, 2021

Dear Ms. Bodenheimer, Mr. O'Donnell, Mr. Mazur, Mr. Khawar, and Mr. Becerra:

The Hospital and Healthsystem Association of Pennsylvania (HAP) represents approximately 240 member institutions, including acute and specialty care, primary care, subacute care, long-term care, home health, and hospice providers, and the patients and communities they serve, and we greatly appreciate the opportunity to comment on the second set of regulations implementing the No Surprises Act (referred to as "Part II").

We strongly support protecting patients from gaps in health care coverage resulting from unanticipated medical bills and believe the No Surprises Act as envisioned by Congress will extend such protections. Our comments regarding the second set of implementing regulations pertain to three specific areas: the independent dispute resolution (IDR) processes; the good faith estimates for self-pay and uninsured patients for scheduled services; and the patient and provider dispute resolution process.

Federal IDR Process: At the outset, HAP is profoundly concerned that the departments overly tilted the No Surprises Act IDR process in favor of plans and issuers. This decision will have a direct impact on patient access to care in our community.

Through this decision, plans and issuers are given significant advantages on two fronts: first, they can obtain favorable reimbursement rates by pushing a provider out-of-network, and second, and they will gain substantial leverage to walk away from negotiations with providers that are unable to accept unreasonable contractual terms—which may have nothing to do with rates. As a result, we expect plans and issuers in our market to further restrict their network offerings. While patients may still retain access to care covered through the No Surprises Act, scheduling care will become much more challenging as there may be no ancillary or other providers in-network who will be able to see the patient.

The policies in the interim final rule direct arbiters to begin with the presumption that the plan's or issuer's median contracted rate is the appropriate out-of-network reimbursement rate. It then sets a high bar for the consideration of other factors. As a result, the IDR process becomes effectively unavailable to providers.

Yet one needs only to look to the No Surprises Act to understand that this is not what Congress envisioned or set forth in statute. The law establishes an IDR process to determine out-of-network rates for specified services following an initial payment and an open negotiation period.[1] By statute, an IDR entity is required to choose between the offer submitted by the provider/facility and the one submitted by the plan/issuer.[2] The statute mandates that, in making its payment determination, the IDR entity "shall consider" a specified list of factors, including the following:

- the median in-network payment rate (the "qualifying payment amount" or "QPA")
- the level of training, experience, and quality and outcomes measurements of the provider or facility
- market share of each party
- acuity of the individual
- teaching status, case mix and scope of services of the provider/facility
- demonstration of good faith efforts by the parties to enter into network agreements over the previous four years
- any other factors that the parties may wish to submit for consideration with several explicit prohibitions[3]

Rather than honoring this statutory requirement, the departments instead have chosen to make the QPA the presumptively appropriate payment amount, relegating all other factors to second-tier status, to be considered only as what the interim final rule preamble refers to as "rebuttal evidence" to demonstrate that the QPA is materially different from the appropriate out-of-network rate. The departments lack the authority to put their collective thumb on the scale in this manner. Congress expressly mandated that the IDR entity consider ***all*** of the specified

[1] Public Health Services Act (PHSA) § 2799A–1(c).
[2] *Id.* § 2799A–1(c)(5)(A).
[3] *Id.* § 2799A–1(c)(5)(C).

factors in rendering its decision. The statute does not contemplate the weighting of factors or the transformation of any of the factors to "rebuttal" status.

The final rule erects multiple extra-statutory barriers to the consideration of any factor other than the QPA, including requirements that the non-QPA factors be based on "credible information" and that a party must "clearly demonstrate" that the QPA is "materially different from the appropriate out-of-network rate." These barriers impermissibly limit the IDR entity's ability fully to consider ***all*** of the statutory factors. In so doing, the rule fundamentally alters the statutory structure and guts the independence of the IDR entity. For these reasons, these provisions in the interim final rule are contrary to law, arbitrary and capricious, and otherwise violate the Administrative Procedure Act (APA).

Congress Did Not Delegate the Departments the Authority to Alter the Way an IDR Entity Determines the Appropriate Payment Amount: Congress in no way delegated to the departments the power to establish this one-sided presumption in the IDR process. Quite the contrary, both the statute and legislative history of the No Surprises Act establish that the IDR entity—and not the departments—is vested with independent authority to evaluate all of the statutory considerations and relevant information, and then to choose between the provider's and payor's out-of-network payment offers. By establishing an ***independent*** review entity, Congress made clear that the payment determination itself is outside the purview of the departments.

The departments have essentially eviscerated the independence of the IDR entity by requiring it to presume that the QPA is the appropriate payment amount. Under the interim final rule, the IDR entity is independent in name only; its "determination" of the appropriate payment amount is essentially a foregone conclusion. In order to overcome the presumption that the QPA governs, the IDR entity must receive "credible information" that "clearly demonstrates" the QPA is "materially different" from the appropriate out-of-network payment rate. The statute simply cannot be interpreted to authorize the departments to so limit the IDR entity's role.

The Restrictions on the IDR Entity are Arbitrary and Capricious: The departments have failed to explain adequately why they possess authority to require the IDR entity to defer to the QPA, and why the other factors should be relegated to second-tier consideration. The departments' policy arguments are similarly inadequate—they ignored information contrary to their preferred outcome and premised their decision-making on illogical assumptions. As a result, the restrictions spelled out in the interim final rule are arbitrary and capricious.

In making this determination, the departments have committed several policy errors. First, they view the QPA to "be a reasonable out-of-network rate under most circumstances."[4] In fact, without reference to the other statutory factors, the median ***in-network*** payment does not rationally correlate to what an ***out-of-network*** provider should be paid. Providers and payors

[4] 86 Fed. Reg. 55,980, 55,996 (Oct. 7, 2021).

consider many factors when deciding whether to enter into a contract. Factors that may be relevant to one provider may not be relevant to another, which means that the median contracted in-network rate may not be the appropriate payment level for all providers. Moreover, weighting the QPA also creates perverse incentives for payors. It is the responsibility of payors to maintain comprehensive provider networks, and making the QPA the presumptively appropriate payment amount removes incentives for payors to contract with providers or offer fair terms.

Second, the departments err in asserting that making the QPA the presumptively appropriate payment amount "will reduce the use of the Federal IDR process over time and the associated administrative fees born by the parties, while providing equitable and clear standards for when payment amounts may deviate from the QPA, as appropriate."[5] First, few out-of-network claims actually go through arbitration in the first place.[6] To the extent that establishing the QPA as the presumptively appropriate payment amount would reduce the number further, that is only because the departments have tipped the scales unfairly in favor of payors.

Finally, the departments' contention that the IDR entity's deference to the QPA will help limit increases in individuals' insurance premiums[7] is also misplaced. Arbitration itself has not been shown to increase health care premiums. New York State regulators report there has not been any indication to date of an inflationary effect on insurers' premiums.[8] In addition, there is nothing in the law or regulation that requires the plans or issuers to pass savings from this provision onto their enrollees, and we question any reliance on the medical loss ratio policy to instill some check on plan and issuer profits.

[5] 86 Fed. Reg. at 55,985.
[6] https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Testimony-Nickels-Surprise%20Billing%20Hearing_061219.pdf
[7] *See* 86 Fed. Reg. at 55,996–98.
[8] *https://nationaldisabilitynavigator.org/wp-content/uploads/news-items/GU-CHIR_NY-Surprise-Billing_May-2019. pdf*

Good Faith Estimates and Patient-Provider Dispute Resolution Comments: Through this interim final rule, the U.S. Department of Health and Human Services (HHS) implements the No Surprises Act good faith estimate requirements for uninsured and self-pay patients scheduling or shopping for care, as well as the patient-provider dispute resolution process. We support policies that help patients access the information they need when making decisions about their care, including information about their potential costs**,** but we have a number of operational concerns that we request be addressed through further guidance in order to reduce inefficient and impractical processes.

Price Transparency Policy Alignment: We urge HHS to further assess the policy changes needed to remove duplication and fully align the federal price transparency requirements. The departments began the work of reducing duplication and aligning *insurer* price transparency policies in their recent FAQ,[9] which addressed overlaps in the No Surprises Act and Transparency in Coverage requirements. However, we believe more is needed to also align the ***provider*** requirements**.**

The first Hospital Price Transparency requirement, or the creation of machine-readable files, provides researchers and other non-patient stakeholders' access to a hospital's negotiated, self-pay, and chargemaster rates. In this interim final rule, HHS asks whether these files can be used by a convening provider or facility to collect co-provider or co-facility estimated charges. We continue to question the value of such files generally, and, in particular, disagree with HHS' suggestion that they could have any utility in meeting the uninsured and self-pay patient good faith estimate requirements. Not all provider or facility rates exist in the machine-readable files since only hospitals are required to publish these files. Therefore, this data only would be available for some co-facility items or services. Even in instances when the convening provider or facility needs information on items or services included on a co-facility's machine readable file, the files do not contain the needed information, as they only include the generic self-pay rate, while the good faith estimates, as we understand them, require individualized self-pay rates that are reflective of any available discounts for the patient. Moreover, without contacting the co-facility directly from the start, the convening provider or facility would not necessarily know which items or services would be delivered during the course of care. Therefore, using these files would not remove a step in the process but instead add an unnecessary one.

The second Hospital Price Transparency requirement, often referred to as the shoppable service requirement, better aligns in purpose with the uninsured and self-pay good faith estimates but differs slightly in expected output and delivery method. Most hospitals are choosing to fulfill the shoppable service requirement through the use of an online patient cost estimator tool.

[9] Departments of Health and Human Services, Labor, and Treasury. FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49. August 20, 2021. Available at: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/FAQs%20About%20ACA%20%26%20CAA%20Implementation%20Part%2049_MM%20508_08-20-21.pdf

Good Faith Estimate: The interim final rule requires convening providers and facilities to deliver good faith estimates to patients within one business day for services scheduled between three and nine days in advance and within three business days for services scheduled at least 10 days in advance or in instances when an estimate is requested prior to scheduling. In order to create a compliant good faith estimate, a convening provider or facility will need to gather a significant amount of information, often from multiple sources such as from any co-provider or facility. This would include information on the expected items and services to be delivered and their charges reflective of any available discount for the specific patient.

The convening provider or facility must also compile information on all providers/facilities involved in the period of care, such as National Provider Identifier (NPI) numbers and Taxpayer Identification Numbers (TIN). Completing this task in three days while also completing all existing administrative functions will require significant planning and workflow adjustments, as well as the hiring of new staff as this level of workload cannot be borne by the existing workforce.

In order to avoid delays in patient care, we urge HHS to streamline these requirements by allowing patients who are shopping to use online cost estimator tools and clarifying that financial assistance eligibility determinations must only be done for those patients who request it or may be reasonably expected to meet the criteria, as well as assist in the development of tools to automate these processes.

Additionally, the good faith estimates are much more labor intensive than the online tools, as they require additional layers of specificity (e.g., accounting for how health status may alter the course of care, financial assistance eligibility) and, therefore, will need to be completed manually in most, if not all, instances. The additional information required by the good faith estimates is more likely to be known for patients scheduling services, as opposed to those who are shopping for services and may not yet have a relationship with the provider. Attempting this level of specificity with the limited information available about a patient shopping for care is not workable and is duplicative when the patient can instead access equally reliable cost estimates through the automated online cost estimator tools.

We recommend utilizing patient cost estimator tools, when available, for all instances when a patient is shopping for care and only requiring the delivery of good faith estimates when a service is scheduled or a cost estimator tool is not available. Specifically, we encourage HHS to deem hospitals with Hospital Price Transparency rule-compliant patient estimator tools to also be in compliance with the good faith estimate requirements for patients shopping for care.

Co-provider/Co-facility Compliance Date and Timeline: HHS indicates in the interim final rule that it will utilize enforcement discretion regarding the collection of good faith estimates from co-providers and co-facilities until January 1, 2023. Although we appreciate this delay in enforcement, the necessary steps that hospitals and health systems must complete to

implement the requirement likely will require additional time. There is currently no method for unaffiliated providers or facilities to share good faith estimates with a convening provider or facility in an automated manner. In order to share this information, billing systems would need to be able to request and transmit billing rates, discounts, and other necessary information for the good faith estimates between providers/facilities. This is not something that practice management systems can generally do, since billing information is traditionally sent to health insurers and clearinghouses, not other providers/facilities. Practice management systems utilize standard electronic transactions to send information to other stakeholders, many of which are codified under the Health Insurance Portability and Accountability Act. This allows providers and facilities to utilize the same transaction across all health insurers and clearinghouses, eliminating the administrative burden of adhering to idiosyncratic technology platforms. The current administrative transactions do not allow for provider-to-provider communications though, so they would not be usable for development of the good faith estimates.

To ensure that co-provider and co-facility information can be accurately and efficiently collected, HHS should identify a standard technology or transaction that would enable convening providers and facilities to automate the creation of comprehensive good faith estimates.

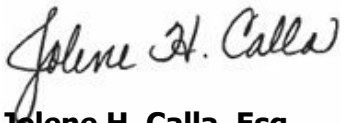
Amount of Variation to Trigger Eligibility for the Patient/Provider Dispute Resolution Process: The interim final rule provides a framework for addressing instances when a good faith estimate is lower than the patient's final bill. These provisions specify that when a patient's bill for a particular provider or facility's services is $400 or higher in excess of that provider or facility's good faith estimate, the patient is eligible to initiate the select dispute resolution process. Although we agree with efforts to ensure that patients do not receive unexpectedly high medical bills, the $400 barometer will likely create an inordinate amount of disputes for legitimate, medically necessary reasons, especially for uninsured and self-pay patients who are not sharing costs with an insurer.

The delivery of first-rate medical care and procedures can be expensive, particularly for complex care involving costly drugs or innovative technologies. All Americans should have access to affordable, comprehensive health insurance coverage as it enables patients to undergo necessary medical procedures and incur the associated costs without experiencing debilitating financial peril. Without insurance, slight changes in medically necessary care can increase the overall cost, leaving even the most diligent patients and transparent providers with unexpected changes in the cost of care.

A $400 threshold to trigger a dispute resolution process is impractical. Slight changes during complex medical treatments would frequently trigger a $400 cost increase, which could lead to an excessive number of disputes going before the select dispute entities. For example, a patient who is under anesthesia for surgery for 135 minutes instead of 120 would quickly surpass this figure, despite the $400 being only a minor amount of the overall bill.

In order to ensure that the dispute resolution process is reserved for instances in which good faith estimates are substantially inaccurate, we strongly encourage HHS to instead require a final bill to be at least 10 percent in excess of the good faith estimate for it to be eligible for the dispute resolution process.

Respectfully,



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