AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

The Honorable Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: Docket No. CMS-2021-0156, Surprise Billing Interim Final Rule; Part 2; Center for Medicare and Medicaid Services Interim Final Rule and Request for Comments

Dear Ms. Brooks-LaSure:

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Surprise Billing Interim Final Rule; Part 2. Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include 94 hospitals and more than 600 other health care facilities across the nation. AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to urban areas of California. With such diverse facilities, populations served and geographic locations, we strive to provide objective and sound policy recommendations that work well for health care as a whole.

While we support the goals of the *No Surprises Act*, we are concerned with many of the provisions within this rule, particularly the short implementation timeframe and the lack of alignment with congressional intent. Congress spent a year debating how to best settle Out-of-Network (OON) claims because they did not want to create a process that unfairly benefited one party over the other. Relying solely on the Qualifying Payment Amount (QPA) during the Independent Dispute Resolution (IDR)process will ultimately lead to narrower provider networks and increased patient costs—an outcome contrary to Congress' intent.

The regulation also fails to account for the momentous pressure that health providers find themselves under in combating the COVID-19 public health emergency. In just a couple of months, providers have been subject to many new regulatory requirements, including compliance

with OSHA's temporary standard and the Omnibus COVID-19 Health Care Staff Vaccination requirements. Digesting these regulations and ensuring compliance requires significant time and resources, adjustments to contracts and operating agreements, the establishment of new processes, internal education campaigns, as well as changes to existing policies and procedures.

Additionally, the burden of compliance has fallen mostly on health providers and facilities. While we have only been granted a few months to comply, most of the provisions within the No Surprises Act impacting insurers and payers have been delayed. We believe that this unfairly puts the onus on providers at a time where resources are limited and health care workers are already stretched thin. On July 9, 2021, President Biden signed Executive Order (EO) 14036, which, among other things, argued that hospital consolidation can negatively impact quality of care. [1] The EO stated that "hospital consolidation has left many areas, particularly rural communities, with inadequate or more expensive healthcare options." We are concerned that the many requirements put on health providers might create an environment where rural or small physician practices and facilities view consolidation as the only option to surviving the surmounting regulatory burdens. A report from the HHS' Office of the Inspector General stated that during the pandemic, hospitals have been operating in "survival mode" due to increased costs and decreased revenues.[2] The COVID-19 pandemic has created staffing and equipment shortages that continue to strain providers and increase costs, further undermining hospitals' ability to provide access to care. Considering these challenges and the existing regulatory environment, AHPA requests that CMS delay the requirements included in this rule by an additional year.

Below we offer additional comments and recommendations on the following issue areas within the rule:

- Independent dispute resolution process
- Good faith estimates
- Patient – provider dispute resolution process

[1] Executive Order on Promoting Competition in the American Economy
[2] HHS OIG: Hospitals Reported That the COVID-19 Pandemic Has Significantly Strained HealthCare Delivery

- Disclaimers
- Requirement to Share Advanced Explanation of Benefits Transaction

Independent Dispute Resolution Process

As stipulated by the No Surprises Act, the IDR process is available to providers, facilities, plans and issuers in the event that an agreement cannot be reached on an Out-of-Network (OON) reimbursement amount. Providers, facilities, plans and issuers must first complete a 30-day "open negotiation" period to determine the OON payment amount. If the parties cannot come to an agreement, either party may initiate the IDR process.

AHPA cannot support the IDR process as it currently stands. Below we discuss in depth our concerns with some of the policies outlined in the rule.

Usage of the Qualifying Payment Amount Calculation in the IDR process

A major concern in the IDR process is the application of the QPA as the most significant factor to be used in determining the OON rate. According to the rule, arbiters must select the offer closest to the QPA. As mentioned in our comments in response to the first interim final rule, the current QPA methodology is inappropriate because it is based on median contracted rates, which are significantly lower than average commercial rates.

Additionally, using the QPA as a payment benchmark goes against what was specified in the No Surprises Act. The statute lists the QPA as one of many factors that an arbiter should consider when determining an OON rate. Examples of other factors to consider include the provider's level of training, the market share and the patient's acuity. Therefore, CMS' policy goes against what is written in the statute and will result in an unequitable process that will have grave negative consequences on the health care industry and access to care. Below is the specific language on the No Surprises Act regarding the determination of an OON rate during the IDR process.

> ‘‘(i) IN GENERAL. — In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR item or service shall consider—
>
> ‘‘(I) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and
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> ‘‘(II) subject to subparagraph (D), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).
>
> ‘‘(ii) ADDITIONAL CIRCUMSTANCES. — For purposes of clause (i)(II), the circumstances described in this clause are, with respect to a qualified IDR item or service of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer of group or individual health insurance coverage the following:
>
> ‘‘(I) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act).
>
> ‘‘(II) The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.
>
> ‘‘(III) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.
>
> ‘‘(IV) The teaching status, case mix, and scope of services of the participating facility that furnished such item or service.
>
> ‘‘(V) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network.

Usage of the QPA as a Price Ceiling

By using the QPA calculation as a payment benchmark, CMS has effectively established a price ceiling for items and services rendered by providers and facilities. It puts the payor at the helm in the open negotiation period, creating a system that removes any leverage that providers and facilities have in the negotiation process. This policy effectively negates the intent of the IDR process altogether. Why would payors make a good faith effort to provide a reasonable payment offer during the negotiation period if they know that the QPA will be the de-facto payment

chosen in the IDR process? Why would providers attempt to seek a fair resolution through the IDR process and risk having to pay additional fees? The process established in this rule provides payors with an unabridged path to strong-arm providers to accept below market payments for services rendered. Providers will therefore be left with virtually no options other than settling in the negotiation period or be faced with additional administration fees to enter the IDR process.

Due to these reasons, AHPA strongly opposes the use of the QPA as a payment benchmark. The implications of what this policy would entail are already being witnessed. For example, Blue Cross Blue Shield of North Carolina has solicited letters to providers seeking an immediate reduction in rates under their commercial agreements.[3] The payor stated that, because of the coming QPA calculations in the No Surprises Act, "there is already enough clarity to warrant a significant reduction in contracted rates." These payment reductions could negatively affect providers and facilities by making it harder to establish in-network rates at reasonable market value. Without adequate in-network payments, there will be significantly less incentive to be an in-network provider or facility. Ultimately, patients' access to care will be limited as a result of this policy.

To avoid the issues referenced above, we again recommend that the Agency use a third-party entity, such as FAIR Health, to ensure that all parties have equal access in determining an OON rate. FAIR Health has a database that maintains the average billed charges for providers by geographic regions. Using a third-party entity to establish the QPA calculations would allow all parties to go to an impartial source to calculate the non-par payment, providing more transparency in the process. Otherwise, there is no guarantee that such rates will not be manipulated by payors. Just this month, a Nevada jury ruled in favor of three Nevada-based health providers that took legal action against United Healthcare. The jury found that the insurance company engaged in unfair and abusive reimbursement practices by deliberately failing to pay emergency room doctors adequately for care provided. [4] This is an example of why

[3] Letter to Providers from the BCBS Association
[4] TeamHealth: Nevada Jury Finds UnitedHealthcare Guilty of Oppression, Fraud and Malice

we believe that a third-party, instead of payors, should be the ones determining OON rates, particularly if the QPA is the only factor considered in the IDR process.

Good Faith Estimates

Beginning on January 1, 2022, the rule requires health providers to offer good faith estimates to uninsured and self-pay individuals prior to all scheduled services or by request if the patient is shopping for care. The good faith estimate must include all expected charges for items or services provided by the initial provider (referred to as the convening provider) and any co-provider or co-facility that will also render items or services for the scheduled service. CMS is deferring enforcement of the good faith estimates for insured patients until they are able to issue a rule that includes "establishing appropriate data transfer standards." The rule notes that they have heard from stakeholders about the infeasibility of implementing the requirements by January 1, 2022, given the significant technical infrastructure needs.

AHPA supports the provision of good faith estimates as many of our AHPA-member health systems have been doing so for many years. However, we believe that the amount of information that is required to be included in the good faith estimates is not feasible and will generate a great burden on providers and facilities. Below we discuss in depth our trepidation to the new good faith estimates requirements.

Timeline for Implementing Convening Provider Responsibilities

In accordance with the No Surprises Act, the rule requires certain providers and facilities to assume the responsibility of providing their own good faith estimate as well as collecting the pricing of items and services from any other co-provider or co-facility contributing to the scheduled service. This rule defines the convening provider as the health care entity who receives the initial request for a good faith estimate from an uninsured or self-pay individual. CMS states that for 2022, it plans to exercise enforcement discretion in situations where the estimate leaves out charges from co-providers and co-facilities. The relaxed enforcement

recognizes the need for "additional implementation time to develop appropriate communication channels that may not yet exist among various co-providers or co-facilities."

AHPA commends CMS for exercising this enforcement discretion and urges the agency to delay this requirement, similar to how it has done for insured patients, until the necessary technological infrastructure exists. Currently, convening providers do not have the ability to compile the items or services that would be rendered from other co-providers and co-facilities as required by the good faith estimate policy. Providers and facilities often have different Electronic Health Record (EHR) systems that do not communicate with each other, making the exchange of the price estimates difficult. Therefore, health providers would need to obtain all the information required via phone calls, which is overly burdensome and can take multiple efforts to obtain. At a time of nationwide staffing shortages, doing this is not feasible.

Before implementing any convening provider requirements, we recommend that CMS work closely with EHR vendors and health providers to develop such technological infrastructure and test it for a period of time before enforcement. CMS should also consider investing resources to develop the needed technology, particularly considering the disparate resources that health providers and facilities have based on their size and geography. Additionally, we recommend that CMS develop a new standard transaction with operating rules that would allow providers and facilities to exchange the required information in a uniform way.

For insured patients, we also urge the Agency to consider making payors the de-facto convening entities for collecting the good faith estimates of all providers and facilities involved in a scheduled service. Payors are already the owners of this information, including contracted rates and patients' copays and deductibles. Providers do not have immediate access to this information and consolidating it would lead to increased overhead costs. Because of this, payors are better fitted to provide such information to their enrollees rather than placing this undue administrative burden on health providers, whose focus should be on patient care. Health providers and facilities, upon scheduling a service, could be required to provide the payor with primary diagnostic codes associated with the service, along with the National Provider Identifier (NPIs) numbers of those that will be involved in the patient's care. The payor would then be able

to identify the price for all items and services and be in a better position to provide the patient with an accurate estimate. The provider or facility scheduling the service, could also provide a notice to the patient, similar to the MOON form, containing their individual good faith estimate and instructing the patient to contact their insurer to view the total estimate for all other services and items associated.

Changes in a Provider or Co-Providers Ability to Fulfill a Good Faith Estimate

The rule requires that in circumstance where a provider or facility is not able to furnish a service or item originally included in the good faith estimate, the convening entity must issue a new good faith estimate no later than one business day before the scheduled service is provided. If this change happens less than one business day before the service is scheduled to be furnished, the replacement provider or facility must accept the original provider or facility's good faith estimate price. CMS seeks comment on whether this policy could have unintended consequences, such as delays in care, if providers and facilities were to refuse to serve as replacements.

AHPA believes that this policy could have the unintended consequence of reducing access to care for patients. **In situations where a provider or facility is no longer able to provide a service, we recommend for the service to simply be rescheduled, allowing the convening provider or facility to create a new good faith estimate with the replacement provider or facility.** Individuals should also be given the choice to accept the changes made to the good faith estimate by the replacement provider before trying to reschedule the service.

Timeline for Good Faith Estimates

The rule establishes a timeline for the convening provider or facility to provide an uninsured or self-pay individual with the requested good faith estimate. The convening provider must deliver the good faith estimate within one business day if the scheduled service is taking place within nine days. If the scheduled service is taking place after 10 days or if the individual is shopping for care, the good faith estimate must be provided within three business days. The convening provider will have one business day to consult with all co-providers to collect their fees for items or services.

AHPA believes that this timeline does not allow adequate time for the convening provider to gather, review and produce *accurate* good faith estimates. As we discussed earlier, the technological infrastructure allowing the seamless exchange of information between providers and facilities is currently limited. Therefore, the timelines set forth in this rule are overly ambitious and are setting the convening provider up for failure. Due to the dispute resolution process outlined below, providing an accurate estimate will be essential to avoid having most claims disputed, an issue that would only frustrate patients further and threaten providers' viability.

While we agree that providing good faith estimates in a timely manner is needed, we request that the window for delivering such estimates be extended to allow more time for providers and facilities to present an accurate estimate. We believe that an appropriate timeline would be:

- Within one business day if the scheduled service will be furnished within five days.
- Within seven business days if the scheduled service will be furnished in more than five days.

Price Transparency Policy Alignment

We urge CMS to assess the policy changes needed to remove duplication and fully align the federal price transparency requirements. The first Hospital Price Transparency requirement, 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, CMS 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 and disagree with CMS' 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. **We recommend CMS streamline the price transparency and surprise billing requirements by allowing the utilization of patient cost estimator tools, when available, for all instances when patients are shopping around for care and only require the delivery of good faith estimates when a service is scheduled, or a cost estimator tool is not available.**

Patient – Provider Dispute Resolution Process

The rule establishes a patient-provider dispute resolution process for instances when an uninsured or self-pay patient's billed charge is "substantially in excess" of the total quoted price in the good faith estimate. "Substantially in excess" is defined as exceeding $400 or more than the total amount of expected charges listed on the good faith estimate. This rate was established based off a 2019 report from the Federal Reserve, which found that nearly four in 10 adults would have difficulty covering an emergency expense costing more than $400.

While we appreciate CMS' consideration for what is financially viable for the consumer, we think that the $400 dollar limit is arbitrary as this is a very narrow amount. This policy, paired with the requirement for good estimates to be provided in a short period of time, would make nearly every claim eligible for dispute resolution. This would result in a backlog of cases similar to the backlog experienced by providers with Administrative Law Judges (ALJs) reviewing claims denied by Recovery Audit Contractors. This policy would create a financial hardship on providers and generate more frustration among patients. **With this in mind, we recommend for "substantially excess" to be defined as a bill that is at least 10% in excess of the good faith estimate instead of using $400 as the benchmark.** The $400 limit completely overlooks and inappropriately marginalizes the myriad of reasons outside of the provider's control that may cause an estimate to be incorrect.

There are several reasons why an estimate can easily exceed $400. First, providers may have the correct primary billing CPT code but the additional billing codes for supplies, drugs and Operating Room (OR) time may cause estimates to be imperfect. As an example, a physician may have taken longer than expected in the OR, which would increase the amount of the overall claim. Providers also have very little insight into how much anesthesia time an Anesthesiologist will provide and whether it will be a physician or Nurse Anesthetist or both that provide the service, which also impacts costs. Furthermore, it is very difficult to anticipate how many surgical pathology slides and specimens will be examined, which would change the CPT billing codes required for an estimate. Secondly, there may be a timing imprecision when anticipating the benefits of the patient's insurance. When generating an estimate, providers query the payor for a standard Eligibility and Benefit Response (EDI) 270/271 transaction that includes information about the patient's insurance benefits, including co-payments and whether deductibles have been met. In our experience, not all payors comply with the requirement to use this standard transaction. Thus, as many as 10% of a provider's commercial volume may require a phone call to obtain member benefits. Not being able to obtain this information in real time makes it harder to produce a good faith estimate within 24 hours or three business days, depending on when the service was scheduled. Requiring providers and facilities to develop an estimate without this key insurance information will likely lead to inaccurate estimates that can easily exceed $400. Finally, even in situations where the convening entity has the correct primary billing CPT code, a physician may decide during the diagnostic exam or medical service to provide additional services that were not expected at the time the estimate was produced. Making these cases subject to the patient and provider dispute resolution process is not appropriate as the plan of care legitimately changed based on the medical necessity and medical judgement of a provider.

With these issues in mind, we recommend for the patient and provider dispute resolution process to be available only if:

- The claim exceeds 10% of the total good faith estimate.
- No additional services were provided to the patient based on medical necessity.

- The inaccuracy in the good faith estimate is not caused by inaccuracies associated with insurance benefits or inaccurate billing codes provided by co-providers and facilities.

Disclaimers

The rules issued require health providers and facilities to provide several disclaimers to patients, including information about the good faith estimates and the prohibition on surprise billing. These disclaimers are required to be shared with the patient no later than at the time payment is requested or when claims are submitted to the patient's health plan.

AHPA recommends additional flexibility in the timing of when providers and facilities convey the disclosure notice to patients. Specifically, there are instances where patients will have ongoing treatment regimens that require multiple visits throughout a year. In these instances, we ask that providers not be required to provide the notice for every visit. Instead, providers could be required to provide the notice at the outset or once every calendar year for patients receiving recurring treatment. This will help to reduce the amount of paperwork that patients receive every time they are sick.

As noted in our previous comments for Surprise Billing; Part 1 we strongly believe that it is important to take patients out of the middle and allow them to focus on what is truly important — their health. We understand that this rule is attempting to do that but the amount of information that providers are required to disclose to patients when they enter the hospital is concerning. **AHPA requests for CMS to reflect on the Patients Over Paper Act, which sought to streamline regulations with a goal to reduce unnecessary burden, to increase efficiencies and to improve the beneficiary experience.** We believe that the required disclaimers should be reevaluated and streamlined with these goals in mind.

Requirement to Share Advanced Explanation of Benefits Transaction

The No Surprises Act requires insurers to provide patients with an Advanced Explanation of Benefits (EOB) once they receive notification that a service has been scheduled. However, there is no requirement for that EOB to also be shared with the providers and facilities involved in the scheduled service.

As mentioned earlier, we view this insurance information as essential to the provision of accurate good faith estimates. Therefore, we recommend that CMS require payors to share the EOB with both patients and payors in future rulemaking. We also urge the Agency to review the CORE/CAQH Guidance document on "Establishing the Building Blocks for Price Transparency: Industry Guidance on Provider to Payor Approaches for Good Faith Estimate Exchanges." There is a need for collaboration between providers and payors to arrive at consensus for these standards.

Conclusion

AHPA welcomes the opportunity to discuss further any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact me at Carlyle.Walton@AdventistHealthPolicy.org or Susana Molina, Director of Public Policy, at Susana.MolinaRamos@AdventHealth.com.

Sincerely,

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