Illinois Health and Hospital Association

December 6, 2021

Xavier Becerra
Secretary
Department of Health and Human Services

Laurie Bodenheimer
Associate Director
Healthcare and Insurance
Office of Personnel Management

Ali Khawar
Assistant Secretary
Employee Benefits Security Administration
Department of Labor

Mark J. Mazur
Acting Assistant Secretary of the Treasury (Tax Policy)

Douglas W. O'Donnell
Deputy Commissioner for Services and Enforcement
Internal Revenue Service

Re: Requirements Related to Surprise Billing; Part II, (CMS-9908-IFC)

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

On behalf of our more than 200 member hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the Requirements Related to Surprise Billing; Part II (CMS-9908-IFC) interim final rule. Illinois hospitals and health systems have been at the forefront of the price transparency conversation, attempting to simplify patient bills and lessen patient financial burden for decades. In fact, the No Surprises Act (NSA) largely mirrors Illinois' preexisting balance billing law, Public Act 96-1523[1](215 ILCS 5/356z.3a),[2] ensuring many of the same protections and providing a similar arbitration process for determining out-of-network payments.

Our hospitals' familiarity with one of the state laws serving as the foundation for the NSA should put them ahead of the curve in terms of implementing NSA processes and requirements. However, due to the overwhelming scope and detail of NSA requirements, that is not the case. This became clear during a recent NSA educational webinar provided by IHA to Illinois hospitals and health systems. The numerous questions stemming from that webinar clearly demonstrate that even providers that

[1] https://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=096-1523
[2] https://www.ilga.gov/legislation/ilcs/ilcs4.asp?DocName=021500050HArt%2E+XX&ActID=1249&ChapterID=22&SeqStart=99300000&SeqEnd=114800000

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have long complied with similar balance billing requirements are unprepared to implement the NSA on Jan. 1, 2022.

IHA appreciates that Congress gave the Office of Personnel Management, Internal Revenue Service, and U.S. Departments of Health and Human Services (HHS), Labor and Treasury (the Departments) a strict timeline for implementing the NSA. Unfortunately, many of the Jan. 1, 2022 provider requirements do not account for long-standing hospital billing and communication practices. Additionally, three sets of very complex regulations have been issued in just the last four months, making meeting this implementation date extremely difficult. Further, recent actions demonstrate that the Departments anticipate problems operationalizing many aspects of the NSA over the coming months, as the Departments have announced enforcement discretion for many aspects of the NSA and have yet to finalize oversight responsibilities across state and federal entities. While we will continue to encourage and assist Illinois hospitals and health systems towards compliance, **it is clear that providers, payers, and government oversight agencies are unprepared to meet the Jan. 1, 2022 deadline for most requirements under the NSA.**

The healthcare community needs additional time, guidance, and technical assistance to create and implement the system outlined under the NSA and this interim final rule. Many NSA requirements lack standards and guidelines necessary for implementation, including processes necessary to produce good faith estimates for uninsured and self-pay patients, technology allowing information to pass between providers and payers, and guidance for patients in navigating the various price transparency resources now at their disposal. Furthermore, we believe the Departments have overstepped their authority by tipping the federal dispute resolution process in the favor of payers. **For these reasons, discussed in more detail below, we urge the Departments to use the next calendar year to implement and evaluate the NSA, delaying enforcement until 2023.**

Good Faith Estimates for Uninsured and Self-Pay Patients

In this interim final rule, HHS outlines requirements for providers to furnish good faith estimates to uninsured and self-pay patients. IHA supports the provision of good faith estimates to uninsured and self-pay individuals and Illinois hospitals have a long history of working with patients to arrive at appropriate payment amounts based on an individual's ability to pay. Unfortunately, we have several concerns regarding good faith estimate requirements under the NSA.

The interim final rule requires providers to furnish good faith estimates to uninsured and self-pay individuals both when an item or service is scheduled and when an individual is shopping for an item or service. Beginning Jan. 1, 2022, good faith estimates must include convening provider/facility self-pay rates reflective of any discounts available to the patient, with similar estimates from co-providers/facilities included by 2023. While we appreciate the enforcement

discretion regarding inclusion of co-provider/facility estimates, this is a monumental task, particularly for convening providers, and potentially confusing for the patient.

First, as much as Illinois hospitals try to engage with uninsured patients about financial assistance prior to services being rendered, typically the assessment for financial assistance occurs after the provision of items and services due to the lack of necessary information related to eligibility. The majority of hospitals in Illinois report applying relevant discounts for items or services after sending an uninsured or self-pay patient an initial bill of charges or after the patient completes a financial assistance eligibility application. Much of the eligibility determination depends on the patient providing accurate and timely information related to employment status and income and often there can be significant delay in obtaining that needed information from the patient. **IHA asks HHS to recognize the constraints of the financial assistance eligibility process, and consider revising its requirement that good faith estimates reflect all relevant discounts prior to furnishing an item or service.**

Additionally, our hospitals do not currently delay provision of care until the application process is complete. Instead, our hospitals act in the best interests of the patient, providing care first and determining ability to pay second. In fact, in response to NSA good faith estimate requirements, one of our academic medical centers (AMC) explained that many uninsured or self-pay patients receive needed items or services either the same or the next day. This is often a result of both an immediate need for care and the provider's desire to ensure the patient does not delay necessary care. For example, this AMC explained that uninsured patients often present with non-emergent earaches. Rather than diagnosing the problem at one visit and treating the problem at a subsequent visit, providers at this AMC prefer to diagnose and treat the same day. While there is currently no requirement to provide a good faith estimate for same-day procedures, **our concern is that patients will now choose to shop around after receiving a diagnosis rather than address the problem immediately and prevent any further infection or complications.** In cases like this, it often turns out that the patient qualifies for free care based on the hospital's financial assistance policy, and thus the potential benefits of receiving a good faith estimate and shopping around are moot and far outweighed by the potential cost of not receiving timely care. **Thus, we urge HHS to reconsider requiring the provision of a good faith estimate upon patient request, instead only making the provision of a good faith estimate required upon scheduling a service.**

Setting care delay concerns aside, the good faith estimate timeline is simply unrealistic given the often-used financial assistance eligibility application process. The interim final rule requires convening providers/facilities to deliver good faith estimates to patients within one to three business days depending on how far out an item or service is scheduled. As explained above, obtaining financial assistance eligibility documentation can take days to complete. Further, financial assistance is just one piece of information that convening providers must collect for the good faith estimate. Convening providers, often hospitals, must also collect information from co-providers/facilities, including estimated charges and identification numbers.

Completing this task in one to three business days will require significant planning, workflow adjustments and resources. Additionally, Illinois hospitals report that there is currently no communication standard for sending such information between providers, making it even harder to conceptualize how this process will play out.

We are also concerned by the suggestion that uninsured and self-pay patients might compare a good faith estimate from one provider to another provider's public consumer price tool under the Hospital Price Transparency final rule. At the most basic level, comparing a good faith estimate furnished under this interim final rule to a price estimator tool compliant with Hospital Price Transparency requirements is not necessarily an apples to apples comparison. The good faith estimate will account for patient-specific factors including the patient's health status, any applied financial assistance, and estimates from co-providers/facilities. Consumer price tools are not required to account for any of this information when producing a cost estimate. Thus, patients may make decisions using price estimates based on completely different sets of information.

Considering the provider effort and potential for patient harm or confusion, we urge HHS to modify requirements and guidance around good faith estimates for uninsured and self-pay patients. The specificity and effort required for good faith estimates under this interim final rule make them appropriate for individuals that have *scheduled a service*. Individuals who are still shopping for a provider to furnish items or services should use public consumer price estimate tools under the Hospital Price Transparency rule. When a patient requests a good faith estimate, we encourage HHS to deem hospitals with Hospital Price Transparency rule-compliant patient estimator tools as also compliant with NSA good faith estimate requirements, negating the need to provide a good faith estimate to individuals who are still shopping for care.

Finally, we encourage HHS to develop tools to automate several aspects of the good faith estimate, including communication between convening providers/facilities and co-providers/facilities. There is currently no method for unaffiliated providers/facilities to share cost estimates with convening providers/facilities in an automated manner. Neither billing systems nor practice management systems allow for the type of communication necessary for creating a single, comprehensive good faith estimate. Thus, **we urge HHS to identify a standard technology or transaction that would enable convening providers/facilities to automate the creation of comprehensive good faith estimates that account for co-provider/facility estimates.**

<u>Patient-Provider Dispute Resolution</u>

IHA agrees with HHS that uninsured and self-pay patients require a path for recourse when the total bill is excessively higher than the good faith estimate. Additionally, we appreciate that the good faith estimate is segmented by provider, ensuring that providers are only responsible for their specific estimated and total charges. However, we fear that the interim final rule

definition of "substantially in excess" as total billed charges that are $400 or more than expected charges per the good faith estimate is unrealistically low.

Despite best efforts, healthcare can be an inexact science. Complications or unexpected issues during care delivery are common, and providing unexpected, medically necessary care often costs much more than $400. For example, a patient under anesthesia for surgery for an additional 15 minutes would quickly surpass the $400 threshold, despite the anesthesia being a minor part of the overall bill. Therefore, we urge HHS to revise the threshold triggering the patient-provider dispute resolution process. A more practical solution would be to require a final bill to be at least 10% in excess of the good faith estimate for it to be eligible for the patient-provider dispute resolution process.

Federal IDR Process

IHA and Illinois hospitals and health systems are also concerned with the federal independent dispute resolution (IDR) process as outlined in this interim final rule. Directing arbiters to assume that the qualifying payment amount (QPA) or median contracted rate is the appropriate out-of-network payment amount not only goes beyond statutory language, but also creates a process that heavily favors payers over providers. An unequal playing field may incentivize payers to rely on the IDR process more often than the Departments anticipate, while simultaneously incentivizing them to narrow networks which will impact access to care.

When Congress wrote the NSA, it established an IDR process that required arbiters to consider a list of factors, including:

- The median in-network payment rate (i.e., 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 or facility;
- Demonstration of good faith efforts by the parties to enter into network agreements over the previous four years; and
- Any other factors that the parties may wish to submit for consideration, barring certain specified factors.[3]

Nowhere in the NSA are the Departments given leeway to require arbiters to weigh any one of these factors over another, nor does the NSA indicate that Congress believes the QPA is an appropriate out-of-network payment amount. Further, in this interim final rule the Departments state that the additional factors listed above need only be considered if the arbiters deem them as credible. Again, Congress did not devise a process that gives arbiters the power to decide whether or not a piece of information is worth their consideration. Instead,

[3] Public Health Services Act (PHSA) § 2799A-1(c)(5)(C).

the NSA requires an arbiter to consider all of the above factors in rendering its decision. While Congress outlined an independent process in statute, the Departments devised an arbitration process that is inherently biased by favoring the QPA and erecting barriers to the consideration of the other factors listed above. Therefore, **we request the Departments revise the IDR process outlined in regulation to align with the mandate laid out in statute. Failing to do so not only fosters a process that is contrary to law, but may lead to unintended negative consequences for the healthcare system and patient access to care.**

Specifically, the Departments contend that treating the QPA as the appropriate out-of-network payment amount under the IDR process "will increase the predictability of dispute resolution outcomes … [and] will aid in reducing prices that may have been inflated due to the practice of surprise billing prior to the No Surprises Act." Indeed, IHA agrees with the Departments that declaring the QPA as the appropriate payment amount for out-of-network care will increase the predictability of IDR outcomes. Outcomes will be so predictable that payers will be all but guaranteed a certain payment rate if they wait out the 30-day open negotiation period in favor of the IDR. Such payment certainty will likely result in many more cases going through the IDR process, increasing costs to the healthcare system as arbiters and HHS assess fees for their efforts.

Further, because the QPA is a median of in-network rates, defaulting to the QPA means that at least half of out-of-network providers are paid less than their in-network counterparts. Providers and payers consider myriad factors when deciding whether to enter into a contract. The relevance of specific factors and the tradeoffs made between payment and other contractual benefits varies by provider, making each contracted rate unique to the parties that negotiated it. Therefore, the median contract in-network rate will not be the appropriate payment level for all providers, particularly those that specifically chose not to enter into a contract with a particular payer.

Skewing the IDR process in favor of the QPA also creates perverse incentives for payers. While payers have a responsibility to maintain comprehensive provider networks, making the QPA the presumptively appropriate payment amount removes incentives for payers to contract with providers or offer fair terms. In fact, relying on the QPA creates payment certainty, and may cause payers to narrow their networks, decreasing patient access to care over time.

Finally, Illinois' balance billing protections include the opportunity for payers and providers to enter into a binding arbitration process. Much like the federal IDR process, both payers and providers submit their best and final offer, and an independent arbiter selects the final out-of-network payment amount based on supporting evidence. The difference between Illinois' process and the federal IDR process is that Illinois' does not weight any one factor more than the others when the arbiter considers the facts. Instead, the process is truly independent, and the result has been virtually no usage of Illinois' arbitration process. Instead, payers and providers are able to come to a payment agreement during open negotiations, and the patient

is protected, being held to in-network cost-sharing obligations just as they will be under the NSA.

Thus, if the Departments' goals include protecting patients and limiting the use of a costly dispute resolution process, then IHA urges the Departments to revise IDR requirements under this interim final rule. Specifically, **we urge the Departments to maintain consistency with the language of the NSA and require arbiters to consider all factors listed in statute equally when deciding the final payment amount under the federal IDR process. Implementing the statute as written will result in a judiciously used IDR process that is truly independent and fair for both providers and payers.**

Mr. Becerra, Ms. Bodenheimer, Mr. Khawar, Mr. Mazur and Mr. O'Donnell, thank you again for the opportunity to comment on this interim final rule. IHA and Illinois hospitals and health systems share the Departments' goals to protect patients from surprise medical bills and remove patients from billing disputes between payers and providers. We urge the Departments to delay enforcement of NSA requirements until stakeholders have had time to develop appropriate standards and policies to facilitate the myriad processes and communications required to implement these patient protections, and IHA welcomes the opportunity to engage with the Departments on this mission. Please direct questions or comments to Cassie Yarbrough, Senior Director, Medicare Policy at cyarbrough@team-iha.org or 630-276-5516.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association