National Alliance of Safety-Net Hospitals

December 6, 2021

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010

Attention: RIN 0938-AU62

Subject: Office of Personnel Management; Department of the Treasury; Department of Labor; and Department of Health and Human Services, 45 CFR Parts 147 and 149 [CMS-9908-IFC], RIN 0938-AU62, Requirements Related to Surprise Billing; Part II

To Whom it May Concern:

The National Alliance of Safety-Net Hospitals appreciates the opportunity to share our views on the No Surprises Act regulation published by the Department of Health and Human Services, Office of Personnel Management, Department of the Treasury, and Department of Labor addressing further implementation of the No Surprises Act in the *Federal Register* on October 7, 2021. In this letter we address three aspects of the interim final rule with comment period: the independent dispute resolution process, patient-provider dispute resolution, and good-faith estimates.

NASH believes patients should be protected from surprise medical bills. On the whole, however, we find that the practices established by this regulation strongly favor health insurers and are detrimental to health care providers – especially to private safety-net hospitals serving vulnerable communities. In the following pages, we explain why.

The Independent Dispute Resolution Process

This regulation creates an independent dispute resolution process: a new mechanism for addressing disagreements between payers and providers over payments. Under this process, when the parties disagree about a payment they must work to negotiate that payment, but if negotiations fail they are to participate in the independent dispute resolution process (IDR) created by the regulation. In this new process, the parties must propose what they feel is an appropriate payment, with a qualified arbiter to choose between the two proposed prices as the final price to be paid. In considering their decision, these arbiters must assume that the formal qualifying payment amount, or QPA, that was calculated by the provider to determine the

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patient's cost-sharing responsibility is the appropriate payment unless the provider offers concrete evidence to the contrary. The manner in which providers calculate this QPA is defined in the No Surprises Act. The rule also presents the factors the arbiters may take into account when deciding the appropriate payment, including whether the information a provider has presented constitutes concrete evidence that the QPA rate would be inappropriate.

NASH believes this process consistently – and unfairly – favors payers over providers.

A Major Problem: The QPA

A major aspect of NASH's concern is how the QPA is to be calculated and used under this new system.

The QPA is Too Heavily Weighted in the Decision-Making Process

NASH disagrees with one of the main assumptions of the IDR process: that absent concrete evidence to the contrary, the QPA should be the final payment for services in dispute. In our view, this assumption constitutes a clear rejection of the statute's language and intent. Even a cursory look at the legislative history of the No Surprises Act finds that Congress considered and then explicitly rejected establishing anything like a benchmark payment for services subject to the IDR. Despite this, the rule has created what amounts to a benchmark payment, in spirit if not in explicit regulatory language: the QPA. In essence, the rule's interpretation contradicts the will of Congress. NASH disagrees with that interpretation.

In the outsized role given to the QPA in the IDR process, the rule points to the lengths to which the No Surprises Act went to define the QPA as a signal of congressional intent. NASH believes this interpretation is mistaken: length does not equate to importance. The first inaugural address of Dwight Eisenhower was 2446 words and that of William Henry Harrison 8445 words; the Gettysburg Address was just 271 words, delivered in less than three minutes, yet no one would dare suggest that the Gettysburg Address was somehow less important because of its brevity and that anything so brief could not possibly be of great consequence. In this case, NASH believes, the lengths to which Congress went to define the QPA should be attributed to the complexity of the concept and not some unspoken direction that the QPA should be used in a manner that Congress never explicitly stated in the thousands of words that constitute the law itself.

The Methodology for Calculating the QPA is Ill-Suited to This Use

The challenges posed by the parameters the rule establishes for the use of the QPA are exacerbated by shortcomings in how that measure is calculated.

The QPA is established under the No Surprises Act to create a means of calculating patient cost-sharing and to give IDR arbiters one measure – but just one measure – to use when considering final payments. The QPA has intentionally been made imperfect as a standard for use in the IDR process to better suit its primary purpose: to create a means to determine patient cost-sharing. NASH believes there are four areas where choices have been made that undermine the QPA's usefulness as a standard for determining provider payments: its use of an unweighted median, the exclusion of single case agreements when calculating the median, an inappropriate inflation factor to be used when adjusting the QPA in the future,

and a decision to exclude factors relevant to establishing rates between providers and payers in favor of factors that were only intended to be used to determine patient cost-sharing.

Collectively, these problems in the manner in which the QPA is calculated make the QPA unsuitable to be the single consideration for resolving disputes in the IDR process. The most immediate problem, from NASH's perspective, is that they will result in unacceptably low payments to community safety-net hospitals – a situation that will no doubt be exacerbated as CPI-U (the Consumer Price Index for All Urban Consumers, the measure the regulation uses to index future cost increases) fails to keep pace with the rising cost of health care. A broader concern, though, is that this system is so seriously biased toward insurers that it gives insurers little reason to negotiate rates with providers. Some observers believe that one of the benefits of the No Surprises Act is that it will encourage payers and providers to negotiate rates, leading eventually to fewer surprise bills of all types, but NASH believes the opposite will occur: insurers, seeing that they are getting their way almost all of the time, will have little or no incentive even to engage with many providers on the subject of rates. This will pose a problem for almost all providers but it will be especially troubling for community safety-net hospitals because those hospitals, most of which treat large numbers of publicly insured patients and relatively modest proportions of privately insured patients, already have very little leverage when it comes to negotiating prices with insurers. The net effect of this regulation will be to reduce that leverage even further. Instead of giving insurers a reason to negotiate rates with providers, this regulation implementing the No Surprises Act will take away any reason insurers might have to negotiate with providers at all.

The statute excludes several specific standards from consideration: it bans the IDR entities from considering usual and customary rates in their rate-making decisions; it bans IDR entities from considering what providers might have billed for their services if there was no No Surprises Act; and it bans the IDR entities from even considering the rates paid by public health insurance programs. Notably absent from these exclusions are the rates typically paid to a provider under its contracts with commercial insurers. NASH believes providers should be permitted to cite applicable commercial rates during the IDR process for a simple reason: we can think of no better an indicator of what an insurer should pay a provider than what other insurers are paying that same provider for the same service in the same market. Consideration of the provider's own typical negotiated payment rates would sidestep the shortcomings created by applying a QPA that has been designed specifically to determine patient cost-sharing to a negotiation to determine the appropriate value of the provided services.

Use of the QPA Defies Congressional Intent

The No Surprises Act never sought to establish benchmark payments in the adjudication of disagreements between payers and providers; the legislative history on this is clear. 152 members of Congress clearly and publicly agree, writing recently in a letter to secretaries Becerra, Yellen, and Walsh that "Congress rejected a benchmark rate and determined the best path forward for patients was to authorize an open negotiation period coupled with a balanced IDR process." Using the QPA in the manner envisioned in this rule, however, belies the concept of an "open" negotiation period – something the 152 members of Congress pointed out in their letter when they wrote that "Unfortunately, the parameters of the IDR process in the IFR released on September 30 do not reflect the way the law was written, do not reflect a policy that could have passed Congress, and do not create a balanced process to settle payment disputes."

NASH agrees and urges the departments to reconsider both the calculation of the QPA and the manner in which this measure is to be used in the IDR process.

Patient-Provider Dispute Resolution

The No Surprises Act rule establishes a process for adjudicating disputes between providers and patients to be used when patients receive bills that are significantly greater than the good-faith estimate they received. At the heart of this adjudication process will be selected dispute resolution entities, or SDRs, to be chosen by the federal government. While NASH supports the idea of such an arbitration process, we believe the manner in which this process and the mechanisms surrounding it have been developed will lead to two different problems: too many cases subject to this process because the threshold for participating in it has been set too low and too many people choosing not to seek the medical care they need because providers, concerned about the prospect of engaging in too many of these processes, will raise their good-faith estimates and, in effect, make their services appear unaffordable to too many uninsured patients. Either way, NASH believes the rule's estimate that fewer than 27,000 cases will go through this process annually is greatly understated.

We also note that the rule estimates that facilities and providers will need one hour to prepare the documentation needed to participate in an individual SDR process at an hourly staff rate estimated to be $101.32. NASH believes the rule has underestimated the time required for this work and seriously underestimated the cost involved – the latter if, for no other reason, it appears to assume that lawyers will not be involved in this process. It is almost certain that lawyers will be involved and providers' costs will rise exponentially as a result. Thus, we also conclude that the rule's estimate that the entire SDR process will cost providers and facilities $3.2 million a year is unrealistic: the cost will be much, much greater.

If the departments do not accept NASH's recommended alternative variance threshold, then NASH also asks the departments to clarify that the $400 variance threshold will apply to each specific item and service within each good-faith estimate rather than the aggregate estimate for all items and services from all providers.

Finally, the rule does not address the question of what credentials the people conducting the SDR process will need to bring to their work. Considering that they will need both financial and at least some medical knowledge, credentials are important. NASH urges the departments to correct this oversight and give stakeholders an opportunity to review this correction before it is formally adopted.

Good-Faith Estimates

The No Surprises Act requires facilities and providers to give uninsured patients and those who are not using their health insurance good-faith estimates of the cost of the services they seek. Many community safety-net hospitals already do this, but we would like to share with you certain concerns we have about how the rule mandates that providers carry out this requirement.

Preparing Good-Faith Estimates is Much More Difficult Than the Rule Anticipates

The rule estimates that it will take providers roughly 30 minutes to prepare the kind of good-faith estimate the departments envision. We believe this seriously underestimates how long this task

will take. At the heart of this underestimate, we suspect, is the assumption that generating estimates will mostly be automated. This will only be the case, however, when the parties involved are a hospital working in concert with a hospital-employed physician and other hospital-employed professionals and hospital-provided ancillary services. Even in these cases, NASH suspects that 30 minutes will not be enough time to prepare these good-faith estimates.

The greater problem is that while the rule estimates that providers will need to generate approximately 3.5 million of these estimates a year, roughly half of them, or 1.75 million cases, will involve multiple participants: facilities, providers, and others. In these cases, preparing estimates will be a manual process accomplished with pen and paper, telephone calls, and multiple emails and even faxes. The additional 30 minutes the rule projects in such cases will not begin to cover such steps; the parties involved will need much more time, making the good-faith estimate process very time-consuming and burdensome for providers.

At the heart of this under-estimate, we believe, is an underlying assumption of the current capacity of non-hospital providers to participate in this process. For the most part, such non-hospital providers lack certain essential capabilities: physician practices, for one, generally lack any type of automated systems for producing the needed data. Instead, theirs will be another paper-and-pencil process that will require far more than 30 minutes. Consider, moreover, the breadth of providers that might be involved in some estimates: a surgical procedure could involve a surgeon – or more than one – an anesthesiologist, surgical technicians, pathology and pharmacy services, the availability of blood, and more. No manual process, no matter how streamlined, will be capable of assembling all of this information in the additional 30 minutes the rule anticipates will be needed when multiple parties are involved in an estimate. The rule's expectation that this might all be accomplished through electronic communication, moreover, is more aspirational than realistic: no technology is currently in place that is uniformly used by all of the parties that will need to participate in the preparation of these good-faith estimates. This capacity simply does not exist at this time. Another potential tool that will not help: the machine-readable price information required of hospitals under federal price transparency laws. Non-hospital providers face no similar requirement and have no comparable data.

NASH also believes the threshold of a variance of more than $400 between good-faith estimates and the final price of the medical service in question before penalizing providers is unreasonable and reflects an incomplete understanding of the variability of the services that can be involved in almost any medical procedure or service delivery situation. Once work begins, numerous circumstances can arise that call for additional providers and new or unexpected equipment, supplies, drugs, and others. Implementing this $400 limit on allowable variances could even end up hurting patients by encouraging providers to seek to protect themselves from variance penalties by intentionally overestimating their costs – on occasion, possibly with the unintentional result of raising those estimates to a point where they discourage patients from pursuing the care they need. We know that is not the intent of the law or the regulation but it could be the result nonetheless.

Finally, we are concerned that the inappropriately small amount of leeway providers have in their estimates of "foreseeable costs" could lead to a feeding frenzy in the legal profession, with patients and their lawyers turning to the courts for relief. Again, we are confident this was not

the regulation's intention but believe this will be the result of the rule's narrow interpretation of what constitutes a significant variance between estimated and actual costs.

Good-Faith Estimates and Community Safety-Net Hospitals

The concept of the good-faith estimate and the manner in which the rule intends to regulate it poses a particular challenge for community safety-net hospitals. These hospitals serve communities with large numbers of low-income, medically vulnerable residents, and many are among the uninsured or underinsured – those covered by sub-optimal insurance products or who participate in health-sharing ministries or similar organizations – who will be turning to their health care providers, and especially safety-net hospitals, for estimates of the cost of the care they need. Safety-net hospitals have in place strong financial assistance policies, and many patients asking for good-faith estimates at our hospitals are likely to qualify for such assistance.

This section of the rule requires providers to make good-faith estimates that anticipate all costs of the care they eventually provide. Some patients who request estimates may be scared off by the final figure and choose not to pursue care – something community safety-net hospitals want to avoid. In many cases, the hospital will not know the financial situation of the patient at the time the patient requests an estimate. Patient inquiries about financial assistance will add time to the process – time to determine eligibility for financial assistance and to revise the estimate. As a result, this process will take longer than the providers have been given by this new rule.

The impact of this added layer on generating good-faith estimates is clear: it prevents hospitals from meeting the timeliness requirements for providing good-faith estimates; it raises new, additional, significant administrative burdens that hospitals must overcome; it increases hospitals' costs; and most important of all, it slows down the process for our patients to receive an appropriate estimate and therefore delays their receipt of the care they need. This illustrates how much more burdensome this good-faith estimate process is than the regulation acknowledges.

In this letter NASH urges the departments to reconsider several aspects of how they have chosen to implement the No Surprises Act. NASH hopes the departments will give special attention to this particular issue because of its significant impact on low-income, economically vulnerable patients – the very people the No Surprises Act was enacted to help – and on the community safety-net hospitals that serve so many of these patients throughout the country.

Recommendations

To address these concerns, NASH offers four recommendations for consideration by the departments.

- Direct the Department of Health and Human Services to hire contractors that would serve as coordinators of good-faith estimates between providers and co-providers and repositories for their data. These HIPAA-compliant entities would receive data – prices, discounts, and more – used to develop good-faith estimates. This initiative could mirror the approach that insurers and providers are currently developing to produce advanced explanations of benefits for insured patients. That process is unfolding very slowly but could be greatly hastened by federal involvement.

- Raise the acceptable variation between quoted price and actual price from the current $400 to $1000 for services estimated at $10,000 or less or 10 percent for services estimated at more than $10,000.
- Deem hospitals that use patient cost estimator tools that comply with hospital-price transparency requirements to be in compliance with this regulation's good-faith estimate requirements.
- Clarify that price estimates can be stated as a range and do not need to be a specific amount.
- Clarify whether the $400 variance threshold will apply to providers' and facilities' aggregated estimated charges or to specific items and services within each good-faith estimate.

Good-Faith Estimates: Conclusion

NASH supports the mandate to compel providers to develop good-faith estimates for patients who are uninsured or not using their health insurance. We do not support, however, the methodology embodied in this regulation. This methodology is administratively burdensome, it will take too much time and cost too much money, and despite investing all of that extra time and all of that extra money, it will yield estimates that are not as accurate as the rule hopes they will be. Worse, this methodology will encourage providers to overestimate their costs, potentially leading some patients to choose not to seek the care they need, while discouraging insurers from working in good faith to establish rate agreements with providers. In addition, the technological and institutional capabilities on which this regulation is based are either non-existent or not nearly as widely used as the rule appears to have assumed.

Despite these concerns, NASH believes it is possible for providers to deliver high-quality, reasonable good-faith estimates to their patients, but to do so, we need help – and this regulation, in its current form, does not provide that help. Consequently, we urge the departments to withdraw the regulation at this time and regroup by engaging the hospital industry and other stakeholders in a broader process to analyze the challenge ahead of us and develop methodologies that will work in practice as well as in theory. Until and unless this is done, NASH urges the federal government to extend its enforcement discretion on all aspects of this rule at least through 2022, until a time when a better methodology for implementing the No Surprises Act has been formulated and introduced.

Conclusion

Bringing the No Surprises Act to life is an enormous challenge. The departments have made a strong start, but NASH believes more work needs to be done to make these processes strong, fair, reasonable, and economical. As it is written now, this regulation creates one-sided processes that greatly favor insurers and work to the detriment of health care providers. Insurers do not provide any health care – have never stitched a wound, set a broken bone, or written a prescription to treat a cough or an infection. That is the work of health care providers, and those providers deserve better than the manner in which this regulation treats them.

For these reasons, NASH encourages the departments to suspend enforcement of this regulation, consult with stakeholders that would actually be involved in these processes, learn more about the challenges we have found, and then formulate a revised approach that addresses the problems we have identified and in so doing introduce a process that will be fair to consumers, providers, and payers. We would welcome an opportunity to be part of any workgroup you might create toward this end.

Sincerely,

Ellen Kugler, Esq.
Executive Director

About the National Alliance of Safety-Net Hospitals

The National Alliance of Safety-Net Hospitals advocates for adequate recognition and financing of community safety-net hospitals that serve America's neediest communities. These community safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are older and poorer; they are more dependent on Medicare and Medicaid for revenue; they provide more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NASH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive Community safety-net hospitals. NASH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates. Private community safety-net hospitals can be found serving communities urban, rural, and suburban across the country.