CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

March 24, 2021

Sent electronically

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

The Honorable Martin Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Subject: No Surprises Act Implementation – Technical Recommendations

Dear Secretaries Becerra, Yellen, and Walsh:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) greatly appreciates the work Congress has done to protect patients from surprise bills when they receive care from out-of-network facilities in emergencies or from out-of-network providers at in-network facilities by passing the "No Surprises Act" (NSA). We look forward to working with the Departments of Health and Human Services (HHS), Labor, and Treasury (hereafter tri-agencies) and health plans to implement the NSA and realize our mutually long-held goal of removing patients from billing disputes that arise when care is provided in situations covered under the NSA.

The NSA is technically complex, with key provisions effective on January 1, 2022. Achieving the law's goal of protecting patients from surprise bills in covered situations will require the tri-agencies to make numerous technical decisions in a short period of time. CHA stands ready to collaborate with the tri-agencies to help develop regulations that create a transparent process for resolving out-of-network bills in covered situations that protects patients, advantages neither health plan nor provider[1] in future contract negotiations, and creates an environment where payment amounts for covered situations are

[1] Unless otherwise specified, "provider" is intended to include hospitals, other facilities, physicians, and practitioners.

499 So. Capitol Street SW, Suite 410, Washington, DC 20003 • *Telephone:* 202.488.3740 • *Facsimile:* 202.488.4418
1215 K Street, Suite 800, Sacramento, CA 95814 • *Telephone:* 916.443.7401 • *Facsimile:* 916.552.7596 • www.calhospital.org
Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

most often determined between plans and providers without having to submit claims to an independent dispute resolution (IDR) entity.

CHA welcomes the opportunity to participate in any listening sessions or workgroups to further the development of a regulatory framework that achieves the NSA's goals. In an effort to assist the tri-agencies, CHA would like to submit pre-regulatory comments related to:

1) **Implementing the IDR Process**: CHA provides suggestions to improve the calculation of the Qualified Payment Amount (QPA). And, in an effort reduce administrative burden on all stakeholders, we offer suggestions related to the timelines for arbitration, the information submitted to the IDR entity, the fees associated with submitting claims to the IDR entity. Finally, CHA requests that HHS allow broad criteria to batch like items and services for submission to an IDR entity.

2) **Increasing the Transparency of Out-of-Pocket Cost and Network Participation Information Available to Patients:** CHA asks that the tri-agencies reduce the risk of confusing patients by developing a coordinated approach to the Good Faith Estimate (GFE) and other efforts to improve transparency. CHA requests clarity regarding the definition of and timeframe for delivering the Notice and Consent (N&C) for post-stabilization services. We also offer recommendations on technical issues that will ensure patients receive the information they need to make value-based care decisions while streamlining the implementation of the GFE and N&C for all stakeholders.

3) **Develop a Transparent, Equitable, and Flexible Enforcement Framework**: CHA asks that the regulations implementing the NSA provide enforcement waivers and additional flexibility for providers experiencing a natural disaster, public health emergency, or financial difficulties. We also suggest the creation of a process that will allow providers to refer health plans that exhibit a pattern of non-compliance with NSA requirements that interferes with the patient-provider relationship to the tri-agencies for enforcement action.

CHA looks forward to working with the tri-agencies and health plans to create and implement a flexible, transparent framework that removes patients from billing disputes between health plans and providers, provides patients with information about their healthcare costs, and ensures continued access to care for patients. Below, please find CHA's specific recommendations we ask the tri-agencies to consider in developing the regulations implementing the NSA.

Implementing the IDR Process

CHA would like to offer a range of suggestions to improve the calculation of the QPA and expand the information submitted to help IDR entities arrive at a fair payment amount. We also ask the tri-agencies for flexible timelines and batching criteria that can reduce the volume of claims submitted to IDR entities. This flexibility will also allow all parties to have sufficient time to submit evidence in instances where arbitration is required. CHA would also like to suggest specific criteria that can be used to qualify IDR entities and a process to ensure selected entities continue to meet these qualifications once certified. Finally, we ask the tri-agencies to clarify the fee structure when submitting claims to the IDR process.

Defining the "Qualifying Payment Amount"
The QPA will be the amount used to calculate cost sharing for patients when they receive care in situations covered by the NSA. Beyond its use calculating the patient's cost sharing amount in covered out-of-network situations, the NSA instructs IDR entities to consider the QPA as one piece of evidence when deciding which payment amount to accept during arbitration.

The QPA is determined based on historic rates between the plan and providers or, if unavailable, an independent database of historic payment rates for such items and services. Specifically, the QPA will be set based on the median contract rate recognized by the health plan on January 31, 2019, within the same insurance market (e.g., health plans cannot consider Employer Retirement Income Security Act (ERISA) plan rates when establishing the QPA for an enrollee in an individual market plan) and similar geographic area. This amount is trended forward to the applicable year using the Urban Consumer Price Index (CPI-U). If a health plan is new and did not offer coverage in 2019 or otherwise does not have sufficient information to calculate the QPA, the plan must use either the median contract rate from the first plan year that it began covering such items or services or information from an independent database, such as an all-payer claims database.

Where a previous contract between a health plan and a provider exists, CHA asks HHS to explore using it to calculate the QPA. In instances where a previous contractual relationship has not existed with a provider, CHA asks HHS to provide detailed instructions to health plans for calculating and revising the QPA in the regulations implementing the NSA. As part of the regulatory development process, we ask HHS to consider how the QPA calculation will accurately capture the relationship between a health plan and provider when they have been unable to negotiate a mutually agreeable contract, how similar services are defined, and how the QPA is inflated forward using the most accurate definition of CPI-U. Additionally, the implementing regulations should create a transparent environment in which patients and providers are able to review the QPA calculation to ensure it is based on comparable factors as intended by Congress.

- **Calculating the QPA When a Previous Contracted Rate Exists***:* Several states that have adopted surprise billing laws similar to the NSA have included provisions in statute designed to ensure their laws have a neutral effect on the balance of negotiations between health plans and providers. In instances where a health plan had a contract in effect with a provider but the contract recently expired, the QPA is the last contracted rate in effect between the health plan and the provider, increased by a percentage (between 8% and 25%) to encourage health plans and providers contract with one another, and adjusted for inflation to the current year using the Consumer Price Index for Medical Care Services (CPI-M). Examples that CHA is aware of include Nevada — between 108% and 115% of the prior contracted amount[2] — and New York, 125% of the prior contracted amount, adjusted for inflation[3].

  CHA believes this is a reasonable approach that will ensure the NSA has a neutral effect on contract negotiations between health plans and providers. We encourage the Secretary of HHS, in consultation with the secretaries of Labor and Treasury, to implement a similar method in the regulations implementing the NSA for calculating the QPA where a previous contract between

[2] https://www.leg.state.nv.us/NRS/NRS-439B.html#NRS439BSec748
[3] https://www.nysenate.gov/legislation/laws/FIS/605

the health plan or provider existed. CHA believes that a previously agreed to contracted rate between plans and providers, adjusted for inflation, is likely the most accurate proxy for the market rate that should exist between a health plan and a provider.

- **Base the QPA on Contracts that Best Reflect the Relationship between the Provider and the Out-of-Network Health Plan**: Rates for services negotiated between health plans and providers take into consideration a variety of factors that are not present in situations where a health plan and provider have been unable to negotiate a mutually agreeable contract. Common factors tend to include situations — similar to other areas of the economy — where a provider offers a health plan deeper per-unit price discounts based on the number of covered lives they will have the opportunity to provide care for under a given contract and streamlined administrative processes. In addition to these considerations, providers will also offer discounts to health plans that are willing to partner with them on initiatives to improve the overall health of the population covered by the contract.

  Typically, a health management organization (HMO), exclusive provider organization (EPO), and other narrow network contracts — as well contracts that include shared risk (either retrospective shared savings and/or shared losses or prospective capitation) for improving population level outcomes and reducing the total cost of care — include per unit price concessions in exchange for the types of consideration described above that are not present in out-of-network scenarios. Therefore, CHA asks HHS to consider excluding HMO, EPO, other types of narrow network, and shared risk contracts from the calculation of a health plan's QPA for a given service. A health plan's QPA should be based only on the median payment rate for the service in question covered by its "broad access" preferred provider organization (PPO) contracts offered in the same geographic region for similar types of providers. An example of a product that is most analogous might include a PPO product offered on a state or the federal health insurance marketplace.

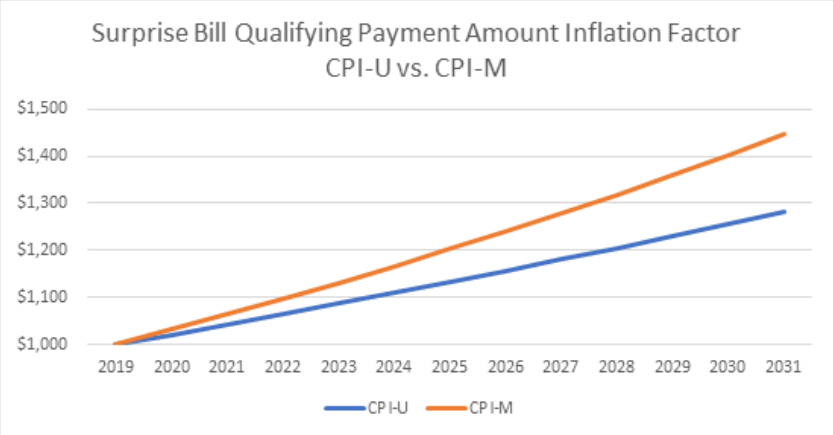
- **Provide Framework for Defining Similar Services**: The concept of "similar services" is key to accurately calculating the QPA – regardless of whether or not a previous contract existed between a health plan and a provider. The NSA does not define similar services or offer a conceptual framework to help health plans and providers identify services with similar resource utilization based on patient acuity that would be appropriate to use in calculating the QPA for a service covered by the NSA. CHA asks HHS to create a framework for defining similar services for calculating the QPA. Given the number of variables and complexity inherent in defining similar services, CHA suggests HHS convene a workgroup of expert stakeholders from the health plan and provider community to create a mutually agreeable framework. As discussed in detail on page 12, CHA does not believe Congress intended the definition of "similar services" used for purposes of calculating the QPA and for batching to be the same.

- **Calculate the QPA for Tertiary and Quaternary Hospitals Using Only Contracted Rates for Similar Facilities***:* CHA asks HHS to analyze the impact of calculating the QPA for tertiary and quaternary hospitals based on all hospitals' median payment for a given service in a geographic region for similar contracts and insurance products. Given the increased cost of delivering tertiary and quaternary care, there is concern the QPA will be artificially depressed for these hospitals relative to their cost to deliver care. And, given that many tertiary and quaternary

hospital patients are admitted through the emergency room, this could create an unintended incentive to drop these hospitals from some networks to secure an artificially depressed payment rate through the IDR process. One way to address this issue would be to instruct health plans to remove non-tertiary and non-quaternary hospitals from the dataset used to calculate the QPA for out-of-network services provided by a tertiary and quaternary hospital.

- **Clarify the Appropriate Inflationary Index for the QPA**: CHA asks the Secretary of HHS to clarify that the QPA should be calculated based on 2019 data (or a subsequent year in the case of a new item or service), adjusted for inflation using the CPI-M component of the CPI-U index. CPI-U is a broad index of inflation that includes an array of items (e.g., food, energy, transportation, medical care, recreation, housing, etc.) of which medical care is one component. Historically, the overall index has grown at a slower rate than medical care, as costs for key inputs to health care (e.g., pharmaceuticals) grow faster than the overall economy. Using the broader CPI-U index instead of CPI-M to adjust the QPA for input price inflation will, over time, result in an amount that fails to cover the cost to provide health care services to individuals in situations covered by the NSA.

  Below is a graph that compares the estimated QPA in 2031, adjusted for inflation using the averages of CPI-U and CPI-M from 2016-2019[4], of a service with a QPA in 2019 of $1,000.



  The QPA calculated using CPI-U is $163 less than the QPA calculated using CPI-M. CHA asks HHS to consider clarifying that health plans adjust the QPA for inflation using CPI-M. Over the long term this will benefit patients by promoting stable provider networks and, when individuals receive care in situations covered by the NSA, payment to the provider from the health plan is more likely to be fair and adequate.

  QPA Calculation Transparency: Given the implications for patient out-of-pocket and provider payments, the health plan's methodology for calculating the QPA should be publicly available and transparent to all stakeholders. CHA asks HHS to consider ways to ensure that all stakeholders can access the QPA calculation. One way to achieve this transparency would be to

[4] https://www.bls.gov/opub/ted/2020/consumer-price-index-2019-in-review.htm#:~:text=Medical%20care%20prices%20rose%204.6,percent%20from%202017%20to%202018.

require health plans to post the methodology on their website. The methodology should include the plan's framework for determining "similar services." Another way to foster transparency would be to transmit the methodology — including the definition of similar services, the specific data points used to calculate the QPA to the patient with their explanation of benefits (EOB), the provider with the payment, and to the IDR entity when materials supporting the health plan's requested amount are submitted. The specific data points should include the number of rates used to determine the median payment amount and the names of providers whose rates were used to determine the median amounts to ensure the rates used are comparable. This level of transparency will reduce the volume of claims submitted to the IDR process as it will ensure a fair initial payment and, when necessary, create a productive basis from which health plans and providers can negotiate the appropriate payment.

Clarify Definition of Health Insurance Issuer

The phrase "health insurance issuer" is used throughout the NSA in the sections of the law addressing the IDR process. CHA notes that "health insurance issuer" could be interpreted to mean a large employer health plan regulated by ERISA and not the third-party administrator (TPA) that administers the plan on behalf of the large employer. CHA does not believe it was Congress' intent for a large employer to participate directly in the IDR process but have its TPA engage in the IDR process on its behalf. This is similar to the role TPAs currently play. Requiring the large employer to participate directly would disrupt the current relationship with the TPA that is responsible for maintaining the provider network and administering the plan. It would also create an administrative burden for employers that they are ill-equipped to manage. CHA asks the tri-agencies to confirm that the TPA that administers the health plan on behalf of a large employer is the entity that will participate in the IDR process.

Information Submitted to an IDR Entity

Exhibit I below outlines the factors specifically described in the statute that IDR entities shall and shall not consider when making their payment selection.

Exhibit I: Factors an IDR Entity Shall/Shall Not Consider

Shall Consider	Shall Not Consider
• Qualifying amount • Provider training/experience • Quality and outcomes • Plan/provider market share • Patient acuity • Teaching status • Case mix • Provider's scope of services • Good faith efforts to contract • Previous contracted rates (prior 4-years)	• Usual and customary charges • Billed charges • Medicare rates • Medicaid/CHIP rates • TRICARE rates

In addition to the items that IDR entities shall consider based on the statute, there may be additional data points the IDR entity will need to consider when determining an accurate payment amount for services provided in situations covered by the NSA. These additional data points include:

- **Specific Median Rate for Broad Network Contracts**: Congress specifically did not include a benchmark rate as part of the IDR process. CHA asks the tri-agencies to consider approaches to preventing the QPA from becoming a de facto "benchmark" payment rate in the regulations implementing the NSA. One approach to ensuring a fair arbitration and provide a counterbalance to the QPA for the arbitrator to consider would be to allow providers to submit their median payment rate for procedures/services similar to those subject to the arbitration for "broad access" PPO contracts (e.g., a PPO product offered on a health insurance exchange). For the reasons discussed above, CHA believes that when providers calculate their median payment rate for "broad access" PPO contracts, HMO, EPO, and other narrow network contracts, as well contracts that include shared risk, should be excluded.

- **Consideration of Payer Mix and Uncompensated Care**: Governmental payers (Medicare, Medicaid, and related managed care plans) pay providers less than the actual cost to deliver health care. For providers to remain economically viable and continue their missions of caring for their communities, these shortfalls must be borne by other payers.[5] Therefore, CHA asks the tri-agencies to consider what types of data could be submitted to an IDR entity as evidence of the need for higher commercial rates to offset underpayments from governmental payers. Allowing a provider to submit its payer mix to an IDR entity — especially those with higher percentages of governmental payers as a part of the overall revenue mix — would be one option that would help IDR entities understand this aspect of a provider's market and finances.

- **IDR Entities May Need to Consider Billed Charges in Select Circumstances**: CHA asks the tri-agencies to consider when it would be appropriate for IDR entities to consider billed charges in determining an appropriate payment amount. It is estimated that almost 20%[6] of hospital revenue is still based on percent-of-charge contracts. Additionally, many hospitals include stop-loss provisions in their commercial contracts that protect them from high-cost cases when payment is based on a fixed amount per discharge or case (examples include but are not limited to MS-DRGs or APR-DRGs for inpatient services, and APCs or APGs for outpatient services). Frequently, billed charges are used in the calculation of stop loss (or outlier) payments for high-cost, complex patients. Allowing the IDR entity to consider billed charges in select instances will ensure that decisions will not be biased in favor of either party to the arbitration.

- **IDR Entities Should Not Consider Medicare Advantage or Medicaid Managed Care Organization Rates to Decide an Appropriate Payment Amount**: Finally, as listed in the table above, the NSA specifically prohibits IDR entities from considering government payment rates (e.g., Medicare, Medicaid, CHIP, and Tricare). CHA asks the tri-agencies to clarify — as intended by Congress — that this prohibition extends to Medicare Advantage (MA), Medicaid managed care organization (MCO), and any other managed care contract for a government-sponsored health insurance program.

  Comparing the negotiated price for a service covered by a commercial health plan with the price paid by a MA or MCO plan for the same service is inappropriate and would unfairly bias the arbitration in favor of the health plan. Typically, the Centers for Medicare & Medicaid Services

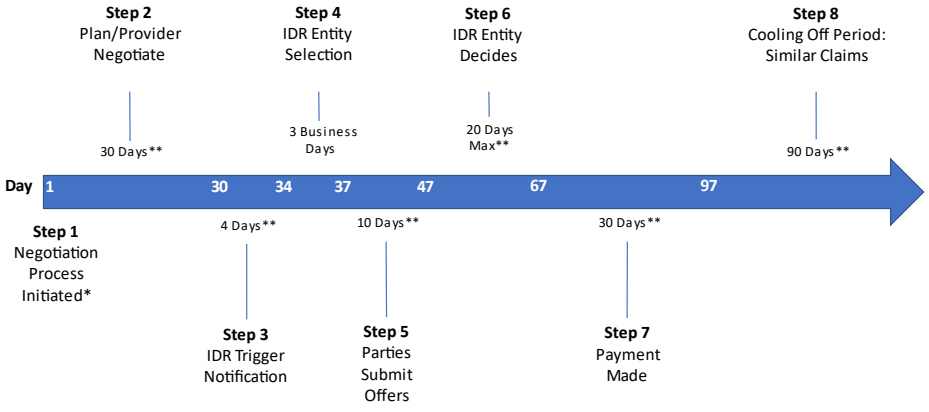
[5] https://www.crowe.com/insights/asset/p/price-transparency-in-healthcare-benchmarking-report
[6] https://www.hfma.org/content/dam/hfma/Documents/PDFs/Price%20Transparency%20Report.pdf

(CMS) or the state Medicaid agency pays a health plan that runs the MA or MCO plan a fixed rate based on average beneficiary spending for the covered population in a given geography. This capitated amount is based on both utilization and fee-for-service payment rates that are administratively set by CMS (e.g., inpatient prospective payment system, outpatient prospective payment system, physician fee schedule) or state Medicaid program. While rates between providers and MA and MCO plans are "negotiated," the negotiations are typically based on the fee-for-service (FFS) rates (administratively set by CMS or the state Medicaid agency), which pay providers less than the cost to deliver care. Therefore, prices in MA, MCO, and other similar "contracts" are below the cost to deliver care and not an accurate reflection of market rates/prices for health care services.

IDR Timelines

The NSA defines specific timelines that the IDR process must follow. Exhibit II below provides an overview of the steps and related timing of the process. CHA notes the NSA provides the Secretary of HHS significant discretion to modify these timelines.

Exhibit II: IDR Process – Timeline of Activities by Step



*Negotiation may be initiated w/in 30-days of initial payment/denial.
** Does not specify business or calendar days.

CHA asks HHS to explore modifying the timelines related to the negotiation period, IDR trigger notification and offer a submission window, payment period, and cooling off period. The modifications discussed below have the potential, if implemented, to reduce the number of claims submitted to the IDR entity and ensure that when the IDR process is triggered, all parties have sufficient time to submit documentation to the IDR entity.

- **30-Day Negotiation Window:** The NSA requires health plans in covered situations to either issue a denial or make a payment to the provider within 30 calendar days of receiving the claim. Given that the plan's initial payment (or non-payment) could be viewed as its opening offer to a potential negotiation, CHA believes it is unlikely health plans will initiate a payment negotiation under the NSA. This belief has been confirmed in conversations with hospitals in New Jersey, as it has an arbitration process similar to the one contemplated in the NSA.

CHA strongly supports the inclusion of a period in which providers and health plans have the opportunity to negotiate an appropriate payment when services in situations covered by the NSA are provided to a patient. We greatly appreciate that Congress, in the NSA, did not include a requirement that providers attempt to resolve out-of-network payment disputes using a health plan's internal dispute resolution process before initiating a negotiation. This would have been administratively burdensome and discouraged providers from pursuing arbitration to receive appropriate payment in covered situations. We encourage the Secretary not to add this step to the IDR process via regulation.

CHA believes negotiations are the best opportunity to arrive at a payment amount that is acceptable to both parties. Not only will this reduce the administrative cost for health plans and providers to settle payment disputes, but it will reduce the volume of claims submitted to the IDR process thus increasing the likelihood that IDR entities are able to render decisions within the statutory timeframe.

As the Secretaries of the tri-agencies are aware, payment negotiations for services provided out-of-network between providers and health plans are complex. These negotiations take into account a broad range of considerations — the acuity of the patient, the provider's scope of services and quality/outcomes, prior contracted rates between the provider and the plan, market payment rates for similar services paid to the provider by other health plans, and what the health plan subject to the dispute pays similar providers in the area for the same service.

Given this complexity, 30 days will be insufficient for providers and health plans to arrive at an acceptable payment amount in many instances. While the NSA allows negotiations to continue during the IDR process — up to the point where a decision is rendered — once the process is triggered, the health plan and provider are required to split the expense of the arbitrator's fee, resulting in unnecessary administrative costs. Therefore, we ask that the Secretaries, in the implementing regulations, allow health plans and providers to jointly request 30-day extensions of the negotiation period as needed. As discussed above, CHA believes this will reduce the overall volume of claims submitted to the IDR process, decreasing administrative costs, and resulting in payment amounts for care provided to out-of-network health plan members that are mutually agreeable to both providers and health plans.

If the regulations implementing the NSA do not allow for health plans and providers to mutually agree to extend the negotiation, we ask the Secretaries to explore other options for allowing negotiations to continue after the IDR process has been triggered without the parties incurring an IDR fee. One possibility is to prohibit the IDR entity from collecting a fee if the health plan and provider can agree on an appropriate amount after an IDR has been triggered but before the parties submit their offers and supporting documentation. Prior to that point, CHA does not believe the IDR entity will have incurred material cost in an effort to resolve the dispute.

When negotiations are not conducted in a productive manner, it only serves to increase administrative costs for health plans and providers. Given that (as discussed above) providers will initiate negotiations, in situations where a provider suspects that a negotiation will not be productive, CHA asks the Secretaries to provide flexibility for providers to trigger the IDR process before the conclusion of the 30-day negotiation period. There is precedent for this in other

states. Under New York's IDR process, if a health plan or provider does not respond to an offer within 15 days, the party that tendered the offer may trigger an arbitration.

While CHA does not believe it is necessary to define what constitutes an unproductive negotiation (and trigger the IDR process prior to the end of the 30-day negotiation period), indications of unproductive negotiations might include, but are not limited to, not responding to an offer in a timely manner, not confirming receipt of information, and/or not responding to offers or submitted information in writing. Beyond negotiation-specific behavior, CHA asks the tri-agencies to consider instances where there are broader patterns of behavior that indicate a history of conducting unproductive negotiations. These could include a high percentage of prior negotiations resulting in arbitration or a history of waiting to respond to information or offers until just before the due date.

- **Trigger and Offer Submission Timelines:** If a provider and health plan cannot come to a negotiated agreement on payment, either party may trigger the IDR process (referred to as "notifying") within four days of the conclusion of the 30-day open negotiation period. The plan and provider then have three business days to jointly select the IDR entity to oversee the case; should that fail, the HHS Secretary has up to three business days to select one on their behalf. Within 10 days of the selection of the IDR entity, each party must submit an offer for reimbursement, as well as any supporting materials.

  CHA asks the tri-agencies to evaluate the sufficiency of the four-day window to trigger the IDR process followed by 10 days to determine a final reimbursement offer and gather supporting documentation (listed in Exhibit I above) during the rulemaking process. Providers need to consider a range of factors that include, but are not limited to, the amount of payment already received, the potential to batch a particular claim with other similar claims to submit to the IDR entity, the fees associated with the arbitration, and the evidence available to support a reimbursement offer.

  Using the flexibility afforded by Congress to allow for a longer trigger and evidence submission period will reduce the number of provider and health plan revenue cycle staff required to manage this process. Reducing unnecessary administrative expense for both plans and providers will not only translate into lower premiums for consumers but ensure that all health plans and providers — regardless of their size and revenue cycle sophistication — can participate in the IDR process when necessary. Ensuring that all health plans and providers have access to the IDR process will not alter the balance of contract negotiations and ensure consumers' access to healthcare providers is not inadvertently impacted by the implementation of the NSA.

  New Jersey's surprise billing law includes an IDR process when negotiations between a health plan and provider do not result in a mutually agreeable payment amount for out-of-network services provided under covered situations. The New Jersey law[7] gives providers and health plans a 30-day window after the conclusion of unsuccessful negotiations to both trigger the IDR process and submit a final reimbursement offer. Based on conversations with hospitals in New Jersey, CHA believes a 30-day period from the end of negotiations affords providers an

[7] https://www.njleg.state.nj.us/2018/Bills/A2500/2039_I1.HTM

appropriate amount of time to trigger the IDR process and submit a reimbursement offer supported by the necessary documentation. Therefore, we ask the Secretaries to explore providing at least 30 business days from the end of the negotiation period for providers or health plans to trigger the IDR. If the tri-agencies are not able to provide additional time, we ask that the current statutory trigger and evidence submission timeframes be defined as business days in the implementing regulations.

- **90-Day "Cooling Off" Period**: The provider that submitted the notification to initiate the IDR process may not submit another claim for the same item(s) or service(s) involving the same health plan during a 90-day period after the initial notification. While CHA understands it was intended to reduce the IDR entities' caseload, we are concerned it could create cash flow issues for distressed providers. And the cooling off period will only initially delay a backlog of cases, not avoid backlogs altogether.

  Instead of a 90-day cooling off period, CHA makes numerous recommendations in this letter that, if implemented in concert, can reduce the number of avoidable arbitrations. Therefore, CHA asks the Secretaries to consider reducing the cooling off period providers are required to wait before submitting another case for the same item or service involving the same health plan to 30 days. The 30-day cooling off period should run concurrent with the negotiation time period. Notably, neither the New York nor New Jersey surprise bill laws include a cooling off period.

  Additionally, providers may batch together like claims, attributable to the same health plan, that occur during a 30-day period. CHA believes Congress intended to allow all providers, including those with a common parent entity (discussed below) to batch all similar claims that accumulated during the cooling off period and submit them at the end of said period. If the regulations implementing the NSA do not reduce the cooling off period to 30 days as recommended above, CHA asks the Secretaries to clarify that providers may batch and submit all claims that accumulate during a cooling off period once the period expires and that health systems may batch all claims from its component providers for the same health plan and submit them to an IDR entity for arbitration.

Clarify Batching Criteria

The NSA instructs the Secretary to create, under the IDR process, a mechanism that will allow for similar items and services to be batched together and considered jointly as part of a single determination by an IDR entity for the purposes of "*encouraging efficiency (including minimizing costs)*[8] of the IDR process." Items and services can be batched for consideration if they are furnished by the same facility or provider, payment is required to be made by the same group health plan or health insurance issuer, the items and services are for the treatment of a similar condition, and the items or services were furnished during the 30-day period following the date on which the first item or service included in the batch was furnished. CHA asks the tri-agencies to clarify the definition of a "facility or provider" and allow for broad batching criteria.

[8] Emphasis added.

- **Clarify Definition of Facility or Provider**: CHA asks the tri-agencies to define "furnished by the same facility or provider," to include all providers in a market who share a common parent entity (e.g., all the hospitals, non-hospital facilities, physicians, and non-physician practitioners that are subject to common ownership or control). Allowing the component providers of a common parent entity to batch similar items and services furnished to the same health plan will achieve Congress' goal of minimizing arbitration costs, reducing the volume of individual disputes sent to the IDR process, and decrease the likelihood of a case backlog occurring.

- **Allow for Broad Batching Criteria:** The NSA allows providers to batch together like claims attributable to the same health plan that occur during a 30-day period. The statute instructs the Secretaries, via regulation, to provide additional details on criteria for such claims. CHA strongly supports claims batching. It will provide an effective means to avoid unnecessary administrative cost for all parties, reduce the potential for IDR entities to develop case backlogs, and accelerate payments to providers — particularly financially distressed providers — when they provide care to patients in situations covered by the NSA.

  However, for batching to be effective, the regulation's criteria should be flexible enough to accommodate a wide range of clinical scenarios and payment methodologies. We believe that Congress appreciated this complexity and gave the tri-agencies latitude to broadly define how "similar services" might be batched. Section 2799A–1(c)(3)(A) states:

  > *IN GENERAL. — Under the IDR process, the Secretary shall specify criteria[9] under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination by an entity for purposes of encouraging the efficiency (including minimizing costs) of the IDR process. Such items and services may be so considered only if...*

  CHA notes that Congress did not specifically instruct the tri-agencies to develop a single criterion for batching. Instead, it used the plural form and without qualification. CHA believes batching criteria should be broad enough to aggregate claims for "treatment of a similar condition" (e.g., emergency services that result in an inpatient admission). However, the statute does not explicitly define treatment of a similar condition as having homogenous resource utilization/costs (e.g., treatment of an acute myocardial infarction may be accomplished through medical means, mechanical intervention – percutaneous coronary intervention, or coronary artery bypass graft surgery). Therefore, we believe Congress intended for IDR entities to disaggregate batched claims for "treatment of a similar condition" and determine the appropriate payment amounts for sub-groups of claims. We encourage the tri-agencies to use the flexibility afforded to it by Congress to create a broad set of criteria that providers can use to batch and submit claims to an IDR entity.

IDR Entity Requirements and Ongoing Compliance Monitoring

The NSA requires the tri-agencies to develop a process for certifying IDR entities through regulation. Generally, the statute requires IDR entities to have both legal and medical experience and sufficient staff to resolve claims submitted to arbitration within the required timeframe. Providers, health plans, their

[9] Emphasis added.

affiliates, or associations are expressly barred from serving as IDR entities. Further, the IDR entities are required to meet basic standards of confidentiality and fiscal integrity. CHA supports a robust process to certify IDR entities, however, we believe this is necessary but not sufficient to ensure fair and timely decisions. CHA asks the tri-agencies to consider how a robust initial certification process could be supported by a comprehensive ongoing monitoring process to ensure that IDR entities continue to meet certification requirements and provide fair and timely decisions as required by Congress in the NSA.

- **IDR Entity Expertise**: CHA appreciates Congress specifically requiring IDR entities to have specific experience with legal and medical issues. One of the challenges facing hospitals in states like Nevada that have implemented an IDR process is that arbitrators lack specific experience settling health care claims payment disputes. Not only does this delay decision making, but it could result in unfair decisions. Therefore, CHA encourages the tri-agencies to require IDR entities to not only have sufficient staff to make decisions but ensure these staffers are well versed in the arbitration process and have working knowledge of managed care contracting, the revenue cycle, and claims adjudication issues. One way for IDR staff to evidence the pre-requisite expertise is by requiring each arbitrator involved in a dispute resolution to hold a current certification in at least one of the following areas:

  - Health care claims coding: Examples include but are not limited to the American Association of Professional Coders[10] Certified Professional Coder or Certified Inpatient Coder
  - Managed care contracting: Examples include but are not limited to the Healthcare Financial Management Association's (HFMA[11]) Certified Managed Care Specialist
  - Health care revenue cycle operations: Examples include but are not limited to HFMA's Certified Revenue Cycle Representative

  Each arbitrator should also be required to receive ongoing education from the American Arbitration Association (or similar professional association), as well as on health care billing issues from a professional association such as the ones listed above.

  Beyond simply ensuring that IDR entities have the prerequisite legal/arbitration expertise on staff, it would be beneficial to all stakeholders if the tri-agencies provided arbitrators with specific guidance, grounded in law and best practices for arbitration, that give the decision makers a framework for how they will consider evidence. This framework should preclude IDR entities from considering factors outside of what has been submitted by the parties to the dispute.

  Finally, if an IDR entity intends to use artificial intelligence or other similar automation tools, CHA asks the tri-agencies to consider how those tools can be employed in a transparent manner. One option for ensuring that all stakeholders understand how the algorithm(s) work is to require the IDR entity to make the algorithm(s) publicly available for the agencies and other stakeholders to review and offer comments. This level of transparency is essential to ensure IDR decisions are not biased by criteria beyond what Congress intended and the agencies defined in

[10] https://www.aapc.com/
[11] https://www.hfma.org/education-and-events/certifications.html

regulation. The implementing regulations could create a process that would allow the IDR entity to resolve concerns about the tool before the tool is used to adjudicate any portion of a dispute.

- **Number of IDR Entities/IDR Staffing Levels**: Given the short timeframe to promulgate and implement regulations establishing IDR entity qualifications, CHA's members ask the tri-agencies to consider how many IDR entities will be necessary to meet the anticipated volume of claims from situations covered by the NSA. One approach to doing this is to conduct and make public the results of an analysis of the volume of claims it anticipates will be sent to arbitration during the first five years and how many IDR entities (and the number of arbitrators each entity must employ) will need to be certified to resolve disputes within the statutory time frame. Experience from states that have already implemented arbitration processes for out-of-network claims can be used to inform this market sizing activity from a staffing perspective. The tri-agencies could use this analysis to develop and make public a workplan outlining the necessary steps to recruit and certify a sufficient number of IDR entities.

- **Independent IDR Entities**: CHA strongly agrees with the NSA's intent to create bias-free IDR entities. Therefore, CHA asks the tri-agencies to consider defining health plan affiliates broadly given that health plans and/or their parent corporations have invested (and are continuing to do so) in a wide range of business that are adjacent to providing health insurance. One example of a broad definition of a health plan affiliate could include an entity that is owned in whole or part by an organization that also owns an interest in a health plan. Entities that meet this definition may have a potential conflict of interest and should be prohibited from being certified as an IDR entity. Additionally, CHA asks the tri-agencies to consider the potential for conflicts of interest that may arise when an organization receives a significant portion of its revenue from providing products or services to health plans. The tri-agencies should explore setting a revenue threshold to identify organizations that may be disqualified due to conflict of interest, or at a minimum require a conflict-of-interest mitigation plan.

  CHA also asks the tri-agencies to consider the potential for decision bias if recovery audit contractors (RACs), Medicare administrative contractors (MACs), or any entity that provides similar services for state Medicaid programs are allowed to be IDR entities. These organizations have deep expertise with governmental payment systems and related regulations. While they have considerable health care experience, their specific experience is with programs that have administratively set rates which is not applicable to managed care contracts negotiated rates in the private sector. This issue is why Congress prohibited the use of rates from governmental payers (e.g., Medicare, Medicaid, CHIP, and Tricare) as evidence in support of an arbitration offer. Unless the tri-agencies can implement guardrails to minimize the potential for decision bias based on RACs, MACs, and other similar contractors, experience with governmental programs it may be necessary to bar these organizations from being certified as an IDR entity.

  Finally, CHA encourages the tri-agencies to consider including federal contracting concepts like the Impaired Objectivity (FAR 9.505-3[12]) standard to determine when a potential IDR entity has a conflict of interest that needs to be addressed during the certification process.

[12] https://www.acquisition.gov/far/9.505

- **Ongoing Oversight of IDR Entities**: A certification process for IDR entities is necessary but insufficient to ensure that arbitrators, once certified, are able to deliver impartial results in a timely manner. Unfortunately, CHA's members have significant experience with programs administered by "certified" organizations (e.g., the RAC program[13] and the Durable Medical Equipment Competitive Bidding Program [DMECBP] [14,15]) that were awarded contracts to administer various federal programs. However, these organizations subsequently did not meet their contractual obligations to Medicare beneficiaries, hospitals, physicians, and the Medicare program due to a lack of oversight. Failures to provide sufficient oversight have resulted in poor patient access (DMECBP) and increased administrative expense for both the program and hospitals (DMECBP, RAC). These failures could have easily been avoided with a robust program of ongoing compliance monitoring. However, partial reform of the RAC program was only achieved after the courts ruled against CMS in multiple lawsuits addressing a wide range of program deficiencies. The failures in the DMECBP program were only resolved when the program's scope was drastically reduced due to concerns about the impact on Medicare beneficiaries.

  CHA's members believe the tri-agencies have an opportunity to prevent similar issues with the IDR process by devising and implementing a rigorous oversight process to ensure that IDR entities are not only meeting minimum criteria related to confidentiality and fiscal integrity but are rendering impartial judgements in a timely manner.

  The tri-agencies should convene a stakeholder workgroup consisting of representatives from health plans and providers to design an ongoing compliance process. Given the IDR process is new for all stakeholders, this workgroup should initially meet quarterly to discuss potential issues with the program and recommend updates to the process. Once IDR entities are certified, they should be included in this workgroup. In general, CHA believes that an effective compliance monitoring program has three components:

  1) *Empowered and Accountable Oversight Entity*: Each state or region should have an ombudsman who has the ability to hold IDR entities accountable to their contract terms with HHS for arbitration services. An effective regional ombudsman should have the authority to require IDR entities to submit a corrective action plan if they are found deficient in the performance of their duties. If an IDR entity does not demonstrate material progress in meeting the corrective action plan (CAP) within 90 days of the CAP's submission, the ombudsman should be required to take remedial action(s) against the IDR entity. These remedial actions may include, but are not limited to, assessing the IDR entity monetary penalties for failure to comply with contract terms, suspending the IDR's ability to receive new cases until satisfactory progress is made against the CAP, and terminating the IDR entity mid-contract for failure to comply with the CAP. A CAP could be triggered based on either a pattern of complaints by filed by parties to arbitrations facilitated by an IDR entity and/or deficient performance on key metrics monitored by the ombudsman.

[13] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf
[14] https://www.calhospital.org/sites/main/files/file-attachments/cha_report_dme_final.pdf?1538676055
[15] https://pubmed.ncbi.nlm.nih.gov/26993148/

2) *Participant Complaint Process*: Health plans and providers should have the ability to submit confidential complaints to the regional ombudsman about IDR entity performance. Complaints about performance may include, but are not limited to, failure to meet the statutory timelines, concerns about partiality in arbitration decisions, and/or insufficient legal and/or medical expertise demonstrated by IDR staff members.

3) *Process and Outcomes Measures Monitoring*: Regional ombudsmen should, on a quarterly basis, measure and publicly report key process and outcome metrics related to each IDR entity. The measurement program should be designed to ensure that the IDR entities maintain sufficient levels of qualified staff to make timely decisions. To that end, examples of potential measures include:

- Arbitrator Qualification: Percentage of decisions made (both number and dollar value of cases in dispute) by IDR staff who demonstrate expertise in managed care contracting, revenue cycle, and claims adjudication by holding a current industry certification (examples provided above). CHA believes that less than 90% of decisions by both volume of cases and dollar value represents a material deficiency.
- Ongoing Education: Number of hours of ongoing education arbitrators complete annually related to legal/arbitration process requirements and maintaining health care revenue cycle expertise. CHA believes arbitrators should complete a minimum of 40 hours annually (20 hours of legal/arbitration and 20 hours of health care revenue cycle education).
- Timely Decision Making: Percentage of arbitrations an IDR entity completes within the statutory time frame as a percentage of the number cases and the total dollar value of cases. Falling below 85% represents a material deficiency.
- Participant Satisfaction: Health plan and provider stakeholders who have recently participated in at least three completed arbitrations within the prior quarter should be surveyed to determine their satisfaction with the IDR process.
- Decision Balance: The frequency of decisions in favor of the health plan or the provider.

Beyond using these measures in concert with IDR participant complaints to trigger corrective action plans, the tri-agencies should use these measures to assign cases to IDR entities when the health plan and provider cannot agree on an IDR entity. For example, IDR entities who fail to satisfy the "timely decision" threshold should not be assigned additional cases until they are able to resolve their case backlogs. For entities that have capacity to process additional disputes, cases could be assigned based on a weighted scoring system that gives equal weight to arbitrator education, participant satisfaction, and decision balance.

Clarify IDR Entity Fee Structure

The NSA requires the party whose offer is not accepted to be responsible for the cost of the arbitration. If, after the IDR process is triggered, a provider and health plan are able to arrive at a negotiated settlement, the parties split the costs of the IDR entity. The statute also references administrative fees to be paid to HHS by both parties. However, it is unclear if those fees are separate and distinct from the

fees incurred by the party whose offer was not accepted by the IDR entity. CHA asks the tri-agencies to clarify the fees associated with submitting a claim (or batch of claims) to the IDR process.

Like the NSA, Nevada's surprise bill law requires the party whose offer was not accepted to cover the costs of arbitration. However, unlike the NSA, the law uses different arbitration processes based on the dollar value of the claim in dispute. For claims of less than $5,000, arbitrations may be conducted by qualified employees of the state and arbitrators from the voluntary program for the use of binding arbitration established in the judicial district (or nearest district that has established a program). Claims of $5,000 or more require the use of arbitrators from nationally recognized providers of arbitration services. The filing fee for claims of $5,000 or more is $1,750 for two-party matters, which must be paid in advance[16]. In addition to the filing fee, a 12% case management fee is assessed against all professional fees. CHA understands that in 2020 (the first year the arbitration law was in effect), relatively few claims of $5,000 or greater were submitted for arbitration. Conversations with hospitals in Nevada suggest that the fee structure is a barrier to using the state's IDR process for this group of claims.

We strongly encourage the tri-agencies to create a fee structure that does not impose an unnecessary cost barrier to submitting claims to the IDR process. One way to lower the cost of submitting claims to the IDR process is to set the fee associated with a batch of claims at the same amount as for a single claim arbitration. Therefore, the fee for submitting a batch of claims will be no greater than the fee for submitting a single claim to the IDR entity. As discussed above, we believe this approach to fees for batched claims is aligned with Congress' intent to minimize the cost of the IDR process on both health plans and providers.

Increasing the Transparency of Out-of-Pocket Cost and Network Participation Information for Patients
CHA supports Congress' intent in creating a GFE process to provide an estimate of charges to patients upon request for scheduled services and inform patients of network limitations using the N&C. CHA encourages the tri-agencies to reduce the risk of confusing patients by clarifying the interaction of the GFE with other health plan and provider requirements to improve transparency. We also ask the tri-agencies to consider the potential impact on patient access to care if the GFE were to be repurposed as a utilization management tool. Finally, CHA offers recommendations to simplify the process of creating and transmitting the GFE from a provider to a health plan.

Related to the N&C, CHA requests clarity on the definition of post-stabilization services and the time frame for delivering the N&C for post-stabilization services and inpatient consultations. We also encourage the tri-agencies to establish shared responsibility between hospitals and health plans to affect timely patient transfers to an in-network facility once a patient is stabilized. Finally, CHA notes that hospitals do not have the charge or network participation information necessary to meet the N&C requirements for their community medical staff and, therefore, cannot deliver it on behalf of their physicians and practitioners.

Requested Clarity Related to the GFE
Beginning on January 1, 2022, the NSA requires providers to send a patient's health plan (if the patient is insured) or the patient (if uninsured) a GFE that includes whether the provider is in-network (if the patient is insured), and the estimated total charges — including charges for ancillaries — for scheduled

[16] https://www.jamsadr.com/files/uploads/documents/demand/ab-439.700-jams_arbitration_demand.pdf

items or services based on the anticipated diagnostic/billing codes for the scheduled items and services to be provided.

Providers must transmit the GFE at least three business days before the service is furnished and no later than one business day after scheduling. If the service is scheduled for more than 10 business days later, the provider will need to furnish the information within three business days of the patient requesting an estimate or scheduling a service.

California's hospitals have a long track record of transparency. In accordance with state law[17], California's hospitals already provide uninsured patients with GFEs of their expected out-of-pocket costs for any planned health care service upon request. Few states have such a requirement and feedback from CHA's members suggests providing an estimate to patients upon request works well. And CHA's members have recently implemented out-of-pocket price estimation tools or posted a list of prices for 300 shoppable services to comply with CMS' price transparency requirements.

CHA asks the tri-agencies to consider both the opportunities to reduce redundancy and the potential for unintended consequences created by the GFE requirement. From a policy perspective, the GFE requirement duplicates existing CMS price transparency requirements for both hospitals and health plans. We believe this duplication increases health plans' and hospitals' administrative costs, translating into increased consumer health insurance premiums, without significantly improving the information available to patients to help them make value-based decisions about where to receive their health care. Thus, the GFE presents an opportunity to streamline information available to patients about their out-of-pocket costs and reduce administrative expenses.

From an operational perspective, this new requirement, if not implemented as Congress intended, could create significant administrative burdens due to the sheer increase in number and scope of the estimates required. And, even if scoped appropriately, developing and using a standardized process to submit the GFE to health plans, can minimize — to the greatest extent possible — costs associated with the administrative burden. Finally, CHA asks the tri-agencies to consider steps to ensure the GFE is not used as another mechanism to delay or deny medically necessary care to patients or inappropriately reduce payments to providers for medically necessary services rendered to patients.

Beyond the specific recommendations discussed below, CHA asks the tri-agencies to delay implementation of the GFE and the related Advanced EOB requirement. This delay will both allow the administration to harmonize its efforts to provide a mechanism for patients and consumers to understand their out-of-pocket costs in advance of a service or procedure. Once an overarching, federal framework that allows consumers to request an estimate of their out-of-pocket costs in advance of a service or procedure is in place, it will allow health plans and providers, and their respective technology vendors to develop a standardized, automated process to exchange this data and effectively communicate it to patients and consumers.

- **Duplicative Requirements for Providing Out-of-Pocket Cost Estimates to Patients:** The GFE and related Advanced EOB is just one of three federal requirements for hospitals and health plans to

[17] California Health and Safety Code Section 1339.585

provide charge and out-of-pocket cost information to patients and consumers. The two others are:

- Hospitals: Effective January 1, 2021, hospitals are required to post a searchable display of standard charges for at least 300 "shoppable" services. Standard charges are defined as the gross charge, payer-specific negotiated charge, de-identified minimum and maximum negotiated charges, and discounted cash price. This requirement can be satisfied by posting an out-of-pocket cost estimation tool. Many hospitals, given the value to the consumer of receiving their specific out-of-pocket costs, have opted to comply with this portion of the CMS price transparency requirements by making such a price estimation tool available on their websites.

  Health plans: For plan years starting on or after January 1, 2022, health plans are required to make available to the public three separate machine-readable files that provide detailed price information. The first file contains the negotiated rates for all covered items and services for all in-network providers. The second file includes historical payments to out-of-network providers. The third file includes in-network negotiated rates for all covered prescription drugs at the pharmacy location level.

  Additionally, starting in plan year 2023, CMS will require health plans to make personalized out-of-pocket cost information (which includes the underlying negotiated rate) for 500 shoppable items and services available via an internet-based, self-service tool (or by request). The remainder of all items and services will be required for these self-service tools for plan years that begin on or after January 1, 2024.

We believe Congress provided the flexibility and encourage the tri-agencies to explore options for harmonizing these requirements to create an environment where consumers can readily access easy to understand information about their out-of-pocket costs. CHA encourages CMS and the tri-agencies to convene a stakeholder workgroup that includes consumers/patients, health plans, and providers to determine an effective strategy for providing patients with an estimate of their out-of-pocket costs upon request, in advance of a scheduled service, and in the most effective manner. We urge the tri-agencies to delay implementation of the GFE and Advanced EOB requirement until the workgroup has developed a recommendation. Otherwise, it risks confusing patients with additional notices.

- **Scope and Scale of GFEs:** Congress intended for GFEs to be provided only to scheduled patients upon request. As evidence of this, the section that adds the GFE requirement, Section 2799B–6, is entitled, "Provision of Information Upon Request *and*[18] for Scheduled Appointments". This has been confirmed in conversations with Congressional staff involved in drafting the legislation. Further, had this requirement been intended to apply to all scheduled services — not just for requested scheduled services — the section title would not have included "upon request."

[18] Emphasis added.

Notably, in 2016 there were over 883.7 million[19,20] physician practice visits in the United States alone. Further, CHA estimates that in 2019 California hospitals performed almost 2 million scheduled surgeries. This number does not include other services or procedures performed in a hospital setting, like MRIs or endoscopies. Given the sheer number of services and procedures that are scheduled annually, CHA asks that the tri-agencies adhere to Congress' intent and require hospitals to deliver GFEs only when they are requested by the patient for scheduled services. If the tri-agencies expand the requirement to all scheduled services it will be impossible — even with automation – for providers to produce that volume of GFEs in a timely manner, transmit them to health plans, and for health plans to provide an Advanced EOB to patients.

The NSA also requires providers to include the:

> *… expected charges for furnishing such item or service (including any item or service that is reasonably expected to be provided in conjunction with such scheduled item or service and such an item or service reasonably expected to be so provided by another health care provider or health care facility), with the expected billing and diagnostic codes for any such item or service …*

CHA asks the tri-agencies to limit the charge and network participation information providers are responsible for delivering as part of the GFE to estimates of items and services the provider will bill for directly. First, providers do not have access to the charge and network participation information for other providers they do not employ (or own in the case of facilities). Second, regarding hospitals specifically, California state law (Business and Professions Code, section 2400) prohibits hospitals from employing physicians. Therefore, hospitals in California do not have access to the charge and network participation information for the physicians and other practitioners who may deliver ancillary services as part of a service or procedure performed in their facilities.

Additionally, CHA asks the tri-agencies to clarify that any items and/or services that may be required at a later date as a result of an item or service provided by a hospital should not be included in the GFE. Examples of this may include but are not limited to surgery that may result from the findings of a biopsy or physical therapy that may be needed after a scheduled surgery. First, in most instances the hospital will not own the downstream provider and, therefore, will not know their charge structure or the health plan networks in which they participate. Second, at the time of the initial GFE, the scope of required downstream services will not be fully known, making providing an accurate estimate even more challenging.

Finally, CHA's members report that the statutorily mandated requirement to produce and transmit a GFE to a health plan within one business day of scheduling will be challenging, if not impossible to meet. CHA asks the tri-agencies to allow providers five business days to transmit

[19] https://www.cdc.gov/nchs/data/ahcd/namcs_summary/2016_namcs_web_tables.pdf
[20] This number does not include inpatient stays or provider-based departments.

the GFE to a health plan (or deliver it to a patient) after a service is scheduled and the estimate is requested.

- **Require Standardized GFE Transmission Format/Mechanism:** The anticipated volume of requested GFEs for scheduled services is significant. Additionally, the timeline to provide the required information to the health plan is short. CHA encourages HHS to identify and mandate the use of a standard format to electronically transmit the GFE to health plans (and health plans be required to use the standard format to receive it). If a standard, electronic format is not used, CHA is concerned that each health plan may require the information to be submitted in different formats (which could even vary for different products offered by the same payer) using proprietary web portals or even manual processes.

  A similar situation currently exists for prior authorizations. According to a recent Coalition for Affordable Quality Healthcare report, despite the existence of a mandated HIPAA transaction standard for prior authorizations, only 21% of prior authorizations are fully automated. The remainder are submitted via proprietary web-portal (45%) or manually (34%)[21]. Providers reported spending an average of 20 minutes conducting a prior authorization manually, 13 minutes conducting one via a web portal, and eight minutes conducting one using the fully electronic, HIPAA-mandated standard. The cost to complete a prior authorization remains the single highest cost transaction for the health care industry at $13.40 per manual transaction and $7.19 per partially electronic web portal transaction. In 2020, 76 million prior authorizations were submitted via a proprietary portal, with an additional 62 million prior authorizations completed manually. If HHS required health plans to use the HIPAA transaction standard it would result in $482 million in annual savings. The vast majority of this cost savings potential accrues to providers, which could reduce prior authorization costs by $322 million annually.

  Providers' experience with manual and partially electronic prior authorization submission is imperfect as an example of the administrative burden the GFE will create. The anticipated volume of GFEs will be higher than the volume of prior authorizations, and it may take longer to calculate estimated charges than the documentation for a prior authorization. However, CHA believes the example of administrative burden posed by prior authorization is a directionally correct analog.

  Therefore, CHA encourages the Secretary of HHS to develop a separate HIPAA transaction standard for transmitting the GFE and require health plans to accept it. In conversations with members, CHA has explored using existing transaction standards to transmit this data – specifically the 837 and 278 HIPAA transaction standards. However, both were ruled out. The current information requirements and related claims edits for the 837 transaction standard are too detailed/complex for providing a GFE. The 237 transaction standard was ruled out as it lacked some data elements necessary to complete the GFE. Additionally, as discussed below, CHA is concerned that the GFE may be used as a tool to inappropriately delay or deny medically necessary care or reduce appropriate payment for necessary care after the fact. Submitting the GFE on the prior authorization transaction standard — even if modified — only exacerbates the likelihood of potential misuse.

[21] https://www.caqh.org/sites/default/files/explorations/index/2020-caqh-index.pdf

- **Expressly Prohibit Health Plans from Using the GFE to Delay, Deny, or Under-Reimburse Necessary Care:** CHA's members are concerned the GFE could become a tool used by health plans to delay or deny necessary care to patients or reduce or deny payment after services are provided. Therefore, we ask the tri-agencies to prohibit health plans from the following, enforceable by civil monetary penalty of up to $10,000 per violation:

  - Requiring a GFE as a Condition of Claims Payment: In instances where the patient requests a GFE, the short timeframes afforded providers to transmit the GFE to health plans, and for health plans to transmit an Advanced EOB to patients, will prove challenging. Additionally, unless HHS requires the use of an automated transaction standard (including a response receipt back to the provider that initiated the transaction) there is no way to prove in a dispute that a GFE was sent or, conversely, for the health plan to prove that it did not receive a GFE. Therefore, we ask the tri-agencies to clarify that health plans may not predicate payment on receipt of a GFE.

  - Using the GFE to Reduce or Retroactively Deny Payment to Providers or Increase Retroactive Claims Reviews*:* CHA believes it is inappropriate for health plans to attempt to limit payment to providers to the lesser of the amount calculated using the billing codes/charges listed on the GFE or actual codes/charges submitted on the claim. It is also inappropriate to use the GFE as a "flag" to identify claims for either pre-payment or post-payment review, or retroactively deny claims based on the GFE that was submitted to the health plan. Congress intended for the GFE to be an estimate — based on what is clinically known about the patient's condition prior to more extensive services — of anticipated services and related charges necessary to treat a medical condition. It is not uncommon for providers to determine during the course of a service or procedure that a patient's medical condition is more complex than initially indicated during the pre-service/procedure evaluation used to generate the GFE. Additionally, providers will base their GFEs on the information provided to them by the physician or practitioner who is referring the patient to the provider for the service or procedure. Beyond being imperfect by its nature, this information may be conveyed or augmented by the patient (or a caregiver) who lacks specific clinical training. Therefore, CHA asks the Secretary of HHS to expressly prohibit the GFE from being used to reduce payment to providers or potentially identify claims for administrative review.

Enforcement

The NSA permits states to require providers to adhere to the NSA's provisions and enforce compliance. Absent state action against any violation, the Secretaries of HHS, Labor, and Treasury each play a role in enforcement, with the HHS Secretary able to issue civil monetary penalties of up to $10,000 per violation. The HHS Secretary may waive these penalties if the provider unknowingly violated the provisions and could not have reasonably known in advance, withdraws the bill, and reimburses the patient (or plan, as appropriate) with interest. In addition, the HHS Secretary has authority to issue hardship exemptions.

CHA strongly supports the HHS Secretary's discretion to waive provider penalties when a provision of the NSA is unknowingly violated. CHA also believes the tri-agencies should work with providers to develop a flexible hardship exemption process that will accommodate circumstances that prevent providers from fully complying with the NSA. In addition to other scenarios that stakeholders may

identify through the rulemaking process, CHA believes that specific hardship exemptions should be available for both natural disasters/public health emergencies and situations where the arbitration process will exacerbate the risk of bankruptcy or closure for a financially distressed provider. Finally, CHA is concerned the NSA's enforcement provisions do not include specific language addressing health plan non-compliance with provisions of the NSA. Therefore, we encourage the tri-agencies to create a robust monitoring and enforcement process to ensure that health plans comply with the intent of certain consumer-focused provisions of the NSA.

Flexibility for Natural Disasters/Public Health Emergencies
During the COVID-19 pandemic, California providers have faced significant challenges meeting health plan administrative billing requirements due to disruptions in operations and the sheer volume of cases. This has not only resulted in cash flow issues for some providers — at a time when liquidity was desperately needed — but required administrative resources that should have been focused on responding to the pandemic.

Given the additional administrative processes created by the NSA, CHA asks the tri-agencies to incorporate the flexibility necessary to allow providers to respond effectively to declared natural disasters or public health emergencies in the regulations implementing the law. Specifically, CHA asks that when a provider is in an area subject to a natural disaster or public health emergency declaration, or a patient resides in an area subject to such declaration, the regulations implementing the NSA:

- Limit cost sharing for affected patients who receive out-of-network care for emergency services as defined in the NSA to the in-network amount based on the "recognized amount"
- Require health plans to pay providers billed charges for emergency and post-stabilization services for affected facilities and patients. CHA's members believe they would not have had sufficient staff resources to pursue arbitration during the surges in COVID-19 cases during the third and fourth quarters of 2020.
- Suspend the requirement for providers to deliver a GFE in advance of scheduled services. During a declared PHE or natural disaster, patients scheduling services are more likely to need urgent care. This coupled with limited staff capacity will make it challenging for providers to deliver a GFE within the statutory timeframe, even if it is modified as requested above.

Support for At-Risk Providers
CHA is concerned that delays in payment due to the IDR process may push financially distressed providers into bankruptcy. Therefore, for providers with fewer than 45 days cash on hand, CHA asks the tri-agencies to create a hardship waiver that allows for providers to request and be granted an accelerated IDR process. This process would:

- Allow distressed providers to immediately move to arbitration instead of first attempting to negotiate with the out-of-network health plan, if the provider so chooses
- Require IDR entities to resolve disputes within five days of receiving bids and supporting evidence from the health plan and distressed provider
- Eliminate the 90-day "cooling off period," allowing distressed providers to bring similar cases from the same health plan to an IDR entity as soon as the out-of-network health plan has either issued a denial or insufficient payment for services

- Require health plans to pay distressed providers within five days of an IDR entity's decision in favor of the provider. If payment is not received within five days, the plan should also pay the distressed provider interest at a rate to be determined by the Secretary. The amount of interest due should be calculated based on the date of the health plan's initial payment or denial notice to the distressed provider.
- Suspend the requirement for distressed providers to deliver a GFE in advance of scheduled services. Distressed providers will likely need to repurpose revenue cycle staff to focus on activities that accelerate collection of outstanding accounts receivable from health plans for services rendered to patients.

Health Plan Compliance Monitoring
CHA asks the tri-agencies to establish a robust process for monitoring health plans' compliance with the NSA's requirements. As discussed above, some health plans may attempt to use the GFE requirement to delay or deny patient care or reduce or deny payment for care after services are delivered. Therefore, we ask the tri-agencies to create a process for providers to refer evidence-based complaints of health plan non-compliance with the NSA or misuse of the GFE to HHS for investigation and enforcement action when necessary.

CHA appreciates the opportunity to offer comments to the tri-agencies on technical issues related to the No Surprises Act. We look forward to working with tri-agencies and health plans to develop and implement a regulatory framework that achieves the goals of the NSA. If you have any questions about the comments, please contact me at (202) 270-2143 or cmulvany@calhospital.org.

Sincerely,
/s/

Chad Mulvany
Vice President, Federal Policy

Cc: Elizabeth Richter, Acting Administrator, Centers for Medicare & Medicaid Services