December 6, 2021

Sent electronically

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

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Martin Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Subject: **CMS-9908-IFC, Requirements Related to Surprise Billing; Part II; Interim Final Rule with Comment Period, Federal Register** *(Vol. 86, No. 192), October 7, 2021*

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 the Departments of Health and Human Services (HHS), Labor, and Treasury (hereafter, tri-agencies) have done to protect patients when they receive care from out-of-network providers at in-network facilities, or from out-of-network providers and facilities (hereafter, providers unless otherwise specified) in emergency situations, by developing regulations implementing the No Surprises Act (NSA). We look forward to continuing to work with the tri-agencies and health plans to implement the law and realize our long-held mutual goal of removing patients from billing disputes that arise when care is provided in situations covered under the NSA.

We appreciate the opportunity to comment on the Requirements Related to Surprise Billing; Part II; Interim Final Rule with Comment Period (hereafter, IFR). Among other provisions, the rule implements

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the arbitration process used when health plans and insurers (hereafter, health plans) and providers cannot agree on an appropriate payment amount for out-of-network care covered by the NSA. Contrary to congressional intent, the rule instructs arbiters to default to a health plan's median payment rate — the qualifying payment amount (QPA) — for a service instead of considering all the factors included in the legislation. Congress included these factors to ensure the arbitrated payment amount fully recognizes the value of care provided to patients.

Overweighting the health plan median payment rate in the arbitration process will encourage health plans to reduce payments to hospitals and other providers to improve the plans' profit margins. This will ultimately limit patient access to care for services that are not covered under the NSA. California learned this difficult lesson through experience. The state's surprise billing law[1] uses a benchmark payment amount in the arbitration process to resolve disputes between health plans and noncontracting individual health professionals for services covered under the statute. According to one survey, after passage of Assembly Bill (AB) 72, 41% of California physicians reported insurers were contracting with fewer hospital-based physicians, 31% experienced insurers refusing to renew contracts, and 23% had an existing contract terminated[2]. **CHA is concerned the tri-agencies are making a similar mistake. We respectfully ask the tri-agencies to protect Americans' access to broad insurance networks by adhering to congressional intent and revising the regulations to instruct arbiters to consider *all the factors Congress included in the NSA equally* to arrive at an appropriate payment rate for care provided in situations covered under the law.** As early evidence of this, we are aware that at least one market-dominant health plan (97% of individual market, 71% of large group market[3]) is using the imbalance created by overweighting the QPA and threatening[4,5] to remove providers from its networks to extract rate concessions from providers. In markets where this happens, it will ultimately create network access issues for consumers, delay much needed medical care, and negatively impact patient outcomes.

While the tri-agencies' overweighting of the QPA is CHA's most significant concern with the IFR, it is not our sole concern. We believe there are opportunities to reduce the administrative burden for health plans, providers, and patients while providing a fair dispute resolution process. Making these changes will ensure that access to broad health plan networks is maintained and avoidable implementation costs associated with the NSA do not increase health plan premiums for consumers. Therefore, we respectfully ask the tri-agencies to address the following issues:

1) *Independent Dispute Resolution (IDR) Process*: Beyond the issue related to the QPA discussed above, CHA has technical concerns with the IDR process. We respectfully encourage the tri-agencies to instruct IDR entities to review the QPA submitted by the health plan to ensure its accuracy. We are disappointed that the IFR baselessly suggests providers will manipulate the QPA while ignoring health plans' long track record of distorting data used to determine payment in their favor. Further, we ask the tri-agencies to revise provisions of the IFR that further

[1] Stats. 2016, c. 492 (A.B. 72).
[2] https://www.cmadocs.org/Portals/CMA/files/public/CMA%20Suprise%20Billing%20Survey%20Results%202019.pdf
[3] https://www.kff.org/state-category/health-insurance-managed-care/insurance-market-competitiveness/
[4] https://www.documentcloud.org/documents/21116581-20211105-bcbsnc-rate-reduction-notice_redacted?responsive=1&title=1
[5] https://www.healthcaredive.com/news/blue-cross-nc-surprise-billing-act-provider-rate-reductions/610501/

encourage IDR entities to select health plans' bids in situations where the initial payment was inadequate to cover the cost of providing medically necessary care. Failing to do so will further harm patient access to in-network care for services not covered under the NSA.

2) *Negotiation Initiation Process:* CHA has concerns with the process used to initiate the negotiations. We respectfully ask the tri-agencies to require health plans to accept negotiation requests via mediums that will give providers proof that the notice was received by the health plan. Further, we ask that health plans confirm that they have received the request to initiate negotiations within 24 hours of receipt.

3) *Self-Pay Good Faith Estimate (GFE):* Even with the 12-month delay — which is much appreciated — CHA does not believe it is possible for convening providers to obtain estimated charge information from co-providers within the time frame required by the NSA and related IFRs. While we appreciate that a consolidated estimate is more consumer friendly, we do not believe it is operationally possible given the way our health care delivery system is structured — particularly in states with corporate practice of medicine prohibitions. Physicians are not employed by hospitals in California and, therefore, hospitals do not have access to the expected charges for ancillary providers. Consequently, we ask that the tri-agencies provide access to the "expected charges" associated with a scheduled service by allowing co-providers to submit GFEs to a patient or consumer separate from the "convening" facility's GFE. Providing the GFE in this manner is how the patient will be billed after services are rendered. CHA is concerned that if a patient receives a consolidated GFE, they may expect to receive a consolidated bill. When they do not, it will likely create additional patient confusion, not eliminate it.

4) *Patient-Provider Dispute Resolution (PPDR) Process*: CHA is concerned that the threshold to bring a dispute is based on a single point estimate. Despite best efforts, it is not possible for a provider to predict the billed charges consistently and accurately for every episode of care. Every patient's clinical presentation is unique to their circumstances, and whether an item or service is "foreseeable" is highly subjective. Therefore, we respectfully ask CMS to allow providers to provide a range of possible total expected charges (instead of a single point estimate), and then base the threshold for which a bill qualifies for the upper end of the expected charges range.

5) *IDR Certification*: CHA greatly appreciates the tri-agencies' inclusion of a mechanism for stakeholders to request the de-certification of an IDR entity. We believe this is necessary to ensure that IDR entities are accountable for the accuracy of their decisions. However, we are deeply concerned that in the IFR the tri-agencies assert they will evaluate IDR entity performance based on the number of times the entity selects a payment amount above the QPA. We believe this further incentivizes IDR entities to select lower payment amounts, which will lead to narrower health plan networks and reduced patient access to in-network providers. Therefore, we ask the tri-agencies to remove this criterion from the evaluation of an IDR entity's performance.

6) *Broad Enforcement Discretion*: In the July 13, 2021, IFR the tri-agencies stated they considered delaying implementation of the NSA due to the considerable operational challenges that health plans, providers, and their information technology business partners must overcome prior to

January 1, 2022. Thus far, the tri-agencies have provided limited enforcement discretion for some facets of the NSA for health plans (advanced explanation of benefits[6], health plan transparency[7]) and providers (insured GFE, including co-providers in self-pay GFE). However, CHA believes this is insufficient and asks the tri-agencies for broad enforcement discretion that extends 12 months after all rules necessary to implement the NSA have been issued and finalized. This will allow for thoughtful and efficient implementation of the law's requirements and will help achieve our shared goal of removing patients from billing disputed in covered situations and providing patients with information that will empower them to make informed health care decisions.

Below, please find CHA's specific comments related to each of these areas.

IDR Process

The IFR implements the federal IDR process that is available to providers and plans when an agreement cannot be reached on the out-of-network reimbursement amount following a 30-day "open negotiation" period. CHA has multiple technical concerns related to the IDR process, as discussed below.

Offer Selection

The IFR discusses the criteria that arbiters must consider when selecting an appropriate payment rate. Beyond overweighting the QPA, CHA is concerned the tri-agencies have erected a barrier preventing arbiters from considering the other factors — that Congress intended — to inform the selection of the appropriate payment amount for out-of-network services covered under the NSA unless the provider offers "credible evidence" the arbiter should consider these factors. Further, we believe there are certain situations where the IDR entity will need to use (and, therefore, consider) billed charges to arrive at an appropriate payment amount. And finally, CHA asks the tri-agencies to clarify that Medicare Advantage and Medicaid managed care rates cannot be incorporated into the calculation of the QPA or considered as part of the IDR process.

Presumption QPA Is the Appropriate Payment Amount

The IFR requires that an "IDR entity must begin with the presumption that the QPA is the appropriate out-of-network rate for the qualified IDR item or service under consideration." As such, IDR entities are required to select the offer closest to the QPA unless "credible information" is submitted by either party that demonstrates the QPA is "materially different" from the appropriate out-of-network rate.

The tri-agencies attempt to justify this decision based on a variety of factors, none of which support, individually or in aggregate, the elevation of the QPA to a de facto benchmark.

1) *Asserting Congressional Intent Inaccurately*: The agencies assert that the amount of detail provided in the statute for how the QPA should be calculated is evidence of Congress' intent that the QPA should be overweighted, creating a de facto benchmark. **CHA strongly disagrees with this patently inaccurate assertion. Congress, during the two-year development of the Act, thoughtfully considered and ultimately rejected multiple proposals that relied on a median in-network rate as a benchmark for determining a provider's payment when services are**

[6] https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf
[7] https://public-inspection.federalregister.gov/2021-25183.pdf

provided to an out-of-network patient. Had Congress intended this result, the statute would have plainly instructed the tri-agencies to use the QPA as a benchmark. Instead, Congress was deeply concerned that using a benchmark rate to determine the appropriate payment amount would financially reward health plans that continue to narrow already inadequate provider networks. This will further reduce patient access to medically necessary services as proven by California's experience with its surprise billing law, AB 72.

This deviation from congressional intent has been documented in multiple letters[8,9] to the tri-agencies expressing congressional representatives' deep concern about the unintended impacts of overweighting the QPA. As an example, in an October 4, 2021, letter to the tri-agencies, House Ways and Means Committee Chairman Richard Neal (D-MA) and Ranking Member Kevin Brady (R-TX) unequivocally state Congress' intent:

> *Despite the careful balance Congress designed for the IDR (independent dispute resolution process), the September 30, 2021 interim final rule with comment strays from the No Surprises Act in favor of an approach that Congress did not enact in final law and does so in a concerning manner. The rule crafts a process that essentially tips the scales for the median contracted rate being the default payment amount.*

2) *Uses "Standard Market Rates" Inappropriately*: The tri-agencies mistakenly assert that the QPA represents "standard market rates" arrived at by *negotiation*[10] and, therefore, reflects a reasonable out-of-network rate under most circumstances. CHA disagrees with this assertion for two reasons.

   - *QPAs Are Not Calculated in a Manner that Results in Standard Market Rates*: The July 13, 2021, IFR calculates the QPA as the median contracted rate for the same service for all plans of the same sponsor, ordered from least to greatest, for the same insurance market for similar provider types. As we noted in our comment letter, we believe this methodology is badly flawed. We believe the methodology must be revised to include all rates the tri-agencies have defined as "contracted rates" for purposes of the NSA.

   - *QPAs Do Not Accurately Reflect Market Conditions between Out-of-Network Health Plans and Providers*: Even if the QPA were calculated in a manner that resulted in "standard market rates," it does not accurately reflect the market dynamics between an out-of-network health plan and providers. As CHA has discussed in prior comments, when a health plan and provider negotiate a contract, there are many factors that inform the mutually agreed to payment rate for services. These factors may include, but are not limited to, a provider offering a health plan a lower per unit price for services based on the number of covered lives the provider will have the opportunity to care for under a given contract, streamlined administrative process, and opportunities to partner to coordinate individual member care and improve the overall health

[8] Richard Neal, Chairman House Committee on Ways and Means; Kevin Brady, Ranking Member, House Committee on Ways and Means. Richard Neal and Kevin Brady to Secretary Xavier Becerra, U.S. Department of HHS; Secretary Martin Walsh, U.S. Department of Labor; Secretary Janet Yellen, U.S. Department of Treasury. Washington, DC. October 4, 2021. Re Implementation of the No Surprises Act.
[9] https://wenstrup.house.gov/uploadedfiles/2021.11.05_no_surprises_act_letter.pdf
[10] Emphasis added

of the covered population.

Ultimately, these non-monetary factors influence the negotiated rates a health plan and provider establish when they agree to a contract. However, these factors are completely absent when a health plan and a provider are unable to negotiate a mutually agreeable contract and the provider cares for a plan's out-of-network patient. Typically, when a health plan fails to contract with a provider, it is because the plan failed to fully account for these non-monetary factors in the negotiation. Therefore, Congress included, in addition to the QPA, a list of additional factors that the IDR entities must take into consideration when they determine the appropriate payment amount for out-of-network services provided in situations covered under the NSA.

CHA believes the only time it would be appropriate to default to an "existing rate" is in instances where the out-of-network health plan and provider previously had a contracted rate in effect. We are aware that several states with surprise billing laws have taken this approach to protect patient access to in-network care and ensure these laws do not create incentives for health plans to further narrow their networks. 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 to contract with one another to ensure access to in-network care for health plan members requiring non-emergent services, 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[11]) and New York (125% of the prior contracted amount, adjusted for inflation[12]).

CHA believes this is a reasonable approach to prevent the NSA from negatively influencing network access for patients who require non-emergent services. We encourage the tri-agencies to protect patient access to in-network facilities and providers by incorporating a similar mechanism for calculating the QPA where a previous contract between the health plan and facility or provider existed.

3) *Increasing Predictability by Biasing the Arbitration Process*: The IFR states that "anchoring the determination of the out-of-network rate to the QPA will increase the predictability of IDR outcomes, which may encourage parties to reach an agreement outside of the Federal IDR process to avoid the administrative costs …" CHA notes that the goal of the NSA is to remove patients from the middle of billing disputes related to out-of-network services in covered situations and provide a fair mechanism to determine the appropriate payment. The goal of the statute is not to create predictable outcomes from the IDR process. And while we greatly appreciate the tri-agencies' concern about administrative costs, we believe it is inappropriate to attempt to reduce those costs by favoring one party to the arbitration (health plans) over another (providers) — and in the process, harming patients' access to in-network care, as has been California's experience with AB 72.

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

Given the insufficient justification for using the QPA as a de facto benchmark, CHA respectfully asks the tri-agencies to protect Americans' access to timely care by adhering to congressional intent and revising the regulations to instruct arbiters to consider *all the factors Congress included in NSA equally* to arrive at an appropriate payment rate in situations covered by the NSA.

Finally, given the importance of the QPA, CHA respectfully asks CMS to develop a standard reporting template that can be used to compare QPAs in each geographic area. Using this standard reporting template, we ask the tri-agencies to require health plans to report to CMS, on a quarterly basis, their QPAs for each item and service they cover. We ask that CMS then display the QPA for each health plan in a geographic area on a publicly available website in a side-by-side fashion. These data should be updated quarterly. We believe this level of transparency is necessary to ensure that health plans are calculating their QPAs for a given service in accordance with the regulations promulgated by the tri-agencies.

Consideration of Other Factors in Offer Selection Aside from the QPA

The IFR requires that other factors included in the NSA must be deemed "credible and relate to the offer submitted by either party …" in order for the IDR entity to consider them. The rule defines credible information as that which, "upon critical analysis the information is worthy of belief and is trustworthy." The tri-agencies also allow the arbiters to determine whether submitted information is immaterial to the dispute — and, therefore, can be cast aside. First, CHA notes that section 2799A-1(c5Ci) as added by the NSA does not give the tri-agencies (and, therefore, the IDR entity) the option to disregard information that is submitted as part of the dispute.

> *(i) IN GENERAL.—In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR item or service shall consider*[13]*—*
>
> > *(I) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and*[14]
> >
> > *(II) subject to subparagraph (D), information on any circumstance described in clause (ii)*[15]*, such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph(B)(ii)*[16,17]*.*

As illustrated above, nowhere in the statutory text does Congress require that arbiters only consider the other factors delineated in the statute to arrive at a payment amount once the information has cleared a

[13] Emphasis added.
[14] Emphasis added.
[15] Includes training, level of experience, outcomes measurements; market share held by the non-participating provider/facility and/or health plan; patient acuity or service complexity; teaching status, case mix, and/ or scope of services offered by the non-participating facility; demonstrations of good faith efforts to contract in the prior four years.
[16] *(ii) may each submit to the certified IDR entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).*
[17] Emphasis added.

highly subjective credibility threshold. **Therefore, we ask the tri-agencies to adhere to congressional intent that all submitted information meeting the statutory requirements be considered by the IDR entity by removing the qualifier "credible information" and related definition from the regulations.** Further, given it is the arbiter who is responsible for determining the credibility of any additional information submitted by the provider, CHA is deeply concerned this creates a conflict of interest that cannot be resolved. It is reasonable to assume that IDR entities will place productivity standards on arbiters. These standards will be used to reward them for resolving as many cases as possible while penalizing them for failing to meet productivity quotas. Further, the IFR states that an IDR entity will be evaluated based on whether its decisions "have an inflationary effect on healthcare costs." We believe this combination of factors will create an environment where IDR entities set high productivity standards that implicitly reward arbiters for selecting the offer closest to the QPA even when information is submitted that suggests otherwise. CHA is deeply concerned that the highly subjective definition of "credible information," coupled with productivity standards and the implicit threat in the IFR to decertify IDR entities whose arbiters frequently select offers that exceed the QPA, creates an environment that encourages arbiters to ignore information that Congress intended for them to consider when determining an appropriate payment amount in out-of-network payment disputes.

Prohibition on Considering Charges

The IFR prohibits IDR entities from considering the amount that would have been billed to a health plan if the provider had not been subject to a prohibition on balance billing. **CHA asks the tri-agencies to reconsider this decision on a limited basis as there are some instances — like high-cost outlier cases — where it will be appropriate for IDR entities to consider billed charges in determining an appropriate payment amount.** Many health plans include stop-loss provisions in their commercial contracts for 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, the hospital's billed charges are used in the calculation of stop loss (or outlier) payments for high-cost, complex patients. Allowing the IDR entity to use billed charges to calculate outlier payments in select instances will ensure that decisions will not be biased in favor of either party to the arbitration.

Prohibition on Considering Governmental Rates

IDR entities are prohibited from considering reimbursement rates payable by public payers. This prohibition includes Medicare, Medicaid, Children's Health Insurance Program (CHIP), and TRICARE payment or reimbursement rates. It also applies to payment rates for demonstration projects under section 1115 of the Social Security Act. 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.

Incorporating the negotiated price for a service covered by a commercial health plan with the price paid by a MA or MCO plan into the QPA is inappropriate and would unfairly bias the arbitration in favor of the health plan. Typically, CMS and state Medicaid agencies pay a health plan that runs an 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 (FFS) payment rates that are administratively set by CMS (e.g., inpatient prospective payment system, outpatient prospective payment system, physician fee schedule) or state Medicaid programs. While rates between providers and

MA and MCO plans are "negotiated," the negotiations are typically based on the FFS rates, which are administratively set by CMS or state Medicaid agencies and 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 Entity's Purview

In the IFR, the tri-agencies clarify that it is not the role of certified IDR entities to ensure that the QPA has been calculated correctly, make determinations of medical necessity, nor review denials of coverage. As expressed in a prior comment letter, CHA is deeply concerned by the limited number of health plans that will have their QPA audited. **Given the importance of the QPA, we respectfully ask the tri-agencies to address this concern by allowing IDR entities to review the QPA to ensure its accuracy. At a minimum we believe IDR entities should be empowered to refer health plans whose QPAs appear incorrect (or anomalous) to HHS for further review.** We do not believe our concern with QPA accuracy is unmerited or the request unreasonable, given past instances where health plans have manipulated payment amounts calculated in a "black box[18]" environment or skewed data impacting payments[19] to their financial advantage. Further, given the volume of claims IDR entities will review in the various geographic markets, CHA believes they will have the ability to identify instances where a health plan is not calculating the QPA for a given service accurately.

The IFR also states that IDR entities may conclude that the QPA does not adequately account for patient acuity or the complexity of furnishing the service in instances where the parties disagree on what service code(s) or modifier(s) accurately describes the service(s) in question. If a health plan has downcoded a claim (altered the service code(s) and/or modifier(s)) and applied a QPA that uses a different service code(s) and/or modifier(s) than billed, the provider can submit information to the IDR entity demonstrating that the QPA applied by the plan or issuer to the claim is based on a service code or modifier that does not accurately reflect the acuity or complexity of furnishing the service to the patient. CHA greatly appreciates the tri-agencies' recognition of the pervasive issue of inappropriate downcoding in the IFR. We believe it would be appropriate for IDR entities to review instances of downcoding if these disputes are mediated by arbiters who hold a current coding certification that applies to the setting where the care occurred, and coding system used by the plan and provider for billing (e.g., American Association of Professional Coding's [AAPC] Certified Outpatient Coder [COC] for outpatient services provided in the emergency department). **Therefore, CHA provisionally supports allowing the IDR entity to review a health plan's code and modifier selection in instances where the plan has downcoded the claim if the tri-agencies clarify that the review must be conducted by an arbiter who holds a coding certification that is germane to the care setting and coding system used on the claim.**

Finally, in the rule, the tri-agencies state the IDR entity audit process will evaluate whether the IDR entities' decisions are contributing to health care inflation due to "failing to properly apply the factors as set forth in these interim final rules." **We ask that if this language remains in the preamble (discussed further below) the tri-agencies clarify that if an IDR entity selects a higher payment amount than the plan's QPA that was based on an inappropriately downcoded service, the IDR entity is properly following these interim final rules.**

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[18] https://www.mssny.org/MSSNY/Resources/Legal_Matters/Class_Action_Settlements/United_Healthcare_Settlement/MSSNY/Practice_Resources/Legal_Matters/Class_Action_Settlements/United_Healthcare_Settlement.aspx?hkey=52f280ad-c706-4fe9-92cd-26fb332d9860

[19] https://oig.hhs.gov/oei/reports/OEI-03-17-00474.asp

IDR Process Timelines

Congress was silent in many parts of the NSA about whether days should be counted using business or calendar days. In the IFR, the tri-agencies clarify that unless there is a reason to use calendar days, the timeline is based on business days to provide the parties to a dispute with the maximum amount of time permitted to meet various deadlines. **CHA thanks the tri-agencies for their appreciation of the truncated timelines in the dispute resolution process. We strongly support the tri-agencies' decision to use business days unless otherwise specified.**

However, we remain concerned that even with the use of business days, the timeline afforded to complete certain processes is operationally unrealistic. For example, providers must initiate the open negotiation within 30 business days of receiving an initial payment or notice of denial. We believe this timeline is entirely too short — particularly if providers must request additional information regarding the QPA from the health plan.

From a process standpoint, provider billing systems must ingest the remittance advice (or the denial) and then staff must review it to determine if it is appropriate to open a negotiation, which could take up to a week or more. If hospitals need to request additional information about the QPA, the July 13, 2021, IFR only requires health plans to respond in a "timely manner." Without the time frame clarification CHA requested in our comments about that IFR, we are concerned that health plans will not respond in a time frame that allows providers to initiate the open negotiation process. This scenario will leave providers with insufficient information to determine if the negotiation process should be initiated for a given out-of-network claim. **Therefore, we ask that if the tri-agencies do not require health plans to submit the rationale for the QPA calculation with supporting evidence (discussed below) with the initial payment (or denial), that the tri-agencies allow providers 30 business days from the date health plans provide all necessary information related to the QPA to submit a negotiation initiation notice. We also reiterate our request that health plans be required to respond to a request for additional information regarding the QPA within two calendar days of receiving the request.**

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 business days of the conclusion of the 30-business-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 business days of the selection of the IDR entity, each party must submit an offer for reimbursement, as well as any supporting materials.

CHA is concerned that four business days is an insufficient amount of time for providers and health plans to determine whether they want to submit a claim to the IDR process. Providers and health plans must 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. And as a result, both will likely need to hire additional staff — increasing administrative expenses that will be passed along to consumers in the form of higher premiums — to manage this process on such short time frames.

CHA believes that if the tri-agencies use the flexibility afforded to them by Congress to allow more time to initiate the IDR process and submit evidence, it 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, therefore, will ensure consumers' access to health care 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[20] 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 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 provide at least 30 business days from the end of the negotiation period for providers or health plans to trigger the IDR.**

Written Decisions

The IFR requires a certified IDR entity to submit its decision and a rationale for it through the federal IDR portal. If the decision is for an amount that is not closest to the QPA, the rationale must include a detailed explanation of the additional factors considered that demonstrated that the QPA is materially different from the appropriate out-of-network rate. CHA questions why the tri-agencies are requiring an arbiter to provide a "detailed explanation" of their rationale for selecting an amount that was not closest to the QPA. As discussed above, IDR entities will likely evaluate their arbiters' performance based on productivity standards. In the absence of a requirement in the IFR for IDR entities to develop and maintain a robust quality assurance process (discussed further below), CHA is concerned that some arbiters will inappropriately select the amount closest to the QPA, when the evidence suggests selecting a different amount, to improve their productivity stats by using the incremental time that would have been expended drafting a "detailed explanation" to review additional cases. **Therefore, CHA respectfully asks the tri-agencies to minimize the amount of explanation required to justify a decision to only that which is necessary to help each party understand why a particular decision was reached. Further, we believe this level of detail should be provided for both cases where the arbiter selects the amount closest to the QPA and those where the QPA is materially different from the appropriate amount.**

Treatment of Batched Services

The IFR allows multiple claims for qualified IDR items and services to be submitted and considered jointly if they are:

1) Billed by the same provider, group of providers, facility, or air ambulance services provider
2) From the same group health plan or health insurance issuer
3) For the same or similar items or services; for example, they are billed under the same service code or a comparable code under a different coding system.
4) Furnished within the same 30-business day period or 90-calendar-day suspension

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

In general, CHA strongly supports the ability of plans and providers to submit batches of claims to an IDR entity. We believe that this will encourage efficiency — allowing for IDR entities to process disputes in a timely manner — and reduce administrative costs for all participants. **CHA's members greatly appreciate that the tri-agencies clarified in the IFR that claims paid from different lines of business (e.g., individual and large group markets) by the same health plan may be batched together for purposes of submission to an IDR entity.**

However, we believe that the tri-agencies' definitions of "facility and provider" and "same or similar service" in the IFR have unnecessarily narrowed the scope of claims that could be batched. This will lead to increased workload (and likely decision delays) for the IDR process while increasing administrative staffing requirements — and costs — for all parties, ultimately putting upward pressure on health insurance premiums for consumers.

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 that share a common parent entity (e.g., all the hospitals, non-hospital facilities, physicians, and non-physician practitioners who 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' goals of minimizing arbitration costs, reducing the volume of individual disputes sent to the IDR process, and decreasing the likelihood of a case backlog occurring.

Definition of Same or Similar Service

For batching to be effective, the regulation's criteria must 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[21] 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." 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 respectfully ask the tri-agencies to adhere to congressional intent and define "same or similar services" in a broad manner that will allow for efficient processing of disputed payments sent to an IDR entity for arbitration.** Under a batching methodology that is consistent with congressional intent,

[21] Emphasis added.

CHA believes that — for example — providers should be able to batch all claims for outpatient emergency services provided to members of the same health plan provided within a 30-day period. Within this batch, each of the five CPT codes (99281–99285) for evaluation and management services provided in the emergency department would have its own QPA. Similarly, for inpatient hospital services, a batch of claims should include all MS-DRGs for a given diagnosis (e.g., appendectomy, MS-DRGs 338–343) with each MS-DRG having its own QPA.

Negotiation Process

The open negotiation period may be initiated by any party during the 30-business day period beginning on the day that the nonparticipating provider or facility receives an initial payment or notice of denial. The party initiating the open negotiation must provide notice. The notice must identify the items and services subject to negotiation, the date the services were furnished, the service code, the initial payment amount or notice of denial, and contact information. The information may be provided electronically so long as the issuer has a good faith belief that an electronic notice is readily accessible and makes a paper notice available free of charge upon request. The notice must be sent within 30 business days of the initial payment or notice of denial. **CHA strongly supports the use of business days instead of calendar days to determine the time frame to trigger the open negotiation period.**

If the health plan and provider are unable to mutually agree on an acceptable payment amount for out-of-network services covered under the NSA, successfully initiating an open negotiation is the required first step to triggering the IDR process. To that end, the IFR cautions that if the notice is not properly provided to the other party, the period has not begun, and any subsequent payment determination may not be enforceable. Given this, the burden of responsibility will ultimately fall on the provider to prove that it properly provided a notice of open negotiation to a health plan.

CHA is deeply concerned that the IFR does not place reciprocal accountability on health plans to ensure they have a monitored mechanism to accept a negotiation notice and provide proof that they have in fact received it. We respectfully request that the tri-agencies clarify that if the party that receives a negotiation initiation notice does not respond to the notice, any subsequent IDR decision is valid as the initiating party attempted to commence the open negotiation process. We ask for the tri-agencies to provide flexibility in the types of documentation that could be used to prove that a notice was sent. One example of sufficient documentation would be a copy of an email sent to the email address listed on the health plan's denial or remittance advice (RA) within 30 business days of receipt of the denial or RA that includes the data elements outlined in the IFR. While CHA appreciates the IFR's suggestion that providers use "read receipts" when sending requests to health plans via emails, we note that an individual who receives a request for a "read receipt" in many email systems can decline to provide a receipt, or the email account could be configured to not provide one. Further, we also ask the tri-agencies to make the following improvements to the open negotiation initiation notice process:

1) *Require Electronic Delivery of Negotiation Notice*: CHA asks the tri-agencies to require health plans and providers to accept the negotiation notice electronically. Examples of delivery mechanisms that health plans should be required to accept are via email and through the billing clearing house used by the provider to submit claims for payment to the health plan.

We also ask that when the tri-agencies clarify this requirement, they also clarify that via facsimile or through a health plan's portal is not considered an electronic form of delivery if it does not provide a confirmation of receipt that can be saved and printed. CHA believes that requiring electronic delivery of the notice will reduce the administrative burden for both plans and providers, while minimizing the likelihood that the notice will not be delivered due to document management issues.

2) *Require a Physical Address Delivery Option*: We ask that the tri-agencies require health plans to provide an address that is capable of providing delivery confirmation notices as an option for providers to use to submit initiation notices. When the initial notice is sent via mail, we ask the tri-agencies to confirm the date the notice is post-marked will be the date used to determine if the notice satisfies the 30-business day criterion.

3) *Require Notification of Receipt*: CHA asks that the tri-agencies require health plans and providers to send a receipt notification to the initiating party within 24 hours of receiving the negotiation notice. We believe this receipt notice should include sufficient information so that it identifies which negotiation initiation notice it was triggered by.

4) *Eliminate the Option of a Paper Copy Upon Request*: CHA questions the need for requiring health plans or providers to also send a paper copy of the negotiation initiation notice upon request. We believe an electronic notice is more than sufficient, and requiring this additional step only adds unnecessary administrative burden. If the tri-agencies persist in requiring the submission of paper copy of the notice upon request, we ask that the tri-agencies confirm the date on which the initial electronic notice is sent is the date that satisfies the 30-business-day requirement.

Information Related to the QPA

The July 13, 2021, IFR required that plans must provide in writing — with each initial payment or denial — information regarding the 30-day open negotiation period, the appropriate contact information (telephone, email address, and contact person or office) for the plan/issuer if the provider or facility wishes to initiate the open negotiation period, and rudimentary information related to the QPA[22]. Further, providers may be able to request additional information[23].

Given the implications for patient out-of-pocket payments and provider payments based on the role of the QPA in the IDR, the health plan's methodology and data used to calculate the QPA should be readily transparent to all stakeholders. Instead of requiring facilities or providers to request additional information, health plans should be required to transmit this information to the facility or provider. This information must include the rationale and/or evidence the health plan used to determine the QPA for the service in question. As discussed in our comment letter in response to the July 13, 2021, IFR, we believe this level of transparency will help providers make more judicious decisions about when to pursue

[22] The QPA for each service and a statement certifying that the QPA was calculated in compliance with the tri-agencies' methodology described in the July 13, 2021 IFR.

[23] 1) Whether the QPA includes contracted rates that were not set on a fee-for-service basis; 2) Information to identify which related service code was used, if one was used, to determine the QPA for a new service code; 3) Information to identify which database was used to determine the QPA (if applicable); 4) A statement that the plan's or issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services that were excluded for purposes of calculating the QPA.

negotiation — and ultimately the IDR process if those negotiations fail — and lower the administrative cost of the NSA for all stakeholders.

As part of the rationale for the QPA, health plans should be required to transmit the specific data points used to calculate the QPA to the provider. The specific data points should include the de-identified array of payment rates used to determine the median payment amount and the names of facilities or providers whose rates were used to determine the median amounts to ensure the rates used are comparable.

This level of transparency will create a productive basis from which health plans and providers can negotiate the appropriate payment amount. Given the relatively short negotiating window contemplated in the IFR — 30 days — it is essential that providers have detailed information about how the QPA was calculated so it can be factored into their negotiations with the health plan for an appropriate payment amount.

Further, the tri-agencies should include a mechanism in the IDR process that provides more time before initiating the negotiation period and "triggering" the IDR process if the provider has questions about the accuracy of the QPA calculation. **CHA asks that the tri-agencies allow a provider to toll the clock on the 30-day negotiation period if the provider has concerns about the accuracy of the QPA calculation. However, during this period, health plans and providers should be allowed to engage in negotiations designed to determine an appropriate payment rate for services provided to a patient who received out-of-network services.**

Good Faith Estimate (GFE) for Uninsured

The NSA requires providers to deliver a GFE to uninsured or self-pay individuals when they schedule services. California's hospitals have a long track record of transparency. In accordance with state law[24], California's hospitals already provide uninsured patients with GFEs of their expected out-of-pocket costs for any planned health care service upon request. In addition, effective January 1, 2022, hospitals will be required to provide this GFE to all uninsured patients regardless of whether it was requested. The estimate must include information about the hospital's financial assistance policies.

CHA notes that when an uninsured patient receives services, the provider of those services will attempt to enroll the patient in Medicaid or other forms of health insurance coverage. It is not uncommon — particularly for Medicaid coverage — for this process to take more than six months. **CHA asks HHS to clarify whether a provider must deliver a self-pay GFE to an uninsured individual if the provider is attempting to enroll the individual in Medicaid.** Further, CHA notes that hospitals may also temporarily enroll uninsured individuals in Medicaid if they appear to qualify based on "presumptive eligibility[25]." CHA asks HHS to confirm that uninsured patients who qualify for Medicaid based on presumptive eligibility do not need to be given a self-pay GFE.

The GFE created by the "convening provider or facility" must include expected charges for the services that are reasonably expected to be provided together with the primary service, including services that may be provided by other providers and facilities (co-providers and co-facilities). If an item or service is not scheduled separately from the primary service, it will generally be included in the GFE.

[24] California Health and Safety Code Section 1339.585
[25] https://www.cdc.gov/phlp/docs/hospitalpe-brief.pdf

To calculate the expected charges necessary to create the GFE, the "convening provider or facility" will need to know the specific billing code(s) for the primary service. This may be challenging for patients who are either shopping for services or attempting to schedule a service themselves. For example, an MRI of the spine or pelvis is a relatively common procedure that we would anticipate a patient would schedule or a consumer would shop for. There are six different CPT codes for both MRI of the spine and MRI of the pelvis, and each CPT code may have a different expected charge associated with it. **CHA asks CMS to clarify that it would be appropriate for a provider to delay scheduling a non-emergent service or providing a shoppable estimate until the patient or consumer can provide a CPT code for the service in question to calculate expected charges.**

As another example, patients with heart conditions require a specific type of anesthesia when they undergo procedures that require them to be sedated or unconscious. If the patient is scheduling the service themselves (e.g., screening colonoscopy under sedation) it is not uncommon for the patient to neglect to convey this crucial clinical information at the time of scheduling. Therefore, the GFE will not reflect the additional billed charges related to providing anesthesia services to an individual with a heart condition.

We ask in instances where the patient or scheduling provider provided incorrect (wrong CPT code[26]) or incomplete information (does not disclose a complication or condition that will increase billed charges) that the specific services in question be exempt from the Patient-Provider Dispute Resolution (PPDR) process. In these cases, the expected charges provided in the GFE were calculated based on inaccurate information provided by the patient or scheduling provider. If providers are penalized in this situation, CHA is deeply concerned that non-emergent care will be delayed to revise the GFE. These providers may also be less willing to provide services to uninsured patients if they risk — as a result of inaccurate or incomplete information provided to them — not receiving payment for medically necessary services.

If an item or service is not included in the GFE and is later determined by the selected dispute resolution (SDR) entity to have been "reasonably expected" to be provided, the patient will not be responsible for paying for the service that was not included in the GFE. Alternatively, the IFR suggests that if a provider's expected charges are frequently greater than the actual billed charges, that provider could be subject to compliance actions under the NSA for inflating their price estimate.

CHA is deeply concerned that the phrase "reasonably expected" is highly subjective and not defined from a clinical perspective (or at all) in the IFR. An item or service for one provider may be normally included in a service — and, therefore, reasonably expected — but may only be used in certain unanticipated situations by another provider who is treating the exact same condition. Further, there are many instances where the referring provider — upon evaluation of lab values and/or diagnostic imaging — believes one procedure is necessary when the service is scheduled. However, once that procedure is underway, the treating provider may determine additional services are required based on the patient's clinical presentation.

[26] (e.g., 72141 - MRI Cervical Spine w/o Contrast, when the patient's condition actually required 72156 – MRI Cervical Spine w/wo Contrast).

However, it is not clear from the IFR's use of the term "reasonably expected" whether, in these instances, the additional services would be determined to be "unforeseeable." For example, screening colonoscopies are commonly provided to uninsured patients. It is not uncommon during the diagnostic service for the gastroenterologist to find a polyp that needs to be removed and evaluated by a pathologist to determine if the polyp is cancerous. In this example, should the "convening facility" where the screening colonoscopy is scheduled provide expected charges for a screening colonoscopy or a polyp removal procedure? Which services' expected charges are included in the GFE is important. The billed charges for the removal of a polyp and related pathology report will far exceed the $400 threshold to submit a case to the PPDR process if the facility and gastroenterologist in this example only provide expected charges for a screening colonoscopy in the GFE. In this example, if the arbiter determines that the polyp removal was "foreseeable" because the pathologist's services were not included in the GFE, if the patient disputes the charges the pathologist will receive no payment. Finally, even if it is known that a polyp must be removed, it will be difficult to provide the expected charges within $400. The method used to remove the polyp depends on its size and the depth of invasion and could cause the billed charges to exceed the GFE.

As the complexity of the service increases (e.g., cardiac catherization for chronic chest pain), so does the likelihood the patient will require additional services that were not included in the GFE and/or the charges for the services included will exceed the threshold. The increased services or new services may or may not be deemed "unforeseeable" by an IDR entity's arbiter, as the IFR is silent on how "unforeseeable" is defined. Further, given the lack of a clinical definition of "reasonably expected," we are concerned that arbiters from the same IDR entity may treat the same clinical scenario where billed charges exceed expected charges by $400 or more differently. One arbiter may deem a new service and/or increased charges as foreseeable while another may determine that the new service and/or increased charges were unforeseeable. Finally, a change in a clinical care plan will not only increase the treating provider's billed charges but will also likely increase the treating facility's and other ancillary provider's billed charges as well. This will likely subject all providers involved to the PPDR process. Based on the IFR, if these additional services are deemed foreseeable by the arbiter, the providers involved may receive no payment for the unanticipated services.

Given this ambiguity, CHA believes that — despite best efforts — in many instances it will not be possible to provide a point estimate of charges for self-pay patients that will be accurate within $400. Therefore, CHA respectfully asks HHS to replace the requirement to provide a singular total expected charge for each provider with a range of expected charges for each provider that is based on probable clinical scenarios. In cases where billed charges exceed the provider's expected total charge upper bound of the range by $400, the billed charges would be eligible for the PPDR process.

Included in the GFE is a list of items or services that the convening provider anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service. However, the IFR does not require expected charges to be provided with the list of anticipated items or services that may need to be scheduled separately prior to or after the primary service included in the GFE. **CHA greatly appreciates that the tri-agencies are not requiring providers to include charge estimates for anticipated services that may need to be scheduled separately.** As discussed above, we believe it will be difficult enough to provide an accurate estimate for services that may be provided with the primary procedure. Predicting additional services is more complicated given that they will — in many instances — be based on the outcome of the primary procedure. And it will be

impossible to know which providers will deliver the services that are scheduled separately, calling into question the accuracy of any estimate of expected charges.

CHA also asks HHS to confirm that the expected charges for services such as medical transport from the facility where the primary service was provided to the patient's post-acute care setting, and items such as durable medical equipment, should not be included in the self-pay GFE. We believe both examples are items that will be scheduled separately from the primary service, so the related expected charges do not need to be included.

Definition of Expected Charge

The IFR defines "expected charges" for the self-pay GFE as the cash pay rate or rate for an item or service set by a provider for a self-pay individual. The expected charge must reflect any discounts for uninsured individuals if the GFE is being provided to a self-pay individual. These discounts may include adjustments required of charitable hospitals under their financial assistance policy requirements.

CHA generally supports the concept of providing self-pay individuals with an estimate of the charges they will be asked to pay, as it is required by California law. However, we are deeply concerned about operationalizing the requirement to include any discounts related to a provider's financial assistance policy in the expected charges for uninsured patients. Hospital policies typically require patients to apply for financial assistance. As part of these applications, patients are required to provide documentation of their financial situation (e.g., pay stubs, bank statements) that support their application[27]. Patients frequently do not have the necessary documentation readily available when they schedule a service or procedure. It is highly unlikely — bordering on impossible — that providers will be able to send GFEs to an uninsured patient on the incredibly tight timeline required by the IFR if the provider must wait for a patient to complete and submit a financial assistance application with the necessary documentation.

CHA asks the tri-agencies to remove the requirement that hospitals include any financial assistance discount in the calculation of expected charges. **In lieu of including any estimated financial assistance discount in the calculation of expected charges, CHA asks that the tri-agencies allow providers to include a written notice in the GFE that educates uninsured patients about the availability of financial assistance and includes the telephone number of the office that can provide information about the financial assistance policy, the related application process, and a URL where copies of the financial assistance policy documents may be obtained.** This approach is operationally feasible and aligned with California state law. CHA is deeply concerned that if the tri-agencies enforce the requirement to include estimated financial assistance discounts in the expected charges included in the GFE, providers will be unwilling to schedule uninsured patients for non-emergent services unless they have completed a financial assistance application out of fear of incurring civil monetary penalties (CMPs) for a requirement the provider cannot meet given the unrealistic turnaround times (discussed below) included in the IFR.

[27] In many instances, documentation requirements for hospital financial assistance policies are aligned with the requirements necessary to deem a Medicare beneficiary indigent for purposes of claiming the charges as Medicare bad debt. Section 312.B of the Medicare Provider Reimbursement Manual requires that, "The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence... The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination."

Convening Facilities Responsible for Including "Co-Provider" Charges

The GFE must be provided by the "convening provider" or "convening facility" — the provider or facility responsible for scheduling the primary service. In the case of a request, the convening provider or facility would be the one responsible for scheduling the primary service. CHA notes that for many procedures (e.g., knee replacement surgery), the patient is "referred" to the hospital by a provider (e.g., orthopedic surgeon) who schedules the service. In these situations, does HHS consider the provider who schedules the service at the hospital the "convening provider" (e.g., the orthopedic surgeon) responsible for creating the GFE? Or is the hospital where the procedure will occur considered the "convening facility" and, therefore, responsible for producing the GFE? **CHA asks HHS to clarify when a hospital is considered a "convening facility" for services that are delivered at a hospital but scheduled by other providers.**

The IFR requires convening providers to integrate the cost estimates of co-providers into their GFE. While we appreciate that a consolidated estimate may be more consumer friendly, we do not believe it is operationally possible given the structure of the health care delivery system. First, hospitals do not have access to charge and network participation information for other providers they do not employ (or own, in the case of facilities), and the infrastructure necessary to easily exchange this information does not exist. 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 financial assistance policy information for any of the physicians and other practitioners who may deliver ancillary services as part of a service or procedure performed in their facilities.

In light of these insurmountable operational challenges, we ask that HHS allow convening facilities, co-facilities, and co-providers to submit separate self-pay GFEs to a patient or consumer. CHA notes this is not dissimilar from the way in which the patient will be billed after services are rendered. We are concerned that if a patient receives a single GFE for expected charges for the convening provider and co-providers in a consolidated estimate, they will mistakenly assume that they will only receive one bill representing the charges for all providers involved in the service. And as a result, they may only pay the bill from the convening provider assuming it included all the charges for the co-providers.

Finally, the rule clarifies that each individual provider/facility is responsible for the accuracy of their own estimates. **If the tri-agencies persist in requiring convening providers/facilities to incorporate the estimated charges for co-providers/facility into the GFE, CHA thanks HHS for not holding the convening provider responsible for the accuracy of estimated charges submitted by co-providers.**

Delay Requirement to Include Co-Providers

Given that the information exchange standards and infrastructure currently do not exist for convening and co-providers to efficiently exchange estimated charge data, HHS will not enforce this requirement until January 1, 2023. **CHA greatly appreciates this deferred enforcement.** However, we do not believe that a 12-month delay in enforcement will allow sufficient time to create the infrastructure to automate this information exchange. The technology and transaction standards necessary to automate this information exchange are largely the same that will be used by providers to transmit the GFE to health plans for insured patients. CHA notes that this requirement has been delayed, allowing for the development of the information exchange standards and the supporting technology to be implemented into revenue cycle workflows. **Therefore, if HHS persists in requiring convening providers to incorporate estimated charges from co-providers, it should begin enforcing the self-pay GFE**

requirement at the same time the insured GFE is effective — after the information standards have been developed and the supporting technology has been implemented.

The IFR states that during the period of enforcement discretion, items or services delivered by a co-provider that appear on the GFE that do not include an estimate of expected charges or that appear as a range of expected charges would not be eligible for the PPDR process. **CHA strongly supports excluding co-provider services that do not have expected charges included in the self-pay GFE from the PPDR process.** Further, during the period of enforcement discretion, we ask HHS to clarify what — if any — information related to co-providers should be included in a self-pay GFE. Our members would like to ensure they are not inadvertently exposing the co-providers they partner with to deliver care to self-pay patients to the PPDR process by not including key data elements. **Given the inability to efficiently exchange billing data between convening and co-providers, we believe requiring service descriptions and related billing codes would pose a similar administrative burden on co-provider administrative staff as providing the expected charges. Therefore, we ask that if these items are not included on the self-pay GFE for the co-provider, that provider will not be subject to the PPDR process because of the exclusion of service descriptions and billing codes.**

Turnaround Time

The IFR requires convening providers to deliver GFEs to self-pay patients within a narrow window. The turnaround time frame allowed under each of the scenarios covered in the NSA and IFR are illustrated in the table below.

Turnaround Time Scenarios for GFE

Example	Timing	Timing Example		
		Scheduling/ Request Date	Date of Service	Estimate Provided By
Scheduled Close In	Not later than 1 business day after scheduling when a service is scheduled at least 3 business days in advance.	Mon (1/3)	Thu (1/6)	Tue (1/4)
Scheduled In Advance	Not later than 3 business days after scheduling when service is scheduled at least 10 business days in advance;	Mon (1/3)	Thu (1/13)	Thu (1/6)
Shopping	Not later than 3 business days after the date of the request when a good faith estimate is requested.	Mon (1/3)	No DOS	Thu (1/6)

CHA has multiple concerns with the time frames included in the IFR as discussed below.

1) *Inoperable Turnaround Time*: CHA's members report that the requirement to provide a GFE to a self-pay individual within one business day of scheduling (if the service is scheduled within three to nine days in advance) or three business days of scheduling (if the service is scheduled within at least 10 business days) will be challenging, if not impossible, to meet given that this requirement will eventually apply to all scheduled patients. **CHA asks the tri-agencies to allow at least five business days once the patient has provided all necessary information to deliver a GFE to a patient after a service is scheduled or the estimate is requested for an unscheduled service.** CHA's members report that they will have to create a special team of medical billers, finance administrative staff, and coders to process the GFEs within the time frame currently required by

the IFR. This will entail hiring new staff and providing them with office space. These additional administrative costs will ultimately be passed on to consumers in the form of higher insurance premiums.

The IFR currently requires "convening" providers or facilities to collect and integrate estimated charges from "co-providers" or "co-facilities" into their GFE. Convening providers have no more than one business day to request good faith estimates from all co-health care providers and facilities. And co-providers or facilities must provide their estimated charges to a convening provider not later than one business day after the request was received.

Physician practices are already struggling with existing administrative burdens that take resources away from providing patient care[28]. **CHA is deeply concerned that many physician practices simply do not have the administrative staff capacity (or the resources to hire additional staff) to meet this turnaround time. Therefore, if these time frames are enforced, many co-providers will stop providing care for self-pay patients, creating additional access barriers for the uninsured population.** This will likely occur with greater frequency in rural areas that feature smaller practice sizes and lower complements of administrative staff.

To illustrate why the time frame is unworkable from the convening provider's perspective, if a patient schedules a procedure on January 3 that is to be performed on January 6, the convening provider must deliver the estimate by close of business (COB) on January 4. Even if the convening provider transmits the request for estimated charges to the co-provider(s) on January 3, the IFR gives the co-provider(s) one business day — until COB January 4 — to respond. CHA notes that this is both the deadline by which the convening provider must deliver the GFE to the self-pay patient and the deadline for the co-provider to submit the estimated charges to the convening provider that requested them so they can be incorporated into the self-pay patient's GFE. Hence, the IFR sets up a conflict where the co-provider will be in compliance with the requirements, but due to the timing of when the co-provider's estimated charges were sent it will be unlikely — if not impossible — for the convening provider to meet the time requirement to deliver the GFE to the patient within one business day. CHA respectfully asks that HHS resolve this conflict by allowing the convening provider more time to deliver the GFE to the patient as discussed above.

Additionally, if the GFE changes between when the initial estimate was provided and the scheduled item or service is delivered (e.g., there is a change from one provider to another), the convening provider or facility must reissue the GFE no later than one business day before the item or service is scheduled. **As discussed above, CHA does not believe it is possible for a new GFE to be provided within one business day. Therefore, we ask the tri-agencies to revise this requirement to allow providers five business days to update their estimate.**

If a change in staffing occurs less than one business day in advance, the replacement provider or facility must accept the initial GFE that was provided by the original provider or facility. CHA is deeply concerned that substitute co-providers will be unwilling to accept the original co-

[28] https://www.mgma.com/getattachment/a6acc774-b5ce-44b1-b98c-d6dcc824db60/mgma-annual-regulatory-burden-report-Final.pdf.aspx?lang=en-US&ext=.pdf

provider's GFE. In doing so, they are assuming risk for the accuracy of a GFE that is not based on the substitute co-provider's practice pattern and experience. We believe this requirement will result in rescheduled procedures which will delay care (and in some cases, reduce access to it). It will also result in increases in the overall cost of care as some supplies and drugs related to the procedure will not be able to be restocked and used. The cost of this needless wastage will ultimately result in increased health insurance premiums. **Therefore, to protect patient access to care and minimize the impact of the NSA on health insurance premiums, CHA asks HHS to exempt substitute co-providers from the PPDR process**.

2) *Mailed GFEs*: The IFR requires that GFEs be provided in written form either on paper or electronically, based on the patient's requested delivery method. CHA notes that most services are scheduled either electronically or via phone. Rarely does a patient schedule a service in person. And even then, they are unlikely to wait to be handed a paper GFE if a hard copy is their preference. However, the proposed rule is silent on when the GFE would be considered "provided" if the convening provider mails it. **CHA respectfully asks the tri-agencies to clarify that the GFE will be considered provided to the patient based on its postmark date.** Further, we believe this is necessary as the U.S. Postal Service's standard delivery time for first class mail is within three days. Due to budget issues, that may increase to five days. If CMS requires a patient to receive a mailed GFE within the IFR's time frames, providers will not be able to comply due to postal delivery times[29].

GFE Delivery Method

The IFR requires the GFE to be provided either on paper or electronically based on the self-pay individual's delivery preference. The rule cites both email and the provider's patient portal as examples of electronic delivery methods. CHA notes that providers do not use unsecured email to transmit documents that contain protected health information. **Therefore, we ask HHS to clarify that if the patient requests the GFE electronically, the provider can send it through its protected patient portal and is not required to send it via unsecured email.**

Specific Issues Related to GFEs Requested for Services that Are Not Scheduled

A GFE must also be provided to self-pay individuals without scheduling a service, upon request. This GFE must contain the same data elements included in the GFE for scheduled services. CHA does not believe this will be possible with the level of precision contemplated in the IFR. First, consumers who are shopping for services typically do not have the exact primary billing code(s) necessary to describe the service(s) they are seeking an estimate for. As discussed above, without the specific primary billing code(s) it will not be possible to provide an accurate estimate of expected charges for the primary service(s) and associated items.

Second, beyond the California-specific issues discussed earlier in this letter, it will be impossible for most hospitals — unless they have a fully employed medical staff — to provide an accurate estimate of expected charges for services delivered by co-providers when a self-pay patient is shopping for services and requests an estimate. As an example, if a consumer is shopping for an MRI and requests a GFE, because the service is not scheduled, the hospital will not know which radiologist will read the MRI.

[29] https://www.cbsnews.com/news/mail-delivery-slower-usps-october-1/

Therefore, the hospital will not be able to provide the name, TIN, and NPI for co-providers, much less the expected charges for each co-provider necessary to deliver the primary service(s).

Given these challenges, we are concerned that the level of precision implied by the IFR's prescribed format does not match operational realities. The expected charges included in the GFE a consumer receives when they are shopping for a service will likely be very different from the GFE that patient receives after the service is scheduled. And the administrative burden required to produce a "precise" estimate based on what is required by the IFR will not yield a more accurate estimate for the patient who is shopping. Therefore, if the recommendations above for all GFEs are not adopted, we ask that, for GFEs related to services that are not scheduled (e.g., when a consumer is shopping for a service), that HHS:

1) Allow the convening provider to use a range of expected charges given that neither accurate billing codes for the services required nor the co-providers who will deliver them will be known in most instances when patients are shopping for services
2) Remove the requirement to provide specific billing codes for all services given it is unlikely those specific codes will be known at the time the estimate is generated
3) Remove the requirement to include co-provider name, NPI, and TIN given it is unlikely that the convening provider will know who the co-providers are when the estimate is generated
4) Replace the requirement to include co-provider expected charges with a disclaimer that the GFE does not include co-provider expected charges and provide a list of additional services that are typically required but not included in the estimate
5) Remove the requirement to incorporate financial assistance discounts into the GFE for unscheduled services and, instead, require providers to include information about how to apply for any available financial assistance

CHA believes taking these steps will reduce the unnecessary administrative cost associated with providing uninsured patients with GFEs for services that have not been scheduled. This in turn will translate into lower future health plan premiums for consumers.

Interaction With Other CMS/HHS Transparency Requirements

In the IFR, HHS seeks comments on how the hospital price transparency requirements for hospitals to display standard charges in a consumer-friendly manner, specifically the voluntary use of online price estimator tools, may be leveraged to provide a GFE under these final rules. CHA appreciates CMS' willingness to explore ways that the use of the online price estimator tool many hospitals have implemented to meet the hospital price transparency requirements could also satisfy the uninsured/self-pay GFE requirement. As this IFR's requirements are currently drafted, we do not believe that the online price estimation tools that hospitals have implemented — at considerable cost — can be used to provide a GFE for self-pay individuals either when services are scheduled or if the individual is shopping. Specifically, the tools that are implemented do not:

1) *Include Expected Charges for Co-Providers*: As discussed above, because California's hospitals cannot employ physicians, the online price estimation tools that have been voluntarily implemented to meet the hospital price transparency requirements do not include expected charges for co-providers and co-facilities that may be involved in the provision of care.

2) *Make Financial Assistance Determinations*: Determining whether an uninsured patient qualifies for a financial assistance discount based on the hospital's policy typically requires a manual review of the individual's application and supporting documentation. And even in the limited instances that a determination of eligibility for financial assistance could be automated, that capability is not incorporated into the price estimation tool.

As discussed in prior sections, it will be extremely difficult — if not impossible — for hospitals to operationalize the IFR's requirements and meet the timeline to provide a GFE to a self-pay patient. These requirements also prevent hospitals that made significant investments in technology and voluntarily implemented online price estimation tools from leveraging those investments to also satisfy the uninsured patient GFE requirement in the NSA. **CHA believes this is further reason for HHS to reconsider and eliminate the requirement that hospitals include in their calculation of expected charges for self-pay GFEs any items or services provided by co-providers and replace the requirement that hospitals include any financial assistance discount in the calculation of expected charges with a requirement to provide information about the hospital's financial assistance policy.**

We believe that with these barriers removed the online price estimation tools that many hospitals have implemented could meet the requirement to provide a GFE to self-pay patients who are shopping for a service. In this scenario, assuming the tool allowed for the patient to print and/or save a copy of the estimate, for patients with internet access, the hospital could send the patient a copy of the URL and allow the patient to generate their own estimate based on the clinical information provided to them by the referring physician. For patients without internet access, hospital staff could use the tool to generate the estimate and mail it to the patient.

PPDR Process

The IFR establishes the PPDR process through which self-pay individuals who received a GFE for services may initiate the PPDR process. In this process a SDR entity may determine the amount to be paid by the individual for an item or service where the billed amount is "substantially in excess" of the expected charges in the GFE. Substantially in excess is defined as total billed charges for each provider exceeding the GFE's expected charges by $400. The threshold may be triggered by services that were not included in the GFE. HHS arrived at this amount based on a variety of Federal Reserve studies detailing Americans' ability to cover emergency expenses with liquid savings.

In California, hospitals already are required to provide uninsured patients with a GFE. While there is always a potential for complications during any patient care procedure — and thus possible additional costs above the GFE — hospitals and physicians do everything possible to deliver the highest quality care possible at the most reasonable cost. It's also important to understand that California's hospitals are already required to have comprehensive financial assistance policies to help income-eligible patients unable to pay the full cost of their care. These policies include sliding-scale discounted payment options based on what governmental payers reimburse hospitals, and no-interest payment plans. Under these payment plans the maximum payment may not exceed 10% of family income — excluding deductions for essential[30] living expenses.

[30] Essential living expenses include rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

CHA is deeply concerned that the threshold to qualify a claim for the PPDR process is too low. In many instances, once a service begins the provider determines the patient's clinical condition is different from what was understood when that service was scheduled. This in some cases results in billed charges that are greater than the charges expected when the service was scheduled. Using the relatively straightforward example of an annual wellness visit (AWV), it is not uncommon for a patient to schedule the service and not relay that, based on a pre-existing clinical condition (or a new condition that the patient raises with the provider during the AWV), additional diagnostic services will be required that are not included in a standard AWV. Based on conversations with CHA's members, it is probable that these services would exceed $400. When the provider reviews the patient's history prior to the visit (for existing patients with a known pre-existing clinical condition), they may identify the additional, necessary services in the patient's medical record. In this situation, if the provider does not reschedule the AWV the patient could dispute the bill. And given the highly subjective definition of "foreseeable services" (discussed above), could receive no payment for those additional services even though they were medically necessary. **Given this likely scenario we are deeply concerned that this unnecessarily low threshold could result in delays in care.**

Further, we believe this common scenario involving a relatively "simple" service further illustrates the challenges of requiring providers to deliver a point estimate of expected charges. **Therefore, CHA reiterates its above request that HHS allow a range of expected charges instead of requiring a single point estimate of charges. If the tri-agencies allow a range of estimates instead of a single point estimate, we believe a $400 variance from the GFE's excepted range of charges to the actual billed charges is a reasonable threshold to trigger the PPDR process.**

Alternatively, if HHS does not allow a range of expected charges, CHA believes HHS must increase the $400 threshold to trigger the PPDR process for GFEs with expected charges that exceed $4,000. In these instances, we believe it is necessary to set a 10% threshold to trigger the PPDR process. For example, if a self-pay patient schedules a service and receives a GFE with expected charges from a provider of $5,000, the actual billed charges must exceed the GFE by $500 or more to trigger the PPDR process. We believe this will provide the necessary protections for patients while allowing for the variability in actual clinical presentation versus what is understood about the patient's condition at the time of scheduling. Otherwise, CHA is concerned that access to care for self-pay patients will be reduced. Given this relatively low threshold in the IFR, co-providers may not be willing to expose themselves to the arbitrary risk of non-payment through the PPDR process if an arbiter determines that a service that was not included in the GFE (or due to patient complexity, an included service took longer than anticipated, resulting in higher charges) was "foreseeable."

Billed Charges Exceed Expected Charges

In instances where billed charges exceed expected charges included in the GFE, the IFR will require providers to submit evidence that the additional services were based on "unforeseen circumstances" that could not have been reasonably anticipated by the provider when the GFE was provided. **CHA is deeply concerned that "unforeseen circumstances" is a highly subjective concept, and the IFR does not provide a clear framework that arbiters can use to determine when a service is due to "unforeseen circumstances." Further, CHA is concerned that arbiters will lack the specific clinical expertise to determine if an increase in billed charges is the result of an "unforeseen circumstance." And even if the arbiters do have the clinical expertise to decide, in many instances it will be difficult for the**

clinicians who review these cases to consistently agree on what could be considered "unforeseeable," based on the information provided at the time of scheduling.

For example, a patient may be scheduled for cardiac catherization due to chronic chest pain. If an arterial blockage is discovered during the catherization, the interventional cardiologist will perform angioplasty to remove the blockage. The number of stents used during the procedure will depend on the extent of the blockage. The GFE in this example would likely only include the expected charges for the cardiac catherization and related services and not include the expected charges related to the angioplasty. If the arbiter determines the expected angioplasty charges excluded from the GFE were "foreseeable," the patient will be required to pay $0 even though the procedure was medically necessary.

Further, the IFR states that a provider intentionally providing expected charges they know to be inaccurate in the GFE violates the requirements in the Public Health Service Act and thus could be subject to enforcement actions. The interim final rule appears to create a classic "Catch-22" for providers. If the provider includes only a narrow range of services that they are 100% certain the patient will need, they risk not being able to receive payment for medically necessary care required by the patient based on clinical circumstances that present during the service. Conversely, if the same provider, to reduce the risk of receiving no payment for potentially medically necessary services, includes items in the GFE that a patient will possibly require — based on the provider's experience with similar clinical cases — but are not always necessary based on the clinical presentation when the patient was scheduled, they risk being assessed CMPs.

CHA is deeply concerned that in response to this intractable dilemma, many providers will reduce their exposure to either receiving no payment for medically necessary services or possible CMPs by limiting the number of uninsured patients they serve, which will further reduce access to care for populations that have struggled with receiving timely care. **As discussed, and recommended above, HHS can mitigate this unintended consequence by allowing providers to include a range of expected charges in the GFE.** The PPDR process threshold can then be based on the upper bound of the range, ensuring that providers are not penalized for caring for patients who are more complex than originally diagnosed. If HHS does not base the PPDR process threshold on the upper bound of a range of expected charges, the agency must convene a clinical workgroup to create a framework for determining when services are "foreseeable" based on the patient's clinical condition. This framework should be distributed to providers and SDR entities. For providers it will offer a degree of predictability regarding what services are considered "foreseeable" based on the patient's clinical condition. And for SDR entities, it will create consistency in their decisions related to items and services that were not included in the GFE.

In instances where the arbiter determines that a billed amount exceeds the expected charge included in the GFE by $400 or more, and the service is medically necessary and a result of "unforeseeable circumstances," the SDR entity must select the payment amount that is the lesser of the billed charge or the QPA for the geographic area based on a third-party database that meets the requirements of the NSA. This methodology is used both for new services — those not included in the GFE — and services that were included in the GFE but exceeded the estimate.

The IFR generically attempts to justify this approach by broadly citing the NSA's intent — which CHA strongly supports — to protect patients from surprise bills. It further attempts to justify this approach by stating that the QPA for the relevant geographic area from a database that meets the requirements of

the NSA represents a median market rate and can be leveraged to determine the payment amount for self-pay patients for the PPDR process. **CHA strongly objects to CMS' assertion that the NSA permits HHS to use the QPA as a de facto payment benchmark in select situations for self-pay patients.** We believe this use of the QPA is contrary to congressional intent. Nowhere in the statute is it contemplated that the QPA — which is calculated solely for individuals with insurance coverage — could also be used to determine payment rates for self-pay patients. And even if it was, as discussed above, we do not believe it accurately represents a market rate. **Therefore, we ask that HHS withdraw this provision and, in these circumstances, instruct the SDR entity to use the provider's billed charge as the payment amount.**

Timeline to Initiate the PPDR Process

The IFR allows self-pay patients 120 calendar days from the date of receiving the initial bill to submit the notice to initiate the PPDR process to the Secretary of HHS. CHA is deeply concerned that if patients are allowed 120 calendar days to submit a notice to initiate the PPDR, they are likely to forget to do so in a timely manner. HHS believes that providing 120 calendar days is necessary to allow self-pay patients sufficient time to gather the necessary information to initiate the PPDR process. These items include:

- Information to identify the disputed service(s) (i.e., date of service and service description)
- Copies of the provider's bill for the disputed service and of the GFE
- Contact information for the provider involved (if not included on the GFE)
- The state where the services were furnished
- The individual's communication preference

CHA notes that the patient should either have a copy of or be able to readily access (e.g., by contacting the provider) the information necessary (e.g., the bill, GFE) to file a dispute. **Therefore, to minimize the risk that patients may inadvertently miss the deadline to file the PPDR process initiation notice, we ask HHS to reduce the time frame to no more than 30 calendar days from the receipt of the initial bill from the hospital.**

IDR Certification

Certified IDR entities must satisfy certain standards. These include adhering to requirements for accreditation, conflict of interest policies, privacy and security standards for individually identifiable health information, and information reporting. Entities satisfying the certification standards will be certified for a five-year period subject to the petition and revocation process discussed later in these comments.

CHA generally supports the requirements as outlined in the IFR that IDR entities must meet. However, we believe they would be improved by a requirement that the IDR entities have a documented quality assurance and improvement program. We strongly encourage the tri-agencies to provide greater detail on staff training requirements, data that IDR entities must report, and how the data reported by the IDR entities will be used and made public. Further, we strongly support providing a mechanism to petition for the decertification of IDR entities when facts and circumstances dictate.

IDR Quality Assurance Process

CHA is deeply disappointed the IDR entity certification process does not include a requirement for such entities to have an internal quality assurance and improvement process. This process should review a sample of each arbiter's decisions to validate that they are based on all allowable information submitted by the parties and that the arbiters are consistently choosing the offer that reflects the appropriate payment amount for a given case based on the allowable information submitted. We believe this is crucial to ensuring a fair and impartial dispute resolution process. **Therefore, we respectfully ask that as part of the certification and recertification process, IDR entities be required to provide details of the process they will use to review their arbiters' decisions for quality assurance and improvement purposes.**

IDR Training Requirements

To be certified, an IDR entity must possess (directly or through contracts or other arrangements) and demonstrate sufficient arbitration and claims administration of health care services, managed care, billing, coding, medical, and legal expertise. The entity must also possess staff with the training necessary to conduct payment determinations by maintaining documentation that personnel have completed arbitration training by the American Arbitration Association (AAA) or American Health Lawyers Association (AHLA). CHA strongly supports the requirement that staff have sufficient training in both medical billing and arbitration. We ask that the tri-agencies clarify that arbiters must not only have received arbitration training from these organizations but hold certifications in dispute resolution from an organization like either the AAA or AHLA. Further, CHA believes that in addition to being certified by an organization like AAA or AHLA, arbiters employed by IDR entities must possess certifications related to medical billing (e.g., managed care coding, coding, revenue cycle processes) from an organization like the AAPC, the American Health Information Management Association, or the Healthcare Financial Management Association. CHA also believes that arbiters should be required to complete a minimum of 40 hours of continuing education annually (20 hours of legal/arbitration and 20 hours of health care revenue cycle education) to maintain sufficient industry knowledge necessary to adjudicate disputes. **Based on the recommendations above, CHA asks the tri-agencies to clarify and strengthen the certification and continuing education requirements for arbiters employed by IDR entities.** This will ensure a fair, unbiased, and cost-efficient arbitration process for all stakeholders.

IDR Data Reporting

The NSA requires the tri-agencies to make certain information available on a public website related to the IDR process. **CHA strongly supports the level of transparency provided by the monthly reporting required by the IFR.** In addition to the items required by the IFR, CHA asks that the tri-agencies require IDR entities to publicly report on a monthly basis:

- The number of times during the prior month the out-of-network rate selected was less than the QPA
- Number of arbiters who were involved in resolving a dispute

To strengthen the reporting process and improve transparency, on a quarterly basis, we ask that the tri-agencies require each IDR entity to report the:

- Average hours of ongoing education arbiters completed in the prior 12 months related to legal/arbitration process requirements and maintaining medical billing expertise

- Number of cases reviewed by the IDR entity's quality assurance process and the outcome of those reviews

Finally, on an annually updated basis, we ask that the tri-agencies require each IDR entity to report the productivity standards used in evaluating and/or incentivizing the performance of arbiters involved in the dispute resolution process. This reporting should include:

- Whether the IDR entity requires its arbiters to meet a productivity standard, and if used
- What those productivity standards are (the name of the metric, how it's calculated, and range of acceptable performance)
- How the productivity standard(s) influence arbiter performance reviews, retention decisions, and compensation packages

We believe this level of transparency is crucial to ensure that IDR entities are allowing their arbiters sufficient time to consider all allowable evidence submitted as part of the arbitration process. As discussed above, CHA is deeply concerned that the implicit incentives, reinforced in this IFR by both the reporting and IDR recertification requirements, may encourage IDR entities to create an environment that rewards arbiters who simply default to the QPA without fully considering the merits of the additional, allowable information submitted.

Petition for Denial or Revocation of IDR Entity Certification

A provider may petition for denial of an IDR entity's certification for failure to meet the requirements set forth in statute or regulation. The provider must submit a written petition identifying the reasons for denying the IDR entity certification or decertifying an existing entity. The tri-agencies will make a public list available of IDR entities seeking certification to help facilitate the petition process. Petitioners will have five business days from an announcement that an IDR entity is seeking certification to submit the written petition. **CHA strongly supports the provisions in the IFR that allow providers to request that certification of a potential IDR entity be withheld, or a current IDR entity be decertified.** We believe this will help mitigate any potential conflicts of interest at the outset of the program. However, we are concerned that five business days is entirely too short of a time frame for a provider to offer detailed feedback as to why a potential IDR entity cannot meet the requirements and, therefore, should not be certified. **We respectfully ask the tri-agencies to allow providers 30 business days to request that a potential IDR entity not receive certification.**

CHA also strongly supports the IFR's provisions allowing for an IDR entity's certification to be revoked prior to the end of its five-year certification period. We believe the measures[31] included in the IFR — with some modifications as recommended in this letter — create the foundation of a robust process to ensure IDR entities are held accountable to render fair and equitable determinations. However, we believe that a binary — certified or de-certified — compliance process is insufficient for ensuring accountability.

Like other governmental programs — particularly those run by CMS — we believe IDR entities should be subject to a progressive compliance process that includes warnings, requires corrective action plans, and other remedial actions that stop short of decertification. To provide sufficient resources to monitor IDR

[31] These measures include the IDR entity audit process, paired public display of the measures included in the IFR (as augmented by the recommendations in this letter), and the ability for providers to petition for the decertification of an IDR entity.

entity compliance, the tri-agencies should create an IDR process ombudsman who can hold IDR entities accountable to their contract terms with HHS for arbitration services. An effective ombudsman should be able to issue warnings when an IDR entity is found deficient in the performance of its duties and have the authority to require IDR entities to submit a corrective action plan if necessary. If an IDR entity does not demonstrate material progress in meeting its 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 should not be 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 filed by parties to arbitrations facilitated by an IDR entity and/or deficient performance on key metrics reported to CMS and monitored by the ombudsman.

Reasons for Revoking IDR Certification

The IFR lists seven reasons why an IDR entity's certification may be revoked prior to the end of the five-year term. CHA is generally supportive of these seven reasons. However, we are concerned that the IFR's focus on "inflationary effects" in the preamble discussion of reason six (compliance with audit requests) may have a chilling effect on arbiters' willingness to select an amount greater than the QPA when it is appropriate based on a review of all allowable information submitted as part of the IDR process. Specifically, the IFR states:

> *Sixth, if the certified IDR entity has failed to comply with requests from the Departments made as part of an audit, including submission of records, its certification may be revoked prior to the end of the 5-year term. The audit process plays an important part in helping to ensure that certified IDR entities are abiding by the requirements set forth in these interim final rules. To ensure that the Federal IDR process is fair, equitable, and does not have an inflationary effect on health care costs due to certified IDR entities failing to properly apply the factors as set forth in these interim final rules[32], the Departments are of the view that it will be prudent to review certified IDR entities' processes and procedures.*

CHA strongly supports the tri-agencies' use of audits of IDR entity processes to ensure the resulting decisions are fair and equitable. However, we question how fair and equitable these decisions will be given that IDR entities are — based on the emphasized text — evaluated by the tri-agencies on how frequently they select the amount closest to the QPA to reduce any potential "inflationary effect." This creates an environment where IDR entities may incentivize their arbiters to select the lowest offer, not the most appropriate offer based on a review of the allowable information submitted.

With the balance of the IDR process tilted in favor of health plans[33], CHA is deeply concerned health plans will use this opportunity to only contract with providers who are willing to accept unsustainably low payment rates. The resulting further narrowing of plan networks — as is demonstrated by California's experience with AB 72 — will reduce access to health care services for many consumers.

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[32] Emphasis added.

[33] Using the QPA as a de facto benchmark, potentially decertifying IDR entities whose arbiters frequently select offers above the QPA, creating an environment where arbiters – who will likely be incentivized based on productivity standards – are allowed to subjectively decide which evidence they evaluate.

Therefore, CHA respectfully asks the tri-agencies to remove the emphasis on the effect IDR decisions will have on health care inflation. First, there will be many instances where the health plans' median payment rate will be lower than the appropriate payment rate based on the patient's clinical circumstances. Therefore, selecting an amount higher than the QPA is the fair and equitable decision based on the resources necessary to provide high-quality care for a health plan's member. Second, given the small number of out-of-network claims that will be reviewed under the IDR process relative to total health care spend, CHA questions the tri-agencies' assertion that any one IDR entity's decisions will have an inflationary effect on health insurance premiums or overall costs.

NSA Enforcement Discretion

The July 13, 2021, IFR notes the tri-agencies considered delaying implementation of the NSA. The rule reviews the significant issues that must be addressed by multiple stakeholders to justify promulgating implementation rules using an IFR (instead of the normal process of issuing proposed and final rules). The issues identified include:

- There is a short period of time between enactment of the law (December 27, 2020) and the application of its requirements on affected parties (plan years beginning on or after January 1, 2022).
- The law and regulations require plans and issuers to make significant changes in the manner that they pay for items and services subject to cost-sharing and balance billing protections, including claims processing changes.
- Plans and issuers must account for these changes in setting premium or contribution rates; IFRs permit them to take into account finalized regulations in determining rates and plan offerings.
- Health care facilities and providers, as well as air ambulance providers, must implement the requirements relating to authorized balanced billing for items and services, including notice and consent procedures and requirements for public disclosure of policies.
- States require time to assess the enforcement requirements established under the Act; those states that opt to enforce the requirements may have to update their statutes or regulations.

CHA agrees that all the issues cited above are significant, and we appreciate the tri-agencies' crisp articulation of them. Beyond the issues discussed in the IFR, the regulations providing additional, necessary details related to the insured GFE and advanced EOB remain outstanding[34]. **Given the short time frame and paucity of crucial information from both state and federal agencies necessary to operationalize the requirements of the NSA, CHA does not believe it is possible for plans, providers, facilities, and states to make the necessary changes to their information systems and operational processes to fully comply with the requirements of the NSA by January 1, 2022.**

We appreciate the tri-agencies' efforts to quickly implement these regulations to protect patients. Further, we appreciate the limited enforcement discretion provided by the CMS Consumer Information and Insurance Oversight's August 20, 2021, FAQs and this IFR. However, we are concerned that this limited enforcement discretion is insufficient, and a rushed implementation based on incomplete and misunderstood regulations is contrary to the interests of affected patients and all consumers. For

[34] CHA's recommendations regarding the IDR process and transparency provisions of the No Surprises Act are available on the CHA website.

patients directly impacted by the law, a rushed and haphazard implementation will create confusion related to the information that is provided to them and when the protections apply. Further, health plans will pass the costs associated with a rushed implementation (both extraordinary efforts to develop compliant systems and any necessary rework as additional clarity is provided about the implementing regulations) in the form of increased premiums to consumers. **CHA asks the tri-agencies to protect patients from confusion and consumers from higher premiums as a result of the NSA by providing broad enforcement discretion for all of the NSA's requirements. Given the need to develop new IT infrastructure and processes, we ask that enforcement discretion extend from the law's effective date — January 1, 2022 — until 12 months after all the final rules necessary to implement the Act have been promulgated.**

CHA appreciates the opportunity to offer comments to the tri-agencies on issues related to the NSA. We look forward to partnering with the 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