MISSOURI HOSPITAL ASSOCIATION

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Laurie Bodenheimer, Associate Administrator
Healthcare and Insurance
Office of Personnel Management

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

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

Ali Khawar, Assistant Secretary
Employee Benefits Security Administration
Department of Labor

Xavier Becerra, Secretary
Department of Health and Human Services

Re: Requirements Related to Surprise Billing; Part II (CMS-9908-IFC, RIN 0938-AU62)

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

On behalf of its 142 hospital members, the Missouri Hospital Association offers the following comments in response to the multi-departmental interim final rule with request for comment related to surprise billing, part II.

UNINSURED GOOD FAITH ESTIMATES

The U.S. Department of Health and Human Services issued regulations that compel a convening health care provider or facility to provide the uninsured with good faith price estimates prior to all scheduled services or by request for patients who are shopping for care.

Convening Health Care Provider or Facility Responsibility

HHS defines a convening health care provider or facility as the provider or facility that is responsible for scheduling the primary item or service. The convening health care provider or facility would be responsible for coordinating the good faith estimates from all co-health care providers or facilities and providing the good faith estimates to the patient. In most instances, the facility or hospital that performs the service will be the convening health care provider. Facilities will be required to contact each of the health care providers from whom a patient could receive a bill, including but not limited to surgeons, radiologists, pathologists, primary care physicians and anesthesiologists. The convening provider would then be responsible for collecting the information, aggregating the results and presenting the final good faith estimate to the patient.

HHS estimates that for each self-pay patient, 30 minutes of business office personnel time will be needed for a convening health care provider or facility to prepare and provide the good faith estimate. HHS further estimates that an additional 30 minutes will be needed when co-health care provider or facility estimates are included. MHA believes that HHS has seriously underestimated the amount of time needed to assemble and provide a good faith estimate to the patient. HHS should reassess its assumptions.

MHA is concerned about the administrative burden that the responsibilities of a convening health care provider or facility would place on hospitals. Convening providers and facilities do not have the access to each co-health care provider or facility's charge description master, intended billing diagnostic or procedure codes, or discounting structures used to set the final good faith estimate. To obtain this information, the convening provider or facility will need to communicate with each co-health care provider or facility. This process often will require multiple contacts. The convening provider or facility will be required to make significant investments in personnel to coordinate the good faith estimate process and in information technology platforms to support the process. Further, the convening provider must do this without a source of funding to pay these costs. MHA encourages HHS to assemble a technical advisory team comprised of both facilities and practitioners to develop a better and more reasonable method of compiling and delivering a good faith estimate to the patient. MHA also recommends that HHS limit the scope of the good faith estimate requirement to patients who request them.

Effective Date of Convening Health Care Provider or Facility Responsibility for Including Co-Health Care Provider or Facility Good Faith Estimates

HHS indicates it will exercise enforcement discretion through December 31, 2022. as it relates to incorporating the pricing data from co-health care providers or facilities into a good faith estimate. MHA applauds HHS for this action and urges its ongoing assessment of the feasibility and readiness of all providers. The enforcement discretion may need to be extended beyond 2022.

UNINSURED PATIENT — PROVIDER DISPUTE RESOLUTION PROCESS

Defining "Substantially in Excess"

When patients are billed "substantially in excess" of the price cited in a good faith estimate, the patient can initiate the patient-provider dispute resolution process. HHS further defines "substantially in excess" as a difference of $400 or more between the actual price charged and the good faith estimate. This standard was based on what was determined to be a reasonable burden to place on the uninsured. HHS explained that "in 2019, the Federal Reserve found that nearly 4 in 10 adults would have difficulty covering an emergency expense costing $400, with 12 percent of adults unable to pay their current month's bills if they also had an unexpected $400 expense." HHS also went into great detail about its consideration and decision to not use a percentage of the good faith estimate to determine "substantially in excess." HHS wrote "if the expected charge for an item or service in the good faith estimate is $100,000, basing 'substantially in excess' on a flat $400 threshold, a billed charge of $100,400 (0.4% difference)

or more would make the item or service eligible for dispute resolution, which could be argued by some as not 'substantially in excess.'" Although HHS' intent behind the $400 standard is laudable, it is not appropriate for all claims. Providers and facilities have significantly different charging and expense structures. Due to this, a $400 floor is far too low for some while too much for others. The $400 floor is simply too low for higher total charge claims. Likewise, a simple percentage may be unaffordable for many patients for higher total charge claims. MHA recommends HHS utilize a blended approach, such as the lesser of a percentage of the total claim or a percentage of the patient's household modified adjusted gross income. This type of approach would eliminate miniscule tolerances applied to higher dollar claims while providing protection to patients based on income.

INDEPENDENT DISPUTE RESOLUTION PROCESS FOR THE INSURED

Determination of Qualifying Payment Amount

The federal surprise billing regulations generally define the qualifying payment amount (QPA) to be the median in-network payment rate. The regulations prescribe the QPA as the starting point for the independent dispute resolution contractors to consider when determining a fair payment rate. Many states do not have a central data warehouse of contracted rates for in-network services. Until robust datasets and data warehouses are developed, the IDR contractors will likely rely upon the insurer to provide the QPA to begin fair payment determinations. MHA is concerned that a biased party likely will be providing information used to begin this process with little or no opportunity for providers to question its veracity. MHA recommends that the agencies develop a fair and transparent process for determining and validating in-network contracted rates in states without an all payer database.

Batching of Claims

The Surprise Billing, Part II regulations allows providers and facilities to batch similar claims during a single independent dispute resolution process. Claims that have the same or similar comparable codes using a different procedural coding system are allowed to be batched. Batched claims also include like items or services provided within the same 30-business day period or during the 90-day "cooling off period" and items or services provided by the same group health insurer. MHA supports batching claims within the independent dispute resolution process and encourages the agencies to allow for other flexibilities to allow providers additional options for batching.

Cooling Off Period

The regulations specify that within 30 days of receipt of a claim from the provider, an insurer must either send an initial payment or denial for the service. The provider and insurer then will have 30 business days to negotiate during an open negotiation period. To initiate the independent review process, providers are required to initiate the IDR process within 4 business days of the end of the open negotiation period. Once a clean claim has been received, providers have a maximum of 64 days to initiate an IDR. The regulations also state that once a party initiates an

IDR review, a subsequent IDR review may not be initiated for a period of 90 days for similar services. This 90-day period is known as the "cooling off period." It is possible for the timeframe for requesting an IDR may be reached before the end of the cooling off period. Although the "cooling off period" is statutorily prescribed, HHS has stated the time period specified within the rule may be extended for extenuating circumstances. MHA recommends that HHS consider instances in which the IDR process could not be initiated due to the cooling off period as an extenuating circumstance. MHA also encourages flexibility in defining a cooling off period for items or services that are high cost and infrequent.

IDR Fees

When the IDR process is used, two types of fees are billed: an administrative fee charged by the federal government and a fee charged by the IDR entity for its services. Both parties participating in the IDR are required to pay both fees. The prevailing party would be refunded the fees held in escrow at the time the IDR process closes. MHA supports this process.

Thank you for the opportunity to comment and for your consideration of these issues.

Sincerely,

Daniel Landon
Senior Vice President of Governmental Relations

Andrew Wheeler
Vice President of Federal Finance

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