Federation of American Hospitals®

Charles N. Kahn III
President and CEO

August 5, 2021

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

Dear Secretaries Becerra, Yellen, and Walsh:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH and our members strongly support the *No Surprises Act*, which first and foremost protects patients from surprise medical bills by holding the patient to in-network cost-sharing in circumstances where the patient has no reasonable control over the network status of the providers administering care. In drafting and enacting the *No Surprises Act*, Congress also importantly preserved the role of health plan and provider payment negotiations while creating a process to fairly resolve payment disputes. It is imperative that the implementing regulations and independent dispute resolution (IDR) process advance and actively maintain that fairness so as not to inappropriately advantage health plans at the expense of patients and their health care providers.

The *No Surprises Act* contains numerous entirely new policies and processes that will require significant engagement across the health care sector and outlines an ambitious and multipronged implementation timeline. We appreciate the opportunity to work with you and your Departments on implementation of the *No Surprises Act* and will provide timely comments on the Interim Final Rule (IFR) issued on July 13, 2021 regarding determination of the qualifying payment amount (QPA); the notice and consent process for certain out-of-network (OON) care; post-stabilization services; and related issues. In addition, in anticipation of upcoming regulations regarding the IDR and advance explanation of benefits (EOB), we offer the below recommendations.

Regulatory Process and Implementation Timelines

As we have previously noted, the *No Surprises Act* outlines an ambitious implementation timeline for numerous new policies and the creation of an entirely new dispute resolution process. The myriad of implementation issues to consider and decisions to make – coupled with the potential impact of these policies on health plan and provider relationships and operations – means it is vital that your Departments provide ample opportunity for stakeholder input on any proposed regulations before they are implemented. Although the FAH acknowledges that the Departments issued the initial regulations implementing the *No Surprises Act* through an IFR, the FAH respectfully urges the Departments to undertake full notice and comment rulemaking for each future implementing regulation, modify the July 13 IFR in response to the Departments' review of stakeholder comments, and promptly respond to comments on the IFR. In addition, the FAH requests that, if final rules cannot be promulgated with adequate time for stakeholders to operationalize the final rules before the *No Surprises Act* takes effect January 1, 2022 (*i.e.*, by October 1, 2021), the Departments adopt regulations that extend the timeline for initiating IDR so that all parties can operationalize the final rules and IDR entities can be certified well in advance of any IDR process.

Independent Dispute Resolution Process

Under the *No Surprises Act*, an OON provider may accept an initial payment made by a health plan. If the provider determines that health plan payment is inadequate, the provider and health plan may engage in a 30-day negotiation period (beginning the day the provider receives the initial payment, or payment denial from the health plan) to reach a mutually acceptable payment. If these efforts do not come to fruition, however, either party may trigger the IDR process. The Departments are required to jointly issue final regulations establishing the IDR process by Dec. 27, 2021.

The FAH urges the Departments to ensure the language and intent of the *No Surprises Act* permits private arms-length negotiations and that an adequate payment rate for OON services is upheld through implementation of the regulations. The recommendations discussed below will help achieve this outcome.

<u>Factors For IDR Entity Consideration</u>

Under the IDR process, IDR entities are required to consider a number of factors when determining the OON rate for the item or service in question, including the QPA, along with

"any information" related to a payment offer as well as a number of other factors, which may include the level of training, experience, and quality and outcomes measurements of the provider; the market share held by the provider or the plan; patient acuity or complexity of furnishing the item or services; teaching status, case mix, and scope of services of the provider; demonstrations of good faith efforts by the provider or health plan to enter into a network agreements; and, if applicable, the contracted rates (over the previous four plan years) between the parties. IDR entities are prohibited from considering provider charges, and payment rates paid by public programs, such as Medicare, Medicare Advantage and other such programs.

This multi-factor approach mandated by Congress in the *No Surprises Act* is of particular importance in light of the many pricing elements that were excluded from the definition of the QPA in the surprise billing IFR issued on July 13, 2021. Although the Departments may appropriately modify the QPA regulations promulgated through the IFR in response to comments, the QPA by definition excludes a wide array of relevant factors specific to the particular provider, the relationship between the plan and provider, and the items and services furnished to the patient. In short, the amount of payment determined in IDR should, in most cases, differ from the QPA in light of Congress's requirement that the IDR entity consider a robust range of relevant factors beyond the QPA and the importance of factors in this determination.

Timeline

If the provider and health plan do not reach agreement on a payment amount during the initial negotiation process, either party can trigger the IDR process within four days of the 30-day negotiation period. The plan and provider then have three business days to jointly select the IDR entity to oversee the case. If not, the HHS Secretary has up to three business days to select one on their behalf. Within 10 days of selection of the IDR entity, each party must submit an offer for payment, along with any supporting materials. The IDR entity must select one of the offers within 30 days of the IDR entity having been selected, and the health plan must pay the provider within 30 days. The statute provides the HHS Secretary with discretion to modify the timelines that are part of the IDR process.

The timelines set out in the statute are very limited, and the FAH urges the Departments to use their discretion to ensure flexibility in the IDR timelines, as is permitted in the statute. The purpose of the IDR process is to allow the IDR entity to select the appropriate payment amount from the parties' offers, that most adequately and fairly reflects the items or services provided. To achieve this statutory intent, it is critical that the parties have a reasonable and realistic amount of time to develop and gather relevant information and submit it to the IDR entity for proper, fair, and timely consideration.

Specifically, we urge the Departments to provide at least 30 days, instead of four days, to trigger the IDR process after the 30-day negotiation period. In addition, the three days to choose an IDR entity should be extended as it may not be reasonable or possible to meet this timeline, especially in cases where an IDR entity is not available or has a back log. Moreover, instead of 10 days to submit information to the IDR entity, there should be at least 30 days as this would allow enough time to develop and submit evidence and appropriate payment offers.

Further, the timelines in the IDR process should be based on business and not calendar days. Moreover, the FAH urges the Departments to provide that in the case of any deadline that would otherwise fall on a Saturday, Sunday, or a federal legal holiday, the deadline would be the next day that is not a Saturday, Sunday, or a federal legal holiday.

Finally, if the final rule addressing the IDR process and deadlines is not promulgated until after October 1, 2021, and/or IDR entities are not certified until on or after such date, the deadline to initiate IDR should be extended to allow at least 90 days after the final IDR process is set up before any deadline to initiate the IDR process. This initial flexibility on deadlines is necessary to ensure that all parties and IDR entities have enough time to operationalize the process before IDR commences.

Flexibility in the IDR timelines would promote a fair and efficient process that achieves the most appropriate result and would not impact the patient – who will have already been removed from the process. Critically, Congress designed the statutory scheme to ensure that the patient cost-sharing amount is determined before, and separately from, any IDR between the provider and the payer. In other words, the patient is completely removed from the process by the time the parties reach the IDR process, and so the provider, health plan, and IDR entity can take the necessary time to present all relevant information without impacting the patient in any way.

Batching of Items and Services

Under the IDR process, for efficiency and cost reduction purposes, the same provider or facility is permitted to batch together multiple items and services related to the treatment of a similar condition and attributable to the same health plan that occur during a 30-day period. These batched claims would be considered jointly by the IDR entity, enabling the more efficient resolution of claims. The statute permits the Departments to establish an alternative time period for batching claims that encourages efficiency and minimizes health plan and provider administrative costs.

The statutory reference to "treatment of a similar condition" should be broadly construed to allow batching of a wide range of clinical scenarios and payment methodologies, for example, all trauma care items and services, neonatal intensive care unit services, anesthesia services and other broad groups of facility and provider items and services. The statutory language does not indicate that Congress intended to restrict bundling based on the diagnosis code or similar distinctions, and the statutory focus on encouraging efficiency and minimizing costs supports broadly construing the bundling requirements.

Further, the statutory bundling provision references items and services "furnished by the same provider or facility" and items and services for which payment "is required to be made by the same group health plan or health insurance issuer." The FAH urges the Departments to broadly construe these references to include affiliates and wholly owned entities such that a group of providers under common ownership or control could batch certain emergency department claims involving issuers under common control, which frequently apply uniform payment practices enabling the efficient batching of claims.

Further, where a group health plan is administered by an affiliate of an issuer, the provider should have the flexibility to batch items and services that the issuer and its affiliates are required to pay or that a group health plan administered by such an entity is required to pay. Providers also should be permitted to add similar claims to an existing IDR arbitration on a reasonable basis to minimize burden on the system and promote the efficient resolution of disputes. Finally, the 30-day period for batching should be extended to 90 days for those claims where initiation of IDR is delayed due to the 90-day cooling off period under section 2799A-1(c)(5)(E)(ii)-(iii) of the Public Health Services Act, section 716(c)(5)(E)(ii)-(iii) of the Employee Retirement Income Security Act of 1974, and section 9816(c)(5)(E)(ii)-(iii) of the Internal Revenue Code of 1986, each as amended by the No Surprises Act.

This flexibility will avert having an excessive number of IDR initiations for a very limited set of services and would help minimize IDR backlogs that could otherwise frustrate the efficient resolution of disputes.

Selection of IDR Entity

The *No Surprises Act* requires the Departments to establish a process via regulation to certify IDR entities. It also requires that this process ensure that a certified IDR entity has: sufficient medical, legal and other expertise, and sufficient staffing to make determinations on a timely basis. In addition, the entity must be independent (i.e., no conflicts of interest) and therefore cannot be a health plan, provider, or facility nor an affiliated professional and trade association, and it must meet other requirements, such as fiscal integrity and confidentiality requirements.

The FAH urges the Departments to ensure that any selected IDR entity does not have any conflicts of interest, such as any affiliations or other relationships with health plans, issuers, managed care organizations, third party administrators, and other payer entities (defined broadly) that may bias the IDR process. IDR entities also should have significant knowledge and expertise with respect to health care claims payment disputes, managed care contracting, revenue cycle, and claims adjudication so that they can efficiently and reasonably review all submissions and make appropriate payment determinations. In addition, each IDR entity should have adequate staff, including arbiters, available to handle the volume of IDR initiations on a timely basis; otherwise, the IDR process will fail. The Departments also should monitor the IDR process over time to ensure that IDR entities have the appropriate expertise and sufficient staffing, are free from conflicts of interests, and maintain the confidentiality of information disclosed in IDR by, for example, designating an ombudsman for each state or region and establishing a meaningful participant complaint process that could address any of these foregoing factors, among other complaints.

Transparency and Advance Notice of Benefits

The FAH supports the goal of ensuring that patients have access to clear, accurate, and actionable cost-sharing information, including provisions in the No Surprises Act that require health plans to provide patients with Advanced Explanations of Benefits (EOBs) prior to scheduled care or upon request by patients. This process requires providers and facilities to

provide plans, or in some cases directly to patients, a good faith estimate of the total expected charges for scheduled items or services, including any expected ancillary services. This requirement will apply whenever items or services are scheduled at least three days in advance or when requested by a patient.

The FAH encourages the Departments to engage with providers, health plans, and all affected stakeholders to remove inconsistencies and duplicative requirements between these EOB provisions and the hospital price transparency final rule so that patients are not confused regarding their medical care costs.

We further urge the Departments to provide clarifications surrounding the EOBs regarding the scope of the services for which the good faith estimate is required. The Departments should clarify that this estimate is only required upon patient request of scheduled services. Otherwise, the requirement would be very burdensome and costly to the health care system overall. The Departments also should clarify that clinicians and facilities are independently responsible for providing the good faith estimate information for the items and services for which they typically bill, as hospitals do not have access to billing by clinicians who are not employed by the hospital. In addition, there needs to be a single format utilizing existing transactional standards for the good faith estimates of expected claims and corresponding codes to all payers, and once forwarded to a plan for its EOB, the provider should have access to that EOB involving their services. Further, we urge the Departments to ensure that provider good faith estimates are used only for patient advanced EOBs and are prohibited from being used as part of medical necessity determinations or other coverage adjudication processes, and if health plans do not timely produce an advanced EOB for which the plan received a good faith estimate, the plan should be required to cover the full cost of service, without patient cost-sharing. Finally, the Departments should clarify how this policy interacts with similar state laws to minimize any confusion and duplicative reporting, including deferring to state law when complying with the federal law would not result in additional patient benefit.

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The FAH appreciates the opportunity to weigh in on these initial areas for implementation under the *No Surprises Act*. We look forward to continued engagement with you to protect patients from surprise medical bills and ensure a fair and operationally feasible process for payments to OON providers. Should you have any questions or follow up, please do not hesitate to reach out to me or a member of my staff at 202-624-1534.

Sincerely,