hfma
healthcare financial management association

December 6, 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

File Code: CMS-9908-IFC

Re: Interim Final Rule with comment period (IFC) implementing certain provisions of the No surprises Act; Part II; Federal Register (Vol. 86, No.192); October 7, 2021.

Dear Secretaries Becerra, Yellen, and Walsh:

The Healthcare Financial Management Association (HFMA) would like to thank CMS for the opportunity to comment on *Interim Final Rule (IFR) with comment period implementing certain provisions of the No Surprises Act; Part II issued by the Department of Health and Human Services, the Department of the Treasury, the Department of Labor, and the Office of Personnel Management (hereafter referred to as the Interim Final Rule (IRF)) on October 7, 2021.* HFMA is a professional organization of more than 75,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with numerous rules and regulations that govern the industry.

Introduction

HFMA would like to commend CMS for its thorough analysis and discussion of the many Surprise Billing decisions addressed in the Interim Final Rule, Part II. Our members would like to comment on the specific proposals related to:

- Provider/health plan negotiation process
- Evaluation criteria for independent dispute resolution (IDR) entities
- The anchoring benchmark of the IDR process is the qualifying payment amount (QPA) the health plan presents to arbitration
- Good faith estimates for uninsured/self-pay patients
- Uninsured/self-pay patient-provider dispute resolution threshold

Provider/Health Plan Negotiation Process

The tri-agencies clearly define that 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 denial.

In a case where the health plan and provider are unable to 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.

The trigger that launches the negotiation process is the notice provided by the party initiating the negotiation within that 30 business day time frame. The notice must identify the items and services subject to notification, the date the services were furnished, the service code, the initial payment amount or denial and contact information.

Although the IFR clearly cautions that if the initial notice is not properly provided to the other party, the period has not begun and subsequent payment determination may not be enforceable, the tri-agencies place no responsibility on the receiving party to acknowledge the receipt of the notice issued by, most likely, the provider.

HFMA encourages the tri-agencies to hold health plans mutually responsible in accounting for the receipt of the initial notification and to provide timely confirmation of such receipt, within 24 hours. We respectfully request that the tri-agencies acknowledge that if the party receiving the initial notification does not acknowledge and provide proof of the receipt of the notice, the subsequent IDR decision remains valid as the initiating party attempted to engage in the open negotiation process.

Evaluation Criteria for IDR Entities

The IFR details seven reasons why an IDR entity's certification may be revoked. HFMA is supportive of six of these reasons, but we are concerned with the tone of the sixth reason as it relates to addressing "inflationary effects of health care costs." The sixth reason states that, "*To ensure that the Federal IDR process is fair, equitable, and does not have an inflationary effect on health care costs due to certified entities failing to properly apply the factors as set forth in these interim final rules, the Departments are of the view that it will be prudent to review certified entities' processes and procedures*".

HFMA strongly supports the tri-agencies use of audits to ensure the IDR entity's decisions are fair and equitable, however, we are concerned that the above language regarding "inflationary effects on health care costs" will incentivize IDR entities to always choose the lowest payment, not the most appropriately aligned payment for the furnished services provided to the patient.

The above "inflationary language" only creates deeper concerns that the IDR process favors health plans and victimizes community providers providing healthcare services to their communities, and HFMA is concerned that this guidance will further push health plans to only contract with providers who are willing to accept unsustainably low reimbursement jeopardizing network adequacy, quality of care and patient safety. **HFMA respectfully request that the tri-agencies remove this language for the evaluation criteria.**

QPA Calculation

The QPA plays two key roles in the No Surprises Act. It will be used both to determine the patient's cost-sharing in qualifying out-of-network situations and as a factor that will be evaluated in the IDR process when out-of-network plans and facilities or providers cannot agree on payment for lifesaving services provided to a patient.

The July 13, 2021 IFR states that the health plan must provide "rudimentary information related to the QPA" and that "providers may be able to request additional information". **Based on the direct impact the QPA has on the IDR process and the patient's out-of-pocket costs, the methodology and data used by the health plans to calculate the QPA should be made readily available and transparent to all stakeholders.**

HFMA is very concerned that the IFR appears to assume that the health plan QPA will be accurate and representative of the median payment for furnished services in all scenarios, therefor without review of methodology, the QPA will be held as a benchmark to begin negotiations during the IDR process. HFMA encourages the tri-agencies to retract this regulation and reissue guidance to give IDR entities the deference to use their expertise to weigh factors according to the situation. We are also concerned that the current regulation does not require plans to pass any savings onto patients, once again optimizing the potential for the health plans to unjustly profit.

Good Faith Estimates for Uninsured/Self-Pay Patients

The IFR states that good faith estimates are required to be given to all uninsured/self-pay scheduled services (3+ days out) and when requested by an uninsured/self-pay patient. The convening provider, defined as the provider/facility responsible for scheduling the primary item/service or that receives the request for an estimate. The good faith estimate should cover all items/services from admission to discharge (e.g., all items/services that wouldn't be scheduled on their own). The estimates should be the cash pay rate or uninsured/self-pay rate, reflective of any discounts available to the patient (e.g., financial assistance).

HFMA respectfully requests clarification on when financial assistance assessments need to occur during the good faith estimate process. HHS should confirm that good faith estimates are only intended to reflect a patient's known financial assistance eligibility at the time of the scheduling/request for an estimate and that this regulation does not require providers/facilities to conduct a full and detailed financial assistance application assessment for every patient prior to scheduling or within the short, good faith estimate timeline.

HFMA cautions the tri-agencies that the timelines for providing good faith estimates are unrealistic for real-world operations. Specifically, the co-provider/co-facility timeline is extremely challenging and out-of-scope. The coordination of one consolidated, all-inclusive good faith estimate cannot be provided within 1 business day after the date of scheduling the items or service. This overly aggressive timeline for all services scheduled at least 3 days in advance is challenging enough to provide when co-providers/co-facilities are not included in furnishing services, but when the convening provider must seek estimates from co-providers outside of its facility, the lift becomes impossible.

HFMA also respectfully requests that the tri-agencies revisit and help identify a standard technology or transaction that would enable automation of the comprehensive good faith estimates and allow sufficient time for providers to implement this new standard. HHS then should reassess timelines once a technical solution is established, to determine what is operationally feasible.

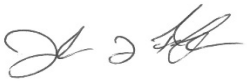
Uninsured/Self-Pay Patient-Provider Dispute Resolution Process

Under the IFR patient-provider dispute resolution process, a patient's bill may be determined eligible for the patient-provider dispute resolution process if the patient received a good faith estimate, if the process is initiated within 120 calendar days of the patient receiving the bill, and if the bill is substantially more than the good faith estimate. HHS has defined "substantially in excess" as the billed charges being at least $400 more than the good faith estimate for any provider or facility listed on the good faith estimate.

HFMA and its members point out that a flat rate of $400 is not an appropriate amount to trigger the patient-provider dispute resolution process. The arbitrary threshold of $400 is not an appropriate triggering amount for complex care and will likely create an inordinate number of disputes for legitimate, medically necessary reasons. **HFMA recommends that HHS should instead require the final bill to be at least 10% more than the good faith estimate for it to be eligible for the patient-provider dispute resolution process.**

HFMA looks forward to any opportunity to provide assistance or comments to support the Departments efforts to refine and improve the No Surprises Act. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS and advisory groups. We are at your service to help CMS gain a balanced perspective on this complex issue. If you have additional questions, you may reach Richard Gundling, Senior Vice President, at (202) 296-2920 or me. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA
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About HFMA

HFMA is the nation's leading membership organization for more than 70,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices and standards.