December 6, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

CMS-9908-IFC: Requirements Related to Surprise Billing: Part 2

Dear Administrator Brooks-LaSure:

America’s Essential Hospitals appreciates the opportunity to submit comments on the above-captioned interim final rule related to balance billing, or surprise billing. While we strongly support protecting patients from payment negotiations between private insurance plans and providers, we are concerned that several provisions in this rule undervalue the services provided by essential hospitals while increasing the strain on staff time and resources.

America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all. Filling a vital role in their communities, our more than 300 member hospitals provide a disproportionate share of the nation’s uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Our members provide state-of-the-art, patient-centered care while operating on margins a third that of other hospitals—2.9 percent on average compared with 8.8 percent for all hospitals nationwide.¹

Essential hospitals are committed to serving all people, regardless of income or insurance status. Their patients face sociodemographic challenges to accessing health care, including poverty, homelessness, language barriers, and low health literacy. Ten million people in communities served by essential hospitals have limited access to healthy food, and nearly 24 million live below the poverty line.² Essential hospitals are uniquely situated to target these social determinants of health and are committed to serving these patients. These circumstances, however, compound essential hospitals’ challenges and strain their resources, requiring flexibility to ensure they are not unfairly disadvantaged for serving marginalized patients and can continue to provide vital services in their communities.

² Ibid.
We are concerned this interim final rule fails to account for the unique position of essential hospitals in their communities and the additional costs and burdens associated with implementation. We urge the Department of Health and Human Services (HHS) to consider the steps outlined below as it finalizes and implements this rule.

1. **HHS must work with essential hospitals to revise the good faith estimate requirements to account for the challenges of providing care to patients with complex social and financial needs.**

The majority of patients served by essential hospitals are uninsured or are covered by Medicaid and Medicare. Overall, 11 percent of essential hospital patients discharged from outpatient services are uninsured, though at some of our member hospitals, more than half of patients are uninsured. A member hospital in Virginia serves roughly 600 to 800 uninsured patients a day. Further, many essential hospital patients have low health literacy and low income, meaning staff already spends a significant amount of time reviewing health care and financial options with patients, as well as helping them with financial assistance applications.

We believe the good faith estimates required in the interim final rule are well intentioned; patients, regardless of their insurance or income status, should understand the health care services they receive and how much they will cost. However, the rule fails to consider situations in which the good faith estimate is needless and should not apply, and it underestimates the amount of staff time and resources necessary to produce and provide such estimates.

a. **HHS should further analyze how to determine which uninsured patients should be offered a good faith estimate.**

The rule defines an uninsured or self-pay individual as a patient who does not have benefits for a service under commercial health insurance, a federal health program, or a state health care program; it uses this definition to determine which patients must be offered a good faith estimate. However, there are several situations in which it is unclear if a hospital must provide a good faith estimate to a patient according to this definition and in which the estimate is unwarranted.

Nearly all essential hospitals have a financial assistance policy (FAP) or a sliding scale fee schedule for patients with low income. In some cases, patients have such little income that their care is provided at no cost to them. In other cases, patients with low incomes are required to pay a set copay for certain service areas, such as a doctor’s visit or an inpatient stay, regardless of specific diagnoses and procedures. In both cases, a good faith estimate is needless. Medical staff will certainly continue to review expected services and the course for care with patients, but they will have little need to go through a detailed cost estimate when the patient is not responsible for payment or has a simple fee schedule. Further, patients cannot use the good faith estimate to shop around, as the FAP and sliding scale fee schedule are hospital-specific.

In addition, each state has different payment policies to address the cost of uncompensated care accrued by the health care system. Some states have low-income pools or fund indigent care programs through disproportionate share hospital payments. In these situations, the rule is unclear if patients receiving discounts under these programs are considered uninsured and thus must receive a good faith estimate, even though the cost of their care is covered through the

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3 Ibid.
program. Again, if the patient is not responsible for the cost of care at all, a good faith estimate is unnecessary.

Finally, Medicaid and Medicare beneficiaries can apply for financial assistance to help pay for deductibles and copays, rendering a good faith estimate unnecessary. The rule does not discuss if these patients should be offered such an estimate.

**To avoid patient confusion and efficiently use hospital resources, HHS must limit requirements to patients for whom a good faith estimate is necessary, rather than applying a blanket policy that is not applicable to all low-income individuals.**

b. HHS should study the effect of the financial assistance application process on good faith estimate requirements.

The interim final rule requires hospitals to provide good faith estimates to patients who request them one to three business days after scheduling a service, depending on when the service is scheduled. The rule also requires the expected charges on the good faith estimate to be no more than $400 above billed charges—a narrow window. However, the rule fails to consider the impact of the FAP application process on these requirements.

Essential hospitals routinely inquire about a patient's insurance coverage when scheduling services. When patients are uninsured, they are referred for an internal FAP assessment or are assessed for eligibility for federal and state programs or marketplace coverage. Some hospitals are required to assess eligibility for public health coverage before offering financial assistance. To provide an accurate account of the expected charges for the good faith estimate, hospitals should wait until the FAP assessment is complete and the patient is either enrolled in public health insurance or approved for financial assistance. However, waiting to schedule the appointment until this is complete could delay care—by months in some cases. On the other hand, the hospital could schedule the service and presume eligibility for financial assistance. However, presuming eligibility and the discount amount might lead to an inaccurate estimate; this could result in underpayment to the hospital or subjection to the patient-provider, or select, dispute resolution (SDR) process.

Further, FAP eligibility and procedures vary widely by state and by hospital. Many require reassessments on an annual basis; others are more frequent. Some FAPs offer tiered discounts based on both patient income and county and state residency. To apply, patients generally meet with a financial counselor, complete an application, and provide proof of income. This process can take time. While some hospitals can pull eligibility information from government databases to auto-populate an online application and determine eligibility more quickly, others still rely on paper forms to complete this assessment. Some member hospitals have reported it might take up to three months for a patient to complete the paperwork, while some patients never complete it.

Consider this scenario: A hospital wants to schedule a service that normally has a one- or two-month lag between scheduling and completing the procedure while also waiting for an assessment of the patient's Medicaid eligibility. They also want to help the patient apply for the hospital's FAP in case they do not qualify for Medicaid. To meet the requirements of the interim final rule, the hospital can avoid a delay in care by scheduling the patient and providing either a needless good faith estimate (in the case of Medicaid eligibility) or guess the patient's eligibility for financial assistance and apply the projected discount to the expected charges. Alternatively, the hospital can wait to schedule the service until Medicaid or FAP eligibility is determined and
the facility is able to provide an accurate good faith estimate, if warranted, delaying care by many months. The first option provides timely access to care while likely confusing the patient with either a needless good faith estimate, or potentially inaccurate estimate that might shortchange the hospital or subject them to the SDR process if they elect to apply the appropriate discounts. The second option significantly delays care. To complicate the scenario further, the patient might need a service for which there are a limited number of providers willing to treat Medicaid or uninsured patients, meaning available appointments are several months out. Waiting for enrollment in either program to provide a good faith estimate in this scenario would further delay care.

Finally, in combination with the quick timetable to provide a good faith estimate after a service is scheduled, the rule’s requirement to apply discounts without verification paves the way for potential FAP misuse. If a patient wants to schedule a service before their financial assistance is approved, the rule allows them to do so and requires the provider to apply presumptive discounts to the expected charges. However, the patient might not qualify for a discount or might qualify for a different amount and, therefore, would receive a good faith estimate that is lower than what the patient should expect to pay. If the patient receives a deeper discount than that for which they qualify, their billed charges are lower than what they should owe. While we believe most patients would not purposely use this situation to avoid paying for their services, the policy does open the FAP to potential abuse. The ability to provide a robust FAP is critical for patients and the health care safety net to maintain access to high-quality care. New policies should protect FAPs rather than leave it open to fraud or abuse.

FAP are provided to give patients with low or no incomes access to high-quality care. In many communities, essential hospitals are the only ones who will offer this type of health care, and they incur considerable costs to do so. In 2019, essential hospitals provided an average of $56 million in uncompensated care, compared with $8 million provided by hospitals nationwide. Creating a policy that allows hospital underpayment and some patients to take advantage of the FAP further disadvantages essential hospitals that provide care to those most in need while already operating on thin margins.

The lack of consideration of FAPs and procedures in the good faith estimate requirements leaves many unanswered questions and complicates the implementation of this rule for essential hospitals, potentially causing significant delays in care or hospital underpayment due to inaccurate estimates. **HHS must work with stakeholders to understand how FAPs interact with good faith estimate requirements and develop policies that support efficient and accurate FAP implementation within this rule.**

c. **HHS must reassess the amount of staff time and resources necessary to provide good faith estimates.**

The interim final rule requires providers to give uninsured or self-pay patients an oral and written good faith estimate for an episode of care. The estimate must include:

- patient name and date of birth;
- a description of the primary item or service and the scheduled date of the service;
- an itemized list of the services grouped by provider or facility, including services reasonably expected to be provided;
- diagnosis codes, expected service codes, and expected charges associated with each listed service;

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4 Ibid.
• name, national provider identifier, and taxpayer identification numbers of each provider or facility represented in the good faith estimate;
• a list of services the provider anticipates will require separate scheduling and that are expected to occur before or following the episode of care, including a disclaimer that a separate good faith estimate for those services will be issued;
• a disclaimer that there might be additional services the provider recommends as a part of the course of care;
• a disclaimer that the good faith estimate is only an estimate and might differ from the actual services or charges that could occur;
• a disclaimer that informs the patient of their right to a patient-provider dispute resolution if the charges substantially differ from the expected charges, as well as where they can find information about the process; and
• a disclaimer that the good faith estimate is not a contract.

HHS assumes it will take one hour to check a patient’s insurance status, offer a good faith estimate, and provide the estimate. This assumption fails to account for essential hospital patients’ low health literacy rates, translation needs, and need for help with financial assistance applications. Essential hospitals will have to hire additional staff to comply with the estimate requirements in the time allotted.

The good faith estimate requires very detailed information meant to provide patients with information to shop for cost-effective health care. However, most essential hospital patients cannot do that. Due to socioeconomic barriers—such as little time off work, transportation, and child care limitations—and the lack of robust financial assistance offered by other health care providers, many essential hospital patients do not have the resources to shop around for their care and are unlikely to find a better “deal.”

As already discussed, staff at essential hospitals check patients’ insurance status; provide financial counseling, including application assistance; and review their course of care. This information can be very confusing and overwhelming—the majority of essential hospital patients have basic or low health literacy. The good faith estimate might help some patients but will require additional staff time to review it with most patients and answer their questions. While essential hospitals will always help patients understand their health care and costs, the extensive information in the good faith estimate might cause more harm than good.

Further, essential hospitals care for a significant number of patients with limited English proficiency, requiring translation of the good faith estimate. While a model estimate translated by HHS will be helpful, providing the estimates still will require individual translation and oral presentation. Access to translation services varies between hospitals; some have sufficient medical staff that already provide services in a given language, some have separate translators, and others rely on an external translation service by phone or video. Regardless of how this is delivered, as the amount and complexity of the information increases, estimates will become more time consuming and costly to provide.

Helping patients with financial assistance applications and reassessments takes a significant amount of time and must be considered. Applying for financial assistance can be frustrating,

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confusing, and overwhelming for patients, especially considering they are likely applying, reapplying, or recertifying for multiple assistance programs beyond health care. Depending on the locality, these applications might be streamlined online with limited paper documentation, while others still use paper-based applications with programs requiring different documentation depending on the local department that oversees it. The same is true for Medicaid and FAP applications. While hospitals attempt to make these processes as simple as they can, required documentation can be extensive and hospitals might not have the resources to offer an online application. When patients apply for FAP, staff could spend significant time reviewing the documentation requirements, in addition to reviewing a patient's financial options. Further, a patient also might have to repeat this process when applying for financial assistance with a co-provider, such as an independent physician or radiologist.

Beyond additional staffing, essential hospitals will need more time and funding to design, implement, and train staff on data systems that will easily transfer information from co-providers for the good faith estimate. Member hospitals are particularly worried about getting accurate information for the good faith estimate for lab appointments and radiology services, as those charges are not always given in advance. Further, some members work with a significant number of independent physicians and surgeons and are concerned about getting expected charges from them in timely manner. Most of this correspondence will be done over the phone or via email before a system can be developed.

A data system to transfer this information will be costly and could take years to develop and implement. Essential hospitals will have to build a system that not only meets their needs and interfaces with their own electronic health record system, but also makes it easy for co-providers to participate. As it remains difficult to share medical information among different provider systems, hope is thin that there will be a data system to communicate between them any time soon. Under the interim final rule, lack of efficient and timely communication between different providers will delay care. Health care staff will have to wait to order labs or refer patients to specialists until the good faith estimates is provided, which will eliminate the option for same-day labs, radiology services, or consults, forcing patients to schedule additional appointments.

Between the amount of time it will take to compile and present the good faith estimate and the lack of resources to develop an efficient data system to transfer information between providers, it will be very difficult for essential hospitals to put together an accurate and timely good faith estimate for scheduled services. HHS must reevaluate and delay the implementation of this rule until the agency addresses the unique needs of essential hospital patients and the financial challenges these hospitals face in providing good faith estimates.

2. **HHS should create an independent dispute resolution process that does not favor payers over providers serving a safety net role.**

Essential hospitals provide high-acuity care, such as level I trauma, burn, and neonatal care. In some cases, they are the only hospital in their community with the resources and experience to provide such services. Essential hospitals also serve patients who are medically complex and face socioeconomic barriers to health and health care. Our member hospitals provide wraparound services—case management, transportation, nutrition support, legal services, language access, and patient navigation, among others—to meet these needs.

Given the provision of these services and their patient mix, essential hospitals tend to have higher costs. In many markets, these factors lead to essential hospitals facing inadequate
reimbursement from private insurers or exclusion from provider networks altogether. Considering these challenges, we are concerned the qualifying payment amount (QPA) is unduly weighted in the independent dispute resolution (IDR) process to determine an out-of-network payment amount. We also are concerned about the short turnaround time in the IDR process in relation to needed documentation for the other factors. We continue to believe the QPA methodology in the previous interim final rule disadvantages essential hospitals.

a. **HHS must reconsider the weight of the QPA and other factors in the payment determination.**

To determine the payment amount for out-of-network services, the IDR entity is to presume that the QPA is the primary factor when considering the offers from the provider and payer and should choose the offer closest to the QPA. As we discussed in previous comments and included for reference below, the QPA methodology fails to consider medically complex patients served by essential hospitals.

While the IDR entity must consider factors other than the QPA, the rule sets an unclear but high bar for the information supporting these other factors. The information must be “credible” and demonstrate that the QPA is “materially different” from the appropriate out-of-network rate. These factors are:

- the provider’s level of training, experience, and quality and outcome measures;
- the market share held by the provider or payer;
- the acuity of the patient;
- the facility’s teaching status, case mix, and scope of services; and
- a demonstration of a good faith effort to enter a network agreement.

The association strongly believes the QPA is inadequate as the primary factor; equal weight should be given to all other factors. Specifically, equal weight should be given to the facility’s teaching status, case mix, and scope of services. These components effect operational costs and are critical in serving essential hospitals’ patient populations. The case mix of essential hospitals is a result of mission-driven care and ensuring access to health care for all while providing a wide variety of services to meet patients’ needs.

Further, teaching hospitals play a critical role in meeting health care workforce needs while training providers to treat complex patients in underserved communities. For example, our member teaching hospitals trained an average of 240 physicians in 2019 compared with an average of 84 physicians at other U.S. teaching hospitals. Further, of those 240 physicians trained at essential hospitals, 59 were trained beyond the federal graduate medical education funding allotment, while only 17 were trained above the federal funding cap at other U.S. teaching hospitals. Even though hospitals already are training more physicians than are federally financed, more medical training and residency slots are needed to address current and future workforce shortages, particularly in underserved communities. As teaching facilities rise to meet this need, their status must be considered during the IDR process.

Further, as discussed above, the majority of patients served by essential hospitals are uninsured or covered by Medicaid or Medicare and their care often is reimbursed below cost. Below-cost reimbursement rates lead to very narrow operating margins for our hospitals. Despite this, essential hospitals provide support services to enable patients to achieve better health

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6 Ibid.
outcomes, though many of these services are under- or unreimbursed. This commitment to patients with high socioeconomic needs also must factor into the payment determination.

Finally, by considering the QPA the primary factor in the payment determination, the rule has created a de facto benchmark—a policy Congress specifically rejected in the drafting of the No Surprises Act. Congress intended the other factors to have equal weight in the payment decision. Therefore, we ask HHS to align the IDR process with the No Surprises Act, as Congress intended.

b. HHS should reexamine the IDR process timeline to account for the amount of supporting documentation required for the other payment determination factors.

The interim final rule lays out a detailed timeline for the IDR process. We request more time be allotted to each step in the process.

It will require significant time to collect information for the negotiation period and IDR process, particularly if claims are batched. This is especially true during the 10 business days allotted for parties to submit offers and supporting documentation. While the rule states the information should be “credible” and demonstrate the QPA is “materially different,” it does not consider the level of detail necessary to prove these requirements. The rule implies summary level information will not suffice; instead, providers will need to submit detailed medical records; specific information regarding the facility and provider; and, potentially, written documentation of network agreement negotiations, for example, to best support consideration of the other factors. Further, the IDR entity may ask for additional information, the breadth and depth of which is unknown. The request for further information is likely to vary from one IDR entity to another, making it harder to prepare for additional information requests. We ask HHS to allot more time to the IDR process, especially to the window for submitting supporting documentation.

3. HHS should revise the QPA calculations to account for contracting issues experienced by providers serving a safety net role.

As submitted previously, we are concerned about the calculation of the QPA. First, and as described below, we believe the QPA will be skewed lower because adequate rates are not included in the calculation. Second, due to the QPA skewing lower, payers will have no incentive to pay essential hospitals adequate rates during contract negotiations or to include them in provider networks. Essential hospitals then might be forced to accept inadequate rates to be included in payers’ networks or be out-of-network and rely on the IDR process for payment.

a. HHS should further analyze factors that will skew the QPA downward, resulting in inadequate payments.

The QPA calculation uses the payer’s median contracted rate for the same or similar services offered by a similar provider or facility type in the same insurance market. However, if a payer has chosen not to contract with essential hospitals or other similar providers, their rates will not be included in the QPA calculation, likely skewing the calculation downward.

Essential hospitals provide services, equipment, and technology, as well as wraparound services, that might not be provided by other hospitals in the area—this robust care and advanced equipment requires additional resources and adequate payment rates to maintain.
When essential hospitals are not included in a payer’s network, the costs for these additional services are not accounted for in the QPA calculation. Conversely, if a payer has contracted with these providers at inadequate rates, this rate will be included in the calculation of the QPA and skew the QPA lower.

For 2022, the median contracted rate will be indexed to calculate the QPA and increased by the percentage increase of the urban consumer price index (CPI-U) over 2019, 2020, and 2021. For 2023 and beyond, the QPA will be increased from the previous year by the annual CPI-U. However, the CPI-U tends totrail the CPI for medical care, which will further lower payments below adequate rates.

Both methodologies will underpay essential hospitals and exacerbate their financial challenges. **We ask HHS to reexamine QPA methodologies to better account for inadequately reimbursed services provided by essential hospitals.**

b. HHS should ensure QPA methodologies do not incentivize payers to exclude essential hospital from their networks.

Given our concern that the QPA methodologies will skew the amount downward, we believe payers will have no incentive to contract with essential hospitals, despite the vital services these hospitals provide. Payers will be able to defer to a QPA in negotiations as a fallback rate if providers will not accept the payer’s offered rate, even if it is inadequate to cover the costs of a given service. Providers then will have to accept this lower rate or rely on the IDR process if they remain out-of-network for that payer. This puts the payer in a potential lose-lose situation as the QPA is heavily weighted in the IDR process.

Consider this scenario: an essential hospital is interested in becoming an in-network provider in the 2023 plan year but has not contracted with the payer in the past. The payer already has several in-network hospitals in this community and has established QPAs for several similar services. The payer can use the established QPAs for these services as a reference amount, knowing that if this essential hospital remains out-of-network and a beneficiary uses their services, the payer can offer this amount for payment, regardless of the actual cost of the service or adequacy of the payment. The established QPA in this scenario does not account for additional vital services the beneficiary might receive at the essential hospital that are not available at other, in-network hospitals. So in negotiations for the 2023 plan year, the essential hospital may try to contract for adequate payment rates, but the payer knows that if the essential hospital does not accept their offered rate, the hospital will have to accept the established QPA as an out-of-network provider or enter the IDR process in an attempt to receive an adequate payment, though they will likely receive the QPA as the payment amount because it is so heavily weighted in the process.

When essential hospitals are not paid adequate rates, it jeopardizes the services on which patients rely. As mentioned above, many essential hospitals offer services that no other hospital in their area can offer—our members operate a third of the nation’s level 1 trauma centers and house almost 40 percent of burn care beds and a quarter of pediatric intensive care unit beds. Further, many patients of essential hospitals need services to support their medical treatment, such as case management, transportation, nutrition support, legal services, language access, and patient navigation. Reimbursement methodologies that do not account for such services

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7 Ibid.
put these vital offerings at risk, which can undermine the patient’s medical treatment and health.

**HHS must reevaluate this methodology and its impact on providers serving a safety net role, as well as network adequacy for services covered under this rule to ensure safety net providers are not purposely excluded from payer networks.**

4. More guidance is needed on the interaction of federal and state balance billing laws.

Essential hospitals in states with existing surprise billing laws will have to invest significant time and financial resources in understanding the interaction between federal and state laws, as well as incorporate those laws into real-time care decisions. This will require a deeper analysis of both the federal and state laws and integration of their requirements into scheduling, registration, electronic medical record, and billing systems to comply with all applicable regulations. Special attention will be necessary when the state law applies to some parts of the patient encounter while the federal law applies to others, and it will require integration of both federal and state notice-and-compliance laws and requirements for good faith estimates. Subsequent system modification and staff training to correctly implement these laws will be expensive.

Further complicating matters, several of our member hospitals provide services in multiple states. Their service areas are more fluid than state lines; patients may receive care at several in-network facilities while receiving services from an out-of-network provider, irrespective of the location of the facility or the provider. Hospitals will have to navigate complex federal and state laws to stay in compliance, which will require additional financial investments. More guidance is needed to address these complexities, as well as application of state laws to out-of-state telehealth consults.

**HHS must provide more guidance on the interaction between federal and state balance billing laws and provide technical assistance and financial resources to help hospitals operationalize these requirements.**

5. Implementation should be delayed until after the COVID-19 public health emergency.

Finally, we are still very concerned about the January 1, 2022, start date. We appreciate the delay of the good faith estimate and advanced explanation of benefits requirements for insured patients outlined in the FAQ document published August 20, 2021. However, given the timing of this rule release and comment period and the previous two interim rules, there is very little time for our members to develop, implement, and train their staff on new policies and procedures related to surprise billing protections. Further, hospitals remain overrun with COVID-19 patients while anticipating the winter surge; their staff and resources are thinning. Implementing this rule during the COVID-19 public health emergency (PHE) would further deplete already limited hospital resources, taking them away from patient care and other aspects of COVID-19 PHE compliance. **We ask that you delay the implementation and compliance deadlines to six months after the COVID-19 PHE ends.**

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America’s Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O’Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO