October X, 2021

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
RE: RIN 1210-AB00  
P.O. Box 8016  
Baltimore, MD 21244-8016

*Submitted Via Portal[[1]](#footnote-1)*

Dear Administrator Brooks-LaSure,

[Health System] thanks the United States Department of Health and Human Services (HHS) for the opportunity to engage in the decision-making process regarding its Interim Final Rule (hereinafter IFR or Rule) concerning Requirements Related to Surprise Billing; Part II.[[2]](#footnote-2)

[Health-System name, mission, geographic area served.]

[Health System] supports HHS’ continued efforts to help patients navigate the No Surprises Act and Transparency sections enacted under the Consolidated Appropriations Act (hereinafter referred to collectively as “Act” or “the Act”) and also clarify the myriad implications and requirements imposed upon healthcare providers and facilities (hereinafter collectively “providers”) by the insurance industry (hereinafter “health plans”). However, in reviewing the proposed language, [Health System] has noted several areas that would benefit from the perspective of those providing care to patients nationwide and who can provide real-world insight into the significant impact the Rule, as currently written, will have on patients and providers. Accordingly, we respectfully request that HHS incorporate the below suggestions to create an equitable Final Rule that more appropriately balances the interests and burdens of both providers and insurers.

As of this writing, health plans are currently billions behind in payments to providers.[[3]](#footnote-3) Health plans have taken advantage of provider resources being occupied wholly by combating a global pandemic in COVID-19 in order to abuse the system. There is also an unprecedented in retroactive denials when providers and patients are at their most vulnerable and rely on already strained resources to fight to obtain payment for care rendered to health plan members. There are is little reason to expect health plans to meaningfully enter into the processes in the Rule in good faith. The potential standard of requiring providers to expend additional resources in the hopes of receiving money owed by health plans in untenable and should be avoided at all costs. We believe that the below comments would be a good start in rectifying some of the issues created by health plans that negatively affect this country’s providers and patients.

**Inaccessibility and Inequity of the Qualified Payment Amount Process**

As the Rule, in conjunction with the No Surprises Act (NSA) health plans have an inequitable amount of control in creation of the Qualified Payment Amount (QPA). One of the stated ways to determine the QPA is based off of the median contracted amount for an item/service, but providers only have access to one data point, their own contract, whereas health plans will be able to access the entirety of data. The total lack of transparency raises concerns for malfeasance by health plans that may not be discoverable until well after the QPA process has been tainted.

At a minimum, health plans should be required to disclose their contracted rates with all relevant providers, along with the corresponding size and type of facility. Further, calculation methodology for payments should be required to be included on the payment remit. Providers should also receive copies of the contracts relied upon by health plans annually so that they may validate good faith compliance by the health plans. Otherwise, HHS is asking providers and their patients to rely wholly on health plans acting in good faith without any means to validate the veracity of a plan’s calculations because of a lack transparency created by a failure of the Act to obligate plans to provide evidentiary support of their rates and methodology.

This is an untenable situation, and [Health System] requests that in addition to disclosure requirements, health plans be required to maintain an up-to-date database of contracted rates broken out by geographic regions and provider types that includes data for any contracts canceled or otherwise ended by a health plan over the previous 10 years. Such data would prevent health plans from artificially deflating QPAs by exiting all but their most lopsided contracts, usually those taking advantage of regional and rural hospitals with vulnerable patient populations. Implementing this process as is would allow health plans to game the process all the way through the IDR with impunity and distort the intention of the NSA.

**Lack of Interest Provision on IDR Late Payments**

While the Rule requires payments pursuant to IDR decisions to be paid within 30 calendar days, HHS has not included a provision to require interest on payments not remitted within that timeframe, nor has HHS included any other mechanism for enforcing payments that health plans are required to remit per the IDR process. [Health System] feels that this is an easily correctible oversight, especially given that a provider who has prevailed in an IDR dispute has already spent multiple months pursuing money they were rightfully owed and thus incurred increased cost to collect which the interest payment would assist in offsetting.

Without the risk of incurring interest or other enforcement provision in the form of a fine, or risk of censure from HHS or other authority, health plans are incentivized to underpay all claims. Without some safety measures, already disadvantaged providers are forced to expend many more resources to recover what they were already owed and then remain vigilant in pursuit even after prevailing in an IDR process. Implementation of interest on payments that do not occur on time should be the minimum measure added to the Rule to guarantee health plan compliance with the IDR. Additionally, given the great application of resources this will incur, we also believe it appropriate to lengthen the timeline to initiate the IDR process.

**Effectively Allowing Health Plans Unilateral Authority to Define “Good Faith” and “Reasonable”**

[Health System] has also noted that throughout the NSA and subsequent IFRs, health plans have been given almost unilateral authority to define what constitutes “good faith” and “reasonable.” The Rule here also reiterates a good deal of “good faith” and “reasonableness” standards that are functionally at the sole discretion of health plans to define. This reflects the continued uneven deference granted to health plans at the expense of providers and patients. The standards for good faith remain vague and allow far too much room for payors to monopolize these definitions, consequently creating an inequitable situation going forward. This imbalance reflects that providers and patients were not adequately considered in the drafting of this rule, nor the one that preceded it.

**Methodology of Creating the Good Faith Estimate for Uninsured/Self-Pay Patients**

[Health System] has noted a lack of clarity and direction in creating a Good Faith Estimate (GFE). In addition to lack of defined parameters on how a GFE should be created, it is also unclear if the total billed charges (TBC) or expected patient liability would serve as the basis for any potential dispute.

Further, while HHS acknowledges that unforeseen circumstances may arise during the course of treatment that may cause deviation from the original GFE provided, there is no guidance on what will be considered a reasonable deviation and which authority gets to set that standard. Consequently, [Health System] recommends that HHS adopts explicit language that defers to the clinical judgment of treating providers when determining reasonable diversions. Otherwise, the dispute process runs the risk of being inundated with meritless complaints.

Further to that effect, HHS specifies a $400 deviation threshold in billed charges from the GFE as one of the factors required to initiate a Patient-Provider Resolution (PPR) process. However, this approach reflects a misunderstanding of how patient liability is calculated and also does not contemplate longer term or more complicated care, the cost of which is more fundamentally more difficult to estimate ahead of time.

Firstly, we feel that a percentage of deviation would be far more appropriate than a set dollar amount, especially in cases of longer courses of treatment and unforeseen circumstances. Secondly, it would be appropriate to institute differing thresholds for differing circumstances, i.e., inpatient treatment vs outpatient, etc. Lastly, we recommend that HHS base this requirement off of estimated patient liability and not TBC.

**Departments Seek Comment on the Random Selection of an IDR in Case of Non-Agreement Between the Parties**

The Departments have specifically sought comment on potential issues with the stated intention to randomly select an IDR if disputing parties cannot agree upon one. As HHS suggests, we agree that only choosing from a pool of IDR Entities within a certain price range would be most appropriate. Without that safeguard, many providers, especially rural and regional medical centers, run an undue risk of assuming greater costs in pursuit of underpaid and owed money. Treating an underserved area should not be a bar to utilizing the IDR process and recovering dollars owed by health plans for treatment of their members.

**Request for Additional Clarity**

Lastly, [Health System] would like to request additional clarity from the Departments on several areas and request that implementation of these provisions be delayed until such time as the additional clarity may be reviewed and commented upon.

Firstly, the Rule does not make clear if a third-party may act on behalf of a provider regarding the IDR process, execution of attestations and notices, or any other processes promulgated under this Rule. We would ask that additional language be issued to clearly state the permissibility of third-parties acting on behalf of providers.

Regarding the objection to a suggested IDR entity from one party by another: there is currently no language specifying the form this objection must/may take (written, oral, etc.), nor is there an indication of its required content. It is further unclear who may make this objection on behalf of their respective party. We feel that additional clarifying language would also be appropriate here.

To what extent must a provider be proactive in updating a good faith estimate to a self-pay patient who revises their desire to be billed instead of requesting their plan be billed. If such a decision is made prior to rendering of services, must such services be delayed until an updated GFE can be formulated?

**Conclusion**

In consideration of the forgoing, [Health System] respectfully requests that HHS revisit these identified issues and delay implementation of this Proposed Rule so that it may be improved to better serve patients and adequately balance the demands made of providers and health plans. Should the rule be implemented as is, then there is a risk of great administrative morass that would threaten providers’ ability to serve their regions. While we largely support HHS’ efforts with this Rule, we feel that these changes are necessary to create a lasting foundation for effective and fair implementation and governance.

[Health System] thanks the Secretary and those working with HHS with the goals of providing the best care possible to patients nationwide and for their time and consideration.

Sincerely,

[Signatory Info]

1. <https://www.regulations.gov/commenton/CMS-2021-0147-0001> [↑](#footnote-ref-1)
2. # 86 FR 55980; Published October 7, 2021

   [↑](#footnote-ref-2)
3. See <https://khn.org/news/article/anthem-united-major-insurers-behind-on-payments-billions-owed-hospitals-doctors-covid/> [↑](#footnote-ref-3)