

March 4, 2022

Kathleen Cantwell
Director, Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Room C4-26-05
Baltimore, MD 21244

**Re: Agency Information Collection re: Requirements Related to Surprise Billing;
Part II (CMS-10791)**

Dear Director Cantwell:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — as well as the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) thanks you for the opportunity to comment on the burden estimates associated with the delivery of good faith estimates to uninsured and self-pay patients and the patient-provider dispute resolution process established under the No Surprises Act.

The AHA continues to support policies that help patients access the information they need when making decisions about their care, including information about their potential costs. Like all policies, though, these must be evaluated by both the potential value they bring to patients and the health care system, as well as any costs. In this case, the government has substantially underestimated the burden associated with implementing the good faith estimates and patient-provider dispute resolution process. We urge the agency to revise its estimates based on the actual experience of providers since implementation on Jan. 1, 2022. We also offer recommendations on how to minimize operational inefficiencies without compromising the policy's important goal.

In preparation for these policies to go into effect, hospitals and health systems dedicated considerable resources to update systems and prepare staff for the change in pre-care processes associated with the delivery of the good faith estimates. Many hospitals already delivered pre-care estimates to uninsured and self-pay patients, but the new timeline and format requirements necessitated workflow and other operational



changes, including from even the most sophisticated hospitals. While these efforts have generally allowed hospitals to meet the requirements in place today, our members report that the ongoing burden is significant. The estimates regularly take between 10-15 minutes to produce, and though hospitals are looking at ways to introduce additional automation, it will be difficult to fully automate given the individualized nature of the estimates. One member hospital reports that their staff can only process 75 estimates per day, which is barely meeting demand at this point. A member health system with several locations reports needing to do 1,500 per day across the system.

The bulk of this work is falling on frontline staff also responsible for other critical front office and patient finance tasks, such as the check-in/check-out and pre-registration processes. With the introduction of these new responsibilities, other work is being delayed which can impact patients' ability to prepare for care. For example, one office reports that frontline staff are taking a much longer time to complete the pre-registration process and share pre-care materials with patients. This strain on the workforce is concerning, particularly given unprecedented levels of burnout and workforce shortages. Even more concerning is that these requirements will only get more complicated and burdensome as patients start utilizing the patient-provider dispute resolution process and the co-provider requirements go into effect.

The regulation grossly underestimates the administrative burden of these requirements, and we appreciate the opportunity to provide early feedback on the realities of implementation. Our particular concerns and recommendations follow.

Convening Provider Responsibility Related to Co-provider Estimates. CMS is utilizing enforcement discretion regarding the collection and compilation of good faith estimates from co-providers and co-facilities until Jan. 1, 2023. Although we appreciate this delay in enforcement, the lack of currently available automated solutions strongly indicates that this process will require a significant manual effort by providers when enforcement begins, which is inefficient and likely insufficient to meet the short statutory timeframes for delivering good faith estimates to the patients.

There is currently no method for unaffiliated providers or facilities to share good faith estimates with a convening provider or facility in an automated manner. In order to share this information, billing systems would need to be able to request and transmit billing rates, discounts and other necessary information for the good faith estimates between providers/facilities. This is not something that practice management systems can generally do, since billing information is traditionally sent to health insurers and clearinghouses, not other providers/facilities.

Practice management systems utilize standard electronic transactions to send information to other stakeholders, many of which are codified under the Health Insurance Portability and Accountability Act (HIPAA). This allows providers and facilities to utilize the same transaction across all health insurers and clearinghouses, eliminating the administrative burden of adhering to idiosyncratic payer technology requirements.

The current administrative transactions do not allow for provider-to-provider communications, so they would not be usable for development of good faith estimates. Without an automated standard in this space, providers would need to individually determine how to transmit this information, which would inevitably lead to widespread variance throughout the industry (particularly given the varied size and levels of technical sophistication among various co-providers). Navigating this non-standardized process would be an enormous administrative burden for providers, beyond what regulators likely considered prior to creating the implementation and enforcement dates.

To ensure that co-provider and co-facility information can be accurately and efficiently collected, HHS should identify a standard technology or transaction that would enable convening providers and facilities to automate the creation of comprehensive good faith estimates. **We urge HHS to refrain from enforcing the comprehensive good faith estimate requirement until after a technical solution for exchanging this information is developed and implemented across all providers.**

Patient Insurance Status Verification. Under the regulation, patients are considered uninsured or self-pay if they do not “have benefits for an item or service under a group health plan.” In order to determine whether an insured patient has coverage for a particular item or service, providers need to be able to confirm procedure-specific insurance coverage with the patient’s health plan, presumably by submitting a standard ASC X12 270 eligibility transaction to a health plan. Prior to these requirements going into effect, providers typically used the batch-eligibility transaction to verify eligibility as it is more resource and cost efficient. The rapid turnaround requirements of the good faith estimate regulations require more regular use of the real-time eligibility checks instead, drastically limiting the utility of the batch-eligibility transaction.

The increased use of real-time eligibility checks will cost providers more to transmit, as clearinghouses typically charge more for real-time, patient-specific transactions than batch transactions. Additionally, based on our understanding of current HIPAA transaction standards and operating rules in this space, health plans are not required to send back procedure-specific eligibility in their ASC X12 271 responses, instead allowing less granular information for compliance. As a result, it may be extremely difficult, if not impossible, for a provider to determine a patient’s eligibility for a particular procedure in the required timelines, as the patient’s health plan may not provide a definitive answer as part of the eligibility response. **In order to reduce the administrative complexities, we recommend that regulators remove the need for procedure specific insurance verification and enable providers to treat patients with “group health insurance” as defined by the regulation as “insured” for the purpose of good faith estimates.**

Patient-provider Dispute Resolution Threshold. The regulation specifies that when a patient’s bill for a particular provider or facility’s services is \$400 or higher in excess of that provider or facility’s good faith estimate, the patient is eligible to initiate the patient-provider dispute resolution process. Although we agree with efforts to ensure that patients do not receive unexpectedly high medical bills, the \$400 threshold is

impractical and will likely create an inordinate amount of disputes when that threshold is breached for legitimate, medically necessary changes in the course of care. This is especially true for uninsured and self-pay patients who are not sharing the costs of care with an insurer. This influx of dispute resolutions will create an enormous administrative burden for providers, detracting from their ability to provide timely care.

The delivery of first-rate medical care and procedures can be expensive, particularly for complex care involving costly drugs or innovative technologies. The AHA has long supported the idea that **all** Americans should have access to affordable, comprehensive health insurance coverage as it enables patients to undergo necessary medical procedures and incur the associated costs without experiencing debilitating financial peril.

Without insurance, slight changes in medically necessary care can increase the overall cost, leaving even the most diligent patients and transparent providers with unexpected changes in the cost of care. Slight changes during complex medical treatments would frequently trigger a \$400 cost increase, which could lead to an excessive number of disputes going before the select dispute entities. For example, a patient who is under anesthesia for surgery for 135 minutes instead of 120 would quickly surpass this figure, despite the \$400 being only a minor amount of the overall bill.

In order to ensure that the dispute resolution process is reserved for instances in which good faith estimates are substantially inaccurate, we continue to encourage HHS to instead require a final bill to be at least 10% in excess of the good faith estimate for it to be eligible for the dispute resolution process. In addition, and specific to this information collection, we urge the agency to revise the burden estimates to more accurately reflect the high number of disputes that may be brought to this process as a result of the \$400 threshold.

Price Transparency Policy Alignment. Finally, the multiple federal price transparency requirements create significant and unnecessary burden for hospitals, as they must navigate several different workflows designed to help the patient better understand their cost of potential care. **The AHA urges CMS to assess the policy changes needed to remove duplication and fully align the federal price transparency requirements.**

As the regulations stand today, the hospital price transparency rule and the good faith estimate requirements are operationally distinct, requiring separate workflows and resulting in discrete outputs. In addition, as currently designed, neither policy offers much implementation support to the other and therefore cannot be leveraged to help achieve consistency or efficiencies.

We look forward to continuing to work together to improve the uninsured and self-pay good faith estimate requirements and the patient-provider dispute resolution process. Please contact me if you have any questions or feel free to have a member of your staff contact Ariel Levin, AHA's senior associate director, at 202-626-2335 or ALevin@aha.org.

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Sincerely,

/s/

Ashley Thompson
Senior Vice President