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December 6, 2021

The Honorable Xavier Becerra
Secretary
Department of Health and Services
Humbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Martin Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, DC 20220

Ms. Kiran Ahuja
Director
Office of Personnel Management
1900 E Street, NW
Washington, DC 20405

Re: Requirements Related to Surprise Billing; Part II (RIN 1210-AB00)

Dear Secretaries Becerra, Yellen, and Walsh and Director Ahuja:

On behalf of the Association of American Medical Colleges (AAMC or the Association), we are writing to provide comments on the Interim Final Rule (IFR) with request for comment, entitled “Requirements Related to Surprise Billing; Part II” 86 *Fed. Reg.* 55980 (October 7, 2021).

The AAMC is a nonprofit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America’s medical schools and teaching hospitals and the millions of individuals employed across academic medicine, including more than 186,000 full-time faculty members, 94,000 medical students, 145,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The welfare of patients, families and communities is the highest priority of the AAMC and our members support safeguards that protect patients from surprise medical bills and promote transparency. Many AAMC members already have made substantial investments in working to achieve this goal. Most have dedicated staff to assist patients in navigating the complex health insurance system and educate them as it relates to their benefits and cost-sharing liabilities. Some have developed online calculators to provide estimates of the costs for scheduled services. However, AAMC members report that they do not have sufficient staff to manage and implement the requirements of the No Surprises Act. In other words, even without the COVID-19 public health emergency, hospitals’ finance and revenue cycle departments would be

challenged to meet the demands of the No Surprises Act. This is on top of the strain that hospitals, physicians, and other providers have been experiencing for almost 2 years. Hospitals are concerned that care will be delayed as a result.

Teaching hospitals often are where individuals go when experiencing an emergency or emergent complex care issue—either by choice, during an emergent transfer to an institution with greater capabilities, or because the teaching hospital is where the ambulance takes them—and it is a time when patients are at their most vulnerable. We are pleased that the No Surprises Act prohibits balance billing and holds patients harmless by only requiring them to pay the in-network cost sharing amount for out-of-network emergency care, and care provided by ancillary providers.

In our discussions with Congress, we supported the establishment of an independent dispute resolution (IDR) process to resolve any disputes between payors and providers about payment amounts and emphasized the importance that the process accounts for the unique qualities of teaching hospitals and the patients they serve. While protecting patients from out-of-network costs, it is also important to ensure reasonable payment rates for providers and a balanced IDR process. We are deeply concerned with the IDR process included in this rule that instructs IDR entities to presume that the median in-network rate is the appropriate payment amount. This process limits the ability of providers to make a case to the IDR entity for a fair out-of-network payment and removes the incentive for health plans to negotiate fair contracts and to include providers in their networks.

We are also concerned with the tight implementation timeline for the good faith estimates for uninsured (or self-pay) patients and urge the Departments to consider delaying enforcement for at least one year to provide sufficient time to implement many of the system changes which providers will have to make to allow for a seamless transition. Communication channels between providers will have to be adapted to allow for exchange of information regarding charges for services. Complying with these new requirements can be further complicated by the complex structures and relationships between physician practices and hospitals; this will be particularly challenging for academic medical centers to which patients who need complex care are referred from community hospitals.

The AAMC's key recommendations on the interim final rule are below. Our comment letter provides further details on these recommendations.

Independent Dispute Resolution Process

- ***Selection of Offer: Presumption Regarding QPA:*** We strongly oppose the presumption that the qualifying payment amount (QPA) is the appropriate payment rate during the IDR process. We ask that the Departments specify that the IDR entities should not presume the QPA is the appropriate payment rate and instead must give equal consideration to all other relevant factors included in the statute if evidence of those factors is submitted. It is essential for arbiters to recognize the important role and value that teaching hospitals play in the health care system and ensure that the payments made

by insurers under the IDR process reflect the costs incurred by these organizations in providing care.

- ***Timelines for the IDR Process:*** We have concerns with the prescriptive time frames for the IDR process. Recognizing that these timelines may not be feasible, the Consolidated Appropriations Act grants the Departments the flexibility to adjust the timelines, and we urge the Departments to exercise that discretion.
- ***Batching Claims Under IDR Process:*** We urge flexibility in how providers can define the scope of claims included in the batches to minimize burden on all the parties.

Good Faith Estimates

- ***Harmonizing with Price Transparency Requirements:*** The Departments should allow providers to leverage their online price estimators and consumer friendly information displayed on their standard charges to reduce and streamline the number of good faith estimates generated.
- ***Distinctions Among Uninsured (or Self-Pay) Patients:*** In determining requirements for good faith estimates, distinctions should be made among uninsured (or self-pay) patients, some of whom will qualify for free care and some of whom may qualify for financial assistance. For those patients who qualify for free care, providers and facilities should not be required to furnish a good faith estimate. Self-pay patients should be defined separately as well; some may be insured but are choosing not to utilize their insurance benefits, opting instead to pay out-of-pocket; others may be insured but their health plan does not cover certain items and services; and some may be uninsured and do not qualify for either free care or financial assistance.
- ***Prevent Delays in Care for Uninsured (or Self-Pay) Patients:*** The Departments should modify policies associated with the good faith estimate for the uninsured to prevent delays in care that would result while providers wait for determinations of eligibility for financial assistance. In addition, the Departments should monitor delays in care due to their instructions to providers regarding good faith estimates and remedy the guidance if needed.
- ***Scope of Good Faith Estimates:*** The regulations should clarify that providers are only required to provide a good faith estimate when there is a scheduled appointment **and** the patient requests the good faith estimate. In addition, the regulations should clarify that good faith estimates are required only for items or services provided at the time of the scheduled service and only for services that the provider is responsible for directly billing to the plan.

Patient-Provider Dispute Resolution Process

- ***Enforcement of patient-provider dispute process:*** HHS should delay enforcement of the patient-provider dispute resolution until January 1, 2023 to allow for providers and facilities to get systems in place to be able to accurately formulate a good faith estimate.
- ***Unforeseen Items/Services:*** Providers should not be financially penalized for unforeseen items and services not included on the good faith estimate.
- ***\$400 Threshold for Dispute Resolution Process:*** Instead of a \$400 threshold to trigger the dispute resolution process, we recommend that to trigger the patient-provider dispute resolution, the bill must be the greater of \$400 over the good faith estimate or more than 10 percent in excess of the final billed charges.
- ***Median Contracted Rate:*** The median contracted rates should not be the default payment amount if they are lower than the billed charges. The median contracted rate will be considerably lower than the costs of providing care at teaching hospitals.

Interaction with State Law and Regulations

- ***Clarification on Application of State or Federal Law:*** The Departments should clarify the circumstances when federal or state law governs. The Departments should implement policies stating all self-funded plans are subject to the provisions of the No Surprises Act to ensure consistency. To assist in determining whether state or federal law applies, plans should be required to inform providers of the type of plan a patient is enrolled in upon a provider's initial query for eligibility and coverage and/or require the patient's insurance card to identify the type of plan.

OVERVIEW: ACADEMIC MEDICAL CENTERS

It is vitally important that the regulations implementing the No Surprises Act recognize and address the complexity of services provided, and populations treated, by teaching hospitals and teaching physicians. In addition to patient protections from out-of-network bills, it is critical to ensure that patients continue to have access to services provided by teaching hospitals and teaching physicians and that these providers are fairly compensated for the complex care they provide and for costs associated with tertiary and quaternary programs. AAMC member teaching hospitals, because of their expert faculty physicians, health care teams, and cutting-edge medical technology, provide care for complex patients and often care for patients for who are unable to receive care elsewhere. For example, our teaching hospitals, while comprising only 5% of all acute care hospitals, provide 25% of the nation's medical and surgical intensive care beds, 36% of cardiac intensive care beds, 61% of pediatric intensive care beds, and are home to 69% of all Level 1 Trauma Centers. Our members are well-established and respected regional referral centers and centers for tertiary care. Their communities know that their emergency rooms are open to anyone in need, with experts in medical specialties available 24/7. As a result, major

teaching hospitals often are sites for emergency treatment as they house such services as trauma centers, burn units, and inpatient psychiatric services.

Teaching physicians who work at teaching hospitals and academic medical centers provide care in what are among the largest physician group practices in the country, often described as “faculty practice plans” because many of these physicians have faculty appointments at affiliated medical schools and supervise medical residents and students as part of their daily work. They are typically organized into large multi-specialty group practices that deliver primary care and also treat the most medically complex and vulnerable patient populations, many of whom require highly specialized care. Faculty practices often have a single tax identification number (TIN) that includes many specialties and subspecialties. Recent data shows that faculty practice plans range in size from a low of 128 individual national provider identifiers (NPIs) to a high of 4,319 NPIs, with a mean of 989 and a median of 816.¹ Often care is multidisciplinary and team based. In addition to patient care, faculty practices support the educational development of residents and medical students who will become tomorrow’s physicians. In addition to primary care, teaching physicians provide critical other services for their local communities, including a large percentage of tertiary, quaternary, and specialty referral care. Given the expertise of physicians who work in faculty practices, it is not unusual for the practices to serve a patient population that is regional if not national.

INDEPENDENT DISPUTE RESOLUTION

The AAMC supports the establishment of an independent resolution process to resolve disputes about out-of-network payment between health care providers and plans. It is crucial for the Departments to establish rules that ensure that the IDR process is fair, unbiased, results in appropriate payment amounts, is efficient, and that cost of the IDR process is not a barrier to resolve disputes. Below are specific recommendations regarding the IDR process.

Selection of Offer: Eliminate the Instruction to IDR Entities to Presume that the QPA is the Appropriate Payment Rate

The rule provides that the IDR entity must select one of the offers submitted by the plan and the provider to be the out-of-network rate for the item or service. In selecting the offer, the rule specifies that the IDR entity must begin with the “presumption that the qualifying payment amount is the appropriate out-of-network rate.”² **Presuming that the QPA is the appropriate payment rate is inconsistent with the statutory language. It will have a detrimental impact on access to care by paying providers inappropriately low amounts for services and has the potential to encourage the proliferation of narrow networks.**

Congress sought stakeholder input over several years to ensure that patients would be protected from surprise medical bills and that providers would have access to a fair process to establish the

¹ The Clinical Practice Solutions Center (CPSC), developed by the Association of American Medical Colleges (AAMC) and Vizient, is the result of a partnership that works with member practice plans to collect data on provider practice patterns and performance.

² 86 *Fed. Reg.* 55995-55996.

payment when negotiations between the two parties did not succeed. Providers warned Congress that rate setting would lead to narrow networks – which oftentimes limit patient access to needed health care services and providers – as health plans would lose the incentive to offer competitive rates and engage in fair business practices to encourage providers to enter into contracts. While the establishment of a “benchmark payment rate” was considered in multiple legislative proposals, bipartisan, bicameral deliberations led to an agreement that rejected that approach and instead established the IDR process in the No Surprises Act.

Congress responded to provider concerns that a median rate would artificially deflate payment rates by establishing an IDR process for dispute resolution, and explicitly including statutory language stating that arbiters “**shall**” consider a number of factors when determining the payment amount through the IDR process including, but not limited to, the median contracted rate; the level of training, experience, quality and outcomes of the provider; market share; patient acuity; teaching status, case mix, and scope of services of the provider; and demonstrations of good faith efforts to enter into network agreements.³ The Departments incorrectly assume that the statute assigns more importance to the QPA in the IDR process and that the statute “contemplates that typically the QPA will be a reasonable out-of-network rate” because the statute includes more details regarding calculation, and provides for oversight of the QPA.⁴ This interpretation is inconsistent with the statutory language. If the QPA was intended to have more weight, the statutory language would have explicitly directed IDR entities to presume the QPA is the appropriate payment amount.

When factors are to be given a certain priority or presumption, the statutory language is clear.⁵ For example, in the redistribution of unused resident positions, the Social Security Act (1886(h)(7)(B)(iii)) says:

- . . . the Secretary shall distribute the increase to programs of hospitals located in the following priority order:
- (I) First, to hospitals located in rural areas.
 - (II) Second, to hospitals located in urban areas that are not large urban areas.
 - (III) Third, to other hospitals in a state if the residency training program involved is in a specialty for which there are not other residency training programs in the state.

According to the rule, to deviate from the QPA as the payment rate, providers must submit evidence that the factors which are set out in statute clearly demonstrate that the QPA is “materially different” from the appropriate out-of-network rates. This creates a high bar for providers seeking a different rate from the QPA. **We strongly oppose this approach and ask that instead the Departments specify that the IDR entities should not presume the QPA is**

³ Public Health Services Act sections 2799A-1(c) (5)(ii) and 2799A-2(b)(5)(C)(ii).

⁴ 86 *Fed. Reg.* at 55996.

⁵ Refer to Social Security Act sections 1848(m)(5)(D)(i), 1855(d)(4), 1861(eee)(2)(B), 1879(f)(1) and (2), and 1833(h)(4)(A) for examples of statutory language with presumptions. Refer to Social Security Act sections 1833(t)(22)(B), 1834(a)(1)(E)(iii), 1848(q)(11)(A), 1848(s)(2)(B), 1851(f)(2), 1874A(h)(3), 1886(h)(4)(H)(vi)(II), 1886(h)(7)(B)(iii), 1886(h)(8)(D) and 1886(h)(8)(E).

the appropriate payment rate and must give equal consideration to all other relevant factors included in the statute if evidence of those factors is submitted. One factor, the QPA or median contracted rate, should not be weighted more heavily than the others.

The statutory factors for consideration in the IDR process when determining payment rates include teaching status. For teaching hospitals and teaching physicians, rates are likely to be different when compared to other providers due to higher patient complexity, tertiary and quaternary programs (such as trauma units, burn units, neonatal ICUs) and the infrastructure needed to support the multiple missions of research, education, clinical, and community engagement. Teaching hospitals and physicians deliver care to the most complex and vulnerable patient populations, many of whom require highly specialized care which often is not available elsewhere. The level of patient acuity seen at teaching hospitals is higher when compared to other facilities and necessitates that teaching hospitals maintain services that frequently are not available elsewhere but are important to the communities they serve. Finally, teaching hospitals remain committed to their mission of training the next generation of physicians and allied personnel and must finance a substantial amount of the costs of training from their operating funds. Each of these factors contributes to costs that differ from those of non-teaching hospitals. Medicare and Medicaid programs in many states have long recognized the need to support teaching hospitals' missions as evidenced by payment adjustments for graduate medical education payments and uncompensated care. **It is essential for arbiters to recognize the important role and value that teaching hospitals play in the health care system and ensure that the payments made by insurers under the IDR process reflect the costs incurred by these organizations in providing care.**

In light of the decisions that the Departments made regarding the QPA methodology in the No Surprises Act Interim Final Rule, Part 1 86 *Fed. Reg.* 36872 (July 13, 2021), it is extremely important that arbiters give weight to these other factors in determining payment rates and not presume the QPA is the appropriate payment. In the IFR Part I, the Departments' decisions on methodology result in driving the QPA as low as possible by excluding case rate agreements, shared savings and other valued-based payment arrangements, and hospital characteristics (such as teaching status) from the calculation of median contracted rates. The QPA methodology does not account for the uniqueness of teaching hospitals and their associated providers who furnish specialized care. It does not reflect the costs of providing care in these settings.

We are also deeply concerned that presuming the QPA is the appropriate payment amount may disrupt private payment negotiation and create a disincentive for health plans to maintain adequate provider networks. It may encourage the creation of networks that do not include tertiary and quaternary hospitals and the expertise the specialists and subspecialists that work at those institutions. If health plans can default primarily to the QPA, which is based on median contracted rates, they may have no incentive to maintain adequate networks and follow fair business practices to encourage providers to enter into contracts. Likewise, low reimbursement rates can be a disincentive for providers and facilities to contract with health plans. The health plans, in turn, may decline to contract with providers unless they accept the QPA rate. There are already increasing numbers of plans that utilize narrow networks that exclude certain types of providers. Driving down reimbursement based on the QPA has the potential to exacerbate this

trend and impact patient access to care.⁶ If a health plan can pay the same rate to all out-of-network providers, there would be little incentive for them to establish comprehensive in-network product offerings for consumers. This problem would not be prevented by network adequacy standards since the large majority of plans are regulated under ERISA, which does not establish specific network adequacy requirements for plans. Teaching hospitals have already experienced the consequences of narrow networks in a number of states. **Inadequate networks could undermine patients' ability to access appropriate levels and types of care**

In summary, the AAMC firmly supports protecting patients from surprise medical bills. At the same time, we are committed to ensuring that patients also have access to critical services provided by teaching hospitals and academic physicians, and therefore strongly oppose the presumption that the QPA is the appropriate payment amount. This approach could decrease patient access to care by underpaying providers and incentivizing the exclusion of teaching hospitals from coverage networks and increasing narrow networks. **We believe that the consideration of all factors during the arbitration process rather than giving preference or priority to one factor (the QPA), is necessary and consistent with the statutory language.**

Clarify that IDR Process Does Not Include Rates Paid by Medicare Advantage Plans and Medicaid Managed Care Organizations

We support the provision in the Act requiring that the IDR process not consider providers' charges or rates paid by public programs, such as Medicare, Medicaid, the Children's Health Insurance Program, or TRICARE. The IFC reiterates this prohibition but does not specifically address whether rates paid by Medicare Advantage plans and Medicaid managed care organizations are excluded.⁷ In response to the Departments' request for comment on the need for additional clarification on these prohibited factors, **the AAMC requests that the Departments clarify that rates paid by Medicare Advantage plans and Medicaid managed care plans, which are also considered public programs, are excluded.**

Time Frames for the Negotiation and IDR Process Should Be More Flexible

The Act includes specific time frames for negotiation during the IDR process. If a provider and plan are unable to come to an agreement on the initial payment amount, the provider and insurer may begin a 30-day open negotiation period during which they can agree upon the payment amount. If the provider and health plan are unable to come to an agreement during the 30-day open negotiation period, either party may trigger the IDR process within 4 days of the conclusion of the open negotiation period. After triggering the IDR process, the health plan and the provider have three business days to jointly select the IDR entity, and within 10 days of selection of the IDR entity each party must submit an offer for reimbursement and supporting materials. The

⁶ See "Health Plans with More Restrictive Provider Networks Continue to Dominate the Exchange Market," Avalere Health (<https://avalere.com/press-releases/health-plans-with-more-restrictive-provider-networks-continue-to-dominate-the-exchange-market>); and "What's Behind 2018 and 2019 Marketplace Insurer Participation and Pricing Decisions?" Holahan et al. (<https://www.urban.org/research/publication/whats-behind-2018-and-2019-marketplace-insurer-participation-and-pricing-decisions>)

⁷ 86 *Fed. Reg.* at 55999.

party that submitted the notification to initiate the IDR process may not submit another case for the same item or service involving the same other party for a 90-day period after the initial notification (referred to as the “lockout period”). **We have concerns with such limited time frames, especially in cases where the provider would like to “batch claims.” Recognizing that these timelines may not be feasible, the statute grants the Departments the flexibility to adjust the timelines, and we urge the Departments to exercise that discretion.**

Payment negotiations between health plans and providers regarding out-of-network services provided involve the consideration of many factors, such as the acuity of the patient, quality/outcomes, case mix of the provider, and market payment rates. Therefore, the 30-day time frame may not be sufficient for providers and plans to conclude these negotiations. While the Act does allow negotiations to continue during the IDR process, once the process is triggered, a fee must be paid to the arbiter. **We recommend that the Departments allow health plans and providers to jointly request a 30-day extension of the negotiation period.**

The AAMC also requests that the Departments consider allowing extensions of the 4-day window to trigger the IDR process and the 10-day time frame for submitting an offer for reimbursement and documentation in certain circumstances. Providers need to consider many factors when deciding whether to trigger the IDR process, including the amount of payment received, claims that may be batched, availability of supporting documentation, and the cost of arbitration. The Departments could use the flexibility granted by Congress to enable modifications to time frames if warranted.⁸ For example, the Departments could allow providers and health plans 30 days to trigger the IDR process and an additional 30 days to submit their offer and supporting materials in certain circumstances. Allowing this extended time frame will reduce unnecessary administrative expense for plans and providers.

The AAMC also is concerned that the 90-day lockout period could cause cash flow problems for providers, and we urge the Department to reduce it to 30 days. While we recognize that the goal of the 90-day lockout period is to encourage settlement of claims and reduce arbitration, we believe that changing the other time frames for negotiation and IDR as we recommend, will reduce the likelihood of pursuing arbitration.

Allow Flexibility in Batching of Items and Services

The Act allows providers to batch together for consideration during the IDR process claims submitted within a 30-day period that are furnished by the “same provider or facility” under the “same plan” and for the “same or similar items or services.” Batching will reduce administrative costs for all parties and accelerate payments to providers.

We support the provision in the rule that items and services billed with the same National Provider Identifier or Tax Identification Number may be batched when defining the “same provider or facility.” For physician group practices, this would mean that claims for multiple clinicians that submit claims as part of the group practice under the same TIN may be batched.

⁸ Public Health Services Act sections 2799A-1(c) (5)(ii) and 2799A-2(b)(5)(C)(ii).

This would be consistent with the approach that is used under the Medicare Quality Payment Program to measure performance and determine payment adjustments for physician practices. This would also reduce burden and costs associated with the IDR process.

The rule defines same or similar items or services as those items and services that are billed under the same service code, or a comparable code under a different procedure code, and defines the same codes as the code that describes an item or service using Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) or Diagnostic-Related Groups (DRGs). Rather than defining items and services on a granular level, we urge the Departments to allow for broader criteria to determine which claims can be batched. For some services, such as specific surgical procedures, the services that could be batched may be apparent. However, for other services, such as emergency medical care, the items and services that should be batched could include a broader range of services. Items and services that are reimbursed through a bundled payment for an episode of care should be included together and considered part of one payment determination by an IDR entity. **We urge flexibility in how providers can define the scope of claims included in the batches to minimize burden on all the parties.**

The rule states that all the qualified IDR items and services must have been furnished within the same 30-business-day period or the 90-calendar-day suspension period. **We support this policy and commend the Departments for using the authority to ensure that items and services furnished during the 90-calendar day suspension period are eligible for the Federal IDR process and can be included in the same batch.**

Ensure IDR Entities Have Appropriate Expertise

The rule requires that IDR entities possess and demonstrate sufficient arbitration and claims administration of health care services, managed care, billing, coding, medical, and legal expertise. The AAMC urges the Departments to ensure that any entity certified as an IDR entity understands the complexities of the health care system and has the experience needed to fairly adjudicate disputes. The entity must ensure that the decisions made are fair to both parties, and that appropriate criteria is used to make decisions that are standardized and uniform. The entity should be staffed with individuals who have expertise in managed care contracting, revenue cycle, and experience with arbitration. IDR staff should also have expertise in the complexities of contracting, including knowledge of narrow networks, shared savings programs, and other payment models. They should have a demonstrated understanding of the distinction between different settings of care (such as teaching hospitals as compared to community hospitals) and the unique services provided by various physician specialties and subspecialties.

Exercise Oversight of IDR Process

It will be essential for the Departments to exercise oversight over the arbitration process to ensure that arbiters have relevant medical and legal expertise and are unbiased, that the process results in fair payment amounts for the parties involved and does not cause an undue administrative burden or high costs.

GOOD FAITH ESTIMATE

Under the rule, health care providers and health care facilities must issue good faith estimates of expected charges for uninsured (or self-pay) individuals (or their authorized representatives). Providers must transmit the good faith estimate at least 3 business days before the service is furnished and no later than one business day after the service is scheduled. For services scheduled more than 10 business days in advance, the provider needs to furnish the information within 3 business days of the patient requesting an estimate or scheduling a service.

The AAMC understands the importance of price transparency for patients to ensure that they understand their out-of-pocket costs when seeking health care. Our nation's teaching hospitals have already risen to this call by developing price estimator tools at their institutions, which allow patients to access their coverage and cost-sharing information as it applies to the services they are seeking. We support the decision by the Departments to delay implementation of provisions in the PHS Act (section 2799B-6(2)(A) which would require providers and facilities to furnish good faith estimates to **all** individuals and instead to limit the good faith estimate requirement in this rule to uninsured (or self-pay) individuals.

We have several recommendations regarding the good faith estimate requirements for uninsured (or self-pay) patients.

Leverage the Use of Existing Hospital Price Transparency Requirements for Good Faith Estimates

In the rule, HHS seeks comments on how the price transparency requirements that hospitals must display standard charges in a consumer-friendly manner and the voluntary use of online price estimator tools may be leveraged to provide the good faith estimates. We appreciate the acknowledgement in the rule that hospitals are already providing consumer-friendly information about charges to patients under the existing price transparency requirements. However, we believe that the good faith estimate requirement duplicates these price transparency requirements already in effect for hospitals and therefore is likely to increase administrative costs for hospitals without improving price transparency for patients. **We urge the Departments to streamline and harmonize the requirements under these programs.** To avoid patient confusion, it is important that providers and health plans provide consistent information to their patients about the charges and costs associated with providing items and services.

Under a previous regulation, effective January 1, 2021, hospitals are required to publicly post standard charges for at least 300 "shoppable" services. To achieve this requirement, many hospitals have price estimator tools on their websites that allows patients to search for items and services and see their costs. Patients can use the price estimator tools to see their cost sharing obligation, whether or not they have insurance. Many of these calculators allow individuals with insurance coverage to see their specific cost-sharing responsibility while also allowing uninsured (or self-pay) patients to see costs and any applicable discounts. Providers and facilities should be able to optimize these calculators and utilize them as good faith estimates, particularly for the 300 shoppable services. The costs shown on these calculators typically reflect most costs associated with a procedure similar to what would be included on the good faith estimate.

Similarly, beginning January 1, 2022, the Transparency in Coverage Rule requires that health plans provide detailed price information in machine-readable files to the public, and in 2023 make personalized out-of-pocket cost information for at least 500 shoppable services available on their websites. This will build upon the price estimator tools developed by hospitals and allow patients to find patient-specific information and better understand their insurance coverage. Health plans are best positioned to provider patient-specific information on coverage and cost-sharing liabilities to patients, as each plan is uniquely different. **We believe that the Departments should consider whether using health plan cost estimators can also be optimized to reduce and streamline the number of good faith estimates and advanced explanation of benefits generated.**

Distinctions Need to Be Made Among Types of Uninsured and Self-Pay Patients

We support protecting all patients from unexpected costs for care but appreciate that initially the good faith estimate requirement will apply only to uninsured (or self-pay) patients. We have several concerns about applicability of the good faith estimate requirements to these patients as defined in the rule. The rule includes a definition of uninsured (or self-pay) individuals and seeks comments on the appropriateness and usability of the definition and whether additional terms should be defined. While the IFC acknowledges that self-pay individuals are not the same as uninsured individuals, we feel that these two groups are distinct and unique and should be treated differently.⁹ First, we believe that distinctions should be made among uninsured patients, some of whom will qualify for free care and some of whom may qualify for financial assistance. Self-pay patients should be defined separately as well; some may be insured but are choosing not to utilize their insurance benefits, opting instead to pay out-of-pocket; others may be insured but their health plan does not cover certain items and services; and some may be uninsured and not qualify for either free care or financial assistance.

For those patients who qualify for free care, we believe providers and facilities should not be required to furnish a good faith estimate. As these individuals will have no cost sharing obligation, it is unnecessary to provide them with a good faith estimate. The patient may be confused by receiving a good faith estimate of the charges when the patient's obligation is \$0. Preparation of the estimate also will be an unnecessary burden on the provider.

For uninsured patients who qualify for financial assistance and for self-pay patients, receiving a good faith estimate from the provider would be more appropriate and beneficial. However, depending on the patient's health insurance coverage, some items or services connected to the procedure may not be covered. Therefore, it may be difficult for providers to develop accurate good faith estimates for some self-pay insured patients when their plan may cover some portions of the service and not other portions. In other words, the patient would be considered "self-pay" for the non-covered portion of the services. To provide an accurate good faith estimate, providers will need to communicate with health plans to obtain accurate information regarding which services are not covered. **To assist providers and facilities in developing an accurate good faith estimate, health plans should be required to provide correct up-to-date information on which items and services are covered—and the extent of the coverage-- upon request**

⁹ 86 *Fed. Reg.* at 55986.

from the patient and/or provider. Some AAMC members report that health plans may not state whether an item or service is or is not covered; rather they describe the item or service as not needing “authorization”. Further, health plan online calculators can greatly assist patients in understanding their insurance coverage and plans should be encouraged to educate their clients on the use of their calculators. **We ask the Departments to provide additional guidance to providers and to health plans regarding requirements for good faith estimates for non-covered items and services.**

Further, if during the course of treatment, medically necessary items/services differ from those included in the good faith estimate, the result may be a bill substantially in excess of the good faith estimate. At this point, the hospital may do a redetermination of whether the patient qualifies for additional financial assistance. In these situations, patients should be encouraged to contact the hospital to discuss the situation before proceeding with the dispute resolution process.

In addition, we ask the Departments to clarify the application of the good faith estimate requirements to international patients. Academic medical centers frequently care for patients who travel from other countries to receive the expertise and highly specialized services provided by academic medical centers and their associated physicians. Some of these patients have international insurance, some pay out of pocket, and others have employers that pay for their items and services.

Policies Should be Amended to Prevent Delays in Care for Uninsured or Self-Pay Patients

We are deeply concerned that the policies set forth in this rule regarding good faith estimates for the uninsured (or self-pay) may have the unintended consequence of delaying care. As required by the Internal Revenue Service through the tax code, not-for-profit hospitals must have in place policies that have criteria that qualify patients for free care (sometimes referred to as charity care) or financial assistance which includes reduced cost and/or payment plans. Qualifying for assistance typically requires the patient to submit an application to the hospital followed by a review and determination of how much assistance, if any, for which the patient qualifies. This process is time consuming and can take several weeks, sometimes because it takes time for patients to provide the needed information. Providers will be unable to determine the discounted charges to include in the good faith estimates until they receive information on the patient’s eligibility for financial relief. Given the good faith estimate requirements, if the service or item can be delayed without harming the patient, a provider will most likely wait until after a determination of the financial assistance to which the patient is entitled is made before scheduling a procedure to ensure that the patient receives an accurate good faith estimate.

The Departments should consider modifications of the policies associated with the good faith estimate for the uninsured (or self-pay) patients to prevent delays in care that would result while providers wait for determinations of eligibility for financial assistance. In addition, the Departments should monitor delays in care due to their instructions to providers regarding good faith estimates and remedy the guidance if needed.

Scope of Good Faith Estimate Requirements

The No Surprises Act requires that the health care provider provide the patient with a notification (in clear and understandable language) of the good faith estimate of the expected charges for furnishing the item or service with the expected billing and diagnostic codes. Specifically, the statute requires providers to include "...expected charges for furnishing such item or service (including any item or service that is reasonably expected to be provided in conjunction with such scheduled item or service and such an item or service reasonably expected to be so provided by another health care provider or health care facility), with the expected billing and diagnostic codes for any such item of service." In this rule, the Departments require that a convening provider or convening facility must determine if an individual is an uninsured individual, or if insured, whether they will submit a claim to their insurance company for the item or service. If they are uninsured (or self-pay) a good faith estimate must be provided to the patient upon request **or** upon scheduling an item or service. The good faith estimates must reflect any discounts for such individuals.

Providers Should Be Only Required to Provide Good Faith Estimates Upon Patient Request

We urge the Departments to amend the regulations to clarify that providers are only required to provide a good faith estimate to the uninsured (or self-pay) patient when there is a scheduled appointment and the patient requests the good faith estimate. Doing this is consistent with the title of the section (2799B-6 of the Public Health Service Act), which is "Provision of Information Upon Request And for Scheduled Appointments." (emphasis added)

Patients will be aware that they have a right to a good faith estimate because providers and facilities are required to inform them of this right. This ensures that any patient wanting a good faith estimate will get one. Providing a good faith estimate for scheduled services when the patient does not request it would be a significant administrative burden on providers, may confuse patients, and could delay care. Teaching hospitals and teaching physicians provide a large volume of patient visits, surgeries, procedures, and ancillary services to uninsured (or self-pay) patients. It would be burdensome to produce good faith estimates in all cases when items and services are scheduled for uninsured (or self-pay) individuals, especially for many teaching hospitals, which are safety net providers. This would result in unnecessary cost to the system and divert important resources away from patient care. **Instead, we recommend that providers inform patients of their right to make a request for a good faith estimate, provide the patients information about their online calculators that include information on cost of items/services, and provide the estimate upon request by the patient.** Further, patients should be given the option to "opt out" of receiving a good faith estimate.

Scope of Services and Items Included in The Good Faith Estimate Should Be Limited

The Departments define a good faith estimate to include items or services that are reasonably expected to be provided **in conjunction with** the primary item or service, including items or services that may be provided by other providers and facilities in addition to the convening provider or convening facility. We appreciate that from January 1, 2022 through December 31,

2022 the Departments will not enforce the requirements that a good faith estimate include expected charges for items and services from a co-provider or co-facility. However, we are concerned about the ability of convening providers to obtain good faith estimates from other providers, particularly in such a short time frame.¹⁰ The rule requires that the convening provider or facility contact all applicable co-providers and co-facilities no later than 1 business day after the request for the good faith estimate is received or after the primary item or service is scheduled and request submission of expected charges for the items or services. To carry out the requirements, providers and facilities would need to establish systems and procedures for providing and receiving the required information from other providers and facilities. The desire of the Departments to avoid a situation in which patients must seek good faith estimates from multiple providers must be balanced against the ability of providers to obtain information on charges from providers they neither own nor employ. **Instead, we ask that the regulations clarify that providers are responsible for providing the good faith estimate only for items and services that they directly bill to the patient.**

We also request that the rule clarifies that “in conjunction with” refers to the obligation to furnish good faith estimates for items or services provided at the time of the scheduled service. We do not believe the statute requires providers to include estimates for items or services, such as post-acute care, that are provided after the scheduled service. **We support the policy in the rule that the good faith estimate does not need to include items or services that are recommended as part of the course of care but that must be scheduled separately.**

We also appreciate the Departments’ provision in the rule that the good faith estimate is not required to include charges for unanticipated items or services that are not reasonably expected and that could occur due to unforeseen events. **We urge the Departments to clarify that this policy includes both “unforeseen circumstances” and “unlikely events” which should not be subject to the patient dispute resolution process.** Unforeseen events are situations that occur that were not anticipated while unlikely events are those that are extremely rare. While the provider furnishes its best estimate of services that will be provided, it is possible that other items or services that deviate from those initially expected will be needed, requiring changes to the services and codes that were included in the good faith estimate. For example, unforeseen medical needs or unlikely events may arise at the time that the service is provided that require the provider to proceed with a different course of treatment. If the need for services arises during the patient visit, it would not be feasible to provide a new good faith estimate at that time. Providers always aim to give patients high quality medical care that is medically necessary and they should not be penalized for using their medical judgment to make changes as more information is gathered about the patient during the course of treatment.

In addition, the Departments state that if any changes to expected providers or facilities represented in a good faith estimate occur less than 1 business day before the time or service is scheduled to be furnished, the replacement provider or replacement facility must accept the good faith estimate as their expected charges for the times or services being furnished. We are concerned that the replacement provider may not be willing to provide the item or service if the

¹⁰ Id. at 56030

good faith estimate of charges is significantly different than the amount that they would charge which would likely result in postponement of the scheduled service.

Good Faith Estimate Should Include Information that is Consumer Friendly

The rules establish requirements for the content that must be included in a good faith estimate issued to an uninsured (or self-pay) individual. We are concerned that the specific information that must be included in the good faith estimate is not consumer friendly and will be neither meaningful nor actionable to patients. For example, patients are not familiar with reading and understanding itemized list of items or services that include diagnosis codes and CPT codes, TINs/NPIs, and some of the other information required in the rule. The Departments should consider aligning the information included in the good faith estimate with the information provided by hospital price transparency calculators and that is included in Explanation of Benefits health plans provide to patients. We suggest that information included in the good faith estimates reflects the total amount of an item or service similar to what the online calculators produce rather than a breakout of each individual item and service. For example, a patient that has a knee replacement should receive the total charge for the knee replacement inclusive of all items/services rather than an itemized list of each item/service. This type of information provides useful and actionable information to patients. **To better understand what consumers and patients would find helpful on the good faith estimate, we recommend that the Departments convene patient and consumer focus groups to explore the types of information that would be meaningful and consumer friendly.**

PATIENT-PROVIDER DISPUTE RESOLUTION PROCESS

Under the IFC, a patient who receives a bill that is at least \$400 more than the amount listed on the good faith estimate for the items and services furnished is eligible to dispute the billed charges through the patient-provider dispute resolution process. An item or service is eligible for patient-provider dispute resolution based on the total billed charges from the provider or facility, regardless of whether such items or services are included in the good faith estimate.¹¹ HHS believes that by limiting the dispute to only items and services included in the good faith estimate, “providers and facilities may be incentivized to omit items and services from the good faith estimate in order to avoid the patient-provider dispute resolution process.”¹²

The Association strongly disagrees with HHS’ assumption that limiting patient disputes to items and services noted on the good faith estimate would incentivize providers and facilities to omit items and services from the good faith estimate. Further, we do not support allowing a patient to bring a dispute based on an allegation that the provider or facility “willfully overestimated the expected charges to avoid dispute resolution”.¹³

The AAMC appreciates HHS’ recognition of the challenges faced by providers and facilities to implement systems to issue good faith estimates. HHS acknowledges that it will take time for

¹¹ Id. 56028.

¹² Id.

¹³ Id. at 56030.

providers and facilities to develop systems and processes for receiving and providing information on the good faith estimate, particularly relating to items and services provided by co-providers and co-facilities. Therefore, HHS has chosen to delay enforcement with respect to good faith estimates provided to uninsured (or self-pay) individuals on or after January 1, 2022 through December 31, 2022, where the good faith estimates does not include expected charges for items and services from a co-provider or co-facility.¹⁴ We support this policy. Gathering the information for the good faith estimates will not only be time consuming but will likely require technology changes to allow for a more seamless process to collect this information from a variety of providers. However, as we discuss below, providers and facilities, particularly those that treat a high volume of uninsured patients, will see an increase in administrative work to provide good faith estimates to uninsured (or self-pay) individuals. These new requirements will further strain hospital systems that continue to struggle during the COVID-19 public health emergency. **Therefore, we ask that HHS delay enforcement of the patient-provider dispute resolution until January 1, 2023 to allow for providers and facilities to get systems in place to be able to accurately formulate a good faith estimate.**

Providers Should Not be Financially Penalized for Unforeseen Items and Services Not Included on the Good Faith Estimate

HHS acknowledges in the IFC that there may be unforeseen circumstances encountered during a procedure that require medically necessary care and that these interventions may not have been included on the good faith estimate. Under the patient-provider dispute resolution process providers and facilities are allowed to submit “credible information” or an explanation to support the billed charges for items and services that were not originally included on the good faith estimate.¹⁵ HHS defines credible information to mean information that upon critical analysis is worthy of belief and is trustworthy.¹⁶ (p. 56037). The selected dispute resolution (SDR) entity must review any documentation to determine whether the provider or facility has provided credible information for each billed item or service to demonstrate that the cost of the billed item or service not included in the good faith estimate is medically necessary and could not have been reasonably anticipated by the provider or facility when the good faith estimate was provided.¹⁷ However, if the SDR entity determines the provider or facility did not provide credible information that demonstrates that the billed charge for the item or service reflects the cost of a medically necessary item or service and was in fact unforeseen and therefore would not have been included on the good faith estimate, the SDR entity will determine the payment to be \$0.¹⁸ We recommend that the SDR entity not establish an overly high bar for evidence to determine that an item or service is unforeseen.

Providers strive to give patients the best and most appropriate care that they need based on their knowledge and judgement. It is not unusual for a provider to encounter an unexpected issue that needs to be addressed at the time the procedure is being performed. Providers should not be

¹⁴ Id.

¹⁵ Id. at 56039.

¹⁶ Id. at 56037

¹⁷ Id. at 56038

¹⁸ Id. at 56039

unfairly penalized because they have chosen to do what is best for the health and safety of the patient by addressing unforeseen medical issues at the time treatment is occurring. It is unreasonable to not pay providers and facilities for medically necessary services that are not included on the good faith estimate.

If the SDR entity determines that payment for the billed charges for the unforeseen item or service is warranted, the SDR entity will determine the payment amount. Once the payment amount is calculated, the SDR entity must inform the uninsured (or self-pay) individual and the provider or facility of the determination along with the SDR entity's justification for making such a determination.¹⁹ However, the IFC does not address how information is transmitted to patients, providers and facilities when the SDR entity determines the billed items and services should not be covered. When issuing all denial decisions under the patient-provider dispute resolution, the SDR entity should be held to the same standard as the provider and facility substantiating the denial with credible information, which is described in the regulation as "information that upon critical analysis is worthy of belief and is trustworthy."²⁰ Additional guidance would be helpful to allow a determination of the type of information that meets this standard.

Finally, HHS should monitor the number of times an SDR entity denies coverage for medically necessary items and services. Increased SDR denials resulting in underpayment or non-payment for medically necessary items and services could lead to access issues for many uninsured (or self-pay) individuals. Providers struggling financially could be forced to stop accepting uninsured (or self-pay) individuals who do not qualify for free care or financial assistance because they have been denied payment for medically necessary items and services by the SDR entity.

The Median Contracted Rate Should Not Be the Default Payment Amount Under the Patient-Provider Dispute Process

If the SDR entity determines that a provider or facility has provided credible information that billed charges for unforeseen items and services not included on the good faith estimate were medically necessary, the SDR entity must determine the charge to be paid by the uninsured (or self-pay) individual. The payment for these services would be the lesser of the billed charge or the median payment for the same or similar service in the geographic area.²¹ The median contracted rate will be considerably lower than the costs of providing care at teaching hospitals and thus significantly underpay teaching hospitals and their associated physicians. Therefore, the median contracted rates should not be the default payment amount if they are lower than the billed charges.

The "Substantially in Excess" Threshold of \$400 is too Low

¹⁹ Id.

²⁰ Id. at 56100.

²¹ Id. at 56039.

We are concerned that requiring providers to furnish patients with a good faith estimate that will be within \$400 of the total bill will be challenging. The cost of complicated procedures could run well into the tens of thousands of dollars and estimating the total costs on a good faith estimate within \$400 of the total amount billed could prove difficult. Unforeseen interventions that are within the bounds of accepted patient care protocols could easily push the billed charges to exceed the good faith estimate by more than \$400. For example, a patient who requires other issues to be corrected at the time services are furnished, needs a few extra hours in the recovery room or requires an extra night or two in the hospital could easily find a bill that exceeds the GFE by more than \$400. Providers and facilities may feel pressure to include all potential clinical scenarios and associated treatments in the good faith estimate, even if they may be unlikely to occur.

The IFC lays out HHS' rationale for using the \$400 limit instead of using a percentage of the total billed charges. We understand the appeal of using a flat rate but doing so does not account for the many unanticipated items and services that are needed during medical treatment. We believe the \$400 threshold is too low and does not recognize the complex nature of some items and services furnished at teaching hospitals. The \$400 threshold invites increased utilization of the patient-provider dispute resolution process that will increase costs across the health care system. **We suggest that to trigger the patient-provider dispute resolution, the bill must be the greater of either \$400 over the good faith estimate or more than 10 percent of the total billed charges.**

Make Clear Whether the HIPAA Privacy Rules Do Not Apply to the Patient-Provider Dispute Resolution

HHS should make clear whether existing Federal standards on privacy such as the Health Insurance Portability Act of 1995 (HIPAA) (Pub.L. 104-191) does not apply to information exchanged as part of the patient-provider dispute resolution. Specifically, will providers be held harmless from privacy violations if they submit patient-specific medical documentation as part of the patient-provider dispute resolution. The rule notes that HHS looked to existing Federal standards on privacy in defining certain terms in the IFC. However, the rule is silent on provider protections when disclosing and transferring patient-specific medical information to SDR entities under the patient-provider dispute resolution. Providers and facilities would be required to send supporting documentation that includes patient-specific information to SDR entities. HHS should finalize a requirement that patients must sign a release of information form at the time they initiate a dispute in order to protect providers that submit additional documentation under the patient-provider dispute resolution.

INTERACTION WITH EXISTING STATE LAW AND REGULATIONS

Clarify How the No Surprises Act Interacts with State Law

Many states have enacted laws to prevent balance billing and the Act defers to state law where applicable. As the Departments establish regulations to implement the Act, it is imperative that attention be given to clarifying when state or federal law applies. The intent of the No Surprises

Act is to provide clear protections for patients and to ensure that there is a method available to resolve reimbursement issues between plans and providers for all non-contracted services. Without clear direction as to whether a state or federal standard applies there is likely to be significant confusion for both patients and providers. There will also be operational challenges to implementing state and federal policies that are not consistent. Therefore, it must be made clear to providers whether for the purposes of the balance billing provisions of the No Surprises Act an insurance product is regulated by state law or federal law.

In addition, the Departments should address whether self-funded plans will be held to federal or state law as it relates to balance billing requirements. Most self-funded plans are regulated by ERISA rather than by state law. However, some states allow self-funded plans to opt-in to the state's consumer protections. Allowing self-funded plans to choose (*e.g.*, opt-in, opt-out) between state and federal consumer protections would be confusing and impose significant burden on providers. To ensure consistency with patient protections and out-of-network claims the Departments should implement policies stating that all self-funded plans will be subject to the provisions of the No Surprises Act.

It is necessary for providers to know the type of plan in which a patient is enrolled when determining whether state or federal patient protections and balance billing requirements apply. Therefore, the Departments should require health plans to provide information on the type of plan upon a provider's initial query for eligibility and coverage and/or require the patient's insurance card to identify the type of plan. This requirement will be a first step in assisting providers in complying with state and federal balance billing requirements, including consumer protections, the QPA, and the IDR process.

CONCLUSION

Thank you for the opportunity to provide input as you develop regulations that protect patients from surprise medical bills and ensure appropriate payment to providers. We would be happy to work with you on any of the issues discussed above or other topics that involve the academic medical center community and their patients and communities. If you have questions regarding our comments, please feel free to contact Gayle Lee at galee@aamc.org and Mary Mullaney at mmullaney@aamc.org.

Sincerely,



Janis M. Orlowski, M.D., M.A.C.P.

Chief Health Care Officer, AAMC

cc: Mary Mullaney, AAMC
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