Minnesota Hospital Association

2550 University Ave. W., Suite 350-S
St. Paul, MN 55114-1900
phone: (651) 641-1121; fax: (651) 659-1477
toll-free: (800) 462-5393; www.mnhospitals.org

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Laurie Bodenheimer
Associate Director
Healthcare and Insurance
Office of Personnel Management

Ali Khawar
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor

Douglas W. O'Donnell
Deputy Commissioner
Services and Enforcement
Internal Revenue Services

Xavier Becerra
Secretary
U.S. Department of Health and Human Services

Mark J. Mazur
Acting Assistant Secretary
Department of Treasury
Washington, DC 20515

Submitted electronically at http://www.regulations.gov

Subject: Requirements Related to Surprise Billing; Part 2

Dear Ms. Bodenheimer, Mr. O'Donnell, Mr. Mazur, Mr. Khawar, and Mr. Becerra:

On behalf of our 129 member hospitals and health systems, the Minnesota Hospital Association (MHA) thanks you for the opportunity to comment on the second set of regulations implementing the No Surprises Act. Minnesota hospitals and health systems strongly support protecting patients from gaps in their health care coverage that may result in unanticipated medical bills, and we look forward to working with you on implementing these critical protections.

MHA generally supports the recommendations and detailed comments submitted by the American Hospital Association (AHA). Rather than duplicating AHA's analysis and suggestions, MHA's comments will focus on the topics of most concern to Minnesota's hospitals and health systems.

Federal IDR Process

Minnesota hospitals and health systems are concerned the proposed regulations have overly tilted the No Surprises Act IDR process in favor of plans and issuers. Through this decision, plans

and issuers will gain substantial leverage to walk away from negotiations with providers. Additionally, plans and issuers will obtain favorable reimbursement rates by pushing a provider out of network while avoiding any other contractual terms. As a result, we expect plans and issuers to restrict their network offerings further. While patients may still retain access to care covered through the No Surprises Act, scheduling care will become much more challenging as there may be no ancillary or other providers in-network who will be able to see the patient.

The policies in the interim final rule direct arbiters to begin with the presumption that the plan's or issuer's median contracted rate is the appropriate out-of-network reimbursement rate. It then sets a high bar for the consideration of other factors. As a result, the IDR process becomes effectively unavailable to providers. This is not what Congress envisioned or outlined in the statute.

The final rule erects multiple extra-statutory barriers to the consideration of any factor other than the QPA, including requirements that the non-QPA factors be based on "credible information" and that a party must "clearly demonstrate" that the QPA is "materially different from the appropriate out-of-network rate." These barriers impermissibly limit the IDR entity's ability to consider all the statutory factors fully. This fundamentally alters the statutory structure and guts the independence of the IDR entity. For these reasons, these provisions in the interim final rule are contrary to law, arbitrary and capricious, and otherwise violate the Administrative Procedure Act (APA).

Good Faith Estimates and Patient-Provider Dispute Resolution Comments

Through this interim final rule, HHS implements the No Surprises Act good faith estimate requirements for uninsured and self-pay patients scheduling or shopping for care, as well as the patient-provider dispute resolution process. We support policies that help patients access the information they need when making decisions about their care, including information about their potential costs**,** but Minnesota hospitals and health systems have several operational concerns that we request be addressed.

<u>Price Transparency Policy Alignment</u>

We urge HHS to assess further the policy changes needed to remove duplication and fully align the federal price transparency requirements. The first Hospital Price Transparency requirement, or the creation of machine-readable files, provides researchers and non-patient stakeholders access to a hospital's negotiated, self-pay, and chargemaster rates. In this interim final rule, HHS asks whether a convening provider or facility can use these files to collect co-provider or co-facility estimated charges. Not all provider or facility rates exist in the machine-readable files since only hospitals are required to publish these files. This means that data would only be available for some co-facility items or services.

<u>Good Faith Estimate</u>

The interim final rule requires providers and facilities to deliver good faith estimates to patients within one business day for services scheduled between three and nine days in advance. Whereas for estimates within three business days for services scheduled at least 10 days in

advance or instances when an estimate is requested before scheduling. To create a compliant good faith estimate, a provider or facility will need to gather a significant amount of information, often from multiple sources such as from any co-provider or facility. This would include information on the everyday items, services to be delivered, and their charges reflective of any available discount for the specific patient. Completing these tasks in three days, while also completing all existing administrative functions, will strain the already depleted workforces in hospitals and health systems. We urge HHS to streamline these requirements by allowing patients to use online cost estimator tools and clarifying financial assistance eligibility determinations.

The good faith estimates are much more labor-intensive than the online tools, given it needs to be completed manually primarily. The additional information required by the good faith estimates is more likely to be known for patients scheduling services than those who are shopping for services and may not yet have a relationship with the provider. Attempting this level of specificity with the limited information available about a patient shopping for care is not workable and is duplicative when the patient can instead access equally reliable cost estimates through the automated online cost estimator tools.

Co-provider/Co-facility Compliance Date and Timeline

HHS indicates in the interim final rule that it will utilize enforcement discretion regarding collecting good faith estimates from co-providers and co-facilities until Jan. 1, 2023. Although we appreciate this delay in enforcement, the necessary steps Minnesota hospitals and health systems will likely require additional time. 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. To share this information, billing systems would need to request and transmit billing rates, discounts, and other necessary information for the good faith estimates between providers/facilities. The current administrative transactions do not allow for provider-to-provider communications, so they would not be usable for developing the good faith estimates. 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.

Amount of Variation to Trigger Eligibility for the Patient/Provider Dispute Resolution Process

The interim final rule provides a framework for addressing instances when a good faith estimate is lower than the patient's final bill. These provisions specify that when a patient's bill is $400 or higher, more than that provider or facility's good faith estimate, the patient is eligible to initiate the select dispute resolution process. Although we agree with efforts to ensure that patients do not receive unexpectedly high medical bills, the $400 barometer will likely create an inordinate amount of disputes for legitimate, medically necessary reasons, especially for uninsured and self-pay patients who are not sharing costs with an insurer.

A $400 threshold to trigger a dispute resolution process is impractical. Slight changes during complex medical treatments would frequently trigger a $400 cost increase, leading to an

excessive number of disputes going before the select dispute entities. For example, a patient under anesthesia for 135 minutes during surgery instead of 120 minutes would quickly surpass this figure, despite the $400 being only a minor amount of the overall bill. To ensure that the dispute resolution process is reserved for instances in which good faith estimates are substantially inaccurate, we encourage HHS to instead require a final bill to be at least 10% over the good faith estimate for it to be eligible for the dispute resolution process.

As always, we appreciate the opportunity to comment on proposed regulations that affect MHA members. If you have any questions, please feel free to contact me at (651) 659-1415 or jschindler@mnhospitals.org.

Sincerely,

Joseph A. Schindler
Vice President, Finance Policy & Analytics