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December 6, 2021

Xavier Becerra, Secretary
Department of Health and Human Services
Attention: CMS–9908-IFC
P.O. Box 8010
Baltimore, MD 21244–8010

RE: CMS–9908–IFC; RIN 0938-AU62 - Requirements Related to Surprise Billing; Part II; published at Vol. 86, No. 192 Federal Register 55980-56142 on October 7, 2021

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

Dear Secretary Becerra,

UnityPoint Health appreciates this opportunity to provide comments on this Interim Final rule with request for Comments (IFC) – Requirements Related to Surprise Billing, Part II. UnityPoint Health is one of the nation's most integrated health care systems. Through more than 33,000 employees and relationships with more than 480 physician clinics, 40 hospitals in urban and rural communities and 14 home health agencies, UnityPoint Health provides care throughout Iowa, central Illinois and southern Wisconsin. On an annual basis, UnityPoint Health hospitals, clinics, and home health agencies provide a full range of coordinated care to patients and families through more than 8.4 million patient visits.

In addition, UnityPoint Health is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. UnityPoint Accountable Care is the ACO affiliated with UnityPoint Health and has value-based contracts with multiple payers, including Medicare. UnityPoint Accountable Care is a current Next Generation ACO, and it contains providers that have participated in the Medicare Shared Savings Program (MSSP) as well as providers from the Pioneer ACO Model. UnityPoint Health also participates in a Medicare Advantage provider-sponsored health plan through HealthPartners UnityPoint Health.

UnityPoint Health appreciates the time and effort of the Office of Personnel Management; the Internal Revenue Service, Department of the Treasury; the Employee Benefits Security Administration, Department of Labor; and the Centers for Medicare & Medicaid Services, Department of Health and Human Services in developing Part II IFC. **As a member of the American Hospital Association (AHA), we are generally supportive of comment letters submitted by those organizations.** In addition, UnityPoint Health has reviewed Part II IFC and respectfully offers the following comments:

OVERVIEW

Surprise medical billing describes a situation when an insured patient unknowingly receives care from an out-of-network provider The Part II IFC targets the independent dispute resolution process, good faith estimates for uninsured (or self-pay) individuals, the patient-provider dispute resolution process, and expanded rights to external review. Part II IFC does not address the audit process for plans and future rulemaking is anticipated.

Comment: As stated in our formal comment letter to the Part I IFC (CMS–9909–IFC)[1], **UnityPoint Health believes the intent of the IFC is appropriate. As envisioned in the No Surprises Act, this should be a consumer-facing rule granting consumer protections for patients seeking emergency care.** In the Part II IFC, the focus expanded from preventing surprise billing for largely emergency out-of-network expenses to requiring comprehensive good faith estimates for emergency and inpatient services for uninsured and self-pay consumers. Price estimates for uninsured and self-insured consumers are already available. Although we are supportive of the spirit of Part II IFC, this rule does shift a significant number of administrative duties and burdens to hospitals and providers as well as unintended consequences, some of which may be avoided or lessened.

Foremost, we are concerned with the rapid-cycle, phased release of rules on this topic. The phased timing of the rules with a January 1, 2022 start date appears disingenuous to the public notice and comment process. First, the succession of releasing IFC rules does not enable the departments to fully take into consideration prior public comments (e.g. Part I IFC) or signals that IFC rules once released are static despite a public comment period. Second, the condensed timeframe requires providers to comment and implement IFC rules without understanding the totality of rules or which provisions may be subject to change. For Part II IFC, there is less than 30 days from the end of the public comment period to implementation.

Given the breadth of the IFC (including the CMS phased approach with releasing companion rules), **UnityPoint Health reiterates our request that CMS delay implementation to no earlier than January 1, 2023.** The current January 1, 2022 date poses the following challenges:

- Short turn-around time to operationalize. While CMS-9908-IFC was released on October 7 with a short comment period, the notice and comment period for the audit process rule is still forthcoming. Without understanding the complete regulatory picture, it is not only difficult to appropriately comment on the impact of the underlying IFC, but it hampers the ability of organizations (both payers and providers alike) to institute relevant policy and procedures, embed workflows, and train staff – not to mention hiring vendors to create health information technology solutions.
- Rule complexity and unknowns. The underlying IFC itself is complex and has numerous uncertainties that will be difficult to operationalize starting January 1, 2022. Again, the audit rule has yet to be released and it is unclear which Part II IFC provisions will be adopted.
- National pandemic and health care workforce shortage. As a health care provider, the timing for

[1] SurpriseBillingPart1_UnityPointHealth_9-7-21.pdf submitted via regulations.gov on September 7, 2021, comment tracking number kta-i8zq-ujbt.

the IFC rule adds another stressor to a health care workforce that is exhausted, overburdened, and in the midst of a national pandemic. At the time of this letter, UnityPoint Health is experiencing inpatient census throughout our service areas that are near or over capacity in med-surg and ICU units. Additionally, we have upwards of 1,500 position vacancies across our three-state footprint. Time spent to operationalize the IFC diverts resources from direct patient care.

- Other federal rules. This IFC added to a cadre of other CMS regulations. Outside of surprise billing, hospitals are responsible for price transparency and 21st Century Cures information blocking rules. Recent OSHA and CMS rules on COVID-19 vaccination are pending court action. Aside from our providers in emergency medicine and hospitalists, many of the same personnel are tapped to implement each of these.

For Surprise Billing, UnityPoint Health has devoted in excess of 1,000 hours to comply and operationalize these rules thus far. This has required time and dollars for revisions to workflow, technology, and training as well as details like notice translations (a cost that could have been avoided through CMS standard notices) and posting requirements. Internal resources have been diverted from across the health system including clinic and emergency medicine leadership, revenue cycle, schedulers, project management, information technology, marketing and communications, and legal/compliance. UnityPoint Health has also had to engage vendors in order to go live under short turnaround expectations.

Finally, as a consumer protection initiative, this complex process does not necessarily support an improved patient care experience. **While UnityPoint Health supports guardrails on surprise billing, the process to achieve this should not negatively impact patient experience nor detract health care resources from care delivery.**

FACTORS IN INDEPENDENT DISPUTE RESOLUTION (IDR) PAYMENT DETERMINATION

The No Surprises Act requires the arbitrator to "consider" the following factors when deciding on a payment amount: the Qualified Payment Amount (QPA) and, upon request by the IDR entity or either party, the provider's training and experience; the complexity of the procedure or medical decision-making; the patient's acuity; the market share of the insurer and provider; the facility's teaching status; the scope of services; any demonstrations of good faith efforts to agree on a payment amount; and contracted rates from the prior year. As proposed, the IDR primarily anchors arbitration outcomes to the QPA, stating that the "IDR entity must begin with the presumption that the QPA is the appropriate out-of-network rate for the qualified IDR item or service under consideration."

Comments: UnityPoint Health supports the No Surprises Act intent to ensure that patients do not receive unexpectedly high medical bills. As we stated in our Part I IFC comment letter, the QPA calculation is complex, and results will be multilayered as bounded by item/service, provider, and geographic area within a plan. **UnityPoint Health does not support a QPA based on average contracted rates, as these do not reflect payment and actualized reimbursement.** This approach does not adequately capture the true cost of care and may place too strong an emphasis on contracted rates that are agreed upon based on a wide range of factors. A reliance on contracted rates falsely assumes that rates for individual services have been specifically negotiated, when instead providers often negotiate contracts more holistically. For instance, QPA calculations may be inflated for services when providers accept certain contract rates without negotiation for services they do not frequently or ever perform. Conversely, QPA calculations may

be undervalued for contracted rates that take value-based arrangements and other quality payments into consideration. While a payer, upon request, must provide a statement that the payer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services involved that were excluded for purposes of calculating the QPA, this statement does not improve the accuracy of the QPA and may even dissuade providers from engaging in value-based arrangements.

As such, **UnityPoint Health is disappointed that the Part II IFC creates a presumption that the QPA is appropriate for the out-of-network reimbursement rate, placing the burden on providers to disprove that assumption.** This effectively ignores the statutory directive that the IDR entity "shall consider" a list of factors,[2] arbitrarily creates a presumption, and sets a rebuttal evidence standard for consideration of the other payment factors. Ultimately, providers are placed at a disadvantage of defending any adjustment to a "median in-network payment rate."

GOOD FAITH ESTIMATES

Part II IFC implements the No Surprises Act good faith estimate requirements for uninsured and self-pay patients scheduling or shopping for care. The Part II IFC requires all providers and facilities to (1) inquire about an individual's health coverage status, and (2) provide a notification that the individual may receive a good faith estimate of the expected charges for furnishing the item or service. Good faith estimates must reflect the anticipated billed charges, including any discounts or other relevant adjustments that the provider or facility expects to apply. HHS anticipates providing a model notice for notifying uninsured (or self-pay) individuals of the availability of good faith estimates.

Comments: **For consumers without insurance, UnityPoint Health agrees that hospitals are the best source of pricing information related to their facilities and employed providers.** Our health system provides estimated pricing information to consumers for scheduled procedures and also has a phone line to provide price estimates for consumers who are planning or shopping for a service. These estimates are individualized and are developed by trained personnel in response to distinct inquiries. Additionally, when consumers contact us directly, we can assist them in obtaining resources that may include filing for Title XIX or Financial Assistance. Without these services and resources, individuals may delay urgently needed medical care.

As proposed in Part II IFC, the good faith estimates pose operational challenges and may even run counter to the intent of the No Surprises Act. Issues include inflexible timeframes, potential delay in care from prioritizing estimates over out-of-pocket costs, potential confusion with price transparency requirements, and inaccuracies inherent in a convener entity role.

- Timeframes: Good faith estimates are required to be produced under more aggressive timeframes and will result in these requests being artificially prioritized over other contracted accounts. This prioritization lacks operational flexibility and must occur without regard to other outstanding requests, or the amount of services involved in the estimate. As a result of the new timeframes, we will need to divert activities of current staff or be forced to hire net new staff to

[2] Public health Services Act (PHSA) § 2799A–1(c)(5)(C).

timely respond to all our customers with inquiries.

- Potential preventive care delay: UnityPoint Health provides personalized education and anticipated personal liability information in response to consumer requests. Our approach respects that each patient is different, and individual counseling adds value, especially for uninsured or underinsured consumers who can be connected with financial counselors. Part II IFC emphasizes a cost estimate over ultimately assisting uninsured or self-pay individuals to find coverage (via Medicaid or Marketplace) or financial assistance policy. Without realistic timeframes that support a comprehensive approach, we have real concerns that amounts contained within cost estimates can be defeating and may result in the avoidance of non-emergent services.
- Price transparency alignment: There are outstanding questions related to the alignment of these two rules. As machine-readable files are only required of hospitals, not all provider or facility rates exist in this format and their utility for convener entity good faith cost estimates will be negligible. In terms of shoppable services under price transparency, it is likely that good faith estimates will differ from our posted list. These differing regulatory requirements place hospitals at the vortex of a perfect storm for patient confusion.
- Convener role: As the site of care, hospitals are charged as the convener entity and required to inform the patient, provide the good faith estimate upon request, and gather all of the components of that estimate. Once the scope of this estimate includes co-providers and co-facilities, the timeliness and accuracy of good faith estimates become dependent upon external parties. Currently there is no platform to self-service this information outside of wholly owned, integrated systems. Convener entities are left holding the bag and will ultimately bear the brunt of ill-will from consumers for actions of others for which they exercise no control.

We urge you to consider:

- **Delay this rule until January 1, 2023**. While we appreciate that HHS will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured or self-pay individual does not include expected charges from co-providers or co-facilities for calendar year 2022, this does not relieve operational pressures for hospitals to implement on January 1, 2022.
- **Implement using a phased-in approach**. HHS should limit initial scope of estimates to facility and providers owned or employed by the convener entity. Again we would propose a start date of January 1, 2023. We would then recommend subsequent phases by year to include other providers that have this information readily available. These providers would be determined by HHS.
- **Further clarify scope of rule requirements**. To streamline requirements, HHS should consider allowing patients who are shopping to use online cost estimator tools and clarify that good faith cost estimates must only be done for patients who affirmatively request it.
- **Encourage process automation**. HHS should provide assistance to develop tools to automate these processes. 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 convener providers and facilities to automate the creation of comprehensive good faith

estimates.

- **Defer to existing patient cost estimator tools, when available**. HHS should deem hospitals with Hospital Price Transparency rule-compliant patient estimator tools to also be in compliance with the good faith estimate requirements for patients shopping for care.

PATIENT-PROVIDER DISPUTE RESOLUTION PROCESS

Part II IFC sets forth a select dispute resolution (SDR) process for uninsured or self-pay patients charged "substantially in excess" of the good faith estimate. This process sets forth a timeframe for initiation, stays collections process and late fee accrual, specifies documentation to support payment determinations, and permits external dispute agreements.

Comments: UnityPoint Health supports a dispute resolution process to ensure due process for patients with unexpectedly high medical bills. We agree that advance notice to patients of accurate costs are part of the solution. **We urge your reconsideration of the arbitrary $400 threshold used to define "substantially in excess."** We anticipate this $400 threshold 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. It should be noted that while we strive to provide accurate and timely information, health care procedures and services are unlike a merchandise purchase in that complications may occur which may alter the original estimates. For instance, when the volume or addition of administered drugs is involved, this threshold will likely be met despite adherence to the remainder of the cost estimate. Generally, this low trigger falsely equates obtaining a knee replacement or a valve repair to the purchase of a toaster or a car repair. **We respectfully encourage the use of a percentage as well as a minimum charge. Namely a dispute resolution may be triggered if a final bill is at least 10% in excess of the good faith estimate and the minimum discrepancy is at least $500.**

We are pleased to provide input on Part II IFC and its impact on our health system, our patients, and communities served. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Executive Director, Government & External Affairs at cathy.simmons@unitypoint.org or 319-361-2336.

Sincerely,

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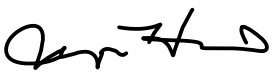

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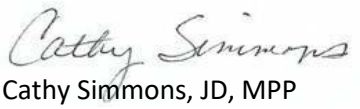

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