



March 5, 2022

Chiquita Brooks-Laure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4192-P
P.O. Box 8013
Baltimore, MD 21244-8013

**Re: CMS-10791 Requirements Related to Surprise Billing; Part II, Document Identifier
CMS-2022-0024-0001**

Dear Administrator Brooks-LaSure,

On behalf of its 123 member hospitals, the Kansas Hospital Association (KHA) offers the following comments in response to the Centers for Medicare & Medicaid Services' (CMS) requirements related to surprise billing, part II. Our comments pertain to two specific areas: the good faith estimates for self-pay and uninsured patients for scheduled services; and the patient and provider dispute resolution process.

Good Faith Estimates and Patient-Provider Dispute Resolution Comments

Through this 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 we have a number of operational concerns that we request be addressed through further guidance in order to reduce inefficient and impractical processes.

Price Transparency Policy Alignment. The Hospital Price Transparency requirement, or the creation of machine-readable files, provides researchers and other non-patient stakeholders' access to a hospital's negotiated, self-pay, and chargemaster rates. HHS expects these machine-readable files to be used by a convening provider or facility to collect co-provider or co-facility estimated charges. We continue to question the value of such files generally, and, in particular, disagree with HHS' suggestion that they could have any utility in meeting the

uninsured and self-pay patient good faith estimate requirements. Not all provider or facility rates exist in the machine-readable files since only hospitals are required to publish these files. Therefore, this data only would be available for some co-facility items or services. Even in instances when the convening provider or facility needs information on items or services included on a co-facility's machine readable file, the files do not contain the needed information, as they only include the generic self-pay rate, while the good faith estimates, as we understand them, require individualized self-pay rates that are reflective of any available discounts for the patient. Moreover, without contacting the co-facility directly from the start, the convening provider or facility would not necessarily know which items or services would be delivered during the course of care. Therefore, using these files would not remove a step in the process but instead add unnecessary ones.

Good Faith Estimate. The rule requires convening providers and facilities to deliver good faith estimates to patients within one business day for services scheduled between three and nine days in advance and within three business days for services scheduled at least 10 days in advance or in instances when an estimate is requested prior to scheduling. In order to create a compliant good faith estimate, a convening 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 expected items and services to be delivered and their charges reflective of any available discount for the specific patient. Completing this task in three days while also completing all existing administrative functions will require significant planning and workflow adjustments, as well as the hiring of new staff as this level of workload cannot be borne by the existing workforce. **In order to avoid delays in patient care, we urge HHS to streamline these requirements by allowing patients who are shopping to use online cost estimator tools and clarifying that financial assistance eligibility determinations must only be done for those patients who request it or may be reasonably expected to meet the criteria, as well as assist in the development of tools to automate these processes.**

Additionally, the good faith estimates are much more labor intensive than the online tools, as they require additional layers of specificity (e.g., accounting for how health status may alter the course of care, financial assistance eligibility) and therefore, will need to be completed manually in most, if not all, instances. The additional information required by the good faith estimates is more likely to be known for patients scheduling services, as opposed to 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. **We recommend utilizing patient cost estimator tools, when available, for all instances when a patient is shopping for care and only requiring the delivery of good faith estimates when a service is scheduled or a cost estimator tool is not available. Specifically, we encourage HHS to 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.**

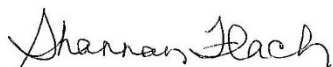
Co-provider/Co-facility Compliance Date and Timeline. The necessary steps that our hospitals must complete to implement the requirement likely will require additional time. There is currently no method for unaffiliated providers or facilities to share good faith estimates with a convening provider or facility in an automated manner. In order to share this information, billing systems would need to be able to request and transmit billing rates, discounts, and other necessary information for the good faith estimates between providers/facilities. This is not something that practice management systems can generally do, since billing information is traditionally sent to health insurers and clearinghouses, not other providers/facilities. **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. This 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 for a particular provider or facility's services is \$400 or higher in excess of that provider or facility's good faith estimate, the patient is eligible to initiate the select dispute resolution process. 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, which could lead to an excessive number of disputes going before the select dispute entities. For example, a patient who is under anesthesia for surgery for 135 minutes instead of 120 would quickly surpass this figure, despite the \$400 being only a minor amount of the overall bill. **In order to ensure that the dispute resolution process is reserved for instances in which good faith estimates are substantially inaccurate, we encourage HHS to instead require a final bill to be at least 25% in excess of the good faith estimate for it to be eligible for the dispute resolution process.**

KHA appreciates your consideration of these issues. Please feel free to contact Shannan Flach, Vice President of Healthcare Finance and Reimbursement, at sflach@kha-net.org.

Sincerely,



Shannan Flach
Vice President, Health Care Finance and Reimbursement
Kansas Hospital Association