

November 30, 2021

Secretary Xavier Becerra
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Requirements Related to Surprise Billing; Part II [CMS-9908-IFC]

Dear Secretary Becerra:

Thank you for the opportunity to respond to the US Department of Health and Human Services' (HHS) interim final rule on Requirements Related to Surprise Billing, Part II, as published in the October 7, 2021, issue of the *Federal Register* (CMS-9908-IFC).

AHIMA is a global nonprofit association of health information (HI) professionals. AHIMA represents professionals who work with health data for more than one billion patient visits each year. AHIMA's mission of empowering people to impact health drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and providers. Our leaders work at the intersection of healthcare, technology, and business, and are found in data integrity and information privacy job functions worldwide.

AHIMA believes that affordability is a critical element that impacts patient access to care. Ensuring patients have access to timely and accurate information about the cost of healthcare services, including information about their expected out-of-pocket costs, is necessary for making informed care decisions. AHIMA supports the use of public policy to ensure that individuals have the information they need to make informed choices about their healthcare, including efforts to find equitable solutions to prevent "surprise billing" for consumers.

A. Good Faith Estimates for Uninsured (or Self-Pay) Individuals

Scope

AHIMA notes the scope of the requirements contained in this rule pertaining to good-faith estimates "apply only to good faith estimate notifications for uninsured (or self-pay) individuals"¹ and that this rule does not "include requirements implementing PHS Act section 2799B-6(2)(A), which requires providers and facilities to furnish good faith estimates to individuals' plans or issuers."² AHIMA appreciates the clarification that "HHS will defer enforcement of the requirement that providers and facilities provide good faith estimate information for individuals enrolled in a health plan or coverage and seeking to submit a claim

¹ 86 Fed. Reg. at 55986.

² 86 Fed. Reg. at 56013.

for scheduled items or services to their plan or coverage.”³ AHIMA supports that subsequent rulemaking “will include a prospective applicability date that gives providers and facilities a reasonable amount of time to comply with any new requirements.”⁴ In our previous comments, AHIMA noted significant operational challenges associated with the operational feasibility of implementing such requirements without sufficient time for providers and facilities to prepare and make necessary operational and systems updates.

Definitions

This rule states the “convening provider is responsible for providing the good faith estimate to an uninsured (or self-pay) individual.” The convening provider is defined as “the provider or facility who receives the initial request for a good faith estimate from an uninsured (or self-pay) individual and who is or, in the case of a request, would be responsible for scheduling the primary item or service.” AHIMA requests clarification as to who would be responsible for providing the good faith estimate in a case in which the initial request for a good faith estimate is made to a secondary provider who is involved in the provision of care but who is not providing the primary item or service, as defined by this rule. Continuing, the rule later states that in a case in which “an uninsured (or self-pay) individual separately schedules or requests a good faith estimate from a provider or facility that would otherwise be a co-provider or co-facility, that provider or facility is considered a convening provider or convening facility for such item or service and must meet all requirements in paragraphs (b)(1) and (c)(1) for issuing a good faith estimate to an uninsured (or self-pay) individual.”⁵ In this scenario, would there be multiple convening providers and would multiple duplicative good faith estimates be required?

Requirements for Convening Providers and Facilities

AHIMA concurs with HHS’ belief that individuals may “use different terminology other than ‘good faith estimate’ when requesting a good faith estimate.”⁶ AHIMA supports the clarification that “convening providers and convening facilities shall consider any discussion or inquiry regarding the potential cost of items or services under consideration as a request for a good faith estimate.”⁷ AHIMA believes this clarification is critical for convening providers and facilities to understand when they are obligated to provide a self-pay or uninsured patient with a good-faith estimate.

AHIMA supports that the convening provider or facility “must inquire and determine if the individual meets the definition of an uninsured (or self-pay) individual” prior to determining whether a good faith estimate must be provided to that individual. AHIMA is concerned that until rules are promulgated pertaining to the provision of good faith estimates for insured individuals, that insured individuals may be confused or upset by an offer of a good faith

³ FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49. Department of Labor, Department of Health and Human Services, Department of the Treasury, 20 Aug. 2021, <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf>.

⁴ Id.

⁵ 86 Fed. Reg. at 56018.

⁶ 86 Fed. Reg. at 56017.

⁷ Id.

estimate that is not available to them and which is rescinded once the provider or facility determines the individual is insured and is not a self-pay individual.

AHIMA also supports that “information regarding the availability of a good faith estimate must be made available in accessible formats and languages spoken by individuals considering or scheduling items or services with such convening provider or convening facility.”⁸ This is a critical provision to ensure that patients have access to cost information regardless of language or disability.

AHIMA supports that a convening provider or facility may issue a single good faith estimate for recurring primary items or services. AHIMA appreciates the clarification that good faith estimates for recurring items or services “must include in a clear and understandable manner the expected scope of the recurring items or services (such as: timeframes, frequency, and total number of recurring items or services).”⁹

The interim final rule states that the convening provider or facility must “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.”¹⁰ Additionally, “good faith estimate information submitted by co-providers or co-facilities must be received by the convening provider or facility no later than 1 business day after the co-provider or co-facility receives the request.”¹¹ AHIMA has significant concerns regarding the operational viability of these requirements and believes that one business day is an inappropriate timeline. While AHIMA appreciates that HHS will exercise enforcement discretion in 2022 in relation to the inclusion of co-provider good faith estimate information in the convening provider’s good faith estimate, AHIMA requests clarification if similar enforcement discretion will be exercised regarding response times for requests to and from co-providers. AHIMA believes that providers and facilities will need significant time to prepare for these requirements and update existing processes and systems.

Continuing, AHIMA questions the operational practicability of these requirements and notes that one business day after the receipt of the request is likely not to be a viable time for providers and facilities to compile pertinent information and conduct outreach to relevant providers regarding a request for a good faith estimate. AHIMA has significant concerns regarding requests received via physical mail and notes these requests may not even reach relevant personnel in a large health system one day after receipt by the system’s mailroom. AHIMA believes a standard of “as soon as practicable, but not to exceed 10 days” strikes the appropriate balance between the need for urgency when compiling good faith estimate information, while still allowing for sufficient operational flexibility when fulfilling requests.

The interim final rule states that if “any changes in expected providers or facilities represented in a good faith estimate occur less than 1 business day before that the item or service is scheduled to be furnished, the replacement provider or replacement facility must accept the good faith

⁸ 86 Fed. Reg. at 56016.

⁹ 86 Fed. Reg. at 56018.

¹⁰ 86 Fed. Reg. at 56017.

¹¹ 86 Fed. Reg. at 56018.

estimate as their expected charges for the items or services being furnished that were provided by the original provider or facility and represented in the good faith estimate.”¹² While AHIMA concurs this approach is “necessary for consumer protections against facing surprise medical bills and without such a requirement an uninsured (or self-pay) individual would be unable to avail themselves of the patient-provider dispute resolution process in these circumstances,”¹³ AHIMA also shares the agency’s concerns that this approach may create significant challenges for patient access to care due to the financial strain such a requirement may place on a substitute provider. AHIMA requests clarification regarding whether substitute providers and facilities will be able to automatically write-off the difference between the provider or facility’s expected charge for the items or services being provided and the charge that was agreed to by the previous provider or facility on the good faith estimate.

AHIMA concurs with HHS that there are likely to be instances in which an uninsured or self-pay individual requests a good faith estimate in order to “compare costs across providers or facilities.”¹⁴ AHIMA agrees it is likely that a good faith estimate may need to be updated in an instance in which the requestor has not “been evaluated for underlying conditions that could impact the accuracy of the good faith estimate.”¹⁵ AHIMA supports that providers should be encouraged to review previous good faith estimates after relevant evaluations and updates have been made and that providers should be encouraged to communicate what has changed between an initial and updated estimate.

Content of a Good Faith Estimate for an Uninsured (or Self-Pay) Individual

AHIMA strongly supports the detailed specifications regarding what is required to be included in a good faith estimate. AHIMA supports the inclusion of the patient’s name and date of birth; an itemized list of items or services expected to be provided by the co-provider or co-facility that are reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care; the applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service; the name, NPI, and TIN of the co-provider or co-facility; the state(s) and office or facility location(s) where the items or services are expected to be furnished by the co-provider or co-facility; and the inclusion of a disclaimer that the good faith estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the good faith estimate.¹⁶ AHIMA believes inclusion of this information is critical for patient understanding of potential cost of care for the various items and services contained in the estimate. AHIMA also appreciates the inclusion of the “Example of How Itemized Lists of Expected Items or Services Could be Displayed in a Good Faith Estimate for Uninsured (or Self-Pay) Individuals” and believes this sample document provides additional clarity surrounding expectations for the provision of good faith estimates. AHIMA believes that it would be beneficial and provide additional clarity regarding the content of a good faith estimate if a safe harbor was established for providers who provide good faith estimates in the format developed by the agency.

¹² 86 Fed. Reg. at 56017.

¹³ Id.

¹⁴ Id.

¹⁵ Id.

¹⁶ 86 Fed. Reg. at 56018.

AHIMA also supports that “in instances where a convening provider or convening facility anticipates that certain items or services will need to be separately scheduled (such as those items or services typical of the standard of care), the convening provider or facility must include a separate list of items or services that the convening provider or facility anticipates will require separate scheduling and that are expected to occur either prior to or following the expected period of care for the primary item or service.”¹⁷ AHIMA believes this is necessary for patients to gain a complete picture of their expected course of care and to avoid patient confusion when charges for separately scheduled services arise. Additionally, AHIMA believes it is appropriate to require a separate good faith estimate be provided to the individual upon scheduling of the listed items or services or upon request.

Required Methods for Providing Good Faith Estimates for Uninsured (or Self-Pay) Individuals

AHIMA supports that that a “good faith estimate must be provided in written form either on paper or electronically (for example, electronic transmission of the good faith estimate through the convening provider’s patient portal or electronic mail), pursuant to the uninsured (or self-pay) individual’s requested method of delivery.”¹⁸ AHIMA also supports that for those provided electronically, “the good faith estimate must be provided in a manner that the uninsured (or self-pay) individual can both save and print, and must be provided and written using clear and understandable language and in a manner calculated to be understood by the average uninsured (or self-pay) individual.”¹⁹ AHIMA believes it would be helpful for HHS to develop model language for what is clear and understandable language and for the agency to consider developing a safe harbor, once model language is developed. Additionally, in cases in which the manner of delivery is not clearly requested, AHIMA requests clarification regarding whether the provider may decide the most appropriate method for delivery of a good faith estimate.

AHIMA believes standards are needed to automate the process by which such good faith estimates are generated and disseminated electronically by providers. Equally important is making sure these standards are built to support the health IT end-users’ needs and operational considerations. AHIMA believes it is critical to ensure that providers are involved in the development of such standards.

Additional Compliance Provisions

The interim final rule states “that a good faith estimate issued to an uninsured (or self-pay) individual is considered part of the patient’s medical record and must be maintained in the same manner as a patient’s medical record, and that convening providers and facilities must provide a copy of any previously issued good faith estimate furnished within the last 6 years to an uninsured (or self-pay) individual upon the request of the uninsured (or self-pay) individual.”²⁰ AHIMA supports the timeframe included in this requirement and believes it is in alignment with similar existing requirements. AHIMA requests clarification regarding how good faith estimate

¹⁷ 86 Fed. Reg. at 56019.

¹⁸ 86 Fed. Reg. at 56021.

¹⁹ Id.

²⁰ 86 Fed. Reg. at 56022.

information should be stored within the health record and if anyone accessing the health record will be able to access the estimates contained in the record.

AHIMA supports that in circumstances in which “a provider or facility, acting in good faith, makes an error or omission in a good faith estimate, HHS is establishing at 45 CFR 149.610(f)(3) that a provider or facility will not fail to comply with this section solely because, despite acting in good faith and with reasonable due diligence, the provider or facility makes an error or omission in a good faith estimate required under this section, provided that the provider or facility corrects the information as soon as practicable.” AHIMA believes that enforcement actions outside of the patient-provider dispute resolution process would be inappropriate for any provider who is acting in good faith and with reasonable due diligence.

Applicability of the Good Faith Estimate Requirements

AHIMA concurs with HHS that that it may take time for providers and facilities to develop systems and processes for receiving and providing the required information from co-providers and co-facilities. As such, AHIMA supports that “from January 1, 2022 through December 31, 2022, 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.”²¹

B. Patient-Provider Dispute Resolution

Definitions

The rule states that “uninsured (or self-pay) individuals are eligible for the patient-provider dispute resolution process after being furnished an item or service for which they received a good faith estimate if the individual is billed, by the provider or facility, charges that are substantially in excess of the good faith estimate.”²² The rule defines the term substantially in excess to mean “with respect to the total billed charges by a provider or facility, an amount that is at least \$400 more than the total amount of expected charges for the provider or facility listed on the good faith estimate.” In our previous comments, AHIMA recommended a standard, in alignment with the Medicare Advance Beneficiary Notice of Noncoverage standard, for estimates to be valid and not “substantially in excess” if the estimate is within \$100 or 25% of the actual costs, whichever is greater. In the rule, HHS elaborates on its rationale for setting the standard for “substantially in excess” based on a fixed dollar value, rather than a percentage basis, or a combined methodology, noting that that “such an approach could effectively put dispute resolution out of reach for uninsured (or self-pay) individuals in situations where the total expected charges for items or services are high, particularly for those who need to undergo more complex procedures.”²³ Although AHIMA concurs that a percentage standard would put the dispute resolution process out of reach in some cases, AHIMA is concerned with the potential burdens associated with the establishment of a new standard, rather than using a standard that many providers and facilities are already familiar with.

²¹ 86 Fed. Reg. at 56023.

²² 86 Fed. Reg. at 56024.

²³ 86 Fed. Reg. at 56025.

Eligibility for Patient-Provider Dispute Resolution

AHIMA supports the clarification that items or services provided are eligible for the dispute resolution process “if the total billed charges (by the particular convening provider or facility, or co-provider or co-facility listed in the good faith estimate), are substantially in excess of the of total expected charges for that specific provider or facility listed on the good faith estimate.”²⁴ AHIMA believes it would be inappropriate for the combined impact of total charges across convening and co-providers or facilities to trigger eligibility for this process, because estimates provided are solely controlled by the providers or facilities providing a particular service and are not under the control of other providers included in the good faith estimate.

Thank you for the opportunity to provide comments in response to the Requirements Related to Surprise Billing, Part II. Should you or your staff have any additional questions or comments, please contact Lauren Riplinger, AHIMA’s Vice President, Policy & Government Affairs, at lauren.riplinger@ahima.org and (202)-839-1218 or Matt Kerschner, AHIMA’s Director of Regulatory Affairs at matthew.kerschner@ahima.org and (312)-233-1122.

Sincerely,



Wylecia Wiggs Harris, PhD, CAE
AHIMA CEO

²⁴ 86 Fed. Reg. at 56027