American Association of Healthcare Administrative Management

The Premier Organization for Revenue Cycle Professionals

Issue: "Surprise" Billing (Out-of-Network billing)

Background: The continued emphasis and heightened focus for consumers to understand and make informed decisions regarding their healthcare coupled with providers and the facilities ensuring that they are compliant in meeting these obligations poses a never ending struggling for all parties involved. The No Surprise Billing Act has been one of the largest undertakings in consumer protections reforms. AAHAM supports this endeavor if the ruling follows the intent that Congress had envisioned it to be. The regulation published on September 30, 2021, has brought forth some real concerns regarding some of the rulings that we feel were not in alignment with Congress's vision.

AAHAM is steadfast in making sure that all patients are treated equitably, fairly and with dignity and respect. AAHAM strongly supports protections for patients from unexpected out-of-network health care costs when the patient does not have time, nor is in the condition to make a choice for their healthcare. Particularly, for costs incurred during an emergency or medical situation in which additional services are provided by out-of-network clinicians without the patient's prior knowledge. The No Surprises Act implemented a "baseball style" arbitration process called the Independent Dispute Resolution for when payment disputes arise between the provider/facility and the payer. This process removes the patient from the equation and AAHAM is in support of that. Based on the latest interim rulings, we have concerns that when an IDR entity is now involved, the final payment determination is based on only one factor as opposed to all factors that were outlined in the initial act. This tips the scales in favor of the insurance payer when payment disputes are being considered. We ask that Congress review and amend the language to state that all factors should be considered when ruling on the final payment. There are several provisions in the interim ruling which are burdensome for providers and facilities and will most inevitably result in not being able to meet these requirements, and worse, in a decline in the patient experience and a potential for delayed care. We would like the opportunity to work with you on changes and amended language as well as address any concerns raised by Congress with an end result of a system that is achievable for providers and facilities.

Recommendations: Our recommendations in achieving this goal are outlined below:

Section 103:

- The time deadlines in the dispute resolution process for out of network payments are impractical, lengthy, and pose a tremendous burden on the provider and facility. If the parties cannot agree on the process, and if the state does not have an established process, the Act provides for an Independent Dispute Resolution Process ("IDR") to determine out of network payments. Both parties must exhaust a 30 business day open negotiation period before the IDR process can be initiated. Below is an outline of the current Federal IDR timeline which AAHAM feels is unrealistic.

FEDERAL IDR PROCESS TIMELINE

4 Business Days	Notice of IDR initiation submitted 4 days after the close of the open negotiation period.
6 Business Days after IDR Initiation	Total of 6 days for an Arbitrator to be selected.
3 Business Days after IDR Selection	IDR entity to submit attestation of no conflicts of interest
10 Business Days after selection	Parties must submit offers
30 Business Days after Selection	IDR has 30 days to determine payment amount
30 Business Days after determination	Payment to awarding party must be paid along with IDR fee no later the 30 business days.

- Also included in this process is the 90 days "cooling off period" that prevents the party submitting the dispute to the IDR entity from submitting another case related to the same item or service involving the same party for 90 days. These time periods will be impossible to meet without adding additional staff and taking resources away from patient care. The dispute resolution process needs to be streamlined to include reasonable and practical time periods for each step in the process.

- The time period to initiate formal IDR should be flexible based on progress made in the informal negotiations. Once a stalemate is determined by either side, initiation of the IDR process should be allowed within a reasonable time, not to exceed 365 days. The time for arbitrator selection should be no less than 60 days and no more than 90, or the selection is made by HHS. HHS should have at least 30 days to make the selection for this to be workable.
- The 90 day "cooling off" period should be eliminated in its entirety. Current ruling states that a provider or facility may not bring another claim under the IDR Process for such item or service with that plan for 90 days.

The interim final ruling favors the insurer by allowing the median contracted rate to be the default as the appropriate payment amount and the IDR entity can only stray from the median amount only when the parties present credible information showing that additional circumstances come into play and that they clearly show that the median in network rate is "materially" different from the appropriate out of network rate. AAHAM is opposed to this as it clearly demonstrates an initial bias toward the one factor and disregards other factors that may have influenced a different outcome. These other factors include prior contracted rates during the previous four plan years, the relative market share of both parties involved, patient's acuity, case mix, and scope of services. In our view, this does not align with Congress's initial intent in implementing the IDR process.

Section 112

- Providers must identify 3 days in advance of service and not later than 1-day post scheduling the service what type of coverage the patient is enrolled in and provide a good faith estimate to the patient. Hospitals are already required to provide cost estimates to patients that request an estimate via the Pricing Transparency regulation. Forcing hospitals to provide this to all patients, and not just those patients that request this information, will increase healthcare cost by forcing hospitals to hire additional staff to comply. There are currently no standardized price estimation tools on the market that will automatically generate and deliver an accurate price estimate to every single patient. Hospitals will be forced to add staff members to comply, which will drive up the cost of healthcare.