

February 17, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Janet L. Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

The Honorable Kiran A. Ahuja
Director
U.S. Office of Personnel Management
1900 E Street, NW
Washington, D.C. 20415

Dear Secretary Becerra, Secretary Yellen, Secretary Walsh, and Director Ahuja:

We thank the Departments of Health and Human Services, Treasury, and Labor, as well as the Office of Personnel Management (the Departments), for publishing interim final rules (IFR) on the No Surprises Act, signed into law as part of the Consolidated Appropriations Act of 2021. Surprise medical bills and price transparency within the healthcare system have been a significant issue for patients for many years, exacerbated recently by the rising number of high deductible health plans which leave patients to assume and manage a greater share of their healthcare costs.

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We agree that the three Interim Final Rules (IFR) and one Notice of Proposed Rulemaking (NPRM) that have been issued by the Departments in response to the No Surprises Act provide a foundation upon which the requirements can be fully implemented. However, the members of the HIMSS Electronic Health Record Association (EHRA) have some concerns about rulemaking to date, as well as several points of feedback that we hope will be informative when it comes to additional regulatory actions expected later this year. We look forward to working with the Departments on ways to fully implement the intent of the No Surprises Act while ensuring the rules are workable and do not add unnecessary burden to the many affected stakeholders across the industry.

EHRA's member companies develop technologies that may be critical to healthcare organizations' successful compliance with the No Surprises Act, and our insights in this letter derive from our efforts to advocate for reasonable timelines and requirements for healthcare organizations using our collective solutions. Practice management, revenue cycle management, Electronic Health Records (EHRs), and other interoperable software solutions are important tools that can provide patients, providers, and payers with the appropriate data needed to ensure accuracy of upfront pricing that is shared with patients, whether in situations involving out-of-network providers, uninsured or self-pay status, or visits with a normal care provider for which insurance will be used (in the future). The EHRA is happy to serve as a resource as you consider the possible role of health IT in detecting, reporting, and preventing surprise billing.

Intersections with health information technology

We strongly support the intentions behind the No Surprises Act and subsequent regulatory actions (and understand the pressure of statutory deadlines), but the timeline on which these requirements are being rolled out is unreasonable. Moreover, the larger framework of the rules is dependent on healthcare-wide infrastructure that simply does not exist yet. The expectations for convening providers to gather extensive data from co-providers or co-facilities are unrealistic and exacerbated by the fact that it is not always clear days in advance of the actual procedure in which co-providers and co-facilities will be involved. Additionally, the lack of any standardized approach to the exchange of required information with health plans and payers adds complexity and unnecessary burden to all involved parties.

As we look ahead to the phase of the regulations in which all patients are expected to have access to Good Faith Estimates (GFE) through an entirely new approach to this process, the burden on health IT developers becomes more apparent, as well as on healthcare providers who will need to support virtually all patients with the intended transparency despite the lack of available infrastructure. The EHRA has long clarified to HHS that software developers need a minimum of 18 (and more ideally 24) months from the release of a major new requirement that relies on net-new functionality until compliance by providers is expected. This reflects the need for sufficient time for the development, testing, deployment, and adoption of health IT, including new workflows and responsibilities that will help satisfy the new requirements.

The timeline provided by the regulations released by the Departments to date does not provide nearly enough time for software developers to make updates that may be necessary to assist clients in their compliance or for those healthcare organizations to train on new functionality and master adjusted

workflows. Even where requirements, such as a GFE for uninsured individuals, *can* be met without the use of health IT, the use of such technologies can assist in reducing manual effort and in lowering the additional time and work that is necessary to create and document the good faith estimates. However, pointing back to our comments about the time necessary for health IT development, we note that without an explicit requirement for health IT adjustments, we are concerned we will be asked to support the necessary workflow, data exchange and reporting changes without sufficient time to do so in such a way as to avoid increased documentation burden.

Impact on workflow and resource needs outside of IT

Communication related to good faith estimates for uninsured individuals is an area that is already leading to additional work for administrative and front-office staff at providers' offices and facilities. While the GFE for uninsured individuals will be a helpful tool in enabling these individuals to take greater control of their health experience and associated costs, this is an entirely new process to many healthcare providers and facilities, and the requirement has an exceptionally short turnaround time. According to the Medical Group Management Association (MGMA), 41% of group practices stated that patient appointments are typically scheduled between 3-10 business days in advance, requiring practices to furnish uninsured or self-pay patient GFEs within one business day of scheduling, and 90% of medical practices responded to a survey to indicate the regulation was already increasing administrative burden and leading them to consider hiring additional staff and, most unfortunately, delay patient care to ensure program compliance.

There are numerous scenarios that have been raised by providers that seem to be unaddressed or insufficiently considered in the regulations released to date, including patients who do not fully understand their insurance coverage with implications related to GFE requirements that don't come to light until too late in the process, patients who show up the day of the appointment expressing an intent to self-pay when an appointment was made months prior, and care environments, such as direct primary care, that don't send bills to their patients because care is covered by a monthly fee. Further, there is little guidance on what should be on the GFE when little or no clinical history exists to inform the provider. Even where tools are eventually developed that help manage the estimate and codification process for all the various scenarios envisaged by the rules, staff within the provider organizations will likely still need to verify the accuracy of what is included in each GFE and codify it, which will carry a continued burden for healthcare organizations.

Need for updates to HIPAA standards and code sets

The balance billing/surprise billing provisions of the No Surprise Act that went into effect on January 1, 2022, would most efficiently be met through updates to HIPAA administrative standards and code sets, including the use of comment codes and fields on claim forms to inform plans and issuers that notice and consent have been obtained, and by the use of claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) for plans and issuers to notify providers and facilities of impacted payments and patient cost-share amounts. These forms and codes can easily communicate routine information because these are standardized already, but these can be helpful for this use case only when there is an understanding between the plan/issuer and provider/facility as to what the fields and/or codes mean. Without that standardization, miscommunication and unnecessary work will occur.

To our knowledge, none of the Departments have begun an effort to update those standards as would be necessary to support automation of these requirements.

Requirements related to convening providers

Despite the described barriers, CMS has indicated it will begin enforcing a requirement for the convening provider/facility to not only generate a good faith estimate for its own expected items and/or services, but to also coordinate and compile the receipt of good faith estimates from co-providers and/or co-facilities beginning on January 1, 2023. While some healthcare organizations may be able to provide an estimate in cases that services will be furnished solely by practitioners and facilities under that healthcare organization's span, once things move beyond a single provider, facility, and/or healthcare organization, it becomes much more difficult to create efficient and repeatable processes to request and receive specific information in such a short time frame.

Identifying all of the out-of-network providers who will participate in a case (and obtaining all of their required coding and pricing information) will require extensive workflow changes, resources, and time from hospitals and other providers. Where health IT is not maximized for any number of reasons, including the lack of relevant industry-wide infrastructure, compliance will likely require facilities to add new staff in order to comply with the 1-day and 3-day timing requirements to produce the good faith estimates.

The requirement placed on convening providers/facilities creates not only a new burdensome workflow but a new interoperability challenge that the entire industry will require additional time to address. Ideally, the efforts for price transparency and good faith estimates lead to the interoperable exchange of discrete data elements related to fee schedule amounts; however, as noted above, there are no processes in place today that focus on the request and receipt of expected charges prior to the delivery of services within the HIPAA code sets.

This type of activity would require the convening provider/facility to identify in a very quick manner potential co-providers/co-facilities (sometimes challenging specific to individual co-providers), notify them of the need for a good-faith estimate, provide the necessary patient information (potentially financial and clinical data) to make the necessary determinations as to what items/services may be necessary for the co-provider/co-facility to furnish to that patient, acquire that information from relevant other providers and then to bring all that information together into an understandable GFE. In some instances, the facility where the procedure will take place has the best visibility as to the various co-providers, not the initiating (and thus convening) provider, but the burden under this regulation sits with the so-called convening provider. The end result of all of these factors will be a significant burden on the provider organizations and their staff.

Recommendations

The healthcare industry recognizes the importance of and supports the intent behind the No Surprises Act, and is working diligently to comply. However, as health IT developers, we believe that the timeframes given for compliance are simply unrealistic. Accordingly, we ask that the Departments consider four requests:

- Refrain from issuing regulations establishing a date by which providers must provide GFEs and/or Advanced Explanation of Benefits (AEOB) to insured patients (who are not self-paying) so as to allow the necessary industry infrastructure to be assembled. We remind CMS of the necessity to allow 18-24 months for development, testing, release, installation, implementation of, and training on needed technologies in whatever regulation is finally issued.
- Include in future rulemaking a requirement that all stakeholders follow a standards-based approach to the exchange of all affected data, including health plans and payers.
- Formally announce a lenient policy for enforcement of the provisions already in effect to the extent that only those providers who blatantly ignore the requirements of the No Surprises Act may be penalized.
- Work with OCR to issue its long-awaited rulemaking on electronic claims attachments, which could be used to support communication of notice and consent and similar documentation so that they can be seamlessly shared between providers/facilities and plans/issuers electronically.

We are happy to continue to serve as a resource for HHS and the other Departments as you continue to implement the No Surprises Act and the important protections it provides to patients. Thank you for your consideration.

Sincerely,



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Cerner Corporation



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Vice Chair, EHR Association
Foothold Technology

HIMSS EHR Association Executive Committee



Pamela Chapman
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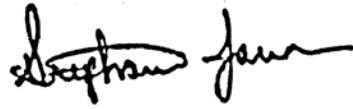
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About the HIMSS EHR Association

Established in 2004, the Electronic Health Record (EHR) Association is comprised of nearly 30 companies that supply the vast majority of EHRs to physicians' practices and hospitals across the United States. The EHR Association operates on the premise that the rapid, widespread adoption of EHRs will help improve the quality of patient care as well as the productivity and sustainability of the healthcare system as a key enabler of healthcare transformation. The EHR Association and its members are committed to supporting safe healthcare delivery, fostering continued innovation, and operating with high integrity in the market for our users and their patients and families. The EHR Association is a partner of HIMSS.

For more information, visit www.ehra.org.