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Submitted via www.regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

The Honorable Lisa M. Gomez
Assistant Secretary
Employee Benefits Security Administration
Department of Labor

The Honorable Laurie Bodenheimer
Associate Director
Healthcare and Insurance
Office of Personnel Management

The Honorable Douglas W. O'Donnell
Acting Commissioner
Internal Revenue Service

The Honorable Lily Batchelder
Assistant Secretary
Department of the Treasury (Tax Policy)

RE: CMS-9900-NC, Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals

Dear Administrator Brooks-LaSure, Ms. Gomez, Ms. Bodenheimer, Mr. O'Donnell and Ms. Batchelder:

Bi-State Primary Care Association (Bi-State) appreciates the opportunity to provide input on the above-referenced request for information on the Advanced Explanation of Benefits (AEB) and Good Faith Estimate (GFE) for covered individuals.

Established in 1986, Bi-State is a nonpartisan, nonprofit 501(c)(3) charitable organization promoting access to effective and affordable primary care and preventive services for all, with special emphasis on underserved populations in Vermont and New Hampshire. Bi-State's combined Vermont and New Hampshire membership includes 21 Federally Qualified Health Centers, one Look-Alike, Planned Parenthood of Northern New England, Vermont's Free and Referral Clinics, North Country Health Consortium, Community Health Access Network, and the Area Health Education Centers in New Hampshire.

Bi-State strongly supports the No Surprises Act's goal of improving consumers' access to accurate information about the costs of health care services and reducing the occurrence of surprise medical bills. Health centers already operate under a robust and comprehensive federal regulatory regime that essentially advances these same goals and provides these same protections for low-income and medically underserved individuals. Over the year, health centers have experienced challenges integrating the Good Faith Estimate (GFE) into their administrative workflow, leading to patient scheduling backlogs and increased administrative burdens. While Bi-State strongly appreciates and supports the intentions behind the Interoperability standards, encouraging health centers to transfer GFE and AEOB data to plans, issuers, and carriers would be duplicative and be cumbersome for the health centers' already strained workforce. This would be a particular challenge for New Hampshire and Vermont health centers as many serve as 'sole community providers' delivering services to patients who are on Medicaid, Medicare, commercial plans, and also those who are uninsured.

Transferring the GFE to plans, issuers, and carriers would be duplicative, as health centers already provide this information to patients.

Health centers are entities that either receive a grant under Section 330 of the Public Health Service Act (PHSA) or, despite not receiving a grant, are recognized by the U.S. Health Resources and Services Administration (HRSA) as meeting the conditions for such a grant ("look-alikes").¹ Unlike other types of providers, health centers have extensive obligations to their patients as a condition of their grant funding. They must meet a host of federal program requirements aimed at ensuring they make comprehensive primary care services available to underserved populations, especially for uninsured and underinsured patients. Many conditions that health centers must fulfill under existing Section 330 and other HRSA program requirements directly relate to the goals and provisions of the No Surprises Act and the PHSA.

Health centers must establish their own fee schedules consistent with prevailing local rates for health services and are designed to cover the reasonable costs that the health center incurs in providing services.² Health centers are also required to establish a sliding fee discount program (SFDP), which reduces or waives the amount that the patient pays, based on the patient's income

¹ See HRSA, [Health Center Program Look-Alikes](#).

² PHSA § 330(k)(3)(G)(i); 42 C.F.R. § 51c.303(f); HRSA, [Health Center Compliance Manual, Chapter 16](#).

relative to the federal poverty level and the patient's family size. The statute requires that individuals whose income is above 200% of the federal poverty level pay full charges, while individuals whose incomes are at, or below, 100% of the federal poverty level pay only nominal fees. The fee schedule is intended to have patients be monetarily invested in their care but also minimize cost-related barriers to care. The vast majority of health center patients – 89.6% per 2021 aggregate data from HRSA's Uniform Data System (UDS) – have incomes at or below 200% FPG, entitling them to SFDP discounts. Nearly 67% of patients have incomes at or below 100% FPG, meaning they pay only a nominal fee or none at all.³

A health center's fee schedule lists the current prices and fees for medical services, usually separated by visit types like primary care, preventive care, specialty care, or lab services. The cost of a visit depends on the patient's age, if they are an existing patient, and the complexity of the services provided. Before applying the sliding fee scale, an annual visit at a health center can range from \$100-300 for new and existing patients.⁴ Once a patient has been evaluated for the health center's sliding fee discount program, the cost of their visit adjusts to a more affordable range based on the patient's financial factors. For instance, an uninsured patient would pay for a primary care visit:⁵

- Fee average for a new patient - \$315
- Fee average for an established patient - \$226
- Fee if the patient is eligible for the sliding fee scale and below 100% FPL - \$12
- Fee if the patient is eligible for the sliding fee scale and 200% FPL - \$37

Considering that 90% of health center patients are eligible for the sliding fee discount program, uninsured and self-pay patients rarely receive bills that are over \$400. If a patient does receive a bill for more than \$400, the visit most likely included dental services or a comprehensive medical procedure.

Our health centers are also required to educate patients on insurance or related third-party payment options available to them.⁶ When health center services are furnished via contract or formal referral arrangement with another provider, the health center must ensure that the contracted or referral provider also provides discounts to low-income patients.⁷ If the health center provides supplies or equipment that are related to but not included in the service itself, the health center must inform patients of the charges of such items before the time of service.⁸ The health center is required to operate in a manner such that no patient shall be denied service

³ HRSA, 2021 National Program Awardee Data, Table 4 (Selected Patient Characteristics) <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=4&year=2021>.

⁴ Accounting for geographical variations based on cost of living and local prevailing rates.

⁵ 2020 Uniform Data System. Bureau of Primary Health Care, HRSA, DHHS

⁶ HRSA, [Health Center Compliance Manual, Chapter 16](#).

⁷ HRSA, [Health Center Program Compliance Manual, Chapter 9](#).

⁸ HRSA, [Health Center Compliance Manual, Chapter 16](#).

due to the individual's inability to pay. The law authorizes health centers to reduce or waive fees – in addition to the SFDP described above – to ensure this standard is met.⁹

In summary, the application of the SFDP and the unique nature of the health center patient population extremely limits the portion of health center patients who may even conceivably be billed full charges. Because health centers set their charges with consideration for the accessibility of services to self-pay, and underinsured, patients, it would be extremely rare for an occasion to arise where health center patients incurred charges at a level that would trigger the dispute resolution process.¹⁰ HRSA program rules ensure that patients enjoy the health center protections with respect to health center services provided on a referral or contract basis, as well. Health centers are federally mandated to ensure that cost is not a barrier for patients, which distinguishes health centers from other providers subject to the good faith estimate requirements.

Imposing requirements to transfer the GFE to issuers would place undue administrative and economic burden on health centers.

As previously mentioned, the vast majority of health centers' uninsured or self-pay patients are low-income individuals who qualify for the SFDP, making it highly unlikely for these patients to incur charges at a level sufficient to trigger the policy concerns the No Surprises Act includes. Health centers would be incurring significant costs – not only the per estimate costs described in the Agencies' burden analysis in the previous IFC, but also structural changes such as reconfiguring staff responsibilities so that “back-office” clinical and coding personnel can provide “front-office” administrative staff with information about potential diagnoses, service codes, and applicable discounts – at a time when health centers are already facing staffing shortages and new service demands as the pandemic continues and with the rise of respiratory illnesses like RSV in our region.

Health centers depend upon over 220,000 clinicians, providers, and staff to deliver affordable and accessible health care. However, a recent National Association of Community Health Centers' survey found that 68% of health centers lost between five and twenty-five percent of their workforce in the last six months, with a majority citing financial opportunities at a large health care organization as the main reason for departure.¹¹ The health centers in New Hampshire and Vermont have lost significant staff and are finding it nearly impossible to recruit new staff as Vermont's unemployment rate is 2.1% and New Hampshire's is 2%. These workforce retention and recruitment challenges impact administrative staff as well as clinical staff. Health centers would further struggle to implement the GFE—including potential diagnoses, services codes, and applicable discounts— and also transfer the data in a way that is compatible to insurers' systems.

⁹ PHS A § 330(k)(3)(G)(iii)(I); 42 C.F.R. § 51c.303(u); HRSA, [Health Center Compliance Manual, Chapter 16](#).

¹⁰ 45 C.F.R. § 149.620

¹¹ The National Association of Community Health Centers. (2022, March). Current State of the Health Center Workforce. Pandemic Challenges and Policy Solutions to Strengthen the Workforce of the Future. <https://www.nachc.org/current-state-of-the-health-center-workforce/>

This could further exacerbate the problems health centers have reported with providing a GFE, specifically those related to administrative burden and patient scheduling backlogs.

Imposing this type of requirement could also be economically burdensome to our health centers through increased staff time needed to meet the obligations. Health centers' payer revenues in New Hampshire and Vermont do not even cover their costs of providing services to insured individuals—much less the costs of furnishing services to the low-income uninsured individuals health centers are required under their Section 330 grant to serve regardless of ability to pay.¹² The Section 330 grant provides “gap funding” to cover costs associated with patient care and related activities that payer revenues do not cover; this means that its chief function is to finance otherwise-unreimbursed services to uninsured low-income patients.¹³ In order to comply with the good-faith estimate requirements in effect, alongside the sharing of GFE data, health centers will be forced to divert other funds, like their Section 330 grant, from the costs of serving low-income patients.

Bi-State is committed to providing New Hampshire and Vermont health centers with the technical assistance they need to smoothly implement the GFE in a timely fashion. One specific barrier for health centers is working with electronic health record (EHR) vendors to update their platforms to generate a GFE. Until a health center's EHR generates a GFE, staff are forced to manually develop GFEs using spreadsheets or other systems. Imposing requirements to share GFE with insurers would impose a barrier to health centers that are already operating on razor-thin margins with a staff that is exhausted from years of managing through a pandemic.

We want to echo the following recommendations that were provided by the National Association of Community Health Centers. These recommendations are intended to meet the goals of the No Surprises Act, but align with the existing responsibilities that health centers have:

- Be more proactive, when feasible, with financial counseling and collecting patient information at the beginning of the scheduling process to evaluate sliding fee discount eligibility. Typically, health centers evaluate patients for eligibility for discounts when they are present for their visit. If health centers conduct financial counseling with patients prior to their visit, this will provide health centers with the required information to include any sliding fee discounts within the GFE.
- Transition to nominal sliding fee scale that establishes flat fees for each income tier to increase transparency and predictability for patients.

¹² See Kaiser Family Foundation, *Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding Explained* (Mar. 26, 2019) (<https://www.kff.org/medicaid/issue-brief/community-health-center-financing-the-role-of-medicaid-and-section-330-grant-funding-explained/>) (“While [Medicaid prospective payment system] payments align generally with the costs of providing care, shortfalls have emerged. In 2010, Medicaid paid 81% of health centers’ cost-linked charges; by 2017, payments covered 79%.”)

¹³ (See PHSA § 330(e)(5)(A) (providing that the amount of the grant made to community health centers for a fiscal year is equal to the amount by which the costs of operation of the center exceed the total of “state, local, and other operational funding provided to the center; and . . . the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in such fiscal year”).)

- Post their schedule of charges for the 10 most common services both online and visibly in the health center waiting room.

Bi-State appreciates the opportunity to provide comments in response to this RFI and urges the Agencies to take into consideration health centers' position when thinking about promoting the sharing of the GFE with insurers. We do not want potential requirements to compromise the effectiveness of the federal health center program and appreciate the consideration of these comments. If you have any questions, please contact Georgia Maheras, Senior Vice President of Policy and Strategy: gmaheras@bistatepca.org.

Sincerely,

Tess Kuening

Tess Stack Kuening, CNS, MS, RN
President and Chief Executive Officer