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December 6, 2021

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9908-IFR, RIN 0938-AU62
P.O. Box 8010
Baltimore, MD 21244-8010

Submitted at https://www.regulations.gov/docket/CMS-2021-0156/document

RE: RIN 0938-AU62, Requirements Related to Surprise Billing; Part II: Impact and Alternative to Good Faith Estimate Requirements on FQHCs

Bi-State Primary Care Association (Bi-State) appreciates the opportunity to provide input on the Interim Final Rule (IFR) entitled, "Requirements Related to Surprise Billing: Part II."

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, one Rural Health Clinic, Planned Parenthood of Northern New England, Vermont Coalition of Clinics for the Uninsured, North Country Health Consortium, Community Health Access Network, and the Area Health Education Centers in both Vermont and New Hampshire.

Our organization is funded by the federal Health Resources and Services Administration (HRSA) to provide training and technical assistance to all the Federally Qualified Health Centers (FQHCs[1]) in Vermont and New Hampshire. Our members are part of the national network of FQHCs, which together provide affordable, high quality, comprehensive primary care to 30 million medically underserved individuals, regardless of their insurance status or ability to pay for services.

Bi-State strongly agrees that patients should not be subject to "surprise billing," and that cost should not pose a barrier to care, for uninsured or any other patients. These commitments are at the heart of the FQHC model, which has been in existence for over 50 years. Nonetheless, Bi-State has serious concerns that the Good Faith Estimate (GFE) requirements outlined in the IFR would not provide additional value to FQHC patients, while imposing major administrative demands on FQHC operations and staff. Accordingly, we request that CMS not apply the current IFR rules to FQHCs, with one potential exception.

[1] Federally Qualified Health Centers (FQHCs) are also commonly referred to as Community Health Centers (CHCs.) These comments use the term FQHC since this is a CMS term.

We begin with a summary of our concerns and proposed alternative, and then will discuss each in detail.

SUMMARY OF COMMENTS

1. The current IFR rules should not be applied to FQHCs, as doing so would:
    - Provide no added value for patients;
    - Often be impossible to implement as they do not fit with the FQHC model of care; and
    - Impose enormous administrative demands on FQHC operations and staff.

2. If appropriate, CMS could require FQHCs to issue GFEs in the rare circumstances when a patient:
    - Has been evaluated by an outreach worker to determine their eligibility for discounts; and
    - Is scheduling/requesting charges information for items or services for which their expected charges (factoring in the discounts for which they are eligible) could be $400 or greater.

3. While we strongly urge CMS to <u>not</u> apply the current IFR requirements to FQHCs, the following adjustments would be critically needed if CMS were to do so:
    - Delay implementation of and/or compliance with the GFE requirement for FQHCs;
    - Use enforcement discretion when working with FQHCs that are demonstrating a good faith effort to implement the new GFE rules, and consider application of flexibilities surrounding civil monetary penalties and related hardship exemptions;
    - Require that GFEs be issued only upon patient request;
    - Not require FQHCs (or other providers) to issue GFEs that are clearly redundant of ones that were recently issued; and
    - Provide additional resources and support to FQHCs, including financial and technical assistance, to help offset the costs that will be incurred by implementing the GFE requirement.

DETAILED COMMENTS

A. BACKGROUND ON FQHC PATIENTS AND EXISTING PROTECTIONS AGAINST SURPRISE BILLS FOR FQHC SERVICES

To provide context for our comments and recommendations, we share the following information about the demographics and literacy levels of FQHC patients, and about the various mechanisms already in place that protect patients from getting "surprise bills" for FQHC services.

1. Demographics of Vermont and New Hampshire FQHC patients in 2020[2]

- 15% have incomes below the Federal Poverty Level (FPL).
- 13% have incomes between 101% and 200% FPL. Thus, 28% of FQHC patients are considered "low-income."
- 9% of FQHC patients are completely uninsured.
- While 39% of FQHC patients have private insurance, many of them tend to have high deductible plans, which (barring a medical crisis), means they are "self-pay" for much of their care.

[2] Most current complete year of Uniform Data System (UDS) data available. The UDS Report is the Annual Review and submission from each FQHC and Look-Alike detailing their operations, including (but not limited to) patient demographics, services, and health outcomes.

- Thousands of our patients in both states are migrant or seasonal farmworkers and 3% self-identify as experiencing homelessness.
- 14% of FQHC patients in NH and 2% of patients in VT are best served in a language other than English.[3]

2. Literacy level of FQHC patients

Even among native English speakers, literacy is a significant challenge for many FQHC patients and, therefore, the FQHC providers who serve them. According to the National Center for Education Statistics, more than 43 million adults in the United States cannot read, write, or do basic math above a third-grade level[4]. As literacy levels are highly correlated with income, it is clear that many patients who struggle with literacy receive care at FQHCs.

Health literacy – meaning the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions – is an even greater challenge among FQHC patients. On its website, HRSA states that "low health literacy is more prevalent among:

- Older adults;
- Minority populations; and
- Those who have low socioeconomic status."[5]

As stated above, many of our FQHC patients have low socioeconomic status and other factors, such as lack of English proficiency, that impact their level of health literacy. Furthermore, many of our FQHC patients experience chronic mental, behavioral, and/or physical health conditions that can affect their ability to process new and complex information. FQHC staff work hard to provide the best service to these patients, including taking great care to explain and help patients understand information about their health and what health care services will cost, providing a sense of predictability and stability. We have already heard from some of our FQHCs that the new GFE could result in confusion among patients, particularly those who are sensitive to changes in routines, and could even lead to disruptions in their treatment. It would also layer on more complexity for staff, which will be taxing and burdensome when they already work hard to help patients achieve improved health literacy.

3. FQHC patients are already protected from "surprise billing"

The central tenet of the FQHC model is that no person is denied care due to an inability to pay. Thus, the idea of sending a patient a "surprise" medical bill they cannot afford is fundamentally inconsistent with the FQHC model of care. Rather, FQHCs work with each patient individually to determine their income and ability to pay, adjusting their charges accordingly.

Since their creation in the early 1970s, FQHCs have been subject to detailed program requirements established in Section 330 of the Public Health Service Act. The statute explicitly prohibits FQHCs from turning a patient away due to an inability to pay. The HRSA – the agency that oversees and ensures FQHC compliance with all Section 330 requirements – lays out detailed rules for these and other

[3] https://data.hrsa.gov/tools/data-reporting/program-data/state/NH
https://data.hrsa.gov/tools/data-reporting/program-data/state/VT
[4] https://nces.ed.gov/pubs2019/2019179.pdf
[5] https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/index.html

statutory requirements in a 100-page Compliance Manual. To ensure that a patient is never subject to charges that they cannot afford for FQHC services, the Compliance Manual first outlines a system for FQHCs to establish fees and discounts that vary based on the patient's income. As detailed in Chapter 9 of the Compliance Manual, every FQHCs must have:

- A schedule of fees for each of their services. These fees must be "consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation."[6]
- A schedule of discounts that are provided to all uninsured and underinsured patients as follows:
    - Persons with incomes above 200% FPL pay the full fee schedule amount.
    - Persons with incomes between 101% and 200% FPL must receive discounts off the fees listed in the fee schedule. There must be at least three "discount pay classes" between 101% - 200%. For example, a CHC might structure their three discount classes in this range as follows:
        - Patients between 167%-200% receive a 25% discount
        - Patients between 134% - 165% receive a 50% discount
        - patients between 101-133% receive a 75% discount
    - Persons with incomes below 100% FPL must pay no more than a nominal fee for each service.

Thus, for each service listed on the FQHC's fee schedule, there are at least five potential charges, and the charges billed to an individual patient is determined by their income.

Furthermore, in the event that a patient cannot afford the discounted fees established under the Chapter 9 rules, Chapter 16 of the Compliance Manual requires that "[t]he health center must assure that any fees or payments required by the center for health care services will be reduced or waived in order to assure that no patient will be denied such services due to an individual's inability to pay for such services."

Also note that FQHCs are required to provide discounts not only to uninsured patients, but also to "underinsured" patients – defined as persons whose insurer would require them to pay more out-of-pocket for an FQHC service than they would pay under the FQHC sliding fee scale.[7] Thus, FQHCs are also structured to prevent underinsured patients from getting hit with surprise – and unaffordable – medical bills for services.

With this background, we will now discuss how the IFR proposals would impact FQHC patients and operations.

[6] https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html#titletop

[7] For example, consider a service for which a FQHC's fee schedule charge (without discounts) is $100, and the discounted charge for a patient at 150% FPL is $20. If that patient has insurance with a high deductible that requires them to pay the full $100 out-of-pocket, the FQHC is required to reduce their charge to the $20 sliding-fee charge, provided that the reduction does not violate its contract with the insurer. If the patient has met their deductible but has a $35 copay for the service, the FQHC is again required to reduce the charge to the $20 sliding fee level, subject to any restrictions in the insurance contract.

B. The current IFR rules provide no added value to FQHC patients; do not fit with the FQHC model of care; and impose enormous administrative demands on FQHC operations.

In response to the following statement in the IFR: "HHS is seeking comment on how the required methods for providing a good faith estimate to uninsured (or self-pay) individuals established under 45 CFR 149.610 may affect small or rural providers or facilities," we offer that *FQHC*s already meet "the spirit" of the No Surprises Act. However, complying with the 'letter of the law' (as established in the IFR) would:

- Provide no added value for FQHC patients;
- Be practically impossible in many ways, as these requirements do not fit with the FQHC model of care and compliance framework; and
- Impose enormous administrative demands on FQHC operations and staff.

1. The IFR's GFE requirements would provide no added value for FQHC patients, as FQHCs are already subject to extensive requirements that prevent surprise billing.

As previously stated, FQHCs in Vermont and New Hampshire strongly support the idea that patients should not be subject to surprise, unaffordable bills for health care services. A commitment to ensure that care is affordable for all patients has been the core of the FQHC model for over 50 years.

While some health care organizations may seek to hide information about their actual charges and potential discounts, FQHCs do the opposite – they proactively share this information with uninsured and underinsured patients. FQHCs begin by advertising that they offer sliding fee discounts on services – on their webpage, in their clinical spaces, near where appointments are scheduled, etc. Chapter 9 of the Compliance Manual requires that:

> The health center has mechanisms for informing patients of the availability of sliding fee discounts (for example, distributing materials in language(s) and literacy levels appropriate for the patient population, including information in the intake process, publishing information on the health center's website).

On an individual level, every new FQHC patient who indicates that they are uninsured or self-pay is immediately assigned to meet with an outreach worker when they first contact the FQHC.[8] The outreach worker first seeks to help them enroll in insurance, if possible. If the patient remains uninsured (or underinsured), the outreach worker will then determine the level of discounts for which the individual is eligible. This includes determining/verifying the patient's income, according to the rules established by HRSA and the specific policies and timeframes established by the FQHC's patient-led Board of Directors. Once the patient's "discount class" is determined, the outreach worker then explains to the patient how much they will pay for various standard services. (As discussed above, each FQHC has a minimum of five different charges for each service, and the outreach worker indicates to the patient which charge level applies to them.)

FQHCs are required to hire and train their outreach workers in a manner that ensures that all FQHC patients receive this charge information in a language, and at a literacy level, that is appropriate for

[8] If the patient's medical needs are urgent, the FQHC's first priority will be to provide them appropriate care; however, they will be assessed for sliding fee discounts and provided information on their expected charges as soon as is appropriate.

them. FQHCs are also required to ensure that outreach workers are available to meet with patients upon request to discuss financial and other issues. In addition, outreach workers are required to reevaluate patients' income on a regular basis, to determine if they have moved to a different "discount class." Thus, FQHCs provide all uninsured and underinsured patients with personalized information about their charges as soon as they begin seeking care and provide them with updated charge information on a recurring basis.

One example of this from a Vermont FQHC is that they have a patient who pays $5 per month regardless of the service cost. For this patient, who seeks regular mental health services with copayments required, having a stable, consistent, reasonable payment plan gives them peace of mind to focus on their care. This custom arrangement was possible because the FQHC's goal is to meet the patient where they are and support the patient every step of the way.

Finally, FQHCs' compliance with these requirements is strictly monitored and enforced. Every FQHC is assigned a HRSA Project Officer who communicates with them regularly to ensure compliance and resolve any issues. Also, at least once during their grant cycle (which can range from one to three years), outside reviewers visit each FQHC to evaluate their compliance with this (and many other) program requirements. FQHCs that fail to comply with these standards risk losing their federal grant and other benefits associated with their FQHC status.

In summary, current requirements already ensure that:

- FQHC patients:
    - Receive personalized information about how much they will be charged for services when they first seek care at an FQHC.
    - Receive updated charge information every time their income is re-evaluated, per the FQHC's Policies and Procedures.
    - Can meet with an outreach worker at any time to review, update, or ask questions about how much they will be charged.
    - Are regularly reminded -- at care delivery sites and on the website – about the availability of sliding fee discounts based on income.

  All of this information is provided in a language and literacy level that is appropriate for the patient.
- FQHCs are regularly assessed for compliance with these and other requirements and face significant repercussions for any non-compliance.

For these reasons, "surprise bills" are not an issue for FQHC services – and GFEs (as required under the IFR) would provide no added value for FQHC patients. Recognizing that our FQHC patients often experience barriers to health literacy, outreach staff work hard to remove those barriers and meet the unique needs of the patient. The new GFE would make this dynamic even more challenging for both patients and FQHC staff.

2. The legislative and regulatory requirements for GFEs often "do not fit" with the FQHC model of care, demonstrating that the GFE requirements are generally inappropriate for FQHCs.

As CMS is well aware, the No Surprises Act provides detailed instructions for what information must be contained in a GFE. However, these requirements often do not fit with the FQHC model of care, demonstrating that the GFE requirements, as promulgated in the IFR, are generally inappropriate for FQHCs:

- FQHCs cannot include diagnostic codes for patients who have never been evaluated for their current concern. The Federal statute explicitly requires that all GFEs include diagnostic codes, which indicates that Congress intended for GFEs to be provided in situations where a patient's diagnosis is already known. For many FQHC (and other primary care) visits, a patient's diagnosis cannot be known until they are actually assessed by a practitioner (e.g., a new patient who calls to make an appointment, an established patient coming in for a new complaint.) Thus, it is often impossible for an FQHC to include diagnostic codes on a GFE, demonstrating that this legislative requirement simply does not "fit" with the type of care that FQHCs provide.

- As outlined above, every FQHC has a minimum of five different charges for every service it provides. These charges range dramatically, from a nominal fee for persons with incomes below 100% FPL to full price (based on prevailing rates) for persons with incomes above 200% FPL. In many cases, an FQHC cannot know which of these charges will apply to a specific patient until the patient meets with an outreach worker. This applies to both brand-new patients who have never been to the FQHC before and existing patients who haven't met with an outreach worker recently and are due for a reassessment of their income and eligibility for discounts. Thus, for many patients and visits, it is impossible for FQHCs to provide a reasonable "Good Faith Estimate" of expected charges in advance of these patients meeting with the outreach worker. However, upon meeting with the outreach worker, these patients will have their expected charges outlined and explained to them and have an opportunity to ask questions about them. Thus, the outreach worker effectively provides the patient with a Good Faith Estimate of their expected charges – making any additional documentation redundant.

- The $400 threshold for the dispute resolution process suggests that the standard GFE rules are intended for higher-charge providers. The IFR indicates that the patient-provider dispute resolution process is available for patients whose actual charges for services are at least $400 above the GFE. This $400 variance is far above the usual range of charges that FQHCs typically charge their uninsured and underinsured patients for services[9]. The fact that the dispute resolution process is the primary enforcement mechanism for the IFR -- and that FQHC service charges for uninsured and underinsured patients would rarely meet this threshold --- again suggests that the standard IFR GFE rules do not "fit" for FQHCs and that the Congressional intent behind this effort should exclude most, if not all, FQHC services.

3. The IFR GFE requirements would pose enormous administrative demands on FQHCs – for no added value.

Complying with the current IFR rules would place enormous administrative demands on FQHCs at a time when they are already stretched to unprecedented levels. In addition to generating, delivering, and storing the GFEs, FQHCs would also need to respond to the confusion and misunderstandings that they would produce. There would also be significant expense to add space (either physical or electronic) to store all these files and maintain these records. We are concerned that these new requirements do not come with additional financial and technical support for FQHCs to implement.

[9] FQHCS provide a few items – e.g., dentures, eyeglasses – whose charges for uninsured and underinsured patients could reach as high as $400. Please see the section on alternatives for our recommendations on how GFE rules should apply to these higher-cost items at FQHCs.

While these new administrative demands would be daunting at any time, FQHCs would be particularly challenged to implement them for calendar year 2022. Even without any new GFE requirements, FQHCs are already stretched to unprecedented levels amid the ongoing COVID-19 pandemic and related workforce challenges.

- FQHCs have been on the front lines of the COVID-19 pandemic since day one. FQHCs in Vermont and New Hampshire have been crucial in the fight against COVID-19 since the earliest days of the pandemic, remaining open throughout the public health emergency, expanding hours, ramping up telehealth visits to meet evolving patient needs, and doing outreach to make sure families do not forego routine care. FQHCs in both states have provided tens of thousands of COVID-19 tests throughout the pandemic, offering outdoor and drive-thru testing for community members, health care workers, and first responders, and providing transportation vouchers to vulnerable patients. Many FQHCs have acquired mobile health clinics to take immunizations, COVID-19 testing, and other services including behavioral health care out into their communities to ensure that hard-to-reach populations are being served. FQHCs are so crucial to the Biden Administration's vaccination and health equity efforts that it created a special program to distribute COVID-19 vaccines directly to FQHCs, with several FQHCs in Vermont and New Hampshire participating. Currently, the Administration is developing plans to send millions of free tests (both at-home and in-clinic) to FQHCs. FQHCs have willingly taken on these crucial roles as they are a part of their mission.
- Staff capacity is being stretched to a breaking point. All of the aforementioned services are being provided in addition to the comprehensive primary care, preventive, and enabling services that FQHCs regularly provide to their patients, with no substantial increase in staff capacity. The pandemic has exacerbated significant recruitment, retention, and workforce pipeline challenges that already existed in both Vermont and New Hampshire and has led to high rates of burnout among providers and frontline staff. These small rural states experience unique challenges that put them at a particular disadvantage for hiring, retaining, and recruiting health care providers and support staff, including aging demographics, lack of public transportation, and low housing stock. Furthermore, both states have been experiencing record high levels of COVID-19 cases and community transmission for the last several weeks and these concerning trends are expected to continue. Despite these challenges, our FQHC workforce overall is dedicated to providing the best care to patients and has been working incredibly hard to ensure that the needs of the vulnerable populations are being met.

In conclusion, requiring FQHCs to comply with the IFR as currently written would:

- Provide no added value for FQHC patients.
- Be operationally and practically impossible in many ways, as these requirements do not fit with the FQHC model of care; and
- Imposing enormous administrative demands on FQHC operations that are already stretched incredibly thin due to the impacts of the pandemic and acute workforce challenges.

C. ALTERNATIVE TO IFR POLICIES FOR FQHCs

This section of our comments responds to the following request in the IFR:

HHS is particularly interested in whether there are alternatives to these interim policies that HHS could consider for potential future rulemaking that could meet the statutory requirements for provision of good faith estimates to uninsured (or self-pay) individuals.

As discussed above, long-standing requirements already ensure that patients do not receive "surprise bills" for FQHC services. These include the following:

- No FQHC patient is denied care due to an inability to pay.
- Charges for FQHC services are discounted based on each patient's ability to pay.
- FQHC patients meet regularly with outreach workers who provide them with personalized information about discounts and charges.
- Except for two situations (discussed below), FQHCs' discounted charges to the uninsured and underinsured are not in a range that could be underestimated by $400 – the threshold for initiating the patient-provider dispute resolution process.

For these and other reasons, the current IFR rules are generally not appropriate for FQHCs and should not be applied uniformly to them.

However, there are two rare situations in which an uninsured or underinsured patient could potentially get an unusually large "surprise" bill from an FQHC. (We define an "unusually large" bill as $400 or more, as CMS has established $400 as the threshold for the initiating the dispute process.) These situations are:

- When a patient receives certain high cost "items" such as dentures or eyeglasses but is not informed about the associated charges in advance. Technically, Section 330 sliding fee discount rules do not apply to these types of high-cost items. One expectation for FQHCs to demonstrate compliance with the billing and collection requirements outlined in Chapter 16 of the Compliance Manual is that FQHCs must inform the patient of these types of charges in advance. However, as this is not an official "requirement," it is possible that an FQHC might not do so.
- When an uninsured or underinsured person has an income above 200% FPL and is scheduling or requesting information on services that, in total, might potentially cost $400 or more. While the exact percentages are unknown, FQHC patients in Vermont and New Hampshire who have incomes above 200% FPL typically have private insurance. Also, if such a person were to be facing a large bill for services, the Compliance Manual expects the FQHC to work with them to make the bill affordable, established in "operating procedures, that include the specific circumstances when the health center will waive or reduce fees or payments required by the center due to any patient's inability to pay." Nonetheless, there is still a tiny possibility that an uninsured patient above 200% FPL could receive a bill that exceeds $400.

Therefore, CMS might determine that in order to "meet(s) the statutory requirements for provision of good faith estimates to uninsured (or self-pay) individuals," the IFR rules could apply to FQHCs in situations where a patient might receive a bill that could total as much as $400. This approach would:

- Avoid placing requirements on FQHCs that have no added value, will create confusion, etc.; while,
- Ensuring that FQHC patients receive a formal GFE any time there is even a remote possibility that they might qualify for the provider-patient dispute resolution process.

In these situations, we would propose that patients be required to meet (or have recently met) with an outreach worker prior to receiving the GFE. While we recognize that this requires an extra effort for patients (beyond simply initiating an appointment or request), we consider it worthwhile as it would

enable the FQHC to provide exact charge information – based on their unique financial situation – as opposed to a broad range of possible fees. Also, while we think such a requirement is unnecessary, CMS could formally require that FQHCs guarantee a patient an opportunity to meet with an outreach worker within the statutory timeframes for providing a GFE – assuming that they have not met with the outreach worker recently. We are also interested in exploring the possibility of whether ONC-certified electronic medical records could include, at no additional cost to the medical practice, an estimator for the GFE. This could provide additional information for the FQHC outreach workers and facilitate individualized payment arrangements.

In summary, we offer the following recommendation for how CMS can "meet the statutory requirements for provision of good faith estimates to uninsured (or self-pay) individuals":

CMS should recognize that existing statutory requirements protect FQHC patients from surprise bills. If necessary, CMS could require FQHCs to issue GFEs to patients who:

a. Have been evaluated by an outreach worker to determine their eligibility for discounts; and
b. Are scheduling/requesting charges information for items or services for which their expected charges (factoring in the discounts for which they are eligible) could be $400 or greater.

D. CHANGES NEEDED TO CURRENT IFR

As discussed above, the GFE rules in the IFR do not "fit" with the FQHC model of care or patient population and should be adjusted to reflect the wide range of surprise billing protections that FQHCs have had in place for years. However, in the event that CMS insists on applying the current IFR rules to FQHCs, we strongly urge CMS to make the following adjustments:

1. **Delay implementation of and/or compliance with the GFE requirement**
   CMS should delay implementation of and/or compliance with the GFE requirement until the latest of the following: 1) the date as of which *all of the requirements* in Section 112 of the No Surprises Act have been implemented via regulation, most notably those that apply to health plans; 2) a minimum of six months after the expiration of the federal public health emergency (PHE); and/or 3) specific to FQHCs, CMS has communicated with the Bureau of Primary Health Care on ways to reduce redundancy and potential conflict between the GFE requirement and the FQHC model of care and Sliding Fee Discount Schedule.

2. **Use enforcement discretion when working with FQHCs that are demonstrating a good faith effort to implement the new GFE rules.**
   As previously discussed, FQHCs are already stretched very thin, between the COVID-19 pandemic, significant workforce challenges, and staff vaccination rules. Over the coming year, FQHCs need to focus their efforts on continuing to battle the pandemic, rather than implementing new rules that provide no added value while imposing enormous administrative demands without dedicated financial and technical support for implementation. CMS should consider application of flexibilities surrounding civil monetary penalties and related hardship exemptions included in the Proposed Rule (NPRM) entitled, "Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement," to protect FQHCs and reduce redundancy and potential conflict.

3. **Do not require that GFEs include diagnosis codes for patients who have not yet been seen by an FQHC clinician, or who are coming in for a new issue.**
   As discussed above, it is impossible for FQHCs to know the appropriate diagnostic codes when a new patient schedules an appointment, or an existing patient schedules an appointment for a new reason.

4. **Require GFEs to be <u>offered</u> every time a patient schedules an appointment at least 3 days in advance, but to be provided only if the patient requests it.**
   Many patients make frequent visits to the FQHC, but not on enough of a pre-planned basis to qualify as "recurring" visits. (For example, consider a patient with a chronic illness who comes in for check-ups, when having a flare-up, and when new symptoms arise.) Assuming no changes to their income, these individuals already know how much they will pay each time; requiring the FQHC to provide them with a new GFE for each new appointment is highly inefficient.

5. **Do not require facilities to provide patients with a new GFE if an identical one was recently provided.**
   The IFR requires that a patient may receive a GFE for a specified service without making an appointment to receive the service. If, after reviewing the GFE, the patient chooses to schedule an appointment for the service, the IFR requires the provider to issue a new GFE. We agree that a new GFE is appropriate if there have been any changes from the original GFE; however, in situations where there have been no changes, it is redundant to issue a new GFE. Instead, the facility should have the option to say that the original GFE is still valid, and to include an expiration date on the GFE.

We thank you for your consideration of these comments, and for your efforts to protect all patients from surprise medical bills. If you have any questions, please contact Georgia Maheras, Vice President of Policy and Strategy (gmaheras@bistatepca.org).

Sincerely,

Lori Real
Lori H. Real, MHA
Acting Interim Chief Executive Officer