HEALTH CENTER PARTNERS
of Southern California

December 5, 2021

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

The Honorable Ali Khawar
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
Deputy Commissioner for Services and Enforcement
Internal Revenue Service

The Honorable Mark J. Mazur
Acting Assistant Secretary
Department of the Treasury (Tax Policy)

RE: CMS-9908-IFC, Interim Final Rules with Request for Comments; Requirements Related to Surprise Billing; Part II

Dear Mses. and Messers. Brooks-LaSure, Khawar, Bodenheimer, O'Donnell and Mazur:

On behalf of Health Center Partners of Southern California (HCP), representing 17 member organizations, including 12 Federally Qualified Health Centers, 4 Indian Health Centers, and Planned Parenthood of the Pacific Southwest, I am writing to provide comments on the above-referenced interim final rule ("the IFC") and request swift action by the Office of Personnel Management, Department of the Treasury, Department of Labor, and Department of Health and Human Services ("the Agencies"). Members of the HCP primary care association are the core of the regional health care delivery system, operating over 160 practice sites across five counties, serving 917,000 patients with 3.9 million patient visits annually, and generating $2.2 billion in economic impact to the region and $1.4 billion in savings to Medicaid.

I am requesting the following:

- Exclude Community Health Centers (CHCs), Planned Parenthood, and Indian Health Centers from the obligation under the regulations to furnish a good faith estimate by amending the definitions of "facility" and "provider" under 45 C.F.R. § 149.610.
- Delay implementation of and/or compliance with the good faith estimate requirement until CMS completes review of this interim final rule and/or a minimum of six months after the expiration of the federal public health emergency (PHE), whichever is later.

I strongly support the goals behind the No Surprises Act to improve consumer access to accurate information about the costs of health care services, and to reduce the occurrence of surprise medical bills. However, Community Health Centers already operate under a robust and comprehensive federal regulatory administration that already advances these goals and provides these protections for low-income and medically underserved individuals.

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CHCs provide quality health care services to a diverse population with more than 70% of patients being people of color. **By mission, CHCs focus on providing culturally and linguistically diverse services to low-income and non-English speaking communities regardless of their ability to pay and immigration status.**

Community Health Centers receive grant funding under Section 330 of the Public Health Service Act (PHSA). So, unlike other providers, CHCs have already extensive obligations to their patients (as a condition of their 330 grant funding) and must meet a host of federal program requirements aimed at ensuring they provide comprehensive primary care services to underserved populations in underserved areas, regardless of patients' ability to pay or their insurance coverage. **I have strong concerns the additional good faith estimate requirements would not only be redundant but also directly undermine existing CHC patient protections.**

Currently, CHCs must already:

- Prepare and maintain a schedule of fees or payments for the provision of their services, consistent with locally prevailing rates and designed to cover their reasonable costs of operation.

- Establish and maintain a schedule of discounts to be applied to the payment of such fees. Discounts must be available for all patients with income at or below 200% of the Federal Poverty Guidelines, with discounts structured in tiers based on the patient's income level. Patients with income under 100% FPG are provided with services free of charge or at most, at a nominal charge.

- Screen and register each new patient, which includes determining their insurance status, income level, and eligibility for the sliding fee discount program (SFDP) and must re-evaluate the patient's discount eligibility periodically.

- Educate patients on insurance or related third-party payment options available to them.

When CHC services are furnished via contract or formal referral arrangement with another provider, the CHC must ensure the contracted or referral provider also provides discounts to low-income patients. Additionally, if the CHC provides supplies or equipment related to but not included in the service itself, the CHC must inform patients of the charges before service.

I am deeply concerned applying the two sets of requirements would be excessively duplicative and redundant for staff and patients. In practice, these requirements make it essentially impossible for a patient at or below 200% FPL to receive a medical bill higher than the fee information they would have already received through the SFDP, let alone an amount that meets or exceeds the $400 threshold to trigger a dispute resolution. Additionally, the Section 330 requirement that assures CHCs' patients are not denied services based on their ability to pay applies to *all* CHC patients, not only those with income at or below 200% FPG. In most cases, a dispute resolution process would be unnecessary where a patient has a concern about potential charges for a CHC appointment, because CHCs already have an obligation to work through such issues with patients. If there is an issue related to a patient's inability to pay, CHCs may, to the extent authorized by their board-approved policies, provide discounts, as needed.

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Additionally, the good faith estimate requirement, which is oriented toward commercial health care settings and collections policies, may deter some patients from accessing services. Under the regulation, the estimate is required to be accompanied by various disclaimers, including notice of the "individual's right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess of the expected charges." The regulatory language conveys a "take-it-or-leave-it" approach that is inconsistent with the mission and vision of health centers. For decades, CHCs have demonstrated their ability to effectively communicate with and serve a unique patient population. This requirement will undermine this relationship. Simply put, it is unreasonable to place these additional operational and financial burdens on CHCs.

Finally, CHCs will incur significant costs and operational changes - such as reconfiguring staff responsibilities so "back-office" clinical and coding personnel can provide "front-office" administrative staff with information about potential diagnoses, service codes, and applicable discounts – all at a time when CHCs are already facing staffing shortages and new service demands due to the ongoing COVID-19 pandemic. To comply with the good faith estimate requirements, CHCs will be forced to divert their already limited funds and personnel from the costs and priorities of serving low-income patients to funding an administrative burden – which is unlikely to provide any benefit for CHC patients, who already receive services on a free or highly-discounted basis.

I respectfully request the Agencies to use their discretion under the No Surprise Act to define the terms "facility" and "provider" for purposes of the good faith estimate requirement in Section 112. I also recommend the Agencies define these terms to OMIT Community Health Centers, Planned Parenthood, and Indian Health Centers. Until these actions can be taken or until six months post PHE, whichever is later, I ask implementation of this rule be DELAYED.

I appreciate the opportunity to comment on this IFR and urge the Agencies to take the actions described above in these comments to ensure the implementation of the No Surprises Act does not compromise the effectiveness of CHCs. For a fuller discussion of the changes requested, please see the comments submitted by the National Association of Community Health Centers (NACHC) and the California Primary Care Association (CPCA).

Sincerely,

Henry N. Tuttle
President and Chief Executive Officer

Cc: HCP Board of Directors
NACHC
CPCA

Health Center Partners of Southern California, a family of companies, includes a 17-membership organization of federally qualified health centers, Indian Health Services Organizations, both urban and sovereign, and Planned Parenthood of the Pacific Southwest, collectively serving 917,000 patients each year, for 3.9 million patient visits each year, at 160 practice sites across San Diego, Riverside and Imperial counties, and is the seventh largest provider group in the region. Read our latest Impact Report.