October 18, 2021

The National Association of Community Health Centers (NACHC) and OCHIN are submitting comment on the Proposed Rule (NPRM) related to “Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement” promulgated by a group of federal agencies (“the Agencies”) on September 16, 2021, implementing certain provisions of Title I (No Surprises Act) and Title II (Transparency) of Division BB of the Consolidated Appropriations Act.

NACHC is the national membership organization for Community Health Centers (also known as Federally Qualified Health Centers (FQHCs) or health centers). Health centers are federally funded or federally supported nonprofit, community directed provider clinics serving nearly 29 million people, including 1 in 5 Medicaid beneficiaries and 1 in 3 people living in poverty. It is the collective mission and mandate of the 1,400 health centers around the country to provide access to high-quality, cost-effective primary and preventative medical care as well as dental, behavioral health, and pharmacy and other “enabling” or support services that facilitate access to care to people located in medically underserved areas, regardless of insurance status or ability to pay.

OCHIN is a national nonprofit health information technology and research network that for over two decades has provided technology solutions, informatics, evidence-based research, and policy insights for providers in underserved communities. OCHIN serves over 1,000 community health care sites with 21,000 providers in 47 states serving nearly 6 million patients. In addition to FQHCS and other community-based clinics including, OCHIN supports Ryan White HIV/AIDS centers, local public health agencies, corrections, school-based mental health programs, youth authorities, and rural providers. The OCHIN
network was built with federal funding and produces research and data-driven best practices that reduce cost and improve health outcomes for patients who are more medically and socially complex as a result of systemic inequities. Among OCHIN’s network members’ patients are 57% women, 7% Asian, 19% Black, and 36% Hispanic/Latinx. In addition, 3 out of 5 have chronic conditions, 1 out of 3 are best served in a language other than English, half have Medicaid coverage, and another quarter are uninsured. OCHIN is the only national research network that systematically includes data on the uninsured and underinsured and leads one of the largest and most complete research data warehouses representing underserved patients in the United States.

**THE CHALLENGES OF IMPLEMENTATION AMONG PROVIDERS AND FACILITIES IN UNDERSERVED COMMUNITIES**

The ability of NACHC members and OCHIN network members to be in compliance with the provider transparency requirements of the No Surprises Act by January 1, 2022, involves an extraordinary effort across a full range of health center departments. The needed changes will impact clinic workflow, operational billing services, revenue cycle, member services including training and health information technology systems re-engineering and technical support. Preparing all clinic sites and staff for re-engineering processes and addressing unanticipated challenges would normally take at least 6 months absent a global pandemic. Currently, staff burnout, retention challenges – including for administrative and health information technology staff – and the growing need for clinical services among underserved communities will require additional lead time. It will be immensely challenging to accomplish this in less than three months and is further confounded by existing processes in place among most providers related to providing information on clinic fees and other steps taken to ensure cost and expense does not deter patients from seeking health care services.

Related to this last point, under Section 330 of the Public Health Service Act (PHSA), every community health center is required, as a condition of its Section 330 grant or FQHC look-alike status, to undertake a raft of measures that provide clarity and transparency about expected costs to a patient. They include the following:

- The health center must prepare a schedule of fees for the provision of their services consistent with locally prevailing rates or charges and designed to cover their reasonable costs of operation.
- The health center must reduce fees or payments required under its schedule of charges, as necessary, to ensure that no patient will be denied services due to inability to pay.
- The health center must implement a schedule of discounts, providing for a full discount (or only nominal fee) to individuals and families with annual incomes at or below 100% of the Federal Poverty Guidelines (FPG) and a set of tiered discounts for patients with income between 101% and 200% FPG.
- The health center is required to register each patient, a process that includes assessing whether the patient, on the basis of household income, qualifies for the sliding fee discount, and determining the patient’s insurance or uninsured status. It must also reassess the patient’s sliding fee eligibility status periodically. (PHSA § 330(k)(3)(G)(i), (iii); HRSA, Program Compliance Manual, Chapters 9 (Sliding Fee Discount Program) and 16 (Billing and Collections).
- So extensive are CHCs’ obligations to communicate with patients about fees, that the CHC must specifically inform patients in advance if the CHC intends to provide supplies or equipment to the

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1 All of the reference data analytics, including these percentages reflect the 137 OCHIN network members that use OCHIN Epic.
patient (such as eyeglasses, prescription drugs, or dentures) that are excluded from the services subject to the sliding fee discount schedule. HRSA, Program Compliance Manual, Chapter 16.

While we very much recognize the goals of the No Surprises Act and the associated rulemaking to protect patients, elements of it redundantly layer on top of previously existing federal requirements that would divert critical time, energy, and resources health centers need to provide care on a prompt basis to vulnerable populations.

We feel confident that the practices that precipitated passage of No Surprises Act are not a serious concern at community health centers who treat underserved communities.

THE NO SURPRISES ACT IMPLEMENTING REGULATIONS DRIVE STRUCTURAL INEQUALITY

It is important to emphasize that the Interim Final Rules (Part I and Part II) and this proposed rule related to enforcement will exacerbate the current crisis among patients and providers in underserved communities already coping with the COVID-19 pandemic and the need to address the mental health and substance use disorder crisis. Despite significant existing federal health program reporting obligations and price transparency policies and practices mandated by existing federal and state program participation requirements, the Interim Final Rules and this proposed role would impose largely duplicative, costly, and complex additional notice and price transparency requirements that in the short-term will increase confusion for both providers and patients and re-direct resources that are already stretched thin away from patient care.

As an initial matter, we note that it is our understanding that only an extraordinary circumstance would result in a community health center or clinic being subject to civil monetary penalties (CMPs) under the No Surprises Act and 45 C.F.R. Part 150, as set forth in the Proposed Rule. As we understand it, the CMP provisions would apply to providers (i.e., used to enforce provisions in Part E of Title XVII of the Public Health Service Act) only in those situations where states have substantially failed to enforce those provisions, and in addition, the enforcement apparatus (as relates to providers) is focused chiefly on the balance billing prohibitions in Section 104 of No Surprises Act (Sections 2799B-1 and 2799B-2 of the PHSA). Further, Section 112 sets forth an independent enforcement mechanism for the provider transparency rules via the patient-provider dispute resolution process, which CMS has implemented through the Interim Final Rule published October 7, 2021, with the provider transparency requirements and dispute resolution process described respectively at 45 C.F.R. §§ 149.610 and 149.620. HHS noted, nonetheless, in the preamble to the NPRM that a provider could conceivably be subject to CMPs with respect to the provider transparency rules in Section 112 of the No Surprises Act, if it intentionally provided false information about expected charges in the good-faith estimate required in that section. 86 FR at 56029. We urge HHS to clarify in the final rule that the enforcement provisions in the NPRM would generally have very limited application to the provider transparency rules (45 C.F.R. § 149.610), so long as providers are making a good faith effort to furnish the required information to consumers. We further suggest that HHS add that limitation to the text of the regulation in 45 C.F.R. § 150.513(b).

CIVIL MONETARY PENALTY MITIGATING CIRCUMSTANCE FOR FQHCS, COMMUNITY CLINICS, AND RURAL PROVIDERS IN UNDERSERVED COMMUNITIES

Further, we recommend changes to the enforcement provisions in the NPRM to recognize the unique situation of safety-net providers. HHS proposes that for every violation subject to a CMP, if there are substantial or several mitigating circumstances, the aggregate amount of the penalty would be set at an
amount sufficiently below the statutory maximum of $10,000 to reflect the mitigating circumstance. CMS proposes several factors as mitigating circumstances. Our organizations strongly urge the Administration to specify that a heavily weighted mitigating circumstance would be the limited resources and funding available for administrative and compliance activities in FQHCS, other community clinics, and rural providers. Community health centers stretch funding to provide equitable care, since they are required by federal law to treat all patients regardless of ability to pay.

**CMP HARDSHIP EXEMPTION FOR FQHCS, COMMUNITY CLINICS, AND RURAL PROVIDERS IN UNDERSERVED COMMUNITIES**

In the proposed rule, HHS recognizes that there may be certain circumstances in which imposition of a civil money penalty would create a significant financial hardship for a provider or facility. The Agency notes that various circumstances may give rise to financial hardship, potentially including the financial impact of natural disasters or public health emergencies, provider disability or death, and provider solvency concerns. The *No Surprises Act* allows HHS to establish a hardship exemption to the civil money penalties that would otherwise be imposed for a violation of Part E of Title XXVII of the PHS Act. HHS proposes to codify the hardship exemption in 45 CFR 150.513(g).

Our organizations strongly support establishing a hardship exemption and urge the Agency to codify in regulation that the hardship exemption presumptively applies to FQHCs, other community clinics, and rural providers in underserved communities. In short, the resources to comply with these requirements, in addition to the resources required to navigate an investigation and administrative dispute process, will likely be prohibitively costly and directly impact our ability to deliver care to underserved communities. Since it is a proposed presumption, it could be overcome if the government is able to demonstrate that it will not result in the diversion of funds and resources away from patient care and the operations needed to ensure equitable access.

**DELAY COMPLIANCE FOR SIX MONTHS AFTER COVID-19 PHE**

The adverse impact of the COVID-19 public health emergency has fallen heaviest on underserved communities and their providers. Imposing a complex and resource intensive set of requirements on community clinics and other providers in underserved communities directly diverts time and resources away from patient care and drives structural inequality and adverse outcomes. While NACHC and OCHIN association and network members are able to leverage economies of scale as well as technical support and assistance, it will require a diversion of staff time, training, and resources away from COVID-19 vaccinations and other critical health care services. Given the disproportionate impact on Communities of Color and others facing structural inequality, this is inconsistent with the President’s Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. We

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2 In the proposed rule, CMS provides that it would consider the provider or facility’s record of prior compliance. If, for example, the provider or facility implemented and followed a compliance plan before receipt of the notice of potential noncompliance, implementing and following such compliance plan would be considered a mitigating circumstance. If the provider or facility had no previous complaints against it for noncompliance, that would also be considered a mitigating circumstance. Second, CMS would consider the gravity of the violation(s). For example, it would be considered a mitigating circumstance if the provider or facility made adjustments to its business practices to come into compliance with PHS Act requirements so that the provider or facility: (i) identified all participants, beneficiaries, and enrollees, or all plans or issuers, that are or were wrongly billed; (ii) withdrew the bill or reimbursed the affected individuals, or plans or issuers, that were wrongly billed so that, to the extent practicable, the affected individuals, plans or issuers are in the same position that they would have been in had the violation not occurred; and (iii) completed those adjustments to its business practices in a timely manner. Finally, it would be considered a mitigating circumstance if the provider or facility demonstrated that the violation was an isolated occurrence.
urge you to delay implementation of Section 112 of the *No Surprises Act* (the provider transparency requirements) until six months after the COVID-19 public health emergency has lifted, at a minimum.

As it stands, HHS has stated its intention to delay indefinitely the implementation of the advance explanation of benefits requirement with respect to insured consumers, but to proceed with a January 1, 2022, implementation date for the good-faith estimate of charges required for uninsured consumers under Section 112 of the *No Surprises Act*. This decision shifts a disproportionate administrative burden onto safety-net providers, such as community health centers. Nationally, 22% of health centers’ patients are uninsured, and thus, health centers would, effective January 1 of next year, have a significant new obligation to comply with a provision that would have a very minimal impact on providers and facilities that chiefly serve patients with private health insurance.

NACHC and OCHIN appreciate the opportunity to comment on the NPRM. We believe adoption of these approaches will prevent duplicative administrative burdens and regulatory requirements to ensure health centers can continue to fulfill their mission. Should you have any questions about our comments, please feel free to contact Jeremy Crandall, Director of Federal and State Policy, at jcrandall@nachc.org or Jennifer Stoll, Executive Vice President, at stollJ@ochin.org.

Sincerely,

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