November 12, 2021

The Honorable Xavier Becerra  
Secretary  
Office of the Secretary  
Department of Health & Human Services

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

The Honorable Martin J. Walsh  
Secretary  
Office of the Secretary  
Department of Labor

The Honorable Ali Khawar  
Assistant Secretary  
Employee Benefits Security Administration  
Department of Labor

The Honorable Kiran Ahuja  
Director  
Office of the Director  
Office of Personnel Management

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

The Honorable Charles P. Rettig  
Commissioner  
Internal Revenue Service

The Honorable Douglas W. O'Donnell  
Deputy Commissioner for Services & Enforcement  
Internal Revenue Service

The Honorable Janet Yellen  
Secretary  
Department of the Treasury

The Honorable Mark J. Mazur  
Acting Assistant Secretary  
Department of the Treasury

**RE: Interim final rule with comment period concerning Requirements Related to Surprise Billing; Part II**

Dear Secretary Becerra, Administrator Brooks-LaSure, Secretary Walsh, Assistant Secretary Khawar, Director Ahuja, Associate Director Bodenheimer, Commissioner Rettig, Deputy Commissioner O’Donnell, Secretary Yellen, and Acting Assistant Director Mazur:

On behalf of OCHIN, we appreciate the opportunity to provide comment on the *Interim final rule with comment concerning Requirements Related to Surprise Billing; Part 2* (IFR 2). 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. The IFR 2 imposes additional administrative burdens and cost as well as regulatory complexity disproportionately on community-based providers in underserved communities. Our network
members already shoulder substantially more documentation and reporting requirements than providers serving patients covered by commercial health insurance, face significant sustainability challenges in maintaining access to health care to medically and socially complex patients, and already provide fee transparency to patients while affirmatively informing them of discount and/or reduced fee eligibility based on income. In short, the good faith estimate (GFE) requirements in IFR 2 overlap with existing cost transparency requirements that community clinics receiving federal funding must meet. OCHIN strongly urges the federal government to deem community-based organizations that meet current federal program transparency and discounts requirements under, for example, the Public Health Services Act section 330, as compliant with the No Surprise Act good faith estimate (GFE) requirements. We further urge moving the implementation date until six months after the COVID-19 public health emergency terminates.

OCHIN serves approximately 1,000 community health care sites with 21,000 providers in 47 states serving nearly 6 million patients. In addition to federally qualified health centers (FQHCs) and other community-based clinics, 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 NO SURPRISES ACT IMPLEMENTING REGULATIONS DRIVE STRUCTURAL INEQUALITY

The Interim Final Rules (Part 1 and Part 2) and the recently issued proposed rule related to enforcement will exacerbate the current crisis among patients and providers in underserved communities already coping with the convergence of the COVID-19 pandemic and the mental health and substance use disorder public health crises. The adverse impact of COVID-19 has fallen heaviest on underserved communities and their providers. In addition to the significant federal health program reporting obligations, price transparency policies, practices mandated by existing federal programs administered by the Health Resources and Services Agency, and state health program participation requirements, the IFR 2 would impose duplicative, costly, and complex additional notice and price transparency requirements (the good faith estimate requirement). This is already creating confusion for providers, and we anticipate it will do so for patients, too. OCHIN along with our members are re-directing resources that are already stretched thin away from patient care. Given the disproportionate impact on communities of Color and others facing structural inequality, the duplicate notice and estimate requirement of the No Surprises Act is inconsistent with the President’s Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.

Further, 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 is immensely challenging to accomplish this in less than two months and is further confounded by existing processes in place among most community clinics 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. Community clinics are adjusting to new workflows and processes now that COVID-19 booster doses are authorized, and eligibility has opened to children ages 5-11. This is happening as the burnout rates monitored through a monthly network member staff survey launched by OCHIN in January 2020 is registering that 47% of clinicians report feeling burnout—the highest levels since the survey was initiated. Implementing numerous additional changes undermines resiliency at a time when providers need to roll-out the next round of COVID-19 vaccinations for eligible children, provide boosters for eligible adults, and implement new measures to address vaccine hesitancy. The complexity of the program is particularly pronounced for community clinics in underserved areas. For example, clinics are required to mail the GFE to patients if they cannot do so electronically. This will be more common for community clinics where patients may lack email. There are added challenges because our members serve a larger percentage of patients who are housing insecure or homeless as compared to providers serving a larger number of commercially insured patients. These present costly logistical challenges that divert resources.

DEEM PUBLIC HEALTH SERVICES ACT SECTION 330 GRANTEES SBA COMPLIANT

We urge the Administration to deem providers adhering to the Public Health Services Act Section 330 requirements related to fee transparency and discounts as compliant in all material ways with the No Surprises Act. Under Section 330 of the Public Health Service Act, every community health center is required to undertake several measures that provide clarity and transparency about expected costs to a patient. The requirements 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, based on household income, qualifies for the sliding fee discount, and determining the patient’s insurance or uninsured status. They must also reassess the patient’s sliding fee eligibility status periodically.
- So extensive are health centers’ obligations to communicate with patients about fees, that the health center must specifically inform patients in advance if the health center intends to provide supplies or equipment to the patient (such as eyeglasses, prescription drugs, or dentures) that are excluded from the services subject to the sliding fee discount schedule.

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1 Source: September Epic Clinical End User Satisfaction survey queried November 9, 2021.
2 See, HHS Announces $143.5 Million to Expand Community-Based Efforts to Address Barriers to COVID-19 Vaccination, November 10, 2021
3 (PHSA § 330(k)(3)(G)(i), (iii); HRSA, Program Compliance Manual, Chapters 9 (Sliding Fee Discount Program) and 16 (Billing and Collections).
4 HRSA, Program Compliance Manual, Chapter 16.
As the goals of the No Surprises Act and the associated rulemaking are meant to protect patients, the implementing regulation 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. Further, the practices that precipitated passage of the No Surprises Act are not a concern at community health centers that treat underserved communities because existing federal requirements provide both transparency and discounts based on income eligibility.

Further, OCHIN technical experts have already identified significant additional documentation and paperwork requirements that community clinic staff will have to undertake to demonstrate compliance in addition to fulfilling the complex (and, frankly confusing) requirements. OCHIN technical staff who focus on work-flow re-design, technical assistance, and educational programming have all expressed pronounced concern with rolling out this program because the requirements are challenging to map out and clearly and simply explain to community clinic staff who are already operating well beyond capacity given the unrelenting demands imposed upon them by the COVID-19 pandemic.

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

The ability of OCHIN network members to be compliant with the No Surprises Act requirements by January 1, 2022, involves an extraordinary effort across a full range of OCHIN departments as 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 the clinic sites and staff for re-engineering processes and addressing unanticipated challenges would normally take at least 6 months, pre-COVID-19. Currently, staff burnout, retention challenges (including for administrative and health information technology staff) and the growing need for clinical services among underserved communities means additional lead time is needed. This will be a challenge with less than two months and is further confounded by existing processes in place among most providers related to providing information on clinic fees, among other steps taken to ensure cost and expense does not deter patients from seeking health care services.

We 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, the government 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 GFE required for uninsured consumers under Section 112. This decision shifts a disproportionate administrative burden onto safety-net providers, such as community health centers and is a clear example of federal policies driving structural inequality. 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 insured patients.

We urge the federal government to deem community clinics already meeting transparency and discount requirements of federal health care programs such as those required by Public Health Services Act section 330 grantees as compliant with the No Surprises Act. Adopting this solution will address structural inequality and prevent duplicative administrative burdens and regulatory requirements so that health centers can continue to fulfill their mission. Should you have any questions about our comments, please
feel free to contact me at stollJ@ochin.org. We appreciate the opportunity to comment and welcome working with the Administration.

Sincerely,

Jennifer Stoll
Executive Vice President
Advocacy, Policy and Partnerships