

August 11, 2021

William N. Parham
Director, Paperwork Reduction Staff
Regulations Development Group
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mailstop: C4-26-05
Baltimore, MD 21244

**Subject: CMS Form Number 10780: OMB Control Number: 0938-XXXX,
Requirements Related to Surprise Billing Regulations: Standard Notice and
Consent Documents and Model Disclosure Notice Regarding Patient Protections
Against Surprise Billing Instructions for Providers and Facilities**

Dear Mr. Parham:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) thanks you for this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) guidance documents implementing the No Surprises Act's provisions related to notice and consent and public disclosure. The focus of these comments are specific to these instructions and forms. We will provide in a separate letter more extensive comments pertaining to the underlying policies for the notice and consent and public disclosure requirements included in the July 13 interim final rule.

The No Surprise Act (NSA) requires that CMS develop guidance for providers and facilities on the notice-and-consent process to be used for patients choosing to waive their balance billing protections, as well as the public disclosure process to inform patients of these protections. In general, the guidance documents reflect the requirements in the law; however, they present some logistical and operational challenges for providers, particularly related to notice-and-consent documents. **While we share the objective of ensuring patients have the information they need to make informed decisions about their care, we believe steps must be taken to accomplish this goal without adding unnecessary costs and burdens to the health care system. The AHA recommends that CMS, as it continues its work to**



implement the NSA, convene a stakeholder advisory group to look at not only the design of these standard forms, but how these forms are to be shared with patients and payers; with a specific focus on the development of standardized transmission protocols.

Standard Notice and Consent Documents

Under the statute, there are limited circumstances in which patients can knowingly and voluntarily waive their balance billing protections and consent to be billed for out-of-network services. Those circumstances are limited to post-stabilization when provided by out-of-network providers and facilities and certain conditions are met, and to out-of-network providers furnishing services at in-network facilities. The notice-and-consent documents are critical to ensuring patients are protected from surprise medical bills while retaining the opportunity to choose their providers.

In document instructions, CMS states that only in certain instances may providers and facilities modify the standard form to include such information as the identification of the out-of-network provider, the out-of-network provider's good faith estimate for services and any care limitations imposed by the patient's health plan. For post-stabilization patients, the facility is instructed to include lists of in-network providers who able to furnish the services described in the notice. The statute specifically requires that the patient sign and date the receipt of the notice and sign and date the form consenting to out-of-network services. The following are specific issues and recommendations with the standard notice and consent form.

Patient's Signature and Date. The law and regulations require two signatures – one when notice was provided and another for when consent is obtained – but there is only one signature line on the form. Specifically, the standard document does not include a separate line for the patient's signature with the date to indicate that the patient received the notice. **The AHA recommends that CMS modify the standard document to include a distinct signature line for when the notice was given, with a separate signature line confirming that consent has been provided.** This would remove any confusion about compliance with the notice requirements.

Good Faith Estimates. The statute requires that good faith estimates of the costs of services be included in the notice to fully inform patients of their potential out-of-pocket costs if they continue with care from out-of-network providers or facilities. The law further instructs such good faith estimates be conveyed using the expected billing and diagnostic codes for items and services. The standard form also requires that good faith estimates reflect the amount the out-of-network provider or facility expects to charge for furnishing such items or services, as well as include the service codes. However, the form does not stipulate which codes are to be used. Given that the underlying policy requires that providers and facilities follow the same rules that apply to the development of the good faith estimates established under another section of the NSA, we urge CMS

to quickly release guidance on how providers are to calculate good faith estimates and to incorporate guidance on the specific codes to be used into this form.

Management of Notice and Consent Process. The rule specifies that each out-of-network provider is responsible for the notice and consent process for the services they provide *unless* they have an agreement with a facility to manage the process on their behalf. We interpret this to mean that facilities can agree to manage the notice and consent process for some, but not all, of the out-of-network providers involved in a patient's care. **As such, the AHA recommends that the standard form and instructions should be modified to clarify that facilities can choose which out-of-network providers they plan to work with as part of their management of the notice and consent process and clearly state that this form may not encompass all potential out-of-network providers.**

Listing of Available In-Network Providers for Post-stabilization Patients. For post-stabilization patients at in-network facilities for which consent is being sought, the notice must include a list of in-network providers at the facility that are able to furnish the services. Providers will need to either rely on the plan's provider directory or contact the plan directly to obtain information on alternative in-network providers. This process will not guarantee accurate information and will be highly burdensome for providers. For example, health plan provider directories are notorious for containing errors. Providers should not be held responsible if they rely on unknowingly erroneous directory information. In addition, there are nuances to how plan provider directories list facilities and providers. For example, the facility could be listed as in-network in the plan directory, but the plan chooses to exclude coverage for certain services performed at the facility, such as outpatient surgery, laboratory and diagnostic services, and specialty drug therapies. These health plan coverage nuances would make it nearly impossible for the in-network facility to know with any certainty which providers would be in- or out-of-network for specific services. **For these reasons, the AHA believes the responsibility should not be placed with the in-network facility. AHA recommends that the standard form and instructions should instead direct the patient to their health plan to identify an alternative.**

Accessible Languages. The regulations require that providers and facilities provide notice and consent in the top 15 languages in a state or geographic region in which the applicable facility is located. In addition, providers and facilities will need to translate the notice and consent form into the top 15 applicable languages. **Because CMS intends to treat the adoption of the standard form as compliant with the law's notice and consent requirements, the AHA recommends that CMS provide translations of the standard form in the top 15 nationally known languages.** This would substantially lower the administrative burden on facilities and providers.

Transmitting of the Standard Form to Payers. The regulations require that facilities and providers alert the patient's health plan that the notice and consent process was used and to share with the health plan the signed consent form. Neither the regulations nor

the standard form provide any guidance on how the signed notice and consent documents should be transmitted. **Because there is currently no standard electronic transaction for this exchange of information, the AHA recommends that CMS adopt a standard process to ensure consistency and minimize the burden of alternate forms of transmission, such as faxing paper copies or use of health plan's unique, proprietary portals. AHA further recommends that the agency expedite the adoption of standard electronic transactions for the exchange of this information between the provider, facility and plan, and that the agency modify the standard form to reflect these transaction standards.**

Model Disclosure Notice Regarding Patient Protections Against Surprise Billing

Patient Notice. As part of the public disclosure requirements, providers and facilities must publically post information about patient balance billing protections as well as provide patients with a one-page notice outlining these protections. By adopting the model form, providers and faculties will be considered compliant with the statute and rule. The implementing rule and the instructions for the model patient one-page notice stipulates that this notice be shared with the patient no later than at the time payment is requested or when claims are submitted to the patient's health plan. **The AHA recommends additional flexibility in the timing of when providers and facilities convey the disclosure notice to patients. Specifically, there are instances where patients will have ongoing treatment regimens that require multiple visits and/or courses of care. In these instances, we ask that providers not be required to provide the notice for either each visit or course of treatment. Instead, providers could be required to provide the notice at the outset, followed by periodic reminders, such as each quarter.** This will allow for continued patient engagement on billing expectations without overburdening providers.

Thank you for the opportunity to provide comments on the stand forms to be used in the in meeting the notice and consent and public disclosure requirements. Please contact me if you have questions, or have a member of your team contact Molly Collins Offner, AHA's director of policy, at mcollins@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development