American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

June 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Subject: Convening Provider and Co-Provider Data Exchange

Dear Administrator Brooks-LaSure:

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) appreciates the opportunity to work with the Centers for Medicare & Medicaid Services (CMS) on implementation of the No Surprises Act. Hospitals and health systems are committed to implementing these new requirements, and the AHA is working closely with our member hospitals and health systems to make sure they have the information and tools they need to successfully do so. In particular, we are grateful that CMS has recognized areas of the legislation that will require additional guidance and time to implement and has chosen to exercise enforcement discretion for those policies until they can be implemented appropriately.

One such area requiring additional guidance and a longer implementation timeframe is the regulatory requirement that convening providers and facilities exchange information with co-providers and co-facilities to create a comprehensive good faith estimate. There are currently no methods for unaffiliated providers or facilities to share or receive good faith estimates with a convening provider or facility in an automated manner. To share this information, billing systems would need to be able to request and transmit billing rates, discounts and other necessary information for the good faith estimates between providers/facilities.

This is not something that practice management systems can generally do, since billing information is traditionally sent to health insurers and clearinghouses, not other providers/facilities. **Due to the lack of currently available automated solutions, this process would require a significant *manual* effort by providers, which would undoubtedly result in the convening provider being unable to meet the short statutory timeframes for delivering good faith estimates to the patients and could also lead to inadvertent errors.**

In the interim final rule implementing this policy, CMS notes that it is exercising enforcement discretion until Jan. 1, 2023, as it may take time for providers and facilities to "develop systems and processes for receiving and providing the required information." We agree that developing and implementing the solution will take time and cannot be achieved efficiently without additional guidance from CMS that identifies a standard technical solution that can be implemented by all providers. **In light of the impending deadline and the to-date lack of guidance from CMS, we request an extension in enforcement discretion until a technical solution has been identified and implemented.**

Practice management systems utilize standard electronic transactions to send information to other stakeholders; many of these standards are codified under the Health Insurance Portability and Accountability Act (HIPAA). This allows providers and facilities to utilize the same transaction across all health insurers and clearinghouses, eliminating the administrative burden of adhering to idiosyncratic payer technology requirements. The current administrative transactions do not facilitate provider-to-provider communications; as a result, they would not be usable for the development of good faith estimates.

Without an automated standard in this space, providers would need to individually determine how to transmit this information, which would inevitably lead to widespread variance throughout the industry (particularly given the differences in size and levels of technical sophistication among co-providers and co-facilities). Navigating a non-standardized process would place an enormous administrative burden on providers, beyond what regulators likely considered prior to creating the implementation and enforcement dates.

To help facilitate the process of identifying a workable standard solution, the AHA is partnering with the American Medical Association (AMA), the Medical Group Management Association (MGMA) and HL7 to create a workgroup to discuss potential technical solutions for sharing and receiving critical information among providers. This group consists of provider representatives and vendors with knowledge of provider systems. We continue to welcome CMS' participation in this workgroup and intend to regularly share updates from the group with the agency to ensure that our efforts help to inform future guidance on a standard solution.

A standard technology or transaction that would enable convening providers and facilities to automate the creation of comprehensive good faith estimates is necessary to efficiently implement the full uninsured/self-pay good faith estimate. **We urge CMS to continue to exercise enforcement discretion with respect to the comprehensive good faith estimate requirement until a technical solution for exchanging this information is developed and implemented across all providers.**

We look forward to continuing to work closely with you on the implementation of the good faith estimates, as well as the other No Surprises Act requirements. Please contact me if you have any questions, or feel free to have a member of your staff contact Ariel Levin, AHA's director of coverage policy, at 202-626-2335 or alevin@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President