American Hospital Association™
Advancing Health in America

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June 30, 2022

William N. Parham, III, Director
Paperwork Reduction Staff
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Provider Complaints Submission Process under the No Surprises Act (CMS–10779)

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 — as well as the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) thanks you for the opportunity to comment on the forms providers may use to file complaints with the Centers for Medicare & Medicaid Services (CMS) regarding implementation of the No Surprises Act**.**

America's hospitals and health systems are committed to protecting patients from unexpected medical bills as a result of an emergency or when they reasonably could not be expected to know their provider was out-of-network. While experience suggests that reimbursement for the vast majority of out-of-network care is handled relatively quickly between plans and providers, there are instances where the two parties may not agree on what constitutes fair compensation. The law, therefore, established a dispute resolution process that includes an open negotiation period between the two parties followed, if needed, by an arbitration process. CMS plays a critical role in ensuring that all parties are adhering to these rules, and this form is the mechanism that providers may use to initiate a complaint about a suspected violation. Therefore, it is important that the form be clear, easy to use, and free of unnecessary requests for information that could either unnecessarily expose a patient's sensitive, personally identifying information or add unnecessary burden to the process.

In order to achieve this objective, we recommend the agency make several changes to this information collection. Specifically, we recommend CMS consider the following changes.

1. **Clarify the scope of uses of this form.** The form is titled "No Surprises Provider Complaint form;" however, based on the information requested through the form, it appears the agency may intend for providers to use it more broadly. Specifically, the first two items under "Complaint Category" relate to questions, not complaints, about the independent dispute resolution process (i.e., "I have a question related to IDR Fee Collection;" and "I have a question about how to start the IDR process or how to initiate or manage my case;" or "I have a question on how to certify as an Independent Dispute Resolution Entity (IDRE).") We recommend the agency clarify the scope of the use of the form and, if necessary, modify the name of the form to minimize any confusion. In addition, we recommend the agency ensure that the examples provided relate to issues that a provider may experience. For example, the regulations at 26 CFR 54.9816–8T(a)(2), 29 CFR 2590.716–8(a)(2), and 45 CFR 149.510(a)(2) preclude providers from qualifying as an IDRE due to potential conflicts of interest. This example should be removed from the provider complaint form to reduce any confusion.

   We also encourage the agency to reformat this section of the form as there appear to be two distinct components but only one is labeled. Specifically, several items are grouped under the header: "Independent Dispute Resolution (IDR)." However, there is another section with one item but no header. We recommend CMS label it "Other Questions and Complaints."

2. **Limit unnecessary disclosure of patients' personally identifiable information.** We are concerned that the form includes a request for a patient's personally identifiable information (PII) that may not be relevant or necessary to initiate all complaints or questions. For example, a provider may want to file a complaint regarding a plan's failure to pay timely on a claim. The provider can still provide ample information to support this complaint without disclosing the specific patient information. While there may be instances in which such information becomes necessary, we encourage CMS to err on the side of minimizing disclosure of patient PII to help reduce security risks. Such information should only be provided on a strictly as-needed basis, which could be determined during the investigation. Alternatively, CMS could modify the form to indicate that providers should only include this information when absolutely critical to their question or complaint. This comment equally applies to the request for policyholder information.

3. **Clarify the types of required supporting documentation.** The directions indicate that providers should submit "applicable" supporting documentation.

However, we believe the form could provide even greater clarity that the types of supporting documentation provided are examples only and that providers do not need to submit all information listed.

In addition, in this section, the form lists several documents that are not applicable to providers, e.g., "explanation of benefits received from your health plan or insurer." In order to minimize any confusion, we recommend the agency only include types of documentation that are relevant to a provider complaint.

4. **Clarify which fields are required.** The top of the form includes the following statement: "* *Indicates a required field*." However, none of the fields are marked with an asterisk. We do not believe it is possible to adequately weigh in on the burden associated with this form when it is not clear which fields are required and which are not. We recommend providing clarity on which fields are required and, if none are required, removing this sentence to reduce confusion.

5. **Reorder the form for ease of understanding.** The form starts with a question regarding document submission without adequate context. We believe this could be confusing and recommend the form instead first ask whether this is a new question/complaint or a modification to an existing submission prior to proceeding to questions regarding document submission.

We look forward to continuing to work together to implement the important patient protections authorized through the No Surprises Act. Please contact me if you have any questions or feel free to have a member of your staff contact Molly Smith, group vice president for policy, at (202) 626-4639 or mollysmith@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President