



November 11, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-9900-NC; Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals

Submitted electronically via <http://www.regulations.gov>

Dear Administrator Brooks-LaSure,

Trinity Health appreciates the opportunity to comment on policies and questions included in CMS-9900-NC. Our comments and recommendations to the Centers for Medicare and Medicaid Services (CMS) reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 123,000 colleagues and more than 26,000 physicians and clinicians caring for diverse communities across 26 states. Nationally recognized for care and experience, the Trinity Health system includes 88 hospitals, 135 continuing care locations, the second largest PACE program in the country, 136 urgent care locations and many other health and well-being services. Trinity Health has 15 medical groups with 1,324 primary care providers and 4,193 specialty care providers. Based in Livonia, Michigan, its annual operating revenue is \$21.5 billion with \$1.4 billion returned to its communities in the form of charity care and other community benefit programs.

Trinity Health has 17 Clinically Integrated Networks (CINs) that are accountable for approximately 2 million lives across the country through alternative payment models. Our health care system participates in 14 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes eleven markets partnering in one national MSSP Enhanced Track ACO, Trinity Health Integrated Care. All of these markets participated in the “enhanced track”, which qualifies as an advanced alternative payment model (AAPM). Two of the 14 markets also participate in CPC+. In addition, we have had 33 hospitals participating in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative, and three hospitals in the Comprehensive Care for Joint Replacement (CJR) program. Our work—and experience in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts.

Below are high level principles submitted in response to the Department of Labor, Department of the Treasury, and Department of Health and Human Services (“Departments”) request for information regarding the No Surprises Act’s requirements related to the advanced explanation of benefits (“AEOB”) and good faith estimate (GFE) requirement for insured patients.

Convening Provider Requirement for Insured GFE/AEOB

Trinity Health believes that plans, issuers, and carriers (collectively “Plans”) are in the best position to coordinate and aggregate GFEs received from providers and facilities. Plans, in the regular course of business, receive separate claims from both facilities and providers that relate to the same item or service a respective member may have received. They must aggregate and review this information in order to properly administer a member’s benefits. Therefore, and in order minimize administrative burden, this pre-bill adjudication process should mimic the post-bill adjudication process as closely as possible.

Moreover, as aggregation of disparate provider and facility estimates is not a function included in provider and facility workflows, requiring providers and facilities to act as the convening entity for purposes of the GFE - AEOB will put a considerable amount of administrative burden on the provider and facility communities. Trinity Health urges the Departments to review the September 27, 2022, letter sent from the American Hospital Association, American Medical Association, and Medical Group Management Association to Administrator Chiquita Brooks-LaSure, as it accurately outlines these burdens.

Transferring Data from Providers and Facilities to Plans, Issuers, and Carriers

Trinity Health supports the development and availability of ONC Health IT Certification criteria for use by Plans. We believe this will eliminate variation between Plans when accepting and ingesting GFEs from providers and facilities. Eliminating variation will greatly assist in reducing provider and facility administrative burden. Trinity Health also believes such criteria will help ensure that AEOB information is transmitted to patients in a consistent, uniform, and secure manner.

Trinity Health believes that until ONC Health IT Certification is made available, CMS should delay the GFE - AEOB requirement. Proceeding before such criteria is established will lead to varying and disparate Plan standards as well as increased administrative burden for Plans, providers, and facilities. It will also lead to confusion for patients.

Other Policy Considerations

Non-Participating Providers/Facilities

Provider notifying Plan of facility’s participation status

When a provider that does not participate with a Plan submits a GFE, the provider should not be required to advise the Plan as to whether the facility (where the scheduled items or services will be furnished) does or does not participate with the Plan. Providers have varying degrees of affiliation with such facilities and may not have real-time or immediate access to the list of Plans with which the facility participates. On the other hand, the Plan will learn the identity of the facility upon receipt of the GFE from the provider. Unlike the provider, the Plan has real-time access to its list of participating facilities, which it would review in the regular course of business in determining the applicable cost sharing amounts due from its member.

Provider/facility notifying Plan if patient consent to balance bill has been obtained

Trinity Health supports advising Plans that an individual has consented to waive their protections under the No Surprises Act. We believe that Departments should, consistent with industry standard coding and billing guidelines, identify or develop a unique code that can be used for such notification.

Providing AEOB to the Provider/Facility

Plans should be required to submit a copy of their AEOB to providers and facilities at the same time the AEOB is submitted to the member/patient. Such a requirement will help eliminate confusion between the patient, provider, facility, and Plan prior to the time of the final bill. For example, if a provider or facility is able to review the AEOB, they can aid in determining whether it is accurate (e.g., does it accurately reflect what the provider or facility reported on the GFE?). If it's inaccurate, the provider, facility, and Plan, as applicable, can collaborate to resolve the same. Moreover, such a requirement will inform the provider or facility as to whether the Plan will cover the items or services. If the Plan has determined it will not cover the items or services, the provider or facility can engage the Plan or patient in a discussion about options.

Secondary and tertiary payers

Like the convening provider/facility requirement for the self-pay/uninsured GFE, the Plan that receives the provider or facility GFE should be treated as the convening Plan for GFE - AEOB purposes. Through its relationships with its member, the Plan is in the best position to determine if it is acting as a primary, secondary, or tertiary payer, as it would have collected the same for coordination of benefit purposes.

Requirement to Verify Coverage and Verify if the Member is Covered by Multiple Payers

Providers and facilities should not be required to verify coverage of each item and service included in a GFE as it will create a significant amount of administrative burden and slow down the GFE -AEOB process. Plans, as the holder and ultimate arbiter of coverage benefits, are in the best position to make coverage determinations upon receiving the provider's or facility's GFE. Trinity Health's understanding is that such information will be communicated to the Plan's member upon receipt of the AEOB. As such, we believe imposing a coverage verification requirement on providers and facilities would be redundant and burdensome. However, if the Plan is required to submit a copy of the AEOB to provider and facilities, this would permit the provider or facility to help inform or guide the patient with respect to their options.

With respect to verifying whether a member may have coverage from multiple payers, our understanding is that Plans have longstanding processes in place that are used to determine whether their members may have benefits with other Plans. We believe it would therefore be unnecessarily duplicative for such a requirement to be imposed upon providers and facilities. It would also create additional administrative burden.

Verifying Coverage - Allowing Providers/Facilities to Rely on Individual Representations

Trinity Health believes care is needed to ensure that attempts at verifying coverage do not delay or otherwise impede care delivery. Therefore, Trinity Health supports this approach in those instances when care is scheduled at least 20 days in advance of the scheduled item or service.

Patient/Member Awareness of AEOB

The Departments and OPM should consider creating a website or adding information to the "Consumers" section of the Centers for Medicare and Medicaid Services current website that's dedicated to providing consumers with information regarding their rights and protections under the No Surprises Act.

Privacy Concerns

With respect to concerns about patient privacy, the office of Civil Rights would be in the best position to determine how to protect patients' privacy rights while ensuring patients have access to estimates and billing information. The OCR has been actively engaged in providing advice regarding permitted and required disclosures since HIPAA was passed and also has issued guidance regarding the patient's right to request and

receive information in a form that may raise concerns about privacy or the security of the information. Patients are in the best position to determine how they want to receive information, including receiving the information in a portal, via an email or text or otherwise. To maximize the options for informing patients, any and all methods should be permitted unless the patient objects to a delivery method. HIPAA contemplates this patient right in the right of patients to request confidential communications.

Conclusion

Trinity Health strongly supports protecting patients from unexpected medical bills and we are available to discuss our comments. If you have any questions on our comments, please feel free to contact me at jennifer.nading@trinity-health.org.

Sincerely,

/s/

Jennifer Nading
Director, Medicare and Medicaid Policy and Regulatory Affairs
Trinity Health