August 2, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave, SW
Washington, DC 20201

**RE: Appropriate Implementation Timeline for Requirements under the No Surprises Act**

Dear Secretary Becerra and Administrator Brooks-LaSure:

As the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) continue to develop and implement requirements under the No Surprises Act, **the Medical Group Management Association (MGMA) urges you to continue utilizing the Department's enforcement discretion and provide medical group practices with at least 6 months final notice prior to the enforcement of any additional surprise billing requirements.**

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups comprising more than 350,000 physicians. These groups range from small independent practices in remote and other underserved areas to large regional and national health systems that cover the full spectrum of physician specialties.

The No Surprises Act established critical patient protections against balance billing and created new cost transparency tools to help patients be empowered in the healthcare decision making process. On January 1, 2022, several provisions of the No Surprises Act took effect, including federal protections against balance billing, uninsured and self-pay good faith estimate (GFE) requirements, continuity of care protections, and provider directory requirements.

While critical policies ensuring patients have access to the necessary and most accurate cost estimate information, these new requirements under the No Surprises Act created significant additional administrative burdens for group practices. The interim final rules establishing these new requirements were published with minimal time prior to the implementation date; such a tight turnaround time created significant confusion among many group practices. And while HHS and CMS have provided several detailed resources for group practices, the additional clarifying information came after the new mandates took effect. As group practices had already rushed to interpret the requirements, additional clarifications caused duplicative work to update processes to be in full compliance with the policies.

Even after seven months of implementation of the aforementioned policies under the No Surprises Act, in a recent MGMA member educational webinar, a majority of attendees indicated that additional guidance is needed related to existing policies to fully understand the mandates:

- 58.2% of respondents indicated additional guidance related to state vs. federal surprise billing requirements is necessary.
- 54.2% of respondents indicated additional guidance related to the uninsured and self-pay GFE requirements is necessary.
- 41.2% of respondents indicated additional guidance related to the prohibition on balance billing is necessary.

With continued uncertainty, layering new requirements will only create additional burdens and uncertainties for both providers and patients.

HHS and CMS have indicated additional rulemaking will be published related to the advanced explanation of benefits (AEOB) requirements, continuity of care protections, and provider directory requirements. **To avoid further confusion among group practices and ensure such policies are fully communicated and understood, MGMA recommends HHS and CMS provide at least 6 months after the publication of any final rule implementing requirements under the No Surprises Act prior to the enforcement date.**

MGMA recognizes the statutory requirements and the urgency to prevent any further delays in patient access to this information, however, we believe that existing cost estimate information provided by both insurers and practices can adequately ensure patients are aware of cost estimate information prior to the implementation of the AEOB requirements. Similarly, group practices have been complying with the continuity of care protections and provider directory requirements in a good faith, reasonable effort according to the statute since January 1, 2022.

Additionally, on January 1, 2023, the convening and co-provider requirements related to the uninsured and self-pay GFE requirements are slated to take effect. The administrative requirements and technical standards necessary to effectively implement these requirements have not yet been established. **As such, MGMA believes HHS and CMS should similarly leverage enforcement discretion and delay the implementation until the requirements can fully be appropriately communicated with practices in a timely manner.** Among MGMA's membership, the convening and co-provider requirements cause significant confusion, 60.8% of members require additional guidance from the Department prior to January 1, 2023, in order to appropriately implement the policy.

These new mandates require significant time to understand and implement. Group practices are currently facing significant staffing shortages, record-breaking inflation, and significant reductions in Medicare payment. With the increasing financial uncertainty among many practices, funding for additional administrative and support staff, that are responsible for implementing new administrative processes, such as the AEOB mandates, is often reduced first. The current environment of the healthcare industry does not lend itself to quick implementation of major policies.

MGMA is committed to continuing to partner with HHS and CMS to empower patients to have the information necessary to actively participate in their care plan. If you have any additional questions, please do not hesitate to contact Kelsey Haag, Associate Director of Government Affairs, at khaag@mgma.org or (202) 887-0798.

Sincerely,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs
Medical Group Management Association