December 6, 2021

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

RE: Requirements Related to Surprise Billing; Part II [CMS-9908-IFC]

Dear Secretary Becerra:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the interim final rule (IFR) with comment entitled, "Requirements Related to Surprise Billing; Part II," file code CMS-9908-IFC.

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 second IFR released by the Department establishes additional requirements for the independent dispute resolution (IDR) process and implements a pathway for uninsured and self-pay patients to understand the cost of care prior to receiving services. The new policies finalized by the Department of Health and Human Services (HHS) are critical to ensure patients are appropriately protected from high medical costs.

MGMA recognizes the implementation date for these new requirements, as established in statute, is January 1, 2022. MGMA remains committed to ensuring patients continue to be protected from exorbitant balance bills and have the tools and resources available to understand the costs of care. **However, MGMA is concerned by the condensed timeline group practices have to implement new workflows in compliance with these new requirements.** Specifically, the uninsured good faith estimate (GFE) requirements were published in a final rule on Oct. 07, 2021, and will be enforced less than three months later. Three months does not provide sufficient time for practices to fully understand and implement these new requirements and places undue burdens on medical practices. **MGMA strongly encourages the Department use enforcement discretion for all surprise billing requirements until the end of CY 2022.**

Further, MGMA would encourage HHS to provide more time for group practices to implement the final policies related to the advanced explanation of benefits (AEOB) and any other requirements that will undergo notice and comment rulemaking in CY 2022. Group practices continue to be under tremendous pressure responding to the COVID-19 pandemic and other administratively burdensome policies. **MGMA**

recommends any new surprise billing policies finalized in CY 2022 have an enforcement date at least one-year after final policies are published.

MGMA appreciates the opportunity to respond to the second IFR implementing surprise billing requirements and would like to offer the following comments for consideration as the Department continues to develop policies related to surprise billing.

Federal IDR Process

Role of the Qualifying Payment Amount (QPA)

HHS Policy (86 Fed. Reg. 55995-55997): HHS requires that certified IDR entities must select the offer that is closest to the QPA, unless credible information is submitted to support an alternative payment amount. The Department determined that the QPA is the assumed appropriate out-of-network rate for services. While the QPA is the assumed rate, the certified IDR entity must also consider other credible information submitted by either party including teaching status, case mix, and scope of services. The IDR entity must also consider whether credible information was submitted that demonstrates good faith effort (or lack thereof) by the provider and plan to enter into a contract agreement during the past four plan years. The IDR entity may only consider other factors to the extent that they are not already incorporated into the calculated QPA.

MGMA Comment: The QPA as the "assumed rate" in the IDR process goes against congressional intent for the arbitration process. Congress had considered such an approach, but ultimately did not create a pathway that would require benchmarking payment rates with the understanding that it would significantly stifle fair contract negotiation between payers and providers. **MGMA urges HHS to remove the QPA as the "assumed out-of-network rate" under the IDR process, in alignment with the No Surprises Act statutory intent.**

HHS states that anchoring the QPA to the out-of-network rate will increase "predictability of IDR outcomes" and encourage providers and health plans to settle negotiation outside of the IDR process. However, while we understand the intent, and likewise encourage parties to settle payment disputes outside of the administratively burdensome and costly IDR process, anchoring the QPA to the out-of-network rate creates a ceiling for negotiated rates. Insurers have little incentive to fairly negotiate a payment rate for services if they will pay the QPA under the IDR process. Our members have already experienced challenges with insurers canceling contracts that have negotiated payment rates that are above the QPA.

Contract negotiation for many providers has been difficult, even prior to the establishment of the surprise billing requirements. One of our member group practices has experienced challenges with closed insurer networks for years. This group has been unable to negotiate a contract and has remained out-of-network. If the QPA remains the assumed out-of-network rate, many more practices will experience difficulties contracting with insurers.

Further, the calculation of the QPA is not a transparent process. If an amount is to be the assumed out-of-network rate, practices must fully understand the data that is informing this amount. Auditing of the QPA calculated amounts is outside the federal IDR process under current policy. The IDR entity is not responsible for auditing the calculation of the QPA amount. Practices may only find errors in the calculation of the QPA far outside the scope of the IDR process.

Establishing the QPA as the assumed out-of-network amount is antithetical to the No Surprises Act as passed by Congress. **MGMA strongly urges CMS to align the federal IDR process with the law and create a fair payment dispute resolution process for patients, providers, and insurers.**

Uninured Good Faith Estimate (GFE)

Patient Request of the GFE

HHS Policy (86 Fed Reg. 56017): HHS requires that a convening provider must provide a GFE for services to an uninsured or self-pay patient upon request or upon scheduling services, within certain required timeframes. When defining what constitutes a patient request, the Department states that any "discussion or inquiry" about the cost of services from an uninsured or self-pay patient should be considered a request for a GFE for services.

MGMA Comment: MGMA appreciates the intent behind the uninsured GFE. Patients without insurance have high medical bills and it is critical for them to understand the cost of care prior to receiving services and the new GFE requirements also permit patients to shop around and compare the cost of care. As part of the requirements established by the Department, providers are required to inform patients about the availability of a good faith estimate. HHS requires information related to the availability of the GFE to be available in writing and prominently displayed:

- On the provider's website;
- In the provider's office; and
- On-site where scheduling or questions about the cost of items or services occur.

MGMA believes that these requirements for providers to communicate the availability of the GFE and other patient communication mechanisms including information from the Department, is sufficient to inform patients about the availability of the GFE. Thus, providers should not be required to furnish a GFE after any discussion about the cost of services. **MGMA recommends HHS amend this policy to define a GFE request as the result of a targeted discussion about the estimated cost of care for specific services.**

Further, MGMA believes that there are other price transparency requirements that could better inform patients about the cost of care. Many group practices have information available online about the cost of care for uninsured patients and have dedicated financial offices that help uninsured patients understand and navigate the complexities of healthcare costs. Such avenues could be more appropriate for a patient that is shopping around for services who may be interested in the potential cost of care for certain services but does not intend to schedule care in the immediate future.

MGMA believes this is an appropriate approach that balances patient access to critical cost information, with simultaneously ensuring practices are not bombarded with administratively burdensome GFE requests from patients who have access to cost information via other more appropriate channels.

Information Required for the GFE

HHS Policy (86 Fed. Reg. 56019): The Department established requirements for the content that must be included in a GFE, including: patient information, an itemized list of items or services expected to be provided by the co-provider or co-facility, applicable diagnosis codes, and provider information. HHS

seeks comment on whether contact information for a provider's financial assistance office should be included on the GFE.

MGMA Comment: MGMA does not believe including the financial assistance office contact information for the convening provider should be included in the GFE. The convening provider estimate is only one component of the GFE. Including this specific contact information will further confuse patients when they will be unable to answer questions about any other cost information included in the GFE. Additionally, including contact information for convening and co-provider financial assistance offices would again increase confusion for patients about who is the appropriate contact with questions about the cost of services.

Practices typically have contact information listed on their websites or in their offices. MGMA believes it is more appropriate and effective for patients to contact financial assistance offices through existing mechanisms. **MGMA recommends the Department does not require providers to include financial assistance office contact information on the GFE.**

Scope of Services Included in GFE

HHS Policy (86 Fed. Reg. 56019): HHS requires that in instances where a provider furnishing a GFE anticipates there will be additional services that will require separate scheduling and are not reflected on the current GFE, the provider must separately list these services in the GFE. HHS anticipates this will be critical information that will inform patients about potential future costs of care that may result from current treatments within a period of care. HHS also seeks comments on whether specific cost information should be included for services that may be required either before or following the period of care for which the GFE is furnished.

MGMA Comment: **MGMA strongly opposes any such policy that would require group practices to provide cost estimate information for services outside of the period of care on an uninsured or self-pay GFE**. It is critical that patients receive cost estimate information from the provider that will be furnishing services. However, if a provider includes cost estimate information for services before or after the period of care and a patient receives care from an alternate provider that has a different cost amount for services, this could result in increased confusion for patients. Additionally, patients may think that because services are listed on a GFE with associated costs, that these services are included in the GFE and that they are scheduling these services in addition to the primary services. MGMA is concerned with this approach and believes that the GFE should only include cost information about the specific items and services that are included in a GFE.

While MGMA believes that it is reasonable to include a *list* of potential services that are integral to the standards for care for the primary service that are outside of the period of care, **we do not support including specific cost estimate information for these services in the GFE.**

GFE Format

HHS Policy (86 Fed. Reg. 56019): HHS seeks comments on whether the Department should issue a standard format for the GFE that would be used by all providers and facilities.

MGMA Comment: We appreciate the Department providing an example of an appropriate GFE document that follows the requirements outlined in this final rule. It is critical for group practices to have

this guidance from the Department, especially as practices have limited time to implement new policies consistent with the requirements related to the uninsured GFE.

MGMA believes it is critical for small and rural practices to have a sample that is complete in the requirements established for the new GFE requirements that can be easily and quickly used in their practice. However, many MGMA member practices have existing workflow pathways created to share this same information with patients. To the extent that current systems and forms can appropriately provide the same information, **we encourage the Department to maintain current policy and not require a specific format be used by group practices to meet the requirements of the uninsured or self-pay GFE.**

Convening and Co-Providers

HHS Policy (86 Fed. Reg. 56023): Recognizing the challenges facing convening and co-providers to share information about the cost of services included in the GFE, HHS is using enforcement discretion in CY 2022 to provide flexibilities for providers. Through Dec. 31, 2022, HHS will not be enforcing the requirement that convening providers include cost estimate information from co-providers on the GFE uninsured patients.

MGMA Comment: MGMA greatly appreciates the flexibilities issued by the Department for CY 2022. However, **we would encourage HHS to re-evaluate how convening and co-providers can effectively and in a timely manner communicate the information necessary for the uninsured GFE prior to enforcing the requirements for convening and co-providers.** Additionally, during this discretionary period, MGMA encourages HHS to evaluate the effectiveness of the information convening providers are providing to patients to help inform the cost of care and determine whether or not convening and co-provider requirements related to the uninsured GFE are required.

Requirements for Co-Providers and Co-Facilities

HHS Policy (86 Fed. Reg. 56018): HHS states that if a patient separately schedules care with a co-provider, this provider will now be considered a convening provider and must meet all requirements related to furnishing a good faith estimate.

MGMA Comment: MGMA seeks clarification from the Department on this topic. If a co-provider becomes a convening provider, we believe this new convening provider should not be subject to requirements to receive estimates from other co-providers.

If patients receive multiple GFEs that reflect the same costs and services, it could provide more confusion than clarity to the total cost of care for the period of care. **MGMA recommends that if a co-provider becomes a convening provider if a patient separately requests a GFE from this provider, the new convening provider costs should not be included in any other GFE provided to the patient** and this new convening provider should not include any co-provider cost estimates in the separately furnished GFE.

Methods for Providing GFE for Uninsured Patients

HHS Policy (86 Fed. Reg. 56021): HHS requires that the GFE for uninsured and self-pay patients be provided in written form, either electronically or on paper. Additionally, if requested by the patient, the convening provider may discuss the GFE orally with the patient.

MGMA Comment: Providers often do not have established relationships with uninsured patients. This creates new challenges for providers to ensure patients receive their GFEs in a timely manner. Currently, due to the COVID-19 pandemic, standard mailing rates are significantly slow, presenting challenges in ensuring patients receive a GFE. Additionally, because uninsured patients do not typically have established relationships with providers, they do not yet have access to patient portals where health information can appropriately be shared. While the rules permit providers to share the GFE electronically via email, HIPAA privacy rules also create challenges with sharing personal health information.

MGMA encourages the Department to provide examples about how they anticipate providers can ensure uninsured patients receive the written GFE information in a timely manner. Additionally, **MGMA recommends the Department determine that if providers choose to mail written copies of the GFE to uninsured patients, the date the documents are postmarked will be the date that is used to determine whether or not the provider is in compliance with the timing requirements related to the GFE.**

Inflation of Costs in a GFE

HHS Policy (86 Fed. Reg. 56030): HHS did not finalize policies that would permit patients to enter into the patient-provider dispute resolution process for GFEs that the patient believes included extraneous services, resulting in an inflated GFE. The Department seeks comments on a potential approach that would permit uninsured patients to initiate the dispute resolution process for GFEs that they believe have been overinflated in order for providers to avoid dispute resolution.

MGMA Comment: **MGMA agrees with the agencies' assessment that it is not necessary to create a pathway for patients to enter into the dispute resolution process for potentially overinflated GFEs.** Group practices providing cost estimates to uninsured and self-pay patients will only provide the estimated costs for the services that are necessary and inclusive of services that are reasonably necessary during the period of care.

Providers are required to include all medically necessary services that should be reasonably known at the time the GFE is provided to the patient. This process will require clinical interpretation of the patient symptoms and potential care pathways the provider anticipates will likely occur. In certain circumstances, the inclusion of services that were not necessary will occur, however, MGMA maintains that it is critically important for patients to fully understand the potential cost of care.

As an example, if an uninsured or self-pay patient schedules care with an OB/GYN provider for a delivery, the provider may include the potential costs of a cesarian delivery if the patient is at a high risk for this type of delivery. However, the patient may ultimately deliver the baby via a vaginal birth. The final billed costs may be significantly lower than the initial estimate. However**, MGMA believes that it is essential for the patient to be well informed about the potential costs of care prior to receiving the services**. Further, patients have the ability to discuss the GFE with provider before receiving the care to determine how the final costs of care may be different from the estimate based off of clinical scenario.

Additionally, within the context of the patient-provider dispute resolution process, the provider is held accountable for the cost of care for all items and services that should have reasonably been anticipated. If HHS creates a policy that permits patients to enter into the dispute resolution process for a GFE that is higher than the final billed amount, the Department will create more confusion and burdens for providers. If such a policy were implemented, providers would have to be able to perfectly predict what items and

services a new patient will require in order to prevent dispute resolution for an estimate that is too high or an estimate that is too low.

Patient-Provider Dispute Resolution

HHS Policy (86 Fed. Reg. 56037-56038): HHS has determined that if the dispute resolution entity determines that the provider has provided credible information that the difference between the billed charge and the cost estimate on the GFE reflects the costs of medically necessary and unforeseeable care, the arbiter must select the lower amount of either (1) the billed amount or (2) the median billed amount for care in a geographic region. The Department states that this policy will protect uninsured patients from billed charges that are above the market rate for items or services provided.

MGMA Comment: We appreciate the Department's continued focus to protect patients from high medical costs. **However, MGMA strongly disagrees with this policy that requires the arbiter to select the lower of either the billed amount or the medical billed amount for care in a geographic region.** If medically necessary unforeseeable care is furnished, the arbiter should be required to determine that the patient is responsible for the billed amount.

One of the stated purposes of the uninsured GFEs is to provide patients with the opportunity to shop around for care. If a patient receives a GFE from a provider that is generally higher for care, the patient should reasonably expect that any medically necessary unforeseeable care not included on the GFE would also be proportionally higher compared to other provider costs.

Deferral of AEOB Requirements

HHS Policy (86 Fed. Reg. 56023): HHS has determined they will not be issuing rulemaking for the AEOB requirements in CY 2022. The agencies will be issuing notice and comment rulemaking in the next calendar year. HHS also seeks comments on whether or not practices will be able to provide estimates to insured patients for the potential cost of care to insured patients during this period of enforcement discretion.

MGMA Comment: MGMA appreciates that the agencies have provided this flexibility for group practices in CY 2022, recognizing that there are significant complexities that must be addressed before practices have the mechanisms in place to communicate the necessary cost estimate information to insurers to issue AEOBs. The technical infrastructure that is necessary to provide the AEOB will require data standards and significant interoperability requirements between providers and health plans. MGMA recommends HHS continue to provide the necessary flexibilities until group practices have the time and ability to implement these complex processes.

When an insured patient seeks care from a provider, the clinician has software available to determine patient eligibility, but this software does not provide the level of information necessary to provide accurate cost sharing information that would be necessary in order for a provider to issue a cost estimate to the insured patient. Additionally, patients already have several cost estimate pathways from their insurers. **MGMA believes that providers should not be burdened with providing estimate information to insured patients amidst the flurry of other administrative rules and requirements.**

MGMA is committed to continuing to partner with HHS to protect patients from surprise out-of-network costs and empower patients to have the information necessary to actively participate in their care plan. As the agencies continue to issue regulations implementing the No Surprises Act, MGMA appreciates the opportunity to provide comments to shape the surprise billing landscape, establishing an effective and appropriate process consistent with the intent of the law to protect patients from surprise medical bills. 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