March 7, 2022

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

RE: CMS–10791; Agency Information Collection Activities: Proposed Collection; Comment Request; Requirements Related to Surprise Billing; Part II

Dear Administrator Brooks-LaSure:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the Request for Information (RFI) entitled, "Agency Information Collection Activities: Proposed Collection; Comment Request," related to the Requirements Related to Surprise Billing; Part II.

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*, as passed as part of the *Consolidated Appropriations Act, 2021* (P.L. 116-260), was a critical piece of legislation that created important patient protections against balance billing and established new processes to improve price transparency for patients. MGMA supports the overall goals of this new law and has been encouraged by the continued collaboration from both the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) to implement policies that reflect the intent of the law. Further, MGMA specifically supports the newest provisions to increase price transparency for patients to provide critical cost estimate information prior to patients receiving care.

Enforcement Discretion for Uninsured and Self-Pay Good Faith Estimate Requirements

The uninsured and self-pay good faith estimate (GFE) requirements to improve patient transparency took effect on Jan. 1, 2022, after practices had only three months to digest, understand, and implement these new mandates to provide cost estimate information to uninsured and self-pay patients. After only three months of implementation, 90% of medical practices indicated in a recent survey that it has already increased the administrative burden on their practices. In the same survey, many practices stated they must hire new employees, devote hours a day to understand the new requirements, and have already experienced delays in patient care due to the new uninsured or self-pay GFE requirements.[1]

[1] MGMA survey of member group practices, "Implementation of Surprise Billing Requirements." January 25, 2022.

MGMA is particularly concerned with the added administrative burden and unforeseen delays these requirements create for uninsured or self-pay patients. We are also concerned with the disproportionate impact this policy will have on patients in rural and underserved areas, as well as racial and ethnic minorities. **To ensure all patients continue to receive the highest quality care, MGMA urges CMS to delay the enforcement of the uninsured or self-pay GFE requirements until practices have the appropriate time to understand and implement the new requirements.** The uninsured and self-pay GFE requirements should be implemented simultaneously with the advanced explanation of benefits (AEOB) policy, which have been delayed in order to provide appropriate amount of time to develop the critical policies, to ensure practices only implement GFE policies at one time.

Ongoing COVID-19 Public Health Emergency

The COVID-19 public health emergency (PHE) continues to greatly impact patients, providers, and group practices. On Jan. 16, 2022, Secretary Becerra affirmed the continued impact of the pandemic on the nation by once again renewing the COVID-19 PHE. The stress the pandemic continues to have on the healthcare system has been well documented. Practices of all sizes, from small rural private practices to large national health systems, are not only experiencing significant shortages in clinical personnel, but also in administrative staff that are critical to ensuring practices and clinics remain open for patients.

A September 2021 MGMA *Stat* poll revealed that **73% of medical practices ranked staffing as their biggest pandemic challenge heading into 2022.** Again, in December 2021, as the Omicron variant surged across the country, medical practices raised concerns about increases in staff shortages due to significant spikes in exposure. In the aforementioned survey, 41% of group practices stated that patient appointments are typically scheduled between 3-10 business days in advance, requiring practices to furnish uninsured or self-pay patient GFEs within one business day of scheduling. However, with the increased administrative burden and serious staffing shortages, practices will likely not have the capacity to provide GFEs within one business day.

While MGMA supports the spirit of the transparency provisions in the No Surprises Act and has continued to partner with HHS, CMS, and other Departments to implement critical patient protections, **the administrative burden during the continuing COVID-19 pandemic and recent Omicron surge places unnecessary pressure on group practices to implement cost estimate mechanisms to meet the prescriptive requirements set forth by the Department.** MGMA urges HHS and CMS to use its available enforcement discretion to delay the implementation of the uninsured or self-pay GFE requirements, permitting group practices to leverage existing cost estimate tools as our members continue to combat the pandemic on the frontlines.

Continued Implementation Uncertainty

The new requirements for providers to issue an uninsured or self-pay GFE began on Jan. 1, 2022. While CMS has issued the final regulations and provided template documents, many questions remain about the requirements. Establishing new processes within a practice to ensure eligible patients have access to GFE documentation is a difficult and resource-intensive process; administrators must understand and communicate the new requirements with clinicians in order to provide accurate cost estimate information to patients prior to a visit, provide training to administrative staff to understand the necessary disclosures, and incorporate new processes to track and retain GFE documentation. **To ensure the implementation of these new requirements is as efficient and effective as possible, practices require complete understanding and direct guidance from the overseeing agency.**

Delaying the enforcement of the new uninsured or self-pay GFE requirements will provide practices with necessary time to engage with the agency and fully understand the new requirements without having to duplicate efforts as new information becomes available and requirements are made clear.

Consistent with Other Enforcement Discretion

MGMA appreciates the enforcement delays HHS has already provided for convening providers, co-facilities, and co-providers, as well as the enforcement delays announced for the AEOB requirements. In statements released by HHS, these enforcement delays were due to complexities in implementing the requirements and recognition by the Department that the technology and workflows necessary would require more than three months to implement.

MGMA urges CMS to employ the same critical evaluation of the uninsured or self-pay GFE requirements to understand the time, staff, and resources it takes to appropriately implement these new requirements. The three months practices had to implement the GFE requirements is insufficient to appropriately and practically implement any new significant process.

Further, implementing the GFE requirements for uninsured and self-pay patients, as well as for insured patients at one time will eliminate significant confusion for both patients and practices. As MGMA has informed members of the currently available surprise billing federal resources, many of our members have reached out with clarifying questions about determining insurance status and providing the most appropriate cost estimate to patients to prevent any confusion. If a patient does not fully understand their insurance coverage, they may not understand that they qualify for the uninsured or self-pay GFE for certain items or services until later. If a practice later learns of the insurance status, this could lead to delays in patient care for the practice to ensure they are in complete compliance with the GFE requirements. Unless all GFE requirements are in place for uninsured, self-pay, or insured patients, confusion will persist and unintended delays in care may result.

Uninsured and Self-Pay Good Faith Estimate Policy Recommendations

MGMA appreciates the continued engagement with both HHS and CMS to ensure policies related to surprise billing and the GFE policies appropriately protect and ensure patients have the information necessary to understand the cost of care. **MGMA recommends CMS issue additional rulemaking to implement the following necessary changes to the uninsured and self-pay GFE policies.**

Content and Timing of GFE

Reason for Visit

Eligible patients will receive a GFE upon request or upon the scheduling of services. Practices are required to issue complete cost estimate information for items or services based on the stated reason provided by the patient upon request or upon scheduling. However, many patients may not be comfortable sharing with the scheduler the reason for the visit, the patient may not fully understand their symptoms and potential courses of treatment, or a patient may bring up a completely unrelated symptom or clinical issue during the scheduled visit, all of which may lead to an incomplete GFE for the period of care.

This could result in an increased volume of patient encounters that result in meeting the $400 threshold to initiate the patient-provider dispute (PPDR) resolution process. **MGMA recommends that CMS add to the existing GFE template to include information about the patient stated reason for the visit to be considered in the potential resulting PPDR process.** The dispute resolution process should consider the

information the patient provided to the practice prior to receiving care and prior to receiving the GFE. **While MGMA recognizes that patients are not expected to fully understand their symptoms and potential courses of treatment, we urge CMS to recognize the limitations in the information provided and the services providers are reasonably able to anticipate prior to issuing a GFE.**

Diagnosis Codes

The uninsured and self-pay GFE requires that practices include a diagnosis code for the primary item or service. This requirement creates significant burdens for many practices, especially for patients with no existing relationship with the provider. **MGMA recommends CMS permit practices to voluntarily include a diagnosis code on GFEs.**

Many practices feel as though they must provide an unpaid consultation prior to scheduling the service with the patient in order to include a diagnosis code on the GFE. This significantly increases administrative burden and confuses the patient as they may believe the consultation is the requested service. Additionally, requiring all practices, regardless of specialty, include a diagnosis code could potentially harm patients. For example, mental and behavioral health services can be sensitive topics for many patients. If a patient were to receive a GFE with a sensitive diagnosis code on a GFE without discussion with the provider, this could potentially result in significant patient harm.

Specific NPI

The GFE requires that a specific provider's national provider identifier (NPI) be included on a patient's GFE. **MGMA strongly recommends CMS remove the NPI requirement from the GFE.** All MGMA member practices champion team-based approaches to patient care. Including a requirement for a provider specific NPI on the GFE will undermine flexibility in a practice's ability to ensure the patient receives the most appropriate care from the most appropriate provider within the practice during the period of care.

Required Timeline for GFEs

HHS and CMS finalized policies that require a GFE to be provided to the patient within one or three business days after the request is made, or after care is scheduled. This strict timeline creates unnecessary burdens on providers. **MGMA recommends CMS implement more flexible timelines for providers to furnish GFEs to patients.**

MGMA is particularly concerned about the potential impact these timeframes will have on delayed access to care. In an MGMA survey, 41% of MGMA members state that most appointments are scheduled between three and ten days in advance, meaning most practices would be required to furnish GFEs within one business day. However, many practices are unable to provide GFEs to patients within one business day due to staffing challenges and the time needed to appropriately gather all the required information for the GFE. As such, a practice may be required to delay scheduling care until at least ten business days in advance in order to have a greater amount of time to issue the GFE, even if appointments are available sooner.

New and Established Patients

Uninsured and self-pay patients may be more likely to be new patients without existing relationships with providers. As such, providing GFEs to this specific patient population has greater barriers compared to patients with existing relationships with providers. While the GFE provided to uninsured and self-pay patients is used to communicate important information to patients about the cost of care, providing flexibility for providers to issue modified GFEs to new patients will improve the utility for patients in understanding potential cost estimate information. **MGMA strongly urges CMS to permit practices to issue modified GFEs for new patients or patients in situations in which a provider cannot reasonably determine the**

appropriate diagnostic or procedure codes. A modified GFE would include a range of potential costs and potential service codes for a patient. This flexibility will ensure that patients have the most meaningful cost estimate information available to them, while preventing potential delays in care.

Changes in Insurance Status

In guidance documentation for providers and facilities to implement the uninsured and self-pay GFE requirements, CMS states that if there are changes in expected services that will be provided to the patient from what was originally included on the GFE, the provider must issue a new GFE at least one business day prior to the furnishing of services. **MGMA recommends that CMS implement a similar policy for patients, that if after a patient schedules care, the provider learns of a change in insurance status that would then lead to the patient being eligible to receive an uninsured or self-pay GFE, the provider should be permitted to issue a GFE to the patient at least one business day prior to the furnishing of services.** Such a policy would be consistent with other policies implemented under the GFE requirements and ensure that providers do not reschedule care farther in advance due to the strict timelines established for the GFEs.

Language Requirements

Ensuring patients can understand their rights to receiving certain cost estimate information, regardless of education, ethnicity, race, or socioeconomic status, is a key component of these patient protections. Practices must ensure they have appropriate disclosures and cost estimate information available to patients in different languages. **MGMA encourages CMS publish template disclosures and GFE forms in common languages, other than English, to ensure all practices can have these critical disclosures related to GFE policies available for patients.**

Patient-Provider Dispute Resolution (PPDR) Process

Initiation of the PPDR Process

Patients can initiate the PPDR process within 120 days of receiving a bill from a provider if the final billed amount is more than $400 more than the amount listed on the GFE. While it is important to allow patients the appropriate time to understand their medical bill and initiate a dispute resolution if certain criteria are met, **MGMA recommends CMS have a robust online platform where providers can be immediately notified of a patient dispute resolution, provide documentation, and track the status of ongoing dispute resolutions.**

Provider Credible Information

MGMA appreciates that practices have the opportunity to submit documentation describing why a final billed amount may be higher than the initial estimate amount, whether or not services were included on the original GFE. **However, practices require additional guidance on what would be considered "credible information" when determining whether additional care or increased complexity in services provided are medically necessary and due to unforeseen circumstances.**

Payment Amount Determination

MGMA appreciates the Department's continued focus to protect patients from high medical costs. **However, MGMA strongly disagrees with the policy that requires the PPDR dispute resolution entity to select the lower of either the billed amount or the median payment amount of a health plan for the same and similar item or service 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.

Additionally, updating this payment policy to require payment to be equal to the billed amount if the provider provides credible information for medically necessary and unforeseen care is consistent with payment methodology that is being updated under the federal IDR process. In response to a ruling in a recent court case, CMS is updating policy stating that the qualifying payment amount or the median in-network amount for services may not be the assumed out-of-network rate for care. **MGMA strongly urges CMS update the PPDR payment determination policy to be consistent with the federal IDR process by determining that for medically necessary care due to unforeseen circumstances the final payment amount should be equal to the final billed amount.**

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