November 15, 2022

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

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

Dear Secretary Becerra,

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the request for information (RFI) from the Department of Health and Human Services, the Department of the Treasury, and the Department of Labor (the Departments) regarding rulemaking for the advanced explanation of benefits (AEOB) and good faith estimate (GFE) requirements of the No Surprises Act.

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 empower patients to be better informed while making healthcare decisions. On Jan. 1, 2022, several provisions of the No Surprises Act took effect, including the uninsured and self-pay good faith estimate (GFE) requirements. Although MGMA supports the spirit of the law, we have concerns about the way certain provisions will be implemented due to the limitations of the current healthcare environment and available infrastructure.

Key Recommendations

To address our ongoing concerns regarding the GFE and AEOB requirements, MGMA recommends that the Departments should:

- **Not enforce AEOB requirements until there are workable solutions that are developed, tested, and implemented.** The Departments stated they would delay implementation of the AEOB policies until rulemaking has occurred — however, this is not necessarily enough time for the industry to roll out and deploy the necessary standards needed to implement these requirements.

- **Allow for patients to opt-in to receiving AEOBs and GFEs**. At a minimum, the Departments should allow for practices to apply for a hardship exemption, which would give them additional time to apply.
- **Not yet rely on FHIR-based standards to implement AEOB requirements, for they are not mature enough.** Whichever standard the Departments support should take into consideration medical practices of all sizes and regions, as well as those who are under-resourced. A standard must be developed, tested, and readily available to medical groups before the AEOB requirements are implemented and enforced.
- **Extend the enforcement discretion for the convening provider/facility and co-provider/facility provisions for GFEs.** Enforcement discretion should continue until appropriate standards have been developed, tested, and implemented by group practices. The Departments should also take into consideration the below recommendations from MGMA, AMA, and AHA regarding convening/co-providers related to AEOBs.
- **Continue soliciting input and working with stakeholders, such as medical groups, to implement workable policies that empower patients, but not at the expense of delivering care.**

General comments

MGMA is supportive of the goals underpinning the transparency provisions within the No Surprises Act — we believe patients should have accurate and timely access to the costs of items and services. However, we are concerned that the law and subsequent regulations implementing these provisions could lead to increased administrative burden on the part of the practice without increased transparency, if executed improperly.

An annual MGMA survey of over 500 medical groups released in October 2022, showed that regulatory burden is on the rise. 97% of respondents indicated that a reduction in regulatory burden would allow them to reallocate resources toward patient care and 82% of medical groups reported that the GFE requirements have increased administrative burden on their practices.[1] According to the 2020 Census,[2] approximately 8.6% of Americans are uninsured — practices are having a difficult enough time providing GFEs for that patient population. 61% of Americans are covered under commercial health insurance — meaning, practices will have to generate about 6 times the number of GFEs once the AEOB requirements go into effect.

Almost a year after the GFE requirements went into effect, medical groups are still struggling to establish workflows to transmit this information to patients, due to the prescriptive timelines and lack of available staff to work on them. 89% of medical groups surveyed indicated that their practice is concerned with the additional administrative burden related to the implementation of the AEOB requirements which introduce a new layer of complexity to this already difficult process. In addition to gathering the required GFE information, group practices will now have to share this information with insurers. Without a

[1] MGMA Regulatory Burden Report, October 2022
[2] Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, January 2021–March 2022

uniform and automated standard, practices will be forced to fax or use multiple platforms to share this information with dozens of different insurers within a short timeframe. It is simply unworkable as is. Moreover, the convening/co-provider requirements further complicate matters. **It is not enough for the Departments to delay implementation of the AEOB requirements until they complete the rulemaking process — there must be workable solutions that are developed, tested, and implemented prior to enforcement of these requirements.**

MGMA also cautions the Departments to be mindful of how confusing the AEOB could be to a patient. The purpose of the AEOB is to provide patients with the transparency needed to plan for care and be an active participant in their own care decisions. Receiving multiple AEOBs from an insurer could potentially cause more confusion. We understand that many requirements for the AEOBs are set in statute, however, we encourage the Departments to provide an exception for cases where the patient decides to forgo receiving an AEOB or GFE. Alternatively, patients could opt in to receiving AEOBs or GFEs. At a bare minimum, when these requirements go into effect, practices should be given the opportunity to request a hardship exemption that would allow for more time to comply due to the cost of establishing workflows, a shortage in available staff, and additional scenarios.

Additionally, much of this information is already provided to the insurer when processing prior authorization requests. While we do not want to increase the number of prior authorization requirements, we do urge the Departments to allow plans to leverage the information already received from providers when conducting a prior authorization request. Providing this information to the plans via the AEOB seems duplicative.

Finally, it is imperative that the Departments continue to solicit input and continue working with stakeholders, such as medical groups, to implement workable policies that empower patients, but not at the expense of delivering care. This should happen both through the rulemaking process and any testing that takes place. MGMA members can provide a "boots on the ground" perspective that is critical when developing these administrative policies.

Transferring data from providers and facilities to plans, issuers, and carriers

The Departments note that they have not yet established regulatory standards for the transfer of GFE data from providers and facilities to plans, insurers, and carriers. Without standardized processes to transfer this information, the AEOB requirements are simply unworkable. Medical practices are contending with devastating workforce shortages, with a number of practices claiming they simply cannot hire administrative staff. 58% of medical practices report staffing is their biggest challenge heading into 2023.[3] A multi-specialty practice in Massachusetts hired 8 FTEs this year to solely work on the GFE requirements — they cite that 8 FTEs is not sufficient, but they cannot find additional personnel to hire and cannot afford to redistribute roles of current staff.

The Departments point to the Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR) standard as a potential solution. Though FHIR certainly holds promising potential, it is not currently

[3] MGMA *Stat*, Sept. 21, 2022

mature enough to be an appropriate option. Whichever standard the Departments support should take into consideration medical practices of all sizes and regions, as well as those who are under-resourced. Large health systems and academic medical centers operate differently than small or rural medical practices. A workable solution would be one that is applicable to all practice types. Standards must be developed, tested, and readily available to medical groups before the AEOB requirements are implemented and enforced. Pilot tests should take into consideration all stakeholders — from vendors to providers to insurers — and must identify obstacles for all types of practices.

Additionally, the Departments should require insurers to send the AEOB to both the patients and the medical groups that provided the GFE to the insurers. If the intent of the AEOB to is provide more transparency around the costs and treatment plans, this information should be communicated to the practices as well, so they can assist patients.

Convening/Co-provider requirements

The Departments previously exercised enforcement discretion as it pertains to the GFE convening/co-provider requirements through Dec. 31, 2022. The Departments state that it may take time for the convening providers and facilities to develop systems and processes for receiving and providing the requirement information from co-providers and co-facilities. To date, a uniform standard for receiving and providing required information does not exist. Moreover, 61% of members reported requiring additional guidance prior to Jan. 1, 2023, to appropriately implement the policy. Only 26% of medical groups reported that their practices have the technical infrastructure to comply with convening/co-provider requirements beginning in 2023.[4] To date, there has been little guidance as to how practices should comply with these requirements. **Therefore, we ask that the Departments continue to exercise enforcement discretion for the convening/co-provider requirements until such standards exist, are tested, and are readily available for medical groups and more guidance is issued.**

In September 2022, MGMA partnered with the American Medical Association (AMA) and the American Hospital Association (AHA) to send a letter[5] regarding our concerns related to convening/co-provider requirements for the AEOBs. We further reiterate that the Departments should:

- Leverage existing provider and health plan workflows, standards, and technologies for claim submission and adjudication to support the creation of accurate AEOBs for patients.
- Reject any standard process that would require billing providers to consolidate cost data into a single GFE prior to submission to an insurer for the creation of an AEOB, as it is neither practical nor in the patients' best interests.
- Adopt a standard that allows each billing provider to submit their own GFE to the health plan for the creation of an AEOB, just as they do today for billing purposes.

[4] MGMA Regulatory Burden Report, October 2022
[5] MGMA, AMA, AHA letter to CMS, Sept. 27, 2022

Conclusion

MGMA appreciates the continued outreach regarding the implementation of the No Surprises Act, as well as the opportunity to share our feedback on the AEOB requirements. Should you have any questions, please contact Claire Ernst at cernst@mgma.org or (202) 293-2350.

Sincerely,

/s/

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