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March 7, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-10791, Requirements Related to Surprise Billing; Part II

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the Agency's Proposed Collection and Comment Request on Requirements Related to Surprise Billing; Part II, and specifically the Good Faith Estimate (GFE) requirements under the No Surprises Act (NSA).

The AMA believes it is critically important for CMS to collect sufficient information from patients to ensure that the patient-provider dispute process is initiated appropriately and correctly, and that, for example, a convening provider is not required to participate when the component of the GFE in question is the responsibility of a co-provider. The AMA supports your proposal to collect such relevant information.

We also believe it is important to use this opportunity to again stress the burdens of these GFE requirements on physician practices and urge CMS to consider the difficulties practices may encounter when trying to fulfill these requirements as you approach enforcement and implementation of the patient-provider dispute process.

The AMA has long supported efforts to provide price transparency to patients. The current lack of timely, standardized information about the cost of health care services prevents health care markets from operating efficiently. The recent influx of high-deductible health insurance plans, as well as challenges with provider networks adequately meeting the needs of enrollees, means that patients are assuming greater financial responsibility for care choices, thereby increasing the demand for better information about anticipated out-of-pocket costs. As the health care market evolves, patients are increasingly becoming active consumers of health care services rather than passive recipients of care in a market where price is often unknown until after the service is rendered. Achieving meaningful price transparency can help lower health care costs and help patients make informed care decisions.

The AMA believes there are ways to accomplish these goals without creating new waste in the health care system or putting new, and potentially insurmountable, administrative burdens on physician practices.

Below is a brief summary of some of the potential burdens associated with the GFE provisions and related patient-provider dispute resolution process on physician practices that could help inform future cost-benefit analyses.

Burden on the convening provider to coordinate GFE

The AMA appreciates the Departments' enforcement discretion during the first year of certain provisions of the GFE requirements as they relate to uninsured and self-pay patients, including the gathering of cost estimates from "co-providers" by the "convening provider." **However, we have serious concerns about the burden placed on providers, especially the convening provider, and the impact these burdens will have on physician practices as the Departments eventually move to enforce these requirements.**

For example, when scheduling a procedure, especially facility-based procedures, the scheduling or convening provider may not know who will be providing services such as radiology, pathology, or anesthesiology services, and that information may not even be available at the time of scheduling. In fact, the convening provider may not be able to determine at the time of scheduling what specific services are even required. As such, just establishing who the co-providers will be, if even possible, has the potential to consume significant resources in a physician practice and create new and tangential workflows that take away from patient care and/or exacerbate the enormous existing administrative burdens. Furthermore, especially given that a convening provider may not have an existing relationship with co-providers, contacting each co-provider to request an estimate of their costs and any follow-up that will be required will undoubtedly prove time-consuming.

We also urge the Departments to recognize that these requirements are being implemented at a time when many physician practices are struggling to retain administrative staff during this public health emergency (PHE). The AMA is regularly hearing concerns from physicians and state and specialty medical associations about disruptions and delays in patient care because physician practices do not have enough employees to get all the administrative and insurer requirements completed in a timely manner. In fact, a September 2021 *Stat* poll from the Medical Group Management Association (MGMA) showed that 73 percent of medical practices ranked staffing as their biggest pandemic challenge heading into 2022, and another December poll from MGMA revealed continued staffing concerns.

We already know that 40 percent of physicians must employ staff specifically to manage prior authorizations, a burdensome administrative requirement that also impedes access to care, and the AMA believes it is important to consider the impact of new administrative requirements on physician practices and the costs and burdens, especially during the PHE, that may result in increasing demands on already strapped physician practices. As such, for uninsured or self-pay patients, a physician should only be required to provide a GFE to the patient that reflects the anticipated services and estimated costs associated with the treatment to be delivered by that particular clinician, as this mirrors the current practice workflow for billing patients who are not using an insurance benefit to pay for care.

Predictability of services

The AMA is concerned that accurately identifying services for inclusion in the GFE at the time of scheduling may be untenable for providers. It is not always clear at the time of scheduling what specific services or procedures will be performed when the visit occurs, making precise cost estimations difficult. It is impractical to expect that staff preparing GFEs will have the information and expertise necessary to anticipate a course of clinical treatment in advance of a visit. Further, medical needs often become apparent during physician office visits, and addressing them at the time of the visit supports efficiency in

health care delivery. For example, a patient may schedule a general primary care visit, and during the visit the provider may identify a need for and perform non-routine labs with the patient's consent. These services would not be included in the GFE because they would have been unforeseeable before the patient was seen by the clinician. Consequently, the difference between the total charges and those estimated in the GFE could be significant. Updating the GFE with every small change to a course of treatment adds additional burden as well.

The inclusion of diagnosis codes on GFEs is similarly unrealistic. Physician office staff preparing GFEs are unlikely to know a patient's diagnosis at the time of scheduling. Diagnosis information will be contained in the clinical record, typically separate from the scheduling or billing systems used when preparing GFEs. It adds additional time and administrative burden to require physician staff to access the clinical record for diagnosis information when preparing a GFE. Moreover, practice staff may not have the clinical expertise to assign a particular existing diagnosis code from the clinical record to a scheduled visit, particularly if the patient did not indicate the specific problem to be addressed at the visit. This burden is unnecessary given that diagnosis is extraneous to patient financial responsibility for a service being scheduled.

Finally, with the unpredictably of services, it is likely that when additional services are provided outside of the original GFE, the patient-provider dispute resolution process will be used. While we support the use of a process to ensure patients are not receiving unexcepted medical bills, it is also important that the use of this resolution process be incorporated into considerations of burdens associated with these new requirements.

Automation concerns

The AMA is very concerned that no standardized, automated approach for transmission of cost estimate requests between providers exists, which will lead to the development of new manual workflows to complete the GFE requirements and creating scenarios where each co-provider, including facilities, has an individual process. Also of importance, there is no standard automated approach for eventually transmitting the GFE to the health plan, as well as for the plan to transmit the Advanced EOB (AEOB) to patients and providers, when the GFE requirement for insured patients is implemented. It is therefore likely that plans will each develop their unique, proprietary formats and methods for GFE submission and AEOB delivery. The industry will inevitably be faced with inconsistencies in the cost information provided to patients, compliance difficulties, and increased administrative waste and manual workflow burdens associated with the proliferation of one-off solutions to meeting the GFE/AEOB requirements. **The AMA urges CMS to work with stakeholders to create a HIPAA-mandated administrative electronic standard to support uniform exchange of this information.**

Obtaining information related to patient coverage

The AMA is also concerned with the burden and confusion that may result when eligibility information may not be granular enough to determine coverage for insured patients. For example, depending on the service, an electronic eligibility and benefits verification response may not show whether a particular service type is covered for a particular patient. Or, more commonly, the eligibility check will show that a general service category is covered but will not provide any information about coverage for the specific procedure or service being performed and requiring a GFE. Furthermore, it is typically not communicated at the time of insurance verification whether prior authorization will be required for a particular service. As such, determinations of patient financial responsibility at the time of scheduling can be tenuous.

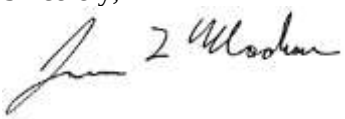
The impact of this gap in information could result in delays in care, last-minute scrambling to generate GFEs to meet these federal requirements, misinformation being provided to patients, and potential payment disputes.

Next steps

In conclusion, we thank you for this opportunity to provide additional input on the NSA's GFE requirements and appreciate your efforts to collect data and information from stakeholders to better implement these provisions effectively. Moving forward, and specifically as you begin enforcement and use of the patient-provider dispute resolution process, **we urge you to consider the obstacles present as physicians navigate these new requirements, the additional burdens that may be placed on physician practices, and the challenging environment in which practices find themselves right now.**

The AMA is ready to work with CMS to ensure patient access to cost information needed to make meaningful and informed health care decisions, while also ensuring that we are not wasting resources or creating unnecessary administrative burdens in the system. If you have any questions, please contact Margaret Garikes at margaret.garikes@ama-assn.org or (202) 789-7409.

Sincerely,



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