September 27, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Subject: Good Faith Estimates for Creation of Advanced Explanation of Benefits

Dear Administrator Brooks-LaSure:

On behalf of our member physicians, hospitals, health systems and medical groups, the American Hospital Association (AHA), the American Medical Association (AMA) and the Medical Group Management Association (MGMA) write to urge the Centers for Medicare & Medicaid Services (CMS) to implement the Advanced Explanation of Benefits (AEOB) price transparency provisions under the No Surprises Act in a way that promotes price transparency for patients without delaying patient care or placing unnecessary administrative burdens on providers.

To promote greater price transparency and give patients a reasonable expectation of the costs of planned treatment, the No Surprises Act requires health plans to deliver an AEOB to patients prior to care delivery. The AEOB is created by insurers using good faith estimates (GFE) from providers. In this way, the GFEs are essentially a pre-claim that the insurers will use to create an AEOB in the same manner as they use claims post-care to create EOBs. We support this type of meaningful price transparency that aims to provide patients with reliable, personalized estimates of their out-of-pocket costs, as we believe such policies can help support patients in making informed health care decisions. We appreciate, however, that CMS has delayed enforcement of these provisions until a standard industry process for such information exchange can be adopted via regulation to ensure that these estimates can be created as efficiently and accurately as possible.

While technology vendors and standards organizations will play a critical role in the solutions being developed, we are deeply concerned by some of their underlying policy interpretations. The solutions we have seen to-date rely on the convening provider/co-provider framework created for the uninsured and self-pay GFEs, which would not provide the information necessary to create an AEOB for insured patients, be untenable

for providers from a workforce perspective, and, as a result, lead to care delays. **As CMS considers proposed solutions from these organizations, we ask that you 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.**

Development of AEOB Process

Recognizing the need for the industry to develop technical solutions to facilitate AEOBs, CMS delayed enforcement of the AEOB requirements until a standard process could be developed and subsequently established through rulemaking. To assist in the development of these solutions, our organizations have participated in industry conferences and standards development processes. Notably, these groups are comprised largely of health plan and vendor representatives.

At this point in the development process, we are concerned that the technical solutions favored most heavily by the standards organizations are inappropriately assuming that the convening/co-provider provider framework developed for the uninsured and self-pay GFEs will apply to the GFEs for the insured population. In other words, these potential solutions assume that a comprehensive GFE compiled by a convening provider will be shared with the insurer to create an AEOB, rather than each provider involved in the care submitting their own GFE to the insurer, which would more closely mirror the process individual providers use today to bill insurers.

Applying the convening provider concept to AEOBs would unnecessarily complicate this process. The creation of a comprehensive GFE is complex and highly burdensome for providers. Operationalizing this process for only those patients that are uninsured or self-pay is already requiring providers to establish new and often manual workflows and communication channels to exchange information between providers, as well as implement costly technology updates to support these new processes. While we recognize the value this investment of time and resources will provide to uninsured/self-pay patients, the same cannot be said for applying this process to AEOBs.

First, the process for generating a GFE for the uninsured will not result in something usable for insurers. As CMS notes in the implementing regulations for the uninsured GFEs, the estimates going to the uninsured and self-pay patients will be inherently different given their different purposes. The uninsured and self-pay GFEs are intended to help patients understand their expected costs. In contrast, the insured GFEs are intended to help insurers evaluate how they may adjudicate the expected claims for a particular patient and ensure the estimate that goes to the patient considers their health care coverage.

Second, applying the convening provider concept to the AEOB will result in excessive new administrative burden with real consequences for patients and the health care workforce. If such a requirement were to be imposed on providers for all patients, rather

than just uninsured or self-pay patients, we would expect a resulting delay in care because of increased demand on an already strained workforce. This burden would be entirely unnecessary as insurers can already handle receiving and processing multiple claims from distinct providers. Indeed, engaging with independent providers involved in an episode of care is a primary function of health insurers today. **Therefore, we urge CMS to 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.**

The following three sections detail the complexities that the convening provider/co-provider framework would create if expanded to all patient types, as well as more detail on the existing infrastructure and processes that could be used instead.

Differences in Information to be Collected

The convening provider/co-provider framework, as spelled out in the regulations implementing the uninsured and self-pay GFEs, would not satisfactorily meet the needs of the AEOB process. Generally, a GFE for an uninsured or self-pay patient requires the collection of information on patient demographics, diagnoses and expected services, corresponding charge rates and any potential discounts. This information should be sufficient to calculate a pre-service estimate for an uninsured or self-pay patient. Such information, however, would be substantially incomplete for insured patient GFEs. In addition to all the information required for uninsured patients, a GFE that is to be used by a payer to produce an AEOB would require all the additional inputs/information that payers require to apply their pricing edits. This process involves proper application of a substantial volume of adjudication-related codes (e.g., modifiers, revenue codes, occurrence codes) necessary to determine a patient's expected charge, which often varies depending on provider-type and contractual terms. The collection of all this additional information would be extremely burdensome and expensive for providers, as it would require additional professional coders to code all GFEs for AEOBs. It also would require technology upgrades beyond what will be required to meet the needs of the uninsured and self-pay GFEs.

In addition, the forms and electronic transactions currently used to report necessary claims information for post-service adjudication are different for institutional (UB-04/837I) and professional (CMS-1500/837P) providers. These forms contain different fields and require substantially different information for adjudication of insurer and patient payment responsibility. For many common episodes of care, a mix of professional and facility providers will be involved, which results in different claim formats being submitted individually by the different providers involved in the patient's treatment. For the AEOBs to resemble the post-care EOB most closely, the GFEs will need to be as reflective of the final claims as possible. This would mean that a convening provider would have to submit GFEs using data fields and formats to which their systems nor staff have familiarity. This cumbersome process would require

significant technology and workflow upgrades — to say nothing of extensive staff retraining — that would add substantial and unnecessary cost to the health care system, given that insurer systems already are designed to take in multiple claims in different formats for an episode of care.

Utilization of Existing Infrastructure and Processes

Determining financial responsibility for insured patients differs significantly from that of the uninsured. As discussed previously, the insured patient revenue cycle process requires each billing provider or facility to send individual claims to the patient's insurer(s), who then applies claims edits and contractual requirements to the information received from each provider involved in care. Ultimately, the plan calculates its obligation and the patient responsibility according to these adjudication processes.

To ensure that the AEOB estimate reflects as closely as possible the post-service patient responsibility, the process for calculating that amount should be consistent whether adjudicating a claim or a preservice estimate. **Leveraging existing provider and health plan workflows, standards and technologies for claim submission and adjudication will support the creation of accurate AEOBs for patients.** This approach also will minimize the development costs involved in implementing the AEOB process, as the industry can use the strong foundation of our current claims process to support the creation of AEOBs.

Unsustainable Volume

In addition to the inefficiencies with creating a new process discussed above, we also are concerned about the volume of comprehensive GFEs that would need to be created if the convening provider/co-provider framework were to be applied to all patients. Although we have been working to map out a potential solution to make the creation of comprehensive GFEs for uninsured patients less burdensome, the process requires a significant amount of administrative time. While this process may ultimately be tenable for the uninsured patient population (if technical solutions can be successfully developed), it will inevitably add burden on providers, who will need to navigate an entirely new process prior to care.

According to the 2020 Census, approximately 8.6% of Americans are uninsured. Conversely, over 61% of Americans are covered under commercial health insurance,[1] whose care would be subject to the AEOB requirements. As a result, the volume of additional administrative work if the convening provider/co-provider were to be applied to the insured population would be impractical and unsustainable. This would likely result in care delays as providers would need substantial time to complete this process in between scheduling and providing care. This added administrative burden would also

[1] https://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_Estimates_2022_Q11.pdf

add substantial costs to the health care system, primarily due to the need to hire many new staff, something that already vexes health care providers today.

Conclusion

Our organizations appreciate the opportunity to work with CMS on the No Surprises Act's price transparency provisions implementation, and we are committed to working closely with our members to ensure that they have the information and tools to successfully implement the new requirements. Additionally, we remain committed to ensuring that patients have access to complete and accurate out-of-pocket cost information for scheduled care and working with you to develop efficient methods of delivering this information.

If you have any questions, please feel free to reach out to Terrence Cunningham at AHA (tcunningham@aha.org), Emily Carroll (emily.carroll@ama-assn.org) at AMA, or Claire Ernst (cernst@mgma.org) at MGMA. We look forward to continued engagement on this policy.