April 4, 2022

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

RE: Agency Information Collection Activities: Requirements Related to Surprise Billing: Qualifying Payment Amount, Notice and Consent, Disclosure on Patient Protections Against Balance Billing, and State Law Opt-in [CMS-10780]

Dear Administrator Brooks-LaSure:

The Medical Group Management Association (MGMA) is pleased to provide comments to the agency in response to the request for comment regarding the surprise billing rules related to the qualifying payment amount, notice and consent process, and disclosures on patient protections against balance billing.

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 was passed by Congress as part of the Consolidated Appropriations Act, 2021 (P.L. 116-260) and created certain patient protections from surprise medical bills. MGMA and our members applaud Congress for protecting patient access to necessary care, while creating a pathway to ensure physicians and practices receive appropriate payment for out-of-network services. On behalf of our member group practices, MGMA appreciates the ongoing engagement from CMS to ensure patients, practices, and payers have the information necessary to adhere to the requirements under the No Surprises Act. Below, please find recommendations from MGMA to improve the patient protections against balance billing processes.

Balance Billing and Cost Estimate Disclosure Templates

For practices to ensure that every patient has access to information about their rights to be protected against certain balance billing practices, disclosure documentation must be translated into multiple languages. Further, after expending many resources to ensure appropriate translations are available, there may still be instances in which a patient speaks a language that a practice does not have the documentation readily available. As these translations require significant investment from practices, **MGMA urges CMS to provide the required disclosures against balance billing and the required documentation related to the uninsured and self-pay good faith estimates be made publicly available in the top 15 languages spoken across the country.** MGMA members proudly furnish care across the nation to patients of all ethnicities and cultures, including many patients whose native language

is not English. By providing the disclosures in multiple languages, CMS is helping to ensure that even small practices that furnish care in diverse areas can provide accessible documentation for these important patient rights.

Timing of Provided Notice and Consent

MGMA supports the intent behind the timing of the provided notice documentation for patients who may be receiving care from out-of-network providers and agrees that patients should not be coerced into waiving surprise billing protections. However, the strict timeline established will place significant administrative burdens on practices to comply with the requirements, without the guarantee that patients have the time to discuss and fully understand the surprise billing notice documents. **MGMA recommends CMS use enforcement discretion for the surprise billing notice and consent timing requirements, thereby providing group practices with the flexibility to provide the notice and consent documentation in a workable time frame that also maintains the spirit of the law.**

Each physician and practice is unique and has different operating procedures to ensure that patients receive timely and effective access to care. The strict and arbitrary timing requirement for the surprise billing notice and consent process will upend physician practice operations. If a patient requires a service be scheduled for that day with an out-of-network clinician, it can require that the physician re-schedule numerous other patients and services to accommodate the strict three-hour timeline for services, causing unnecessary disruption and possible delayed care.

Good Faith Estimate of Costs in Notice and Consent Documentation

The intent of the good faith estimate is to ensure that patients are aware of the potential out-of-pocket costs they may face if they receive care from the out-of-network clinician, recognizing that the costs will be higher than they otherwise may have been had the care been provided by an in-network clinician. MGMA agrees that patients need transparency in the care they receive and the potential costs they may incur. However, the established good faith estimates of costs will result in unnecessary and overburdensome administrative hurdles. The good faith cost estimates require medical groups to predict what services will be provided to patients during a single episode of care, before the practice has an opportunity to conduct a visit. Each patient is unique and requires a specific course of treatment and care plan. Requiring group practices to apply general estimates of services to different patients will undermine the clinical practice of clinicians.

MGMA urges CMS to consider the impact of the good faith estimates on patient understanding of the costs of services. The intent behind the requirement to provide cost estimates to patients is to communicate with the patients that the services are not covered by their insurance company and there may be outstanding costs that the patient must pay. However, out-of-network clinicians will be unable to provide patients with meaningful cost estimates of services as their insurance may cover a portion of the medical bill. Additionally, there are numerous other mechanisms for which the patients can receive estimated costs for services, such as charge masters hospitals are required to publicly publish. **MGMA recommends CMS focus on ensuring patients have access to current price transparency methods established by the federal government and not layer on additional burdensome administrative hurdles to provide similar information to patients.**

Initial Payment or Notice of Denial Required Documentation

CMS requires that certain information be communicated by a payer or health plan issuer with either the initial payment or notice of denial following services protected under the No Surprises Act, including:

1. The Qualifying Payment Amount (QPA) for each item or service involved,
2. A statement certifying that, based on the determination of the plan or issuer: (1) the QPA applies for purposes of the recognized amount and (2) the QPA was determined in compliance with the methodology outlined by CMS,
3. A statement that if the provider or facility wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate the open negotiation, and
4. Contact information, including a phone number and email address, for the appropriate office or person to initiate open negotiations.

(86 Fed. Reg. 36898)

Many MGMA members have reported that this information may not always be communicated from payers when a practice receives on out-of-network claim that is covered under the No Surprises Act. **MGMA strongly urges CMS to expeditiously provide payers and practices with additional guidance about how this information should be communicated in a standardized manner.**

According to the National Association of Insurance Commissioners, there were 1,096 health insurers that filed claims in 2019.[1] While this figure represents the number of different insurers across the nation, it demonstrates the vast number of insurers that practices may interact with under the No Surprises Act. Each insurer may have different processes in place to communicate the required information with claims that are protected under the independent dispute resolution (IDR) process. It is critical that all health plans communicate this information in a standardized manner to ensure practices can quickly identify claims that are eligible to undergo the IDR process.

Additional Requirements for the IDR Process

In the interim final rule with comment entitled, "Requirements Related to Surprise Billing; Part I" [CMS-9909-IFC], the issuing Departments sought comment on if there should be a minimum payment rate or methodology for a minimum initial payment to be established in future rulemaking (86 Fed. Reg. 36901). The Departments considered how this could impact the number of cases that ultimately ended in arbitration. While MGMA does not believe there should be an established rate required for an initial payment for out-of-network care protected under the No Surprises Act, **MGMA urges CMS to require that a payer's initial payment must also be used as their offer to an IDR entity under the IDR process if a either party chooses to undergo the arbitration process.**

Such a policy would ensure that whatever the payer offers as an initial payment to the provider, prior to any negotiation or IDR determination, would be most comparable to the fair rate that the payer believes should be the final payment amount and would prevent payers from low-balling providers. MGMA believes this is an appropriate solution to limit the number of cases that ultimately undergo the federal IDR process and greatly incentivize payers and providers to settle dispute resolutions outside the IDR process.

MGMA appreciates the opportunity to continue our partnership with CMS 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

[1] U.S. Health Insurance Industry Analysis Report, National Association of Insurance Commissioners (NAIC). Accessed: March 30, 2022. https://content.naic.org/sites/default/files/inline-files/2020-Annual-Health-Insurance-Industry-Analysis-Report.pdf

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