September 3, 2021

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

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

RE: Requirements Related to Surprise Billing; Part 1 [CMS-9909-IFC]

Dear Secretary Becerra and Administrator Brooks-LaSure:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the interim final rule with comment entitled, "Requirements Related to Surprise Billing; Part I," file code CMS-9909-IFC.

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. The regulations finalized by the appropriate agencies during the latter half of calendar year 2021 will be critical to shape how the surprise billing protections are effectively implemented and enforced.

MGMA recognizes the effective date for the statutory ban on surprise medical bills is January 1, 2022, and that the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) lack the authority to delay the implementation date for the ban on surprise billing. **However, MGMA strongly urges the agencies to continue using their regulatory and enforcement discretion when enforcing the surprise billing requirements.** We appreciate the agencies' announcements in delays of enforcement of specific requirements related to surprise medical billing, including the delay of enforcement of the advanced explanation of benefits, and encourage the agency to continue to evaluate the impact the ban on surprise billing regulation will have on group

practices. Over the past 18 months, clinicians have been on the frontlines providing critical care to patients during the COVID-19 pandemic. While MGMA agrees with and supports patient protections against astronomical surprise medical bills, practices lack the administrative bandwidth to create new workflows to respond to the surprise billing requirements in such a short time frame. **MGMA urges the agencies to honor practices' good faith attempts to comply with the surprise billing regulations as the agencies continue to establish rules related to surprise billing.**

As the agencies continue to refine the regulatory framework to implement the surprise billing protections, MGMA is pleased to offer comments in response to the agencies' first interim final rule with comment (IFC) related to the notice and consent requirements for out-of-network care provided to patients.

Timing of Provided Notice and Consent

HHS proposal (86 Fed. Reg. 36906): HHS and CMS establish the timeline for which out-of-network providers must provide notice to patients that the care furnished is being provided by a physician whose services are not fully covered by their health insurance plan. The agencies state that for services scheduled at least 72 hours in advance of the procedure, notice must be provided to the patient no later than 72 hours before the scheduled service and for services scheduled on the same day they will be provided, the clinician must provide the patient with notice three hours before the service will be provided.

MGMA Comment: 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 urges HHS and CMS to 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 time frame that works for the individual clinician while continuing the maintain 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. Physicians will continue to provide necessary care to patients, without flexibilities, regardless of the consequences it may have on their practice and the disruption in care for other patients continuing to demonstrate their unwavering commitment of ensuring no patient goes without care.

Good Faith Estimate of Costs

HHS proposal (86 Fed. Reg. 36908): In the IFC, the agencies establish requirements for out-of-network clinicians to provide patients with estimates of the total out-of-pocket costs for services as part of the notice and consent process. The good faith estimate is to include all reasonable costs that may be provided as part of the episode of care, including those provided by the facility or other out-of-network clinicians that will be providing care to the patient. Those costs that are not included in the good faith estimate provided to patients prior to the furnishing of out-of-network care will continue to be covered under the surprise billing protections for patients.

MGMA Comment: 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. 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 HHS and CMS to consider the impact of the good faith estimates on patient understanding of the costs of services. Again, 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 HHS and 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.**

Disclosure of Prior Authorization and other Care Management Requirements

HHS request for comment (86 Fed. Reg. 36908): HHS and CMS request stakeholder comment on the appropriateness and ability for out-of-network providers to share what, if any, prior authorization requirements or other care management services are required by a patient's insurer or health plan issuer when communicating cost estimates with notice and consent documentation.

MGMA Comment: **MGMA and its members strongly recommend the agencies do not establish additional requirements for clinicians to provide specific information to patients about the prior authorization and care management requirements that apply to services covered under the notice and consent for out-of-network services.** Obtaining such information would require significant time and energy for practices to identify prior authorization information for in-network services, and it would be nearly impossible for clinicians to determine what specific prior authorization requirements exist for a patient covered under a health plan that the clinician does not contract with. While patients should have access to information important to make appropriate decisions about their care, MGMA recommends that HHS and CMS evaluate alternative pathways to ensure patients have access to important information about the coverage of services while ensuring practices are not spending hours tracking down information readily available through an insurer or health plan. The onus of ensuring patients are cognizant of any applicable utilization management mechanisms, such as prior authorization, should be on the plan that controls, implements, and oversees the care management procedures.

MGMA will continue to partner with HHS and 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 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