

August 11, 2021

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: Implementation of the No Surprises Act - Advanced Explanation of Benefits and Good Faith Estimates

Dear Administrator Brooks-LaSure:

On behalf of our physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to offer input on the implementation of the No Surprises Act (NSA), which was signed into law as part of the Consolidated Appropriations Act, 2021 and addresses surprise medical billing at a national level.

On May 21, the AMA submitted comments related to the implementation and calculation of the Qualifying Payment Amount (QPA) under the NSA, as well as the QPA audit process due to the statutory guidelines. Shortly after, on June 14, the AMA submitted comments focused on the implementation of the Independent Dispute Resolution (IDR) Process, the Notice and Consent requirements, and the determination of a Specified State Law. The following comments focus on sections 111 and 112 of the NSA—the advanced explanation of benefits (AEOB) and good faith estimate (GFE) requirements. The AMA continues to work to build consensus on these issues among many of the state medical associations and national medical specialty societies, particularly those impacted by the provisions covered in this letter. The recommendations below largely reflect such work.

Support for Meaningful Transparency

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.

With these goals in mind, the AMA views AEOBs as meaningful price transparency tools. In fact, providing information to patients about their financial liability prior to services being rendered allows them to make informed choices about their care, where they receive it, and how to plan for the financial responsibilities of those services. The following comments are largely an effort to clarify the processes involved in generating an AEOB and ensure that stakeholders have the necessary resources and information to communicate patients' costs effectively and efficiently.

Good Faith Estimates

It is the AMA's understanding based on the statutory language that a physician must submit to a health plan (when coverage is being sought by an insured patient) a GFE of their charges to trigger creation of an AEOB. This GFE must be provided within a tight timeframe (one business day if care is scheduled three to ten days in advance, and three business days if care is scheduled more than ten days in advance). Given these timeframes, we urge CMS to limit the requirements of the GFE to only the information critical to generating a meaningful AEOB for the patient and only the information that is reasonably within the physician's ability to quickly and easily obtain.

For example, a single physician involved in a procedure should not be held responsible for determining the service codes and other billing information for care delivered by other providers in conjunction with a scheduled procedure. We believe, unless clarified in regulation, that these requirements could extend to intake procedures, post-surgical care, and even rehabilitation, making it nearly impossible for an independent physician practice to obtain and submit the required information for a timely GFE request.

The AMA urges CMS to clearly limit the scope of GFE requirements for an individual provider to only the information related to the treatment that will be delivered by that particular clinician. This would appropriately mirror the current claim coding and submission process when there are multiple physicians and other providers involved in a full episode of care—each individual provider and/or facility prepares and submits claims for the specific treatment it delivers.

As stated above, the AMA believes the most valuable information to a patient is the cost information related to their financial liability. Therefore, in an effort to reduce burden while still ensuring meaningful cost information is provided to the patient, the AMA urges CMS to relieve in-network physicians from being required to submit an estimate of their charges to the plan, as their payment (and resulting patient cost-sharing) is predetermined by the contracted fee schedule. Rather, in-network physicians would simply be required to communicate the services they anticipate providing to the patient. Additionally, the AMA requests that those providers who are not permitted to obtain consent to provide out-of-network care at a participating facility also be exempt from having to submit an estimate of their charges to plans, as the only relevant information for the patient in these situations is the recognized amount (based on the QPA).

Additionally, the AMA seeks additional clarity on several components under sections 111 and 112 of the NSA. First, it is unclear if the GFE and AEOB requirements apply to all scheduled services or only those provided at in-network facilities. Also, some patients may not want a cost estimate in the form of an AEOB and may be more accustomed to other price transparency tools. The AMA interprets the statute to require the GFE and AEOB only upon request by the patients, but we seek to confirm (and encourage) that interpretation. Furthermore, **the AMA seeks clarity on whether current processes that practices or hospitals have in place to provide cost estimates will automatically trigger an AEOB** or if there is space for providers to continue with these practices outside of that process without being required to do duplicative administrative work.

Good Faith Estimate under Notice and Consent Requirements

The July 12 IFR explains that a GFE of charges, as well as information about available in-network providers and utilization management, is required to be given to patients by out-of-network physicians as part of the notice and consent provisions under section 104 of the NSA. The AMA understands this requirement to be different than the GFE requirement under section 112 to be submitted to health plans. The AMA is concerned that the charge estimates required under the notice and consent provisions combined with the GFE requirements under section 112 may overwhelm physician practices and provide patients with potentially confusing cost information from multiple sources.

For example, a patient may schedule care with an out-of-network physician at an in-network facility and be provided with notice and consent forms that include an estimate of the physician's charges. Other out-of-network providers involved in the patient's care will do the same. As such, patients may receive multiple estimates from multiple providers with notice and consent forms prior to care. Providers will then, abiding by a different timeline, collect the information required under section 112 and provide a GFE to the plan to generate an AEOB. Patients will subsequently receive the AEOB that details their estimated financial responsibility, which could be significantly different than the initial charge estimates depending on their coverage. While recognizing statutory constraints, the **AMA urges CMS to consider the implications (and value) of multiple and varying price estimates for patients, and to consider ways to reduce patient confusion and administrative burden.**

Quality as a Factor in Cost Estimates

In discussing price transparency and patient decision making, the AMA wants to highlight the fact that true value-based care decisions require both cost *and* quality information. The AMA recognizes that integrating cost and quality information in a useable format in transparency efforts is challenging, aggravated by the fact that many health care services still lack relevant quality metrics. Studies indicate that patients are willing and able to make choices based on value as long as the information is presented clearly. The AMA urges CMS to consider how quality information can be communicated to patients with cost estimates and would be happy to have further discussions to advance this goal.

Workflow Concerns and Ensuring Physician Access to the AEOB

A patient is likely to request a GFE and AEOB from just one of the providers involved in the scheduled care, but there will frequently be multiple providers who will need to submit a GFE to the plan. As a result, it seems that the provider from whom the GFE has been requested may need to alert other providers of the requirement. Understandably, this process, because it is outside of the current workflow and there is no automated means of communicating this information, will require time and resources from physicians. The AMA urges CMS to consider providing guidance on this notification process and expectations of providers involved in the scheduled care. Additionally, the AMA urges CMS to offer allowances for providers who are not notified of the request in time to meet the deadlines and allow resolution without penalty.

Additionally, the AMA is concerned that there are no requirements that the AEOB be transmitted to the physicians and other health care providers submitting a GFE. **We strongly urge CMS to put such a requirement in place.** Upon receiving the AEOB, the patient may have questions regarding the cost and care information and will likely approach their health care providers first to answer their questions. **It is imperative that physicians and hospitals be equipped to answer these questions, and the AEOB will be needed to support informed conversations.**

The Honorable Chiquita Brooks-LaSure

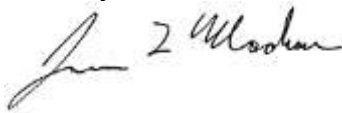
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Finally, the AMA is very concerned that no standardized, automated approach for transmitting the GFE to the health plan, as well as for the plan to transmit the AEOB to patients and providers, exists. If health plans each develop their unique, proprietary formats and methods for GFE submission and AEOB delivery, the industry will inevitably be faced with inconsistencies in the information, compliance difficulties, and increased administrative waste and manual workflow burdens. **The AMA urges CMS to work with stakeholders to create a HIPAA-mandated administrative electronic standard to support uniform exchange of this information.**

In conclusion, we thank you for this opportunity to provide additional input on the implementation of the NSA and look forward to continuing to work on this effort. If you have any questions, please contact Shannon Curtis, Assistant Director of Federal Affairs, at shannon.curtis@ama-assn.org or 202-789-8510.

Sincerely,

A handwritten signature in dark ink, appearing to read "Jim L. Madara", written in a cursive style.

James L. Madara, MD