Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9900-NC
P.O. Box 8013
Baltimore, MD 21244-8013.

Dear Administrator Brooks-LaSure,

The Healthcare Business Management Association (HBMA) appreciates this opportunity to provide feedback to CMS on the Advanced Explanation of Benefits (AEOB) requirement of the No Surprises Act (NSA). HBMA believes this requirement, and the related Good Faith Estimate (GFE) requirements, will create major time, administrative and financial burdens on physician practices. We welcome this opportunity to provide recommendations on how CMS can implement these statutory requirements in a way that avoids many of these burdens.

HBMA is the leading national trade association for the healthcare revenue cycle management (RCM) industry. HBMA is a recognized RCM authority by both the commercial industry and the governmental agencies that regulate or otherwise affect the U.S. healthcare system. Although HBMA membership includes some of the nation's largest billing companies (1,000+ employees submitting millions of claims), the typical HBMA member is a small to medium-sized business employing, on average 5-100 individuals. Nearly half of HBMA members have clients in more than one state.

HBMA understands the AEOB is intended to give patients more information about the cost of their care. CMS delayed the implementation of the AEOB because it recognizes the healthcare system is not currently able to operationalize these complex requirements. CMS issued this RFI to gather information about how it can implement the AEOB requirement. However, we believe that it is not possible to implement the AEOB requirement in a practical way that does not impose major administrative and financial burdens on providers.

In many ways, the AEOB is a solution in search of a problem. Patients already have access to the information the AEOB is intended to provide. This requirement shifts the burden of gathering this information from the patient to the provider despite the fact that patients are better positioned to gather this information on their own behalf.

Good Faith Estimate

Before we discuss the AEOB requirement and the RFI's questions in more detail, we feel it is important to first express our disappointment that this RFI did not also ask questions about the provisions of the NSA's Good Faith Estimate (GFE) requirement that have not yet been implemented by CMS. Specifically, the requirement that GFEs include care reasonably expected to be furnished in connection to the primary item or service.

There are two overarching challenges to implementing the GFE and AEOB requirements. The first is the operational challenges. The second is the electronic data transaction standards. Our comments will predominantly focus on the operational challenges while also addressing the data transaction standards at a high level.

This connected care provision of the GFE will be equally, if not more burdensome than the AEOB requirement. This will require providers to communicate with other providers who will almost always be from a different healthcare system, facility or practice to gather this information in an incredibly short period of time. A standardized electronic process to facilitate this communication does not exist. Providers will need to use manual processes such as phone calls and emails to gather this information in incredibly tight time frames.

Every practice typically has different EHR and practice management systems. Even in cases where the system is the "same", i.e. EPIC, CERNER, etc., these systems often cannot communicate electronically with each other due to the myriad versions and unique implementations. Although a specific hospital ***may*** have a standard system, different physician offices and specialties do not. In fact, there are many recent examples where a practice must print and fax medical records housed in a given system to a different practice locations or between hospitals using the same system.

What's more, providers must go through this process without knowing if the patient will actually use that co-facility or co-provider. The convening provider will often have no way of knowing what co-provider or co-facility the patient is planning to use for their connected care, such as a lab or image service. A convening provider will often make a referral but there is no way of knowing if the patient will utilize the provider from the referral.

There are no data transaction standards or established operational workflows to facilitate this communication between healthcare providers, just as there are no data transaction standards for the AEOB requirement.

To comply with these regulations, practices must:

- Have scheduling processes to screen patients to see if they are eligible for a GFE and AEOB.
- Verify a patient's insurance status and if the services in the GFE are covered by the patient's health insurance.
- Communicate with other practices and facilities using manual processes to share information for the GFE.
- Verify what co-facility or co-provider the patient chooses to use for their care.
- Communicate the GFE to patients and health plans.

These administrative processes require significant additional staff and technology resources – costs that are not reimbursed by government and commercial payers. The connected care providers are not held responsible for failure to respond, failure to meet specified unreasonable deadlines, or inaccurate responses.

In many cases, it is impossible for a provider to know the correct plan for sending the AEOB. These scenarios are most often caused by health insurers that use a "multi-plan" umbrella of plan options. These "multi-plans" typically have a list of enrolled plans that are many pages long. This list also changes as frequently as every month.

CIGNA, one of the nation's largest health insurers, uses multi-plans in several states. A patient might report that they have CIGNA, and a copy of the insurance plan card may not be available or provide needed detail at the time of scheduling or a visit. Providers therefore have no way of knowing if the patient is in- or out-of-network. When a claim is filed, CIGNA's remittance advice states denied and "forwarded to correct plan", which is also not identified. Providers then must manually contact CIGNA by email or phone to get the correct information. Many of these inquiries are unanswered.

Online portals have no available information specific to the in or out of network questions, whether the NSA applies, the allowable, the covered services, or the amount paid to the patient, if any. This type of issue is a set up for failure for both the physician office and the patients.

There is no mechanism under the NSA for the physician office (non-hospital setting) to file a complaint against the plan. Physicians are therefore forced to assume all patients are out-of-network and provide a GFE. Because of the confusion created by multi-plan lists, the provider is then unable to correctly identify the patient's health plan for the AEOB.

Proposed Solutions

Data transaction standards can be achieved through industry consensus. They can then be implemented from a technical standpoint after that consensus is reached. However, the operational changes that will be required of the entire healthcare system will be incredibly burdensome for comparatively little benefit to patients. Right now, the only way to operationalize the GFE connected care requirement and AEOB requirement is through administratively burdensome manual processes.

1. GFE Connected Care
   We recognize that CMS is statutorily required to implement these policies and that the only way to do so is by creating operational processes that do not currently exist. **We believe there is a simple way to implement the NSA's GFE and AEOB requirements without the need to create these new operational processes: eliminate the GFE connected care requirement.**

   CMS should not require the convening provider or facility to include connected care from a co-provider or co-facility on the GFE. Instead, patients would request or receive a GFE from each individual provider or facility with whom they are requesting or scheduling care. Patients still receive the same information with less administrative burden placed on clinicians.

2. Redefine "Reasonably Expected"
   We also recommend that CMS use its authority to define "care that is reasonably expected to be furnished in connection to a primary item or service" in a way that imposes the least amount of burden on practices.

CMS should also create hardship exemptions – as it does for many other policies – for scenarios where it would be impractical to facilitate this communication.

3. Delay Enforcement

   Another way CMS can phase in this requirement is to initially require GFEs and AEOBs only for patients who request them. Right now, patients are entitled to a GFE either upon request or when scheduling care. Patients who do not request GFEs might not be aware of this requirement and might be confused to receive a GFE and AEOB. This is especially true for the connected care portion of the GFE. CMS used its discretion to delay enforcement of the AEOB and connected care portion of the GFE. **CMS should use this same discretion to not enforce the GFE and AEOB requirement unless a patient requests a GFE.**

4. Provide Clarity on Implementation

   The industry must prepare for these policies even though they are currently delayed. It might be years before CMS implements these policies, if they ever are implemented. We appreciate CMS's decision to indefinitely delay implementation of the GFE connected care and AEOB requirements until CMS can establish a process to operationalize these policies. However, these delays cause uncertainty. Providers must always prepare as if they will be implemented in the coming year. CMS's continued decision to delay implementing the payment penalty phase of the Appropriate Use Criteria (AUC) requirement for advanced imaging services is an example.

   CMS can provide clarity to the healthcare system and reduce burdens by stating that it will indefinitely delay the GFE and AEOB requirements and that it will give the industry at least one year before any final rule implementing these requirements takes effect. This will prevent the healthcare system from investing resources towards compliance until we have certainty about how and when it will be implemented.

5. Require Health Plans to Disclose Accurate AEOB Information

   Health plans that use "multi-plan" models make it almost impossible for providers to correctly identify the patient's health plan. However, providers need this information to send the patient's GFE to the health plan for the AEOB requirement. Providers attempt to verify this information with health plans using burdensome manual processes such as phone calls and emails. Often, these inquiries do not receive any response from the health plan.

   CMS must alleviate burdens associated with multi-plans by requiring health plans to be more transparent about a patient's coverage. Health plans must include accurate information about a patient's health plan on the health insurance cards they provide to their members. Health plans also must be responsive to providers when inquiring about this information via email or phone calls.

Responses to RFI Questions

Requiring Diagnostic Codes on GFE and AEOB

The GFE regulations already require the GFE to include applicable diagnosis codes – despite the fact that these diagnosis codes are required to be furnished before any examination of the patient. Providers must select a diagnosis code based on information provided by the patient during the scheduling process, which is frequently incorrect because patients are not coders or diagnosticians. That inaccurate information would likely lead to an incorrect AEOB because diagnosis determines coverage for many exams.

If providers must go through the trouble of selecting a diagnosis code for the GFE, health plans should also be required to include that information in the AEOB they furnish to patients.

Economic and Administrative Burdens of FHIR-based APIs

CMS asks for feedback about using FHIR-based APIs to facilitate the AEOB data transfer. CMS suggests modeling this framework on the API framework it created to facilitate patient health data between EHR systems and with patients. We believe this can work in concept. However, CMS only just began implementing this model for interoperability. We feel it is best that CMS sees how this works for interoperability before replicating this concept for the AEOB.

We also believe there will be significant administrative and cost burdens on small providers that do not have the resources to understand and utilize the many APIs that will exist for this transaction.

CMS also asks about the cost burden to practices that would need to purchase third-party APIs for the AEOB. It is unfortunate CMS needs to ask this question. The APIs will impose an additional, non-reimbursable cost onto practices to comply with a policy that will have a nominal benefit for patients.

Time and Cost Burden Associated with AEOB Requirement

The GFE connected care and AEOB requirements will impose significant time and cost burdens on practices that will not be reimbursed by health plans. We have articulated these burdens throughout our response.

HBMA did not have time to facilitate a survey of members on the potential time and cost burdens of these requirements before the RFI submission deadline. We will consider conducting this research and will share any results with CMS in follow-up to this RFI response.

Conclusion

The GFE Connected Care and AEOB requirements will impose massive administrative and financial burdens on healthcare providers for limited benefit. Patients already have access to much of this information through their health plan and by requesting estimates from providers.

We hope CMS considers our suggestions which are summarized again below.

- **CMS should not require the convening provider or facility to include connected care from a co-provider or co-facility on the GFE. Instead, patients would request or receive a GFE from each individual provider or facility with whom they are requesting or scheduling care.**

Patients still receive the same information with less administrative burden placed on clinicians.

- **CMS should use its authority to define "care that is reasonably expected to be furnished in connection to a primary item or service" in a way that imposes the least amount of burden on practices.**
- **CMS should also create hardship exemptions – as it does for many other policies – for scenarios where it would be impractical to facilitate this communication.**
- **CMS used its discretion to delay enforcement of the AEOB and connected care portion of the GFE. CMS should use this same discretion to not enforce the GFE and AEOB requirement unless a patient requests a GFE.**
- **CMS must alleviate burdens associated with multi-plans by requiring health plans to be more transparent about a patient's coverage. Health plans must include accurate information about a patient's health plan on the health insurance cards they provide to their members. Health plans also must be responsive to providers when inquiring about this information via email or phone calls.**
- **CMS should also create a mechanism for office-based physicians to file complaints against health plans that prevent their members and providers from accessing this important coverage information.**
- **CMS can provide clarity to the healthcare system and reduce burdens by stating that it will indefinitely delay the GFE and AEOB requirements and that it will give the industry at least one year before any final rule implementing these requirements takes effect.** This will prevent the healthcare system from investing resources towards compliance until we have certainty about how and when it will be implemented.
- **If providers must include a diagnosis code for the GFE, health plans should also be required to include that information in the AEOB they furnish to patients.**

Thank you for considering our response. Please contact HBMA Director of Government Affairs Matt Reiter (reiterm@capitolassociates.com) or HBMA Executive Director Brad Lund (Brad@HBMA.org) if you wish to discuss our recommendations in more detail.

Sincerely,

Jennifer Hicks

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President
Healthcare Business Management Association