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

The American Alliance of Orthopaedic Executives (AAOE) submits these comments on behalf of our over 1,300 members and 660 medical practices across the country whose mission is to promote quality healthcare practice management in the orthopedic and musculoskeletal industry.

AAOE appreciates the opportunity to provide these comments to the U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (HHS), the Treasury (collectively, the Departments) and the Office of Personnel Management (OPM) regarding rulemaking for advanced explanation of benefits (AEOB) and good faith estimate (GFE) requirements stemming from the No Surprises Act, which was enacted as part of the Consolidated Appropriations Act, 2021 (CAA). AAOE's purpose with these comments is to provide insight and recommendations on how these rules impact the musculoskeletal industry and our patients.

Are there factors that should be considered that might alter the number of providers and facilities that would incur the burden and cost of providing a GFE to plans, issuers, and carriers for covered individuals?

1) Recommendation: Simplify or provide flexibility to the requirements for providing the GFE.

Reasoning: A December 2021 Medical Group Management Association (MGMA) survey indicated that 41% of group practices typically schedule patient appointments between 3-10 business days in advance of a health care visit.[1] Practices require this amount of time to determine insurance eligibility and complete prep work prior to confirming the appointments. Adding additional requirements demanding practices to furnish uninsured or self-pay patients GFEs no later than 1 business day before the items or services are scheduled to be furnished increases critical front office and patient finance tasks, such as the check-in/check-out and pre-

[1] MGMA GovChat Live, Surprise Billing, Dec 2021 https://www.mgma.com/resources/govchat-live-surprise-billing-slide-deck

registration processes that in turn delays care for these patients and in the overall burden to all pay patients.

Due to the increased administrative burden and continuing staffing shortages, practices will not have the capacity to provide GFEs within one business day. They will instead be forced to schedule services significantly further in advance to comply with the strict timing requirements. This in turn will negatively impact those patients most in need of care.

In short, by the Departments simplifying or offering flexibility, the requirements can more manageably be met and in turn medical care will not be delayed. This will benefit not only health care providers but those most vulnerable patients as well.

2) Recommendation: Propose a fee schedule for providing GFEs to the patients and do not make this an unfunded liability on the health care practices.

Reasoning: As health care practices are trying to recover from the COVID-19 pandemic, with unprecedented levels of burnout and workforce shortages compounded with inflation and higher costs, adding additional costs to these struggling practices is an unintended negative consequence of the policy. The GFE process requires significant manual effort by providers as there is currently no method for unaffiliated providers or facilities to share good faith estimates with a convening provider or facility in an automated manner. This is not something that practice management systems can generally do since billing information is traditionally sent to health insurers and clearinghouses, not other providers/facilities, and not to each other. This will result in additional costs for health care providers such as hiring staff for processing unpaid work. Additionally, this will require the ongoing costs of training staff for the change in pre-care processes associated with the delivery of the good faith estimates.

Patients are considered uninsured or self-pay if they do not “have benefits for an item or service under a group health plan,” meaning health care providers must do pre-authorization on every patient that asks for an estimate, not batch-eligibility transactions to verify eligibility as it is more resourceful and cost efficient. Additionally, health plans are not required to send back procedure-specific eligibility in their ASC X12 271 responses which instead allows for less granular information.

Increasing the expense to deliver health care through increases in administrative services means that more patients must be seen in a clinic. This directly impacts the amount of time a healthcare provider can spend providing treatment and doing their job. As a result, this will have a negative influence on all patients regardless of insurance status. Therefore, it is important that CMS propose a fee schedule for providing GFEs to the patients and not make this an unfunded liability on health care practices

3) Recommendation: Increase the $400 threshold for disputes.

Reasoning: The $400 threshold is impractical as they are based on practice charges and actual reimbursements. An office visit involving multiple touch points can vary significantly from patient to patient based on patient condition. It may or may not involve x-ray, MRI, injections based on patient acuity, splinting/casting/DME, etc. Slight changes during complex medical treatments would frequently trigger a $400 cost increase, which could lead to an excessive number of disputes going before the select dispute entities, wasting significant time and money better spent towards the care of our patients.

It is not possible to give an accurate GFE prior to an initial visit. The standard to meet should be the expected charges for the office visit and likely diagnostic tests. Otherwise, a GFE will be given that includes every probability which is ultimately uninformative. If a patient is trying to assess if they can afford a course of treatment this could demonstrate that seeking medical attention is unaffordable. We are recommending that the Departments allow health care providers to offer a GFE based on the initial appointment and then offer further information on costs associated with additional testing, treatment, or therapies based on the initial appointment. Rather than trying to account for all possibilities prior to an evaluation, account for the GFE of the evaluation and then a GFE for further testing, treatment, and therapies. Therefore, by increasing the threshold along with patient education on what will occur at a visit, CMS can help ensure that patients are not given too little or too much information on which to base their decision.

The Departments and OPM are interested in plans', issuers', and carriers' perspectives on whether a diagnosis code would be required for the calculation of the AEOB. Are there items or services for which a plan, issuer, or carrier would not be able to determine points of information such as: (1) the contracted rate; (2) the coverage level (that is, if the plan or issuer covers an item or service associated with one diagnosis at a higher rate than an item or service associated with another); or (3) whether an item or service is covered (that is, if the item or service is covered for one diagnosis but not another) for an item or service based on the service code and other information in the GFE in the absence of a diagnosis code?

1) Recommendation: Change the requirements around requiring diagnosis during the GFE.

Reasoning: When a patient calls to make an appointment they typically speak to the scheduling staff. A medical diagnosis is the process of determining which disease or condition explains a person's symptoms and signs and is limited by the scope of practice regulations in states to providers based on licensure. Requiring a diagnosis and level of care on a GFE from an initial phone call without a proper medical examination is impractical and increases the medical liability on practices. For example, inflammatory disorders, malignancy, pregnancy, trauma, osteoporosis, nerve root compression, radiculopathy, plexopathy, degenerative disc disease, disc herniation, spinal stenosis, sacroiliac joint dysfunction, facet joint injury, and infection can all present as “back pain” and can only be diagnosed by the relevant medical provider.

Without changing the requirements around needing diagnosis during the GFE, it is likely that unintended and unnecessary information is provided. Removing this requirement ensures that diagnoses are made by the proper medical authority, and which are beneficial to patients.

Comments on Interoperability

1) Recommendation: Delay implementation until there is standardization in interoperability requirements between EMRs.

Reasoning The convening provider or convening facility that schedules an item, service, or receives the initial request for a GFE from an uninsured or self-pay patient may not have the

practice management software interoperability with the other providers or facilities that the item or service may be provided with to obtain/coordinate the GFE. This adds an increased burden of time to prepare the GFE and could negatively impact patients by not having a way to freely share and secure information related to the GFE. We therefore recommend a delay in implementation until there is a standardization in interoperability requirements between EMRs.

Lack of Insurance Transparency and No Final Guidance from CMS

Recommendation: Delay implementation until CMS has provided additional guidance on how the lack of insurance transparency impacts patients who are underinsured or self-pay.

Reasoning: Obtaining accurate information including current benefits and remaining deductibles for patient benefits from insurance companies is extremely difficult due to the dynamic nature of claims and processing timelines of insurance carriers.

If a patient does not fully comprehend their insurance coverage, they may not understand that they qualify for the uninsured or self-pay GFE for certain items or services until after their appointment. If a practice later learns of the insurance status, this could lead to delays in patient care for the practice to ensure they are in complete compliance with the GFE requirements. Unless all GFE requirements are in place for uninsured, self-pay, or insured patients, confusion will persist and unintended delays in care may result.

Additionally, the accuracy of the GFE is dependent on the actual benefit information received from carriers and should not be the primary responsibility of the provider who has made good faith efforts in obtaining them from the carrier. By ensuring insurance carriers provide accessible and accurate benefit information ensures that providers and facilities can provide accurate GFE's.

Conclusion

Thank you for your time and attention to the concerns of the American Alliance of Orthopaedic Executives (AAOE) on this important topic. AAOE looks forward to working closely with the Departments on further improving our health care system and to enhancing the care of musculoskeletal patients in the United States. Should you have questions on any of the above

comments, please do not hesitate to contact Addy Kujawa, Chief Executive Officer, at akujawa@aaoe.net.

Sincerely,

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2022 – 2023 President, American Alliance of Orthopaedic Executives