aapm&r

9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org

PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

November 15, 2022

The Honorable Kira Ahuja
Director
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

The Honorable Martin Walsh
Secretary
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Ave NW
Washington, DC 20220

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

RE: Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals (RIN 3206-AO45; RIN 1545-BQ37; RIN 1210-AC14; RIN 0938-AU98)

Dear Director Ahuja, Secretary Yellen, Secretary Walsh, and Secretary Becerra:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), we appreciate the opportunity to submit comments in response to the Request for Information (RFI) on requirements for an Advanced Explanation of Benefits (AEOB) and Good Faith Estimate (GFE) for Covered Individuals. AAPM&R is the national medical specialty organization representing physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

As noted in the RFI, the *No Surprises Act* requires providers and facilities, upon an individual's scheduling of an item or service, to inquire if the individual is enrolled in a group health plan or group or individual health insurance coverage. If the individual is enrolled in a plan or coverage and is seeking to have a claim for such item or service submitted to such plan or coverage, providers and facilities must provide to the plan, issuer, or carrier a GFE of the expected charges for furnishing the scheduled item or service (and any items or services reasonably expected to be provided in conjunction with those items or services, including those provided by

aapm&r
9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org
PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

another provider or facility), along with the expected billing and diagnostic codes for these items or services. If the individual is not enrolled or is not seeking to have a claim submitted to such plan or coverage, providers and facilities must provide the GFE directly to the individual. Upon receiving a GFE, group health plans and health insurance issuers offering group or individual health insurance coverage must send to a covered individual an AEOB in clear and understandable language. Federal Employee Health Benefit (FEHB) carriers must also comply with AEOB requirements.

The Departments of Treasury, Health and Human Services (HHS), and Labor (collectively, "the Departments"), along with the Office of Personnel Management (OPM) previously issued an interim final rule with comment (IFC) titled "Requirements Related to Surprise Billing; Part II" on September 30, 2021, which specified the requirements for provision of the GFE to patients who are uninsured or self-pay. In that rule (hereinafter referred to as "the September 2021 IFC"), HHS finalized an elaborate and burdensome set of requirements that would require "convening providers and facilities" to coordinate with "co-health care providers and facilities" and collect expected charge data to incorporate into a single GFE – reflective of all expected charges reasonably expected to be provided in conjunction with a scheduled or required item or service – to be furnished to patients in unreasonably accelerated timeframes. While HHS noted that it would exercise enforcement discretion in situations where a GFE does not include expected charges from co-providers or co-facilities, and encouraged states to do the same when applicable, the period of enforcement discretion will end on December 31, 2022. As such, providers and facilities should expect to be held accountable for adhering to these challenging and time-intensive requirements for their uninsured and self-pay patients starting in January 2023.

AAPM&R is concerned that the expansion of GFE requirements to include all patients enrolled in a group health plan or group or individual health insurance coverage would impose substantial new burden on physician practices – particularly small and rural practices, and those disproportionately serving disadvantaged populations. Requirements to send GFE information to health plans and issuers for the services they themselves furnish would already double the workload involved in submitting claims for payment to plans and issuers. Imposition of further requirements consistent with the September 2021 IFC GFE requirements – that a primary scheduling provider also request, collect, and submit consolidated information across all providers and facilities that are reasonably expected to furnish care in conjunction with a required item or service – would be crippling. And it is possible that GFE requirements for insured versus uninsured patients may be even more burdensome to scheduling providers, who may have to verify patients' enrollment in plans and/or co-providers' network

aapm&r
9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org
PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

participation status with patients' plans. Practices are already facing significant state and federal regulatory burden, for example related to medical record documentation requirements, Merit-based Incentive Payment System (MIPS) reporting requirements, HIPAA Privacy and Security requirements, information blocking requirements, and occupational safety requirements. Physician practices also additionally face burdens imposed by health plans and issuers under their contractual obligations, for example related to provider credentialing, prior authorization, and medical record review. Together, these requirements – combined with the demands and pressures of the COVID-19 pandemic – have already contributed to the highest rates of physician burnout on record.

AAPM&R has significant concern that imposition of new GFE reporting requirements for insured patients would be unsustainable if sufficient protections are not put in place. Indeed, we note that such requirements would require considerable staff time and added administrative costs, yet it is not clear that physicians' payments would or even could increase to offset those costs. For example, under the Medicare Physician Fee Schedule (PFS), budget neutrality requirements would prevent payments for practice expenses to increase except to account for small annual updates to the PFS conversion factor that are specified in statute, when such updates become available starting in 2026; statute currently requires 0 percent updates until that time. As private payer rates are routinely tied to Medicare payment rates, physicians' ability to absorb these costs would be further limited.

In light of these considerations, AAPM&R believes that it will be of utmost importance to minimize the burden imposed on physician practices when developing and finalizing requirements for GFE and AEOB requirements. AAPM&R believes that an approach that requires health plans to utilize electronic data exchange using a FHIR-based application programming interface (API) would be important to reducing physician burden under the GFE and AEOB requirements. However, such a requirement would not be sufficient on its own, particularly given inconsistent utilization of APIs and ongoing adoption barriers. Instead, we urge the Departments and OPM to consider additional protections that could be implemented to minimize burden on physician practices. Potential avenues that could be explored include:

- Ensuring that electronic health record (EHR) technology that can accommodate development and transmission of GFE data is available and broadly implemented across the nation's physician practices, while also minimizing additional burden and costs for electronic data exchange on clinicians.
- Ensuring that all data that may be necessary to populate GFEs are available electronically and easily extracted from/via EHRs. At a minimum,

aapm&r

9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org

PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

this should include data on patients' enrollment status with health plans, providers' participation status with health plans, and plan and issuer covered benefits by procedure and diagnosis code.

- Requiring health plans to determine those services that should reasonably be expected to be furnished with a scheduled item or service and to incorporate those services and associated negotiated network payment rates to populate AEOBs, as feasible for routine services, rather than requiring providers and facilities to coordinate across the range of other providers and facilities that might be involved in the scheduled care to prepare a consolidated GFE; to the extent possible, physician practices should only be responsible for providing GFE data on the items or services they personally furnish.
- Providing special accommodations for small and rural practices and for practices disproportionately serving historically disadvantaged populations.

In alignment with our comments above and the need to further explore options, including but not limited to those detailed above, AAPM&R also urges the Departments and OPM to delay implementation of final regulations for GFEs and AEOBs until concrete solutions to minimize burdens for physician practices are developed.

We appreciate the opportunity to submit these comments on this important topic. If the Academy can be of further assistance to you on this or any other issue, please contact Megan Roop at 847-737-6018 or by email at mroop@aapmr.org.

Sincerely,

Thiru Annaswamy, MD
Chair; AAPM&R Quality, Practice, Policy & Research Committee