December 6, 2021
Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9800-IFC
P.O. Box 8010
Baltimore, MD 21244

SUBMITTED ELECTRONICALLY VIA http://www.regulations.gov
Re: CMS-9908-IFC: Interim Final Rule with Comment Period: Requirements Related to Surprise Billing: Part II

Dear Administrator Brooks-LaSure:

On behalf of the Society of General Internal Medicine (SGIM), thank you for the opportunity to provide comments on the Interim Final Rule with Comment Period (IFC): Requirements Related to Surprise Billing; Part II (CMS-9908-IFC). SGIM is a member-based internal medical association of more than 3,500 of the world's leading academic general internists, who are dedicated to improving the access to care for all populations, eliminating health care disparities, and enhancing medical education. Our members are committed to providing comprehensive, coordinated, and cost-effective care to all individuals. We appreciate the agency's commendable efforts to provide patients with meaningful information on the anticipated cost of their care using good faith estimates (GFE). **However, SGIM has significant concerns that this provision as currently written will lead to unintended consequences potentially resulting in limited patient access to care and increased administrative burden on physicians and health care facilities.**

Expected Increase in Administrative Burden for Convening Providers

SGIM members provide long-term, primary care for patients with various and multiple chronic conditions, such as diabetes and hypertension. Many SGIM members also manage the conditions of vulnerable populations who are often uninsured and at higher risk of presenting with more severe illness. It is our understanding that the IFC would require providers to supply GFEs to all individuals who are uninsured or classified as self-pay regardless of whether they ultimately receive care from that provider.

Specifically, the IFC implements the detailed statutory requirements for convening providers who provide care for uninsured and self-pay patients. Specifically, the convening provider must deliver a GFE that includes the following information: a description of the primary service; an itemized list of items and services reasonably expected to be furnished as part of the primary service or in conjunction with that service; applicable diagnosis codes, expected service codes, and expected charges for each; name, National Provider Identifier, and Tax Identification Number of each provider represented by the GFE; a list of items and services that the convening provider or convening facility anticipates will require separate scheduling; a disclaimer that informs the patient that there may be additional items or services recommended as part of the

course of care that must be scheduled separately; and a number of disclaimers, including those that state this is only an estimate, the patient has the right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess of the those included in the GFE, and that the GFE is not a contract between the provider and the patient. Convening providers will be required to deliver this information to the uninsured or self-pay patient within three business days of scheduling an item or service and one business day for an item or service scheduled to be provided in three business days.

With these requirements in mind, SGIM is very concerned about the significant amount of work this will require providers to carry out in advance of the scheduled service, particularly since there is a possibility the patient may ultimately choose not to seek care from the provider following receipt of the GFE. Furthermore, providers may need to hire additional staff to fulfill these requirements, requiring an additional investment of already limited resources.

SGIM believes fulfilling the GFE requirements will prove to be a challenge, particularly for providers who serve in rural and underserved areas and those who may not have the staff or resources required to transmit this amount of information accurately and efficiently to best serve patients' needs. As an example, we believe it will be a particular challenge for convening providers to identify the necessary co-providers and co-facilities necessary in a patient's episode of care without a prior evaluation including history and physical exam of the patient. Primary Care Providers frequently see new patients without any prior medical records, thus making it difficult to know ahead of time whether it will be a routine visit focused on preventative health, or a visit to manage multiple complex medical issues requiring diagnostic testing and referrals. Even for established patients, providers often are asked to see patients with little information besides a single new symptom – prior to evaluation, it is difficult to estimate whether the evaluation will be a harbinger of serious illness or a benign finding. **For these reasons, SGIM believes it is necessary for CMS to limit the scope of the information included in the GFE to reduce undue burden on the convening provider.** SGIM worries that increased administration burden may have direct consequences on the delivery of patient care.

Unintended Challenges to Patient Access to Care

SGIM believes narrowing the scope of the GFE requirements is important for many reasons, especially to ensure this provision does not limit access to care for uninsured and self-pay patients. According to the IFC, should the patients' actual billed charges be at least $400 more than the GFE, patients have the right to invoke the patient-provider dispute resolution process. We are concerned that due to the broad scope of GFE requirements and corresponding administrative burden and the possibility of undergoing the dispute resolution process, providers may decline to offer services for uninsured or self-pay patients.

Providers are continuously being asked to do more work, with less resources and declining payment, as Medicare reimbursement rates have not remained consistent with inflation. These new requirements are being implemented at the same time as providers are expected to see a 10 percent cut in Medicare reimbursement if Congress does not take action to mitigate these cuts, meanwhile they are experiencing increased workload due to the COVID-19 pandemic.

Further, our country still faces a shortage of primary care that continues to pose barriers to access to patient care. **Therefore, SGIM respectfully requests the agency reconsider how to balance the necessary needs of patients and capabilities of providers by limiting the scope of the GFE requirements included in this IFC.**

Delay of Advanced Explanation of Benefits for Insured Patients

SGIM recognizes that the agency has deferred the enforcement of the provision which requires an advanced explanation of benefits (AEOB) for insured patients. This provision, once implemented, will require providers to transmit information similar to that included in the GFE to an insurance plan. **Consistent with our comments above, SGIM urges CMS to consider the scope of the AEOB and ensure that this requirement is less extensive than the GFE requirement.** We note that insurance plans would not require the same level of detail in an AEOB as an uninsured or self-pay patient would require in the GFE.

We thank you again for the opportunity to provide comments on this IFC. SGIM stands ready to work with you to ensure that patients have access to the information they need to prepare for their care, while preventing undue burden on providers. Should you have any questions, please don't hesitate to contact Erika Miller at emiller@dc-crd.com.

Sincerely,

Monica Lypson, MD, MHPE
President, Society of General Internal Medicine

1500 King Street • Suite 303 • Alexandria • VA 22314
Tel: 202.887.5150 • 800.822.3060 • Fax: 202.887.5405
Web: http://www.sgim.org