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American Association of Oral and Maxillofacial Surgeons

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November 4, 2022

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

Submitted online via www.regulations.gov

Re: File Code CMS-9900-NC Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals

Dear Sir/Madam:

On behalf of the American Association of Oral and Maxillofacial Surgeons (AAOMS), which represents more than 9,000 oral and maxillofacial surgeons (OMSs) in the United States, we appreciate the opportunity to provide information regarding certain price transparency provisions of the No Surprises Act (NSA), including the provision of good faith estimates (GFEs) for covered individuals.

OMSs – many of whom are part of small practices – are also an integral part of hospital systems, providing emergency department coverage, serving as essential members of trauma teams throughout the country and performing complex procedures at hospitals and other types of healthcare facilities.

AAOMS supports efforts to increase cost transparency in the delivery of healthcare services and understands the significance of empowering patients to make informed decisions about their care. We agree that the provision of a GFE for scheduled or requested services- regardless of a patient's insurance status- is an integral component of the consumer protections set forth under the NSA.

Our association also appreciates that the Centers for Medicare & Medicaid Services (CMS) has delayed enforcement of certain provisions, such as GFEs for covered individuals. The cost transparency requirements currently in effect have placed considerable administrative burden on healthcare providers across all specialties. Therefore, it is crucial the remaining GFE provisions are implemented in such a way as to mitigate further administrative burden on providers and prevent unnecessary delays in patient care.

To date, health information technology vendors and standards organizations have made significant contributions in addressing the technological challenges presented by the provision of GFEs for covered individuals and advanced Explanation of Benefits (AEOBs). Data standards and operating rules adopted industry-wide will be essential to facilitate accurate and meaningful healthcare information exchange. Despite the existence of mechanisms that show potential in meeting data transfer requirements, the fact remains that the price transparency provisions of the NSA, including the provision of GFEs for covered individuals, still pose significant operational challenges for healthcare providers. These challenges include, but are not limited to, structuring new workflows and establishing communication channels between providers, healthcare facilities and insurance carriers. **AAOMS supports the goal of cost transparency but encourages CMS and other federal agencies to ensure the appropriate technology infrastructure, such as a Health Insurance Portability and Accountability Act (HIPAA) administrative standard, for the transmission of good faith estimate information from providers to health plans is in place with guidance prior to implementing remaining cost transparency provisions.**

GFEs for covered individuals will place additional administrative burdens on an already strained healthcare workforce

Through the ongoing public health emergency (PHE), providers and healthcare organizations have continually met the challenge to deliver safe, quality and cost-effective care while finding novel ways to maintain a sound business model. Navigating a return to normalcy has been particularly difficult for solo or small practices – which describe most oral and maxillofacial surgery practices. Research by the American Dental Association’s Health Policy Institute shows that dental practice schedules were, on average, approximately 86 percent full as of September 2022¹. Although this is positive, staffing shortages remain a significant constraint to expanding patient volume to pre-pandemic levels; this is compounded by the fact that dental practice expenses have increased significantly in the past year¹.

Industry-wide inflation and staffing shortages have been exacerbated by the need to allocate increasingly scarce resources to develop the infrastructure and processes necessary to ensure compliance with NSA requirements, including the provision of GFEs to uninsured or self-pay individuals. Small office-based practices generally lack a robust administrative framework; yet operationalizing this process has required providers to establish new and often manual workflows and communication channels. This has placed an undue administrative burden on an already strained healthcare workforce. Indeed, reports throughout the industry have indicated that non-clinical and/or administrative staff are required to devote a considerable amount of work hours to complete GFEs for uninsured or self-pay individuals in accordance with the regulation.

Comprehensive GFEs for covered individuals are inherently more complex. Developing accurate advanced cost estimates for covered individuals and transmitting the requisite information to their respective health plans, within the significantly restrictive regulatory timeframes, will undoubtedly require more administrative staff hours to complete. The nature of this process will require staff

¹American Dental Association Health Policy Institute. State of the Dental Economy – Q3 2022 Update. https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/state_of_dental_economy_q3_2022_slides.pdf?rev=caa5c08c6ecc4a9298e2630126a39c3f&hash=FC9E3A38B95C47287D7AA73ECD0B42C7. September 2022. Accessed October 10, 2022.

with competencies in coding, billing, revenue cycle management and health information technology, as well as some clinical knowledge. This may entail hiring more administrative staff or extensive re-training and education of team members reassigned from other critical responsibilities, as hiring may not be an option.

Regardless of whether patient case loads reach pre-pandemic levels, GFEs for covered individuals will apply to a much broader patient population, significantly increasing the burden placed on providers to meet NSA cost transparency requirements. For instance, according to the 2020 Census, over 61 percent of Americans are covered under commercial health insurance, whose care would be subject to GFE and AEOB requirements². With such constraints as high-volume demand, staffing concerns and quick turnaround times, the provision of GFEs for covered individuals for the creation of an AEOB is simply not feasible in the current healthcare landscape, especially for those working within the limitations of small practice settings. **For these reasons, AAOMS urges CMS to adopt a standard for the provision of GFEs for insured individuals and the creation of advanced EOBs that would mitigate the administrative burden placed on providers.**

Expanding convening provider requirements to GFEs for covered individuals may create unnecessary delays in patient care

From a coding and reimbursement standpoint, an AEOB is similar to a pre-claim or pre-service cost estimate, generated to outline benefits and patient cost-sharing amounts prior to a patient receiving a particular item or service. In this way, health plans will utilize GFEs from providers in a similar manner claims are used post-care to create EOBs. Under the NSA, AEOBs will be created utilizing the GFE submitted by the provider which, according to regulation, is required to include all items or services reasonably expected to be furnished in connection with the patient's care, including those from other providers and facilities.

For uninsured or self-pay patients, this process is challenging. It requires communication between convening and co-entities at a level and pace that has proven difficult both to facilitate and maintain, given the constraints of the current healthcare environment. Although providers continue to develop potential solutions to these system inefficiencies, the application of a convening provider framework to GFEs for covered individuals will be exceedingly more difficult to navigate. As stated, comprehensive cost estimates for covered individuals will require extensive administrative staff time to complete in accordance with the regulation. It will also require the development and adoption of data transfer standards between insurers and both contracted and non-participating providers.

It should also be noted the information exchanged between providers and health plans is far more complex than the information required to develop a cost estimate for an uninsured or self-pay individual. For instance, the collection of information on patient demographics, diagnoses, anticipated services, charge rates and any applicable discounts should be sufficient to develop an accurate cost estimate for an uninsured patient. However, for an insured patient, such information is markedly incomplete from a claims adjudication standpoint. The proper application of

²Cohen RA and Cha AE. Health insurance coverage: Early release of quarterly estimates from the National Health Interview Survey, January 2021–March 2022. National Center for Health Statistics. https://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_Estimates_2022_Q11.pdf. July 2022. Accessed October 14, 2022.

adjudication-related coding information such as procedure codes, modifiers, diagnostic codes, place of service and revenue codes, within the context of plan terms (and contract terms, when applicable), significantly impact an individual's coverage for certain items or services. Therefore, both the submitting provider and the health plan must ensure processes are in place to aggregate and process this information accurately, consistently and efficiently.

Furthermore, many common episodes of care will include the involvement of both professional and facility providers. The forms and electronic transaction standards used to communicate claims information are unique to each provider type, with different data inputs, formats and coding. Should the convening provider framework be implemented in such circumstances, it would result in a significant amount of data that must be aggregated by a single provider – regardless of their familiarity with a particular claim standard or data set – to accurately reflect the episode of care so the health plan may appropriately determine coverage and patient cost-sharing.

Such a process would be cumbersome, resource draining and highly susceptible to error, not to mention impossible in some circumstances. Foreseeably, it may also create further system inefficiencies and delay patient access to essential healthcare services as providers and facilities would require additional time to schedule, coordinate and deliver healthcare services.

Currently, each provider involved in an episode of care may submit a pre-claim to the patient's health insurer for benefit determination prior to the item or service being rendered. The health plan receives and processes this information by provider type, forwarding an estimate of coverage, benefits and cost-sharing to the patient. The provisions of the NSA specific to GFEs for insured individuals and the creation of AEOBs would not prohibit this methodology from being applied here as well. Indeed, it would eliminate the burden placed on a single or convening provider from being held accountable for the submission of GFEs for all providers and facilities involved in the episode of care. Therefore, **AAOMS encourages CMS to adopt a standard that would allow each billing provider to submit a GFE to a patient's health plan to help reduce provider burden..**

Small practices and solo providers will face challenges in the implementation of new industry transaction standards

Although the development and adoption of a HIPAA administrative standard is undoubtedly necessary for the transmission of good faith estimate information from providers to health plans, technology platforms such as Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR) and the deployment of FHIR-based Application Programming Interfaces (APIs) may be cost prohibitive for small practices or solo providers, including OMSs.

Although OMSs treat patients in a variety of care settings, most are primarily office-based, functioning within the constraints of smaller practice settings. Many OMS practice management software solutions already include medical billing capabilities, which may be leveraged to support the transmission of cost estimate information for GFEs and AEOBs through FHIR-based APIs. Taking advantage of existing mechanisms in this way, particularly by adapting well-established processes with which providers across all specialties are well versed, would help to reduce administrative waste and lessen the strain on financial resources.

Despite this, the cost of implementing new transaction standards, operating rules and software applications will still be significant. Cost may also vary, depending on the individual practice needs, current software and the requirements established by CMS. Although AAOMS believes this to be a

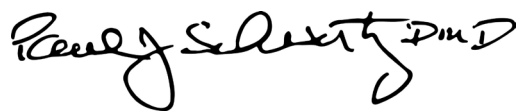
necessary investment to help facilitate meaningful and accurate cost transparency, any added burden on scarce resources threatens small business owners, particularly those in healthcare, to make difficult decisions that may ultimately impact access to quality healthcare services. As such, **AAOMS encourages CMS and other federal agencies to consider targeting assistance, such as payment incentives and technical support, to smaller healthcare practices and solo providers to facilitate the adoption of new technologies.**

Lastly, in the implementation of remaining GFE and advanced cost estimate provisions, AAOMS encourages CMS to consider the following:

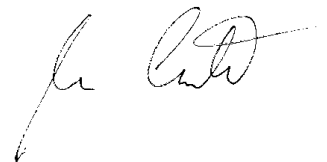
- **Implementation guidance must address instances in which health plans and providers must engage in multiple communications concerning the adjudication of a pre-service estimate. This is a frequent occurrence and, while feasible by claims processing standards, regulatory timeframes for advanced EOBs make such communications unworkable.**
- **It remains unclear as to how advance cost estimates will be handled for covered individuals when multiple health plans are involved. Coordination of benefits between carriers is a multi-stage process that is likely not feasible given the time constraints for GFEs and AEOBs.**
- **Clear and targeted education and outreach will ensure stakeholders across the industry fully understand the requirements related to the transmission of good faith estimate information between providers and health plans. This will also aid providers and healthcare managers to train and educate staff responsible for the completion of GFEs for covered individuals in accordance with the regulation.**
- **Providers will need sufficient time to upgrade their systems and incorporate new workflows.**

Thank you for your consideration of these comments. Please contact Patricia Serpico, AAOMS Director of Health Policy, Quality & Reimbursement, with any questions at 800-822-6637, ext. 4394 or pserpico@aaoms.org.

Sincerely,



Paul J. Schwartz, DMD
AAOMS President



Joshua E. Everts, DDS, MD, FACS
Chair, AAOMS Committee on Healthcare Policy, Coding & Reimbursement