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Establishing the Building Blocks for Price Transparency

Industry guidance on provider to payer approaches for good faith estimate exchanges

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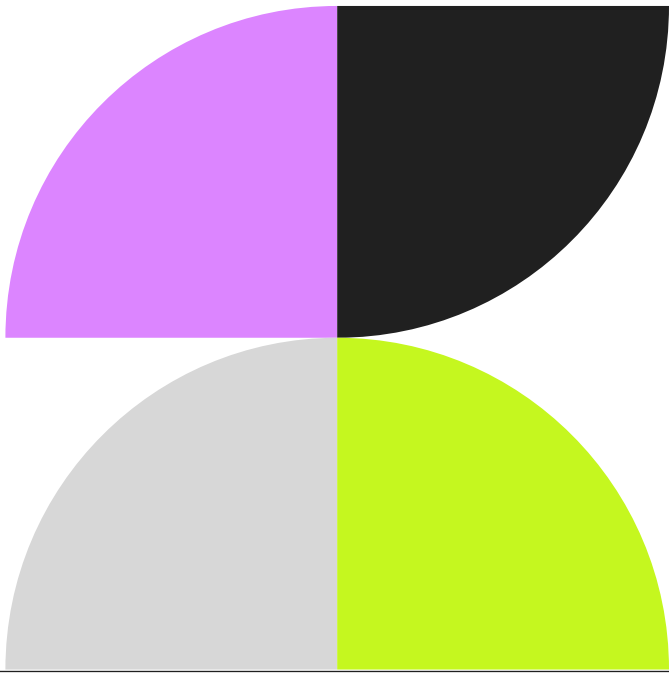
Introduction

About the effort

This guidance document is the first of a series of recommendations developed by the Advanced Explanation of Benefits (EOB) Advisory Group. The Advisory Group was convened as a forum for stakeholders across the healthcare industry to collaborate and build implementation, particularly regarding components of the No Surprises Act in the Consolidated Appropriations Act.[1] The Advisory Group included over 60 participants representing over 30 diverse healthcare organizations including providers, health plans, vendors, clearinghouses, associations, government entities, and standards development organizations.

The scope of this guidance, informed by the Advisory Group, is recommendations pertaining to messaging standards, industry-established methods for data connection, and standardized data elements to support the exchange of Good Faith Estimates between providers and payers. These recommendations are intended to support healthcare stakeholders and policymakers.



Background

Policy overview

The healthcare industry has seen several laws and regulations related to price transparency, including the Centers for Medicare & Medicaid Services (CMS) Hospital Price Transparency Rule,[2] CMS Transparency in Coverage Rule,[3] the No Surprises Act, and related regulations. The purpose of these policies is to increase consumer awareness of the cost of care and limit surprise billing practices.

The No Surprises Act, signed into law as part of the Consolidated Appropriations Act of 2021, addresses surprise medical billing at the federal level. Section 111 of the Act requires health plans to provide an Advanced EOB for scheduled services at least three days in advance to give patients transparency into which providers are expected to provide treatment, the expected cost, and the network status of the providers. Additionally, Section 112 states that healthcare providers and facilities must verify, three days in advance of a service and no later than one day after scheduling a service, what type of coverage the patient is enrolled in and provide notification of a Good Faith Estimate of charges to the payer client.[4]

A mandated compliance date was set for industry implementation of the No Surprises Act via an Interim Final Rule.[5] Although, the rule does not directly address Advanced EOBs, stakeholders were expected to implement the requirements using a good faith, reasonable interpretation of the statue by January 1, 2022. However, in August 2021, CMS published FAQ guidance indicating that the Department of Health and Human Services (HHS) will delay the issuance of regulations and defer enforcement activity for Advanced EOBs, Good Faith Estimates for those enrolled in a health plan, and other requirements of the No Surprises Act.[6]

Advanced EOB and Good Faith Estimate requirements

Guidance related to the No Surprises Act and Good Faith Estimate requirements state that the Advanced EOB must be shared with the member/patient by mail or electronically, depending on the individual's preference, and include the following information[7]:

- If a provider/facility is in- or out-of-network with respect to the item/service.
  - If the provider/facility is in-network, the contracted rate based on billing and diagnostic codes sent by the provider.
  - If the provider/facility is out-of-network, a description on how the individual can find contracted providers/facilities, if any.
- A Good Faith Estimate of expected charges based on billing and diagnostic codes.
- A Good Faith Estimate of the plan's payment responsibility and member's cost sharing responsibilities for the item/service.
- A Good Faith Estimate of the amount the member has incurred toward meeting their financial responsibility limit (including deductibles and out-of-pocket maximums) under the plan.
- Disclaimers that the coverage is subject to medical management requirements and the estimates are subject to change.
- Any other information health plans deem appropriate to include consistent with other requirements.

Industry initiatives

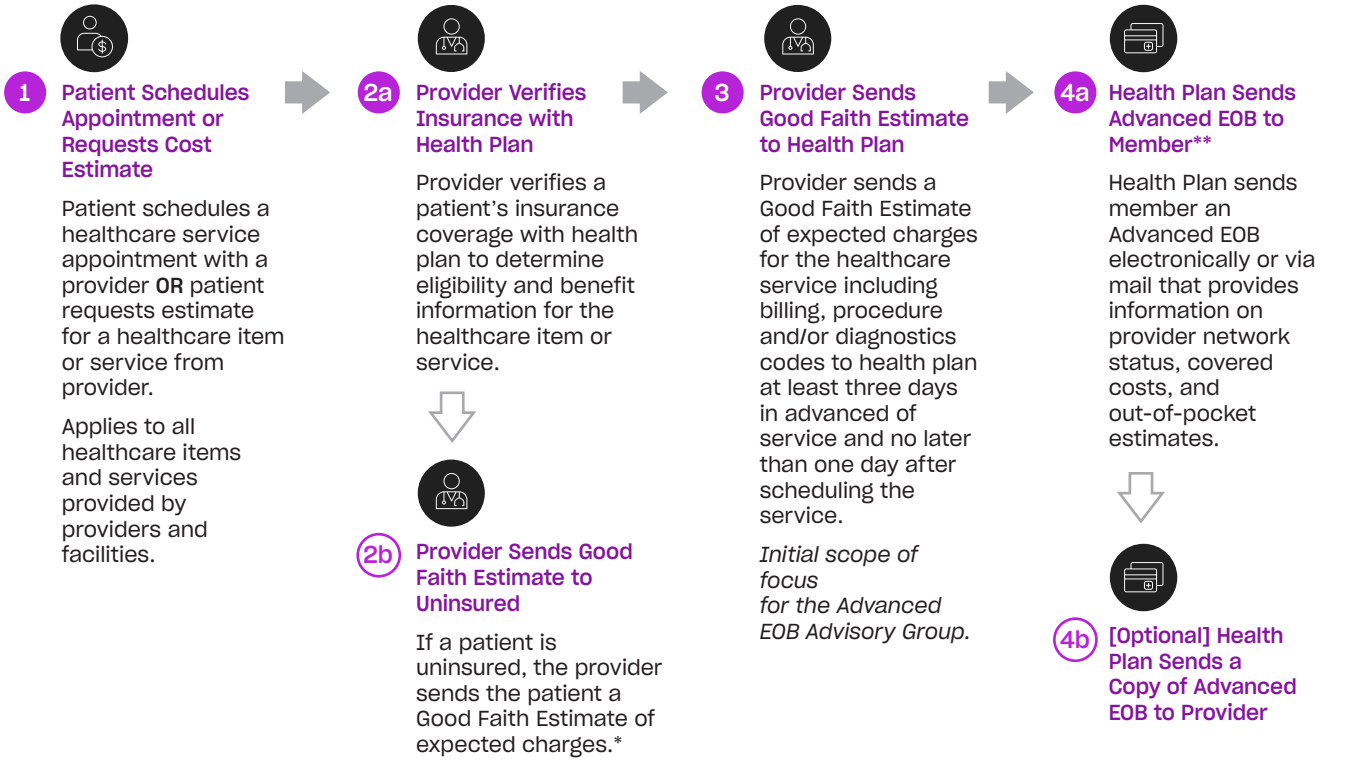
We sought to complement the efforts of other industry initiatives to support various aspects of the No Surprises Act and the Advanced EOB requirements. These initiatives included:

- Coordinating between X12 to identify potential transactions that support provider to health plan data exchange.
- Engaging with HL7® Da Vinci Project work to define a standard Health Level Seven International (HL7®) Fast Healthcare Interoperability Resources (FHIR®) Implementation Guide.[8]
- Aligning with CARIN Alliance's efforts to develop a common payer consumer data set (CPCDS) and corresponding CARIN IG for Blue Button HL7® FHIR® implementation guide .
- Working with The Workgroup for Electronic Data Interchange (WEDI) to focus on business challenges associated with the No Surprises Act and provide feedback to HHS, CMS, and other agencies.
- Provide recommendations from the Cooperative Exchange on clearinghouse perspectives on standards-based solutions to support predetermination of benefit/ estimation workflows as required by the No Surprises Act.[9]

Scope of focus: The Good Faith Estimate

The initial focus of the Advisory Group was the exchange of the Good Faith Estimate between payers and providers. This exchange occurs after a patient schedules an appointment or requests a cost estimate and the provider verifies insurance with the health plan. After those two actions, a provider/ facility must send a Good Faith Estimate that covers the period of care of expected charges for the healthcare service(s), including billing, procedure, and/ or diagnosis codes, to the health plan at least three days in advance of the service(s) and no later than one day after scheduling the service(s).[10] After the Good Faith Estimate is sent, the health plan sends the Advanced EOB to the member and optionally to the provider.

FIGURE 1: Advanced EOB Workflow



*Good Faith Estimates for the uninsured must be issued within one business day for services scheduled three to nine days for intended service date.

*Good Faith Estimates for the uninsured must be issued three business days for services scheduled more than 10 days from intended service date.

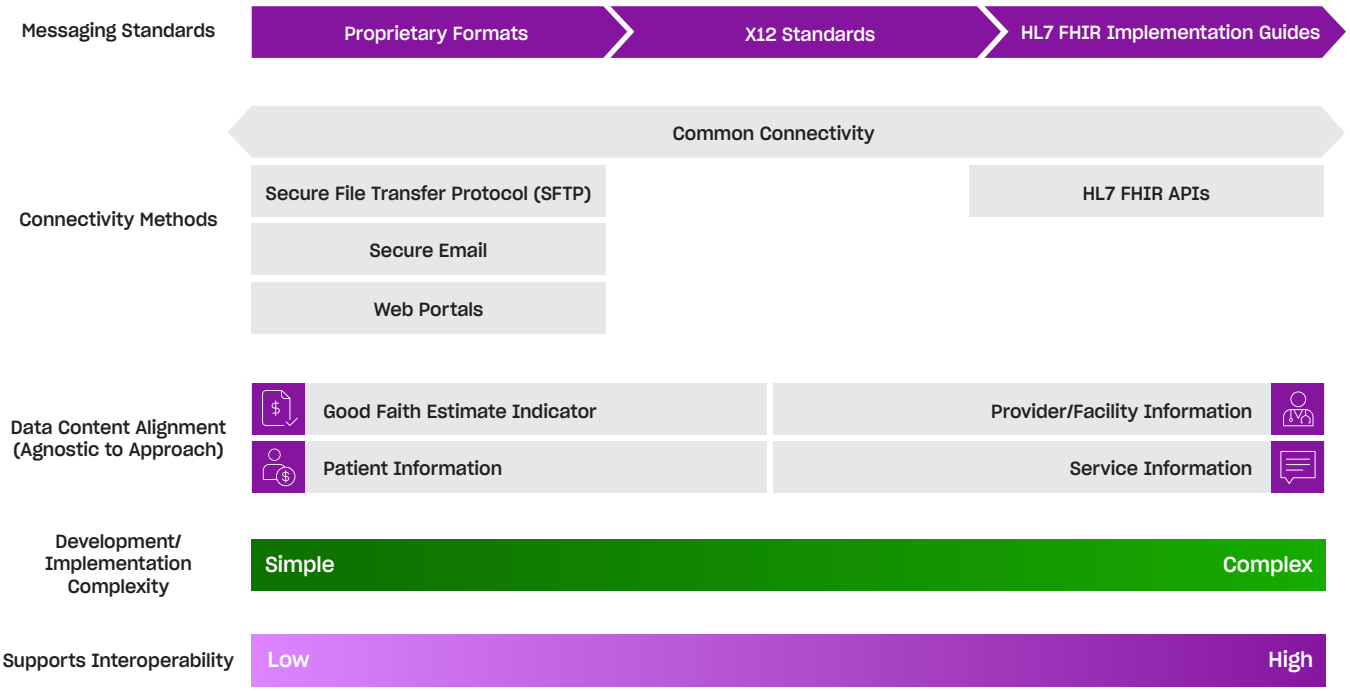
**Advanced EOBs must be issued within one business day after receiving Good Faith Estimate for services scheduled three to nine days before intended service date.

**Advanced EOBs must be issued within three business days after receiving Good Faith Estimate for serviced scheduled more than 10 days from intended service date.

Consensus-based Industry Recommendations

Today, there are a variety of implementation approaches the industry could consider when determining how to support the exchange of Good Faith Estimates between providers and payers. Each approach has varying degrees of development and implementation complexity, as well as levels of interoperability support. The Advanced EOB Advisory Group evaluated several approaches in detail, engaged in consensus-building,[11] and agreed to support a series of recommendations on the messaging standards, connectivity methods, and uniform data content needed in efforts to provide industry guidance on standardized approaches to facilitate the exchange Good Faith Estimates between providers and payers.

FIGURE 2: Implementation approaches for Good Faith Estimates



1

Messaging Standard Recommendation:

USE OF X12 837 PROFESSIONAL PRE-DETERMINATION X291, X12 837 INSTITUTIONAL PRE-DETERMINATION X292, AND HL7 FHIR

Messaging standards are agreed-upon methods for how data should be formatted and structured to support interoperable data exchanges. Some examples of organizations that develop consensus-based standards include X12, HL7, and the National Council for Prescription Drug Programs (NCPDP). In healthcare, there are a wide array of messaging standards that are regulated and mandated to support various use cases. However, in instances where a use case does not have an aligned standard to support its need, stakeholders implement a variety of approaches, which creates burden on the industry, adds complexity, and dissuades interoperability. As the healthcare industry evaluates options on how to exchange Good Faith Estimates for services between providers and payers, a standard-based approach should be pursued.

The Advanced EOB Advisory Group evaluated multiple messaging standards that could be leveraged to support Good Faith Estimate exchanges between providers and payers and coalesced to recommend the support of X12 837 Professional Pre-Determination 005010X291 (X12 837P v5010 Pre- Determination), X12 837 Institutional Pre-Determination 005010X292 (X12 837I v5010 Pre-Determination), and HL7 FHIR. The X12 837 P/I Pre-Determination transactions have the capacity to facilitate the exchange of Good Faith Estimates between providers and health plans. As an example, a provider can send a pre-determination claim to a health plan that includes the service with the necessary data — including provider, member, and associated billing information (procedure, diagnostic codes with associated modifiers, etc .) and a health plan can process and adjudicate the pre-determination claim to generate an Advanced EOB for the provider. Furthermore, the X12 837 P/I Pre-Determination transactions allow for multiple services and providers to be identified to support potentially complex billing scenarios that occur over a period of care.

Stakeholders advocated support for the X12 837 P/I Pre-Determination transactions as industry can leverage their implementations with the HIPAA-mandated X12 837 Professional 005010X222 and X12 837 Institutional 005010X223 transactions. Although there was strong consensus supporting the use of the X12 837 P/I Pre-Determination v5010 transactions, it should be noted that the X12 837 v8010 transaction also supports predetermination workflows.

Pre-Determination workflows are commonly used in the dental industry today and dental providers currently use HIPAA-mandated X12 837 Dental 005010X224 Implementation Guide to send predetermination claims to health plans to retrieve cost and patient responsibility information. To support X12 837 P/I Pre-Determination transaction implementations, the medical industry should leverage, adapt, and evolve predetermination frameworks already established by the dental industry.

In looking at options for using HL7 FHIR as a messaging standard for Good Faith Estimates, the Da Vinci Project Patient Cost Transparency Work Group (PCT WG) is working to develop a standard FHIR-based Implementation Guide to support near real-time requests and responses for patient cost.[12] While Advisory Group members recognized implementing the X12 837 P/I Pre-Determination transactions offers a faster path to delivering standards-based functionality, they also supported development of a standard FHIR- based methodology to support near real-time requests and responses for patient cost as a complementary, longer-term strategy.

Considering the level of adoption that already exists with X12 to facilitate the exchange of administrative healthcare transactions, stakeholders should look at implementing the X12 837 P/I Pre-Determination transactions to support Good Faith Estimates. Additionally, the Da Vinci Project PCT is leveraging the X12 837 P/I Pre-Determination transactions in efforts to harmonize data for a hybrid X12 and HL7 FHIR model. Regardless of the differences between the messaging standards, pathways forward should support the use of X12 and/or HL7 FHIR with aligned data content and not require one method over the other.

Although stakeholders may wait for regulatory direction prior to implementing a messaging standard, these consensus recommendations can inform policy decisions and early pilot efforts. By adopting the use of recommended standards whenever possible, healthcare organizations can reduce costs and complexities, accelerate implementations, and contribute to greater efficiencies.

2

Connectivity Method Recommendation:

COMMON CONNECTIVITY AND HL7 FHIR APIS

Connectivity is a generic term for connecting devices such as computers, information systems, or networks to each other to facilitate data access and exchange. Aligning on connectivity methods is essential to establish a foundation for interoperability as it provides the ability to exchange and integrate information across different information systems. A variety of connectivity methods are deployed in healthcare today to support information exchange. These methods include proprietary methods such as web portals, Secure File Transfer Protocol (SFTP), and Secure Email, or standard-based approaches such HL7 FHIR APIs. In evaluating approaches of how to transport, secure, and deliver Good Faith Estimates between providers and payers, a uniform framework should be pursued.

The Advanced EOB Advisory Group evaluated and discussed a variety of connectivity methods that could be used to transport Good Faith Estimates and coalesced to recommend connectivity approaches and HL7 FHIR APIs. Connectivity methods enable a framework for interoperability that is universal, easy to implement, low cost, secure, trusted, and industry recognized. Per federal mandate, common connectivity is required for all HIPAA-covered entities and widely implemented by industry. Thus, a large installed base of connectivity processes exist among HIPAA-covered entities that exchange administrative transactions.

Well positioned connectivity processes support the exchange of Good Faith Estimates between providers and payers by:

- Addressing connectivity and security of administrative and clinical data exchange and establishing a national base guiding healthcare communication.
- Aligning to support frameworks outlined in the CMS and the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) Interoperability Rules for modernized connectivity and security requirements.
- Using the internet as a delivery option and establishes a Safe Harbor connectivity method that application vendors, providers, and health plans can be assured will be supported by certified entities.
- Being payload agnostic by supporting the exchange of X12, HL7 FHIR Resources, and other data formats over SOAP Web Services and REST APIs.
- Ensuring secure transmission of information by requiring the use of TLS 1 .2 or higher for encryption, X .509 Digital Certificates for authentication, and OAuth 2.0 for authorization.

While common connectivity supports both recommended messaging standards to support the exchange of Good Faith Estimates, HL7 APIs are also recommended by the Advisory Group to transport HL7 FHIR Resources and Bundles. HL7 APIs are central to CMS and ASTP/ONC interoperability rules that provide patient access to information exchanged between providers and health plans. As healthcare organizations align on messaging standards, pathways can be established to identify which connectivity approach to use for a given messaging standard.

In general, the Advisory Group agreed stakeholders should avoid implementing proprietary connectivity methods, such as web portals, as these solutions discourage uniformity, add burden to implementers, and restrain interoperability. Instead, the healthcare industry should promote scalable solutions that can leverage existing EDI connections to support the exchange of X12 and/ or HL7 standards. As healthcare organizations align on existing and emerging messaging standards, a safe harbor can be established to identify which connectivity approach to use for a set standard, alongside the use of existing trading partner connections in place today. As an example, healthcare organizations can choose to transport the X12 837 P/I Pre-Determination transactions today via connectivity processes and, once a standard FHIR-based approach is developed, HL7 FHIR APIs can be used to transport HL7 FHIR Resources and Bundles in order to support the exchange of Good Faith Estimates.

3

Uniform Data Content Recommendation:

FOUR DATA GROUPS AND ASSOCIATED DATA ELEMENTS TO SUPPORT UNIFORM DATA CONTENT WITHIN A MESSAGE STANDARD, WHETHER X12 837 P/I PRE-DETERMINATION TRANSACTIONS OR HL7 FHIR

Data content refers to specific information requirements that must be included to ensure clear, concise, and successful communication. Within a single messaging standard there may be numerous individual data elements that can be communicated. Identifying base requirements on what data elements should be exchanged is essential for effective information exchange. When working with multiple standards, data nomenclature can vary, creating complexities on how IT systems should interact with data. Supporting a uniform scope for data content can help address this barrier and support interoperability goals. As the healthcare industry explores the types of data that need to be included in a Good Faith Estimate, it's imperative that a base set of data be identified and that the data aligns across recommended messaging standards.

The Advanced EOB Advisory Group identified four data groups and associated data elements to support uniform data content within a message standard, whether X12 837 P/I Pre-Determination transactions or HL7 FHIR, for the exchange of Good Faith Estimates:

- **Indicator:** Specifies how to notify a health plan that a standard transaction is for a Good Faith Estimate per No Surprises Act requirements, rather than a provider-driven query or a billable claim for payment.
- **Patient:** Defines patient demographics data needed for a health plan to identify and match the member who is receiving scheduled service or has requested an Advanced EOB.
- **Provider/Facility:** Identifies provider or facility demographic data needed for a health plan to determine who will be providing the scheduled service.
- **Service:** Data elements needed to attribute a scheduled service as indicated by a Good Faith Estimate.

The X12 837 messaging standards are well positioned to support data content needs for the exchange of Good Faith Estimates as they clearly define the required indicators, data content, identifiers, and code sets to support the estimation (pre-determination) or billing of a service or item for a period of care. As the industry considers implementation of the X12 standards, stakeholders should follow the usage of data elements per implementation guidelines and engage standards development activities to address any potential limitations.

As Good Faith Estimates are sent from provider to payer, indicator data is essential to determine that the message sent is to support an Advanced EOB. Given the Advisory Group recommended the use of the X12 837 P/I Pre-Determination transactions for a Good Faith Estimate, the need to align on uniform indicators may be resolved given the inherent purpose of the transaction. However, there may be other considerations for the use of indicators such as a Pre-Determination Indicator or Good Faith Estimate Indicator to ensure a Good Faith Estimate is properly routed and appropriate workflows can be triggered.

In review of patient information to be included on a Good Faith Estimate, the Advisory Group recommended, at the minimum, the inclusion of a patient's Member ID, Date of Birth, First Name, Last Name, and Subscriber/Dependent status to ensure a health plan can identify and match a member.

To attain accurate cost estimates, provider and/or facility information is an important driver that impact a patient's financial responsibility for a scheduled service. For example, a provider's network status, primary care versus specialist determination, and where the service is rendered are all factors that affect cost sharing. As such, the Advisory Group recommended that, at a minimum, industry should establish uniform data content requirements for the following: Provider/Facility Name, NPI, Place of Service, Provider Taxonomy, and Practice Location.

Drilling down into the actual service(s) or item(s) to be performed during a period of care is critical information for a health plan to generate an Advanced EOB. Providers must inform the health plan of an expected procedure planned or diagnosis indication alongside projected charge amounts via a Good Faith Estimate. Health plans in return must adjudicate this information against a member's plan design to generate cost sharing responsibilities on an Advanced EOB within a set timeframe. To ensure these processes are as automated as possible, the Advisory Group recommends that industry establish base data content guidelines requiring the inclusion of the following data elements, as applicable: Schedule Date of Service, Procedure Codes, Diagnosis Codes, Modifiers, and Charge Amounts.

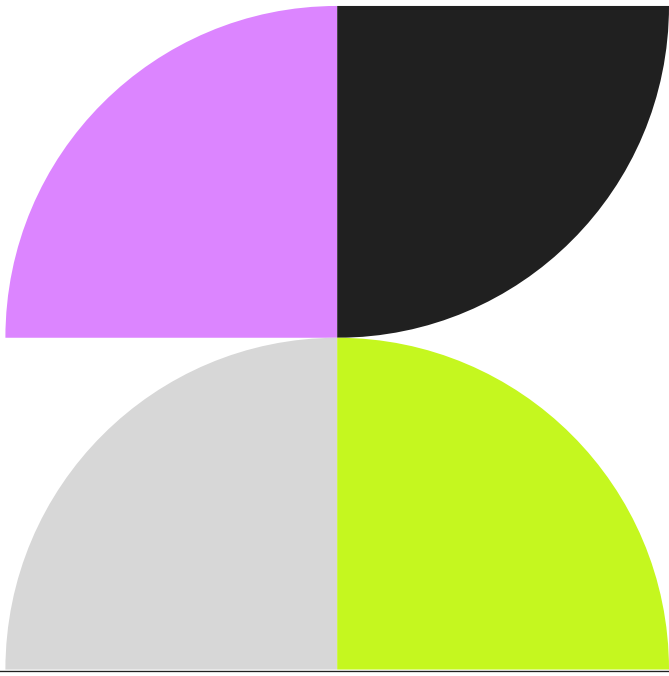
As the healthcare industry seeks to understand and align on data content needs for the exchange of Good Faith Estimates, it should be recognized that the X12 837 P/I Pre-Determination standards contain the data content required to support an estimate of services or items. This process requires similar data content needed for the billing of services or item, signifying that an Advanced EOB request workflow may mimic a claim submission. Although the uniform data content recommended by the Advisory Group is essential for building a Good Faith Estimate, the data elements are only a starting point for the industry to evaluate and the specific data needs need to be determined for specific scenarios.

Next Steps

The recommendations outlined in this report address one component of how industry can implement a standard approach to meet the No Surprises Act requirements for an Advanced EOB effectively and efficiently; however, there are still opportune outstanding issues for creating a holistic, standard approach. As acknowledged throughout this report, many industry initiatives are working to identify approaches.

In addition to these efforts, the Advanced EOB Advisory Group discussed and built consensus to address additional use cases for future consideration. The most pressing issues were identified as:

1. The collection of Good Faith Estimates that aggregates all items or services to be performed during a period of care.
2. A uniform and consistent set of data elements that enable a common information flow and format across all Advanced EOBs.
3. The exchange and delivery of an Advanced EOB from Health Plan to Member for a scheduled service or service estimates.
4. The exchange and delivery of an Advanced EOB from Health Plan to the Provider for scheduled service or service estimate.



Appendix

ADVANCED EXPLANATION OF BENEFITS ADVISORY GROUP

Participants in the Advanced EOB Advisory Group represented a diverse cross- section of healthcare stakeholders. The table below lists all participants who engaged in the Advisory Group. The recommendations outlined in this paper received at least 66 percent or two thirds support from Advisory Group organizations and do not necessarily represent the views of individual participants.

Participant	Organization
Heather Morgan	Aetna
Amy Neves	Aetna
Kellene Parthemore	Aetna
Merri-Lee Stine	Aetna
Terrence Cunningham	American Hospital Association (AHA)
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Thomas Mort	Availity, LLC
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Continued

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Bettina Vanover	Cognizant
Pat Wijtyk	Cognizant
Cristina Boincean	Edifecs
Alex Lucyk	Epic
Roger Johnson	Experian
Dan Wiens	Experian
Katherine Kilrain	Harvard Pilgrim Health Care
Parag Desai	Healthedge Software Inc
Douglas Hanna	Healthedge Software Inc
Melanie Combs-Dyer	Mettle
Drew Voytal	MGMA
Dennis Zanetti	NantHealth
Tonia Bateman	New Mexico Cancer Center
Sue Schlichtig	NextGen Healthcare Information Systems, Inc.
Nancy Team	NextGen Healthcare Information Systems, Inc.
Randy Gabel	Ohio Health
Bill Campbell	OneHealthPort
Linda Michaelsen	OptumInsight
Tara Rose	OptumInsight
John Balose	PaySpan
Robert Pinataro	PaySpan
David Mistkawi	The SSI Group, Inc.
Dawn Duchek	TriZetto Corporation, A Cognizant Company
A J Johnson	TriZetto Corporation, A Cognizant Company
LiLi Liu	Tufts Health Plan
Nicole Waickman	Tufts Health Plan
Robert Tennant	Work Group on Electronic Data Interchange (WEDI)

Endnotes

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9. "No Surprises Act Good Faith Estimate / Advanced EOB Standards-based Approach," cooperativeexchang.org website, https://www.cooperativeexchange.org/site_announcements_detail.cfm?pk_association_announcement=18829
10. "Requirements Related to Surprise Billing; Part II," federalregister.gov website, https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-tosurprise-billing-part-ii
11. This consensus-based process included a series of calls and straw polls that gave participants the opportunity to engage in meaningful discussion as well as indicate their level of support and provide comments for each recommendation. The recommendations outlined in this paper received at least 66 percent or two thirds support from participants and do not necessarily represent the views of individual participants, but the majority view.
12. "PSS for Patient Cost Transparency," hl7.org website, https://confluence.hl7.org/display/FM/PSS+-for+Patient+Cost+Transparancy