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Advancing Health in America

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November 4, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations and our clinician partners — including more than 270,000 affiliated physicians, two million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide comments in response to the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) regarding advanced explanation of benefits (AEOBs) and Good Faith Estimates (GFEs) for covered individuals.

The AHA appreciates CMS efforts to promote greater price transparency and give patients a reasonable expectation of their costs of planned treatment through the issuance of an AEOB to patients prior to care delivery. We support this type of meaningful price transparency that aims to provide patients with reliable, personalized estimates of their out-of-pocket costs, as we believe such policies can help support patients in making informed health care decisions. At the same time, we appreciate that CMS has delayed enforcement of these provisions until a standard industry process for such information exchange can be adopted via regulation to ensure that these estimates can be created as efficiently and accurately as possible.

In order to ensure that the AEOB process is secure and accurate for patients, any CMS technical solution should utilize the existing claims processing framework. The AEOB is created by insurers using GFEs from providers. In this way, the GFEs are essentially a pre-claim that the insurers will use to create an AEOB in the same manner as they use claims post-care to create EOBs. The standard claim transaction is specifically designed to contain and communicate all necessary information in a format

that allows health plans to apply edits and adjudication rules to them. These same rules and edits will need to be applied to a GFE in order to ensure that the AEOB closely reflects the patient's final bill, should no changes to their health care needs occur. In order to ensure that the patient's AEOB closely reflects the corresponding post-service claim, its creation needs to mirror that of the claim.

In addition, to ensure that all patients have access to the transparency for which the AEOB process was designed, the technical solution must be accessible to all providers. The development of a technologically sophisticated solution with cost-prohibitive implementation fees will not work for the industry, as patients whose providers could not afford to implement the solution would be left without equitable access to cost information. Particularly, the need for additional workforce to sufficiently implement and support a solution using completely new infrastructure could be challenging for many providers amidst the significant and ongoing workforce strain. Although adoption of automated processes varies considerably across different providers, claims submission is performed almost uniformly via standard transaction, with 97% of all claims processed electronically.[1] In order to ensure that a standard transaction will be available and useable for all stakeholders, **we urge CMS to incorporate the standard claims transaction when establishing an AEOB solution.**

In order to assist in your considerations, we provide specific, detailed responses to your questions below. The AHA is pleased to be a resource on these issues and would welcome the opportunity to provide any additional information that would be helpful to the agency. Please feel free to contact me if you have any questions, or have a member of your team contact Ari Levin, AHA's director of health insurance coverage policy, at alevin@aha.org or Terrence Cunningham, AHA's director of administrative simplification policy, at tcunningham@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President
Government Relations and Public Policy

[1] https://www.caqh.org/sites/default/files/explorations/index/2021-caqh-index.pdf

EVALUATION OF FHIR-BASED API SOLUTION

As described below, the AHA does not believe that an entire Fast Healthcare Interoperability Resources (FHIR)-based API solution has been sufficiently proven to be the presumed solution in this space. **Instead, we urge CMS to utilize the existing claims adjudication process as a foundation off which to build any potential solution.**

In order to evaluate any potential standard for producing and transmitting AEOBs and GFE data, CMS must assess the efficiencies created by the solution and the degree to which it can be widely adopted and implemented by the various market participants. Such an evaluation will ensure that the No Surprises Act price transparency provisions are available to the greatest number of patients.

The currently available DaVinci Patient Cost Transparency Implementation Guide (IG) is neither published nor sufficiently developed to be considered the presumptive solution in this space. The IG is currently undergoing its first ballot reconciliation, after which it can be voted on for publication as a Standard for Trial Use. The entire process will continue to undergo numerous ballot cycles and publication iterations until it is considered normative (i.e. finalized).

Moreover, the IG has only been tested minimally at HL7 Connectathons. In fact, the Patient Cost Transparency IG states that this specification "is expected to continue to evolve and improve through Connectathon testing and feedback from early adopters."[2] Because the cost transparency process impacts not only provider resources but also patient care, **the AHA recommends that any patient cost transparency solution be fully developed and tested in real-world settings prior to wide scale industry rollout.** This process should include careful consideration as to the transaction's scalability, usability and ability to complete administrative tasks in a real-world setting, rather than a controlled environment, such as an HL7 Connectathon.

Additionally, the currently available IG fails to outline specific ways in which it can efficiently produce reliable and accurate price estimates. For example, the IG does not identify the specific data elements that providers need to submit to an insurer, nor how this information will be populated by the provider, whose coding and revenue cycle procedures and systems are designed for X12 claim submission.

Furthermore, the IG does not indicate how plans will apply their payment rules and edits to the FHIR GFE information, an issue that has proven to be a substantial challenge because payer adjudication systems adjudicate claims information and are generally not programmed to process FHIR information. Despite announced plans to create FHIR to

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[2] Health Level Seven, "Patient Cost Transparency Implementation Guide Home Page." Accessed at: https://build.fhir.org/ig/HL7/davinci-pct/

X12 mapping for use in FHIR transactions impacting revenue cycle, these specifications have not been created for industry use. Without such mapping, the GFE information delivered would require an entirely new adjudication system to be built by the plans, of which we do not know of any available today.

In addition, FHIR-based APIs will require a potentially significant investment to adopt. As detailed above, we are concerned that this necessary expenditure will exclude many providers who cannot afford the up-front costs.

For these reasons, **we urge CMS to utilize the existing claims adjudication process — and not a FHIR-based API — as a foundation off which to build any potential solution.**

PRIVACY AND SECURITY

The transmission of protected health information should always invoke privacy and security considerations, as patients need to be able to trust systems sending their sensitive health care information. The GFE and AEOB process clearly invoke such considerations, as these transactions contain substantial protected health information.

The degree to which the transfer of AEOB and GFE data between providers and health plans creates ***new*** concerns in this area depends on the solution adopted. As recommended above, the AHA believes that any implementation standard should utilize the existing infrastructure that facilitates submitting claims for payment. These systems are already designed to securely and privately transmit the same information that would be contained in an AEOB, which should minimize the need to develop additional security controls. Alternatively, in the event that a new technology and process is utilized, the administration would need to carefully review the specifications to ensure that privacy and security issues do not arise.

BURDENS OR BARRIERS FOR SMALL, RURAL OR OTHER PROVIDERS

We appreciate CMS consideration of the difficulties that many providers might experience in adopting a standards-based API technology solution for the exchange of AEOB information. As CMS indicates, smaller, resource-strapped providers often underutilize many industry solutions in this space, as evidenced by providers frequently relying on manual processes rather than adopting electronic solutions. In order to reduce barriers to automation, CMS should (1) adopt a standardized process of completing necessary tasks that is accepted by all health plans and payers, and (2) limit implementation costs.

Providers benefit from standardization of administrative processes across payers, as implementing alternate protocols depending on a patient's insurance carrier requires varied procedures for completing the same process, creating inefficiencies. When considering new technology for insurance tasks, health care providers must look at the

scope of payers that accept the technology and balance the inherent inefficiencies of having multiple ways of performing the same task against the intended benefits of the enhanced method. In order to encourage providers to invest the resources in the technology necessary to complete the processes described in the rule, CMS should create a standard, uniform process that will be accepted for AEOBs and GFEs, regardless of the payer.

Additionally, sophisticated technology, including EHRs and FHIR-based API platforms, traditionally carry a substantial implementation and maintenance price tag. In such instances, even solutions that present legitimate reductions in administrative overhead and verifiable benefits often are simply cost-prohibitive. Particularly, in light of the enormous financial troubles that many hospitals face, with more than half of hospitals operating at negative margins[3], CMS should place particular attention on ensuring that a technical solution for AEOBs is accessible for all provider types. Adoption of a standard with an impractical cost would only serve to exacerbate health disparities, as costly API solutions may only be able to help patients with access to providers with the resources to pay for their implementation.

To prevent such disparities, it is imperative that CMS name a standardized solution without excessive implementation costs. **For these reasons, we stress the importance of utilizing established processes for the creation of AEOBs, particularly utilizing the standard claims framework.** Such a solution-base is already implemented in all payers and the overwhelming majority of providers, and would not feature significant up-front costs to implement, as the process and technology are already part of most provider workflows. Indeed, 97% of all claims are processed electronically using these standards.[4] **In order to ensure that the GFE process is accessible to small, rural and other providers who may struggle to implement new technology in this space, a solution should focus on using the existing, widely-adopted claims submission infrastructure.**

NOTICE AND CONSENT IMPLICATIONS

In order to support the creation of accurate AEOBs on which patients can rely, it is critical to align the notice and consent GFE and AEOB processes in instances when a patient would be receiving both (i.e., for scheduled services at an in-network facility when a nonparticipating provider has received consent to balance the bill). Patients deserve to have an accurate and clear understanding of their expected costs, which includes having consistent estimates. In this instance, a patient will receive an estimate through the notice and consent process and separately through the AEOB. It's imperative that these estimates are the same, or the value of these estimates become negligible because the patient would still lack clarity on their expected costs. Therefore,

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[3] https://www.aha.org/system/files/media/file/2022/09/The-Current-State-of-Hospital-Finances-Fall-2022-Update-KaufmanHall.pdf
[4] https://www.caqh.org/sites/default/files/explorations/index/2021-caqh-index.pdf

a nonparticipating provider should inform a plan, issuer or carrier that it has obtained a patient's consent to balance bill as part of the AEOB process, including the estimate given to the patient reflected on the provider's GFE, as this information needs to be accurately reflected in the patient's AEOB as well.

In keeping with the intent of the AEOB, nonparticipating providers should not be required to inform a plan, issuer or carrier merely if they plan to ask for notice and consent or have asked but did not receive it, because that information does not impact the patient cost estimates reflected on the AEOB. In other words, the health plan should assume that no consent has been given when developing the AEOB unless explicitly notified by the nonparticipating provider. The notice and consent provisions of the No Surprises Act already ensure that the patient is informed and understands the implications of waiving balance billing protections, thereby negating any need to again educate the patient as part of the AEOB process. Instead, such information delivered outside of the notice and consent process may confuse a patient rather than elucidate the patient about their financial responsibilities, while creating an unnecessary burden on the provider.

Importantly, the convergence of the notice and consent requirements with GFE processes requires us to reiterate our Sept. 27, 2022 comments[5] that applying the convening provider concept to the insured GFE and AEOBs would unnecessarily complicate the process. It would be highly burdensome for a convening provider to manage nonparticipating provider GFEs that are based on a notice and consent process of which they are not a part. Instead, to streamline workflows and alleviate confusion, all providers and facilities, including any nonparticipating providers and facilities, should send their GFEs and any relevant notice and consent documentation directly to the insurer just as they will ultimately send their bill.

INCLUSION OF NON-ESSENTIAL INFORMATION IN THE AEOB

We recognize that many states have surprise billing and cost-sharing protections for patients. We recommend that the patient's AEOB reflect any relevant state protections that may be implicated in the patient's care, but that such protections not be spelled out in each AEOB. Absent a need for this information to accurately understand expected costs, there is no need to list the specific laws and regulations affecting the patient's AEOB. For example, a nonparticipating anesthesiologist cannot request notice and consent from a patient being treated at an in-network facility, so the AEOB should show the in-network cost-sharing amount pursuant to the No Surprises Act. However, the provision of the law granting such cost-sharing protections does not need to be listed on the AEOB.

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[5] https://www.aha.org/system/files/media/file/2022/09/cms-urged-not-create-advanced-explanation-of-benefits-burdens-under%20no-surprises-act-letter-9-27-22.pdf

Finally, the AHA urges CMS not to require that an AEOB reflect non-applicable cost information. Not only will this burden stakeholders with duplicative requirements resulting in administrative waste, but, more importantly, the AEOB is intended to help consumers better understand their insurance benefits and anticipated financial responsibility prior to receiving care. Therefore, to best facilitate patient clarity and understanding and to guard against unnecessary administrative burden, if a patient has consented to waive No Surprises Act or state protections, the AEOB should reflect the cost that reflects this consent. If a patient has not consented to waive NSA or state protections, the AEOB should reflect the cost accordingly.

COORDINATION OF PRICE TRANSPARENCY TOOLS

Over the last several years, patients have seen increased access to information about their health care costs as a result of technological advances and federal and state policies. Currently, most patients have access to several different types of estimates from many different sources, including the patient's provider, their insurance company (if insured), state-based websites and private companies, in addition to large datasets from hospitals and health plans with negotiated rates and out-of-network allowed amounts. Depending on the source of the estimates and the inputs included (e.g. common ancillary services, other providers), these estimates will assuredly vary, and we continue to be concerned that introducing new options that are not aligned to what already exists will hinder, not help, patients' understanding of their cost obligations.

We strongly urge the agency to take steps to align the different price transparency policies that exist today to minimize any confusing or conflicting information for patients. To do this, the agency should work to eliminate overlap and duplication by identifying the most appropriate price transparency resource for specific patient needs and aligning the various price transparency policies to meet these needs. Doing so also will help mitigate the substantial new costs added to the health care system of implementing each of these distinct policies. For example, it is not possible for patients *considering* care to access the same level of precise, individually tailored estimates as a patient that has *scheduled* care given potential unknowns related to the final care plan, specific patient needs and available providers. A patient considering a hip replacement prior to scheduling is unlikely to have all of the details required to create an accurate individualized estimate at that point because, prior to scheduling and the corresponding process to develop a care plan, specifics such as the attending ancillary providers, expected surgical hardware required, and expected surgery time would all be unknown. Patient cost estimator tools that rely on historic claims data and course of care trends, such as many of the tools hospitals offer their patients today, can provide some level of detail to help the patient understand their potential costs. Such a patient could also go through the AEOB process for an estimate. However, the providers would need to make the same assumptions based on historic trends to develop the GFE and so the AEOB would not be able to provide the same level of precision as an AEOB developed using a GFE with a known care plan. Given that the estimate accuracy would be similar between the

AEOB and online tool but the cost to produce the estimates would be much greater if going through an AEOB process, shopping patients should rely on the online tools rather than AEOBs. **AEOBs should be reserved only for patients with scheduled care that would benefit from the fully tailored estimate that is not possible to produce through the online tools.**

Unfortunately, we do not believe that CMS can leverage the other technical work done to comply with the existing price transparency requirements to reduce the burdens of the GFE and AEOB processes. Specifically, the machine-readable files required by the Hospital Price Transparency and Transparency in Coverage rules will not reduce hospital or health plan burden related to GFE and AEOB compliance as these will not be the appropriate sources of rate information to convey to the plans. Rather, hospitals will need to develop new processes (ideally reliant on existing technology) to create a document similar to a claim, which the hospital will populate with rates from existing databases in the same way they currently populate claims for payment. Similarly, while the health plans will need to access negotiated rate information to create the AEOB, it will be much more efficient to use their internal systems to access the information and not the standalone spreadsheets. Overall, these spreadsheets have proven little value to patients; to-date, no vendors of which we are aware have been able to use them to create patient estimator tools that are better than those that already exist through other capacities. Once the AEOBs go into effect, their value will be further diminished as the AEOBs should be the source of truth for patients on their expected costs.

PROVIDER ACCESS TO AEOBS

In order to facilitate discussions about planned care and alternate treatment options that include a patient's financial implications, patients and providers must have access to the same cost estimate information provided by the AEOB. Without such information, providers would not have complete information to discuss the financial implications of patients' planned care or respond to patients' financial questions. This would result in unnecessary work and frustration for the patient, who would either need to share the AEOB information with or attempt to explain its contents to their provider. Since the primary goal of the AEOB is to provide patients with necessary information to make informed care decisions, ensuring that their providers can discuss cost concerns raised by the AEOB only makes sense. **Therefore, we recommend that CMS require health plans to enable providers to access the AEOBs involving their prospective services.**

VERIFICATION OF COVERAGE/ELIGIBILITY

Although verifying eligibility with a patient's health plan is traditionally performed today, the requirements established under the No Surprises Act create new considerations. In order to verify whether a patient has coverage and to determine whether the patient specifically has coverage for a particular item or service, providers need to be able to confirm procedure-specific insurance coverage with the patient's health plan,

presumably by submitting a standard ASC X12 270 eligibility transaction to the health plan. Although transmitting an eligibility check is a common practice today, given the tight compliance timeframes, providers would need to submit real-time, rather than batch, eligibility checks. Frequently today, providers use the batch-eligibility transaction to verify coverage, as it is more resource and cost efficient. Batch eligibility transactions permit a provider to send one transaction to an insurer to check the eligibility of a group of patients, with the result being received the following business day. Real-time eligibility is specific to one patient, and is responded to immediately. The increased use of real-time eligibility checks to meet the tight timelines will be resource intensive and cost providers more to transmit, as clearinghouses typically charge more for real-time, patient-specific transactions than batch transactions.

Additionally, under the regulation, patients are considered uninsured or self-pay if they do not "have benefits for an item or service under a group health plan," which will require procedure-specific eligibility checks. However, based on our understanding of current HIPAA transaction standards and operating rules in this space, health plans are not currently required to send back procedure-specific eligibility in their ASC X12 271 responses, and instead only need to provide less granular information about coverage generally for compliance. As a result, it may require substantial additional work for a provider to determine a patient's eligibility for a particular procedure in the required timelines, as the patient's health plan may not provide a definitive answer as part of the eligibility response. **In order to reduce the administrative complexities, we recommend that regulators require plans to respond to eligibility request with procedure-specific detail to enable providers and patients to determine their insurance status for a prospective episode of care.**

ACCESSIBILITY OF AEOBS FOR PATIENTS OF UNDERSERVED AND MARGINALIZED COMMUNITIES

The AHA appreciates CMS's commitment to ensuring that GFEs/AEOBs are available to underserved and marginalized communities. The success of a price transparency tool is measured in its ability to help prospective patients understand their potential cost of care, and a tool fails if its design impedes the ability of certain patients to use it. In order to ensure that the AEOB process is available and accessible to patients from underserved and marginalized groups, CMS must ensure that the AEOB process is (a) accessible to the providers who care for these patients, and (b) tailored to ensure that patients can understand their AEOB and/or access assistance as necessary.

In order for a solution to assist underserved and marginalized populations, it must be available to their care providers. Hospitals and physicians caring for underserved and marginalized communities often have substantial budgetary restraints, especially as a result of caring for higher numbers of uninsured and underinsured individuals, as well as

receiving lower reimbursement rates for covered care.[6] As a result, any regulatory requirement and solution, including an AEOB standard for the No Surprises Act price transparency provisions, needs to be crafted in a way that does not require unrealistic overhead expenses for these providers. If a new technology was adopted that required significant up-front costs, these providers may be unable to implement it, instead being forced to share GFEs with health plans to produce AEOBs through largely manual processes that would tie up limited staff resources and potentially reduce or delay care. As discussed above, **the AHA believes that the most economically pragmatic approach to automating the AEOB process is to utilize the claims infrastructure as a basis, and in no place is this more important than for providers serving a large number of underserved and marginalized populations.**

In addition to provider accessibility, the AHA believes that equipping patients with culturally and linguistically appropriate AEOBs/GFEs can help eliminate health care disparities and advance health equity. The AHA shares CMS's interest in addressing barriers to care and agrees with the suggestion to adopt AEOB language access requirements similar to those for claims and appeals for group health plans and insurers. Mandating language requirements on health plan AEOBs would help ensure that health plans are fully engaged in the important work of providing clear, transparent, and accessible information to patients about their benefits. **Ensuring that health plans provide patients with culturally and linguistically appropriate information is vital to improving access to care, quality of care and ultimately patient outcomes.**

TIME AND COST ESTIMATES

We appreciate the agency's desire to consider provider and facility time and cost burdens when determining the most appropriate regulatory directive for GFEs and AEOBs. Although it is difficult to project the specific time and cost requirements for an undeveloped and unspecified standard, CMS should look to provider experiences in complying with the uninsured and self-pay GFE requirements that are currently in effect. Hospitals and health systems have dedicated considerable resources to update systems and prepare staff for the change in pre-care processes associated with the delivery of the GFEs for the uninsured. Although many hospitals already delivered pre-care estimates to uninsured and self-pay patients, the new timeline and format requirements necessitated workflow and other operational changes, including from even the most sophisticated hospitals. According to our members, the uninsured GFEs regularly take between 10-15 minutes to produce. One member hospital reports that their staff can only process 75 estimates per day, which is barely meeting demand for

[6] https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/WMD%20Health%20Equity%20Report_07.2020_FINAL.pdf

uninsured/self-pay patients. Additionally, a member health system with several locations reports needing to do 1,500 per day across the system.

The bulk of this work is falling on frontline staff also responsible for other critical front office and patient finance tasks, such as the check-in/check-out and pre-registration processes. With the introduction of these new responsibilities, other work is being delayed which can impact patients' ability to prepare for care. For example, one office reports that frontline staff are taking a much longer time to complete the pre-registration process and share pre-care materials with patients. This strain on the workforce is concerning, particularly given unprecedented levels of burnout and shortages.

The costs of all of the additional business functions and technology requirements associated with producing the estimates for the uninsured/self-pay patients has already been startlingly high. One large academic medical center indicated that they have already spent over $2.5 million on additional staffing to meet compliance with current price transparency regulatory requirements, with an expectation of that number greatly increasing as additional requirements go into effect. We do not believe that Congress intended for these policies to add such significant costs to the health care system, especially as some policymakers have supported such policies because they believed they would *reduce* health care spending. We urge CMS to consider the substantial implementation and compliance costs of these policies and avoid unnecessary and duplicative requirements that provide little value to patients and may indeed increase the cost of providing care.