November 15, 2022

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

In reference to: *Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals - File code CMS-9900-NC*

Point-of-Care Partners (POCP) appreciates the opportunity to respond to the request for information (RFI) from the Office of Personnel Management (OPM); Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration (EBSA), Department of Labor (DOL); and Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS). The Departments are seeking comments and recommendations regarding the data transfer standards needed for providers and payers to issue and exchange good faith estimates (GFEs) and advanced explanations of benefits (AEOBs). We share our observations and insights with the intent to help reduce the implementation burdens and speed compliance to these aspects of healthcare cost transparency.

POCP brings a perspective that is unique to those held by providers, payers, and other health IT vendors. As healthcare management consultants since 2003, we have led the development of transaction and terminology standards as they have evolved since the adoption of the Health Insurance Portability and Accountability Act (HIPPA) and Medicare Part D. We frequently provide technical assistance to both the ONC and the Centers for Medicare and Medicaid Services (CMS) on interoperability issues in addition to commercial entities. The National Committee on Vital and Health Statistics (NCVHS) frequently requests our expert testimony at hearings involving heath IT standards.

Our team includes subject matter experts who are currently providing leadership at the program and use case level to the Health Level7 (HL7) Da Vinci Project. The team has been driving progress, industry education and early adoption of the existing Da Vinci Implementation Guides (IGs) to transform how the industry tackles payer-provider workflows with the shift to value-based care including patient cost transparency and medical authorization automation. We also support the work of other multi-stakeholder FHIR accelerator groups, including but not limited to, the FHIR at Scale Taskforce (FAST) and CodeX. FAST is aimed at helping identify and address infrastructure barriers to scalable FHIR solutions, and CodeX is a community of organizations creating data standards and tools for oncology, cardiology, and genomics. For over a decade, as members of the National Council for Prescription Drug Programs (NCPDP), POCP has also been leading the creation and implementation of the standards for prescription benefit Claims (Telecommunication), ePrescribing and ePA (SCRIPT), Formulary and Benefit (F&B) and Real-Time Prescription Benefit Standard (RTPB).

API-Based Technology Solution

We believe true interoperability is dependent upon cooperation. Technology is not the solution—it is a tool we will use to build solutions. People must collaborate within their own organizations and with business partners, competitors, and customers to drive changes in healthcare operations. Patient-centered healthcare requires transparency with true information exchange. This cannot be achieved without aligned incentives and a greater culture of cooperation that transcends competitive boundaries.

Evolving and new policies related to Application Programming Interfaces (APIs), should be incentivized to assist in facilitating adoption and scale. Additionally, the use of FHIR-enabled APIs should continue to be evaluated for applicability to policies. FHIR-enabled technologies in the medical services arena have been growing. In the time since the FHIR standard was first created, the healthcare industry has embraced the use of FHIR standards through substantial investments in industry pilots, specification development and the deployment of FHIR-based APIs supporting a variety of business needs. Some industry led FHIR Accelerator programs, such as Da Vinci and CARIN, have created implementation guides (IGs) that CMS recommends for use in meeting the requirements of the CMS Interoperability and Patient Access Final Rule for Patient Access and Provider Directory APIs. This existing infrastructure has paved the way for smoother and more efficient implementation of FHIR-based APIs to support upcoming cost transparency regulations, specifically Good Faith Estimates (GFEs) and Advanced Explanation of Benefits (AEOBs).

The efforts underway within Da Vinci are being driven by impacted industry stakeholders to solve for executing on the current and potential future requirements derived from the No Surprises Act. We recommend the agencies continue to engage and evaluate the work happening at Da Vinci to develop an open-source solution that aligns with claim submission standards and balances minimum data known at the time of scheduling with a rich data set for accurate estimation. This community is collaborating across standards and existing technology to meet the industry where it is and reduce burden for implementation.

ONC Incentives and Implementation Considerations

We believe the ONC should update Health IT Certification requirements so certified HIT vendors must advance to the latest USCDI version. This would help prioritize infrastructure improvements related to data exchange and support alignment between providers and payers. By requiring more advanced standards for HIT vendors, ONC can help the industry evolve to greater transactional transparency as well as cost transparency.

The convergence of clinical and administrative data is critical for all stakeholders. Creating standard based digital pathways for patients, providers and payers is a must. The Consolidated Appropriations Act, 2021 (CAA) is already requiring prescription drug data aggregation and reporting by December 27, 2022, to establish protections for consumers related to surprise billing and transparency in health care. Impacted health plans should have already developed these capabilities to ensure compliance, expanding IT certification for price-related information will increase and improve implementation. Patients have grown accustomed to their providers and viewing their own heath data first through a patient portal and now through apps on their phone. While they have not yet demanded the same ease-of-use and accessibility from the health care payers, it is changing. Patients want to receive and view their AEOB and GFE information in ways that simplify the data and clearly show costs and options. Patient Access APIs enable this use. While customer demand is driving some payers to implement these programs now, others will need certification requirements or other incentives before making changes.

While we recognize that some healthcare stakeholders will not be able to implement FHIR-based information exchange without substantial investments and well-defined standards in which to do so, FHIR is emerging as the native language of Patient Applications. The Da Vinci Patient Cost Transparency Implementation Guide (PCT IG) outlines the standards needed to implement necessary changes and aligns with current revenue cycle management and claims processes and systems where possible. As payers and providers configure their backend business process to generate GFEs and AEOBs, it can significantly save time and resources to invest in API systems that provide more complete patient data exchange. The Da Vinci PCT IG will be useful for payer and provider organizations of various sizes as its use will help speed compliance with requirements of expected No Surprises Act regulations. The PCT IG provides a standard API for data exchange of GFEs from provider to payer and the payer to provider the AEOB for the Patient, and optionally for the submitting provider.

Also, we recommend that the proposed rule encourage patient "requests" for estimates be directed to the online shopping tools required through the No Surprises Act and Transparency in Coverage rule. Additional guidance and alignment with these requirements for the online shopping tools would be welcome to reduce payer confusion in the industry and ensure tools can support estimates for all services, lines of business, products, and benefit plans subject to the No Surprises Act. Without synergy across sources of estimates -- including hospital shopping tools -- payer shopping tools, GFEs, AEOBs, consent forms with estimates, and phone calls to Patient or Member Services teams, there will be great confusion among patients and care teams and the spirit of No Surprises and cost transparency may be lost.

Phased Approach

We recommend a phased schedule of mandated use to allow for planning and more thorough testing of the business processes, and standards provided in PCT implementation guide. A key component of this phased-in approach would be reducing the immediate burdens on a convening provider or facility to identify all the appropriate co-providers/facilities, collect all their GFEs, and get them to the payer in the designated timeframe. By allowing two or three phases before GFEs and AEOBs are necessary for all services and products consolidated across providers in rapid turnaround time, you will give the industry time to evolve business processes and implement necessary technology without overburdening their resources. The first phase requiring GFEs for uninsured /self-pay patients began with simple services from singular providers and the AEOB for insured patients should align. We also believe further explanation is necessary to define the role of the convening provider, responsibilities, and technical requirements. Please reference the Da Vinci RFI response for details.

Under Part 2 of the NSA Regulation, providers are already required to provide GFEs to uninsured/self-pay patients. It's more difficult for non-participating providers and payers to exchange data when they don't have business relationships and therefore would be highly manual. Instead, payers should ensure their patient-facing self-service shopping tools and customer support centers are able to share non-participating allowed amounts for specific services for patients upon requests across lines of business, plans, and products.

The goal of cost transparency is to improve patients' abilities to make informed decisions about their healthcare and be better stewards of their healthcare dollar. We view cost transparency as a valuable incremental step toward CMS's goal to put patients first, supporting competition on the basis of cost and quality data. This can be achieved over time, i.e., through the recommended phased rulemaking approach, while patients benefit from some aspects immediately, such as the comparison shopping tools and real time pharmacy benefits.

Consent

In relation to patient consent for out of network providers balance billing, we recommend education on the timing requirements for the patient consent and for the GFE/AEOB process. The Da Vinci PCT IG will provide the ability for providers to share patient consent to balance billing with payers as discrete, computable data within the GFE to the payer. Thus, the payer can accurately reflect total expected patient responsibility within the AEOB as agreed to or in case of no or unknown consent, with the NSA protections in place. It should be assumed that if consent is received following the AEOB, the most recent estimate provided through the consenting process from the provider directly should be sourced should a dispute process occur. We recommend limiting requirements for iterations of the AEOB based on updated consent information to avoid patient confusion, particularly if electronic delivery is not used.

Summary of Recommendations

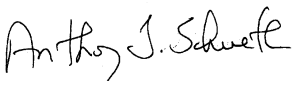
In summary, Point-of-Care Partners Specific Recommendations are:

- New and evolving policies related to API technology should be incentivized to increase speed to adoption.
- ONC should update Health IT Certification requirements so certified HIT vendors must advance to the latest USCDI version.
- Policies related to advancing the No Surprises Act should be phased to minimize burden on those required to act and comply. Phased rulemaking should coincide with the phased approach of standards development happening within the Da Vinci PCT use case.
- The proposed rule encourages "requests" for estimates directed to the online shopping tools and that the online shopping tools support estimates for all services, lines of business, products, and benefit plans subject to the No Surprises Act. Member Services teams should be trained to use the same online shopping tools to avoid variations between online estimates vs. estimates provided by phone.
- The industry continues to grapple with who is responsible and the process for gathering specific GFE information for multiple providers. Policy makers should assure that policies are clear on who is the responsible party or parties for gathering all GFE information and more specifically when there are multiple providers involved in delivering the care or service(s) to the patient. These clarifications are needed to address the industry debate and confusion to assure patients receive a complete and accurate AEOB. Policy makers should further assure policies are clear on compliance and enforcement of GFE/AEOB rules related to multiple providers.
- Any new policy or rule related to GFEs, AEOBs should clearly communicate the consent process to waive the no surprise billing and cost-sharing protections provided by the No Surprises Act or state law.
- The agencies should continue evaluation of the work happening at Da Vinci to develop an open-source solution that aligns with claim submission standards and balances minimum data known at the time of scheduling with a rich data set for accurate estimation.

We commend the agencies that are working to refine this new rule and set the parameters for its enforcement. The phased deployment of these initiatives will help organizations reconfigure workflows to put the patient at the center of all healthcare transactions and prioritize their infrastructure improvements to improve accuracy and transparency.

When patients have a clear picture of their treatment plan and understand what they will be billed for each service, procedure, and prescription, they can make informed choices about the care they need. This leads to stronger participation in their own health, greater adherence to completing scheduled care, and better health outcomes—something everyone in the healthcare industry agrees is our primary purpose.

Sincerely,



Tony Schueth, CEO & Managing Partner
Point-of-Care Partners, LLC