November 15, 2022

Sent electronically

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Ave., N.W.
Washington, D.C. 20220

The Honorable Martin Walsh
Secretary
U.S. Department of Labor
200 Constitution Ave., N.W.
Washington, D.C. 20210

Subject: CMS–9900–NC, Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals, Federal Register (Vol. 87, No. 179), September 16, 2022

Dear Secretaries Becerra, Yellen, and Walsh:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) greatly appreciates the work the Departments of Health and Human Services (HHS), Labor, and Treasury (hereafter, tri-agencies) have done to protect patients when they receive care from out-of-network providers at in-network facilities, or from out-of-network providers and facilities (hereafter, providers, unless otherwise specified) in emergency situations, by developing regulations implementing the No Surprises Act (NSA). We look forward to continuing to work with the tri-agencies and health plans to implement the law and realize our long-held mutual goal of removing patients from billing disputes that arise when care is provided in situations covered under the NSA.

We appreciate the opportunity to respond to the tri-agencies' request for information related to the advanced explanation of benefits (AEOB) requirements included in the NSA. We believe the AEOB

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presents a unique opportunity to provide patients and consumers (hereafter, patient, unless otherwise specified) with information to make a value-based decision on where to receive their health care. However, given that it overlaps with other Centers for Medicare & Medicaid Services (CMS)-driven transparency initiatives, it is duplicative of other requirements. This not only increases the risk that the patient will receive multiple, different estimates of their out-of-pocket costs — increasing the risk of patient confusion and dissatisfaction with their providers and health plan — but will increase overall health care costs. Therefore, we believe the AEOB presents an opportunity for CMS to rationalize price transparency initiatives. Doing so will improve the quality of price information the patient receives and reduce health costs that do not create value for patients.

CHA asks that the tri-agencies promulgate a single, electronic transaction standard to exchange information between providers and plans to create the AEOB. Further, to reduce costs and implementation burden on small, rural, and safety-net providers — thereby ensuring that AEOBs will be available to those in underserved and marginalized communities — we ask the tri-agencies to leverage existing transaction standards to exchange the data necessary to create an AEOB. Finally, given the complexity of implementing a new data exchange standard, we ask the tri-agencies to allow for a minimum of two years from the date the final rule is promogulated to the required compliance date.

In terms of operationalizing the AEOB, CHA asks the tri-agencies to ensure the convening provider concept is not required for good faith estimates (GFEs) that are transmitted by providers to health plans. As discussed in detail below, it has proven incredibly difficult to operationalize the convening provider concept for self-pay patients. Given that providers today do not bundle and submit all claims associated with a clinic visit or inpatient admission, requiring them to do so in advance of service will increase the cost of complying with requirements related to the AEOB and delay implementation. Further, to simplify the AEOB for the patient/consumer, CHA asks the tri-agencies to only require that providers submit information on the GFE that pertains to the patient's immediate, specific clinical and administrative scenario. Finally — particularly for individuals with high-deductible health plans — we ask the tri-agencies to require health plans to transmit the AEOB to the provider who submitted a triggering GFE. This will allow providers to address any perceived issues of affordability with patients to ensure they don't skip medically necessary care.

Below, please find CHA's detailed comments addressing each of these key areas.

Coordination with Other Price Transparency Requirements

California's hospitals have a long track record of transparency. In accordance with state law,[1] California's hospitals provided uninsured patients with GFEs of their expected out-of-pocket costs for any planned health care service upon request prior to the passage of the NSA. Few states had such a requirement. And CHA's members have implemented out-of-pocket price estimation tools or posted a list of prices for 300 shoppable services to comply with CMS' price transparency requirements.

CHA asks the tri-agencies to consider both the opportunity to reduce redundancy and the potential for unintended consequences created by the myriad competing price transparency initiatives. The insured GFE and AEOB duplicate existing CMS price transparency requirements for both hospitals and health plans. This duplication increases health plans and hospitals' costs, translating into increased health insurance premiums without significantly improving the information available to patients to help them make value-based decisions about where to receive their health care. Thus, the GFE and AEOB present

[1] California Health and Safety Code Section 1339.585

an opportunity to improve the information available to patients about their out-of-pocket costs and reduce administrative expenses.

The GFE and related AEOB is just one of three federal requirements for hospitals and health plans to provide out-of-pocket cost information to patients and consumers. The two others are:

- ***Hospitals***: Effective Jan. 1, 2021, hospitals are required to post a searchable display of standard charges for at least 300 "shoppable" services. Standard charges are defined as the gross charge, payer-specific negotiated charge, de-identified minimum and maximum negotiated charges, and discounted cash price. This requirement can be satisfied by posting an out-of-pocket cost estimation tool. Many hospitals, given the value to the consumer of receiving their specific out-of-pocket costs, have opted to comply with this portion of the CMS price transparency requirements by making such a price estimation tool available on their websites.

- ***Health plans***: For plan years starting on or after Jan. 1, 2022, health plans are required to make available to the public three separate machine-readable files that provide detailed price information. The first file contains the negotiated rates for all covered items and services for all in-network providers. The second file includes historical payments to out-of-network providers. The third file includes in-network negotiated rates for all covered prescription drugs at the pharmacy location level.

  Additionally, starting in plan year 2023, CMS will require health plans to make personalized out-of-pocket cost information (which includes the underlying negotiated rate) for 500 shoppable items and services available via an internet-based, self-service tool (or by request). The remainder of all items and services will be required for these self-service tools for plan years that begin on or after Jan. 1, 2024.

CHA notes that health plans are now posting machine-readable files containing all their negotiated rates with all providers for all items and services. This provides a "one-stop" data source for hospital prices that third parties can use to create transparency applications for employers, consumers, and other health plans. Further, the GFE and AEOB requirements of the NSA provide more accurate out-of-pocket cost data for uninsured and insured individuals than the requirement to post 300 shoppable services. The self-pay GFE requires that hospitals provide the uninsured with their out-of-pocket costs, including any financial assistance or other discounts. For insured individuals, the AEOB is a more accurate reflection of out-of-pocket costs as it best mimics how the claim will be adjudicated against the health plan's payment rules. Thus, requiring both the AEOB and hospitals to post a list of shoppable services or an out-of-pocket price estimator runs the risk of confusing patients. When a patient receives both an AEOB and uses the hospital's out-of-pocket price estimator, the different transparency tools will more often than not provide different out-of-pocket estimates for the patient. This confusion could be further exacerbated as the patient may also use their health plan's online shoppable service tool to get yet a third estimate that will likely conflict with both the AEOB and the hospital shoppable service estimate.

The statutory flexibility exists for the tri-agencies to harmonize these overlapping transparency requirements. Section 2718(e) of the Public Health Service (PHS) Act only requires hospitals to "make public … a list of the hospital's ***standard charges***[2] for items and services provided by the hospital …" Based on widely accepted definitions of charges, we continue to believe that Congress did not intend for

[2] Emphasis added.

hospitals to post the prices they negotiate with health plans when it passed the Affordable Care Act (which included Section 2718(e) of the PHS Act). CMS has long defined "charges" in Section 2202.4 of the Provider Reimbursement Manual as follows:

> *Charges — Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions.*

This definition is consistent with how other stakeholders have historically defined "charge" and was well understood by those drafting the Affordable Care Act. For example, the Healthcare Financial Management Association's (HFMA) Price Transparency Taskforce — which included consumer, hospital, health plan, and physician representatives — defined charge[3] and price as follows:

- *Charge:* The dollar amount a provider sets for services rendered before negotiating any discounts. The charge can be different from the amount paid.
- *Price:* The total amount a provider expects to be paid by payers and patients for health care services.

And the Provider Reimbursement Manual and commonly held definition of charges are consistent with how CMS initially interpreted Section 2718(e) of the PHS Act. In the federal fiscal year (FFY) 2015 inpatient prospective payment system (IPPS) final rule (79 FR 50146), CMS required hospitals to post their chargemasters (a file that includes charges for all items and services provided by a hospital).

However, in calendar year (CY) 2020 outpatient prospective payment system (OPPS) proposed rule, CMS added a new meaning, not intended by Congress, to the well-defined phase "standard charge" in this proposed rule and the final regulations implementing the hospital price transparency requirements. At 84 FR 65524, CMS invented the term of art "payer-specific negotiated charges" in an attempt to create a legal justification for requiring hospitals to post their prices. In it, CMS defines payer-specific negotiated charges as the "charge that a hospital has negotiated with a third-party payer for an item or service."

CHA notes that in attempting to define standard charges as payer-specific negotiated charges, CMS has materially edited Section 2718(e) of the PHS Act by deleting the word "standard" and adding the words "payer specific negotiated." In CMS' rewriting of the statute, the concept it described in the definition at 84 FR 65524 is actually the price based on the generally understood definition of that word. This is not what Congress intended when it used the words "standard charge" in Section 2718(e) of the PHS Act based on the well-understood meaning of the word "charges" as evidenced by Section 2202.4 of the CMS PRM and HFMA Price Transparency Guidelines.

While we recognize that CMS prevailed in court on this issue, we fully believe the agency has the flexibility to revert to the requirements outlined in the FFY 2015 IPPS final rule. Therefore, CHA respectfully asks CMS to eliminate the requirements for hospitals to post a machine-readable file containing the negotiated rates for all services and a web-based file that contains 300 "shoppable

[3] https://www.hfma.org/content/dam/hfma/Documents/PDFs/Price%20Transparency%20Report.pdf

services" or an out-of-pocket payment estimator. We believe that both requirements far exceed what Congress intended in Section 2718(e) of the PHS Act. In their place, we ask that the agency reverts to its initial, correct interpretation of Section 2718(e) of the PHS Act in the FFY 2025 IPPS final Rule (79 FR 50146) and require hospitals to post only their chargemasters. Not only will this reduce the risk of confusing patients by ensuring that they don't receive multiple, conflicting estimates of their out-of-pocket costs, but it will reduce unnecessary costs that do not improve patient outcomes or their experience of care.

AEOB Transaction Standard

CMS requests feedback on a range of issues related to the implementation of the AEOB, including the standards used to transmit data between providers and health plans and the resources required to implement these standards. CHA is deeply concerned that if the tri-agencies adopt a standard that has not been used by hospitals to transmit billing information to health plans, it will unnecessarily increase health care costs and further delay implementation. CHA also asks the tri-agencies to provide sufficient time to implement a data exchange mechanism for the GFE and AEOB once one has been identified, fully piloted, and validated.

Set a Single, Mandatory Standard for Transmitting Data

CHA greatly appreciates that CMS is interested in defining a single standard to transmit a GFE for an insured individual to health plans to create an AEOB. We are deeply concerned that if CMS does not create and require health plans to receive the GFE via one standard, electronic transmission mechanism, plans will adopt a variety of mechanisms. This will both increase the cost of compliance and the time it takes to transmit the information from the provider to the plan and will make it even more challenging for plans and providers to comply with the incredibly stringent time frames required by the NSA. The current lack of a process for prior authorization offers a cautionary example of how health care administrative costs could increase unnecessarily if CMS does not establish a required, automated standard.

According to a recent Council for Affordable Quality Healthcare report, despite the existence of a HIPAA transaction standard for prior authorizations, only 26% are fully automated. The remainder are submitted via a proprietary web portal (39%) or manually (35%).[4] Providers reported spending an average of 23 minutes conducting a prior authorization manually, 18 minutes conducting one via a web portal, and seven minutes conducting one using the fully electronic, HIPAA-mandated standard. The cost to complete a prior authorization remains the single highest cost transaction for the health care industry at $14.49 per manual transaction and $10 per partially electronic web portal transaction. In 2021, 61 million prior authorizations were submitted via a proprietary portal, with an additional 43 million prior authorizations completed manually. If the U.S. Department of Health and Human Services (HHS) required health plans to use the HIPAA transaction standard, it would result in $437 million in annual savings. The vast majority of this cost savings potential would accrue to providers, which could reduce prior authorization costs by $350 million annually.

Providers' experience with manual and partially electronic prior authorization submissions is imperfect as an example of the costs the GFE will impose on the health care system. However, CHA believes the example of costs imposed by prior authorizations is a directionally correct analog for the implementation costs of the GFE. We note that our members estimate that it currently takes between 5 and 15 minutes to create a self-pay GFE. We believe that the insured GFE will take considerably longer than either the

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

self-pay GFE or prior authorization documentation. In addition to charges, the insured GFE will require a provider to select the correct diagnosis, procedure, revenue, place of service, and modifier codes. This — combined with the sheer anticipated volume of insured GFEs — ensures that the costs to comply with the AEOB-related requirements far exceed costs associated with prior authorization.

The tri-agencies can help reduce these unnecessary costs. Therefore, CHA strongly encourages the Secretary of HHS to develop a separate transaction standard for transmitting the GFE and require health plans to accept it as a means to reduce unnecessary health care expenditures that neither improve patient outcomes nor their experience of care.

Base Insured GFE Transaction Standard on Existing Claims Infrastructure

CHA is deeply concerned the request for information (RFI) only identifies Fast Healthcare Interoperability Resources (FHIR) application programming interfaces (APIs) as a mechanism for exchanging GFE and AEOB data. CHA notes that the FHIR implementation guide referenced in the RFI is in the early stages of development and has not been piloted or tested to any degree. Not only will mandating an FHIR API result in a longer implementation, but it will also significantly increase implementation costs.

Below is one, limited, example of how requiring hospitals to transmit the GFE to health plans using an FHIR API will increase costs. Currently, hospitals transmit claims to health plans using the 837 X12 payment transaction standard. Health plan claims systems are optimized to accept this claims transaction and process it against the health plan's claims adjudication logic. Neither the provider nor the plan revenue cycle systems that will produce and transmit the GFEs and resulting AEOBs have FHIR models in them. If an X12 "pre-claim" transaction was developed, the existing revenue cycle infrastructure could be used to accept GFE data and create an AEOB. However, if the tri-agencies insist on mandating that hospitals use a FHIR API to transmit the GFE to health plans, providers will unnecessarily incur implementation expenses creating a bridge from their revenue cycle billing systems to the FHIR API. On the other side of the transaction, health plans will need to also create a bridge from the FHIR API into their claims adjudication systems. Beyond increased technology expenses, hospitals and health plans will incur additional, unnecessary costs to retain consultants, hire new IT and administrative staff, and train existing staff to implement and maintain an FHIR API-based standard.

These unnecessary costs associated with AEOB implementation are not illusory. Any implementation costs associated with the AEOB requirement will ultimately be passed along to patients and consumers, unnecessarily increasing the cost of health care. Further, the more expensive it is for providers to implement a process to transmit AEOBs to health plans, the greater the likelihood that safety-net providers will be unable to comply. This will deprive underserved and marginalized communities of an important tool to understand their out-of-pocket health care costs. Therefore, it is important for the tri-agencies to minimize unnecessary implementation costs like the mandated use of an unproven FHIR API. Instead, CHA strongly recommends the tri-agencies work with stakeholders to finalize a new X12 pre-claim transaction standard and mandate its use.

CHA is aware there is an X12 transaction under development that could be used to process a pre-claim transaction. While this is also not currently available for use or testing for the AEOB process, it has the benefit of leveraging existing infrastructure that both plans and providers have implemented. Not only could this accelerate adoption, but will likely reduce the compliance costs incurred by plans and providers and associated with implementing the AEOB-related requirements. This, in turn, will make it easier for

smaller, rural, and safety-net providers to participate, ensuring that underserved and historically marginalized communities will have access to AEOBs. Therefore, CHA strongly encourages the tri-agencies to pilot and test the X12 "pre-claims" transaction standard that is currently under development as a vehicle for providers to submit the GFE to health plans.

CHA understands the tri-agencies' interest in using an FHIR API may stem in part from the fact that many health plans are deploying this mechanism to communicate with plan members. We note that if tests of an X12 "pre-claim" transaction are successful and it is adopted as the standard to communicate the GFE to health plans, nothing in this action would preclude health plans from using FHIR APIs from transmitting the AEOB to members.

Time Frame to Implement the AEOB Transaction Standard

As discussed above, there currently isn't a transaction standard being tested (much less in use) that allows providers to transmit GFEs to health plans and then health plans to transmit AEOBs to both members and the provider who submitted the GFE. Given this, CHA strongly believes the tri-agencies must allow sufficient time for a standard to be fully developed, piloted, and implemented. We ask the tri-agencies to engage all stakeholders — not just the revenue cycle and electronic health records vendor communities — in the development process. During the piloting process, CHA believes the tri-agencies must provide periodic updates on the pilot and as needed seek feedback from the providers and health plans that will ultimately use the standard to exchange data. When a standard to transmit the GFE from a provider to a health plan is fully tested, we ask that CMS uses the notice and comment rulemaking process to propose the standard, receive feedback from stakeholders, and finalize the implementation. Once the rule is finalized, providers and health plans should have at least two years to implement the standard, as is allowed with other HIPAA transaction standards.

AEOB Operationalization

CHA believes there are a range of issues CMS needs to consider as it develops the regulations that will govern the operations related to the AEOB process. First, CHA asks the tri-agencies to limit the data included in the GFE that is sent to a health plan by a provider to only the services that the provider anticipates final billing for based on the current clinical and administrative understanding of the patient's condition at the time the GFE is created. Second, while most hospitals and providers verify a patient's coverage, that verification may not occur within a time frame that facilitates the creation of the AEOB. Therefore, we believe that providers should be allowed to rely on coverage information relayed by the patient. Third, while an individual provider will know if they are in-network for a patient, it is unlikely they will know if the facility where they will perform a service is in-network as well. Therefore, we do not believe that it is practical for a provider to communicate to a health plan whether the facility where he or she is performing a procedure is in-network. Fourth, CHA strongly believes that the AEOB represents a powerful tool to assist the patient with discussions about their care. Therefore, providers should receive a copy. And finally, we remain concerned that it could be abused by health plans and used as another tool to unnecessarily deny care. We ask the tri-agencies to take necessary steps to protect patients' access to medically necessary care. Please see our detailed comments on each of these issues below.

Clinical – Data Required to Complete the GFE

CHA believes that only the items and services the hospital believes — based on current clinical understanding — it will bill for during an individual[5] outpatient visit, or inpatient stay, should be included

[5] If the hospital or provider is providing recurrent care (e.g., physical therapy) the hospital/provider should be able to submit one GFE to a health plan that will cover all dates of service for which the care will occur.

in the GFE that is transmitted to the health plan to create the AEOB. We are concerned hospitals will be unable to develop relatively accurate GFEs without an initial service encounter. It is frequently difficult for a hospital or provider to accurately estimate what services are necessary to address a patient's condition without physically examining the patient and possibly performing diagnostic testing and/or procedures. For example, patients calling and stating they have a specific issue (i.e., back pain) should not expect the provider to guess with a high degree of accuracy the full suite of services that will be required.

If the tri-agencies do require providers to guess, the result will often be generic GFEs that include unnecessary items and services that address a wide range of potential clinical scenarios and ultimately have little or no relationship to the actual item(s) and service(s) required. Not only will these have no value to the patient, but may even discourage some from seeking medically necessary care due to the high estimated costs for services that — in reality — will not be provided. In instances where it is unclear what services are required, CHA recommends the tri-agencies permit the provider to transmit a GFE to the health plan for the initial encounter and explain that more complex services may be required following evaluations and diagnostic testing. Once those are complete, the provider can develop a more accurate GFE based on the specific item(s) and service(s) recommended.

Further, CHA is deeply concerned about the time frame required to provide the GFE to health plans and the turnaround times in which health plans are required to transmit the AEOB to patients/members. During the claims adjudication process — which the AEOB process will mimic — health insurers and providers frequently engage in back-and-forth communications to ensure that the submitted claim contains all necessary information and is structured properly. However, in order to meet the strict timelines required under the law, such communications are not possible. If health plans are not able to adequately engage with providers about submitted information, AEOBs are more likely to be inaccurate and unhelpful for patients. CHA respectfully asks the tri-agencies to allow both providers and plans additional time to develop the GFE and AEOB. If the tri-agencies do not take this necessary step, they must clarify in the proposed rule how best to address situations in which a health insurer needs additional information from a provider.

Administrative – Data Required to Complete the GFE

In the RFI, the tri-agencies include questions related to how a provider's network participation status should impact the information transmitted to the health plan in the GFE for purposes of creating the AEOB. CHA believes that if a patient has provided consent to be balance billed for care received out of network, that consent should be transmitted[6] to the health plan in the GFE. We believe it is important for the AEOB to reflect the patient's actual cost-sharing based on the clinical and administrative information that is known at the time the GFE is transmitted to the health plan. This will help the patient best understand their estimated out-of-pocket costs and allow for informed conversations with their provider. To that end, in instances where the patients have provided consent to be billed by an out-of-network provider, we do not believe it would be productive for the tri-agencies to require health plans to also include the in-network cost-sharing on the AEOB. We are deeply concerned that this extraneous information will only confuse the patient and lead them to believe that their out-of-pocket costs are limited to the in-network amount. If this situation occurs, it will result in patients being dissatisfied with their experience of care through no fault of the provider.

[6] As recommended earlier in this letter, CHA strongly recommends the tri-agencies create a new X12 pre-claims transaction standard to transmit the GFE from the provider to the health plan. One of the benefits of adopting this recommendation is that the tri-agencies could then leverage the soon-to-be released claims attachment standard as the mechanism for providers to transmit the notice of consent to health plans.

The RFI also asks about requiring non-participating providers to notify health plans if they are providing care at an in-network facility, regardless of whether the patient has provided consent to be balance billed. In many instances, a provider who does not participate in a health plan will not know the network status of the facility where they provide care. This is especially true in California, where state law (Business and Professions Code section 2400) prohibits most hospitals from employing physicians. Therefore, physicians in California may not have access to the network participation information for the facilities where they deliver care and should not be required to report it on a GFE.

Limit Information on the GFE to What is Billed by the Submitting Provider

The RFI does not include questions related to the "convening provider" or "convening facility" (hereafter, "convening provider," unless otherwise specified) concept. CHA hopes this is a signal the tri-agencies will not incorporate this well-intended but unworkable concept into the AEOB process. We are deeply concerned that many in the vendor community are assuming this concept will be included in the AEOB requirements. However, our members' experience attempting to implement the "convening provider" requirement for the self-pay GFE illustrates just how challenging it is to operationalize. And, if California hospitals are struggling to implement the "convening provider" concept for self-pay patients, we believe it will be impossible to operationalize for all insured patients due to both technology and workforce constraints.

First, we respectfully ask the tri-agencies to eliminate the "convening provider" requirement for self-pay GFEs. Our members report piloting a number of technology solutions in an attempt to automate the collection of GFEs from co-providers. Unfortunately, none of these efforts has yielded a workable solution. Therefore, if the tri-agencies insist on maintaining it, the process of aggregating GFEs from co-providers will be an expensive, manual one for the foreseeable future. CHA notes that this concept is not included in the language of the NSA. Therefore, the tri-agencies have full discretion to eliminate this costly requirement that will harm access to patient care and increase health care costs. If the tri-agencies are unwilling to eliminate the "convening provider" requirement for the self-pay GFE, we respectfully ask that they indefinitely delay enforcement of it until a workable technology solution can be identified and implemented that allows providers to easily transmit the necessary data between the convening provider and the co-providers. Further, CHA respectfully asks the tri-agencies not to incorporate this costly requirement into the AEOB process because it could jeopardize access to care.

Challenges with the Self-Pay GFE

The self-pay GFE must be provided by the "convening provider" — the provider or facility responsible for scheduling the primary service. This is a new concept the tri-agencies created that did not exist in health care prior to the promulgation of *CMS-9908-IFC, Requirements Related to Surprise Billing; Part II; Interim Final Rule with Comment Period, Federal Register (Vol. 86, No. 192), October 7, 2021.*

In the case of a request, the convening provider would be the person or entity responsible for scheduling the primary service. CHA notes that for many procedures (e.g., knee replacement surgery), the patient is "referred" to the hospital by a provider (e.g., orthopedic surgeon) who schedules the service. In these situations, does HHS consider the provider who schedules the service at the hospital the "convening provider" (e.g., the orthopedic surgeon) responsible for creating the GFE? Or is the hospital where the procedure will occur be considered the "convening provider" and, therefore, responsible for producing the GFE?

CHA and other stakeholders respectfully raised these questions in comments responding to CMS-9908-IFC. However, almost a year after CMS-9908-IFC was released, there is still not a clearly defined process for identifying who the convenor is nor is there guidance on how to proceed in the event that one entity does not believe they are the convenor. Recent survey data[7] from the Workgroup for Electronic Data Interchange (WEDI) illustrate how significant of a barrier to implementation this is.

- **66%** of providers responded that it will be ***difficult or very difficult*** to determine who should be the "convening provider."
- **90%** of providers responded that it will be ***difficult or very difficult*** to identify all appropriate co-providers.

Given the challenge, CHA again respectfully asks the tri-agencies to clarify when a hospital is considered a "convening provider" for services that are delivered at a hospital but scheduled by other providers.

The implementation challenges do not stop with simply identifying who is the convening provider vs. the co-provider(s). The interim final rule requires convening providers to integrate the cost estimates of co-providers into their GFE. However, this is not operationally possible given the structure of the health care delivery system. This is again reflected in the WEDI survey data as 92% of facilities and providers responded that it will be ***difficult or very difficult*** to collect GFEs from co-providers.

There are several reasons for this. Hospitals do not have access to charge and network participation information for other providers they do not employ (or own, in the case of facilities).
Currently, there are no methods for unaffiliated providers to share or receive GFEs with a convening provider in an automated manner. To share this information, billing systems would need to be able to request and transmit billing rates, discounts, and other necessary information for the GFEs between providers. This is not something that practice management systems can do, as billing information is sent to health insurers and clearinghouses, not other providers.

This challenge is exacerbated in California. State law (Business and Professions Code section 2400) prohibits most hospitals from employing physicians. Therefore, hospitals in California do not have access to the charge and financial assistance policy information for any of the physicians and other practitioners who may deliver ancillary services as part of a service or procedure performed in their facilities. In addition, California hospitals do not have an automated process for exchanging this information.

CHA members report experimenting with many potential workflow solutions that would partially automate the process and reduce the number of FTEs (and thereby the cost) to implement the convening provider requirement. However, none of the solutions CHA members have explored are feasible. Without automated solutions, this process will require significant manual effort by providers' revenue cycle staff. This will undoubtedly result in the convening provider being unable to meet the short statutory time frames for delivering GFEs to patients and could also lead to inadvertent errors.

In light of these insurmountable operational challenges, we ask that the tri-agencies allow convening providers and co-providers to submit separate self-pay GFEs to a patient or consumer. CHA notes this is not dissimilar from the way in which the patient will be billed after services are rendered. We are concerned that if a patient receives a single GFE for expected charges for the convening provider and co-

[7] https://www.caqh.org/sites/default/files/core/events/CAQH-CORE-No-Surprises-Act-Industry-Readiness-Webinar-Slides.pdf

providers in a consolidated estimate, they will mistakenly assume that they will only receive one bill representing the charges for all providers involved in the service. And as a result, they may assume it included all the charges for the co-providers and only pay the bill from the convening provider. If the tri-agencies decline to eliminate this costly requirement that will jeopardize access to care, we request an extension in enforcement discretion until a technical solution has been identified and implemented.

Implications for the AEOB

The challenges that providers face in implementing the convening provider requirement for the self-pay GFE will only be exacerbated if the tri-agencies apply it to the AEOB process. First, the sheer volume of insured GFEs required for the AEOB process will swamp an already overextended revenue cycle workforce — particularly if the GFE process cannot be automated. California hospitals' revenue cycle staff are already struggling to meet the requirements for the self-pay GFE prior to the enforcement of the convening provider requirement. And California's uninsured population — approximately 7% of the total population (2.97 million individuals) — is a small fraction of California's 21.5 million insured individuals (55% of the population).[8,9,10] As a result, the volume of additional administrative work — if the self-pay convening provider requirement were to be applied to the AEOB process for the insured population — would be impractical and unsustainable. This would likely result in care delays as providers would need substantial time to complete this process between scheduling and providing care. The additional staffing resources required would also add substantial costs to the health care system. This would ultimately translate into increased insurance premiums, primarily due to the need to hire a lot of new staff, something that already vexes health care providers today.

Second, the GFEs are essentially a pre-claim that insurers will use to create an AEOB in the same manner that they use claims post-care to create EOBs. However, the GFE transmitted to a health plan as part of the AEOB process will be materially different from the GFE provided to a self-pay patient (as CMS notes in the implementing regulations for the self-pay GFEs). Self-pay GFEs are intended to help patients understand their expected costs. In contrast, the insured GFEs are intended to help insurers evaluate how they may adjudicate the expected claims for a particular patient and ensure the estimate that goes to the patient considers their health care coverage.

Generally, a GFE for a self-pay patient requires the collection of information on patient demographics, diagnoses and expected services, corresponding charge rates, and any potential discounts. This information should be sufficient to calculate a pre-service estimate for a self-pay patient. Such information, however, would be incomplete for insured patient GFEs. Given that an AEOB is a pre-claim that will need to be run through the health plan's provider-specific claims adjudication logic, the GFE must include the information required by payers to apply their contract-specific pricing edits. This includes the modifiers, revenue codes, occurrence codes, etc., that are necessary to determine a patient's expected out-of-pocket costs, which often vary depending on provider type and contractual terms.

While revenue cycle vendors and standards organizations will play a critical role in the solutions being developed, CHA is deeply concerned by some of their underlying policy assumptions. We understand that many of the solutions under development rely on the self-pay GFE's convening provider concept. As discussed above, this will not provide the information necessary to create an AEOB for insured patients

[8] https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22california%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[9] https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps/?
[10] CHA Analysis

and will further tax an already short-staffed administrative workforce. This will result in care delays as providers reschedule patients when they are unable to complete the GFE within the required time frames to remain in compliance with statutory requirements.

The forms and electronic transactions currently used to report necessary claims information for post-service adjudication are different for institutional (UB-04/837I) and professional (CMS-1500/837P) providers. These forms contain different fields and require substantially different information for adjudication of insurer and patient payment responsibility. For many common episodes of care, both providers and facilities will be involved, which results in different claim formats being submitted individually by the different providers involved in the patient's treatment.

For the AEOBs to resemble the post-care EOB most closely, the GFEs will need to be as reflective of the final claims as possible based on the clinical and administrative information known at the time the GFE is created. If the convening provider requirement is shoehorned into the AEOB process, a convening provider would have to submit GFEs using data fields and formats that neither their systems currently include nor their staff are familiar with. This cumbersome process would require significant technology and workflow upgrades — to say nothing of extensive staff retraining. It would add substantial and unnecessary costs to the health care system, given that insurer systems already are designed to take in multiple claims in different formats for a single care event. Additionally, this process will increase staffing costs and likely exacerbate existing administrative staffing shortages. Further, unless the process of transmitting insured GFEs from the co-providers to the convening provider can be fully automated, additional staff will be required to manually input pre-claims billing information into the system that transmits the convening provider's GFE to the health plan.

As the tri-agencies consider proposed solutions for creating the AEOB, we respectfully ask that you reject any standard process that requires convening providers to consolidate clinical, charge, and other administrative data into a single GFE prior to submission to an insurer for the creation of an AEOB. If such a requirement were to be imposed on providers for all patients, rather than just uninsured or self-pay patients, CHA expects a resulting delay in care because of increased demand on an already strained workforce. This burden would be entirely unnecessary as insurers can already handle receiving and processing multiple claims from distinct providers. Indeed, engaging with independent providers involved in an episode of care is a primary function of health insurers today. Therefore, we urge CMS to adopt a standard that allows each billing provider to submit their own GFE to the health plan for the creation of an AEOB, just as they do today for billing purposes.

Verification of Coverage and Provider Network Status

Most, if not all, hospitals verify scheduled patients' health insurance status using the HIPAA 270/271 transaction. However, these are batch transactions that only verify that an individual has active health insurance for the plan in question. It is neither done in "real time," as is contemplated in the RFI, nor does it verify that coverage extends to the claim line level for specific items and services. This degree of coverage verification typically occurs during the claims adjudication process. Requiring providers to verify coverage in real time would significantly increase the volume of manual transactions submitted, which would increase implementation costs. Therefore, to minimize the costs associated with implementing the AEOB requirements for both providers and plans, CHA strongly encourages the tri-agencies to rely on an individual's representation that he or she has coverage by the health plan in question.

Using the AEOB to Facilitate Patient Financial Navigation

CHA strongly encourages the tri-agencies to require health plans to return AEOBs to the providers who submit GFEs on behalf of their patients'/plans' members. Frequently, patients/members have questions about their care in advance of receiving the actual service. These questions can be both clinical and financial in nature. Having the AEOB included in the patient's file will allow for a robust clinical discussion.

Further, many health plans' benefit designs include deductibles that members/patients cannot afford. Approximately 44%[11] of Americans worry about affording their deductible before their insurance kicks in. An individual with a high deductible may elect to forgo medically necessary non-emergent care if they receive an AEOB that indicates their out-of-pocket costs for a service will be considerable. If the facility or provider also has a copy of the AEOB, it will allow that facility or provider to address issues of affordability when the patient raises them and ensure that the patient receives any financial assistance for which they are eligible or establish a payment plan for the individual that he or she can afford.

Protecting Patients from Unintended Consequences of AEOB

CHA's members are concerned the GFE could become a tool used by health plans to delay or deny necessary care to patients or reduce or deny payment after services are provided. Therefore, we ask the tri-agencies to prohibit health plans from doing the following, enforceable by civil monetary penalty of up to $10,000 per violation:

- Requiring a GFE as a Condition of Claims Payment: In instances where the patient requests a GFE, the short time frames afforded providers to transmit the GFE to health plans, and for health plans to transmit an AEOB to patients, will prove challenging. Additionally, unless HHS requires the use of an automated transaction standard (including a response receipt back to the provider that initiated the transaction) there is no way to prove in a dispute that a GFE was sent or, conversely, for the health plan to prove that it did not receive, a GFE. Therefore, we ask the tri-agencies to clarify that health plans may not predicate payment on receipt of a GFE.

- Using the GFE to Reduce or Retroactively Deny Payment to Providers or Increase Retroactive Claims Reviews: CHA believes it is inappropriate for health plans to attempt to limit payment to providers to the lesser of the amount calculated using the billing codes/charges listed on the GFE or actual codes/charges submitted on the claim. It is also inappropriate to use the GFE as a "flag" to identify claims for either pre-payment or post-payment review, or retroactively deny claims based on the GFE that was submitted to the health plan. Congress intended for the GFE to be an estimate — based on what is clinically known about the patient's condition prior to more extensive services — of anticipated services and related charges necessary to treat a medical condition. It is not uncommon for providers to determine during the course of a service or procedure that a patient's medical condition is more complex than initially indicated during the pre-service/
procedure evaluation used to generate the GFE. Additionally, providers will base their GFEs on the information provided to them by the physician or practitioner who is referring the patient to the provider for the service or procedure. Beyond being imperfect by its nature, this information may be conveyed or augmented by the patient (or a caregiver) who lacks specific clinical training.

[11] https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/#:~:text=One%2DThird%20Of%20Adults%20Say%20They%20Or%20A%20Family%20Member,They%20Have%20Delayed%20Needed%20Care

Therefore, CHA asks the secretary of HHS to expressly prohibit plans from using the GFE to reduce the payment to providers or potentially identify claims for administrative review.

CHA appreciates the opportunity to offer comments to the tri-agencies on issues related to the AEOB. We look forward to partnering with the tri-agencies and health plans to develop and implement a regulatory framework that achieves the goals of the NSA. If you have any questions about the comments, please contact me at (202) 270-2143 or cmulvany@calhospital.org.

Sincerely,
/s/
Chad Mulvany
Vice President, Federal Policy