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November 15, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Martin Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 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:

Thank you for the opportunity to provide feedback about the implementation of Advanced Explanation of Benefits (AEOB) and Good Faith Estimate (GFE) for Covered Individuals. CAQH CORE supports the objectives of the No Surprises Act and appreciates the efforts of the Departments of Labor, Health and Human Services, and Treasury, and the United States Office of Personnel Management (hereafter, the Departments and OPM) to facilitate a uniform, streamlined process for the provision of GFE and the creation of AEOB. This RFI represents important first steps to fulfill the promise of the No Surprises Act and extend price transparency and surprise billing protections to all Americans.

The Committee on Operating Rules for Information Exchange (CORE), an initiative of CAQH, is a non-profit, national multi-stakeholder collaborative that drives the creation and adoption of healthcare operating rules that support standards, accelerate interoperability, and align

administrative and clinical activities among providers, payers, and consumers. CAQH CORE Participating Organizations represent more than 75 percent of insured Americans, including health plans, providers, electronic health record (EHR) and other vendors/clearinghouses, state and federal government entities, associations, and standards development organizations.

CAQH CORE uses a multi-stakeholder, consensus-based process to create Operating Rules that are both federally mandated and available for voluntary implementation. Federally required Operating Rules, the purpose for which was established by the Affordable Care Act, support HIPAA administrative healthcare transactions, including eligibility and benefits, claim status, and payment and remittance. Voluntary Operating Rules support other common healthcare transactions and emerging standards, such as the exchange of medical information to support prior authorization and healthcare claims adjudication. Whether compulsory or voluntary, CAQH CORE Operating Rules are central to the uniform and secure exchange of information in support of healthcare.

The comments submitted by CAQH CORE for this RFI are representative of a commitment to system-wide standardization and informed through deep collaboration with healthcare industry stakeholders. Collectively, it is recognized that there is a need for a uniform, reproducible approach to the creation and provision of GFEs and AEOBs that prevents implementation variance and minimizes duplicative efforts. Detailed responses to many of the questions posed by the Departments and OPM are included in the Appendix of this document. Given the extensiveness of the RFI, CAQH CORE has highlighted several key points that provide cohesion to the responses for individual questions below.

Utilize existing standards and workflows in program design

CAQH CORE supports the advancement of technologies and standards that promote uniformity, automation, and serve to streamline the business of healthcare. However, the Departments and OPM should acknowledge existing standards and propose emerging solutions as being complementary to present industry approaches. Leveraging existing standards that have high rates of adoption, such as those outlined by X12 to electronically fulfill HIPAA-mandated and other voluntary transactions, could enable more stakeholders to fulfill GFE and AEOB requirements without taking on costly and resource-intensive implementation activities.

For example, the X12 837 transaction that supports the healthcare claims submission workflow is widely adopted across industry stakeholders, with 97% of health care claims transactions being carried out fully electronically.[1] Utilizing components of this transaction, such as pre-determination workflows for professional and institutional claims could empower the transmission of cost information between providers and payers in advance of a claim submission, providing some or all of the information necessary to meet data content requirements for the generation of a GFE and AEOB.

Relatedly, the Departments and OPM are encouraged to consider workflows that support the GFE and AEOB process but do not directly result in their creation. For example, HIPAA-mandated eligibility and benefits transactions (X12 270/271) supported by CAQH CORE

[1] CAQH Index (2021). Retrieved from: https://www.caqh.org/sites/default/files/explorations/index/2021-caqh-index.pdf on October 18, 2022.

Operating Rules for infrastructure and data content requirements, are tightly integrated into many provider and payer workflows, with 89% transactions conducted fully electronically.[2] The transaction set can benefit the GFE and AEOB process by seamlessly confirming coverage, detailing benefit designs, and assigning category of service – setting the stage for essential coordination to efficiently and accurately produce estimates.

Taking into consideration both emerging and existing standards and workflows that can help fulfill GFE and AEOB requirements also furthers overarching goals of advancing equity. Rural, small, or otherwise under-resourced providers or those who serve disenfranchised populations will disproportionately feel the burden of implementing new technologies to meet emerging standards due to constrained time and financial resources. By integrating existing workflows and existing standards into the design of AEOB and GFE requirements, these stakeholders will be put on a level playing field and may avoid some conformance burdens.

Seek simplicity of GFE and AEOB requirements for initial implementation

CAQH CORE recognizes and applauds the extensive efforts being undertaken by the Departments and OPM to ensure a complete and equitable design of GFE and AEOB requirements for insured populations. While it is necessary to consider all potential variations and —in some cases — eventualities that stakeholders will encounter during implementation, CAQH CORE strongly recommends that, at this stage of development, the Departments and OPM focus on establishing minimum requirements that address most scenarios surrounding the creation and distribution of GFEs and AEOBs. Situations contemplated by the Departments and OPM where multiple GFEs and AEOBs would be required for the same service or procedure should be actively avoided to reduce burden of implementation and conformance.

Establishment of a minimum set of requirements benefits the industry by clarifying expectations for implementers who are eager for direction. In turn, this may speed implementation and conformance, empowering the Departments and OPM to identify variations in execution effectively and efficiently. By extension, this process could inform future iterations of regulatory requirements or the potential expansion of ONC Certification. Though CAQH CORE recognizes the role that certification can play in ensuring uniform implementation of GFE and AEOB requirements, the Departments and OPM should delay consideration until greater clarity is achieved around what standards are being used for implementation, the workflows created to fulfill requirements, and understanding the role of Electronic Health Records, Practice Management Systems, and other vendors in implementation.

Further, CAQH CORE urges the Departments and OPM to identify synergies with other price transparency initiatives, when appropriate. Leveraging transparency efforts, such as the Transparency in Coverage and Hospital Price Transparency regulations, may allow providers and payers to streamline "shoppable" requests for select services that do not require "bundling" (e.g., discreet psychotherapy visits). In instances where a GFE and AEOB are the only way to fulfill a "shoppable" service request, CAQH CORE recommends the Departments and OPM devise methods that allow implementers to gather as much clinical detail as possible to aid the accuracy of the estimates being produced. The Departments and OPM should solicit further

[2] CAQH Index (2021).

input from clinical stakeholders to identify key considerations, as well as services and procedures, that would benefit from increased scrutiny when producing a "shoppable" AEOB.

Clarify roles responsible for generating GFE and AEOB

CAQH CORE observed that the RFI is largely silent on the parties responsible for the generation of GFEs and AEOBs, aside from the broad roles of providers and payers, respectively. Any regulations informed by this RFI need to explicitly call out the intent to carry-over the concept of "convening provider" that is a centerpiece of the GFE requirements for self-pay or uninsured individuals. Of note, CAQH CORE also recommends that the Departments and OPM identify whether health plans are required to share the AEOB with providers; something for which CAQH CORE has observed strong industry support.

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Thank you for considering our comments. We look forward to continuing our support of this important work as the industry seeks alignment for standards and content and eagerly anticipate any future rulemaking. Should you have any questions, please contact me at atodd@caqh.org.

Sincerely,

April Todd
Senior Vice President, CAQH CORE & Explorations

CC:

Robin Thomashauer, President, CAQH

CAQH CORE Board Members

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Appendix

Below, please find detailed answers to select questions posed by the Departments and OPM in the RFI. Where appropriate, we have addressed multiple questions with a single response.

Please contact us for questions or clarifications.

What issues should the Departments and OPM consider as they weigh policies to encourage the use of a FHIR-based API for the real-time exchange of AEOB and GFE data?

CAQH CORE recognizes the positive impact that HL7 FHIR standards may have on the industry and, to that end, support their consideration as a method to fulfill GFE and AEOB requirements. Though HL7 FHIR standards hold significant potential for advancing industry-wide interoperability, it should be recognized that the standards are not tested or adopted for administrative use cases and, in many cases, lack maturity. For that reason, CAQH CORE raises concern that, if HL7 FHIR standards are used as the primary or only data exchange method to fulfill GFE and AEOB requirements, varying levels of maturity and implementation could jeopardize industry-wide interoperability. Supporting this concern, in a recent CAQH webinar only 15% of respondents were currently considering adopting HL7 FHIR solutions at their organizations.[3]

To promote greater uniformity and faster initial adoption, CAQH CORE suggests the Departments and OPM also consider widely implemented standards, such as X12 EDI, to facilitate data exchange for the fulfillment of GFEs and AEOBs. For example, the X12 837 transaction supporting the exchange of healthcare claims data, which is carried out fully electronically 97% of the time throughout the medical industry,[4] has available data fields that could support the creation of GFEs and AEOBs. Additionally, there is industry support for utilizing the X12 837 professional and institutional pre-determination workflows to help obtain accurate cost information prior to care being delivered. There is implementation precedent for using the X12 837 pre-determination workflow as the dental industry widely and successfully uses the transaction to provide cost estimates to patients in advance of a service or procedure.

Additional transactions, such as the X12 270/271 eligibility and benefits, could aid in outlining benefit structures or identifying categories of service that on their own does not create a GFE or AEOB but can help streamline production. This transaction is supported by federally mandated CAQH CORE Operating Rules that provide a uniform approach for eligibility and benefit determination and assists with the determination of complex benefit designs (e.g., tiered benefits), categories of service, and procedure codes. Eligibility and benefits transactions are performed fully electronically 89% of the time across the industry.

How could updates to this program [ONC's Health IT Certification Program] support the ability of providers and facilities to exchange GFE information with plans, issuers, and carriers or

[3] A recording of the CAQH CORE Price Transparency Industry Perspectives on GFE Requirements webinar and supporting documents can be found here.
[4] The CAQH CORE Index is the industry source for tracking health plan and provider adoption of fully electronic administrative transactions. The 2021 CAQH Index Report can be found here.

support alignment between the exchange of GFE information and the other processes providers and facilities may engage in involving the exchange of clinical and administrative data, such as electronic prior authorization?

CAQH CORE agrees that certification programs aid in supporting industry alignment and uniformity. However, prior to the establishment of data exchange standards, it is premature to consider ONC Health IT certification for the associated workflows used in the creation of GFEs and AEOBs. Further, accommodating standards prior to certification may allow the Departments and OPM to identify variance, bottlenecks, and vendors associated with implementation, which will help inform certification requirements.

Would the availability of certification criteria under the ONC Health IT Certification Program for use by plans, issuers, and carriers, or health IT developers serving plans, issuers, and carriers, help to enable interoperability of API technology adopted by these entities?

Through conversations with industry stakeholders, CAQH CORE has learned there is concern surrounding over-extending the ONC Health IT Certification Program into the governance of the actions of practice management systems (PMS) and health plans. Considering this, CAQH CORE does not currently support the creation of certification criteria for GFEs and AEOBs. If the Departments and OPM are interested in certifying PMS systems, plans, issuers, carriers, and their IT developers, CAQH CORE recommends that the Departments and OPM also consider the success of existing, industry-driven certification programs, such as the Electronic Healthcare Network Accreditation Commission (EHNAC) or CAQH CORE.

In time, CAQH CORE recognizes the benefit of an ONC Health IT Certification supporting the No Surprises Act Requirements but encourages the Departments and OPM to understand how the AEOB and GFE will be implemented prior to proposing such requirements. It is presently unclear how implementers plan to conform to regulations and their workflows may require the use of practice management systems. ONC Certification has traditionally focused on EHRs and establishing requirements too early may not fully recognize the role of PMS in implementation. Though ONC requirements do not extend to PMS, their involvement is an important consideration when establishing what can and cannot be certified.

What, if any, burdens or barriers would be encountered by small, rural, or other providers, facilities, plans, issuers, and carriers in complying with industry-wide standards-based API technology requirements for the exchange of AEOB and GFE data? How many small, rural, or other providers, facilities, plans, issuers, and carriers would encounter these burdens or barriers in complying with such technology requirements?

CAQH CORE strongly supports technical and operational advancements that automate business processes to the benefit of providers, patients, payers, and other healthcare industry stakeholders. As such, CAQH CORE recognizes the potential positive impact that HL7 FHIR standards may have on the industry and understands why they are being considered as a method to fulfill GFE and AEOB requirements. Despite potential positive impacts, CAQH CORE encourages the evaluation of the benefits of emerging standards against the cost and time burden of implementation across all implementers.

A recent CAQH CORE poll showed that the industry is split on whether to implement HL7 FHIR-based standards to meet patient cost transparency requirements, or whether they would prefer using existing X12 standards or other methods.[5] CAQH CORE recognizes and conditionally supports the incorporation of new technologies; however, the Departments and OPM are encouraged to consider the utility of existing X12 standards or other options to meet patient cost transparency requirements.

For example, healthcare claims pre-determination workflows facilitated by the X12 837 transaction would allow payers and providers to transmit anticipated cost information prior to delivering the service. Additionally, the HIPAA-mandated X12 270/271 Eligibility and Benefits transactions could benefit the GFE creation process by aiding providers in understanding benefit structure, patient cost-sharing responsibilities, and the clinical category the requested service falls under. As previously mentioned, both transaction sets have high rates of implementation. 97% of health care claims transactions are performed fully electronically, this high electronic usage could be leveraged to support pre-determination workflows. 89% of eligibility and benefits transaction are performed fully electronically.

Are there any approaches that the Departments and OPM should consider, or flexibility that should be provided (such as an exception or a phased-in approach to requiring providers and payers to adopt a standards-based API to exchange AEOB and GFE data), to account for small, rural, or other providers, facilities, plans, issuers, and carriers? If the Departments and OPM were to provide such flexibility, what factors should they consider in defining eligible providers, facilities, plans, issuers, and carriers?

CAQH CORE does not support exceptions based on stakeholder type and recommends that broad implementation across all constituents is necessary to support interoperability and avoid regulatory complexity and fragmentation. In line with previous comments from CAQH CORE, facilitating the implementation of GFE and AEOB requirements leveraging existing standards with high rates of adoption will help ease the burden of technical implementation for all stakeholders, including those who would have difficulty funding or devoting resources to the administration of emerging HL7 FHIR standards. Maintaining a standards-agnostic approach that supports both existing and emerging standards will benefit the broader industry landscape beyond considerations for patient cost transparency.

As an alternative to exceptions, CAQH CORE recommends that the Departments and OPM consider a staged approach to implementation of non-technical aspects of GFE and AEOB requirements – applied equally across all stakeholders – in recognition that the complexities of conforming with these requirements are likely to be experienced across the industry. Staged implementation allows for an iterative approach that empowers stakeholders to allocate resources to the most resource-intensive aspects of conformance. Staged implementation is currently being used to support concurrent price transparency initiatives for Transparency in

[5] A recording of the CAQH CORE Price Transparency Industry Perspectives on GFE Requirements webinar and supporting documents can be found here.

Coverage and Hospital Price Transparency regulations, phasing from machine-readable files to user-friendly "shoppable" service tools.

To provide an example of a potential phased approach, the Departments and OPM may consider staging implementation by categories of service using a transparent schedule that focuses early conformance on services that do not require extensive coordination, such as discreet imaging studies, and gradually introduce more complex services, like surgical procedures. Ideally, such an approach would allow implementers to prepare their activities to fulfill GFE and AEOB requirements in advance of conformance deadlines. This could be helpful for implementers providing services that require extensive coordination across specialties, or for those who routinely encounter variance in the services they offer and could benefit from additional time to hone estimates to avoid disputes.

If the Departments and OPM selected a staged implementation by categories of service, the requirements could be informed by the CAQH CORE Eligibility and Benefits Operating Rules which support the HIPAA-mandated X12 270/271 transactions. The operating rule set requires the return of patient financial responsibility across 178 service type codes and additional requirements to respond at the procedural level (e.g., CPT, HCPCS) for surgery, radiology, physical therapy, and occupational therapy. This level of detail is in turn used by providers and payers to indicate the service being queried and outline benefit coverage and patient financial responsibility, which is valuable information to help prepare GFE and AEOB estimates.

In instances in which a plan, issuer, or carrier has been notified by a provider or facility that consent has been obtained from an individual to waive the No Surprises Act's or a State's surprise billing and cost-sharing protections, should the cost and benefit data in the AEOB explicitly reflect that those protections do not apply? Should the AEOB specifically state that the data is premised on the relevant provisions not applying as a result of the individual's consent? Should the AEOB reflect two different sets of cost and benefit data instead, one set reflecting that the No Surprises Act's or a State's surprise billing and cost-sharing protections do not apply, and one set reflecting the application of these protections (to account for the possibility that the individual might later revoke consent)?

In instances in which the plan, issuer, or carrier, at the time it is preparing the AEOB, has knowledge that the No Surprises Act's or a State's surprise billing and cost-sharing protections would apply unless individual consent has been given, but the plan, issuer, or carrier does not know whether consent has been given by the individual to waive those protections, should the AEOB include two sets of cost and benefit data, one set that would apply if consent is given, and one set that would apply if consent is not given?

While CAQH CORE applauds efforts by the Departments and OPM to consider all potential variations that stakeholders may encounter during implementation, CAQH CORE recommends the Departments and OPM to establish a minimum set of requirements that fulfill most scenarios surrounding the creation and distribution of GFEs and AEOBs before considering unique situations in the short term. Situations contemplated by the Departments and OPM where multiple AEOBs would be required for the same service or procedure should be actively avoided at this time to reduce burden of implementation and conformance.

In the future, after industry has built the necessary infrastructure to support AEOBs, CAQH CORE sees potential value in providing different sets of cost-sharing protections and cost and benefit data; however, the Departments and OPM should delay consideration of these use cases.

To what extent could the Departments' and OPM's coordination of the internet-based self-service tool requirements with AEOB requirements help minimize the burden on plans, issuers, and carriers in implementing both requirements?

Whenever prudent, CAQH CORE supports a thoughtful approach to scaling and integrating existing efforts to promote efficiency and care delivery for providers, payers, vendors, and patients. As such, leveraging existing internet-based self-service tool requirements as outlined in the Transparency in Coverage regulations could present a potential path to limiting the implementation burden of AEOB requirements, particularly in "shoppable" scenarios when a comprehensive examination of a patient's condition has not been completed.

Transparency in Coverage regulations began enforcement in July 2022, and though payer compliance data has not yet been issued, early indicators show that several major payers are actively posting price transparency information and are pledging their intent to support future phases of implementation.[6] At present, requirements only dictate the provision of machine-readable files containing cost information and, as such, are not of great utility to patients seeking detailed information; however, Phase 2 and Phase 3 of implementation, respectively "going-live" in 2023 and 2024, require the establishment of "shoppable" service tools that will soon be more easily accessible and interpretable by patients. This phased approach will prove to be informative not only for Transparency in Coverage but may also provide much needed industry input into AEOB.

Though "shoppable" service tools may not fulfill all AEOB requests, particularly for complex procedures that require the coordination of multiple services and providers, they have obvious utility for simple or discreet services, such as radiologic studies or patient well-visits. As such, CAQH CORE recommends that the Departments and OPM explore synergistic relationships between AEOB requirements and existing price transparency regulations, like Transparency in Coverage, to simplify implementation and avoid unnecessary duplication of work.

Can plans, issuers, and carriers leverage technical work done to comply with the internet-based self-service tool requirements to help streamline the process for complying with AEOB requirements?

Transparency in Coverage requirements can be complementary to AEOB requirements because implementation of "shoppable" service tools may serve to eliminate duplicative efforts for discreet or simple services. CAQH CORE supports the use of technical requirements necessary for payers to meet Transparency in Coverage requirements to complement the generation of an AEOB, whether developed using HL7 FHIR-enabled APIs or X12 standards. CAQH CORE

[6] https://www.healthcaredive.com/news/insurer-price-transparency-takes-effect-compliance/626449/

recommends that the Departments and OPM consider the applicability of multiple standards and solutions when identifying efficiencies between synergistic regulations and initiatives.

What, if any, obstacles would be encountered if plans, issuers, and carriers were required to provide AEOBs to covered individuals for all covered items or services (rather than a specified subset, similar to the rule for the first year of the internet-based self-service tool requirement) beginning with the first year of implementation of the AEOB provisions?

CAQH CORE supports phased implementation of AEOB provisions. Facilitating implementation of all covered items and services at once may lead to unintended delays as providers attempt to coordinate the generation of GFEs across multiple, and sometimes complex, services and procedures. Given the dependency of AEOB provisions on the generation of GFEs, it is imperative that the Departments and OPM consider obstacles holistically and ensure that the inter-connectedness of challenges is understood.

Staging implementation by covered items, services, or categories of service allows resources to be allocated to items that are high priority or resource intensive. Further, staged implementation assists with setting transparent, achievable timelines that aid providers and payers in establishing workflows to meet requirements in a high-quality and timely manner.

Staging implementation may also allow payers and providers the opportunity to establish precise estimates, thus leading to higher accuracy and minimizing the opportunity for disputes. To generate an accurate AEOB, health plans require certain adjudication-related codes (e.g., modifiers, revenue codes, occurrence codes) to determine expected charges, which can be a challenge for "shoppable" scenarios and when more clinical information is needed to determine detailed course of care. If the Departments and OPM choose to stage implementation by service type, CAQH CORE recommends they reference the CAQH CORE Operating Rules for Eligibility and Benefits and Operating Rules for Prior Authorization, both of which outline infrastructure and data content requirements that support the identification of categories and types of services being provided.

Are there reasons why the Departments and OPM should or should not propose a requirement that plans, issuers, and carriers provide a copy of the AEOB to the provider or facility, as opposed to allowing such a transfer but not requiring it?

The requirement for payers to provide a copy of the AEOB to providers is a reasonable proposal. Sharing the AEOB with the provider presents an opportunity for additional quality assurance to ensure that nothing was transcribed incorrectly that could lead to inaccuracies or disputes. In addition, patients should have cost transparency information available to them at every touchpoint along their care pathway, as it may assist with better coordination and accountability of all stakeholders involved with their care.

What, if any, burdens or barriers should be considered if the Departments and OPM propose to require plans, issuers, and carriers to communicate a covered individual's request for an AEOB to a particular provider or facility in order to receive GFE information from the provider or facility for use in formulating the requested AEOB?

There are several operational considerations when supporting a patient request for an AEOB. First, for an unscheduled service that is initiated by a patient "shopping," the Departments and OPM should consider the utility of "shoppable" service tools required under the synergistic regulations of Transparency in Coverage and Hospital Price Transparency. Though the requirements stated under both complementary regulations cannot fulfill GFE and AEOB requirements in total, they may prove effective at providing accurate cost estimates for "simple" or discreet services. It should also be noted that investigation of price by patients is relatively uncommon, and it may not serve the Departments and OPM well to focus significant resources addressing "shoppable" scenarios for initial implementation.[7]

If a request cannot be fulfilled by complementary regulations, the Departments and OPM should consider who is responsible for the compilation of GFE information that will inform the generation of AEOB for covered individuals. The concept of a "convening provider" is used to fulfill the GFE for uninsured or self-pay individuals, yet it is unclear whether the Departments and OPM intend to extend this concept to GFE and AEOB provisions for covered lives. Therefore, CAQH CORE requests timely clarification from the Departments and OPM on whether the intent is to have the insurer coordinate GFEs from all involved parties or if the concept of "convening provider" will be carried forward. In the "insured" scenario, CAQH CORE recommends an approach that does not involve a "convening provider." Rather, processes may be best served as a parallel to existing payment workflows that facilitate payers receiving multiple inputs from all the providers involved in a service. Applied to the development and provision of an AEOB, payers should be equipped to compile disparate GFEs to generate a reliable estimate of patient financial responsibility.

CAQH CORE recommends that the Departments and OPM should also consider the presence, or lack, of a comprehensive examination that would reveal key diagnostic information and other contextual information that informs the generation of a GFE and provision of an AEOB. Providing cost information without detailed information of a patient's condition may result in inaccuracies or significant variances that invalidate the estimate and expose providers and payers to dispute processes. The Departments and OPM should exercise caution and devise methods that ascertain as much detail as possible to diminish the risks faced by providers and payers.

What approaches should be considered when proposing requirements related to the AEOB and GFE that account for, or do not account for, secondary and tertiary payers?

CAQH CORE recommends that the Departments and OPM focus on primary payers prior to addressing coordination of benefits in the provision of AEOB and GFE during initial implementation. Additionally, CAQH CORE further recommends that coordination of benefits only be used in the creation of a GFE once a service is scheduled. To ease payer burden of implementation, "shoppable" requests may be better suited to only account for the primary payer. The patient can then use this comprehensive information to coordinate with their carriers to come to an estimate of their financial responsibility. CAQH CORE also refers the

[7] https://revcycleintelligence.com/news/most-healthcare-consumers-do-not-research-pricing-options-in-advance

Departments and OPM to previous comments that encourage leveraging of complementary requirements of Transparency in Coverage and Hospital Price Transparency regulations.

CAQH CORE does note opportunities may exist to streamline this process in future iterations. X12 has proposed to NCVHS for consideration for federal mandate to HHS the v8020 X12 837 healthcare claims transactions. Version 8020 of the standard has greater capability to automate coordination of benefits across payer-to-payer relationships, potentially obviating the need for proprietary processes. Workflows could also be streamlined using accepted coordination of benefits tools, such as the CAQH COB Smart platform, which is updated weekly, and contains coverage information for over 225 million lives and has 100% national health plan representation.

What factors should the Departments and OPM consider when determining what items or services have low utilization or significant variation in costs (such as when furnished as part of a complex treatment) for the purposes of modifying AEOB timing requirements, and why?

Low-volume services may not have standardized workflows at provider organizations, requiring additional ad hoc coordination of stakeholders to create an accurate GFE. Likewise, high cost-variation services stemming from complex disease processes may require input from multiple stakeholders or specialties to generate a precise estimate. Such diligence is necessary to generate high-quality information but may result in delays in production and return of an AEOB. CAQH CORE recommends the Departments and OPM coordinate with provider and payer stakeholders to ensure that all the variables of low-volume or high cost-variance services are being considered and reflected in future regulations.

The Departments and OPM should also consider that an AEOB, and by extension a GFE, only be provided for a scheduled service after a patient has received a comprehensive examination. Employing such a strategy could help providers and payers identify significant areas of variance that would serve to invalidate a "shoppable" estimate. CAQH CORE notes that any services that are not low utilization or high variation, or otherwise fulfilled under complementary price transparency initiatives, that are used in the clinical work up process could follow standard AEOB requirements.

How should AEOB timing requirements be modified with respect to the specified items or services, and why?

A balance should be achieved between providing patients with timely price transparency information and the implementation burden to providers, payers, and vendors. As such, CAQH CORE supports a phased-in approach to implementation that would initially require GFE and AEOB generation for simple, "easy to estimate," or low cost-variation services and gradually incorporate more complex services and procedures on a predictable and transparent timeline. Doing so would allow stakeholders to thoughtfully plan out the resources necessary to conform with requirements over time, and not be burdened by complexities in the early stages of implementation.

As has been a theme throughout, when a GFE is requested and the requirement for an AEOB is triggered, efforts should be made by the Departments and OPM to leverage existing price

transparency tools to generate cost liability information. Doing so may simplify implementation and aid stakeholders in meeting requirements.

What, if any, additional burden would be created by requiring providers, facilities, plans, issuers, and carriers to conduct (1) verification to determine whether an individual is uninsured, self-pay, or enrolled in a health plan or coverage for AEOB and GFE purposes; (2) verification of coverage for each item or service expected to be included in an AEOB or GFE; or (3) verification of coverage from multiple payers? Do providers and facilities already perform these types of verifications in the regular course of business, such that minimal additional burden would be imposed?

For scenarios where a patient's payer is known, this requirement would result in minimal additional burden. The Eligibility and Benefit transaction is HIPAA-mandated and is broadly implemented across industry: In 2020, 89% of nearly 5.4 billion eligibility and benefit transactions were conducted fully electronically.[8] CAQH CORE supports this transaction through a set of federally mandated and voluntary operating rules specifying infrastructure and data content requirements. The rule set empowers stakeholders to return information, such as tiered benefit coverage, number of benefits remaining for a service, categories of service and procedure code-based coverage determination, and whether prior authorization is required, that can be used to inform costs of treatment for the generation of a GFE and an AEOB, in addition to treatment options.

Would it alleviate burden to allow providers and facilities, for purposes of verifying coverage, to rely on an individual's representation regarding whether the individual is enrolled in a health plan or coverage and seeking to have a claim for the items or services submitted to the plan or coverage? What might be the implications of taking this approach?

Patient self-representation of coverage would not alleviate burden from providers or facilities. In fact, it may increase complications that ultimately lead to higher implementation burdens. While it is unlikely a patient would purposely misrepresent their coverage when seeking care, it is possible that they may not understand the nuances of their coverage that would only be revealed through an eligibility and benefit verification using the HIPAA-mandated electronic standard. For example, a patient may know what health plan they are covered by but be unable to indicate their provider network, which could drastically alter their cost-sharing liability. If for some reason a patient refuses or cannot submit to an eligibility and benefit check, but has stated their intent to file a claim, CAQH CORE encourages the Departments and OPM to design requirements that either direct the patient to a complementary cost transparency tool or allow the provider to generate a self-pay or uninsured GFE that can be used by the patient to approach their insurance company to get a more accurate estimate of their liability.

Code section 9816(f), ERISA section 716(f), and PHS Act sections 2799A–1(f) and 2799B–6 require the AEOB and GFE to be provided in clear and understandable language. What additional approaches should be considered that would facilitate the provision of AEOBs and GFEs that are accessible, linguistically tailored, and at an appropriate literacy level for covered individuals, particularly those from underserved and marginalized communities and

[8] CAQH Index (2021).

those with disabilities or limited English proficiency? Is there any specific language or phrasing that should be used to help mitigate any potential consumer confusion?

Should the Departments and OPM consider adopting AEOB language access requirements that are similar to the Departments' existing requirements for group health plans and health insurance issuers, such as the internal claims and appeals and external review and Summary of Benefits and Coverage (SBC) requirements to provide oral language services, notices in non-English languages, and non-English language statements in English versions of notices indicating how to access language services? If so, what is the best way to ensure that information about language access services is communicated far enough in advance to facilitate the provision of the AEOB In the language that is most accessible to the individual?

Clear and understandable GFEs and AEOBs are essential to providing meaningful information to patients considering the costs of medical services. As such, CAQH CORE appreciates the Departments' and OPM's considerations regarding accessibility of AEOBs and GFEs to all people, regardless of literacy level, their community, disabilities, or English proficiency. To the greatest extent possible, the Departments and OPM should require simple language without obscuring any information provided to patients. Language access requirements that already exist for group health plans and health insurance issuers can be adopted into the AEOB and GFE access requirements for all creators to further promote consistency in language use across all documents patients may receive.

CAQH CORE also recognizes the benefit of standardized templates for GFEs and AEOBs across all providers, health plans, and carriers so that all documents a patient may receive are as consistent as possible, whether they are sent electronically or by paper. Additionally, through discussions with industry stakeholders, CAQH CORE has heard concern that patients may mistake a GFE or AEOB as their financial responsibility. The Departments and OPM should ensure proper education of GFEs and AEOBs among all patients and require clear language that indicates that GFEs and AEOBs are estimates only.

What would be the costs for purchasing and implementing a standards-based API for the real-time exchange of AEOB and GFE data from a third-party vendor, compared to building standards-based API functionality in-house? What percent of providers, facilities, plans, issuers, and carriers are likely to either purchase and implement the API via a third-party vendor compared to building and implementing the API in-house? How do these costs compare to alternative methods of exchanging AEOB and GFE data, such as through an internet portal or by fax?

CAQH CORE appreciates the appeal and value of standards-based APIs and understands that it is a viable option for many organizations across the healthcare industry; however, the whole industry may not yet be at an appropriate point along the technology spectrum to expect implementers to devote significant resources to purchase and install third-party solutions for the exchange of GFE and AEOB data. In fact, a recent CAQH CORE poll showed that the industry was split between implementing HL7 FHIR standards and using X12 standards or another solution. Given that most payers and providers already exchange data using X12 EDI methods, leveraging these existing standards, alongside emerging HL7 FHIR standards, would be cost-effective and would minimize the inherent burdens of purchasing and installing new platforms.

Additionally, CAQH CORE invites the Departments and OPM to use data published in the CAQH Index to appreciate the wide adoption of fully electronic administrative transactions among health plans and providers.

Are there factors that should be considered that might alter the number of providers and facilities that would incur the burden and cost of providing a GFE to plans, issuers, and carriers for covered individuals?

Is there other information that the Departments and OPM could find useful for quantifying the benefits of implementing requirements related to AEOB and GFE for covered individuals?

CAQH CORE directs the Departments and OPM to the CAQH Index that outlines the resources – quantified by time and cost – necessary to carry out HIPAA-required and voluntary transactions manually, partially electronically, and fully electronically. The CAQH Index is an invaluable resource for the Departments and OPM to understand the potential impacts on implementers.