November 11, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9900-NC

Submitted electronically to: http://www.regulations.gov

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

Dear Administrator Brooks-LaSure:

Premier Inc. appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding the request for information (RFI) for advanced explanation of benefits (AEOBs) and Good Faith Estimates (GFEs) for covered individuals. The RFI seeks information and recommendations on transferring data from providers and facilities to plans, issuers, and carriers; other policy approaches; and the economic impacts of implementing these requirements.

In our comments, Premier shares the concerns of our member hospitals, their employed physicians and independent physicians aligned with them. Specifically, Premier asks CMS and the Departments to consider the following:

- Utilize the existing claims adjudication process as a foundation for data sharing between payers and providers, rather than adopting a new Fast Healthcare Interoperability Resources (FHIR)-based application programming interface (API) solution;
- Align and streamline current price transparency programs and requirements to minimize confusion among healthcare consumers;
- Require AEOBs only for patients with scheduled care who would benefit from personalized cost-sharing estimates;
- Permit providers to access AEOBs for services they plan to provide;
- Require plans to respond to eligibility requests with procedure-specific detail to enable providers and patients to determine their insurance status for a prospective episode of care; and
- Require non-participating providers to inform payers directly through the GFE process when they have obtained patient consent to balance bill, reducing administrative burden and ensuring consistent information is included in the AEOB.

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,400 hospitals and approximately 250,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data gleaned from nearly half of U.S. hospital discharges, 812 million hospital outpatient and clinic encounters and 131 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,300 manufacturers to source the highest quality and most cost-effective products and services. Premier's work is closely aligned with healthcare providers, who

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drive the product and service contracting decisions using a data driven approach to remove biases in product sourcing and contracting and assure access to the highest quality products. In addition, Premier operates the nation's largest population health collaborative having worked with more than 200 accountable care organizations (ACOs).

Contigo Health, LLC, a subsidiary of Premier, creates new ways for all stakeholders to work together to optimize employee health benefits. At its core, Contigo Health, with 900,000 network providers across 4.1 million U.S. locations, and claims repricing technology, helps improve access to care, and provides health plan payors, and their health plan members, medical claims savings through pre-negotiated discounts with network providers.

A Malcolm Baldrige National Quality Award recipient, Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government, and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. BACKGROUND ON THE NO SURPRISES ACT

The *No Surprises Act* requires providers and facilities to develop a "good faith estimate" of expected charges related to scheduled appointments, or upon a patient's request. Providers or facilities must first inquire whether the individual is enrolled in a group health plan or group or individual health insurance coverage. If the patient is enrolled in health coverage and is seeking to have a claim filed with their health plan for the items or services, providers must send the GFE, along with expected billing and diagnostic codes, to the health plan. If the individual is uninsured or plans to self-pay, the GFE is provided directly to the individual.

Upon receiving a GFE for a covered individual, the health plan must provide an AEOB to the covered individual. By statute, the AEOB must include the network status of the provider or facility, the contracted rate for the item or service, the GFE received from the provider or facility, cost-sharing and plan responsibility amounts, information about amounts incurred towards meeting financial responsibility limits (e.g., deductibles and out-of-pocket maximums) and other information.

Premier supported the passage of the *No Surprises Act* as a solution to protect Americans from unexpected medical bills. We appreciate that both the surprise billing legislation and the Departments' subsequent rulemaking provide opportunities for payers and providers to negotiate mutually agreeable solutions. ***When providers and payers work together to control the total cost of care, patients are less likely to face unexpected medical costs.***

Premier also appreciates that the *No Surprises Act* offers patients a reasonable expectation of their planned healthcare expenditures through access to AEOBs prior to care delivery. Premier supports meaningful price transparency that provides patients with reliable, personalized estimates of their out-of-pocket costs, as we believe such policies can empower informed healthcare decisions.

In the RFI, the Departments request feedback on standards and procedures for data transfer between providers and health plans, and on other stakeholder concerns that should be addressed as the Departments implement GFE and AEOB requirements in future rulemaking. Below, Premier offers responses to the RFI and highlights opportunities to improve the AEOB and GFE processes for providers, payers and patients.

III. EVALUATION OF FHIR-BASED API SOLUTIONS

To evaluate a potential standard for producing and transmitting AEOBs and GFE data, CMS must assess both the efficiency of the solution and the degree to which it can be widely implemented by providers and payers. Premier does not believe that current-state FHIR-based API solutions for real-time exchange of AEOB and GFE data would improve efficiency or be widely adopted because they would require additional testing, building of security protocols, and significant financial investment to implement. ***Instead, Premier urges CMS to utilize the existing claims adjudication process as a foundation for building any potential future solution.***

The currently available DaVinci Patient Cost Transparency Implementation Guide (IG) is neither published nor sufficiently developed to be considered the presumptive solution for AEOB and GFE production and transmittal. The IG is currently undergoing its first ballot reconciliation, after which it can be voted on for publication as a Standard for Trial Use. This process must undergo numerous ballot cycles and publication iterations until it is considered finalized. Moreover, the IG has only been tested minimally at HL7 Connectathons, which do not fully emulate real-world environments. The current Patient Cost Transparency IG states that this specification "is expected to continue to evolve and improve through Connectathon testing and feedback from early adopters."[1] ***Premier recommends that any patient cost transparency solution be fully developed and tested in real-world settings prior to wide-scale industry rollout.***

Additionally, the currently available IG fails to outline specific ways in which it can efficiently produce reliable and accurate price estimates. It does not identify the specific data elements that providers need to submit to an insurer, nor how plans will apply their payment rules and edits to the FHIR GFE information. Because payer adjudication systems adjudicate claims information and are generally not programmed to process FHIR information, plans would need to develop an entirely new adjudication system for GFE information. This would require substantial investment by payers, in addition to the up-front investments that providers would need to make in FHIR-based APIs. ***Therefore, Premier recommends the utilization of existing claims adjudication processes to alleviate these concerns.***

IV. PRIVACY AND SECURITY

The GFE and AEOB process clearly invokes privacy and security considerations, as these transactions contain substantial protected health information. The degree to which the transfer of AEOB and GFE data between providers and health plans creates new concerns in this area depends on the solution adopted. ***As recommended above, Premier believes that the AEOB and GFE processes should utilize the existing claims payment infrastructure.*** These systems are already designed to securely and privately transmit the same information that would be contained in an AEOB, which should minimize the need to develop additional security controls. If a new technology and process is utilized, the Administration would need to carefully review the specifications - alongside provider, payer and patient stakeholders - to ensure that privacy and security issues do not arise.

V. CONSIDERATIONS FOR SMALL AND RURAL PROVIDERS

We appreciate the Departments' acknowledging the difficulties that providers may experience in adopting a new API technology solution for the exchange of GFE and AEOB information. All providers, and particularly small and rural providers, benefit from standardization of administrative processes across payers. Implementing different protocols for different insurance carriers across a patient population creates inefficiencies. Resource-strapped small and/or rural providers must carefully analyze whether adopting new technology for insurance tasks provides a fair return on investment, taking into account both the scope of payers that accept the technology and whether the solution reduces their administrative burden. ***To incent***

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

providers to make these technology investments, CMS should create a standard, uniform process for producing and transmitting AEOBs and GFEs that all payers must accept.

Additionally, implementing and maintaining FHIR-based API platforms may be prohibitively expensive for many providers, given the high cost of these products. Particularly, considering the significant financial turmoil that many hospitals and health systems currently face, CMS should ensure that any technical solution for GFEs and AEOBs does not cause undue financial burden on providers. ***Premier reiterates our recommendation that the Departments utilize the existing standard claims framework, which is already implemented by all payers, would minimize significant up-front costs to providers and is already used to electronically process 97 percent[2] of all medical claims.***

VI. COORDINATION OF PRICE TRANSPARENCY TOOLS

Technological advances and recent federal and state policies have dramatically increased patients' access to information about healthcare costs. Patients may access pricing information directly from hospitals' and health systems' websites, or from state-based or private pricing tool websites, in addition to large, publicly-posted health plan datasets with negotiated rates and out-of-network allowed amounts. Depending on the source, these estimates will vary widely. Premier and our members are concerned that introducing new healthcare pricing options may hinder patients' understanding of their cost obligations unless requirements are carefully coordinated.

Premier strongly urges the Departments to align the various price transparency requirements to minimize confusing or conflicting information for patients. The first step in alignment is identifying the most appropriate and patient-centric price transparency resource for patients' needs, and then streamlining the constellation of federal and state price transparency policies to meet these needs. For example, a patient who is "shopping" for a provider for a joint replacement procedure may not have access to the breadth of information necessary to create a personalized estimate of cost-sharing responsibility. Producing an accurate AEOB would require scheduling an appointment with a provider to develop a care plan, identifying ancillary providers who would be involved in the procedure, identifying expected surgical hardware and supplies and considering how other health factors may affect the length of the procedure. Under current regulations, the patient in this example could request a GFE before scheduling an appointment and proceed through the AEOB process to receive an estimate based on historical claims data and care trends, but the AEOB is unlikely to be as precise an estimate as an AEOB developed using a GFE based on a known care plan. In fact, AEOBs that precede care plan development are likely to be equally as precise as using web-based shoppable services tools. Premier also urges CMS to be cognizant of various levels of health literacy, especially among the disabled communities, and take steps to ensure all patients can navigate these documents.

Premier recommends that AEOBs be required only for patients with scheduled care that would benefit from tailored cost-sharing estimates, which could not be produced through online tools. As stated previously, creating GFEs and AEOBs requires significant legwork, particularly for providers – even if the Departments utilize existing claims processing frameworks rather than requiring new FHIR-based API standards. Unfortunately, existing requirements for publishing price transparency information will not help expedite the GFE and AEOB processes for providers and payers. Hospitals must develop new processes to create "claim-like" documents, which the hospital will populate with rates in the same way they currently populate claims for payment. Health plans will need to access negotiated rate information to create the AEOB, but it is more efficient for plans to use internal claims systems rather than looking back at their published rates in online spreadsheets. ***Ultimately AEOBs will be the source of truth for patients looking for accurate cost liability, and Premier urges the Departments to reconsider whether continuing to require generic lists of charges, negotiated rates and allowable amounts will be helpful to consumers who are weighing decisions about their healthcare.***

[2] 2021 CAQH Index. Accessed at https://www.caqh.org/sites/default/files/explorations/index/2021-caqh-index.pdf

VII. NOTICE AND CONSENT IMPLICATIONS

Patients deserve to have an accurate and clear understanding of their expected costs, which includes having consistent estimates. It is critical to align the notice and consent GFE and AEOB processes in instances when a patient would be receiving both estimates (e.g., for scheduled services at an in-network facility when a non-participating provider has received patient consent to balance bill). In this instance, a patient will receive an estimate of the cost of services through the notice and consent process and separately through the AEOB. It is imperative that these estimates are identical, or the mismatched estimates cause confusion. ***Therefore, Premier believes that a non-participating provider should inform the payer that it has obtained a patient's consent to balance bill as part of the AEOB process, including the estimate given to the patient reflected on the provider's GFE, as this information needs to be accurately reflected in the patient's AEOB as well.***

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

Importantly, applying the convening provider concept to the insured GFE and AEOBs would unnecessarily complicate the process. It would be highly burdensome for a convening provider to manage non-participating provider GFEs that are based on a notice and consent process of which they are not a part. ***Instead, to streamline workflows and alleviate confusion, Premier believes all providers and facilities, including any non-participating providers and facilities, should send any relevant notice and consent documentation directly to the insurer along with the GFE, just as they will ultimately send their bill.***

VIII. ENSURING PROVIDER ACCESS TO AEOBs

In order to facilitate discussions about planned care and alternate treatment options that include a patient's financial implications, patients and providers must have access to the same cost estimate information provided by the AEOB. Without such information, providers would not have complete information to discuss the financial implications of patients' planned care or respond to patients' financial questions. Since the primary goal of the AEOB is to provide patients with necessary information to make informed care decisions, ensuring that their providers can discuss cost concerns raised by the AEOB is only logical. ***Therefore, Premier recommends that CMS require health plans to enable providers to access the AEOBs involving their planned services.***

IX. VERIFICATION OF COVERAGE

To verify whether a patient has coverage and to determine whether the coverage applies for a particular item or service, providers need to be able to confirm procedure-specific insurance coverage with the patient's health plan. Although transmitting an eligibility check is a common practice today, given the tight compliance timeframes, providers would need to submit real-time, rather than batch, eligibility checks. Providers frequently use batch-eligibility transactions, sending a single transaction to a payer to check the eligibility of a group of patients. Results are typically received the following business day. Real-time eligibility checks are patient-specific and elicit immediate response. The increased use of real-time eligibility checks

to meet the prescribed timelines will be resource-intensive and cost providers more to transmit, as clearinghouses typically charge more for real-time, patient-specific transactions than batch transactions.

Additionally, plans currently are not required to provide a level of granularity of coverage information that allows providers to determine a patient's eligibility for a particular procedure in the timelines required by recent regulations to produce GFEs. ***To reduce the administrative complexities, Premier recommends that the Departments require plans to respond to eligibility requests with procedure-specific detail to enable providers and patients to determine their insurance status for a prospective episode of care.***

X. INCLUSION OF NON-ESSENTIAL INFORMATION IN AEOB

A number of states have surprise billing and cost-sharing protections for patients. ***Premier recommends that the patient's AEOB amounts reflect the application of any relevant state protections that may be implicated in the patient's care; however, the Departments should not require that the basis for such protections be spelled out in each AEOB.*** Absent a need for this information to accurately understand expected costs, there is no need to list the specific laws and regulations affecting the patient's AEOB. Similarly, while the AEOB amounts should reflect accurate, personalized patient financial liabilities associated with any given consent to waive *No Surprises Act* or state protections, the Departments should not require documentation on the AEOB of such consent. The AEOB is intended to help consumers better understand their insurance benefits and anticipated financial responsibility prior to receiving care. Cluttering the AEOB with additional information yields confusion for patients and additional administrative burden for providers and payers.

XI. CONCLUSION

In closing, Premier appreciates the opportunity to submit these comments on the request for information regarding AEOBs and GFEs for covered individuals. If you have any questions regarding our comments or need more information, please contact Mason Ingram, Director of Payment Policy, at Mason_Ingram@premierinc.com or 334.318.5016.

Sincerely,

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