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November 15, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & 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 J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Kiran Ahuja
Director
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

Re: AMA Comments on Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals

Dear Secretaries Becerra, Walsh, and Yellen and Director Ahuja:

On behalf of the physician and medical student members of the American Medical Association (AMA), thank you for the opportunity to provide comments on your *Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals*.

The AMA has long supported efforts to provide price transparency to patients. The current lack of timely, standardized information about the cost of health care services prevents health care markets from operating efficiently. The recent influx of high-deductible health insurance plans, as well as challenges with provider networks adequately meeting the needs of enrollees, means that patients are assuming greater financial responsibility for care choices, thereby increasing the demand for better information about anticipated out-of-pocket costs. As the health care market evolves, patients are increasingly becoming active consumers of health care services rather than passive recipients of care in a market where price is often unknown until after the service is rendered. Achieving meaningful price transparency can help lower health care costs and help patients make informed care decisions.

The AMA believes there are ways to accomplish these goals without creating new waste in the health care system or putting new, and potentially insurmountable, administrative burdens on physician practices. As we have stated in several comment letters to the Departments of Treasury, Labor, and Health and Human Services (the Departments) and Office of Personnel Management (OPM) since initiation of implementation of the No Surprises Act (NSA), we have concerns that the Good Faith Estimate (GFE) and Advanced Explanation of Benefits (AEOB) requirements have the potential to wreak havoc on physician practices and create confusion among patients if not implemented in an intentional, incremental and strategic way, with attention to the challenges associated with the collection and exchange of these data.

As you consider our comments below in response to this Request for Information (RFI), we ask that you do so with consideration of the broad health care data exchange ecosystem that exists. It is important to consider existing technology, realistic expectations of developing technology and the impact of new technology requirements on different stakeholders, notably small physician practices, rural health care physicians and providers, and physicians practicing in marginalized communities.

I. Transferring Data from Providers and Facilities to Plans, Issuers, and Carriers

Q1: 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?

The AMA supports the Department of Health and Human Services' (HHS) desire to promote the use of fast health care interoperability resources (FHIR)-based application programing interfaces (API) for the real-time exchange of AEOB and GFE data. We agree that FHIR holds promise, and the AMA is actively participating in several collaborative efforts to advance the development and use of FHIR. The AMA is involved in multiple Health Level Seven (HL7) workgroups, including as a co-chair of the Financial Management Workgroup, and the AMA is represented on the SMART on FHIR Project Advisory Committee and the HL7 Gravity Project Accelerator.

Through our ongoing supportive efforts, the AMA has identified opportunities for FHIR's use. However, we have also identified gaps in the development of FHIR implementation guides (IGs) and discrepancies between the theoretical use of FHIR IGs and the practical impact of FHIR-enabled APIs at the point of care. For instance, FHIR IGs are often developed and tested in tightly controlled, "happy path" environments that do not replicate real-world practice and the associated handling of processing errors. Moreover, IG authors typically represent the largest payers, technology companies, consultancies, and health insurers. IGs are therefore developed to meet the needs of those groups. Physicians, clinical staff, and patients are not widely represented in IG development, and IGs often do not reflect real-world care team needs—especially practices that are small, rural, and/or serve marginalized communities. The Departments' and OPM's policies should promote IGs that incorporate the views of frontline professionals who understand the data and workflow needs required by administrative and clinical processes. IGs also lack sufficient testing. Testing occurring at "Connectathons" does not mirror the real-world workflows, environments, technology stacks, or data feeds in many of our members' medical practices. **The gap between IG development and testing and the needs of real-world clinicians and medical office professionals must be considered as the Departments and OPM weighs policies to encourage the use of a FHIR-based API for the real-time exchange of AEOB and GFE data.** FHIR-enabled API adoption can also impact medical practices with limited resources. While FHIR is being adopted by the largest electronic health record (EHR) vendors, hundreds of smaller EHR and health information technology (health IT) vendors have yet to implement FHIR APIs—many of which support independent medical practices. The health care ecosystem is diverse, comprised of small, solo, and rural medical practices along with large health systems. Large and sophisticated academic medical centers are uniquely different environments than small, solo, and rural medical practices. EHR vendors supporting many of our members' smaller practices are struggling with FHIR adoption. Administrative and workflow disruptions have an outsized impact on these less-resourced health care facilities. **The Departments' and OPM's policies should therefore consider low- and under-resourced physician organizations.**

We also strongly urge careful consideration of gaps in FHIR standards and the expectations of end users. The AMA has heard from several health plans about the disconnect between what FHIR-based APIs can do versus what patients and physicians will expect from AEOB and GFEs. For instance, HHS officials might make assumptions that FHIR can be uniformly implemented across physician and patient-facing platforms, e.g., EHRs and health plan portals/consumer apps, and allow a "unified view" of AEOB and GFE data for all users. This is not the case. As previously discussed, testing and end user input is lacking from FHIR IG development. The lack of real-world testing and gaps in end-user feedback impacts the utility of FHIR IGs. For example, we are very concerned that underdeveloped FHIR IGs will cause physicians and patients to get noticeably different data sets and AEOB/GFE data feeds, causing a discrepancy between what the physician and patients see. This would impact direct patient care, the AEOB/GFE experience, and could hurt the physician-patient trust dynamic. **The Departments' and OPM's policies should ensure that both physicians and patients and their caregivers see the same data to maintain a consistent AEOB/GFE experience.**

Along with these broader concerns regarding the readiness of FHIR-based standards across physician practices of all sizes, we would in particular caution the Departments and OPM that the **HL7 Patient Cost Transparency (PCT) implementation guide identified is not sufficiently mature at this time to be "useable by industry today,"** as suggested in this RFI**.** In fact, the HL7 workgroup tasked in its development is actively making changes to the IG. Those include substantive additions such as new operations, functionalities, conformance language, etc. The IG has yet to be published as a Standard for Trial Use 1.0 (STU1), which is the bare minimum threshold deemed implementable by HL7. It has never been tested outside of a handful of Connectathons, and questions remain as to its scalability. Patients would benefit from having a price cost transparency solution that has been fully vetted by the health care industry. Given the tight timelines required by the NSA, **we propose that the Departments and OPM consider an alternate solution—at least in the interim until the PCT IG is sufficiently mature and tested—one that would not be costly to the industry and is readily available now**.

The Health Insurance Portability and Accountability Act (HIPAA)-mandated X12 5010 837 is overwhelmingly used by providers of all sizes—from large hospitals to small physician practices—to submit electronic claims to health plans. The 2021 CAQH Index reports current adoption of the electronic claim at 97 percent.[1] There is industry consensus that the data elements and information exchange required for GFEs/AEOBs closely mirror those used today for the electronic submission of claims and subsequent remittance advice processing. To use the claim transaction for this use case, the X12 837 transaction would need to be tagged as a predetermination, rather than a payable claim. While this change would require some programming changes, existing practice and health plan information technology systems and connectivities could be extensively leveraged and re-used for the GFE/AEOB use case. This would be especially helpful for the specific vulnerable practice types identified by the Departments and OPM in this RFI (small or rural practices, and/or those predominantly serving minoritized populations): organizations with substantial fewer resources would find this "repurposing" of the electronic claim to be a much easier and realistic charge than adopting a nascent FHIR-based standard.

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

Again, we support the Departments' and OPM's commitment to a FHIR solution in the long term but would strongly caution against this approach until the PCT IG is at an appropriate level of maturity, has proven scalability, and has undergone end-to-end testing. Instead, **we urge the Departments and OPM to base any initial GFE/AEOB standards on existing X12 electronic claim and remittance advice transactions to capitalize on the industry's widespread investment in these well-functioning technologies**.

Q2. What privacy concerns does the transfer of AEOB and GFE data raise, considering these transfers would list the individual's scheduled (or requested) item or service, including the expected billing and diagnostic codes for that item or service?

The AMA recommends careful consideration of the privacy and security implications of bidirectionally exchanged provider-to-payer data. Appropriate guardrails are necessary to limit payer access and use of data to completing AEOB and GFE business functions. While there is a clear imperative to exchange AEOB and GFE data, the protection of patients' medical information must remain relevant. These new requirements are potentially putting insurers into the clinical decision-making space *for every scheduled service.* These requirements create opportunities for insurers to communicate with patients about altering the course of treatment, steer patients to other providers or care alternatives, and create a prior authorization-like process for every component of scheduled care.

We are concerned that there are insufficient safeguards, controls, and policies in place to ensure the privacy and security of patient data. For instance, health plans are already partnering with EHR vendors to cull clinical data from patients' medical records for various use cases, and there is little transparency about what guardrails are in place to protect patient privacy. With unfettered access to EHRs, health plans could misuse patient health information. **In fact, the AMA is aware of HL7 IGs that are purposely being developed to allow payers to "eavesdrop" on physician clinical decision-making.** Further encouragement of payer access to EHR data will impact patient trust in physicians as curators and protectors of the medical record.

AMA research has shown that patients overwhelmingly trust physicians and health systems with their medical information.[2] That trust must be preserved. We stress that the exchange of GFEs/AEOBs will take our health care system into uncharted waters, as health plans will not just be receiving patient medical data to support the actual payment or operations of delivered health care, as is currently permitted today under HIPAA. Notably, AEOB and GFE data are exchanged in *advance* of medical services and even sometimes orders, meaning that health plans will be receiving patients' medical data in anticipation of a service that may or may not ultimately be provided. In fact, several AEOBs and GFEs exchanges could happen before a treatment plan is finalized. The amount of interim data captured by a payer via the exchange of GFEs/AEOBs has the potential to be immense. Because it is unclear what payers will do with the medical information received unrelated to medical services that have actually been delivered, we harbor major concerns regarding the unintended consequences of GFE/AEOB data exchange and any downstream impact on patients' trust in physicians as stewards of their medical record.

2 https://www.ama-assn.org/system/files/ama-patient-data-privacy-survey-results.pdf

Prior to implementing polices for AEOB and GFE data exchanges, the Departments and OPM should seek answers to questions such as:

- What will payers do with patients' medical information that is captured during AEOB and GFE data exchanges but is unnecessary for payment of the actual medical service?
- How could a payer utilize ancillary medical information in restricting coverage, payment, or access to additional care? What polices are in place to prevent misuse of patient data and to prevent steerage of patients away from treatment ordered by their physician or to other physicians and providers?
- How will AEOB and GFE data impact physician networks or contract arrangements? What polices are in place to prevent the narrowing of networks?
- How will AEOB and GFE data be used in prior authorizations?
- Are payers able to establish meaningful firewalls between those departments that generate AEOBs and other departments within the health plan, as well as other safeguards that would prevent intrusion into the clinical decision-making process?

The AMA strongly urges the Departments and OPM to consider methods to prevent payers from misusing data captured during AEOB and GFE interactions. Moreover, the Departments and OPM should initiate policies that explicitly prevent payers from using AEOB and GFE data for anything other than the provision of advanced estimates and require internal firewalls between systems and teams involved with GFE/AEOB data and all other arms of the health plan, such as network maintenance, utilization management, and coverage policies. Without such safeguards, any transparency gains may come at the price of patient privacy and data security, as well as access to medically necessary care.

Q3. How could updates to the ONC Health IT Certification Program support the ability of providers and facilities to exchange GFE information with plans, issuers, and carriers or 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?

We appreciate the Departments' and OPM's interest in utilizing certification criteria to help enable interoperability of API technology among plans, issuers, and carriers, or health IT developers serving plans, issuers, and carriers. However, the current approach to health IT certification will not work with the GFE requirements.

Electronic systems necessary to enable the GFE process are as unique as the stakeholders who use them. Provider organizations have widely varying approaches to the adoption and deployment of health IT systems. Some use a single, integrated health IT solution that encompasses all the functionality required to enable GFEs, but others—typically larger provider organizations—may have capabilities distributed across multiple health IT solutions from different vendors, mirroring a more distributed or federated approach. It is unclear how the Office of the National Coordinator for Health IT (ONC) would establish a certification program that extends to non-certified health IT, e.g., practice management systems and health IT used by payers, to orchestrate the end-to-end information exchange and informatics needs to support GFE using FHIR.

We are also concerned with the readiness of the FHIR PCT IG for health IT certification. ONC's Certification Program currently tests for conformance to Certification Program criteria and federal agency requirements (e.g., the Centers for Medicare & Medicaid Services reporting programs). Testing for typical federal program compliance does not consider the innate complexity and variability in the GFE process. We stress that, if ONC seeks to establish a GFE certification program, ONC should consider how its Certification Program will translate GFE standards and IG testing in a way that supports end-to-end information exchanges between plans, issuers, and carriers, or health IT developers serving plans, issuers, and carriers. For example, successful GFE interoperability will require testing of health IT modules or products used by payers, clearinghouses, or other intermediaries that are not typically required to use certified health IT. This is a gap that must be addressed.

In addition, and as stated above, the AMA has strong concerns regarding the adoption of a FHIR-based standard for the GFE/AEOB use case due to concerns about the immaturity of the PCT IG and lack of testing. As such, we believe it would be extremely premature to create ONC EHR certification requirements around a FHIR API for GFEs.

The standards challenge is not limited to the PCT IG. The United States Core Data for Interoperability (USCDI) may also be problematic for its lack of agility when it comes to allocating the relevant subset of USCDI data for specific use cases. Not all systems that will exchange data as a part of the GFE process will adhere to the USCDI, nor does the USCDI contain the necessary data classes or elements needed to support a GFE. It would be a fallacy to assume certified health IT and the USCDI together are sufficient to meet GFE data needs.

We urge the Departments and OPM to consider the gaps in health IT regulation between:

- **Certified EHRs, e.g., products used extensively by physicians and health systems;**
- **Health plan IT systems, i.e., products not covered by any HHS agency testing or certification process but are required to implement specific IGs; and**
- **Intermediaries who use highly customized and proprietary technologies but have no IG, testing, or certification requirements.**

As a starting point, the Departments and OPM should consider methods to positively incentivize GFE testing across health care provider and health plan trading partners, such as intermediaries, clearinghouses, pharmacy systems, certified health IT, revenue cycle, and practice management system vendors. ONC may also consider establishing a voluntary GFE testing program like its voluntary certification of health IT for pediatric care and practice settings.

Lastly, ONC's Certification Program tests and certifies health IT to program criteria using a pass/fail approach. The FHIR PCT IG is being developed to facilitate the functional needs of GFEs and cannot easily be adapted to demonstrate conformance to ONC's certification criteria or testing programs. ONC's Certification Program includes both pre-certification testing and post-certification reporting requirements. This includes Authorized Certification Bodies (ONC-ACBs) and Testing Labs (ONC-ATLs). It is unclear if ONC-ACBs and ONC-ATLs are capable of testing GFE workflows or support post-certification reporting given the vast array of administrative and clinical information exchange, variability in information, myriad health IT environments, and uniqueness of health plan requirements. **The**

Departments and OPM must consider the holistic ONC process if health IT certification is to play a major role in GFE data exchanges.

Q4: 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?

The AMA recommends evaluation of several key criteria to ensure that the benefits of new technology will offset what will likely be significant implementation costs. As such, any FHIR IGs under consideration should first be proven successful in real-world piloting in physician practices, medical groups, and hospitals of all sizes. While Connectathons and similar closed testing systems are a first step in advancing new technology, they do not accurately reflect real-world workflows in small- to medium-size physician practices with fewer resources. The AMA recommends a thorough analysis of a FHIR-based API return on investment (ROI) across all stakeholders, of all sizes, before the Departments and OPM proceed. We again reiterate that an ROI assessment must account for the costs of a full-scale implementation and all the underpinning development, not just the minimal work needed to program a single Connectathon demonstration. For example, in evaluating the costs involved in implementing the FHIR IGs, **the Departments and OPM should detail the resources and time involved in converting each health plan's AEOB and GFE data into FHIR-based APIs necessary to support all medical services across small, rural, or other providers**.

Further, the AMA recommends that any recommendations to improve data sharing should be practical and scalable across the health care system. Disparate health IT systems must function at syntactic (information structure) and semantic (information meaning) levels, but also—to be most effective—all participants must agree upon certain rules and policies. Common agreements are needed for each participant-type within the health care ecosystem regarding transaction types, purposes (acceptable uses), transport standards, format standards, vocabulary standards, patient access, security levels, patient matching, and consequences for violating the rules. Data governance, trust, business, and administrative processes must also be established and supported to facilitate AEOB and GFE processes. The AMA is concerned that, absent this level of consideration, AEOB and GFE implementation would not meet the needs of small and rural providers, facilities, and health plans and, therefore, would not provide those patients and physicians the vital information needed to make informed care decisions**.**

All of the challenges we have noted to implementation of a FHIR-based API for the GFE/AEOB use case will be significantly amplified in small, rural, and other under-resourced practices. **For this reason, we urge the Departments and OPM to consider a flexible, phased-in approach to any API standard for GFEs/AEOBs that would allow early adopters to thoroughly vet and test the technology long before smaller organizations would be burdened with required implementation.**

II. Ensuring that plans get requisite information to prepare an AEOB that takes into account a patient's consent, or lack of consent, to waiving balance billing and cost-sharing protections

Q5: Should a nonparticipating provider of non-emergency services be required to inform a plan, as part of or concurrently with the GFE, whether the requested or scheduled items or services would be furnished with respect to the patient's visit to a participating facility?

As with all related GFE and AEOB requirements, the AMA urges the Departments and OPM to consider whether the relevant information is known to the plan and refrain from placing requirements on physicians and other providers to submit duplicative information. In this case, the health plan will ultimately have the information related to the network status of the facility, and it would be unnecessary and burdensome for the non-participating physician to submit such information to the plan.

Q6: Should the provider or facility be required to inform a plan of the individual's consent, as part of or concurrently with providing the GFE, if it has already obtained the individual's consent?

While consent is potentially relevant to the patient's out-of-pocket costs, exchange of this information from a physician to a health plan could be technically challenging. Moreover, timing associated with the generation of the AEOB may not line up with the notice and consent process. For most scheduled out-of-network care where the physician or provider is permitted to obtain consent, the AMA thinks that, at least initially, it would be most efficient to assume *for AEOB purposes* that consent has been given, recognizing that consent information is required to be provided to the plan as part of the claims process. A health plan can provide the patient with its out-of-network allowable (i.e., how much it intends to pay the out-of-network provider) as part of the AEOB. The patient will have the estimates from the out-of-network provider that are included in the standard notice and consent form and will be able to make an informed estimate of costs based on both estimates. The AEOB sent from the health plan to the patient could indicate that the estimated payment to the out-of-network provider should be considered in combination with the estimate from the provider included in the standard notice and consent form.

III. Connection with NSA and state surprise medical billing laws

Q7: How should the AEOB reflect the way in which the NSA's or a State's surprise billing and cost-sharing protections may affect a patient's benefits related to the services specified in an AEOB, and patient's financial responsibility for these services?

Information related to the applicability of the NSA and a state's surprise billing protections may be helpful to patients in determining their out-of-pockets costs. The AMA urges the Departments and OPM to recognize that physicians are not equipped with this information and that the **health plans should be responsible for determining the impact of state and federal surprise billing protections on the cost estimates given to patients in the AEOB**.

Q8: In instances in which a plan, has been notified by a provider or facility that consent has been obtained to waive the NSA's or 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 reflect two different sets of cost and benefit data instead, one set reflecting that 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 patient might later revoke consent)?

The plan should communicate to a patient their out-of-network allowable for the service to be provided. Because the notice and consent forms include a requirement for a cost estimate from the out-of-network provider, the patient can estimate their out-of-pocket cost based on the allowable and estimate. It could be useful for an AEOB to state that the allowable is the amount the plan intends to pay the out-of-network

provider, and if the patient has consented to be billed the difference, they should use the estimate included in the notice form to determine their out-of-pocket costs.

The AMA would not suggest that patients should be provided with two different sets of cost data to reflect cost-sharing with and without consent, as this could be confusing to the patient.

IV. Interaction with Transparency in Coverage requirements and AEOB requirements

Q9: To what extent could the Departments' 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?

The AMA appreciates the Departments' and OPM's recognition of potentially overlapping price transparency efforts and an interest in considering where efficiencies can be gained. With the pending implementation of the Transparency in Coverage requirements, which will provide price information to patients prior to scheduling care, the **AMA suggests that the Departments and OPM delay implementation of the AEOB requirements for unscheduled care** and allow the new Transparency in Coverage requirements to take effect**.**

Q10: What, if any, obstacles would be encountered if plans 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?

As stated in these and previous comments on the AEOB/GFE processes, the scope of these requirements and the potential volume of new administrative responsibilities on physician practices are enormous. The AMA believes there must be a long on-ramp associated with implementation due to all the technology and privacy concerns mentioned above, and in order to allow the Departments and OPM to address problems as they arise and change course if needed. This will be particularly important for small and rural practices and those physicians serving marginalized communities. **Therefore, the AMA urges the Departments and OPM to consider a similar "phased-in" approach to that of the Transparency in Coverage requirements, with initial application being limited to a small, defined set of services.**

V. Obstacles in providing an AEOB to the provider or facility that furnished the plan, issuer, or carrier with the GFE

Q11: Are there reasons why the Departments should or should not propose a requirement that plans provide a copy of the AEOB to the provider or facility, as opposed to allowing such a transfer but not requiring it?

The AMA urges the Departments and OPM to require that health plans issue a copy of the AEOB to all physicians and facilities that have submitted GFEs for a patient's scheduled treatment. It is in the best interest of the patient that the provider has the same record of cost and coverage information the patient has received related to scheduled health care services. The physician-patient relationship is founded on trust and communication; without a copy of the AEOB, a physician will not be able to fully answer questions the patient may have related to the cost of care, which could undermine the patient's confidence

in their physician's expertise and potentially lead to poorer health outcomes. In our discussions with health plans, they have made it clear that, unless required under regulation, returning a copy of the AEOB to the provider and/or facility will not be included in their envisioned workflow or build-out of AEOB technology. Currently in the PCT IG, health plans may opt—but are not required—to send an AEOB to providers. In addition, even when a provider requests a status update on an AEOB, the PCT IG allows health plans to return an empty (and hence useless) bundle. Given the law was written with patient protection in mind, it is critical that providers receive a copy of the AEOB to facilitate informed conversations regarding care costs. **As such, we urge the Departments and OPM to require health plans to send AEOBs to both patients and their treating physicians and facilities.**

VI. Verification of patient's coverage

Q12: What, if any, additional burden would be created by requiring providers, facilities, plans, 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?

Physicians and facilities routinely verify a patient's insurance coverage prior to the delivery of care via the electronic eligibility transaction standard (X12 270/271); in fact, most providers perform these checks both at the time a service is scheduled and again immediately prior to treatment to confirm that the patient's status has not changed in the interim period. **However, we underscore that the current level of granularity provided regarding a patient's individual benefits and coverage in electronic eligibility transactions may often not be sufficient to determine if a specific service is covered by a plan.**

Health plans are currently required to provide real-time electronic eligibility verification establishing if a patient has coverage under a particular health plan, and, if so, whether the plan covers a general service category—for example, surgery. It is crucial to note that although the electronic transaction does allow physicians to request coverage information for a particular service or procedure code, **health plan eligibility systems currently do not provide responses at this level of detail.** Absent this level of granularity in electronic eligibility verifications, physician practices seeking coverage information for a particular item or service during GFE preparation will need to use much more burdensome methods of determining coverage, such as phone calls or inputting data into proprietary health plan portals. The hassles involved in using these manual methods of obtaining procedure-specific information will obviously be time-consuming and burdensome; moreover, we anticipate that care may be rescheduled and delayed due to concerns with meeting the strict timeframes of the GFE/AEOB requirements. **We urge the Departments and OPM to consider the limitations of the currently available electronic eligibility verification transaction and the significant impact this will have upon physicians' ability to provide accurate GFEs within the stringent legislative timelines and allow for flexibility in future GFE/AEOB processing.**

Q13: Would it alleviate burden to allow providers and facilities, for purposes of verifying coverage, to rely on patient's representation regarding whether they are enrolled in a health plan or coverage and seeking to have a claim for the services submitted to the plan or coverage? What might be the implications of taking this approach?

The AMA appreciates that the Departments and OPM are considering reducing physician practice burdens by proposing reliance on patient-supplied coverage information. However, given the highly complicated benefit structures offered by many plans, the challenges that patients will have in locating—let alone understanding—coverage data, and the lack of granularity in plan documents, physician practices would not be able to safely rely on coverage information supplied by patients, particularly as it relates to specific procedure or service codes.

VII. Impact on underserved and marginalized communities

Q14: What unique barriers and challenges do underserved and marginalized communities face in understanding and accessing health care that the Departments should account for in implementing the AEOB and GFE requirements for covered individuals?

As the AMA has stated in this and previous comment letters, the **new GFE and AEOB requirements have the potential to negatively impact all physician practices but may be particularly difficult for physicians providing care to underserved and marginalized communities.**

Throughout these comments, we have highlighted the challenges associated with the potential technology requirements for data exchange needed to submit the GFE to the plan. Should new technology be mandatory to meet regulatory requirements, many physicians will have to shift resources away from other priorities (e.g., reduce staff, delay technology upgrades, cut back on community investments, etc.) in order to comply. This shifting of resources will likely be especially pronounced in small, independent practices that may already be stretching their resources to meet their communities' needs.

In addition to the potentially costly technology requirements, attaching this new and consuming administrative requirement to the provision of care could have the impact of delaying appointments and procedures for practices that simply do not have the financial resources to hire new staff or extend staff hours as needed to meet these mandates and in the required timelines. Care delays could be particularly impactful for those with chronic health conditions such as diabetes or heart disease. Additionally, we know that care delays can be associated with treatment abandonment for those seeking mental health care, reproductive health care, treatment for substance abuse disorder, and even preventative care. **In these and similar situations, valuing a timely AEOB over timely care seems misaligned and not in the best interest of patients.**

Q15: Should the Departments 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 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?

The AMA envisions the GFE/AEOB process mirroring existing claim submission and adjudication processes, and therefore it would seem that health plans could leverage their existing technologies and templates for post-treatment, patient-facing EOBs for AEOBs (with notice that the information was a pre-service cost estimate). As such, existing requirements to improve patient understanding of EOBs would be applicable to AEOBs.

VIII. Economic impacts for implementing the AEOB and GFE for covered individuals

Q16: What are estimates of the time and cost burdens on providers and facilities, and separately on plans, issuers, and carriers, for building and maintaining a standards-based API for the real-time exchange of AEOB and GFE data?

The FHIR standard for GFEs/AEOBs is not in production in the United States and has yet to be published as an STU1. As such, it is impossible to estimate implementation time or costs. That said, as a new electronic standard, implementation of the HL7 PCT IG will take time and resources for the entire industry, and we would anticipate that adoption will be particularly onerous and perhaps even cost prohibitive, at least initially, in less-resourced care settings.

Q17: To what extent are providers, facilities, and plans, building and maintaining standards-based APIs for multiple purposes, or already have standards-based APIs in place that they can leverage to implement AEOB and GFE requirements?

We strongly caution the Departments and OPM against assuming that the APIs stakeholders may have implemented to meet the requirements of the CMS Interoperability and Patient Access final rule can be easily leveraged and/or repurposed to create GFEs/AEOBs. The GFE/AEOB use case is separate and distinct from currently developed APIs and, as noted above, closely parallels the current claim submission and adjudication process—a workflow that has not been robustly developed or tested in FHIR-based technology. In addition, many of the data elements required for GFEs/AEOBs are not currently included in the USCDI, which presents a major challenge for an API-based approach. For these reasons, the Departments should not assume that APIs that stakeholders have implemented for other purposes or to meet unrelated federal requirements will reduce the burdens, costs, or timelines of adopting API-based technology for GFE/AEOB creation. Rather, the Departments should view the building, testing, and costs associated with a FHIR-based API as a completely new and independent project that organizations will need to add to their development calendars and budgets.

IX. Additional recommendation: generating GFEs for AEOB vs. self-pay or uninsured patients

As a final recommendation, **the AMA urges the Departments and OPM to reject any standard process that would require billing providers to consolidate cost data into a single GFE prior to submission to an insurer for the creation of an AEOB**.

Support for this recommendation was detailed in a recent letter[3] to Administrator Brooks-LaSure from the AMA, the American Hospital Association (AHA) and the Medical Group Management Association (MGMA). The letter highlights several challenges associated with applying the "convening provider" model to the GFEs used to generate AEOBs and the insurmountable burden for physicians and other providers should such a model be extended to cost estimates for insured patients.

[3] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfr.zip%2F2022-09-27-Joint-Letter-to-CMS-re-Convening-Provider.pdf

For example, there are significant differences in the information that would need to be collected for the GFE for self-pay or uninsured patients as opposed to the information needed to generate an AEOB, including inputs and information that payers require to apply their pricing edits. The collection of this additional data would be extremely burdensome and expensive for providers, as it would require professional coders to code all GFEs for AEOBs and physician practices to potentially be working with data fields, formats and systems used by institutions with which they have no familiarity or training. In order for a "convening provider" to collect this information, they would need technology and workflow upgrades beyond what will be required to meet the needs of the uninsured and self-pay GFEs.

The application of the "convening provider" model to the GFEs for AEOBs would significantly increase the volume of additional administrative work for physician practices and likely result in care delays and increased costs to the health care system. As such, **we urge to the Departments and OPM to allow each provider involved in an insured patient's care to submit their individual GFE to the plan to generate an AEOB.**

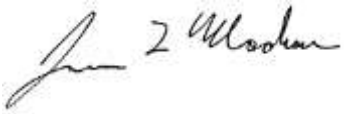
X. Conclusion

In conclusion, the AMA appreciates the opportunity to provide input to the Departments and OPM as you work to implement these provisions of the NSA. As outlined above, we believe there are a number of significant challenges that need to be addressed before implementation of the NSA's AEOB requirements. We again urge you to consider the complicated data exchange ecosystem in which these new requirements will be inserted, as well as the new administrative burdens that will be placed on already strained physician practices. Without recognizing and addressing all of the data exchange barriers prior to implementation, the AEOB requirements will not be able to achieve meaningful price transparency for patients, and may in fact, delay and impede patient care.

We remain committed to working closely with the Departments and OPM to get this right and with our physician members to ensure that they have the information and tools to successfully implement the new requirements.

Please contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409 with any questions or follow-up.

Sincerely,



James L. Madara, MD