Patient Cost Transparency
Use Case Public Kick Off

June 25, 2021

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Approved by the ANSI Board of Directors
May 22, 2014
Da Vinci 2021 Multi-Stakeholder Membership

**PROVIDERS**
- athenahealth
- Cerner
- Epic
- Healow Insights
- veradigm.
- RUSH
- Providence St. Joseph Health
- OHSU
- UC Davis Health
- UNC Health Care
- Weill Cornell Medicine

**EHRs**

**PAYERS**
- Anthem
- Blue Cross Blue Shield of Alabama
- Blue Cross of Idaho
- Blue Cross Blue Shield of Tennessee
- Cambia
- Cigna
- CMS Health
- GuideWell
- Humana
- Independence
- UnitedHealthcare

**DEPLOYMENT**
- Availity
- Change Healthcare
- Cognizant

**VENDORS**
- casenet
- cognosante
- edifees
- infor
- InterSystems
- juxly
- mcg
- OPTUM
- surescripts
- ZeOmega

**INDUSTRY PARTNERS**
- HIMSS
- HL7 International
- NCQA

*Indicates a founding member of the Da Vinci Project. Organization shown in primary Da Vinci role. Many members participate across categories.

For current membership: [http://www.hl7.org/about/davinci/members.cfm](http://www.hl7.org/about/davinci/members.cfm)
• Project Team and Summary
• Dimensions of Patient Cost Transparency
• Policy Considerations and Intersections
• Discovery of Use Case
  – Clinical Scenario
  – Data Elements
  – Workflows
  – Glossary
• Success Metrics
• Next Steps
### Project Team

<table>
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<tr>
<th>Role</th>
<th>Name</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Project Co-Lead (Payer)</td>
<td>Alice O'Carroll</td>
<td>FL Blue</td>
</tr>
<tr>
<td>Project Co-Lead (Provider)</td>
<td>Luke Rockenbach</td>
<td>Providence St. Joseph</td>
</tr>
<tr>
<td>Project Co-Lead (Vendor)</td>
<td>Jacob Woodford</td>
<td>EPIC</td>
</tr>
<tr>
<td>Lead Analyst</td>
<td>Mary Kay McDaniel</td>
<td>HL7</td>
</tr>
<tr>
<td>IG and RI Lead</td>
<td>Larry Decelles</td>
<td>MITRE</td>
</tr>
<tr>
<td>IG and RI Support/Co-Lead</td>
<td>Gary P. Gryan</td>
<td>MITRE</td>
</tr>
<tr>
<td>PMO/Technical Director</td>
<td>Viet Nguyen, MD</td>
<td>Stratametrics, LLC</td>
</tr>
<tr>
<td>PMO/Program Manager</td>
<td>Jocelyn Keegan</td>
<td>Point of Care Partners</td>
</tr>
<tr>
<td>PMO/Project Co-Lead and Project Manager</td>
<td>Vanessa Candelora</td>
<td>Point of Care Partners</td>
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</tbody>
</table>

Additionally, other active Da Vinci Member Participants from:

- FL Blue
- EPIC
- Providence St. Joseph
- Providence Health Plan
- Cigna
- Evernorth
- Optum
- United
- BCBSA
- Cambia
- SureScripts
- Athena Health
- CMS
- Weill Cornell Medicine
- HCA Healthcare
- Sutter Health
Overview

• Patient Cost Transparency is “In health care, readily available information on the price of health care services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value”

• Good faith estimates are reliant on the information known at the point in time of the patient journey.

• Patient cost data must flow between multiple stakeholders if effective collaboration is to occur

Goals

• Define standard FHIR-based methodology (data input, data output and format) to support real-time requests and responses for patient cost

• Ability to communicate good faith estimates for single service, collection of services, and items

• Ability to communicate cost estimates in advance of scheduled service or upon request

Patient Cost Transparency Da Vinci Project Confluence
HL7 Project Scope Statement (PSS) for Patient Cost Transparency
Primary Sponsoring HL7 Work Group – Financial Management
See HL7 Calendar for Public Meeting Kick off (6/25) and ongoing Fridays at 11am EST

https://www.hfma.org/topics/price-transparency.html
Dimensions of Patient Cost Transparency

- Perspective (Patient, Provider, Payer)
- Information Gap (eg, Providers more likely to know specifics than Patient)
- Timing (where in the process are requirements available)
- Technology (currently available and future opportunities)
- Industry Solution Readiness (Balance of fast and future proof)
- Collection of Services (varied definitions challenge true comparison shopping)
Automated capabilities that provide timely, robust pricing transparency between payers and providers, as well as payers and consumers, is an industry priority.

Robust pricing transparency presented prior to the delivery of services will enable patients with their clinician’s guidance to make informed decisions on their course of treatment and the cost to the patient:

Patients need accurate, timely access to cost of medical care prior to delivery of care in order to become better stewards of their healthcare dollars.

Providers need accurate, timely access to pricing transparency prior to and immediately after delivery of care.

Payers need to educate members to make informed decisions, have good customer service and higher member satisfaction.
Information Gap (Patient, Provider, Payer)

Patient
- How much will this cost me?
- May not know service details as precisely as others
- May request an estimate or receive an Advanced EOB upon scheduled service (as applicable)

Provider
- Ordering provider and servicing providers may be different.
- Know more detail about services and items needed beyond patient knowledge.
- Providers may have contractual relationship with each other that impact cost.
- May be responsible for good faith estimate

Payer
- Know coverage, benefits, spend history for patient (eg, deductible and other accumulators)
- Provider network information (in and out of network) and negotiated prices
- Responsible for Advanced EOB
Recognize that more accurate information will result in a more accurate estimate.

- **Factor:** Role of Requester and level of information they'll have available
- **Point in Time** – what do we know when
- **Richer** data input yields **narrower** estimate
- **Less** data input yields **broader** estimate
Technology and Information Readiness

Technology (currently available and future opportunities)

• Developing an Implementation Guide, recognizing the business process is new/not fully established
• Investigating existing technology to meet short timelines
• FHIR Core

Industry Solution Readiness (Balance of fast and future proof)

• Payer and Provider data to support the workflows and requirements
  – Networks
• Recognize that implementation takes time
• Estimate for Single Item or Service
• Estimate for Collection of Services
  – Definition may be different (eg, does Total Knee Replacement include the post-hospital care)
  – Various tools available for grouping services together (ie, Episode Groupers)
  – Single organizations bill or multiple organizations bill

• The challenge to determine and generate the list of services precedes the exchange of data to provide the estimate.
Policy Considerations
Policy: Laws and Regulation

CMS Hospital Price Transparency Rule — U.S. Hospitals required to provide clear, accessible pricing information (gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges) online for items and services, Effective 1/1/2021

CMS Transparency in Coverage Rule (TCR) - CMS-9915-F - Requires health plans to offer an online shopping tool that will allow consumers to see the negotiated rate between their provider and their plan, as well as a personalized estimate of their out-of-pocket cost for items and services – Effective Rolling Requirements 1/1/2022, 1/1/2023, 1/1/2024

Consolidated Appropriations Act (CAA), No Surprises Act (NSA)
- Section 111 and 112 – Good Faith Estimate and Advanced EOB
- Section 114 – Payers to provider a member price comparison tool – synergies to TCR.
- Section 116 – think “Maintenance of Provider Directories”

https://www.cms.gov/hospital-price-transparency
https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf
Consolidated Appropriations Act (HR133) - No Surprises Act

1. **Provider**
   - Schedule appointment or on request

2. **Provider**
   - Verify Insurance

3. **Provider**
   - If commercial insurance

4. **Provider**
   - Good faith estimate for costs and codes for planned services

5. **Provider**
   - In network alternatives to out-of-network providers

6. **Provider**
   - Advance EOB
     - Covered costs, patient responsibilities, accumulators

7. **Member**
   - Member Request

8. **Provider Directory**
   - Determine services and cost -
     - Including planned services from other providers

9. **Commercial Payer**
   - Negotiated cost information, Patient Responsibility “rules” Accumulators

**Cost Tool**

- Member cost comparison experience
- Patient Responsibility “rules”
- Accumulators

**HR 133 Cost Transparency Implications V8b draft.pptx**
Discovery of Use Case
Clinical Scenario
Data Elements
Workflows
Glossary
We recognize there are varying complexities to clinical services

- MRI – In process
- Schedule Sick Visit
- Upper GI
- Physical Therapy
- Total Knee Replacement
- CPAP or Home Oxygen Therapy
Eve Betterhalf sees Dr. Patricia Primary (PCP) at ABC Medical Group on Monday with a prolonged migraine headaches lasting over a 4-month period, Dr. says let's do a brain MRI (CPT 70551.) She walks to the PCP front desk, they enter the order into the EMR system, and direct the patient to ABC's Radiology department. Radiology reviews the order for completeness and accuracy and confirms all needed information is present. The next day, Eve calls the radiology facility (Office of Dr. Christine Curie, NPI - 1234567893) to schedule her brain MRI, CPT 70551 and provide her coverage information, which she plans to use. The MRI is scheduled for 9 days from today.

This triggers the process for an Advanced EOB to be sent. Optionally, Eve can also login to the Radiology's site to download the information about her expected services, should she want to request an estimate separately.

The ABC's Radiology Office Administrator enters the services and coverage information, initiates the process with other potential providers to generate the Good Faith Estimate for costs and services. This information is sent to the payer. The payer receives the good faith estimate, adjudicates to determine patient costs and sends the Advanced EOB securely to Eve. Optionally, the payer also sends a response to ABC's Radiology Office Administrator with the same cost estimate information.
Eve receives the Advanced EOB from her payer based on the information provided by ABC Radiology. She realizes there may be a radiology center that is more affordable and closer to her home, so she logs into her Payers’ Patient access portal to request estimates for other providers within a 15 mi radius of her home address that perform MRIs.

She enters the specific service information provided from ABC Radiology (or the Advanced EOB) to request estimates from her payer for services at St. Johns Hospital Radiology department, Center for Imaging, and Safe MRI.

Upon clicking submit on these requests, the Payer receives, processes, and returns Advanced EOBs back to Eve based on the information provided for St. Johns Hospital Radiology Department (Facility), Center for Imaging (a stand alone in-network center), and Safe MRI (which is out of network, so alternate in-network providers are shared for consideration).

Eve now has four different estimates to make a more informed decision about where to have her needed MRI.
Assumptions:

- Patient has a single commercial insurance coverage and plans to use it
- This is clinically appropriate (have a Clinical Decision Support (CDS) Score)
- Service Location is known (e.g., Address)
- All providers are in network - PCP, imaging facility, and reading radiologist
- If required, Prior Authorization is indicated as a disclaimer
Advanced EOB (Patient to Provider)

- Triggered by patient request or scheduled service

Patient

Service Provider

Secondary Provider(s) (if needed)

Payer

Compose Good Faith Estimate (GFE)

Compose Good Faith Estimate (GFE)

Get Advanced EOB (optional)

Return Advanced EOB (optional)

Return Advanced EOB
Advanced EOB (Patient to Payer)

- Assumes order is complete and provider is known
- Triggered by patient request or scheduled service
- One payer
- One provider
Multiple Estimate Requests (Patient to Payer)

- Advanced EOB triggered by patient request
- One payer, other providers
- Patient uses an existing Advanced EOB to get other Advanced EOB(s) for same service(s) or item(s)
- Includes in-network provider info for any out of network providers
- APIs, not UIs - Consumer business decision to display (eg, third party patient app or shopping tool may share alternative options, provider/EHR may not share)
DRAFT Advanced EOB Leveraging X12 Standard

- Triggered by patient request or scheduled service
- Hybrid X12 and FHIR
At time of scheduling (assume more than 10 days out) to build good faith estimate:

- **Patient insurance**
  - Including benefits (RTE = Real Time Estimate (ANSI X12 270/271 eligible & benefit check is done but may not be easy to breakdown and get an estimate to patient today)

- **Patient demographics**

- **Service location**
  - If at facility A - (eg all inclusive room and airfare)
    - Global charge
  - If at facility B - Radiologist reading fee (often not employees of the hospital)
    - Split pro and tech (if radiology is owned)
  - Place of service codes
  - Taxonomy (specialist code)
  - Location (address)

- **Billable codes and charges:**
  - Basic codes for service known:
    - Associated care plan activities (need contrast, sedation, anesthesia, anxiety medication)
    - This could include bringing in other providers (eg, Anesthesiologist)
  - Codes (CPT)
  - Modifiers

- **Diagnosis Codes**
  - Depends on scenario
  - For MRI, diagnosis impacts with or without contrast and thus varies the cost
- **Member out of pocket estimate**
- **Accumulators:**
  - Deductible
  - Out of pocket max
  - Relevant treatment limitation(s)
  - Billed amount (total)
  - Line level charges
  - Contractual Amount / Allowed Amount / Fee Schedule / Covered Amount - Defined as: "Amount that the payer will contribute"
    - Type of insurance - government, commercial
    - In network/out of network
    - Plan design - e.g. family deductible,
  - Billing message codes
- **In network provider info for any out-of-network providers**
- **In-network rate (comprised of negotiated rate, fee schedules)**
- **Approval process needed indicator (e.g., Yes/No for Referral/Prior Authorization)**
- **Disclaimers**
  - As of date -
    - Deductible represents claims that are applied/finalized
  - Estimate based on knowledge at point in time
  - Source of proposed collection of services/care plan (grouper, or other – typical/common vs. happy path)
  - Required Notices
- **Support data elements in the API for a shopping tool filtering (e.g., location, language, accepting new patients)**
- **CoPay amount**
- **Co-insurance amount**
• PCT – Patient Cost Transparency
• CAA - Consolidated Appropriations Act or H.R. 133 – Law passed by Congress in Dec.2020
• NSA - No Surprises Act - part of the CAA that is designed to prohibit surprise medical bills
• GFE - Good Faith Estimate of expected services and costs (outlined in CAA)
• AEOB – Advanced Explanation of Benefits - The No Surprises Act requires that group health plans and insurers provide advance cost estimates, called advanced explanations of benefits (advanced EOBs), for scheduled services
• TCR – Transparency in Coverage – CMS-9915-F Rule that impacts Payers
• Collection of Services - The list of services expected to be performed as part of gathering the good faith estimate
  – Distinction from “Grouper” or “Episode of care” which is often based on start and end date – i.e. diagnoses to complete recovery.
• Cost vs. price – perspectives: Payer, Provider, Patient, Purchaser
• Consumer “Out of pocket" - includes deductibles, coinsurance, and copayments for covered services plus all costs for services that aren’t covered

Glossary in progress: https://confluence.hl7.org/display/DVP/Da+Vinci+PCT+Glossary
Success Metrics

Why is this Use Case important?

Value of Standardization and Potential Metrics
Success Metrics

• Better informed patients and providers
  – Improved decision making
  – Enable shopping

• Better patient experience
  – Ability to plan and prepare
  – Higher satisfactions scores

• Higher rate of collection
Next Steps
Sample Project Timeline

IG Development
- Discovery
- Assemble Team
- Requirements
- Project start
- IG Framework
- Specify profiles, ...
- Create Draft IG
- Revise and Finalize IG
- FHIR Gap Analysis
- RI Tech Approach
- Build Initial RI
- Build Data Set
- Test RI
- Update Final RI
- Build Test Set

RI Development

Targeted HL7 ballot cycle - January 2022
IG: Implementation Guide
RI: Reference Implementation

Work with appropriate HL7 workgroup for IG sponsorship and input
# Anticipated Project Milestones

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<th>Milestone</th>
<th>Timeframe</th>
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<td>Discovery</td>
<td>September 2020 – June 2021</td>
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<tr>
<td>Requirements Gathering</td>
<td>June – July 2021</td>
</tr>
<tr>
<td>FHIR Gap Analysis</td>
<td>July 2021</td>
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<tr>
<td>FHIR IG Development</td>
<td>July – Nov 2021</td>
</tr>
<tr>
<td>Test Case Development</td>
<td>Aug – Sept 2021</td>
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<tr>
<td>Reference Implementation</td>
<td>Aug – Sept 2021, ongoing to publication</td>
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<tr>
<td>Connectathon (HL7 event)</td>
<td>CMS in July 2021, HL7 Sept 2021</td>
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<tr>
<td>STU1 Ballot (HL7 cycle)</td>
<td>Jan 2022</td>
</tr>
<tr>
<td>Published Implementation Guide - STU</td>
<td>Q1/Q2 2022</td>
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</tbody>
</table>

STU = Standard for Trial Use
Requirements Gathering (Focus for Coming Weeks)

- **Perspective (Patient, Provider, Payer)**
- **Information Gap (eg, Providers more likely to know specifics than Patient)**
- **Timing (where in the process are requirements available)**
- **Technology (currently available and future opportunities)**
- **Industry Solution Readiness (Balance of fast and future proof)**
- **Collection of Services (varied definitions challenge true comparison shopping)**

See [HL7 Calendar](#) for Public Meeting Kick off (6/25) and ongoing Fridays at 11am EST
• **Patient Cost Transparency Da Vinci Project Confluence**
  – [https://confluence.hl7.org/display/DVP/Patient+Cost+Transparency](https://confluence.hl7.org/display/DVP/Patient+Cost+Transparency)

• **Community Calls**
  – Fridays starting June 25th at 11am – 12noon ET
  – **HL7 Calendar Meeting Event**
    (For you to add to your own calendar)
    • [http://www.hl7.org/concalls/CallDetails.cfm?concall=56458](http://www.hl7.org/concalls/CallDetails.cfm?concall=56458)

• **Join us! Fridays at 11am ET**
Vanessa Candelora, Point of Care Partners
Vanessa.Candelora@pocp.com

Viet Nguyen, MD, Stratametrics LLC
vietnguyen@stratametrics.com
Thank you!
How to Represent Cost as a Formula?

Viet Nguyen
How to Represent Cost as a Formula

\[
(Cost)_j = f(memberID, gender, coverage, network, deductible, 
copay, outOfPocketMaximum, 
\left(\sum_{i=1}^{n} \text{negotiatedPricePerItem}_i\right)_j, facility_j)
\]

\[j = \text{facility}, \ i = \text{item (eg, professional service, DME, Rx, bundle, etc.)}\]

\[\text{memberID will give you(?):}\]
\[\text{gender, coverage, network, deductible, copay, outOfPocketMaximum,}\]
\[\text{negotiatedPricePerItem}_i = f(\text{PlanID, item}_i, ...)]
• Each item has a negotiated price

\[ \text{negotiatedPricePerItem}_i = f(\text{PlanID}, \text{item}_i, \ldots) \]

• If a patient is self or cash-pay, then they would have to request the price from one or more providers

• An app could potentially support this (like the travel sites do), but this requires the provider to have an API
Appendix
Transparency in Coverage Rule – Payers (CMS Announced on 10/29/2020)

- The rule requires most private health plans, including group health plans and individual health insurance market plans to disclose pricing and cost-sharing information.

- January 1, 2022 – Requirement to make public 3 separate machine-readable files that include detailed pricing information.

- Negotiated rates for all covered items and services between the plan or issuer and in-network providers.
  1. Historical payments to, and billed charges from, out-of-network providers.
  2. In-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.

- January 1, 2023 the rule will require health plans to offer an online shopping tool that will allow consumers to see the negotiated rate between their provider and their plan, as well as a personalized estimate of their out-of-pocket cost for 500 of the most shoppable items and services.

- January 1, 2024, these shopping tools will be required to show the costs for the remaining procedures, drugs, durable medical equipment and any other item or service they may need.

- Note: FHIR not specified.
- Limited to 500 condition areas. Table 1 of page 93.

Hospital Price Transparency Rule CMS - [Hospital Price Transparency](https://www.cms.gov/hospital-price-transparency)

- Hospital price transparency helps Americans know the cost of a hospital item or service before receiving it. Starting January 1, 2021, each hospital operating in the United States will be required to provide clear, accessible pricing information online about the items and services they provide in two ways:
  - 1. As a comprehensive machine-readable file with all items and services.
  - 2. In a display of shoppable services in a consumer-friendly format.
- This information will make it easier for consumers to shop and compare prices across hospitals and estimate the cost of care before going to the hospital.
- For comparison, the CMS Mandate (again): "Single machine-readable digital file containing the following standard charges for all items and services provided by the hospital: gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges."
Requirements for Advanced EOB (No Surprises Act)

The Advanced EOB must include this information:

1. Whether the provider/facility is a participating provider and, if participating, the contracted rate or, if nonparticipating, a description of how an individual may obtain information about participating providers/facilities

2. Good Faith Estimate (GFE):
   
   I. The **good-faith estimate** included in the notification received from the provider/facility based on codes
   
   II. A **good-faith estimate** of the amount the plan is responsible for based on the estimate
   
   III. A **good-faith estimate** of the amount of participant cost sharing
   
   IV. **Good faith estimate** of the accrued amounts already met by the participant toward the deductible and out-of-pocket maximum as of the date of the notification

3. If the item or service is subject to medical management (e.g., concurrent review, prior authorization, and step-therapy or “fail-first” protocols), a disclaimer to that effect

4. A disclaimer that the information is only an estimate

5. Any other information or disclaimer the plan determines appropriate

https://www.segalco.com/media/2089/advanced-eob.pdf
Consolidated Appropriations Act
No Surprises Act

Provider Directory

Determine services and cost -
- Including planned services
  from other providers

If commercial insurance

Best faith estimate for costs and
codes for planned services

If not commercial insurance

Member Request

Member

Provider

Schedule appointment
  or on request

Advance EOB
Covered costs, patient responsibilities, accumulators

In network alternatives to out-of-network providers

Negotiated cost information,
Patient Responsibility “rules”
Accumulators

Member cost comparison experience

Patient

Cost Tool

Commercial Payer

Provider

Provider

Section 112
Section 111
Section 114
Section 116

Needs new or updated standard
Focus on Provider and Payer Requirements for the Advanced EOB

1. Schedule appointment or on request
2. Verify insurance
3. Determine services and cost - Including planned services from other providers
4a. If not commercial insurance
4b. If commercial insurance

- Best faith estimate for costs and codes for planned services

5. In network alternatives to out-of-network providers
6. Advance EOB Covered costs, patient responsibilities, accumulators

- Member Request
- Member
- Patient

- Section 112
- Section 111

Needs new or updated standard
Focus on Provider Requirements

1) Patient schedules an appointment (or requests a quotation) ①

2) Provider determines the services to be delivered (and the charges for each)

3) If services to be delivered require services from other providers, the provider gathers the total set of services (codes and the charges for each) ③

4) If the patient does not have commercial insurance or will not ask to have their commercial insurer billed ②, the provider provides the patient with a best faith estimates ④a

Information requirements (transactions that currently do not exist)

③ Request quotation from another provider (Order?)
Only needs patient insurance / coverage (not other demographics)
Response to request (provider services and charges)
May need claim format if commercial insurance

④a API and paper format to quote (by provider) all services and charges
Includes all disclaimers
Focus on Provider and Payer Requirements for the Advanced EOB

1) Steps 1-3 same as for the Provider Requirements
2) If Patient has commercial insurance, provider sends codes for services to be performed with costs to commercial insurance

Information requirements (transaction exists but needs additional support)

- May be able to use X12 837 predetermination
- Need to supply “claims” in a “set” that includes multiple providers
- Need to indicate that this set is for the “advanced EOB”
  (May need to add disclaimers from providers)
Focus on Provider and Payer Requirements for the Advanced EOB

1) Steps 1-3, 4b same as for prior slide

2) Payer creates advance EOB with patient responsibility, accumulators, disclaimers

3) If provider is out of network, payer provides in network providers to consider

4) Member may request an advance EOB

Information requirements

- May be able to use PDex Plan Net with some changes
- May be able to use CARIN EOB with significant changes
  - Need grouping based on multiple providers / claims
  - Need disclaimers

- Is Patient request in Section 111 any different that patient request in 114 – if so, what is different

Determine services and cost - Including planned services from other providers

Best faith estimate for costs and codes for planned services

If commercial insurance

Member Request

In network alternatives to out-of-network providers

Advance EOB
- Covered costs, patient responsibilities, accumulators

Needs new or updated standard

Section 112

Section 111

Schedule appointment or on request

Verify Insurance

Member

Provider

Patient
This section of the CAA is focused on the same conceptual requirements as the Transparency in Cost regulation but changes both the timing and only addresses part of the functionality.

1) Requirement to start on 1/1/2022
2) No requirement for machine readable files
3) No phase in for services (e.g., all services not an initial list of 500)

2) Commercial insurers shall offer price comparison guidance by telephone and make available on the Internet website of the plan or issuer a price comparison tool allows an individual enrolled under such plan or coverage, with respect to
   • plan year,
   • geographic region, and
   • participating providers,
   to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.

Information requirements
Similar to the Transparency in Coverage regulation
May utilize the X12 837 predetermination transaction
Reference/Pilot Implementation
REST Architecture Model

Provider EHR Implementation Scope

Da Vinci’s Deliverable Scope

Payer Implementation Scope

EHR Backend Services

EHR Database

Implementations conforming to the DaVinci FHIR Profiles following the Implementation Guides

EHR Translation Services

EHR Endpoint & APIs

Industry standard DaVinci Use Case FHIR Profiles with respective Implementation Guides

Response Resource

Request Resource

Payer Database

Payer Backend Services

Payer Implementation Scope

Implementations conforming to the DaVinci FHIR Profiles following the Implementation Guides