Da Vinci PCT Phase 2 Kick Off: Good Faith Estimate (GFE) Collection
Feb 3 2023
Da Vinci PCT Core Team
Vanessa Candelora
Da Vinci PCT Co-Lead, Point-of-Care Partners
Da Vinci Project Introduction

Patient Cost Transparency (PCT) Use Case:
- Overview
- Timeline & Current State
- Regulatory Landscape

PCT Phase 2: Good Faith Estimate Collection
- Regulatory and Market Drivers
- Scope
- Discovery to Date

Project Timeline and Next Steps

How to Get Involved
To ensure the success of the industry’s **shift to Value Based Care**

**PROJECT FOCUS**

**Transform out of Controlled Chaos:**
Develop *rapid multi-stakeholder* process to identify, exercise and implement initial use cases.

**Collaboration:**
- **Minimize** the development and deployment of *unique solutions.*
- **Promote** industry wide standards and adoption.

**Success Measures:**
Use of FHIR®, implementation guides and pilot projects.
For current membership: http://www.hl7.org/about/davinci/members.cfm

The above listed Blue Cross and Blue Shield companies are independent licensees of the Blue Cross and Blue Shield Association.

Use Case Readiness

Clinical Data Exchange
- Payer Coverage Decision Exchange
- Clinical Data Exchange (CDex)
- Payer Data Exchange (PDex)

Quality & Risk
- Value Based Performance Reporting (VBPR)
- Data Exchange for Quality Measures inc. Gaps In Care (DEQM/GIC)
- Risk Adjustment (RA)

Coverage, Transparency & Burden Reduction
- Coverage Requirements Discovery (CRD)
- Documentation Templates and Rules (DTR)
- Prior-Authorization Support (PAS)

Foundational Assets
- Member Attribution List
- Notification
- Health Record Exchange (HRex)

* Referenced in or supports Federal Regulation
△ Aligned with expected Federal Regulation
Dial denotes progress in current STU Phase

Overall Maturity:
- Most Mature
- Active Growth
- Least Mature

Use Cases: https://confluence.hl7.org/display/DVP/Da+Vinci+Use+Cases
Jan 2023: Community Roundtable
Patient Cost Transparency
Summary and Review of Phase 1
Use Case Goal:
- Develop a standard data exchange in support of patient cost transparency for devices, services and collection of services using FHIR APIs for exchange of data

Phase 1 Objectives:
- Ability to communicate good faith estimates (GFE) for single service, collection of services, and items from provider to payer
- Ability to communicate advanced explanation of benefits (AEOB) prior to scheduled service or upon request from Payer to patient and optionally, to provider
- Support current and future regulations and enable compliance (one piece of No Surprises Act)
<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
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<tr>
<td>Project Co-Lead (Da Vinci PMO)</td>
<td>Vanessa Candelora</td>
<td>Point-of-Care Partners</td>
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<tr>
<td>Project Co-Lead (Payer)</td>
<td>Alice O'Carroll</td>
<td>GuideWell/FL Blue</td>
</tr>
<tr>
<td>Project Co-Lead (Provider)</td>
<td>RCM &amp; IT</td>
<td>Providence</td>
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<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>Rick Geimer</td>
<td>Lantana</td>
</tr>
<tr>
<td>RI Support/Co-Lead</td>
<td>Brandon Stewart, Sean McIlvenna</td>
<td>Lantana</td>
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<tr>
<td>Testing Lead</td>
<td>Ryan Moehrke</td>
<td>Aegis</td>
</tr>
<tr>
<td>Policy SME</td>
<td>Denise St. Clair</td>
<td>Acumen, LLC</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>
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DA VINCI PATIENT COST TRANSPARENCY (PCT) TIMELINE REVIEW

Note: in 2019, Da Vinci Members gained approval for the PCT Project Scope Statement (PSS)
COST TRANSPARENCY REGULATION LANDSCAPE

- Increased regulatory activity at Federal level
- Aimed at delivering unprecedented cost transparency for healthcare services
- Industry waiting for additional regulatory guidance on No Surprises Act provisions for insured patients as well as synergies across shopping tool provisions

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No Surprises Act
Personalized Good Faith Estimates and Advanced EOBs for Patients
Law in effect 1/1/2022
Active Rulemaking

CMS Hospital Price Transparency Rule
Charges for all covered items and services

CMS Transparency in Coverage Rule
CMS-9915-F
All covered items and services

Negotiated Rates in Machine Readable Files
Shopping Tool - comparing costs
GOOD FAITH ESTIMATE AND ADVANCED EOB
Simple FHIR-based Workflow

Phase 1

- Good Faith Estimate (to Payer) and Advanced Explanation of Benefits (Payer to Patient)
- Starting Trigger for Phase 1 IG is the GFE
- Submit to the Payer
- Support for the Return AEOB to Provider is not outlined in CAA Law but Da Vinci agrees it’s critical for health equity
- FHIR<>X12 mapping (supported and published by X12)
- The IG is meant to facilitate the necessary data sharing to meet the legislative and future regulatory requirements without limiting provider and payer implementation.

Note: There are no HIPAA mandated transactions for PCT. There are transactions that HIPAA mandates for OTHER transactions (claims) that can support PCT transactions too.

AEOB = Advanced Explanation of Benefits
PCT PROFILES
Good Faith Estimate (GFE) Bundle

- Patient – Information about the person expected to receive care or other health-related services
- Coverage – The member’s coverage the services are to be paid under
- Payer - The organization providing the coverage
- Good Faith Estimate – Expected services claim
  - Each represents a billing provider
  - Institutional or Professional
  - Includes service dates, diagnoses, procedures, and charges
  - Each references Practitioner and/or Organization resources in the bundle including:
    - Billing Provider
    - Care Team Providers
    - Servicing Facility/Location
- Supports one or multiple GFE (claim resource profiles) within one GFE Bundle

GFE and AEOB bundles. For full details, see the PCT FHIR Artifacts.
An AEOB Bundle is created in response to a GFE Bundle

Patient – Information about the person expected to receive care or other health-related services

Coverage – The member's coverage the services are to be paid under

Payer - The organization providing the coverage

Advanced Explanation of Benefits – Estimated adjudication of an expected claim
  - Institutional and Professional
  - Reference to GFE
  - Billing Provider (Organization or Practitioner)
  - Expected Adjudication Amounts (eligible, deductible, copay, coinsurance, etc.)
  - Applicability of Medical Management Requirements (e.g., prior auth, step therapy, concurrent review)

Supports one or multiple AEOB (EOB resource profiles) within one AEOB Bundle

GFE and AEOB bundles. For full details, see the PCT FHIR Artifacts. Note: All resources (supporting info, etc.) needed to process the GFE and produce the AEOB SHALL be included in the GFE Bundle. Relevant resources referenced by such resources SHALL also be included.
Key Takeaway: GFE Submitter receives the Patient AEOB from Payer including a “side car” GFE with details for the billing provider(s).
PATIENT COST TRANSPARENCY PHASE 2

Regulatory and Market Drivers
Scope
Discovery to Date
Timeline and Next Steps
REGULATORY AND MARKET DRIVERS

Patients

- **Patients absorbing costs** of systemic issues. Medical bills are reported to be the **number-one cause of US bankruptcies**. One study has claimed that 62.1% of bankruptcies were caused by medical issues.
- Many cost estimators have low utilization and don’t meet patients’ needs
  - lack consumer friendly language, lack searchability; based on historical claims not current contracted rates, not comprehensive across services, difficult user experience, leading solutions don’t support care team/minors
- Need for patient education/simplification to reduce confusion, high customer care costs

Provider

- **Administrative Burden on Providers**
  - Shift in operational process
  - Sharing price/cost data across providers is new
  - Convening provider
- Manual Process leaves room for error and delay, is cost prohibitive, creating liability for providers and potential delay to patient care

- **No Surprises Act** (Law in effect 1/1/2022)
- **Interim Final Rule** (HHS passed Oct 2021)
  "Requirements Related to Surprise Billing; Part II" (Effective 1/1/2022)
  - Providers and facilities must give a good faith estimate (or GFE) to an uninsured (or self-pay) individual who requests it or who schedules an item or service
  - GFE will include items or services expected to be provided from another provider or another facility (12/2/2022 - deferred enforcement, focus on Interoperability)
  - Convening provider or facility must provide a consolidated good faith estimate to patient within 1 or 3 business days based on scheduled service date. (deferred enforcement 1/1/2023)
- CMS, DOL, and Treasury’s RFI for Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals RFI (Fall 2022) See Da Vinci Response here: [20221114 Da Vinci RFI 87 FR 56905 Response.pdf](#), NPRM expected Aug 2023

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WORKING GLOSSARY

Note: Definitions may evolve as we learn more throughout the Phase 2 work. Providers and facilities will determine what role they play. Providers and facilities may need to prepare to play the convening provider or co-provider, depending on their role in the patient’s service.

- **Good Faith Estimate (GFE)** - The Good Faith Estimate is a notification of reasonably expected charges and billing codes for a scheduled or requested item or service. For a complete breakdown of what needs to be included in the GFE see [42 U.S. Code 300gg-136](https://build.fhir.org/ig/HL7/davinci-pct/#terms-and-concepts).

- **Collection of services** - The list of services expected to be performed during the period of care as part of gathering the Good Faith Estimate for the expected charges, billing and diagnostic codes for one or multiple providers.

- **Convening provider** – The provider who is scheduling the primary item or service and who is responsible for submitting the GFE to the patient (if self-pay/uninsured) or the payer (if the patient is insured).

- **Co-provider** - The provider(s) who are supplying items or services reasonably expected to accompany the primary item or service scheduled. These providers must share estimates with the convening provider to include in the GFE.

- **Coordination Platform** – The responsible entity designated by the convening provider to aggregate the GFE information across providers. This could be the convening provider’s practice management system, EHR, Cost Estimator tool, clearinghouse, payer, or other third party.

More can be found in the PCT IG Terms and Concepts: [https://build.fhir.org/ig/HL7/davinci-pct/#terms-and-concepts](https://build.fhir.org/ig/HL7/davinci-pct/#terms-and-concepts)
Use Case Goal:
- Develop a standard data exchange in support of patient cost transparency for devices, services and collection of services using FHIR APIs for exchange of data

Phase 2 Goal Summary: Support Good Faith Estimate data exchange via FHIR APIs when multiple providers are involved

Standard for Trial Use (STU) Phase 2 Objectives
- Add Ability for convening provider to notify co-providers and request data to inform good faith estimates (GFE) for expected service(s) and item(s)
- Add Ability for co-providers to respond to a request for data back to convenor (convening provider, third party, or payer) with cost and planned service(s) or item(s) information
- Add Ability for Coordination Platform to communicate GFE to Patient (leveraging existing FHIR API), payer (leveraging existing PCT IG workflow,) and to other providers in the care team, prior to scheduled service or upon request
- Support current and future regulations and enable compliance (No Surprises Act) for GFEs to All Patients (self-pay, uninsured, and insured patients)
- Update to support additional enhancements to phase 1 work including:
  - Add AEOB Summary (Across claims)
  - Build out Linking Identifier capability
- Fixes and Improvements based on Implementation, Connectathon Learning
PHASE 2 GOAL: SUPPORT GOOD FAITH ESTIMATE DATA EXCHANGE

Focus of Phase 2 is to support the composing the GFE with multiple providers involved in the patient’s care.

*The Request and Response for GFE information may involve additional actors beyond what’s depicted here.
CLINICAL EXAMPLE FOR GFE COLLECTION ACROSS PROVIDERS FOR SELF-PAY/UNINSURED

Note: This is one example scenario. Providers and facilities will determine what role they play. Providers and facilities may need to be prepared to play the convening provider or co-provider, depending on their role in the patient’s service.

• **STEP 1:** Patient schedules a surgical procedure at XYZ Hospital (Convening Provider). Patient declares they are Self Pay (SP)

• **STEP 2:** XYZ Hospital identifies the co-providers needed for the procedure, then triggers request to an external Surgeon (Co-Provider 1) and Anesthesiologist Group (Co-Provider 2) for surgery

• **STEP 3:** Surgeon and Anesthesiologist Group review the procedure and respond to data request with their procedures, pricing, allowed, and patient responsibility

• **STEP 4:** XYZ Hospital’s assigned Coordinating Platform aggregates all co-provider estimates into one GFE

• **STEP 5:** GFE is posted to Patient API
• Patient – Information about the person to receive the service(s)

• Good Faith Estimate
  – Represents a billing provider
  – Institutional or Professional
  – Includes service dates, diagnoses, procedures, and charges
  – Reference Practitioner and/or Provider/Facility Organization including information on:
    • Billing Provider
    • Care Team Providers
    • Servicing Facility/Location
  – Discounts: Prompt Pay, Self Pay, FPL, Bundled Rates
  – Known eligibility for financial Assistance (?)
  – Relevant clinical information
  – Patient waiving right for Balance Billing

• Summary of Totals across providers, in addition to each individual billing provider totals

• Actors
  – Providers (in the broadest definition), Vendors, Platforms

• Systems
  – Provider’s practice management system, EHR, Cost Estimator tool, clearinghouse, payer, or other third party

  Will leverage existing FHIR IG Resource Profiles, Operations, Value Sets, Code systems, wherever possible, based on requirements
<table>
<thead>
<tr>
<th>What is sending/submitting the information?</th>
<th>Who is receiving the information?</th>
<th>Where does that information live?</th>
<th>What information needs to be exchanged?</th>
</tr>
</thead>
</table>
| Patient, ordering provider (eg, surgeon) | Provider(surgeon)/ facility | Variable; where we need a new system | • Patient Demographics  
• Procedure/Service  
• Date/Time?  
• Order*  
*“We understand that there is variation in what might be contained in an order, a complexity that will need to be taken into account”  
**Could be asked to send information back to another person or system (eg, new vendor system that compiles comp GFE) |
| Provider responsible for developing care team | Providers that are expected to deliver services as part of the scheduled patient’s care (eg, preferred lab that is not part of the scheduling provider’s organization) | Variable | • Services that the patient is getting/convening provider envisions  
• Amount of time the convening provider expects the service to take (important for anesthesiologists)  
• Everything known for previous step (eg, DRG, ICD-10 code, CPT) |
| Highly variable; could be a work queue that many people could access/use (eg, surgical scheduler, rev cycle, centralized team for all registration/just for estimates, etc.) – need it to be someone who has enough clinical knowledge but also at the very start of the process - Needs to be flexible! | Highly variable. Would likely be the same person who sends the information. Important for multiple people to have access | Variable | • Services that the patient is getting/convening provider envisions  
• Amount of time the convening provider expects the service to take (important for anesthesiologists)  
• Everything known for previous step (eg, DRG, ICD-10 code, CPT) |
| Highly variable; could be office coordinator/manager, front desk staff. Must be someone in the office with a computer, patient’s medical record, and diagnosis and service codes. Recipient should have revenue cycle and coding knowledge to verify incoming information. Must be flexible  
*Billing may be done by a 3rd party, adding complexity | Highly variable. Would likely be the same person who sends the information. Important for multiple people to have access | Variable | • Services that the patient is getting/convening provider envisions  
• Amount of time the convening provider expects the service to take (important for anesthesiologists)  
• Everything known for previous step (eg, DRG, ICD-10 code, CPT) |
| Highly variable; could be office coordinator/manager, front desk staff, financial team. Likely whoever maintains interaction between provider and patient. | Patient (how and what format?) | Highly variable; could be office coordinator/manager, front desk staff, financial team. Likely whoever sends Comprehensive GFE to patient. | • Services that the patient is getting/convening provider envisions  
• Amount of time the convening provider expects the service to take (important for anesthesiologists)  
• Everything known for previous step (eg, DRG, ICD-10 code, CPT) |

**Source:** Convening/Co-Provider Workflow and Solution subgroup hosted by AHA, AMA, MGMA
CHALLENGES TO ADDRESS

- Identifying and Coordinating the Participating Providers
- Gathering of GFEs From Convening and Participating Providers
- Leveraging Existing Technologies and Vendors Participating in the Current EHR and RCM Processes
GFE–AEOB WORKFLOW FOR UNINSURED PATIENT

Insert steps for:
1. Status
2. Notification of changes
3. “Finalize”

Opportunities for automation
BENEFITS

- Accommodates the current human driven coordination processes
- Convening provider determines the coordination platform which could be a practice management system, RCM, EHR, Cost Estimator tool, clearinghouse, payer, or other third party
- Leverages a coordination platform to identify and coordinate the GFEs
- Uses FHIR/open APIs to standardize the transactions
- Reuses FHIR artifacts from PCT IG
• Provider internal processes to determine their planned items and services and associated cost data to share
  – It is recognized that provider and facility business processes may need to change to gather this information in advance, at the time of scheduling or GFE request

• Network (in, out) of providers is not needed at this GFE collection as that would be indicated by the payer downstream from these steps in workflow.

• Other data that would typically come from the payer (e.g. Allowed Amounts)
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<th>Timeframe</th>
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<td>Discovery</td>
<td>Jan 2023</td>
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<tr>
<td>Requirements Gathering</td>
<td>Feb – Mar 2023</td>
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<td>FHIR Gap Analysis</td>
<td>Mar - Apr 2023</td>
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<td>Profile and Operation Development</td>
<td>Apr – Jun 2023</td>
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<td>Test Case Development</td>
<td>Jun 2023</td>
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<td>Reference Implementation</td>
<td>Jun – Sept 2023</td>
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<td>STU Ballot</td>
<td>Jan 2024 (Goal)</td>
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GET INVOLVED
Use Case confluence site:
https://confluence.hl7.org/display/DVP/Patient+Cost+Transparency

Implementation Guide:
PCT CI IG: https://build.fhir.org/ig/HL7/davinci-pct/#overview

Project Scope Statement:
Project Scope Statement approved by HL7 (FM Sponsor, PIE co-sponsor)

Zulip Chat
https://chat.fhir.org/#narrow/stream/301151-Da-Vinci.20PCT

Join Us: Weekly community calls on Fridays, 11am – 12pm ET
• Join Us every Friday from 11:00am to 12:00noon ET!
  – Add the call to your calendar: http://www.hl7.org/concalls/CallDetails.cfm?concall=64953
  – Bring your Revenue Cycle and Cost Transparency colleagues as we gather and validate requirements in an open public consensus-building process
  – Near-term agenda topics will include: clinical scenario alignment, workflow, what’s out of band/human/tech, the role of time and deadlines, info changes, non-happy path scenarios

• Read the current Patient Cost Transparency Implementation Guide (STU1) at https://build.fhir.org/ig/HL7/davinci-pct/
• Learn more at our confluence space: Patient Cost Transparency (PCT)

Conference Call Sign Up
• HL7 Conference Call Center - check the HL7 calendar for cancellations/changes! (it takes time to load)
• Da Vinci Conference Call Sign Up Instructions
• Note: There is no invitation, add to your own calendar
• HL7 Da Vinci General Inquiries: DaVinciPMO@pocp.com
QUESTIONS?

Contact Us:
vanessa.candelora@pocp.com
Appendix
“HL7 Da Vinci Project was founded and continues to focus on solving interoperability challenges between providers, patients and payers. The pervasive reality is that patients and their care providers need accuracy and clarity on patient cost for services. Da Vinci has a well-honed process to bring together impacted stakeholders to understand business challenges, identify workflow impacts and then leverage those inputs to build specific recipes, aka HL7 FHIR implementation guides, and supporting tools and materials to help solve these industry-wide challenges. Our work around data exchange required for full transparency of cost for patients dates to 2019.

The Da Vinci Steering Committee fully supports the Patient Cost Transparency use case team’s efforts to look at the long term, end to end problem, and encourages this community to take a thoughtful, incremental approach to building FHIR APIs and the necessary crosswalks to other existing and emerging standards, so we can begin to unlock these long-standing industry challenges.

The community should acknowledge and be informed by regulatory and potential policy inputs, and where there are external regulatory or industry dates these may inform and help prioritize the order of the work; however the work of Da Vinci is not to be constrained to only meeting regulation, expected regulation. In all of our work, the focus is to create the supporting rails and connectors to achieve semantic interoperability and deliver value for all stakeholders to begin to unleash the data needed, so industry participants can get to true price transparency for patients. We acknowledge this is only one part of the necessary activities to move forward.”

https://confluence.hl7.org/display/DVP/Da+Vinci+Steering+Committee+PCT+Scope+Statement
Patient Cost Transparency (PCT)

Implementation Guide (STU1)
- CI Build [https://build.fhir.org/ig/HL7/davinci-pct/](https://build.fhir.org/ig/HL7/davinci-pct/)
- IG Github Repo: [https://github.com/HL7/davinci-pct](https://github.com/HL7/davinci-pct)

Hosted Reference Implementation
- Server: [https://pct-payer.davinci.hl7.org/](https://pct-payer.davinci.hl7.org/)
- Client: [https://pct-client.davinci.hl7.org/](https://pct-client.davinci.hl7.org/)

Reference Implementation Code (Apache 2.0 license)
- Server: [https://github.com/HL7-DaVinci/test-pct-payer](https://github.com/HL7-DaVinci/test-pct-payer)
- Client: [https://github.com/HL7-DaVinci/pct-client](https://github.com/HL7-DaVinci/pct-client)

Test Scripts
- [https://touchstone.aegis.net/touchstone/testdefinitions?selectedTestGrp=/FHIRSandbox/DaVinci/FHIR4-0-1-PCT](https://touchstone.aegis.net/touchstone/testdefinitions?selectedTestGrp=/FHIRSandbox/DaVinci/FHIR4-0-1-PCT)

Confluence
- [https://confluence.hl7.org/display/FHIR/2023+-+01+Da+Vinci+Patient+Cost+Transparency](https://confluence.hl7.org/display/FHIR/2023+-+01+Da+Vinci+Patient+Cost+Transparency)
AEOB SUMMARY DISCOVERY

- Requirements:
  - Estimate Summary across providers in period of care (across claims/eobs)
    - Total Expected Amount Patient May Owe
    - Your Deductible Status
    - Providers with Claims this period
      - List of service date/period and provider name from all included gfe resources
      - In Bundle and Across Bundles
      - Use on all AEOBs, whether there is 1 or many claims
  - Parking Lot of Solutions to explore further:
    - EOB Resource
    - FHIR Basic Resource
    - Liquid Templating