Patient Cost Transparency
Use Case Update

Sept 17 2021
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 near 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
Use Case kicked off on June 25, 2021
Use Case confluence site:  
https://confluence.hl7.org/display/DVP/Patient+Cost+Transparency
Weekly community calls on Friday, 11am – Noon ET
Plan to ballot 1\textsuperscript{st} STU during the 2022 January Ballot Cycle
Project Scope Statement approved by HL7

Big Thank you!

Alice O’Carroll (Florida Blue)
Caitlyn Campi (Florida Blue)
Jacob Woodford (Epic)
Luke Rockenbach (Providence)
• Starting Trigger for Phase 1 IG is the GFE Submit to the Payer.

• The support for the Return AEOB to the Provider is not outlined in CAA Law but Da Vinci agrees is good to do.
Phase One Goal and Scope

• Goal: Define standard methodology (format) for Providers to communicate the Good Faith Estimate to the Payer and for the Payers to provide the Advanced EOB to the Patient and Provider

In Scope – Phase One

• FHIR based API
• Provider GFE data to Payer
• Payer AEOB to Patient and Provider
• FHIR<>X12 mapping (supported and published by X12)

Potential topics to address in Phase Two

• Provider to Provider communication in addressing GFE
• Patient initiated request for AEOB
• Shopping tool and other aspects of No Surprises Act and TiC
• Payer to Provider for collecting GFE information.

Out of Scope

• How Provider determines what items go into the “collection” that is submitted to the Payer
• Email and paper methods for communication between parties
Activities

COMPLETED

• Project management work breakdown
• Defined overall workflow
• Identified data requirements from Discovery and X12 support*

IN PROGRESS

• Discussions of representing AEOB
• FHIR Profiling
• Defining FHIR Operations
• Reference implementation design/development

STARTING SOON

• IG Authoring
• Testing and Feedback from Community

FUTURE

• IG Balloting/Ballot Reconciliation/Publication

*Community Review and Feedback welcome.
• Decision: Da Vinci data exchange will support Business workflows with:
  - One Good Faith Estimate (GFE)
  - Mechanism to link multiple providers’ services together across GFEs. (Linking ID, Total Claims, Total Providers)

• Interim Final Rule Analysis Complete
  - Opportunity for Phase 2 to support Patient Consent/Approval with the GFE so Payer is informed for the unique balanced billing scenario. (Provider is out of network for an in-network facility)

• Started AEOB Data Elements Requirements (Payer to Patient) and profiling in FHIR.
Today’s Goal: Clarify GFE Requirements on 2 Questions

Goal of discussion to align the GFE data elements and exchange with the following questions:

1. Are Payers storing the GFEs and AEOBs to use later after AEOB provided (for claims processing, for other reasons)?
   - May not be answered internally at Payers yet.

2. Once the GFE is sent to the Payer, how will the GFE Submitter know it was received?
   - Avoid re-submit, additional inquiries

But First……..
Friday Community Call Alignment

We hear you!

• This is not easy!
• Our Goal is to define standard FHIR-based methodology for data exchange to support GFEs and AEOBs.
• Technology is here to support the many ways payers and providers will work through their business process.
• Da Vinci has the Opportunity for technical standard IG to be named in future regulation.
• We are all Patients and stakeholders of this use case. The Patient experience is a critical component to drive our work.

• Project Timeline: Targeting January 2022 HL7 Ballot Process
• Project Pace and Goal: We are moving forward swiftly and with the long-term solution in mind for an IG and RI for community implementation and feedback.
• Regulation and Law Timeline: See HHS FAQ 8/20/21
  – Enforcement of the 1/1/2022 date for AEOB and GFE delayed.
  – Expect notice and comment rulemaking after 1/2022 including establishing appropriate data transfer standards.
• What AEOB Business Processes will the technology support?

• What is needed for the Payer to Provider AEOB/Advanced Remittance and what information will be sent to what provider in different scenarios?
  – What will the providers do with this? How will the Payer know how to unpack to get to the right Provider (NPI vs. Tax ID)? Is there enough info in the GFE?
  – There is no Remittance FHIR resource today. EOB?
  – Define different term for AEOB to Providers.
  – Which providers receive which AEOBs…. Do all receive all? Or does each one only receive his/hers only?

• Role of Plan Net / Direction IG for the Provider network status.

• Providers need a way to store Billing Provider and charges information
  – Need Tax ID, NPI, Provider Name, and Provider Address.

• Plan Net IG is planning to have endpoints for providers that may be leveraged for this process.
Workflow Visuals

Business workflows the industry may choose to implement (All are combinations of: One or Many GFEs, One or Many AEOBs which FHIR Solution plans to support)

Note: the collection of GFE info is out of scope for Phase 1.

Special Thanks to Melanie Combs-Dyer, Mettle Solutions
Scenario 1  
(Scheduling Provider Pulls All into One)  

1. Patient encounter with practitioner  
2. Scheduling Provider asks other providers if they have time to take the case, and if so, requests their GFE data elements  
3. Other Providers send their GFE data elements to the Scheduling Provider  
4. Scheduling Provider sends Full GFE to Payer  
5. Payer sends AEOB to Patient with cc to providers  

Out of Phase 1 Scope: collecting GFE information  

Source: Mettle Solutions, (with input from BCBSA, SmileCRD, Point of Care Partners)
Scenario 2a
(All Providers Solo into single AEOB)

1. Patient encounter with practitioner
2. Scheduling Provider submits a Partial GFE to Payer
3. Provider #2 sends a Partial GFE to Payer
4. Provider #3 sends a Partial GFE to Payer
5. Payer sends AEOB to Patient with cc to providers

Out of Phase 1 Scope: collecting GFE information

Source: Mettle Solutions, (with input from BCBSA, SmileCRD, Point of Care Partners)
Scenario 2b
(All Providers Solo; multiple AEOB)

1. Patient encounter with practitioner
2. Scheduling Provider submits a Partial GFE to Payer
3. Provider #2 sends a Partial GFE to Payer
4. Provider #3 sends a Partial GFE to Payer
5. Payer sends AEOB to Patient with cc to providers

Source: Mettle Solutions, (with input from BCBSA, SmileCRD, Point of Care Partners)

Out of Phase 1 Scope: collecting GFE information
Scenario 2c
(All Providers Solo; multiple AEOB; together with summary)

1. Patient encounter with practitioner
2. Scheduling Provider submits a Partial GFE to Payer
3. Provider #2 sends a Partial GFE to Payer
4. Provider #3 sends a Partial GFE to Payer
5. Payer sends AEOB to Patient with cc to providers

Out of Phase 1 Scope: collecting GFE information

Source: Mettle Solutions, (with input from BCBSA, SmileCRD, Point of Care Partners)
Scenario 2d
(All Providers Solo + Scheduling Provider Notifies Payer of Involved NPIs)

1. Patient encounter with practitioner
2. Scheduling Provider submits a Partial GFE to Payer
3. Provider #2 sends a Partial GFE to Payer
4. Provider #3 sends a Partial GFE to Payer
5. Payer sends AEOB to Patient with cc to providers

Out of Phase 1 Scope: collecting GFE information

Source: Mettle Solutions, (with input from BCBSA, SmileCRD, Point of Care Partners)
Scenario 3
(Payer Orchestrates the Providers)

1. Patient encounter with practitioner
2. Scheduling Provider submits a Partial GFE to Payer
3. Provider #2 sends a Partial GFE to Payer
4. Provider #3 sends a Partial GFE to Payer
5. Payer sends AEOB to Patient with cc to providers

Source: Mettle Solutions, (with input from BCBSA, SmileCRD, Point of Care Partners)

Out of Phase 1 Scope: collecting GFE information

Not part of Phase 1 - “Chatty” piece is an opportunity for Phase 2.
Scenario 4
(Payer Uses Data to calculate an estimated payment)

1. Patient encounter with practitioner
2. Scheduling Provider submits a Partial GFE to Payer
3. Provider #2 sends a Partial GFE to Payer
4. Provider #3 sends a Partial GFE to Payer
5. Payer sends AEOB to Patient with cc to providers

Open Question: Do we need to define these terms?

VC - Same as Scenario 1 in FHIR.

Out of Phase 1 Scope: collecting GFE information

Source: Mettle Solutions, (with input from BCBSA, SmileCRD, Point of Care Partners)
Today’s Goal: Clarify GFE Requirements on 2 Questions

Goal of discussion to align the GFE data elements and exchange with the following questions:

1. Are Payers **storing** the GFEs and AEOBs to **use later** after AEOB provided (for claims processing, for other reasons)?
   - May not be answered internally at Payers yet.
   - Yes, storing them. Customer service would see them (through similar interface to look at Clams internally)
   - Not using to process claim later.
   - **Yes - storage in document repositories for members to access completed AEOBs for a period of time.**
   - **For GFE, storing the data in the request/response.**
   - Both to be future used to audit compliance as well as future state compare the differences between the AEOB and then the post service claim.

2. - Need Inquiry to Payer for the AEOB (which includes the GFE).

   • Supports future potential Patient Request workflow

   - Who is allowed to ask for it beyond the GFE Submitter, all the providers listed as part of the GFE and the Patient? (Business Process question)

   - NOT using remittance process,

   - What data does the Payer need to get the info back to the Provider? Have same data elements for all providers in service – NPI, Tax ID, Provider Name, address – will we have all of this.

   - Add Provider endpoint within the GFE data elements for all the performing providers.
Goal of discussion to align the GFE data elements and exchange with the following questions:

2. Once the GFE is sent to the Payer, how will the GFE Submitter know it was received?
   - Avoid re-submit, additional inquiries

3. Do we have enough data elements in GFE to get the info back to the provider?
   - If splitting patient from provider to get the AEOB back, do you need more than the NPI?
   - Right now, likely Providers will get a .pdf just like the Patient back to the end point we got the GFE from.
   - No to sending back AEOBs to the providers.
• **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 at 11am – 12noon ET
  - [HL7 Calendar Meeting Event](http://www.hl7.org/concalls/CallDetails.cfm?concalt=56458) (For you to add to your own calendar)

• **Join us! Fridays at 11am ET**
Call to Action

- Friday 11 AM ET
  HL7 Community Call

- Need Implementers for real world feedback
  Implement and Test

- January 2022
  Ballot upcoming
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Appendix
Advance EOB | Collection of Providers’ Services

Provider enters provider info, billing codes, charges for all providers, creating a "Collection of the services" to be estimated.

REQUEST
Surgeon A
Facility B
Anesthesia C
Imaging D

Pricing
• Separates the collection by provider
• Applies the allowed amounts
• Each estimate can be priced in parallel

Estimate A
Surgeon A
Estimate B
Facility B
Estimate C
Anesthesia C
Estimate D
Imaging D

Benefit Adjudication
• Applies benefits to each component
• “Rolls” accumulator across components to calculate accurate deductibles, etc.
• Each estimate must be available and processed together

Estimate A
Surgeon A
Estimate B
Facility B
Estimate C
Anesthesia C
Estimate D
Imaging D

Member
Share 1
Share 2
Share 3
Share 4

Member
• Plan packages the transactions, adds other content, and provides the member the Advance EOB

FINAL ESTIMATE FOR REQUEST
Total Member Cost: $$$
Provider A $$
Facility B $$$
Anesthesia C $
Imaging D $$

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Assumptions:

- Given the expected personalization of estimates, the same logic found in claims processing systems will be needed for both pricing and benefit adjudication.
- Since claims processing systems have logic to cover all payment scenarios today, this process will work with minimal adaptation for all services.