CAQH CORE

No Surprises Here: Recommendations from the CAQH CORE Advanced Explanation of Benefits Advisory Group

November 17, 2021

Agenda

- CAQH CORE Overview
- Background: No Surprises Act
- Recommendations for the Exchange of Good Faith Estimates Between Providers and Payers and Next Steps
- Q&A

Logistics

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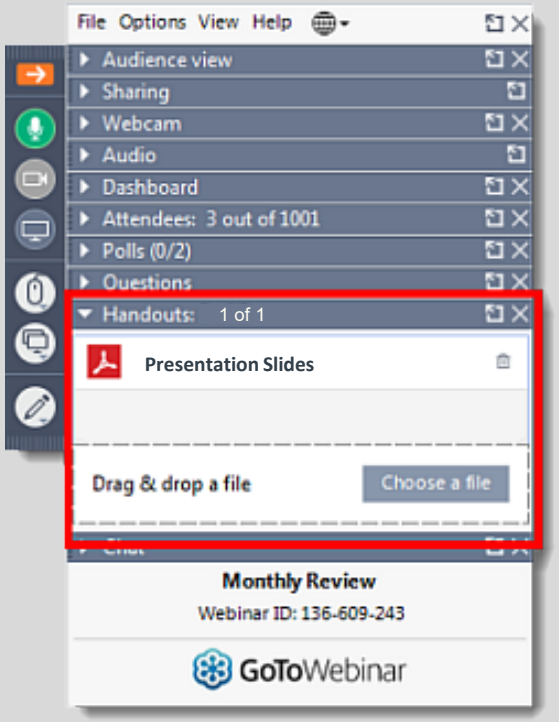


CAQH CORE

CAQH CORE Overview

Erin Weber, CORE Director

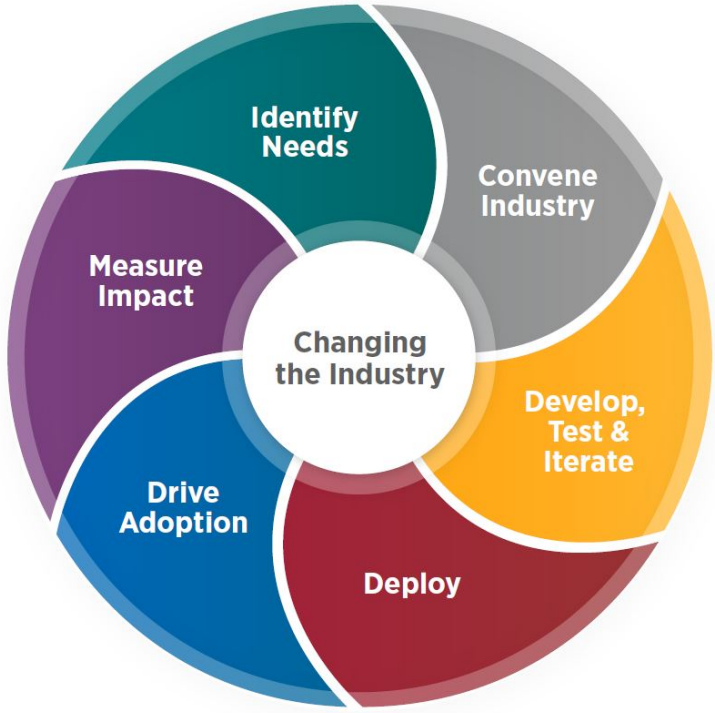
CAQH CORE Mission/Vision & Industry Role

Industry-led, CAQH CORE Participants include healthcare providers, health plans, vendors, government entities, associations and standard-setting organizations. Health plans participating in CAQH CORE represent **75 percent of the insured US population.**

MISSION Drive the creation and adoption of healthcare operating rules that **support standards**, **accelerate interoperability and align administrative and clinical activities** among providers, payers and consumers.

VISION An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.

DESIGNATION CAQH CORE is the **national operating rule author to improve the efficiency, accuracy and effectiveness of industry-driven business transactions.** The Department of Health and Human Services (HHS) designated CAQH CORE as the author of national operating rules for the HIPAA-covered administrative transactions.



INDUSTRY ROLE **Develop business rules to help industry** effectively and efficiently use electronic standards while remaining technology- and standard-agnostic.

CAQH CORE BOARD **Multi-stakeholder.** Members include health plans, providers (some of which are appointed by associations such as the AHA, AMA, MGMA), vendors, and government entities. Advisors to the Board include SDOs (X12, HL7, NACHA, NCPDP) and WEDI.

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CAQH CORE Participating Organizations

Over 120 CAQH CORE Participating Organizations work together to develop and implement rules of the road that streamline the business of healthcare, across all components of the revenue cycle.

A Sample of Organizations that Participate in CAQH CORE

(See full list here)

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CAQH CORE Initiatives

CAQH CORE drives **industry interoperability** and **alignment on administrative and clinical activities** through a variety of approaches.

CORE Participation

- Influence the direction of health IT policy through participation in CAQH CORE work groups.
- Lead development of industry guidance and operating rules that remove unnecessary cost and complexity from the healthcare system.
- Ensure that operating rules continue to meet evolving business needs by contributing to the maintenances of existing operating rules.

Pilot & Measurement Initiatives

- Rapidly develop and evaluate the impact of existing and potential operating rules that support greater automation of end-to-end workflows.
- Ensure that operating rules support industry organizations in varying stages of maturity along the standards and technology adoption curve.

Education & Outreach

- Engage and inform industry through innovative education and outreach efforts including webinars, conference presentations, podcasts, an annual Survey on satisfaction and priorities, and quarterly Participant newsletters.
- Provide thought leadership on how operating rules can serve as a bridge between current and emerging standards through the development of comment letters and white papers.

CORE Certification

- CORE Certification Seals are awarded to entities that create, transmit, or use the healthcare administrative and financial transactions addressed by the CAQH CORE Operating Rules.
- CORE Certification means an entity has demonstrated that its IT system or product, is operating in conformance with applicable requirements of a specific CAQH CORE Operating Rule.

Background: No Surprises Act

Erin Weber, CORE Director

No Surprises Act

No Surprises Act, Advanced EOB, & Good Faith Estimate

The **No Surprises Act**, signed into law as part of the Consolidated Appropriations Act of 2021, addresses surprise medical billing at the federal level.

Section 111 of the Act requires health plans to provide an **Advanced EOB** for scheduled services one to three business days in advance, dependent on date of intended service/item, to give patients transparency into which providers are expected to provide treatment, the expected cost, and the network status of providers.

Section 112 requires health care providers and facilities to verify what type of coverage the patient is enrolled in and provide notification of a **Good Faith Estimate** of charges to the payer/patient at least three days in advance of service/item and no later than one day after scheduling the service.

No Surprises Act

Advanced EOB & Good Faith Estimate Requirements

- **The Advanced EOB must be shared with the member/patient by mail or electronically, depending on the individual's preference, and include the following information:**
  - If a provider/facility is in- or out-of-network with respect to the item/service.
    - If the provider/facility is in-network, the contracted rate based on billing and diagnostic costs sent by the provider.
    - If the provider/facility is out-of-network, a description on how the individual can find contracted providers/facilities, if any.
  - A Good Faith Estimate of expected charges based on billing and diagnostic codes.
  - A Good Faith Estimate of the plan's payment responsibility and member's cost sharing responsibilities for the item/service.
  - A Good Faith Estimate of the amount the member has incurred toward meeting their financial responsibility limit (including deductibles and out-of-pocket maximums) under the plan.
  - Disclaimers that the coverage is subject to medical management requirements and that the estimates are subject to change.
  - Any other information health plans deem appropriate to include consistent with other requirements.

CAQH CORE Advanced EOB Advisory Group

Background

The Advisory Group **launched in August 2021** as a forum for stakeholders across the healthcare industry to **collaborate and build consensus around recommendations for how to implement components of the No Surprises Act** in the Consolidated Appropriations Act.

The Advisory Group included over **60 participants representing over 30 diverse healthcare organizations** including providers, health plans, vendors, clearinghouses, associations, government entities, and standards development organizations.

The initial focus of the Advisory Group is the **exchange of the Good Faith Estimate between payers and providers**. Additional use cases well be considered as part of next steps.

The Advisory Group **evaluated various implementation approaches in detail, engaged in consensus-building, and agreed to support a series of recommendations to provide industry guidance on standardized approaches** to facilitate the exchange Good Faith Estimates.

CAQH CORE Advanced EOB Advisory Group Background

Advanced EOB Workflow and Initial Group Scope

1

Patient Schedules Appointment or Requests Cost Estimate

*Patient schedules a healthcare service appointment with a provider **OR** patient requests estimate for a healthcare item or service from provider.*

Applies to all healthcare items and services provided by providers and facilities.

2a

Provider Verifies Insurance with Health Plan

Provider verifies a patient's insurance coverage with health plan to determine eligibility and benefit information for the healthcare item or service.

2b

Provider Sends Good Faith Estimate to Uninsured

*If a patient is uninsured, the provider sends the patient a Good Faith Estimate of expected charges.**

3

Provider Sends Good Faith Estimate to Health Plan

Provider sends a Good Faith Estimate of expected charges for the healthcare service including billing, procedure and/or diagnostics codes to health plan at least three days in advanced of service and no later than one day after scheduling the service.

Initial Scope of Focus for the CAQH CORE Advanced EOB Advisory Group.

4a

Health Plan Sends Advanced EOB to Member**

Health Plan sends member an Advanced EOB electronically or via mail that provides information on provider network status, covered costs, and out-of-pocket estimates.

4b

[Optional] Health Plan Sends a Copy of Advanced EOB to Provider

**Good Faith Estimates for the uninsured must be issued within one business day for services scheduled three to nine days for intended service date.*
**Good Faith Estimates for the uninsured must be issued three business days for services scheduled more than 10 days from intended service date.*
***Advanced EOB's must be issued within one business day after receiving Good Faith Estimate for services scheduled three to nine days before intended service date.*
***Advanced EOB's must be issued within three business days after receiving Good Faith Estimate for serviced scheduled more than 10 days from intended service date.*

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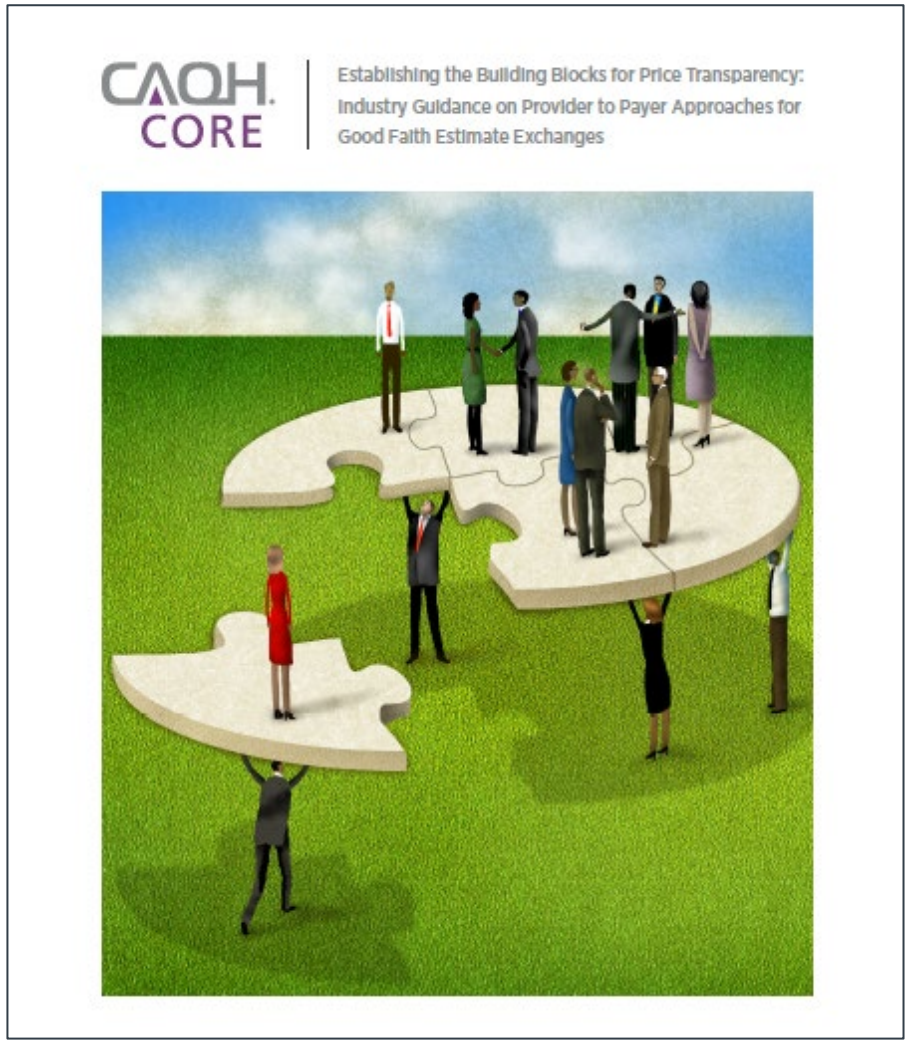
Consensus-based Industry Recommendations and Next Steps

Robert Bowman, CORE Director

CAQH CORE Advanced EOB Advisory Group

Guidance Document Overview



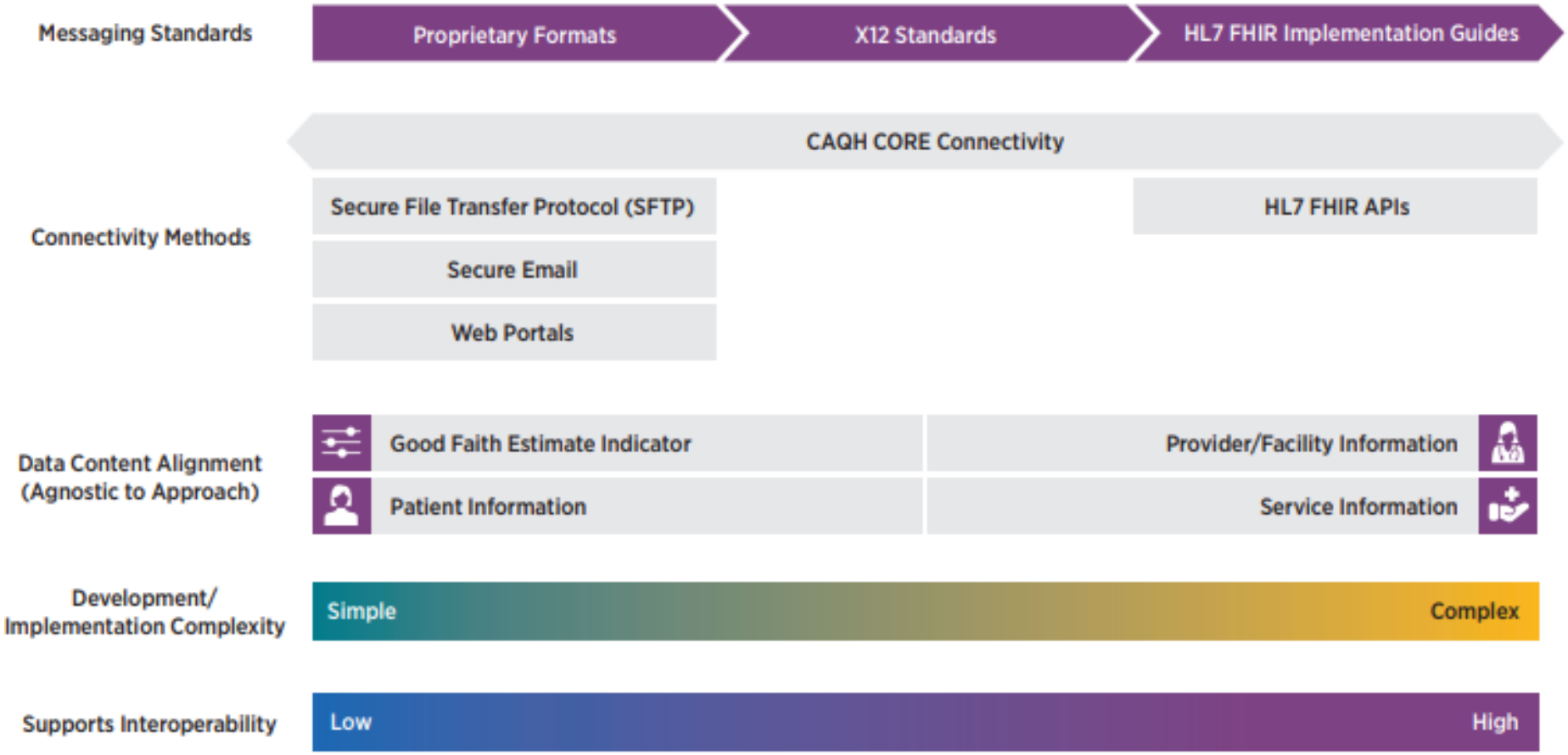
Guidance Document *(Published November 2021)*

- Illustrates how industry can **meet Advanced EOB requirements leveraging uniform frameworks and industry standards**.
- Developed using a **consensus-based approach**.
- Provides recommendations for how industry should implement **connectivity protocols**, **messaging standards**, and **related data content** to support provider to payer exchanges of Good Faith Estimates.

Recommendations for the Exchange of GFE Between Providers and Payers

Implementation Approaches for Good Faith Estimates

The Advisory Group considered different approaches with **varying degrees of development**, **implementation complexity**, and **interoperability support**.



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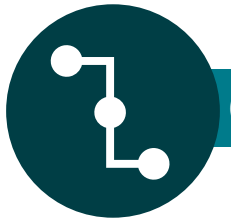
Recommendations for the Exchange of GFE Between Providers and Payers

Overview of Recommendations

Messaging Standard: X12 837 Professional Pre-Determination X291, X12 837 Institutional Pre-Determination X292, and HL7 FHIR



Connectivity Method: CAQH CORE Connectivity and HL7 FHIR APIs

Uniform Data Content: Four data groups and associated data elements to support uniform data content within a message standard

Recommendations for the Exchange of GFE Between Providers and Payers

Messaging Standard Recommendations

Messaging Standard: X12 837 Professional Pre-Determination X291, X12 837 Institutional Pre-Determination X292, and HL7 FHIR

The Advanced EOB Advisory Group recommends the support of X12 837 Pre-Determination 005010X291 (X12 837P v5010 Pre-Determination), X12 837 Institutional Pre-Determination 005010X292 (X12 837I v5010 Pre-Determination), and HL7 FHIR.

- **X12 837 P/I Pre-Determination** transactions can facilitate the exchange of Good Faith Estimates between providers and health plans with the inclusion of necessary data, such as provider, member, and associated billing information (procedure, diagnostic codes with associated modifiers, etc.). These transactions also allow for multiple services and providers to be identified to support complex billing over a period of care. Further, industry can leverage and align implementations with the HIPAA-mandated 837 P/I transactions.

- **HL7 FHIR-based methodology** can also be used to support near real-time requests and responses for organizations with advanced technological capabilities. The Da Vinci Project Patient Cost Transparency Work Group (PCT WG) is working to develop a standard FHIR-based Implementation Guide.

Recommendations for the Exchange of GFE Between Providers and Payers

Connectivity Recommendations

Connectivity Method: CAQH CORE Connectivity and HL7 FHIR APIs

The Advanced EOB Advisory Group recommends CAQH CORE Connectivity and HL7 FHIR APIs.

- **CAQH CORE Connectivity** enables a framework for interoperability that is universal, easy to implement, low cost, secure, trusted, and industry recognized. It is required for all HIPAA-covered entities and widely implemented by industry.

- **HL7 APIs** can be used to transport HL7 FHIR Bundles and Resources. They are central to CMS and ONC interoperability rules that provide patient access to information exchanged between providers and health plans.

Recommendations for the Exchange of GFE Between Providers and Payers

Uniform Data Content Recommendations

Uniform Data Content: Four data groups and associated data elements to support uniform data content within a message standard

The Advanced EOB Advisory Group identified four data groups and associated data elements to support uniform data content within a message standard, whether X12 837 P/I Pre-Determination transactions or HL7 FHIR, for the exchange of Good Faith Estimates:

- **Indicator**: X12 837 P/I Pre-Determination transaction, pre-determination indicator, or good faith estimate indicator
- **Patient**: Member ID, Date of Birth, First Name, Last Name, and Subscriber/Dependent status
- **Provider/Facility**: Provider/Facility Name, NPI, Place of Service, Provider Taxonomy, and Practice Location
- **Service**: Schedule Date of Service, Procedure Codes, Diagnosis Codes, Modifiers, and Charge Amounts

CAQH CORE Advanced EOB Advisory Group

Next Steps

The Advanced EOB Advisory Group will continue to apply its consensus-based process to **engage in industry discussions**, **assess additional use cases**, **evaluate operating rule opportunities**, and **consider pilot projects** to drive the industry forward to support price transparency.

Tentative Next Steps

- The Advisory Group's next call will be on **Tuesday, 12/14/21 from 2:00 – 3:00 pm ET**.
- Develop recommendations for a **comprehensive advanced EOB data** set that will enable a common information flow and format across all advanced EOBs.
- Conduct industry environmental scan for the **provider aggregation** of service items and estimates performed during a patient's scheduled visit.

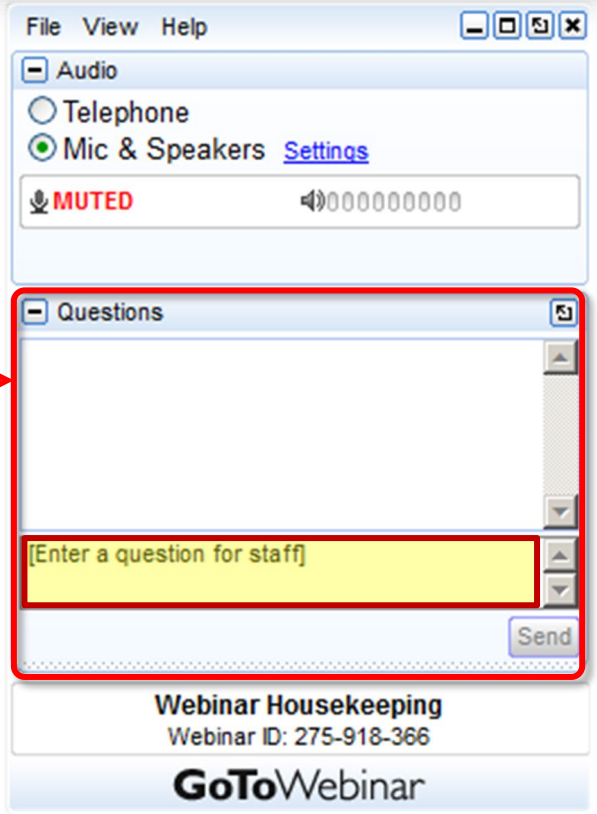
If you would like to be involved in this work, contact core@caqh.org.

Audience Q&A

Please submit your questions

Enter your question into the “Questions” pane in the lower right-hand corner of your screen.

You can also submit questions at any time to CORE@caqh.org



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Thank you for joining us!

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Website: www.CAQH.org/CORE

Email: CORE@CAQH.org

The CAQH CORE Mission

Drive the creation and adoption of healthcare operating rules that support standards, accelerate interoperability and align administrative and clinical activities among providers, payers and consumers.