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September 07, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

Re: Comments on the No Surprises Act

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to provide input on the No Surprises Act (CMS-9909-IFC) to protect consumers from surprise medical bills. We support the basis of the No Surprises Act and appreciate your efforts related to the No Surprises Act.

X12 has operated as an ANSI-accredited standards development organization (SDO) for more than 40 years. As a consensus-based SDO, we focus on the development, implementation, and ongoing use of interoperable electronic data interchange standards that drive business processes. X12 is supported by a strong and diverse membership that includes business leaders, process experts, and technologists, encompassing health care, insurance, transportation, finance, government, supply chain, and other industries.

X12 standards are the workhorse of business-to-business exchanges proven by the billions of transactions based on X12 standards that are used daily in various industries including supply chain, transportation, government, finance, and health care. Millions of entities around the world have an established infrastructure that supports X12 transactions.

As you are aware, most of the administrative transactions adopted under the Health Insurance Portability and Accountability Act (HIPAA) and other related legislation and regulations were developed and are maintained by X12. In addition, X12 has a robust set of transactions and code sets beyond those already adopted that are being used voluntarily within the health care industry.

X12 works closely with federal and state agencies, other SDOs, and health care industry groups to ensure the needs of the stakeholders are met consistently and seamlessly across the industry. X12 is committed to continuing our tradition of reducing administrative burden and increasing consistency in information exchanges while ensuring the data stakeholders need is available when they need it, in a format compatible with their technical infrastructure.

Our detailed comments are included below.

Please contact me at csheppard@x12.org for more information or any questions.

Sincerely,

CSheppard

Cathy Sheppard
X12 Executive Director

Overall Comments

X12 suggests that more detailed federal requirements are needed to ensure consistent and interoperable solutions are developed and implemented across the health care industry. Worst case outcomes for this Rule include having disparate solutions that each meet the intent of this Rule put forward by various health care industry organizations or having a multitude of proprietary solutions endorsed by various health plans, vendors, or clearinghouses. The reason federal requirements call for solutions developed by ANSI-accredited standards developers is because those organizations are held to procedures that ensure significant consensus is achieved before standards are approved.

X12 notes that the coalescing of disparate business practices and the requirements for disclosing information that health plans and provider consider to be competitive differentiators are likely to be much more difficult to address than the data content and permitted syntaxes of the actual EDI messages. Similar complexities have impacted the adoption and use of other EDI messages such as preauthorization. It would be beneficial to the industry to have clear demarcation of business practice challenges and EDI messaging challenges. It is likely that well-chosen operating rules related to these business practices could reduce implementation barriers in this area. However, the introduction of data content operating rules is not necessary as ANSI-accredited SDOs should be the single-source for data content instructions and operating rules are not permitted to supersede or override the data content requirements defined by a named standard.

It appears there may be gaps in the current Rules that will make consistent and interoperable exchange of this data difficult to achieve. For example, there is some question as to whether every provider involved in planned care submits their good faith estimate of services to the responsible health plan individually or whether the provider considered to be the coordinator of the care submits a consolidated estimate that includes the services expected to be provided by all the providers and facilities that are expected to be involved in the care so that the health plan can provided the greatest specificity to the patient in a single notice. Another example where more clarity is needed relates to the health plan's response to the providers' good faith estimate of services to be provided. The submitting provider(s) may need to receive the same information that the patient receives so the provider(s) can respond to questions from the patient. At the least, the submitting provider(s) should receive an acknowledgement that the health plan received their good faith estimate of services to be provided.

Over the past few years there has been much discussion within the health care industry and between the health care industry and federal agencies related to provider burden and additional stressors related to increasing the workload on these health care providers. The Departments should consider the impact of these Rules on the humans who invest so heavily of themselves to provide excellent care to their patients so a balance can be reached that provides health care consumers with the information they need without contributing to provider stress and/or burnout.

Related to the Departments request for recommendations on how HIPAA standard transactions to submit claims could be modified to include whether the surprise billing protections apply to the items and services included on a claim, whether the item or service was furnished during a visit at a participating health care facility, and whether the requirements for notice and consent have been met

X12's 837 claim transaction is mandated under HIPAA for the submission of claims. X12's ANSI-approved consensus process supports publication of revised EDI standards annually. At the upcoming X12 Standing Meeting, the X12N Insurance Subcommittee intends to document how the 008020 version of the HIPAA mandated claim transactions could support these requirements using existing data elements as well as identifying modifications that would support any gaps between the 008020

implementation instructions and the requirements identified in the No Surprises Act. X12 will have this information available to the agencies in October 2021.

Related to Section 111 Consumer Protections Through Health Plan Requirement for Fair and Honest Advance Cost Estimate

Section 111 requires health plans to provide an advanced EOB for scheduled services at least three days in advance to give patients transparency into which providers are expected to provide treatment, the expected cost, and the network status of the providers. X12's position is that naming a specific X12 implementation guide that describes the data content and rules for a compliant fair and honest advance cost estimate, or good faith estimate, is the best approach for ensuring consistent exchange of the required information. X12 is currently creating a use case level 837 implementation guide that will provide specific, concise instructions for a good faith EDI message. X12 recognizes that some health care industry stakeholders may be interested in using HL7's FHIR framework as an alternative syntax for this message. To that end, X12 and HL7's Da Vinci Project are working cooperatively to ensure that X12's new use case level implementation guide supports interoperability between the syntaxes when applicable.

Related to Section 112 Patient Protections Through Transparency and Patient-Provider Dispute Resolution

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 or patient three days in advance of service and not later than one day after scheduling of service.

X12 has several implementation guides that support the exchange of coverage information, including the HIPAA mandated 270/271 transaction set pair. X12's position is that naming a specific X12 implementation guide that describes the data content and rules for a coverage inquiry and response is the best approach for ensuring consistent exchange of the required information. X12 recognizes that some health care industry stakeholders may be interested in using HL7's FHIR framework as an alternative syntax for this message. To that end, X12 and HL7's Da Vinci Project will work cooperatively to ensure that X12's implementation guides support interoperability between the syntaxes when applicable.

Related to Section 116 Protecting Patients and Improving the Accuracy of Provider Directory Information

Section 116 requires health plans to create and maintain an accurate provider directory that is easily accessible to patients and other consumers.

X12's 274 heath care provider information transaction supports the exchange of provider information for various business purposes. X12's X109 implementation guide specifically addresses the data content requirements for provider directories. ANSI-approved consensus process supports publication of revised EDI standards annually. At the upcoming X12 Standing Meeting, the X12N Insurance Subcommittee intends to document how the 008020 version of the X109 implementation guide supports these requirements using existing data elements as well as identifying modifications that would support any gaps between the 008020 implementation instructions and the requirements identified in the No Surprises Act. X12 will have this information available to the agencies in October 2021.

X12's position is that naming a specific X12 implementation guide that describes the data content and rules for a coverage inquiry and response is the best approach for ensuring consistent exchange of the required information. X12 recognizes that some health care industry stakeholders may be interested in using HL7's FHIR framework as an alternative syntax for this message. To that end, X12 and HL7's Da Vinci Project will work cooperatively to ensure that X12's implementation guides support interoperability between the syntaxes when applicable.