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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-9900-NC, Request for Information, Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals

Dear Administrator Brooks-LaSure:

On behalf of our 162,000 members, the American Dental Association (ADA) is pleased to provide comments on the request for information (RFI) for the Advanced Explanation of Benefits (AEOB) and Good Faith Estimate (GFE) for Covered Individuals. These comments focus on the Transferring Data from Providers and Facilities to Plans, Issuers and Carriers, AEOBs, GFEs, diagnostic codes, and provider burdens.

Transferring Data from Providers and Facilities to Plans, Issuers and Carriers

What issues should the Departments and OPM consider as they weigh policies to encourage the use of a FHIR-based API for the real-time exchange of AEOB and GFE data?
The ADA applauds the efforts of the Department of Labor, Department of Health and Human Services, and the Treasury Department (collectively, the Departments) and Office of Personnel Management (OPM) to promote the adoption of Fast Healthcare Interoperability Resources (FHIR)-based Application Programming Interfaces (APIs) for AEOB and GFE transactions.

Dental practice management and record systems have limited adoption of FHIR, instead, the industry has experienced rapid development of proprietary APIs to meet data access and exchange requirements. The ADA, in collaboration with Health Level Seven (HL7), has developed dual CDA and FHIR implementations guides based on ANSI/ADA Standard No. 1084: Reference Core Data Set for Communication Among Dental and Other Health Information Systems, which provides the foundation for the technical specifications to extract, format, transmit, and receive a patient's demographic data, dental or medical encounter data, and clinical data for exchange among information systems, to achieve syntactic and semantic interoperability. Additionally, the ADA continues to work with several HL7 workgroups on developing the dental content in various FHIR standards including the CARIN EOB. We would support incentives and significant investment in dental-specific FHIR-based pilots and technology to move the dental industry towards FHIR-based APIs for real-time exchange of AEOB or GFE data in the near or mid-term future.

We also note that as currently specified the USCDI does not clearly require the use of CDT codes for procedure data in the FHIR standard. USCDI (V3) identifies CDT as an applicable

vocabulary standard but is often interpreted by software vendors to be optional. This limits access to procedures documented using CDT through the FHIR API even when one is available. The dental industry relies on CDT, a HIPAA administrative standard code set, to report procedures on administrative transactions. We encourage CMS to look into USCDI before promoting the use of FHIR for administrative purposes.

How could updates to this program support the ability of providers and facilities to exchange GFE information with plans, issuers, and carriers or support alignment between the exchange of GFE information and the other processes providers and facilities may engage in involving the exchange of clinical and administrative data, such as electronic prior authorization?
Currently, a majority of dental practices do not use electronic health record systems, preferring to use electronic dental records and practice management systems that are unlikely to be ONC certified. Any updates to the ONC Certification Program would not benefit dental providers, nor remove barriers to the exchange of dental clinical or administrative data. We would encourage the ONC to review the Certification Program and address gaps within this program to move the dental practice management technology toward improved interoperability and data exchange.

Would the availability of certification criteria under the ONC Health IT Certification Program for use by plans, issuers, and carriers, or health IT developers serving plans, issuers, and carriers, help to enable interoperability of API technology adopted by these entities?
Given the limited participation of dental vendors in the ONC Health IT Certification process, it is unlikely that updated certification criteria for plans, issuers, and carriers would have a significant impact on API technology in the dental industry. Further investigation is needed into the gaps between current criteria and criteria that would meet the needs of the dental industry and should be tied to industry-specific incentives.

Are there any approaches that the Departments and OPM should consider, or flexibility that should be provided (such as an exception or a phased-in approach to requiring providers and payers to adopt a standards-based API to exchange AEOB and GFE data), to account for small, rural, or other providers, facilities, plans, issuers, and carriers?
Before requiring providers and payers to adopt a standards-based API to exchange AEOB and GFE data, efforts should be focused on programs that enable the dental industry to take advantage of standards-based API without passing on the financial and implementation burden to dental providers. The dental industry needs a federally supported roadmap to interoperability that takes into consideration the unique business operations of dentistry. Additionally, education and messaging are also needed to help dental providers understand the regulations coming from the Departments and OPM, with clear, industry-specific guidance.

Other Policy Considerations

What approaches should be considered to address application of the requirements related to the AEOB and GFE that account for, or do not account for, unique benefit designs, such as account-based plans?
Although dental benefit plans fall under the category of excepted benefits, we strongly believe and encourage that requirements related to AEOBs be applicable to dental plans as they work together with GFEs for the benefit of the individual and provider. For example, if an individual with a dental benefit comes to a dentist, the dentist does not know what, if any, of the covered benefit has already been utilized, but even if basic assumptions can be

utilized to provide a very rough GFE, it's not possible to be accurate within $400 if the dental plan ends up denying coverage after the fact. The patient will also often not know the details of their plans or the benefits that they have already used for that year. The AEOB is necessary for dental plans to provide to the patient and must go together with the provider GFE.

It is not appropriate to require dental practices to have to issue a GFE to the carrier when the carrier has no obligation to issue an AEOB to the patient.

The Departments and OPM are interested in plans', issuers', and carriers' perspectives on whether a diagnosis code would be required for the calculation of the AEOB. Are there items or services for which a plan, issuer, or carrier would not be able to determine points of information such as: (1) the contracted rate; (2) the coverage level (that is, if the plan or issuer covers an item or service associated with one diagnosis at a higher rate than an item or service associated with another); or (3) whether an item or service is covered (that is, if the item or service is covered for one diagnosis but not another) for an item or service based on the service code and other information in the GFE in the absence of a diagnosis code?

Dental claims are usually adjudicated without consideration of diagnosis codes. The ADA appreciates the already stated guidance[1] (related to self-pay individuals) where HHS indicated that a provider or facility is required to provide a diagnosis code only where one is required for the calculation of the GFE. The guidance noted that "*if there is not a **relevant** diagnosis code for an item or service, such as for certain dental screenings or procedures, providers and facilities are not required to include diagnosis codes on a GFE"*. We request further guidance in clarifying this point if diagnosis codes would be applicable for GFE and AEOB in cases of patients with a dental benefit.

What, if any, burdens or barriers would be encountered by small, rural, or other providers, facilities, plans, issuers, and carriers in complying with industry-wide standards-based API technology requirements for the exchange of AEOB and GFE data? How many small, rural, or other providers, facilities, plans, issuers, and carriers would encounter these burdens or barriers in complying with such technology requirements?

While there have been some shifts in the composition of practice ownership in the dental industry, small practices constitute a large group of dental businesses. These small practices operate on dental software products which meet the minimum requirements for daily operation and care delivery. New technology requirements are likely to increase costs for these practices, as vendors will pass the financial burden on to the providers in the form of fees for additional features, new releases, and subscription services. These additional costs, in addition to the disruption of implementing new software and the loss of administrative time for training, lead to a significant burden on the practice and may prohibit providers from participating in programs that are tied to such requirements. Hence, we believe that significant federal incentives and investments are needed to promote use of these standards by the dental practice management software industry before requirements are placed on dental offices.

[1] FAQs About Consolidated Appropriations Act, 2021 Implementation—Good Faith Estimates (GFE) for Uninsured (or Self-Pay) Individuals—Part 2 (April 5, 2022), available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ-Part-2.pdf*.

Would it alleviate burden to allow providers and facilities, for purposes of verifying coverage, to rely on an individual's representation regarding whether the individual is enrolled in a health plan or coverage and seeking to have a claim for the items or services submitted to the plan or coverage? What might be the implications of taking this approach?
As described above, it would not alleviate provider burden to allow individual representation of coverage to be determinate of benefits available for utilization without plans being required to provide AEOBs for accurate and timely GFEs to individuals. The implications of not requiring plans to provide AEOBs are inaccurate GFEs that lead to greater utilization of the independent dispute resolution (IDR) process, consuming time from all participants that would not have been needed had AEOBs been required of plans.

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We would welcome the opportunity to meet with you to discuss how we can meet these challenges together. If you have any questions, please contact Mr. David Linn at 202-789-5170 or linnd@ada.org.

Sincerely,

George R. Shepley, D.D.S.
President

Raymond A. Cohlmia, D.D.S.
Executive Director

GRS:RAC:dl