CAQH Insights℠

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ISSUE BRIEF

Increasing Transparency of Healthcare Charges: It's a Manual Process

Introduction

Effective January 2022, the No Surprises Act (NSA) mandates that healthcare providers and facilities provide uninsured or self-pay individuals a Good Faith Estimate (GFE) of expected charges for a scheduled or requested service. In addition to the primary service, the "convening" provider's GFE also needs to include any additional items (i.e., medical equipment, prescriptions) or services provided, even if they were offered by another provider (co-provider).[1,2] The purpose of GFEs is to increase transparency of medical and dental charges—protecting patients from surprise medical bills and unforeseen expenses.[3]

While GFEs are meant to benefit patients, the ability to gather accurate information is a challenge for providers. Due to the lack of automated systems that collect GFE information and the lack of standardized methods for exchanging the data, providers are struggling to meet the requirements.[4] Varying formats and technology have also made it difficult for convening providers to gather accurate GFEs from co-providers resulting in additional administrative burden.[5]

As the mandate becomes more widely adopted, it is important to examine how medical and dental GFEs are being generated and communicated to patients to streamline the process and reduce administrative burden. By understanding the workflow and resources associated with this regulation, the healthcare industry can target opportunity areas that reduce provider burden and increase interoperability between providers, health plans and patients.

Survey Findings

The 2022 CAQH Index[6] asked medical and dental providers about the number of GFEs generated and sent as well as the methods, time and costs associated with performing these tasks. Providers were also asked if they have started assuming the role of a convening provider.

GFE Volume Varies Significantly by Industry, Practice Type and Size

The total number of GFEs generated and sent in 2021 leading up to the mandated implementation date increased as practice size increased and services became more specialized and complex. For the medical industry, smaller practices generated, on average, fewer than 20 GFEs annually, whereas larger practices generated approximately 600 GFEs. Hospitals, which serve more patients, often with complicated and unplanned needs, reported generating and sending an average of nearly 17,000 GFEs annually.

Average Number of GFEs Generated by Medical Providers

Medical		
Less than 5 Physicians	More than 5 Physicians	Hospitals
19	596	16,833

The number of GFEs generated by dental providers was also associated with the size of the practice and services provided. Solo dental practices, which tend to serve fewer patients and accept a smaller number of insurance plans[7], generated an average of 107 GFEs in 2021. Larger group practices and Dental Support Organizations (DSOs), which serve more patients and provide more comprehensive services[8], generated ten times as many GFEs annually. DSOs, which are continuing to grow in number[9], are better able to accommodate the uninsured and self-paying due to their lower operating expenses which may contribute to the volume of GFEs generated and sent.[10]

While both industries experienced an increase in GFEs as more services were provided and the level of complexity in services grew, the dental industry, in general, reported larger average volumes than non-hospital settings due, in part, to the higher number of uninsured and self-paying patients—around three times more adults lack dental insurance than medical insurance.[11]

Across both industries, hospitals generated the most GFEs given the complexity and volume of services.

Average Number of GFEs Generated by Dental Providers

Dental		
Non-DSO Solo	DSO	Non-DSO Group
107	1,093	1,268

Refer to endnote for dental practice type definitions.[12]

Generating and Communicating GFEs is a Manual Process

The individualized nature of GFEs makes it difficult to implement automated workflows that accurately capture the necessary level of detail. Thus, convening providers need to manually contact co-providers to gather information and complete a GFE.

This analysis found that medical and dental providers typically generated a GFE manually (71 and 62 percent, respectively), while approximately one quarter or fewer of GFEs were generated automatically. Given the newness of the mandate and challenges encountered, only five percent of providers have begun assuming the role of convening provider or have begun collecting GFEs from co-providers.

Primary Method Used to Generate GFEs

Method Used to Generate GFEs	Medical Providers	Dental Providers
Manually	71%	62%
Automatically	11%	26%
Don't know	14%	9%
Other (verbal, therapy notes)	3%	3%

Once a GFE is generated, it must be communicated to a patient within 1-3 days after scheduling a service.[13] GFEs can be communicated to patients

using various methods – phone, mail, email, patient portal, or in-person. Medical and dental providers indicated that approximately three-quarters of GFEs were communicated manually to patients via phone, mail or in-person. The use of manual processes to communicate GFEs is due, in part, to the Department of Health and Human Services (HHS) policy[14] stating that if a patient requests the GFE information to be provided in a format that is not paper or electronic delivery, like orally over the phone or in-person, the provider must follow up with a written or electronic copy—increasing GFE volume by duplicating communication.

Primary Method Used to Communicate GFEs for Medical and Dental Providers

Communication Method	Medical Providers	Dental Providers
Phone	40%	21%
Mail	15%	19%
Email	10%	14%
Patient Portal	10%	4%
Other (in person paper form)	17%	35%
I don't know	7%	7%

Cost and Time to Generate and Send a GFE Varies Across Provider Groups

Time to Generate and Send a GFE:

Without a uniform process, generating and sending GFEs requires manual effort which can be costly and time-consuming. Larger medical practices and hospitals reported spending, on average, one half hour generating and sending a GFE compared to smaller practices that only spent five minutes. Providers at larger locations tend to perform more complicated services and procedures, often requiring staff to coordinate with multiple departments when generating a GFE.

Challenges associated with staffing also impacted the time and cost to generate and send a GFE since fulfilling a GFE requires staff to be knowledgeable about multiple aspects of the patient encounter and have the ability to coordinate with different departments or co-providers.[15,16] Staffing shortages have made it difficult during the past year to find and hire people with these skills.[17]

Average Time to Generate and Send a GFE for Medical Providers

Medical		
Less than 5 Physicians	More than 5 Physicians	Hospitals
5 mins	30 mins	31 mins

In comparison, the dental industry reported spending less time generating a single GFE—approximately half as much time as the medical industry. This may be due to the less complicated nature of billing[18,19] for dental services given they generally require fewer codes than medical services. Non-DSO groups reported spending the most time generating and sending a GFE, 16 minutes, as these practices may handle more complex services that involve multiple codes, some of which may not be routinely used.

For both industries, as more comprehensive services are provided and the level of complexity in those services grows, providers may require more information about a patient's history and condition, which can result in extensive lists of services that may be difficult to obtain quickly and accurately to generate the appropriate GFE.[20]

Average Time to Generate and Send a GFE for Dental Providers

Dental		
Non-DSO Solo	DSO	Non-DSO Group
3 mins	12 mins	16 mins

Refer to endnote for dental practice type definitions.[12]

Cost to Generate and Send a GFE:

As time spent generating and sending a GFE increased as practice size, patient volume and the complexity of services increased, so did cost. Smaller

medical providers reported spending less than $10 to generate and send a single GFE while larger providers and hospitals spent more than double this amount. Similarly, larger dental practices reported spending five times more than smaller practices generating and sending GFEs.

Average Cost to Generate and Send a GFE for Medical Providers

Medical		
Less than 5 Physicians	More than 5 Physicians	Hospitals
$9.33	$23.70	$27.25

Comparing costs for the two industries, overall, dental providers spent less than medical providers performing these tasks. The cost to generate medical GFEs may be greater than dental due to the complex nature of medical services which require multiple service and diagnosis codes and often involve gathering information from convening providers within multiple departments.

Average Cost to Generate and Send a GFE for Dental Providers

Dental		
Non-DSO Solo	DSO	Non-DSO Group
$3.17	$14.42	$16.76

Refer to endnote for dental practice type definitions.[12]

As patient out-of-pocket costs increase and practices grow both in size and service offerings, the need to generate and send GFEs increases. Additionally, Medicaid redetermination, which began April 1, is predicted to result in millions of people changing or losing coverage, which may increase the number of uninsured and self-paying patients.[21] Without help and support from the industry, provider burden associated with GFEs could increase current administrative costs and time in the near future.[22]

Conclusion

Knowing that generating and sending GFEs is primarily a manual process for medical and dental providers, the industry should focus efforts on helping to ease the transmission of this data. Efforts to develop technical infrastructure, and industry-wide standards for exchanging GFEs, is needed as providers adopt the NSA requirements and future requirements.

To provide industry guidance on standardizing GFE exchanges, in November 2021,[23] the CAQH CORE Advanced EOB Advisory Group assessed several implementation approaches. The group recommended using the X12 837 Professional Pre-Determination X291, X12 837 Institutional Pre-Determination X292, CAQH CORE Connectivity Rules and HL7 FHIR APIs to facilitate the exchange of GFE information.[24] These approaches build on existing widely adopted transactions, support the connectivity and security of data exchanges, and are aligned with the frameworks outlined by the CMS and ONC Interoperability Rules.[25]

Supporting new and emerging transparency requirements to better the patient experience without burdening providers is needed within the healthcare industry. The use of automation and standards can help ease challenges faced by providers when gathering and sending accurate GFE information. In turn, providers can communicate the costs associated with services being offered to patients in a timely manner, helping reduce unexpected medical bills and fostering the patient-provider encounter.

Methodology

The 2022 CAQH Index asked medical and dental providers questions related to Good Faith Estimate generation, communication, cost and time. The measurement period was representative of January 1 to December 31, 2021. Results from this survey have been weighted to represent a national distribution of physicians by practice size as reported by the American Medical Association (AMA) and the American Dental Association (ADA) distributions of dental practice type.

About CAQH Insights

Through research and partnerships across the industry, CAQH Insights identifies opportunities to streamline business practices and measure the impact of a more automated healthcare workflow. For more information about research conducted by Insights, please visit caqh.org/insights

Endnotes

1 According to CMS, a convening provider or convening facility is the provider or facility who schedules an item or service or who receives the initial request for a good faith estimate from an uninsured (or self- pay) individual. "The No Surprises Act's Good Faith Estimates and Patient-Provider Dispute Resolution Requirements," CMS, accessed April 3, 2023, https://www.cms.gov/files/document/gfe-and-ppdr-requirements-slides.pdf.

2 Enforcement of the convening provider requirement to produce a consolidated GFE has been delayed. https://www.cms.gov/files/document/good-faith-estimate-uninsured-self-pay-part-3.pdf

3 To promote greater price transparency and give patients a reasonable expectation of the costs of planned treatment, the No Surprises Act requires health plans to deliver an advanced explanation of benefits (AEOB) to insured patients prior to care delivery. The AEOB is created by health plans using good faith estimates (GFEs) from providers. CMS has delayed enforcement of the AEOB requirements until a standard information process can be adopted via regulation to ensure that these estimates can be created as efficiently and accurately as possible.

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6 Data from the 2022 CAQH Index represents calendar year 2021. "2022 CAQH Index," CAQH, January 2023, https://www.caqh.org/sites/default/files/2022-caqh-index-report%20FINAL%20SPREAD%20VERSION.pdf.

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12 Non-DSO solo practices are owned solely by the dentist. Non-DSOs are practices which share administrative and office management tasks. DSOs, or dental support organizations, are organizations that manage non-clinical administrative and business tasks for a practice.

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16 https://cms.amga.org/AMGA/media/PDFs/Advocacy/Correspondence/CMS%20Correspondence/GFE/amga-gfe-letter6-6-2022.pdf.

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