February 5, 2024

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9897-P
PO Box 8016
Baltimore, MD, 21244-8016

Submitted via the Federal Regulations Web Portal, http://www.regulations.gov

RE: CMS-9897-P; RINs: 0938-AV15; 1210-AC17; 1545-BQ55; 3206-AO48

Dear, Secretaries Becerra, Su, and Yellen, and Director Ahuja,

Thank you for the opportunity to respond to the Notice of Proposed Rulemaking entitled "Federal Independent Dispute Resolution Operations" (88 FR 75744). The Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE, hereafter: CORE) is supportive of the actions of the Office of Personnel Management, Department of Labor, Department of Treasury, and the Department of Health and Human Services (hereafter: Tri-Departments and OPM) to implement the price transparency and associated dispute resolution provisions of the Consolidated Appropriations Act (hereafter referenced as the No Surprises Act).

CORE is the Department of Health and Human Services (HHS)-Designated Operating Rule Authoring Entity. Operating rules are defined in the Affordable Care Act as "the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications." Since 2012, several CORE Operating Rules governing data content, infrastructure, and connectivity requirements have been mandated under HIPAA for use by covered entities, including those pertaining to eligibility and benefits, claim status, claim payment, and remittance advice. CORE actively collaborates with government agencies, standard development organizations, associations, and industry stakeholders from provider organizations, health plans, and vendors to align around consensus-based requirements that promote automation and ease industry burden. CORE Operating Rules have contributed to greater than $18 billion in industry cost-savings through elimination of manual workflows.[1]

CORE supports the Tri-Department and OPM proposal to require the use of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) to standardize communication relevant to provisions of the No Surprises Act. The included comments, representative of the thoughts and priorities of CORE Participants, to convey the following:

[1] CORE analysis of the 2023 CAQH Index and CORE Certification data. https://www.caqh.org/sites/default/files/2024-01/2023_CAQH_Index_Report.pdf.

1. Support for the Tri-Department and OPM Proposal.
2. Necessary alignment of NPRM requirements with CORE Payment & Remittance Operating Rule requirements.
3. Immediate opportunity to leverage CORE's maintenance process for CARC and RARC code combinations.

CORE's role in the implementation and maintenance of CARC and RARC code combinations is an essential component of industry remittance advice workflows. Requirements are stated in the HIPAA-mandated CORE Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule, and are affirmed through the maintenance of a maximum set of CARC and RARC code combinations across a minimum set of CORE-defined Business Scenarios. On-going updates to CARCs and RARCs and emerging business needs are addressed using a proven, consensus-based maintenance process consisting of tri-annual compliance-based reviews and periodic market-based reviews.

Establishment of these requirements has enabled health plans and providers to automate their exchange of remittance advice. As implementation guidance and future regulation is developed, CORE encourages the Tri-Departments and OPM to leverage these long-standing processes to align to existing industry expectations.

Proposal for the Required Use of CARCs and RARCs on Paper or Electronic Remittance Advice

CORE supports the Tri-Department and OPM proposal requiring a plan or issuer to use CARCs and RARCs on paper and electronic remittance advice (ERA) when communicating information subject to provisions of the No Surprises Act. CARCs and RARCs benefit the industry by establishing a standard language to communicate payment, adjustments, and denials of healthcare claims. Leveraging these existing workflows simplifies communication of No Surprises Act Provisions and reduces plan, provider, and beneficiary abrasion.

This is particularly true of the parties and scenarios to which the proposed requirements apply - communication from a plan or issuer to entities with whom they do not have a direct or indirect contracted relationship. When considering the persistence of and disputes related to balance billing activities carried out by out-of-network providers, clear, consistent communication of the impact and applicability of No Surprises Act requirements holds significant benefit for the industry.

The Role of CORE in Promoting Automation

Exchange of ERA - facilitated through the ASC X12N 835 transaction - is ubiquitous. The 2023 CAQH Index shows that 88% of remittance advice transactions in the medical industry are fully electronic, a figure that has risen by 91% since 2014 when the CORE Payment & Remittance Rules were first mandated.[2] CORE Operating Rules defining uniform infrastructure and data content requirements are central to this rise.

Despite progress toward automation, manual and paper remittance workflows persist, and cost the medical industry as much as $701 million annually.[3] Because of this, while CORE generally agrees with the proposals, CORE Participants suggest that the Tri-Departments and OPM use published guidance and regulatory authority

[2] 2023 CAQH Index. https://www.caqh.org/sites/default/files/2024-01/2023_CAQH_Index_Report.pdf.
[3] Ibid.

to further stimulate the uptake of ERA. CORE welcomes the opportunity to discuss potential strategies for how this can be achieved.

The On-going Role of CORE in the Use of CARCs and RARCs

CORE is pleased to know the departments and OPM are thoughtfully considering the creation of industry implementation guidance for the proposed requirements. CORE emphasizes that any guidance issued by the Tri-Departments and OPM must be aligned with the established, industry-driven process for the maintenance of a maximum set of CARCs and RARCs applied across a minimum set of CORE-defined Business Scenarios.[4] The CORE maintenance process is effective at capturing the nuances of remittance advice communication, enhancing the wide applicability of CARC and RARC code combinations to multiple products and business lines; including to the complex, highly proprietary workflows at commercial health plans.

Request for Meeting Between CORE, the Tri-Departments, and OPM

The timing of these proposals creates an opportunity to align CORE priorities with the actions of the Tri-Departments and OPM. CORE is working with its industry partners to define and scope requirements for the incorporation of a new CORE-defined Business Scenario addressing No Surprises Act provisions and plans to initiate this important work **June 2024** in alignment with existing compliance-based maintenance. This work best serves industry partners if it coincides with efforts at the Tri-Departments and OPM in effort to avoid the publication of conflicting guidance. As such, **CORE requests a meeting with the Tri-Departments and OPM to collaborate across efforts.**

CORE thanks the Tri-Departments and OPM for the opportunity to respond to these proposals.

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Cc: Sarah Ahmad, CEO, CAQH
CORE Board Members

[4] Process is defined by the CAQH CORE Payment & Remittance (835) Uniform Use of CARCs and RARCs Operating Rule. The complete list of the maximum set of CARCs and RARCs for the minimum set of four CORE-defined Business Scenarios can be found here.