Note: The CMS RFI – Make Your Voice Heard was submitted using an online fillable form therefore our responses are aligned with the specific questions on the form and not in a letter format. A downloadable copy of the RFI and its questions are available here.

1. Accessing Healthcare and Related Challenges

CMS wants to empower all individuals to efficiently navigate the healthcare system and access comprehensive healthcare. We are interested in receiving public comment on personal perspectives and experiences, including narrative anecdotes, describing challenges individuals currently face in understanding, choosing, accessing, or utilizing healthcare services (including medication therapies) across CMS programs.

Access to care is a known challenge that affects patients and consumers across the United States. Issues surrounding access are complex and span the continuum of public and private payers. The Committee on Operating Rules for Information Exchange (CORE), an initiative of CAQH, emphasizes the important roles automation and interoperability play to alleviate industry burden and promote equitable access. Notably, CAQH CORE contends that current prior authorization and referral workflows, which frequently rely on manual adjudication processes, represent a considerable "pain point" for beneficiaries seeking care and serve to further inequities within the U.S. healthcare system.

At present, according to the 2021 CAQH Index, only 26% of prior authorization and referral transactions are completed fully electronically using the HIPAA-mandated standard. This means the medical industry overwhelmingly relies on outdated methods, such as phone, fax, or proprietary payer portals, to obtain prior authorizations. The use of these outmoded technologies can lead to delayed approval, often precipitated by lengthy hold times, or "missed" communications sent via unsecured or otherwise un-trackable methods, such as fax. Downstream, shortcomings of prior authorization workflows have direct and significant impacts on patient care. A recent MGMA survey showed that 95% of practices directly attributed delayed or denied care to prior authorization activities.

Additionally, prior authorization workflows often require the exchange of supplementary medical information to aid in the determination of medical necessity. This transfer of "attachments" is equally burdened by the lack of an interoperable and automated healthcare infrastructure. The 2021 CAQH Index shows that only 21% of the medical industry has adopted fully electronic means of sending attachments. Like the other components of the prior authorization and referral workflow, providers and payers rely on manual and proprietary methods to support the exchange of supplementary information, increasing the risk of costly or dangerous delays of care.

CAQH CORE encourages CMS, in collaboration with other agencies, to support and enforce the adoption of electronic standards and operating rules under HIPAA to automate prior authorization workflows and streamline the exchange of attachments.

Recommendation for CMS can address these challenges through policies and programs.

CAQH CORE recommends the following actions to alleviate burdens associated with prior authorization and additional documentation (e.g., attachments) workflows. As required by HIPAA, CMS should use its authority to issue and enforce regulations establishing standards and operating rules for prior

authorization, including the electronic exchange of attachments. Guidance from the highest level would aid in unifying the industry, in turn reducing variation, promoting automation, and avoiding potentially harmful delays in care.

Through a collaborative multi-stakeholder process, CAQH CORE has developed Operating Rules supporting infrastructure and data content requirements for electronic prior authorization and the electronic exchange of attachments. These rulesets (available here: https://www.caqh.org/core/caqh-core-prior-authorization-referrals-operating-rules) will aid industry stakeholders by establishing a uniform approach to conform with current and potentially new standards set by CMS and collaborating agencies. Additionally aiding in implementation and conformance, the attachments operating rules are written to be standards-agnostic, ensuring flexibility and application to multiple technologies.

The proposal and subsequent adoption of standards, aided using standard-agnostic operating rules, will help streamline burdensome prior authorization and attachments workflows and enhance equitable access for patients.

2. Understanding Provider Experiences

CMS wants to better understand the factors impacting provider well-being and learn more about the distribution of the healthcare workforce. We are particularly interested in understanding the greatest challenges for healthcare workers in meeting the needs of their patients, and the impact of CMS policies, operations, or communications on provider well-being and retention.

According to the 2021 CAQH index, the financial impact of administrative complexity of U.S. healthcare amounts to about $391 billion. About 11% or $42 billion of that total is directly attributable to carrying out the administrative transactions necessary to support day-to-day operations. Supporting this work can be burdensome to providers, particularly if transactions are not automated or facilitated electronically. Over time, bearing this weight can lead providers to feel dissatisfied with their career, which contributes to burnout and departures which harms equitable patient access.

Through a consensus-based, multi-stakeholder process, CAQH CORE has developed operating rules that support the electronic automation of HIPAA-mandated and voluntary transactions. Adoption of these operating rules results in time and cost savings for providers and their staff, reducing burden and staving off harmful burnout. For example, the HIPAA-mandated Eligibility and Benefits transaction, if carried out fully electronically, saves on average 21 minutes of provider time per transaction relative to when performed manually. Similarly, the adoption of electronic prior authorization and attachments standards can save up to 16 and 6 minutes per transaction, respectively. Considering millions, if not billions, of these administrative transactions are conducted annually – the potential provider time savings is substantial.

Provider and staff time saving engenders greater job satisfaction and allows practices to spend more time providing care to their patients. Gratefully, HIPAA-mandated transactions with complementary, mandated Operating Rules, such as Eligibility and Benefits, have uniformly high electronic adoption; however, transactions supporting prior authorization and attachments are primarily manual, with only

26% of the medical industry supporting fully electronic prior authorization transactions using the HIPAA-mandated standard and only 21% supporting the fully electronic exchange of attachments for which there is no mandated standard (despite being required under HIPAA). Operating Rules have not been mandated for either prior authorization or attachments.

The persistence of using manual workflows to carry out transactions for prior authorization and the exchange of attachments stands out as a missed opportunity in the medical industry to decrease burden and promote job fulfillment. Supporting this, CAQH CORE, in collaboration with a large provider, demonstrated the value of automating the prior authorization transaction. Results demonstrated increased staff satisfaction, decreased job-related stress, and an 80% reduction in staff time, which is nearly 12 minutes.

Recommendations for CMS policy and program initiatives that could support provider well-being and increase provider willingness to serve certain populations.

CMS and its collaborating agencies can support provider well-being and enhance equitable access to care by issuing regulations that promote the electronic automation of healthcare transactions. CAQH CORE Operating Rules directly support this goal through the establishment of uniform infrastructure and data content requirements that allow implementers to conform with regulatory requirements. CAQH CORE Operating Rules have been used to good effect supporting HIPAA-mandated transactions, including Eligibility and Benefits. CMS and collaborating agencies can continue this positive impact by periodically updating the versions of the mandated operating rules mandated to ensure new and emerging business needs are met and addressed in regulation.

CMS can additionally support provider well-being through the adoption of standards that support the electronic exchange of clinical information or attachments. Respectively, across the medical industry, prior authorization and attachments transactions are only performed fully electronically 26% and 21% of the time. Adopting attachments standards and operating rules will help streamline these cumbersome processes and heighten provider and staff satisfaction.

3. Advancing Health Equity

CMS wants to further advance health equity across our programs by identifying and promoting policies, programs, and practices that may help eliminate health disparities. We want to better understand individual and community-level burdens, health-related social needs (such as food insecurity and inadequate or unstable housing), and recommended strategies to address health inequities, including opportunities to address social determinants of health and burdens impairing access to comprehensive quality care.

CAQH CORE strongly supports initiatives designed to enhance an equitable health system. To augment equity-related initiatives, there is a strong need for data that can quantify social determinants of health (SDOH) experienced by patients, as well as the disparities to which they are exposed. The collection and analysis of SDOH data provides insights that providers can use to make better-informed decisions around patient care, factoring in key social influencers that may affect effectiveness or long-term adherence of care plans.

CAQH CORE encourages CMS and its collaborating agencies to devise meaningful tests of change meant to incorporate and quantify the impact of SDOH. For example, one vehicle to achieve this goal would be to incorporate the collection of ICD-10 Z-codes into CMS/CMMI stewarded value-based care programs as a mechanism to collect SDOH data at the point-of-care. CAQH CORE believes such incorporation could also aid CMS and other collaborating agencies in clarifying what SDOH data will be used for and how it can or will be used to engage stakeholders.

Recommendations for how CMS can promote efficiency and advance health equity through our policies and programs.

CAQH CORE encourages CMS and its collaborating agencies to adopt technologic standards, as well as the supporting CAQH CORE Operating Rules, to promote the uniform implementation of automated, electronic healthcare transactions. The cost savings realized through adoption of these electronic workflows can be reinvested by health plans and providers to support underserved communities in a variety of ways, for example by hiring new providers to increase access or establishing partnerships with community-based organizations to address unmet social needs.

4. Assessing Impact of Waivers and Flexibilities provided in response to COVID-19 (PHE)

CMS wants to understand the impact of waivers and flexibilities issued during the COVID-19 PHE, such as eligibility and enrollment flexibilities, to identify what was helpful as well as any areas for improvement, including opportunities to further decrease burden and address any health disparities that may have been exacerbated by the PHE.

Waivers and enforcement discretion used during the COVID-19 Public Health Emergency (PHE) by the Centers and collaborating agencies provided necessary relief to patients and providers during uncertain times. For example, waivers allowing the use of telehealth for previously ineligible services enabled continuity of care to be maintained without unnecessarily exposing patients and providers to COVID-19. Telehealth waivers effectively served as a proof of concept for how the healthcare system can accommodate telehealth modalities into the care pathway. CAQH CORE encourages continued support and innovation of remote care methods that help ensure equitable access to care for all populations.

CAQH CORE would also highlight that enforcement discretion of price transparency initiatives, such as the Advanced Explanation of Benefits (AEOB) requirements of the No Surprises Act, reduced burden on providers and payers who were faced with unforeseen challenges in maintaining care during the pandemic. Ultimately, enforcement discretion used during the PHE will foster a more thoughtful approach to implementation by providing additional opportunities for industry feedback.

Recommendations for CMS policy and program focus areas to address health disparities, including requested waivers/flexibilities to make permanent; any unintended consequences of CMS actions during the PHE; and opportunities for CMS to reduce any health disparities that may have been exacerbated by the PHE.

CMS, in collaboration with other agencies and Congress, should continue its investigation of expanded telehealth services past the expiration of the PHE waivers. As evaluations continue, CAQH CORE encourages several considerations, including the appropriateness of a service to be provided remotely,

the potential for fraud, waste, abuse, the need – or lack thereof – for reimbursement parity, and the providers and modalities eligible for reimbursement.

CAQH CORE notes that voluntary updates have been made to the Operating Rules for Eligibility and Benefits that support the provision of telehealth services. These updates are currently being considered by the National Committee on Vital and Health Statistics (NCVHS) for recommendation to HHS for federal mandate.