CΛQH

2020 K Street, NW
Suite 900
Washington, DC 20006

202.517.0400
www.caqh.org

August 9, 2019

Alex M. Azar II, J.D.
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 2020

Seema Verma
Administrator
U.S. Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Request for Information on Reducing Administrative Burden to Put Patients over Paperwork
– CMS-6082-NC

Dear Secretary Azar and Administrator Verma,

Thank you for the opportunity to provide feedback on the Request for Information CMS-6082-NC on Reducing Administrative Burden to Put Patients over Paperwork to focus the healthcare delivery system on patient-centered care, innovation and outcomes. We are supportive of efforts to reduce administrative burden, increase healthcare efficiency and improve the patient-provider relationship.

CAQH is a non-profit alliance of health plans and related associations working together to achieve the shared goal of streamlining the business of healthcare. In concert with a wide range of healthcare stakeholders, CAQH develops and implements shared, industry-wide, national initiatives to eliminate long-term administrative business inefficiencies, producing meaningful, concrete benefits for healthcare providers, health plans and patients.

The CAQH Committee on Operating Rules for Information Exchange (CORE), an initiative of CAQH, is a non-profit, national multi-stakeholder collaborative that drives the creation and adoption of healthcare operating rules that support standards, accelerate interoperability and align administrative and clinical activities among providers, payers and consumers. CAQH CORE participating organizations represent more than 75 percent of insured Americans, including health plans, providers, electronic health record (EHR) and other vendors/clearinghouses, state and federal government entities, associations and standards development organizations. CAQH CORE is designated by the Secretary of the Department of Health and Human Services (HHS) as the Operating Rule Authoring Entity for HIPAA-

1

mandated administrative transactions. Operating rules are developed by CAQH CORE participants via a multi-stakeholder, consensus-based process.

CAQH comments on the Request for Information CMS-6082-NC are set forth below based on our history of working with stakeholders across the healthcare industry to reduce administrative burdens in areas such as eligibility and benefit verification, prior authorization, attachments or exchange of medical documentation, claims submission and payment, value-based payment and provider data.

Thank you for considering these recommendations and comments. Should you have questions, please contact me at rthomashauer@caqh.org.

Sincerely,

Robin J. Thomashauer
President, CAQH

CC:
April Todd, SVP CAQH CORE and Explorations
Mark Pratt, SVP CAQH Public Affairs
CAQH Board Members
CAQH CORE Board Members

**CAQH Comments on the Request for Information CMS-6082-NC on
Reducing Administrative Burden to Put Patients over Paperwork**

CAQH has organized comments under the areas outlined in the Request for Information (RFI):

1. **Modification or streamlining of reporting requirements, documentation requirements, or processes to monitor compliance to CMS rules and regulations.**

CAQH supports the principles contained in this portion of the RFI to streamline reporting and monitor compliance. Our comments focus on two topics: education and enforcement of existing regulations and adoption of a federal attachment standard.

Education and Enforcement of Existing Regulations
Most HIPAA Administrative Simplification provisions have been federally adopted, and industry implementation is well underway. The 2018 CAQH Index[1], the sixth produced annually by CAQH, tracks adoption, volume, cost and time associated with HIPAA-mandated and other electronic administrative transactions between healthcare providers and health plans including eligibility, claims and prior authorization. Findings from the 2018 CAQH Index suggest that positive change is occurring, but continued efforts are needed to significantly reduce the volume of expensive, time-consuming manual transactions and adapt to the changing administrative needs of the healthcare system. The 2018 CAQH Index estimates that the combined medical and dental industries could save an additional $12.4 billion annually with full adoption of electronic administrative transactions. To measure industry progress and value, CAQH encourages HHS to leverage existing initiatives, such as the CAQH Index and CAQH CORE, by supporting and expanding the work effort including cost benefit analyses and ROI studies via additional resource, funding and recruitment support.

To drive further adoption of electronic administrative transactions, CAQH encourages HHS to fully enforce under its authority the existing regulations covering their implementation, and enhance education efforts. This will encourage full industry implementation and compliance, as well as discourage continued use of ineffective and inefficient use of manual (fax and paper-based) and partially manual (web portal) transactions. CAQH is pleased that the CMS Division of National Standards has launched the Compliance Review Program to ensure compliance among covered entities with the HIPAA Administrative Simplification provisions. Enforcement of the HIPAA transactions, operating rules, code sets and unique identifier standards has been primarily complaint-driven and CAQH is encouraged that there is progression to more proactive enforcement and remediation efforts.

In addition to these enforcement and remediation efforts, broad-based education on the requirements of HIPAA are continually needed to increase awareness and improve compliance. Enhanced education efforts are particularly needed in areas with lagging electronic adoption such as prior authorization. For example, CAQH CORE has learned through a variety of research efforts that many providers are unaware that HIPAA requires health plans to offer the 5010X217 278 Request and Response to conduct prior authorizations electronically. To enhance education efforts, CMS should work in collaboration with industry-driven organizations such as CAQH to drive awareness of the HIPAA Administrative Simplification Requirements.

Adoption of a Federal Attachment/Clinical Documentation Standard
In 1996, HIPAA mandated the adoption of an electronic standard for attachments, and the healthcare industry has been waiting for HHS action on this standard for many years. The extended wait for a federal attachment standard has fueled a sense of uncertainty, deterred vendor development of a standardized approach and resulted in varied electronic solutions and manual workarounds.

According to the 2018 CAQH Index, 51 percent of prior authorizations are submitted manually, 36 percent are submitted via health plan web portals or interactive voice response and 12 percent are submitted via the HIPAA Prior Authorization 5010X217 278 Request and Response. The lack of an attachment standard to support the prior authorization standard is one reason for the high volume of manual prior authorization transactions. Additionally, according to the 2017 CAQH Index[2], only 6 percent of attachments are processed using a fully electronic method. The Index has estimated that adoption of electronic attachment transactions could reduce healthcare industry per-transaction costs for exchange of attachments by over 60 percent[3].

Through its HHS designation as the Operating Rule Authoring Entity for HIPAA-mandated administrative transactions, a key goal of CAQH CORE is to accelerate the adoption of electronic transactions and streamline communication of clinical information through the development of operating rules. CAQH CORE has engaged in a variety of work efforts to survey industry utilization and barriers to identify opportunities for greater uniformity and to educate and promote industry adoption of electronic attachments. CAQH CORE will launch operating rule development for attachments in the fall of 2019 regardless of federal action on an attachment standard given the industry clamor for adoption and uniformity. Rule development will consider priority use cases including claims, prior authorization and value-based payment. Federal rules regarding an attachment standard are urgently needed to support and align industry efforts towards a more efficient and streamlined process to exchange clinical documentation.

2. **Aligning of Medicare, Medicaid and other payer coding, payment and documentation requirements, and processes.**

CAQH agrees that alignment of requirements and processes is critical to ensure all stakeholders are working together towards achieving the same goal of efficient and effective healthcare delivery. Our comments focus on two topics: stakeholder alignment on provider data and value of standards and operating rule alignment.

Stakeholder Alignment on Provider Data
Provider data drives the most fundamental processes in the health care system and CAQH encourages HHS and CMS to consider a single approach for ensuring its accuracy and reliability, including within CMS programs such as Medicare Advantage and Medicaid. Notably, as CMS considers the attributes of a "centralized repository" for demographic provider directory data, we urge CMS not to increase provider burden by introducing additional complexity or by introducing approaches that are not consistent among CMS programs. Moreover, we encourage CMS to embrace opportunities to simplify and standardize data elements to reduce provider burden, which will, in turn, enhance provider engagement and improve data quality.

Industry stakeholders rely on provider data to connect patients with their healthcare providers, license and credential providers, exchange information and pay for services. Though the industry spends more than $2 billion annually[4] to maintain provider data, inaccuracies and inefficiencies are still pervasive, and costs and complexity are growing as a result of increasing and uncoordinated state and federal requirements. Multiple underlying issues contribute to the persistence of these problems, including limited authoritative sources, variation of requirements and standards, frequent data changes and lack of consistent provider engagement. HHS should work with stakeholders to develop a more accurate, efficient and sustainable provider data ecosystem. This provider data ecosystem should be driven by public and private stakeholders.

Value of Standards and Operating Rule Alignment
CAQH supports the consistent use of existing and emerging standards to drive interoperability across the industry regardless of the mechanism of exchange, or the intended sender or receiver of information. Specifically, CAQH supports consistent use of data content so that, regardless of the standard or intended use, the exchange of information between plans, providers and patients can be seamless without undue burden placed on the backend IT and operational systems of health plans and providers or the use of costly intermediaries. In addition, it is important to recognize that technology alone will not result in industry alignment on interoperability. CAQH urges CMS to consider the business perspective as well. Specifically, the vital role of operating or business rules to govern the processes that support standards and technical specifications. Common expectations for when, what and how data is shared is critical for true administrative efficiency.

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[5]." Commonly used in other industries, including financial services and telecommunications, operating rules support technology solutions by providing uniform business requirements to enhance the exchange of healthcare information. The rules go beyond reference or implementation guides by enabling business to consistently use technology and standards to generate value and reduce administrative burden. CAQH CORE participating organizations have tackled some of the most difficult healthcare administrative tasks with a shared goal of aligning administrative and clinical activities among providers, payers and consumers. We encourage HHS and CMS to continue to support the use of operating rules to assist in fulfilling the desired goal of industry alignment.

Lastly, CAQH urges HHS to use its authority through HIPAA to drive uniformity across healthcare payers for administrative transactions such as prior authorization, rather than a limited scope on government-funded payers covered by CMS programs. To drive needed change and alignment, standards and rules need to be applied consistently to all HIPAA covered entities.

3. **Enabling of operational flexibility, feedback mechanisms, and data sharing that would enhance patient care, support the clinician-patient relationship, and facilitate individual preferences.**

CAQH agrees that operational flexibility, feedback mechanisms and data sharing are critical to ensure CMS programs are successful in meeting the needs of patients and providers. Our comments focus on the topic of data sharing.

Critical Need for Interoperable Data Sharing
CAQH supports the goals contained in this RFI as effective clinical care requires more interaction among a wide variety of clinicians and this interaction typically requires data exchange. In addition, value-based payment models are transforming a sizable portion of the U.S. healthcare economy by aligning provider compensation with improvements in quality and cost containment. The success of value-based payment is fundamentally dependent upon reliable business interactions and information exchanges between all healthcare stakeholders. The scope and scale of direct collaboration required for value-based payment stands in stark contrast to the more limited stakeholder interactions in the fee-for-service market.

That said, requiring technology is only a first step toward automation and streamlined clinical workflows. Operating or business rules ensure industry stakeholders are operating in a synchronized and efficient fashion and are a valuable tool for driving interoperability and uniformity in the exchange of data.

One example of how CAQH CORE is working with industry to improve data sharing is through the CAQH CORE value-based payment initiative[6]. Providers participating in value-based payment arrangements require more clinical data on their patients deployed earlier in the continuum of care to effectively manage populations. Furthermore, the varying reporting requirements across and within health plans can cause an additional administrative burden. CAQH CORE participants are currently developing operating rules to allow health plans to provide patient attribution status and reporting requirements to providers at or prior to the point of care. Minimizing end of year reporting and enhancing patient interactions with real-time, actionable data can support the clinician-patient relationship and enhance patient care. These operating rules can be considered updates to existing operating rules by CMS and applied to the entire industry under existing statutory authority.

4. **New recommendations regarding when and how CMS issues regulations and policies and how CMS can simplify rules and policies for beneficiaries, clinicians, and providers.**

CAQH supports more timely, incremental updates to standards and operating rules when there is a strong business case to support the updates. Our comments focus on the frequency of updates to HIPAA Administrative Simplification provisions which can significantly impact provider burden, especially for transactions like prior authorization.

Frequency of CMS Regulations and Policies
Organizations invest significant resources into system updates related to the HIPAA Administrative Simplification provisions and thus expect a return on investment (ROI). The industry should drive the need for updates within the existing statutory framework that specifies a 90-day, expedited interim final rule by HHS per Section 1104(i)(3) of the ACA[7], versus arbitrary timelines set by HHS. Requiring updates simply to meet pre-determined timeframe requirements will only result in industry fatigue and frustration.

In addition to the use of timelier regulatory processes, enabling flexibility within regulations to allow the industry to maintain aspects of standards and operating rules outside the regulatory process is critical. CAQH CORE supports greater adoption of processes over specific requirements, such as the CORE Code Combinations[8] maintenance process for the Phase III CAQH CORE Uniform Use of CARCs and RARCs. The CORE Code Combinations are maintained as a separate document from the rule to enable more rapid updates to meet industry need and prevent delays via the regulatory process. CMS recognized this process in a Notice to Industry[9].

CAQH CORE urges HHS and CMS to consider how to adopt regulations that reference standards and operating rules recommended by the National Committee on Vital Health Statistics (NCVHS) versus detailing the specific requirements in the regulation. HHS should also consider publishing an annual notice referencing the most current set of standards and operating rules recommended by NCVHS that would be mandated for the industry and the date required for adoption.

5. **Improve the accessibility and presentation of CMS requirements for quality reporting, coverage, documentation, or prior authorization.**

CAQH supports the goal of reducing provider burden and is encouraged that CMS is looking at streamlining requirements for quality reporting, coverage, documentation and prior authorization. Our comments focus on the need for efficient prior authorization processes, as well as a federal attachment standard.

Need for Efficient Prior Authorization Process
CAQH CORE has developed operating rule requirements for the HIPAA-mandated prior authorization (5010X217 278 Request and Response) transaction. The Phase V CAQH CORE Operating Rules[10] for prior authorization were released in May 2019. These rules include the Prior Authorization (278) Request / Response Data Content Rule and the Prior Authorization Web Portal Rule. They join the Phase IV CAQH CORE Prior Authorization Infrastructure (278) Operating Rule[11] to form the foundation of a roadmap to move the industry toward an end-to-end automated workflow for prior authorization adjudication.

The Phase V CAQH CORE Prior Authorization Operating Rules require a provider submit data in a standardized way in addition to a requirement on the health plan to normalize the data in the response. The rules focus on standardizing components of the prior authorization process, closing gaps in electronic data exchange to move the industry toward a more automated adjudication of a request. A rule package containing the Phase V Operating Rules will soon be

presented to NCVHS for recommendation to HHS for a federal mandate. These prior authorization operating rules will improve the use and accessibility of the HIPAA-mandated prior authorization transaction.

Additionally, CAQH CORE is conducting extensive research on two additional topics related to prior authorization. First, CAQH CORE has identified opportunity areas to address challenges with the additional documentation often required by prior authorization and anticipate a future phase of rule development to support broader adoption of emerging and existing standards for electronic attachments. Second, CAQH CORE is launching prior authorization pilot tests designed to identify opportunities to refine existing and develop additional rules and measure the impact of operating rules and corresponding standards on the pilot organizations' efficiency metrics. Pilot workflows address the intersection of CAQH CORE Operating Rules, X12 standards and HL7 standards, including FHIR, to ensure operating rules support industry organizations in varying stages of maturity along the standards and technology adoption curve. These pilots are intended to expand current efforts on prior authorization and develop a more automated end-to-end workflow. We encourage CMS to support the Phase IV and V CAQH CORE Operating Rules as well as CAQH CORE's efforts to pilot specific use cases to improve the end to end prior authorization processes.

Need for Federal Attachment Standard
The healthcare industry has been waiting for action on an attachments standard to support the need for clinical documentation for many years. In a 2018 CAQH CORE Town Hall Webinar poll[12], participants overwhelmingly responded that the wait for direction from federal regulators was their biggest barrier, or reason for delay, in implementing electronic attachments. See our response to Topic Area #1 for more detail on the need for an attachment standard.

As the healthcare industry transitions from fee-for-service to value-based payment, there is a clear need for clinical and administrative systems to streamline the exchange of information to support patients, providers and plans. Attachment standards and operating rules are therefore needed to align the exchange of clinical information and medical documentation across the industry. More specifically, attachments can be used for sharing clinical information and quality measure reporting documentation between health plans and providers. We are encouraged that the HHS Unified Agenda[13] lists the release of an Attachments Standard Notice of Proposed Rulemaking (NPRM) in December 2019 and strongly encourages HHS and CMS to meet that deadline.

In the meantime, CAQH CORE Participants will proceed with the development of operating rules to support the exchange of clinical documentation. These operating rules will support flexibility in the use of electronic standards, ensuring consistent data content and exchange methods, with the goal of driving industry automation.

8. **Simplify beneficiary enrollment and eligibility determination across programs.**

CAQH is encouraged that HHS and CMS are looking at ways to simplify the beneficiary experience, particularly by looking at enrollment and eligibility determination. Our comments focus on the existing eligibility transaction and how operating rules ensure consistent utilization across industry, ways that provider data improvement can assist beneficiaries with their use of healthcare, as well as how to ensure beneficiary claims are paid by the correct health plan.

Value of Operating Rules for the Eligibility Transaction

The X12 270/271 Health Care Eligibility Benefit Inquiry and Response transaction set is used to request information from a healthcare insurance plan about what services are covered for a patient or health plan subscriber and patient financial responsibility. It may also be used for questions about the coverage of specific benefits for a given plan, such as wheelchair rental, diagnostic lab services, physical therapy services, etc. The X12 270 Health Care Eligibility Benefit Inquiry transaction is used in conjunction with the X12 271 Health Care Eligibility Benefit Response transaction to transmit the information requested in the original inquiry. The HIPAA-mandated Phase I and II CAQH CORE Operating Rules[14] for the X12 270/271 Health Care Eligibility Benefit Inquiry and Response transaction set include requirements for specific patient financial and eligibility information to be shared in the transaction in real time. According to the 2018 CAQH Index[15], the X12 270/271 eligibility transaction is the highest volume transaction exchanged in the industry today. As new information needs are identified, additional operating rules could be considered to support more robust data exchange via this commonly exchanged transaction set and share that information with a patient through, for example, an application programming interface (API).

In 2019 CAQH CORE launched a multi-stakeholder Value-based Payment Advisory Group[16] consisting of executive leaders representing health plans, providers, vendors, government entities and advisors. The group evaluated pain points caused by value-based payments across the traditional revenue cycle workflow, homing in on opportunity areas for administrative simplification and clinical integration in value-based payments to be considered for further deliberation. One of these efforts will be focused on the eligibility inquiry and its potential impact on provider/patient attribution status. Development of new operating rules in this area could be considered an update to the existing eligibility rules by CMS and applied to the entire industry under existing statutory authority.

Accurate Provider Data to Enhance Beneficiary Utilization of Medicare Programs

Inaccurate, incomplete and outdated provider directory information is a longstanding problem that impacts plans, providers and patients. CMS has conducted three annual reviews of Medicare Advantage online provider directories since 2016 and has determined that problems with directory quality persist. To improve the accuracy of provider data in health plan directories, CAQH launched DirectAssure. This industry-led solution is a fully automated approach that enables more than 1.4 million providers participating in CAQH ProView to easily review and update their self-reported professional, demographic and directory information and share it with multiple health plans at once. CAQH participating health plans serve more than 85% of Medicare Advantage beneficiaries. Through CAQH work with plans and providers, both

nationally and at the state level, we are demonstrating collective progress towards improving directory accuracy and welcome interest from CMS in advancing public-private techniques and solutions.

Improving directory accuracy, completeness and timeliness is a focus for CAQH and our member health plans. We believe that collective industry action, enhanced provider engagement and public/private collaboration – when combined with emerging technologies such as APIs – will lead to meaningful progress that will benefit healthcare consumers.

Ensure Beneficiary Claims are Paid by the Correct Health Plan
Coordination of Benefits (COB) challenges result in delayed and inaccurate payments, heightened administrative expenses, increased appeals and costly recovery activities. The CAQH COB Smart initiative enables health plans to identify which of their members have other coverage so that benefits can be coordinated, and claims can be processed and paid by the appropriate party in an efficient manner. Health plans using this tool supply information to the registry each week, where it is compared with data from other health plans to identify members with overlapping benefits. National Association of Insurance Commissioners' (NAIC) rules are applied to determine the correct order of primacy for benefit coverage. Relevant coverage information is then shared with each participating health plan for integration into their existing operational workflows and processes. Providers may also access COB Smart information so they can route claims to responsible health plans correctly. We encourage HHS and CMS to consider utilities like COB Smart that are used by most large health plans to enhance the beneficiary experience. CMS participation would help create a seamless process between commercial and government coverage administration.

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[1] CAQH, 2018 CAQH Index, CAQH website, https://www.caqh.org/sites/default/files/explorations/index/report/2018-index-report.pdf.
[2] The CAQH Index tracks both the X12 275 and HL7 CDA (Clinical Data Architecture) for claim attachment. https://www.caqh.org/sites/default/files/explorations/index/report/2017-caqh-index-report.pdf.
[3] CAQH, 2017 CAQH Index, https://www.caqh.org/sites/default/files/explorations/index/report/2017-caqh-index-report.pdf.
[4] CAQH, An Industry Roadmap for Provider Data, 2018, https://www.caqh.org/sites/default/files/explorations/pdaa-industry-roadmap.pdf?token=Dvjk2GpS
[5] PUBLIC LAW 111–148—MAR. 23, 2010, https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.
[6] CAQH CORE Value-based Payment Initiative, CAQH website, https://www.caqh.org/core/value-based-payments.
[7] PUBLIC LAW 111–148—MAR. 23, 2010, https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.
[8] CORE Code Combinations, CAQH website, https://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule.
[9] CMS Notice to Industry, CAQH website, https://www.caqh.org/sites/default/files/core/mandate/notices/CMSEFTERAFinalRuleAnnouncement.pdf.
[10] Phase V CAQH CORE Operating Rules, CAQH website, https://www.caqh.org/core/caqh-core-phase-v-operating-rules.
[11] Phase IV CAQH CORE Operating Rules, CAQH website, https://www.caqh.org/core/caqh-core-phase-iv-operating-rules.
[12] CAQH CORE Webinar, "CAQH CORE National Town Hall, October 30, 2018, CAQH website, https://www.caqh.org/sites/default/files/core/oct-town-hall-final.pdf?token=5erfG6ne.
[13] HHS Unified Agenda, RegInfo.gov website, https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201810&RIN=0938-AT38.

[14] Phase I and II CAQH CORE Operating Rules, CAQH website, https://www.caqh.org/core/caqh-core-phase-i-rules, https://www.caqh.org/core/caqh-core-phase-ii-rules.

[15] CAQH, "2018 CAQH Index," CAQH website, https://www.caqh.org/sites/default/files/explorations/index/report/2018-index-report.pdf.

[16] CAQH CORE Value-based Payment Initiative, CAQH website, https://www.caqh.org/core/value-based-payments.