March 3, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0037-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-0037-P: *Administrative Simplification: Certification of Compliance for Health Plans*

Dear Administrator Tavenner:

The CAQH CORE Board of Directors, representing multiple stakeholders to the health plan certification process, is pleased to offer comments on the above-referenced notice of proposed rulemaking (NPRM) concerning *Administrative Simplification: Certification of Compliance for Health Plans. Our comments reflect aspects of the NPRM for which we:*

- *State **support.***
- *Request attention and **changes** to the Final Rule in order assure a successful implementation.*
- *Believe the Final Rule would greatly benefit from **clarification.***
- *Offer CAQH CORE **assistance** with any additional aspects of implementing the HHS health plan certification program.*

We <u>support</u> that HHS proposed two options, reasonable timeframes, and an experienced administrator, as components of the first stage of an evolving program for health plans to certify compliance with the Federally mandated standards and operating rules noted in the NPRM. These structural components are prudent aspects to promoting further improvement in administrative simplification and addressing the ACA legislation.

As the first stage of HHS health plan certification is solely a single snap shot in time, HHS has recognized in CAQH CORE the only existing national health plan certification program for operating rules and standards that has multi-stakeholder approved test scripts and independent testing vendors. HHS has also provided a low cost, documentation-focused, attestation alternative to this existing and well recognized process. Additionally, HHS is proposing adequate time – in some cases more than 24 months – for entities to submit documentation for already mandated requirements.

As an experienced administrator, CAQH CORE can implement the very basic HIPAA Credential processing quickly, while keeping HIPAA Credential costs within the nominal fee structure proposed in the NPRM. While the HIPAA Credential submission process is not yet available, its content requirements are. CAQH CORE's multi-stakeholder Board and open industry collaboration process assures a commitment to developing a HIPAA Credential process that is not materially different than as described in the NPRM. As noted in the NPRM, pages 307 – 308, CAQH CORE is very well qualified to serve in the proposed certification administrator capacity. The organization has a multi-stakeholder Board, has a process for health plans and other entities to submit documents on compliance with the HIPAA transactions standards and operating rules (already using an automated process to do so), maintains tools and education at no cost to the public on any program it offers, and recognizes independent testing vendors to conduct testing. For the CORE Certification testing, the CORE-authorized testing vendors set their own prices. Any vendor can build an on-line testing site per the CORE multi-stakeholder approved test scripts and approval by a CAQH CORE multi-stakeholder committee. Although there is only one CORE-Authorized Testing Vendor at this time, another testing vendor was authorized in the past, and additional vendors have stated interest in applying given the NPRM.

CAQH CORE has no conflict of interest arising from its existing role as CORE Certifier or the proposed HIPAA Credential administrator. It uses an independent testing process for the CORE Certification Seal. For the Credential, it is clear from the NPRM (p. 305) that CAQH CORE <u>will not</u> be responsible for: setting the fees, investigating what a CHP knew or did not know if it submits an inaccurate Credential application package, or addressing any claims that it may receive about a CHP's intent behind any inaccuracies or incomplete information. CAQH CORE is a non-profit organization committed to using any funds received through the certification program in excess of the cost into the process of educating the industry and providing resources on how to implement the certification, or they may also be used to improve business processes through the use of standards and operating rules, including using lessons learned to develop future operating rules.

The recent announcement by CCHIT, a non-profit established to conduct EHR certification, that it will no longer offer certification programs (including its ONC-approved role for Meaningful Use) contains a number of lessons learned on why HHS is making a prudent decision in selecting one administrator, but two certification options, for the initial phase of HHS health plan certification. Although there has been some discussion in the industry of the need for multiple certification administrators for this initial phase, the fee structure for the HIPAA Credential as proposed in the NPRM is insufficient to cover costs for multiple administrators who must develop or retool information technology, develop their own test scripts and processes (for the testing option), hire and train staff, and develop the comprehensive knowledge base necessary to answer questions – all for the first certification of compliance which is a one-time process with the administrator having a very short-lived role. Per the NPRM, future certification programs may be very different than the initial stage. CAQH CORE welcomes the opportunity to present any lessons learned it may gain from the initial stage so later stages can continue to evolve.

We request the below <u>changes</u> with respect to the NPRM. We strongly believe that these changes are essential to ensuring a pathway to a successful implementation of this compliance-focused regulation:

1. **Compliance with obtaining the HPID**: We recognize that this NPRM is not the HPID regulation, and therefore the NPRM ***is not*** (as stated in the NPRM) a mechanism to establish uses for the HPID beyond health plan certification. We also recognize that the requirement to obtain an HPID provides a uniform and unique identifier for each CHP certification application, and therefore provides HHS the means to ensure that CHPs satisfy the ACA obligation for certification, as described in the NPRM on pages 311 – 313. Although we understand these distinctions, we also know there is significant room for industry confusion given the HPID is not a well understood regulation and its potential uses are still being determined. Many CHPs have not yet obtained the HPID, and there are concerns that CHPs with products being sold in the health insurance exchange (HIX) marketplace may not obtain an HPID. There also remain many implementation issues, especially regarding the potential future application of the HPID in real-world HIPAA transactions, which unlike the health plan CHP certification is not a snap shot in time. Many in the industry are concerned with how the HPID could be misused in the HIPAA transactions unless further education and implementation testing is done. Others are concerned of the cost of integrating a new HPID enumeration system into the HIPAA transactions when, for many in the industry, proprietary identifiers have been established by the clearinghouse industry over the past decade. Finally, there are some that are concerned that the CHPs used in the health plan certification will have a cascading effect on the use of the HPID in the HIPAA transactions, thus having some health plans enumerate in a way that they may need to adjust should the CHPs and/or its SHPs be used in the transactions when the transactions have the ability to uniformly hold such enumeration.

   <u>*Recommendation*</u>: Specify in the Final Rule which plans need to have HPIDs. For example, products being sold in the HIX are subject to health plan certification and must obtain an HPID, and those with Major Medical Policies (see comment number 4 below regarding Major Medical policies and number 5 below on self-insured) also need a file certification based on CHP. This said, also specify in the Final Rule for health plan certification that the HPIDs used in health plan certification will not be used for any purpose other than as regulated by the rule, (i.e., for enumeration of CHPs for certification); and that use of HPIDs will not be required in transactions or for any other uses beyond what is already Federally mandated ***unless*** any such additional use is proposed through rulemaking open to public comment. Additionally, CMS, along with key industry partners, should provide extensive education on the permitted and non-permitted uses of the HPID. Included in this very necessary education should be that any CMS public listing of certified CHPs will be accompanied by a statement that the CHPs listed for HHS health plan certification reflect a snap shot in time. Thus, any future use of the HPIDs for these CHPs for health plan identification in the HIPAA transactions will be addressed by the market at a later time and will include necessary education and regulatory guidance.

2. **Scope of certification is not fully end-to-end**: We understand that the HHS health plan certification is focused on health plans and any penalties would apply at the CHP level. The full cycle of HHS administrative simplification, however, will not be complete until practice management systems and other patient financial management systems also are required to be certified. Precedent is already set by HHS requiring certification of electronic health record (EHR) technology in order for providers to earn incentives under the Meaningful Use program. Additionally, since CAQH CORE's inception, CORE Certification and its related testing was designed for, is available to and has been used by *the various types of entities that touch the transactions including practice management systems*. Having certification for all entities demonstrates that these other supporting entities process the financial and administrative transactions in accordance with the HIPAA requirements.

   <u>*Recommendation*</u>: In future rulemaking through HHS, via CMS or ONC, require a certification program that includes practice management and other patient financial management systems that process HIPAA transactions in order to ensure end-to-end compliance for complete administrative simplification.

3. **Health Plan Reliance on Healthcare Clearinghouses in Implementation Testing**: It is appreciated that the ultimate goal for certification is "to help move the health care industry incrementally toward consistent testing processes in order to transition as seamlessly as possible to new standards or operating rules" (NPRM p. 311). We understand that industry testing of new non-mandated industry standards with limited use, e.g., attachments or ASC X12 v6020, is different than testing industry compliance with mandated standards. We also understand that this NPRM is focused on the latter of these two. Thus, it is also appreciated that two options for certification are afforded in order to accommodate both those who already have invested in testing with multi-stakeholder developed test scripts operated by a third party tester (i.e., the CAQH CORE Certification Seal for Phase III) and those who seek a lower cost option not entailing a recognized third-party testing process (i.e., the HIPAA Credential). This said, a missing element of the transition toward consistent testing is to formally recognize the key role many clearinghouses play in health plan standard and operating rule compliance. For example, CAQH CORE Certification for a health plan that uses a clearinghouse to provide all or some of the health plan's transactions processing support must include achievement of CORE Certification for the version, if applicable, of the clearinghouse product used by the health plan.

   Recommendation: In the Final Rule, allow CHPs that use a CAQH CORE-certified clearinghouse product to utilize that clearinghouse's CORE Certification in lieu of the required HIPAA Credential testing with trading partners for those transactions processed by the CAQH CORE-certified clearinghouse(s) on behalf of the health plan. The version of the clearinghouse product must be included in this provided information or a statement that the clearinghouse product does not have versions and thus is always updated per Federal regulations. This recommendation accompanies the recommendation in 10b below, which addresses the role of product level data for successful testing for the HIPAA Credential. Alternatively, consider the option of broadening the scope of required certification beyond CHPs to include all healthcare clearinghouses working with CHPs to further support the move to end-to-end compliance. Ideally, for complete administrative simplification, the required certification should include all IT systems, including provider-facing vendor systems such as practice management systems, that touch the transactions.

4. **"Major Medical Policy"** is not clearly defined. On p. 313 of the NPRM it is noted that HHS proposes to define "major medical policy" for purposes of this proposed rule as "an insurance policy that covers accident and sickness and provides outpatient, hospital, medical, and surgical expense coverage." There is considerable confusion as to whether or not this definition includes vision, dental, long term and post-acute care (LTPAC), and employee assistance programs (EAPs); whether capitated products are included; and a confirmation that all covered entities on the health insurance exchanges (HIX) are included. There is also confusion as to whether the regulation applies to CHPs that do not conduct HIPAA transactions, such as FSAs (flexible spending accounts), which the CMS HIPAA FAQ #421 specifies are health plan covered entities[1] and portions of health plans, such as FSAs and LTPACs that do not conduct transactions. The recent proposed rule for Excepted Benefits included a category of benefits that are exempt from the ACA yet subject to HIPAA Administrative Simplification, such as Employee Assistance Programs. Excepted benefits in this category have limited practical applicability to electronic transactions and as such may not be construed as a "major" medical policy. This said, we understand that if a health plan with a major medical policy(ies) for which the HHS health plan certification applies decides to outsource some or all of its HIPAA responsibilities, the health plan is still responsible for ensuring it meets the regulatory requirements (see recommendation #5 below).

   Recommendation: Clarify in the Final Rule precisely what is included in the term "major medical policy," outlining the types of health plans that are required to have met the HHS health plan certification requirements, including covered health plans offered on the HIXs. Reiterate or reference HIPAA's definition of "health plan." Address whether health plans that do not conduct transactions directly or indirectly via outsourcing are required to obtain certification. Additionally, clearly state if any exceptions exist for a health plan that has only nominal aspects of its business using HIPAA transactions, e.g., LTPAC.

5. **Self-insured health plans** that meet the definition of a CHP as defined in §162.103 are estimated in the NPRM on p. 316 to number in the tens of thousands. Self-insured health plans may be self-administered, administered by other health plans under an ASO (administrative services only) agreement, or administered by a TPA (third party administrator). As such, a given ASO or TPA may have many self-insured plans it is administering – resulting in the 30 percent testing threshold being repeated many times for the same transactions production systems. Given the massive volume of self-insured health plans, the industry needs a way to crisply execute/implement the HHS health plan certification for self-insured plans if self-insured plans are part of this regulation. For example, the ASO or TPA could provide documentation to each of their self-insured health plan clients of their services provided and support for the self-insured health plan's certification.

[1] See: http//www.hhs.gov/hipaafaq/providers/covered/421.html

Recommendation: Specify in the Final Rule that self-insured health plans are required to obtain certification and thus file under a CHP(s); CMS should reference appropriate health plan definitions. Allow that certification for self-insured plans that do not conduct the transaction themselves can have their HHS health plan certification occur via the ASO or TPA's certification. A proxy system could be extremely useful. For example, an option for streamlined implementation would be for the ASO or TPA to provide documentation to each of their self-insured health plan clients of their services provided and support for the self-insured health plan's certification. Once clarified, CMS should conduct extensive education and outreach to assure that stakeholders are fully aware of their obligations to obtain health plan certification, especially self-insured health plans.

6. **Which plans are subject to health plan certification penalty:** An outline of which plans are subject to penalties is proposed, on page 313 and in §162.926, to exclude those without major medical policies. It appears that this separation of CHPs with major medical policies and those without was made in the ACA and not able to be changed by regulation.

   Recommendation: Clarify in a preamble to the Final Rule that regulation cannot change legislation and it is for this reason that CHPs without major medical policies are excluded from penalty. In future regulations, determine how best to include these other HIPAA covered health plans in the HHS health plan penalty process.

7. **Number of Covered Lives: "**Covered lives" are defined on p. 312 of the NPRM. However, due to issues associated with both the volume of self-insured health plans (as noted above) and with enrollment and disenrollment, it may be difficult to capture precisely the number of covered lives *on the date the CHP submits documentation*, as required on p. 304 of the NPRM. There are some CHPs that may not know the number of covered lives in a plan, such as some government plans that provide funding to providers for services to a specific population (e.g., "waivered services"), but do not know how many individuals will receive those services until they are performed. Also, some commercial plans only document the employee subscriber in a family as part of an employer health plan, but all of the employee's dependents are eligible, although not identified by name. Furthermore, how and if CHPs that serve as ASOs/TPAs should count the covered lives of the self-insured is unclear in the NPRM.

   Recommendation: Permit CHPs to report their number of covered lives within a range of time, such as within 30 days of the date of submission. Address specifics of CMS reporting of covered lives where the number is unknown or when double counting of lives could occur when a person has both self-insured and other health plan coverage. (Note: Having the ASO/TPA provide proxy documentation will assist in avoiding the potential for unintentional double counting as only the self-insured would report those lives, understanding that the ASO/TPA provided verification to the self-insured client that the HIPAA transactions were compliant for their contracted lives.)

8. **Processing Requirements for HIPAA Credential**, elaborated upon in pages 304 – 305 of the NPRM, do not appear to be included in the amendments to Parts 160 and 162. It is noted in the NPRM on p. 304 that "information about mechanics for meeting the submission requirements for the first certification of compliance will be forthcoming at or near the time the Final Rule is published." On page 305, the NPRM further notes that "should the final HIPAA Credential differ in any material way from the way we describe it herein, we would reopen the comment period for this topic to allow for further comment." Although we do not believe, as some in the industry suggest, that it is necessary for comments to be sought on mechanics that are aligned with the processing requirements, it is noted that mechanics for meeting submission requirements (e.g., the form to be submitted – see example forms[2] developed by CAQH CORE and for which CAQHH CORE is seeking comments) are not the same as the required content or processing requirements (e.g., testing with trading partners that accounts for 30% of total number of transactions conducted with providers) that are finalized by the regulation and for which comments are been sought via this NPRM.

   Recommendation: Processing requirements, as described in pages 304 - 305 of the NPRM should be included in the final requirements in Part 160 or 162 as applicable. A date, presented in relation to the deadline for the compliance dates, should be stated for when the HIPAA Credential submission will be formally available from CAQH CORE. CMS should educate the industry that the HIPAA Credential fee and processing scope will be set by the Final Rule. CAQH CORE will take comments on the example forms, but the forms will not in any material way differ from the final regulation.

9. **Consideration for temporary exemptions:** Current voluntary CAQH CORE Certification permits temporary/limited exemptions for both IT system migration in a merger and acquisition situation where a newly acquired entity's system must be brought into compliance and an IT system overhaul. The NPRM, however, explicitly states that a CHP must not be under the

[2] See example forms at: http://corecertification.caqh.org/CORE_certification_proposed

CORE Certification exemption policy at the time of document submission for certification of compliance. It is understood, and agreed, that the rationale for no exemptions is that it will be several years since the compliance deadline for the standards and operating rules. Stakeholders responding to CAQH CORE's request for input on the NPRM suggest, however, that mergers and acquisitions must still be taken into consideration given all the market consolidation occurring. Beneficiaries of newly acquired entities could be greatly disadvantaged if the acquired entity is not capable of being certified. Additionally, Market acquisitions could also be negatively impacted if sufficient time for upgrading systems from newly acquired CHPs is not afforded.

Recommendation: **A**dopt an exemption status for a period of up to 12 months following the date of a merger or acquisition, after which the CHP must be re-certified as current without exemption. Address that when specific health plan products cannot meet certain of the mandated standard or operating rule requirements, e.g. Medicare Supplement pre-visit coverage inquiries, these requirements will never be applied to these health plans.

10. **Corrective action for missing documentation, obvious errors or minor errors**: Although the proposed two programs rely on automated processing, there may be missing documentation or obvious errors that are identified by the automated system. Such identification may require manual attention by CAQH CORE on items that could be readily corrected by the CHP. Additionally, there may also be missing documentation on the covered lives submission. After submission to CMS is complete, there could be minor errors occurring with a very small aspect of a CHP's complex and massive transactions processing systems. These errors may be identified during a CMS audit, whether that audit be proactive or complaint-driven.

    Recommendation: Address the need for allowing time, such as 90 days, for correction by the CHP prior to finalizing the certification. Offer a corrective action plan to address minor operating rule and/or standards compliance errors identified in either proactive or complaint-driven audits where there is clearly no intent to defraud or not comply. We recommend this given we understand the HHS goal is to increase adoption rather than applying the health plan certification penalty for something like a single transaction mistake or infrastructure issue. We understand that Meaningful Use does not allow for any errors if incentives are to be achieved. However, the HHS health plan certification is penalty driven, versus incentive-based, and thus some level of corrective action is viewed as a reasonable recommendation, especially given the size of business that some of the CHPs operate.

11. **Several terms that are foundational to the proposed HHS health plan certification need further definition:**
    a. **"HIPAA Credential"** is a term that unfortunately is incorrectly being used today by some IT vendors to suggest that they have undergone some form of Federally-sanctioned process that demonstrates their compliance with privacy and security requirements (outside of the scope of the ONC certification of EHR technology). *Recommend Final Rule:*
        i. Use a term such as "HIPAA *Transactions* Credential," "HIPAA *Electronic Transactions* Credential," or other term that better focuses on the transactions to ensure less market confusion
    b. **"Successful testing"** is not defined in this initial stage, and there are several important issues associated with successful testing. *Recommend Final Rule*:
        i. Require that a successful test should include a valid response to each transaction sent.
        ii. Affirm that being in production is considered successful testing. The level of testing required with trading partners could create a huge bottleneck that would significantly impact turnaround time on processing production transactions. For those who have been in **successful production** for some period of time, CMS must specify the nature of documentation required to be submitted. It may be the same documentation, e.g., list of trading partners, contacts, etc. that the NPRM already proposes.
        iii. Define successful as inclusive of testing across all lines of business.
    c. **"Trading partner"** and references to **"entities that have service contracts with health plans"** are not defined or distinguished between. In addition, there is no assurance that **transactions with a provider's** trading partner, either directly or through a clearinghouse will be in compliance. The attestation process, as described on p. 305 of the NPRM, requires conducting the transactions with trading partners accounting for at least 30 percent of transactions conducted with providers, but no requirement that some percentage of the 30% is testing with providers' trading partners or providers directly. *Recommend Final Rule:*
        i. Clarify the definition of trading partner in relationship to the testing requirement
        ii. Provide clear language regarding what a health plan with only one trading partner should do if it selects the HIPAA Credential option
        iii. Require that at least one trading partner be a provider if such trading partners exist/provider receives health plan transaction data directly or through the health plan's clearinghouse.
    d. **"Transaction"** with respect to how it is used in the denominator for total number of transactions to be conducted (of which 30 percent must be accounted for in trading partner testing) could be clearer. *Recommend Final Rule:*

i. Include examples of numerator and denominator, and clarify definitions.

Recommendation: In the Final Rule address the above recommendations regarding the foundational terms with the goal of ensuring a smooth implementation.

12. **Inclusion of Acknowledgments:** Including Acknowledgements in the testing process would further contribute to administrative simplification. CAQH CORE has long urged adoption of the Acknowledgment standards in previous comment letters and via inclusion of CAQH CORE requirements for Acknowledgements in the CAQH CORE Certification Seals. Those health plans which opt for the CAQH CORE Certification Seal to satisfy requirements for health plan certification currently have to adopt Acknowledgments, while it is proposed those health plans that use the HIPAA Credential attestation approach do not have to adopt Acknowledgments.

    Recommendation: Given the importance that HHS places on electronic Acknowledgements and the health care industry's history of not adopting electronic transaction standards voluntarily, we urge HHS to use the guidance the ACA supplies and the recommendations of the NCVHS to move rapidly to either adopt a standard and operating rules for Acknowledgements; or very appropriately recognize that Acknowledgements are, in fact, not specific HIPAA standard transactions but infrastructure protocols that support all standards and should remain as part of the adopted operating rules and not excluded. CAQH CORE stands ready and willing to work with HHS to address any potential concerns.

Clarification is sought for the following items:

13. **With respect to the number of transactions addressed in the NPRM,** there are several references (on pages 305, 318, 319, and 320) to "three transactions:" (1) Eligibility, (2) Claim Status, and (3) EFT and Remittance Advice. As was noted in the Interim Final Rule on Administrative Simplification: Adoption of Standards for Health Care EFT and Remittance Advice, the two EFT-ERA standards are separate from the X12 835 TR3 Electronic Remittance Advice (ERA). The IFR states: "The X12 835 TR3, which is the standard originally adopted for ERA in the Transactions and Codes Sets Final Rule, remains the standard for ERA transmissions (§162.1602)."[3] Because not all trading partners will always do both EFT and ERA, treating EFT and ERA as one set of standards/operating rules instead of two could make calculating the 30% of transactions conducted with trading partners difficult.

    Recommendation: Clarify in the Final Rule that there are four transactions: (1) Eligibility, (2) Claim Status, (3) EFT, and (4) Electronic Remittance Advice. Many health plans have completely separate processing for EFT and ERA transactions.

14. **Clarify use of new or adjusted CARC/RARC/CAGC code combinations:** The version of the CORE-required Code Combinations for CORE-defined Business Scenarios is specified as Version 3.0.0, June 2012. This is the version adopted in the Administrative Simplification: Adoption of Operating Rules for Health Care Electronic Funds Transfers (EFT) and Remittance Advice Transactions Final Rule. However, CAQH CORE is expected to "establish an open process for soliciting feedback and input from the industry on a periodic basis, no less than three times per year, on the CARC/RARC/CAGC code combinations" (p. 48018). "New or adjusted combinations can be used if the code committees responsible for maintaining the codes create a new code or adjust an existing code" (p. 48033).

    Recommendation: It would be prudent to clarify that the current version of the code combinations must be used at the time of CORE Certification or conducting transaction testing with trading partners. Part of the Federally mandated operating rule is that health plans have a process in place to stay up-to-date with the current version of the code combinations, which are updated no less than three times per year given code authors issue new/modified/inactive codes three times per year.

15. **Inclusion of compliance with HIPAA privacy and security requirements**: Current voluntary CAQH CORE Certification includes the requirement for attestation to compliance with the HIPAA privacy and security provisions. The NPRM, on p. 308, indicates that CMS "anticipate[s] that CAQH CORE's HIPAA Credential application process will similarly require such an attestation for the HIPAA Credential." Because this was not stated as an absolute requirement, we are hearing from some stakeholders that it may not be necessary or appropriate for a certification that focuses on transactions compliance to also require attestation to HIPAA privacy and security compliance, especially because CMS administers the HIPAA transactions

[3] *Federal Register*, January 10, 2012, Administrative Simplification: Adoption of Standards for Health Care EFT and Remittance Advice; Interim Final Rule, p. 1565. CMS-0024-IFC Announcement to Industry indicated that the IFR is a final rule in effect as of July 10, 2012.

enforcement and OCR administers the privacy and security enforcement. Alternatively, we know that there is precedent in the CMS-administered incentive program for meaningful use of EHR technology for including a requirement for providers to conduct a security risk assessment and attest to compliance with the technical security controls.

Recommendation: It would be prudent to explicitly address in the Final Rule whether or not attestation to HIPAA privacy and security provisions must be included in the HIPAA Credential application process.

16. **Timing issues relating to submission of documentation:** Several issues relating to timing of submission of documentation are identified. These include:
    a. **CHPs that form after December 31, 2016**: There is no provision for certification by CHPs that form after December 31, 2016; are these CHPs required to be certified?
    b. **When submission of documentation to CAQH CORE can begin**. It appears that this can be no earlier than January 1, 2015, given that the Final Rule must be published before CAQH CORE should begin to offer this documentation option and thus ensure its process adheres to the Final Rule, e.g., fees, processing requirements.
    c. **How long it takes to acquire an HPID** is unknown and some believe that it could be a fairly lengthy process.
    d. **Completion of some or all of CORE Certification prior to HPID enumeration.** Clarify that health plans that have earned CAQH CORE Certification Seal for Phase I, II or III before enumerating for HPID can use that certification without having to repeat the process and that they can do so by providing CAQH CORE the appropriate CHPs.

    Recommendation: Clarify areas above. Overall, it would be helpful to include examples of key aspects of the timelines for different scenarios, including the amount of time required to obtain the HPID at the front end and exception processing at the back end, in the preamble to the Final Rule so that all timelines are clear for compliance planning.

17. **Operational processes, including fees,** relating to the following topics could also use clarification in the Final Rule:
    a. Where there are **multiple SHPs within a CHP**, there may be a mix of SHPs, some which have or pursue the CAQH CORE Certification Seal for Phase III, and some of which have the HIPAA Credential. Clarification is sought as to whether a mix of the two HHS health plan certification options for the various SHPs under a CHP is permitted by CMS.
    b. Some **CHPs have fewer than three trading partners**, such as a health plan that has a single provider clearinghouse as their trading partner that accounts for over 90% of their provider transactions. Clarification is sought on how "trading partner" in this respect applies when trying to execute/implement the proposed process (see 11c and 11d above). A key example of this is a Medicare Supplement insurer that receives its claims via Medicare crossover. In this case, the Medicare Supplement insurers receiving their claims via Medicare crossover should be permitted to certify based upon testing with CMS. There needs to be clarification for health plans that are faced with the one trading partner reality.
    c. **NPRM, Table 4, sets fees for the HIPAA Credential** and lists fees CAQH charges for the Phase III CORE Seal including Phase I and II Seals. We support the NPRM specifying the fees for the HIPAA Credential and appreciate that the fees are set at a nominal rate given that the program is a one-time certification and it may significantly evolve in its next steps. Clarify if it is expected that CAQH CORE must offer the HIPAA Credential per the fees in the Final Rule and that it is expected CAQH CORE will continue its tradition of not increasing the CORE Certification fees during the initial certification period.

    Recommendation: Clarify areas above.

18. **ACA and Annual Penalties.** ACA requires HHS to assess penalties "annually" and to increase the penalty amount "on an annual basis." The statute also requires that the caps on the penalty amounts be applied "on an annual basis." The NPRM, however, refers to a "one-time" penalty fee being assessed on non-compliant health plans.

    Recommendation: Provide clarification as to whether the "one-time" penalty refers to the fact that the NPRM proposes only a one-time, initial certification, with subsequent rulemaking addressing certification for additional transaction standards and operating rules and accompanying penalties for noncompliance.

CAQH CORE assistance for health plan certification program implementation:

CAQH CORE has done its due diligence with respect to its potential role as certification administrator. We would like to acknowledge that there are liabilities CAQH CORE is incurring in accepting the role of certification administrator for the health plan certification program. As part of our process to ensure that we will make every effort to minimize the potential for risk, we have identified a few potential liabilities. These include: the possibility for data loss, theft, or corruption; failure to have a management reporting system in place to know and be able to report on any data loss or corruption; and failure to process

applications in a timely manner, identify obvious errors and omissions, notify submitter of identified errors and omissions, and deliver or provide access to the application database to HHS. In order to mitigate its liability, CAQH CORE has initiated the following steps:

- Contractual terms regarding software development assurance, including comprehensive testing of related database software and Web site hosting.
- Review of business insurance coverage to ensure the appropriate level of liability for errors and omissions and cyber-attacks.
- Plans for inclusion of a Notice of Limits of Liability on the Website where certification applications are received and for an acknowledgement of limits of liability to be included on its certification submission form.
- Indemnification for loss or theft of data that would otherwise be available through the Freedom of Information Act (FOIA).
- Hold harmless provisions for minor errors or omissions not identified; and for failure to obtain corrections of these errors or omissions from CHPs.

Beyond addressing liability, CAQH CORE would welcome the opportunity to work with CMS on related efforts such as HPID education. Additionally, CAQH CORE is prepared to coordinate with CMS on any outreach or education that CMS would like to initiate on the Final Rule.

Thank you for considering our comments, upon which the CAQH CORE Board has carefully deliberated. These comments represent the views of the multiple stakeholders on the CAQH CORE Board, including health plans, healthcare clearinghouses and other vendors, providers, associations/standards development organizations, government agencies, and others. In addition, over 300 attendees participated on a CAQH CORE-sponsored public call on January 22, 2014 to solicit comments, and CAQH CORE received written comments from CORE and non-CORE participants on two sets of draft comments that evolved each time based on comments. Please let us know if we can provide further clarification on these comments. In addition, we stand ready to provide any further assistance with respect to preparing the Final Rule and implementing the health plan certification program.

Sincerely,

George S. Conklin, CAQH CORE Board Chair
CHRISTUS Health, CIO and SVP for Information Management
On behalf of the CAQH CORE Board members:

Martha Beard
JP Morgan, Managing Director, Treasury & Security Services

Raza Fayyaz
AultCare, Director of Information Systems

Kat Gesh-Wilson
BlueCross BlueShield of North Carolina, VP, Government Operations

Mitchell Icenhower
Allscripts, VP of Solutions Management

Tim Kaja
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