America's Health Insurance Plans
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July 31, 2020

William Stead, MD
Chair, National Committee on Vital and Health Statistics
c/o Rebecca Hines
CDC/National Center for Health Statistics
3311 Toledo Road
Hyattsville, MD 20782

*Submitted electronically via NCVHSmail@cdc.gov*

**RE: AHIP Comments for the Record on Proposed CAQH CORE Operating Rules**

Dear Dr. Stead:

On behalf of America's Health Insurance Plans (AHIP)[1] members, we appreciate the opportunity to submit written comments for the record in advance of the National Committee on Vital and Health Statistics (NCVHS) virtual hearing on August 25-26, 2020 regarding operating rules proposed by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE). Specifically, in February 2020, CAQH CORE submitted three operating rules to be considered for adoption under the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordable Care Act (ACA):

- **CAQH CORE Prior Authorization (278) Data Content Rule v5.0.0**
- **CAQH CORE Prior Authorization (278) Infrastructure Rule v4.1.0**
- **CAQH CORE Connectivity Rule v4.0.0**

We appreciate NCVHS' efforts to engage stakeholders and solicit input on the CAQH CORE operating rules. Our comments are informed by the experiences of AHIP's member health plans in implementing HIPAA transaction standards and Administrative Simplification requirements under the ACA.

AHIP believes these operating rules represent positive progress toward increasing automation, streamlining processes, standardizing data elements, and decreasing manual work. However, we acknowledge that implementation of these rules may be costly and burdensome and does not provide a seamless solution to prior authorization. Some of the proposed requirements would require major technology system changes and upgrades that will be resource-intensive in terms of both personnel time and technology investments, so plans and providers should be granted reasonable time to gradually implement them. It is especially important to allow sufficient time – at least 24 months - for implementation, in light of the COVID-19 pandemic, competing Department of Health and Human Services (HHS) priorities, such as implementation of the Interoperability Rule, and the resulting capacity of health plans, providers, and technology intermediaries or trading partners to dedicate sufficient attention to the complexity of implementing the three operating rules being considered for adoption. In addition, we are concerned that some of the accelerated turnaround timeframes included in the prior authorization rules and safe harbors allowing providers to continue to use older methodologies in the connectivity rule pose potentially significant additional challenges.

We provide detailed responses to the Committee's questions below:

1. **Participation in development of the rules: If your organization participated in identification and development of the proposed operating rules for prior authorization and/or connectivity, describe the skill set of the individuals involved (business or technical) and in what way they participated in the process.**

AHIP did not participate in development of the proposed operating rules. Our comments are informed by member health plans who participated in the development and review of all three proposed operating rules, including the CAQH CORE Prior Authorization Subgroup, the CAQH CORE Rules Work Group, and the CAQH CORE Connectivity Subgroup.

2. **Workflow (prior authorization rules): In what way(s) will the proposed operating rules for prior authorization improve workflow for your organization's industry sector? Discuss the prior authorization data content and infrastructure rules and describe how the proposed requirements from each will impact your workflow, reduce burden (if relevant) and better support patient care.**

The proposed operating rules clarify expectations for prior authorization submission and responses between payers and providers. Some AHIP members report that adoption of these operating rules and use of the 278 transaction by providers will support implementation of an automated response process for prior authorization requests that are currently reliant on more manual methods (e.g., phone, fax). The requirements would support an automated workflow for pending a request due to the need for additional documentation as well as returning a response regarding why an initial 278 request could not be successfully processed.

At the same time, our members raise three important concerns related to the prior authorization rules. First, the ability of the health care ecosystem, including health plans, to realize benefits of adopting the prior authorization operating rules depends on whether providers and trading partners increase their use of the mandated 278 transaction. It is not clear whether adoption of these operating rules will result in increased use of the transaction across the entire ecosystem – health plans, intermediaries/trading partners, electronic health records (EHRs), doctors and other providers. Unless that happens, the promise of the potential progress will not be realized despite the significant investment required by health plans. Given the momentum of many health care organizations working on Fast Healthcare Interoperability Resources (FHIR) and application programming interfaces (API) to accelerate electronic information exchange and interoperability, including for prior authorization, it is difficult to know the potential impact of these rules.

Second, there is concern that lack of an attachment standard will limit the success of the 278 transaction and proposed operating rules. While we should continue to make progress toward more automated prior authorization, an attachment standard is needed for broader adoption and use of the 278 transaction.

Third, we are aware there are significant concerns with some of the accelerated response timeframes included in the proposed prior authorization infrastructure operating rule. The proposed operating rule requires a 20 second response time. Payers with existing automated processes for the 278 report response times closer to 60 seconds, and would need to revert to old processes or significantly rework their processes to move closer to a 20 second response time. The difference between a 20 second response time and a 60 second response time is unlikely to have material impact on providers or patients and may not be an appropriate requirement. We note there is some concern that applying the same initial response time

that is applied to the less complex 270/271 transaction could have the unintended consequence of stalling progress on end to end automation. In addition, we are concerned that the required two-day time frame in the infrastructure rule for health plans to review a prior authorization request and either request the additional documentation needed to support the request or make a final determination, does little to speed the process when parallel timeframes are not applied to providers to supply the required documentation.

3. **Transaction exchange (connectivity rule): In what way(s) will the proposed operating rule for connectivity improve the processing of transactions, message payload, connectivity, security, etc. if adopted by HHS? What are the anticipated benefits that this operating rule offers vs. the current state?**

The proposed operating rules for connectivity have the potential to provide two key benefits. First, it would create a minimum floor for exchanging health care data. Creating an industry-wide method for transaction exchange could reduce the complexity some payers face in supporting transaction exchange. Second, it would promote more secure transmission of data and could enable newer interoperability technologies that support greater privacy and security protocols. However, safe harbor provisions allow providers to continue to use older and different connectivity methodologies, forcing plans to maintain and support multiple methods or use contractual provisions to ensure consistency in connectivity methods among their providers. This is likely to add cost and limit the benefits of implementation.

4. **Improving use of transactions and/or adoption of standards (all proposed operating rules): Describe how adopting the proposed operating rules will or could increase in the use of any of the adopted HIPAA transaction standards.**

Currently, inconsistent expectations and variable processes hinder adoption and use of transactions, especially as it relates to the 278 transaction. Adopting the proposed operating rules could enhance electronic exchange of administrative health care data by promoting more uniformity in connectivity and data content. Standardizing baseline requirements for the 278 transaction should promote uniformity in prior authorization products, which would enable payers and providers to move away from payer-specific processes or requirements and engage in more standardized exchange of prior authorization requests. Consistency in standards and processes should encourage greater adoption and use of those standards. However, this promise relies on entities not currently using the 278 transaction to adopt and use the transaction and new operating rules. And given that prior authorization is a more complex and interactive transaction, adoption of these operating rules remains an imperfect solution, particularly given the efforts underway to use newer business interoperability technologies like FHIR to exchange information.

6. **Implementation time frame for each proposed rule:**

a. **What is the anticipated lead time needed by your organization to develop, test and implement the proposed operating rules? What are the dependencies that impact the timeline, e.g., vendors, trading partners and business associates? If possible, please provide an estimate of the amount of time your vendors would require to develop their component of the solution?**

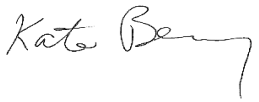
To promote successful adoption and implementation of the prior authorization and connectivity operating rules, we recommend at least 24 months for implementation. Some of the requirements will entail major system changes and upgrades and therefore significant investments. Plans and providers should have reasonable time to gradually implement, especially in light of the COVID-19 pandemic. Trading partners should be strongly encouraged to conduct testing prior to the compliance date.

**11. General: For each rule, please provide the rationale for your support or opposition to its adoption to inform the Committee's deliberations.**

Overall, we are supportive of adoption of the three proposed operating rules for their potential to enhance adoption and use of mandated electronic transaction standards, lower administrative costs, improve interoperability, and streamline payer-provider communication if implementation is not required for at least 24 months. However, the success of these operating rules is contingent upon resolution of the aforementioned concerns and adoption not just by health plans but by the entire ecosystem - trading partners, EHRs, and providers.

Thank you for the opportunity to provide comments on the three proposed CAQH CORE operating rules. If the Committee has any questions regarding our comments, please feel free to contact us.

Sincerely,



Kate Berry
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