NCVHS Request for Comment (RFC) on Proposals for Updates to X12 Transactions and New and Updated CORE[1] Operating Rules

Version 3 – November 28, 2022[2]

The National Committee on Vital and Health Statistics' (NCVHS), Subcommittee on Standards will host a hearing on January 18-19, 2023. The purpose is to receive input to inform the Committee's deliberations as it develops recommendations to HHS on adopting proposed updated standards from X12 and proposed updated and new operating rules from the Committee on Operating Rules for Information Exchange (CAQH CORE) as described in the Federal Register Notice.[3] The standards and operating rules are those adopted by HHS through policies established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and section 1104 of the Affordable Care Act (ACA). In addition to information obtained at the hearing, NCVHS is soliciting written comments through a Request for Comment (RFC) from any individual and organization that would like to provide input. NCVHS will review written submissions in advance of the hearing and consider them together with the hearing testimony.

Please note, the set of questions below are offered as a guide, and other commentary is welcome. The questions provided here represent the type of information sought from stakeholders. Commenters should provide any other information about the proposed standards and operating rules under HIPAA they deem relevant to inform the Committee's recommendations to HHS.

Please submit comments to NCVHSmail@cdc.gov with the subject line: **RFC on X12 and CAQH CORE Proposals, by December 15, 2022.**

Updated X12 Transaction Standards

On June 7, 2022, X12 submitted a letter to NCVHS to recommend an update of mandated transactions and to propose the use of both the EDI (electronic data interchange) standard representation and the XML schema representation as permitted syntaxes. X12 proposed that the current standard be updated from version 5010 to version 8020 for the adopted administrative standard for the health care claims (professional, institutional, and dental) and the remittance advice transactions.[4]

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[1] CAQH CORE is the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange: https://www.caqh.org/caqh-core

[2] This version reflects edits provided by CAQH CORE and are noted by text highlighted in blue.

[3] Federal Register Notice: https://www.federalregister.gov/documents/2022/11/01/2022-23678/national-committee-on-vital-and-health-statistics-meeting-and-rfc

[4] Letter from X12 to NCVHS, June 7, 2022: https://ncvhs.hhs.gov/wp-content/uploads/2022/09/X12-Request-for-review-of-8020-transactions-060822-to-NCVHS-508.pdf

HIPAA requires the Secretary of HHS to promulgate regulations adopting standards, code sets, and identifiers to support the exchange of electronic health information between covered entities, including standards for retail pharmacy and medical transactions. Standards setting organizations or the Designated Standards Maintenance Organization (DSMO) bring forward new versions of the adopted standards to NCVHS after completion of a consensus-based review and evaluation process. Under Section 1173(3)(B), the organizations with whom a DSMO should consult for input include the National Uniform Billing Committee (NUBC), the National Uniform Claim Committee (NUCC), the Workgroup for Electronic Data Interchange (WEDI), and the American Dental Association (ADA).

Interested commenters may address the suggested questions below, or other topics NCVHS should consider when making recommendations to HHS regarding adoption of proposed updates of the X12 standard.

1. **Costs.** If your organization has conducted an analysis of the cost impact to implement the updated X12 version 8020 claims (e. g. the professional, institutional or dental claim) and remittance advice transactions, to what extent, relative to the potential cost of implementation, do the updated transaction implementation guides provide net positive value? Please explain.

2. **Operational impacts.** If your organization has conducted an operational assessment or workflow analysis of the impact of transitioning to the updated X12 8020 claims and remittance advice transactions, what process improvements has your organization identified would result from implementation of the updated versions of any of the updated transactions? Please provide information for the Committee to reference in its considerations and feedback to HHS.

3. **XML Schema.** X12 has indicated that each of the X12 implementation guides included in their recommendation has a corresponding XML schema definition (XSD) that supports the direct representation of the transaction using XML syntax. In its letter to NCVHS, X12 noted that it mechanically produces these representations from the same metadata used to produce the implementation guide. X12 recommends that HHS permit both the 8020 EDI Standard representation (the implementation guide) and the XML representation, and that both be named in regulation as permissible syntaxes. Please comment on the proposal to adopt the 8020 EDI standard and the XML representation as permitted syntaxes.

4. **FHIR Crosswalks.** X12 indicated that it intends to provide FHIR crosswalks for the proposed X12 version 8020 transactions (claims and electronic remittance advice) submitted for consideration in time for inclusion in the Federal rulemaking process. Please comment on how FHIR crosswalks would apply to the implementation of the HIPAA claims and remittance advice transaction standards.

5. **Unique Device Identifier (UDI)**. The device identifier (DI) portion of a medical device's unique device identifier (UDI) is now included as a data element on the updated claim transaction in the institutional and professional version of the 8020. The UDI is also an element in the US Core Data for Interoperability (USCDI) for Certified Health Technology required by the Office of the National Coordinator, and can be found in certified Electronic Health Records, and in standardized hospital discharge reports. Please discuss the additional value, if any, that the DI and UDI provide as data elements in the updated version of the X12 claim transaction

6. **Alternative Payment Models (APM) and Value Based purchasing (VBP)**. Does X12 version 8020 support VBP claims? In what ways does the version 8020 of the claims transactions accommodate APMs such as medical homes or accountable care organizations (ACOs)? Please discuss the implications of this topic to HIPAA administrative simplification policies and continued innovation of non-fee-for-service business models.

7. **Implementation time frame.** HIPAA provides a two-year implementation window for health plans and providers after publication of a final rule (three years for small health plans). Thinking about the changes in health care, what would be the ideal time frame for the adoption and implementation of new versions of standards, and of their implementation, e. g. does the window need to be longer than two years from the publication date of a final rule? Past practice generally stipulated a January 1 implementation date; previous testimony to NCVHS indicated going live on January 1 could be problematic to some implementing organizations. What date (i.e., month/day) might be better for as the implementation date, (i.e., the close of the implementation window)?

8. **Implementation.** NCVHS recently recommended the potential concurrent use of multiple versions of a standard over an extended period of time. Would industry benefit from being able to use either the version 8020 or version 5010 for some extended period of time vs. having a definitive cutover date?
9. **Simultaneity.** What, if any, are the data impacts, limitations or barriers of using the version 8020 of a claims or remittance advance standard transaction while using version 5010 of any of the other mandatory transactions, e.g. claim status, eligibility, coordination of benefits, enrollment and disenrollment, authorizations and referrals and premium payment?

10. **Alternatives Considered.** X12 indicated that there were over 2,000 changes identified in the change logs for the four updated transactions in version 8020, categorized by operational, technical and editorial. If your organization has conducted assessments of the technical changes, what is your determination of these with respect to reducing burden on payers or providers once the updates have been implemented? What is the opportunity cost of remaining on Version 5010 and not implementing the updated version 8020 of the claims and remittance advice transaction standard? What will the healthcare industry risk

by not adopting version 8020?

11. **General**. Does your organization support HHS adoption of the updated version of the X12 transactions for claims and remittance advice as HIPAA administrative simplification standards? Please provide a brief rationale.

CORE Operating Rules

In May 2022, CAQH CORE submitted a letter to NCVHS requesting review of updates to the adopted eligibility and claim status operating rules for the adopted HIPAA transactions (version 5010), as well as a proposal for consideration of operating rules for connectivity and operating rules to support the adopted standard transaction for prior authorization. The letter included a request to review an operating rule for attachments related to prior authorization, for which a standard has not yet been adopted under HIPAA.[5]

Section 1104 of the Patient Protection and Affordable Care of 2010 (ACA) amended HIPAA and introduced the requirement to adopt operating rules to support the business function of each adopted standard transaction.

Interested commenters may address the suggested questions below, or other topics NCVHS should consider when making recommendations to HHS regarding the current proposals from CAQH CORE.

1. **Efficiency Improvements. Infrastructure updates to the adopted Eligibility and Benefits and Claim Status Operating Rules.** CAQH CORE has proposed updates to the adopted versions of the eligibility and benefits and claim status operating rules currently required for use. Updates include an increase in overall system availability from 86% per calendar week to 90%, ~~and for the response time for a claim status request from 20 seconds 86% of the time to 20 seconds or fewer 90% of the time~~ and an optional 24 additional hours of system downtime per quarter to accommodate large system migrations, mitigation and more integrated system needs, when applicable. Please comment on the potential for improvements in efficiency for your organization these updates would contribute when using the adopted X12 HIPAA transaction standards.

2. **Data Content updates for Eligibility and Benefits Operating Rule.** The updated version of the Eligibility and Benefits operating rule includes the requirement to indicate coverage of telemedicine, remaining coverage and tiered benefits, and to indicate if prior authorization or certification is required. The rule has been updated to include a list of CORE-required service type codes (section 5) and CORE-required categories of service for procedure codes. If your organization has conducted an analysis of these updates and

[5] Letter from CAQH CORE to NCVHS dated May 23, 2022: https://ncvhs.hhs.gov/wp-content/uploads/2022/09/CAQH-CORE-Board-Letter-to-NCVHS-re-New-Updated-OR-052322-508.pdf

the potential impact to increasing use of the adopted standard, please comment on your assessment of these enhancements for **your organization** and/or your trading partners.

3. **New: Patient Attribution. Content rule within the new Eligibility and Benefits Operating Rule (vEB.1.0).** CAQH CORE has proposed a new operating rule to apply to the selection of value-based payment models by providers. If your organization has conducted an analysis of this operating rule, please provide information on your organization's evaluation of the extent to which the proposed operating rule requirements support the adopted HIPAA transactions or improve administrative simplification.

4. **Companion Guide Template.** CAQH CORE has updated the requirements for the companion guides in the adopted operating rules to promote flexibility. Please comment on your organization's experience with the companion guide template in the first set of operating rules, how it has impacted workflows and whether your assessment of the proposed new template indicates value for implementations of the standard transactions.

5. **Updated Connectivity Rule**.

   A) As part of the re-structuring of the CAQH CORE operating rules for each administrative transaction, CAQH CORE updated the connectivity requirements and published a stand-alone Connectivity Rule (vC4.0.0), for which it is seeking a recommendation for adoption. In addition to the requirements for the use of HTTPS over the public internet and minimum-security conditions, the Connectivity Rule addresses Safe Harbor, Transport, Message Envelope, Security, and Authentication. What changes would be necessary to your organizational infrastructure, policies and contracts to implement the CAQH CORE c4.0.0 Connectivity rule?

   B) The updated Connectivity rule adds support for the exchange of attachments transactions, adds OAuth as an authorization standard, provides support for X12 (HIPAA) and non-X12 (non-HIPAA) exchanges, and sets API endpoint naming conventions. The CAQH CORE letter states that the impact of mandating these requirements for HIPAA covered entities includes: "setting a standards-agnostic approach to exchanging healthcare information in a uniform manner using SOAP, REST and other API technologies; facilitates the use of existing standards like X12 in harmony with new exchange methods like HL7 FHIR, and enhancing security requirements to align with industry best practices." Please comment on the scope of the CAQH CORE Connectivity operating rule vC4.0.0 under consideration for adoption under HIPAA.

6. **Costs**. If your organization has conducted a cost analysis to determine the impact of implementing the updated eligibility and benefits and or claim status operating rule updates for your entity type, what are the estimated costs or types of costs for system

and operational changes? In what programmatic ways do the updates to the operating rule for infrastructure (system availability and response time), data content, additional data elements for telemedicine, prior authorization coverage benefits, tiered benefits and procedure-level information add value for your organization? Please provide examples pertinent to your organization.

7. **Alternatives considered for operating rules**. What are the consequences to your organization if NCVHS recommends adoption of the updated versions of the eligibility or claim status operating rules? Please provide specific examples to describe the impacts (benefits, opportunities) of the changes included in the update for each operating rule.

8. **Attachments Prior Authorization Infrastructure and Data Content Rules (vPA.1.0) and Attachments Health Care Claims Infrastructure and Data Content Rules (vHC.1.0).** CAQH CORE has proposed infrastructure and data content operating rules for Prior Authorization and health care claims. The proposed infrastructure rules for attachments for prior authorization and health care claims include requirements for the **u**se of the public internet for connectivity, Batch and Real Time exchange of the X12 v6020 275 transaction, minimum system availability uptime, consistent use of an acknowledgement transaction, use of uniform data error messages, minimum supported file size, a template for Companion Guides for entities that use them, a policy for submitting attachment specific data needed to support a claim adjudication request (standard electronic policy), and support for multiple electronic attachments to support a single claim submission. The operating rules include the requirement for a health plan or its agent to offer a "readily accessible electronic method to be determined…. For identifying the attachment-specific data needed to support a claim adjudication request by any trading partner, and electronic policy access requirements so services requiring additional documentation to adjudicate the claim are easily identifiable (health care claims only)." The CAQH CORE letter indicates that the proposed attachments data content rules for prior authorization and health care claims apply to attachments sent via an X12 (HIPAA) transaction and those sent without using the X12 transaction (non-HIPAA). Please provide your assessment of this proposed operating rule.

9. **Attachments operating rules – general question.** HHS has not proposed adoption of a standard for attachments under HIPAA. Please comment on the proposed operating rules for attachments. What should NCVHS consider prior to making any recommendations to HHS regarding operating rules for attachments?