National Committee on Vital and Health Statistics
Standards Subcommittee
Hearing on Requests for New and Updated Transaction Standards and Operating Rules

Transcript

January 19, 2023, 10:00 a.m. – 3:10 p.m. p.m. ET

Virtual

SPEAKERS

Name	**Organization**	**Role**
Tammy Banks	**Providence St. Joseph Hospital**	**Co-Chair**
Denise Love	**Individual**	**Co-Chair**
Rich Landen	**Individual**	**Co-Chair**
Rebecca Hines	**NCHS**	**Executive Secretary/DFO**
Debra Strickland	Conduent	Member
Denise Chrysler	University of Michigan School of Public Health	Member
Jamie Ferguson	Kaiser Permanente	Member
Margaret Skurka	Indiana University Northwest and Principal, MAS, Inc.	Member
Valerie Watzlaf	University of Pittsburgh	Member
Wu Xu	Individual	Member
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Name	**Organization**	**Role**
Lorraine Doo	CMS	Staff
Marietta Squire	NCHS	Staff
Maya Bernstein	ASPE	Staff
Grace Singson	ASPE	Staff
Presenters		
Name	**Organization**	**Role**
Dan Kalwa	CMS, National Standards Group	Deputy Director
Erin Weber	CAQH CORE	Director, CORE
Linda Reed	CAQH CORE	Board Chair
Tim Kaja	CAQH CORE	Immediate Past President

Robert Tennant	WEDI	VP, Federal Affairs
Cathy Sheppard	X12	Chief Executive Officer
Viet Nguyen	HL7 International	Chief Standards Implementation Officer
Terrence Cunningham	American Hospital Association	Director of Administrative Simplification Policy
Heather McComas	American Medical Association	Director, Administrative Simplification Initiatives
Kirk Anderson	Cambia Health Solutions	VP and Chief Technology Officer
Anna Taylor	MultiCare Connected Care	Associate VP, Population Health and Value-Based Care
Margaret Schuler	Aspen Dental	Sr. VP, Revenue Cycle Management and Practice
Christol Green	Elevance Health	Sr. Consultant/Advisor
Gail Kocher	Blue Cross Blue Shield Association	Director, Commercial Markets
Barry Hillman	Blue Cross Blue Shield North Carolina	Director, Provider Digital Strategy
Nora Iluri	athenahealth	VP of Product, RCM (Collector)
Arthur Roosa	Symed/Cosentus Business	On behalf of HBMA
Pam Grosze	Cooperative Exchange	Board Chair

Agenda Item: Welcome, Call to Order

Rebecca Hines: We are a minute after the hour. Good morning, everyone. Welcome to Day 2 of this hearing of the National Committee on Vital and Health Statistics. We are delighted you can join us for the second day where we will be focused on the second request from CAQH CORE on updated and new operating rules.

My name is still Rebecca Hines, if you were here yesterday, and I serve as executive secretary and designated federal officer for the committee. A warm welcome to everyone joining us here today. Still meeting virtually.

Let us start off and take care of roll call, beginning with our co-chairs. Tammy, can you start us off please?

Tammy Banks: I sure can. Tammy Banks, independent consultant, co-chair, Subcommittee on Standards, member of Executive Committee, no conflicts. Thank you, Rebecca.

Rebecca Hines: Thank you.

Denise Love.

Denise Love: Denise Love. Co-chair, Subcommittee on Standards, member of the Full Committee, no conflicts.

Rebecca Hines: Rich Landen.

Rich Landen: Good morning. Rich Landen, co-chair, Subcommittee on Standards, member of the Full Committee, member of the Executive Subcommittee. I have no conflicts.

Rebecca Hines: Debra Strickland.

Debra Strickland: Hi. Debra Strickland. I am a member of the Full Committee and a member of the Standards Subcommittee. No conflicts.

Rebecca Hines: Denise Chrysler.

Denise Chrysler: Good morning. Denise Chrysler. I work for the University of Michigan School of Public Health and the Network for Public Health Law. I serve on the Full Committee and the Privacy, Confidentiality, and Security Subcommittee and I have no conflicts.

Rebecca Hines: Jamie Ferguson.

Jamie Ferguson: Good morning. My name is Jamie Ferguson. I work for Kaiser Permanente. I am a member of the Full Committee and the Subcommittee on Standards, and I have no conflicts.

Rebecca Hines: Margaret Skurka.

Margaret Skurka: Hi. My name is Margaret Skurka. I am Professor Emeritus at Indiana University. I am a member of the Full Committee and the Standards Subcommittee. I have no conflicts.

Rebecca Hines: Valerie Watzlaf.

Valerie Watzlaf: Good morning. Val Watzlaf. I am with the University of Pittsburgh faculty. I am a member of the Full Committee and I co-chair the Privacy, Confidentiality, and Security Subcommittee. I have no conflicts.

Rebecca Hines: Wu Xu.

Wu Xu: Good morning. My name is Wu Xu. I am a member of the Full Committee and have no conflicts.

Rebecca Hines: Thank you, members. Have I left anyone out? I think that is everyone who is here right now.

Let us move over to our staff starting off with Lorraine Doo.

Lorraine Doo: Thank you. Lorraine Doo, Centers for Medicare and Medicaid Services, Health Informatics and Interoperability Group. I just wanted to first make sure I did not forget to thank both Rebecca and Marietta Squire for putting this together. It was a very complicated hearing this time. I just want to make sure to do a shout out to both of you for this event.

Rebecca Hines: Thank you, Lorraine. It is definitely team sport. We really appreciate the opportunity to work with you on this as well. Thanks.

Grace Singson with ASPE. Good morning.

Grace Singson: Good morning. My name is Grace Singson. I am in the Office of Assistant Secretary of Planning and Evaluation in the Office of Finance and Data Policy.

Rebecca Hines: Thank you. Anyone else on the team that I missed?

I, again, want to especially echo Lorraine thanking all of you here today who are willing to offer your input and feedback, both our invited panelists and those of you who are going to participate in public comment. Note on today's agenda, which we will go through in a minute. There is public comment scheduled for early afternoon. We will have a slide up at that time, which you can see here now with the instructions. We will go over that so you can open – we will open the audio line for you then.

We will do our best to stay with the schedule on the agenda. If you do plan to participate in public comment, please stay tuned. Sometimes we run a little short or a little long. Hopefully, it will be at the time posted on the agenda. I think that is it for now. I will turn it over to Tammy Banks, our co-chair.

Opening Remarks/Agenda Review

Tammy Banks: Again, I would also like to welcome everyone here today and echo Rebecca's comments. I have the pleasure of passing it over to Denise Love, who is going to be running the CAQH CORE proposal review. Thank you, Denise.

Denise Love: Thank you, Tammy. Could I have the slides up please for the agenda?

Rebecca Hines: Agenda coming right up.

Denise Love: Welcome, everybody. For those of you who were with us yesterday, I welcome you back. For those who were not, I will go through the format. It will be the same pretty much as yesterday, the same format. Again, the public comment at 1:30 is the big difference.

The first part of the agenda. I will do some level setting of the subcommittee's work, the work to date, and the activities since we have received these proposals and then some of our work going forward. This level setting will be followed by the National Standards Group's Dan Kalwa. He will provide some really useful information about how this all works and how CMS' role and responsibilities fit into this.

Then we go to the CAQH CORE. It will be Erin Weber and her board members, Linda Reed and Tim Kaja. They will go over their proposal and fill us in on what they are and how they will work. That will be followed at 11:20 by WEDI's Rob Tennant. Again, they have some valuable information on the member survey and position advisory event outcomes.

At 11:40, we will hear on Panel 1 from Cathy Sheppard, X12 and HL7, Viet Nguyen. They will present their perspectives on the CORE Operating Rules.

We will break at 12:15. At 12:45, we will be back with the provider perspective on the CAQH CORE proposals. Again, 1:30 is public comment and we welcome those who have some at that time.

And then at 1:45. Panel 3 will be the payor perspectives on the CORE proposals on the Operating Rules. At 2:20, we will have Panel 4. That will be the vendor and clearinghouse perspective on Operating Rules. This roughly follows the flow that we used yesterday.

We have a break at 2:50 p.m., 3:05, subcommittee Q&A. This will be for any clarifications or questions that the subcommittee may have of certain panelists. We will conclude at 3:45. Did I miss anything, Rebecca?

Rebecca Hines: Perfection. Thank you, Denise.

NCVHS Presentation Regarding the Proposal from CAQH CORE on Updated and New Operating Rules

Denise Love: Okay. I will then ask for slides. Next slide please. The purpose of today's subcommittee hearing is really to gather input from industry stakeholders regarding the proposal from CAQH CORE for updated and new operating rules. This input together with the previously gathered input and I will talk about that in a minute will be used to inform the subcommittee's recommendations to the HHS Secretary regarding the adoption of these proposals.

The subcommittee has been quite busy since these proposals came through. The subcommittee received an overview by CAQH CORE in July of 2022. We have established a great collaboration with WEDI, who has been named the advisor to HHS and the HIPAA statute. We have had informational sessions. The WEDI survey that you heard about yesterday and you will hear more about today and their MPA advisory event, which we participated in November of 2022.

The Request for Comment was published. We have received a great response. These responses really help me and other subcommittee members understand some of the issues related to these proposals.

We have held consultative conversations with CMS, the Office of Burden Reduction and Health Informatics, CMS' National Standards Group, and HHS' ONC. Again, this is very helpful to learn what their roles are and how they fit in and then this hearing, which is another important piece of our process.

The requested updates to the Operating Rules under HIPAA are the following. These are the proposed updates to adopted Operating Rules, the Eligibility and Benefits Data Content Rule, otherwise known as 270/271. The Claims Status Infrastructure Rule, 276/277, updates and its reference to the updated connectivity rule. The Payment and Remittance Advice Infrastructure Rule, otherwise, 835, also referenced to updated Connectivity Rule. And Eligibility and Benefits 270/271 Infrastructure Rule, again, updates plus reference to the updated Connectivity Rule.

Additional proposals from CAQH CORE that we will hear about today. The Connectivity Rule Version 4.0 includes updates to the Connectivity Rule that is included in the existing operating rules. This Connectivity Rule replaces existing connectivity requirements in infrastructure components of adopted operating rules, plus adds new requirements to all operating rules. This is an important component.

Eligibility and Benefits. Another component is the Single Patient Attribution Data Content Rule. We will also hear about attachments, Prior Authorization Infrastructure Rule, and Data Content Rule, and Health Care Claims Infrastructure Rule and Data Content Rule. That is a lot here and we will look to CAQH to unpack it a little bit.

I do know that we will hear from the National Standards Group about operating rules for rules that have not been adopted. There are some nuances there that we need to talk about.

Why are we here? Per Section 1104 of the ACA under HIPAA, operating rules are business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.

The Secretary shall adopt a single set of operating rules for each transaction with the goal of creating as much uniformity in the implementation of the electronic standards as possible.

Operating rules shall be consensus based, reflect the necessary business rules affecting health plans and health providers in the manner in which they operate to support the standards adopted under HIPAA. That gets into those that have not been adopted versus the adopted standards and how those –

What is our role? The role of the National Committee for Vital and Health Statistics in making recommendations on operating rules advise the Secretary as whether a nonprofit entity meets certain requirements for authoring operating rules, review these rules, developed and recommended by this entity, determine whether operating rules present a consensus view of health care stakeholders and are consistent with and do not conflict with other existing standards, evaluate whether operating rules are consistent with electronic standards adopted for health information technology, and submit to the Secretary a recommendation as to whether the Secretary should adopt operating rules. Thus, this hearing is very important today for the committee to gather this necessary information.

The process and agenda. I will not go over it too much. We will hear from CAQH CORE and panelists representing invited stakeholders from across the health care ecosystem will provide input on the value, concerns, and other topics of their choosing pertaining to these proposals. We are also accepting written comments for those that were not able to attend this hearing and all of these comments are important. WEDI will provide a presentation of its findings from their industry survey and member advisory session, as I stated earlier.

To the subcommittee, just like yesterday, we will provide time at the end of each panel for any points of clarification or questions you may have and then we will have the public comment period after the break.

What are we looking for? We are looking for your input. These are some specific things that might be helpful for a decision today. What is the value-add of updates to the operating rules, the benefits and applicability to HIPAA Standards to which the operating rules apply, those that are mandated and those that may be used voluntarily? Availability of cost-benefit information for implementing updated operating rules where they exist would be helpful. What are the expected business process improvements of these operating rules? Changes to the companion guide template and benefits of these changes. Implications for proposed operating rules for attachments for claims and for prior authorization. What are those implications for these pending rules? And impacts of adopting or not adopting the proposed operating rules.

After the hearing, the subcommittee will analyze this input. Some of this has already started. But in earnest, it will start after these hearings. We will discuss and deliberate the input that

you are providing. We will work on drafting recommendations and presenting these to the Full Committee and then sending ultimately a letter to HHS secretary, conveying the Full Committee recommendations.

Again, like yesterday, you can find the NCVHS' materials on the web at this link. I think that is it. There are no other slides.

I am going to turn this over to Dan Kalwa of CMS, the National Standards Group. And Dan. We welcome you today. We rely on your expertise, and it is all yours.

CMS Presentation Regarding Adoption of Operating Rules under the Affordable Care Act

Daniel Kalwa: Good morning, Denise. I think I will alter how I am going to present a little bit because you have already reviewed and correctly reviewed some of the information I was going to share. I will not burden everyone with a re-explanation.

What I have restated there is of course what Denise just shared with you. What I would like to do is point out, as part of the discussion today, some things that operating rules explicitly cannot do. I do not believe any of the proposed operating rules ever do but it is worth considering as you think about what is being proposed.

The purpose of the operating rules under the Affordable Care Act is to expand on and elucidate the implementation specifications that are adopted for the transactions. Two things they cannot do is alter those implementation specifications. That is, we cannot come back with an operating rule and for example, change a data element from not used to used in an operating rule if it does not already exist in the implementation specification.

The other thing that we cannot do in operating rules is adopt other implementation specifications that should go through the rulemaking process. I am sure some are unhappy about this. But we cannot, for example, adopt other implementation specifications for transactions or additional transactions in an operating rule when they should be adopted more properly under the HIPAA standards adopting process. That is something to think about. For those that are not aware or were not there when these discussions were originally had, that is why there are those carve-outs in the regulation language for not requiring, for example, acknowledgments. That is a thing we could not require because the acknowledgment implementation specifications never went through the rulemaking process.

Denise already covered the requirements for NCVHS, and she was correct in those. NCVHS is the reviewing body here. The interesting part is they are also responsible for determining and we did not necessarily talk about this and I do not expect it to come up today, what an operating rule entity is and whether an entity meets that criterion for consideration.

I do not believe that this will come up today, but it is also worth keeping in mind, that some SSOs and SDOs do create their own operating rules. I have mentioned that at the Academies several times. NCPDP develops full and complete operating rules essentially whereas X12 has

never taken that as their business model. We have an operating rule for X12 and not one for NCPDP because operating rules only need to exist where the underlying implementation specifications do not otherwise give those instructions.

I will skip a little more. There is nothing new in those slides. That is just some more citations if you would like another way to look at them.

Something that I really wanted to talk about and make sure the committee understood is that as a general rule when you are thinking about this, virtually everything does require rulemaking on our part. Even changing the version of the operating rules, changing the titles, the way incorporation – it is called incorporation by reference in regulations work is that we even have a date of the version of the manual that is specified in the regulations. Even should the industry decide to go from an April version to a December version, that still requires an update to the rule on our part. Absent changes to the regulatory language, the industry is technically required to comply with what is expressed in the regulation. Despite the fact that the operating rule structure has been updated and altered and, in many cases, for the existing operating rules, nothing has changed. It is just the format. Technically, the compliant version is the version specified in the regulation.

Of course, adopting operating rules for a transaction that does not currently have adopted operating rules would require regulatory action on our part and also removing any existing exceptions or altering how the exceptions for certification and acknowledgements works.

I also wanted to note that as the committee and as the community is thinking about when and how to implement operating rules, it is worth noting that operating rules do not have the same time requirements that modification and the new adoption do under HIPAA. That concept under HIPAA, for example, of when we are adopting a new standard of not to exceed two years for large health plans or three years for small health plans, which does not exist for operating rules and neither does the concept of minimum of 180 days. Although I do not expect practically that anyone would desire a shorter timeframe. The operating rules have some – a much larger leeway and how the industry and how the committee might recommend adoption should you decide to do so.

That is a very short version. But I think those are the most salient points. The committee, of course, can contact us directly. But if the public has any further questions, you can again send any of your questions or comments to the Administrative Simplification mailbox at CMS.

Denise Love: Thank you, Dan. We are ahead of schedule. That was very brief but concise. I think it provided clarity on the adopted rules versus non-adopted. I think the subcommittee will have some questions or comments.

I have a question because I am curious. If there is an operating rule for a proposed rule or proposed standard but that standard is not adopted or not finalized in rule, the industry can adopt the operating rules on a voluntary basis, can you dig into that a little bit?

Daniel Kalwa: I probably would not use the term adopt. I would say that NSG would have no comment until we finish our rulemaking process. Should there be operating rules recommended and they integrate with the proposed rules, that is something we can discuss. But in the meantime, and until there is a final rule, we at NSG and there would, for example, be nothing to comply with. We would not require compliance with anything. If the industry chose to do operating rules, we would not have any comment until such time as there is a final rule and then a final compliance statement and then after that would be when we would require compliance.

Denise Love: But there is nothing though that would prevent trading partners voluntarily adopting those. And would that provide useful information to CMS on how that voluntary implementation went? I am just trying to figure this out.

Daniel Kalwa: I would expect so. Yes. When considering technology and how to use it, so long as there is no adopted standard, NSG and HIPAA and Administrative Simplification has no comment. To the extent that the industry wants to test things where there are no adopted transactions and are now operating rules, they are free to do so. I think we have noted yesterday that there are significant risks and costs to testing those implementations.

The only time one would need to, for example, ask for an exception in order to test would be if there are already operating rules, if there is already a standard. The purpose of that exception process is it regularized the process so that we get a report and as part of that exceptions process, you are required to issue a report that goes to the Secretary but also to ensure that no one is – there is no accidental enforcement activities and there is no complaint. It alleviates the liability for everyone that is working in exception. But where there are no requirements around compliance, we would not comment or have a concern with that.

Denise Love: Okay. That helps me. I hope it helps others.

Subcommittee, do you have any comments, questions of Dan? Okay. They are drinking coffee. They are probably firing up their brain cells.

Daniel Kalwa: It is a problem of going early in the morning. But I will be here all day should there be any further questions.

Denise Love: As yesterday, it started getting kind of active about 1:30 or so.

Okay. Rebecca, may we take leeway and keep moving to CAQH CORE?

Rebecca Hines: Assuming everybody on the panel – we have Erin Weber and fellow board members. Are you all set to go a few minutes early?

Erin Weber: I think so.

Rebecca Hines: Great. Thank you.

Denise Love: Thanks for being flexible. I will just turn it over to you to get to the meat of what you are proposing.

Presentation from CAQH CORE Regarding Proposals for Updated and New Operating Rules

Erin Weber: Great. Awesome. Good morning, everyone. I would just like to start off by thanking the subcommittee and staff for your time and effort planning this hearing. We recognize that there is a lot of industry activity at this time. We appreciate the efforts of the committee, the committee staff, and industry stakeholders to support an informed recommendation to HHS.

Today, we will present on the content, impact, and importance of the proposed new and updated CAQH CORE Operating Rules as you consider recommending them to HHS for federal adoption.

Our goal today is to impress upon you three key points. First, operating rules are a proven industry-developed tool for driving automation across health care business processes and are required for standard transactions under HIPAA.

Second, updates to the existing operating rules must be adopted to modernize and align requirements with advancements in health care since first mandated.

And third, we urge NCVHS to recommend inclusion of the attachments operating rules in the final rule for the attachment standards. This is a rare opportunity to ensure robust electronic adoption and uniform implementation across industry. I know on a WEDI webinar, we had heard it noted that it was in bounds to include operating rules in the final rule.

Many of you know me already from our time together in the industry over the years. I am Erin Weber, vice president of CAQH CORE. I am joined today by our immediate past CORE Board Chair, Tim Kaja, who is currently the President of Optum Health Networks and Network Support and our Current Board Chair, Linda Reed, Senior Vice President and Chief Information Officer at St. Joseph's Heath in New Jersey.

Our agenda for the next 35 minutes is really designed to drive home the key points I laid out a minute ago. There is a lot of detail on the slides, and we are just going to touch on the highlights. If you miss anything, they will be available on the NCVHS website.

Let us kick off today's presentation with a brief reminder of who we are at CAQH CORE. We will then take a deep dive into the proposed operating rule set. Tim, Linda, and I will detail the included requirements, impacts on day-to-day workflows, and value and cost-benefit analyses provided by our industry partners. Then we will close with a brief call to action.

Lastly, we will make sure to save some time for comments and questions so we can hear from you too.

Now, for a bit of background about the CORE initiative. Modeled after the financial services industry, CORE was founded by the industry in 2008 to develop business rules for the effective

and efficient use of electronic transactions, are more than 100 participating organizations include health plans, provider organizations, vendors, government entities, associations and standards development organizations. They collaborate through a multi-step consensus-based process to develop operating rules.

CORE is directed by several key tenants outlined by our mission, vision, and HHS designation as confirmed by Secretary Sebelius in 2012. Our certification, education, and pilot and measurement efforts support this directive by ensuring widespread adoption and awareness.

CAQH CORE is a well-established and highly respected multi-stakeholder initiative and the drive towards automation and interoperability. Our participating organizations specifically designed this proposed set of operating rules to align with overarching national goals to advance technology and minimize the usage of proprietary solutions, reducing administrative burden for all industry stakeholders.

CAQH CORE is accountable to a multi-stakeholder, executive-led board that balances participation across key stakeholders, including providers, health plans, and vendors as well as regulatory and standards development organization advisors. There is a lot of information on this slide. But what I would like you to focus on is the diversity in our membership, which moves beyond the insights of technical implementers and includes perspectives across health care disciplines from clinical to business to operational backgrounds. Our participating organizations are similarly diverse, ensuring every aspect of the health care workflow is represented in our operating rules.

I want to highlight here that health plans participating in CORE represent about 75 percent of total covered lives in the United States, providing a direct channel between CORE participation and impacts on the patients and members being served. In fact, I believe almost all of the organizations presenting on the operating rules today are CORE participants and many of them have been with us since the early beginning.

This slide is a little bit of a history review. But the groundbreaking ROI demonstrated by early voluntary implementations of the CAQH CORE Operating Rules garnered widespread industry support. And the passage of the Affordable Care Act formally established the regulatory role of operating rules. In fact, I actually signed my job offer with CAQH on the day the ACA passed. It was really an incredible experience and privilege to see the industry come together in those first few years and collaborate at such unprecedented levels, not really sure I knew what I was in for though.

Between 2010 and 2015, the pathway and pace between CORE proposal, NCVHS review, and HHS mandate of new operating rules was clear and consistent and resulted in federal mandate of eligibility and benefits, claim status, an EFT and ERA Operating Rules.

The effectiveness of this process led to the recommendation and affirmation of CORE as a designated operating rule authoring entity for the remaining HIPAA transactions by NCVHS and HHS respectively.

As the industry progressed into the late 2010s, regulatory hurdles slowed progress and new business cases and technology emerged. During this timeframe, NCVHS observed variable implementation of standards and operating rules. And the committee developed comprehensive recommendations to drive interoperability, including for standards and operating rules to be more predictable, have demonstrable ROI and support industry coalescence around new technologies.

Operating rules continue to be recognized as an important driver of automation, but proposals were only recommended for voluntary implementation until they could better align with the items I just noted.

Really, in reflection, we really appreciate the candor of NCVHS' recommendations meant to align our operating rules with current business needs and standards. It really led us to evaluate and strengthen our proposals to ensure industry expectations were met.

The rules – forward today represent upfront appraisals of ROI infrastructure and data content requirements that meet current and emerging needs and close automation gaps and meticulously design support for the newly-proposed attachment standards. These rules are the product of a rigorous, collaborative, consensus-based process, which I will now briefly review.

The CORE Rule Development Process begins with extensive research to identify opportunities, leading to broad participant engagement through countless workgroup calls, straw polls, and ballots to confirm targets. The CORE team really goes the extra mile to ensure broad engagement.

And finally, all participant votes solidify support from implementer organizations prior to being passed on to the CORE Board for final approval. Our workgroups are chaired by diverse industry leaders who bring technical, operational, and business perspectives to the rule development process.

The currently proposed rule set engaged over 140 organizations across a two-and-a-half-year timeframe with each rule receiving no less than 88 percent in the final all-participant vote. Each proposed rule received unanimous support from the CORE Board.

Not only do these highly supported proposed rules meet all the requirements of operating rules as defined by HIPAA, but the rules also comprehensively address past feedback and guidance from NCVHS by reducing burden, modernizing requirements, and addressing current business scenarios. They also provide timely support for the uniform implementation of proposed attachment standards.

We will now walk you through the high-level requirements and predicted benefit and impact of the operation rules. The data we share is informed by the CAQH Index, impact and cost benefit assessments conducted by the CORE Board organizations at the end of last year, analysis from early adopters of the proposed rules.

As we present, I ask you to keep the following industry feedback in mind. Across the board, industry representatives consider implementation of this proposed rule set to be of high value. The resources required for implementation vary by rule and can be significant but do not add operating costs beyond implementation.

An implementation timeframe aligns with the typical regulatory conformance deadlines, meaning that industry would be well equipped to meet conformance deadlines within the standards two-year cycle.

Let us begin with the updated Connectivity Rule Version 4. I first want to just clear something up from earlier this morning. The Phase I and II CORE Connectivity Rules are currently federally mandated. These rules are specifically named in HIPAA, not just referenced by the Infrastructure Rules. There is precedent for including connectivity under HIPAA. Organizations continue to maintain some of the outdated protocols in the Phase I and II CORE Connectivity Rules simply for compliance reasons right now.

Our Connectivity Subgroups specifically saw it to connect and align our work with the ONC FAST Taskforce, in particular, to support the multiple standards anticipated to be proposed for attachments.

While I will not read every item included here, I wanted to – you to several key improvements. Updated security standards referencing OAuth 2.0 and digital certification represent modern, technical best practices for the exchange of information and reduce reliance on outmoded technical methods like username and password authentication. Several updates such as those made to error codes and new references to the X12 Version 6020 ensure alignment with current technologies and business scenarios.

Lastly and perhaps most important, Version 4 adds support for REST protocols, empowering the use of APIs for the exchange of health information and alignment with national objectives.

It is important to note here that the CORE participants unanimously voted to support these updated requirements. Building on prior implementations, our industry partners predict a relatively low cost and time burden to implement the updated requirements and believe that changes carry a relatively high value.

Tangible benefits such as the expansion of available trading partners, security updates, and maintenance of safe harbor requirements are well accepted by our industry partners and contribute to a high-value implementation.

Reported costs and time to implementation are relatively modest, not exceeding $350,000 or 12 months and are primarily shouldered by health plan and vendor implementers, given they were required to support both SOAP and REST while providers have a choice. Implementation is not expected to add to day-to-day operational costs.

What do these changes look like in practice? Under the currently mandated version of connectivity, health plans and vendors are required to maintain SOAP and MiME methods, plus accommodate mutually agreeable connections. The updates eliminate MiME, which has become outdated and requires support for REST protocols.

These changes empower provider choice of how information is exchanged, allowing them to specifically request the exchange information, using EDI or through API formats while maintaining the ability to exchange, using other secure, mutually agreeable methods such as SFTP, using the safe harbor provision.

Let us take a look at the updated infrastructure requirements. In addition to modernizing connectivity requirements, the infrastructure updates align the template for the Master Companion Guide with non-5010 versions of the X12 standard. This promotes flexibility as NCVHS and HHS consider updates to standards and CMS references newer versions of standards and proposed rulemaking.

Additionally, system availability requirements are updated from 86 percent to 90 percent per calendar week for systems conducting eligibility and benefits and claim status transactions, helping ensure platform availability during off hours and weekends.

It is interesting. Four percent does not sound like a tremendous increase. But the result is an additional 364 hours of system up-time annually, an hour a day, without sacrificing a health plan's ability to accommodate larger system improvements or maintenance. Couldn't we all use an extra hour each day?

I remember when these rules were being discussed. Our provider partners and even our board felt really strongly. We can get to 95, 99 percent. But the discussions in our workgroups helped us understand that health plan systems, in particular, are much more complex than they were ten years ago. There is dependency across systems that did not exist ten years ago. This compromised to allow 24 hours of additional quarterly system downtime and really accommodates the need for these larger system migrations and mitigations.

In practice, universal adoption of the infrastructure requirements for system availability and connectivity essentially creates a new floor for industry expectations.

In our impact and cost-benefit assessment findings, most sophisticated stakeholders reported already meeting 90 percent availability requirements and have committed to conforming with the updated connectivity requirements.

They are able to achieve those through relatively modest resource devotion and recognize how these changes contribute to realizing an estimated 14-billion-dollar savings opportunity associated with the full automation of claim status and eligibility and benefit transactions across industry according to the CAQH Index.

They do caution, however, that these requirements are not yet universally implemented. These requirements will bring laggard organizations up to the industry standard and create that new floor to better support the 24/7 nature of health care.

Let us now turn away from the connectivity and infrastructure rules and into the eligibility update. I am going to pass it over to the immediate past-chair of the CORE Board, Tim Kaja, to walk us through the updates and impact of the Eligibility and Benefits Data Content Operating Rules.

Tim Kaja: Great. Thanks, Erin. I appreciate that. Interestingly enough, I testified before the NCVHS on behalf of United Health Care back in 2011 when the Eligibility and Benefits Operating Rules were first considered for federal mandate a long time ago. But at that time, I expressed UHC strong support for the rules and I am pleased to sit here before you today once again to speak in their favor.

In fact, I recognize a couple of the names here. At the time, I testified that the EDI data, the 510 transactions that were coming in at the time – it really did not make much sense without the operating rules deployed behind them. The variability that gets added to the industry absent the operating rules really makes the transaction processing piece of this untenable. Nearly all the value at the time, at least the way we calculated it, was locked up by the operating rules. You will hear similar sentiments from me here again today.

You might be doing the math and say 2011 was 12 years ago. It is important to state that explicitly because we all know that the health care industry has evolved significantly since then. The current mandated version of the Eligibility and Benefits Data Content Rule is really no longer an alignment with this evolution and needs to be updated.

The updates that I am going to present today represent top-priority items, identified across CORE participating organizations and include the growing complexity of benefit designs and the need to automate prior authorization requirements along with the use of telehealth, which has been driven, as you all know, from the pandemic.

Specifically, these updates add new discretionary and mandatory service type codes including dental for a total of 178 service type codes, which means that providers will receive a wealth of additional coverage details and patient financial information in real time like co-pay, deductible, co-insurance, et cetera, for these services in the eligibility response.

They require specific coding to indicate if telehealth is covered. They require the return of maximum and remaining benefit data for critical services like PT and OT. They require the return of eligibility and benefit information at the procedure code level for PT, OT, surgery, and imaging. And they require plans to indicate prior authorization is required at the service type code and procedure code levels. They also support the inclusion of detailed information for tiered benefit coverage.

Additionally, by leveraging the Eligibility and Benefits transaction, CORE has also addressed the growth and adoption of value-based payment models in the single patient attribution rule, which provides detail on a patient's attribution status in real time.

Let us talk about the impact of federally mandating these eligibility data content requirements. I shared some of the tangible benefits of these updates in my introduction, but I want to further highlight the alignment this rule has with regulatory priorities such as the No Surprises Act for its ability to automate the return of very granular coverage detail. This will allow providers to determine if a service is not required and, as required under the No Surprises Act, issue a good faith estimate for self-paid care, addressing the currently unmet business need related to the No Surprises Act implementation.

As for reported implementation burden, resources required to conform to this are fairly significant but manageable. In the context of the efficiencies that are gained, predicted costs for a regional health plan are just north of $2 million over a two-year period, which is a capital investment that would require likely high-level approval in the plan but one that would likely also be approved when considered against the value it adds by reducing phone calls, claim appeals, et cetera.

Current workflows for eligibility verification are complex and would require significant staff time to manage more so today. Through this upfront capital investment, we can close automation gaps and limit the resources necessary to manage eligibility verifications. This investment is then offset by about a 60 percent decrease in annual maintenance costs and an 80 percent reduction in eligibility-related call center volume associated with the new service type codes.

The plans anticipate a reduction commensurate of ongoing FTEs with the automation with implementation of the eligibility updates. The value of these updates are inherent both from a time and cost perspective as well as through their ability to streamline communication at the point of care, contributing to a more positive experience for providers, health plans, and patients alike.

Our next slide speaks to the ROI of these requirements for an overall industry perspective. I was talking specifically about just a health plan level. According to the CAQH Index and CORE certification data, over $55 billion have been saved from incremental improvements to automation since the Operating Rules were first federally mandated in 2013. Approximately one-third of this total is attributable to the operation rule implementation with eligibility and benefit transactions accounting for about 70 percent of that.

The industry currently conducts more than 18 billion eligibility transactions annually. Given this high volume, there still is an opportunity to save more than $10 billion annually by automating the last 11 percent of eligibility transactions that are not electronic today.

Prior to the pandemic, there was an $8.64 per transaction cost savings opportunity for eligibility transactions, which were primarily related to complex benefit designs associated with benefit limits, tiered benefits, procedure-level code details and the like.

During the pandemic, the introduction of telehealth drove the cost savings opportunity for eligibility up to $15.09 per transaction. The Eligibility Rule updates proposed today purposefully address each of these items.

Additionally, recent supplemental data collected via the CAQH Index further supports the value of the proposed Single Patient Attribution Rule. The research found that providers receiving attribution information via the eligibility transaction reported identification of attributed patients took seconds compared to the one to three hours to find attributed patients using other methods. Clearly, the proposed eligibility rule updates stand to save our industry significant time and cost.

But before we move on, let us just look at a real-world example. Under the current standard and operating rule requirements where a provider confirms telehealth eligibility for a request service, they have to call the health plan today or log into a portal regardless of whether the eligibility inquiry indicated it was covered.

If the updated rule requirements are mandated, health plans would be required to return to CMS Place of Service codes for telehealth. Remember from the last slide in 2020, telehealth was responsible for driving up the cost of manual and partially manual eligibility transactions by an additional $6.45 per transaction. Electronic access to this information in real time would be a real game changer.

Finally, I would also like to raise the addition of automating the return of prior authorization requirements via the eligibility transaction. Commercial health plan benefit design has become more complex and among other changes, requirements for prior authorization are becoming more common at the very specific patient, provider, and procedure code levels. I think we have all experienced that in addition to where services are actually performed.

This eligibility update has significant implications for health care operations, empowering providers and patients to receive greater detail about their benefits and prior authorization requirements before or at the point of care.

It is also complementary to the recently proposed look-up tools included in the electronic prior authorization regulation, which may not be patient and/or provider specific.

I would like to turn things over now to our current CAQH CORE Board Chair Linda Reed to discuss the proposed Attachment Operating Rules.

Linda Reed: Thank you, Tim. I am really excited to share today with you the benefit of the CAQH CORE Attachment Operating Rules for claims and prior authorizations. As a representative of a safety net health care provider, I can tell you that automating today's very burdensome manual

transaction translates into more patient care time. Today, I would really like to review why these rules are so critical for the implementation of the newly proposed standards.

First, the operating rules are specifically designed to be standard agonistic in anticipation that the proposed rule would reference multiple standards. The rules support both the X12 275 and the HL7 C-CDA among other standards.

Second, the rules follow past recommendations from NCVHS and HHS, aligning their content with long understood best practices for attachment data content and infrastructure.

Third, I would also like to highlight that the proposed rules recognize the role of operating rules and explicitly names the proposed rules and the current review process. Additionally, CMS has also publicly stated that operating rules can be considered for simultaneous adoption with the standards in the final rule.

Together, all of these points really outline a foundational case for the critical role of operating rules in the adoption of attachment standards and establish that they align with current industry and regulatory priorities.

With regard to specific recommendations, the infrastructure rules for prior authorization and claim attachments carry forward best practices requirements for system availability, connectivity, and acknowledgements and establish a maximum and minimum file size of 64 megabytes. This creates baseline assurances for consistent data exchange across the named standards.

The Attachment Data Content Rules also support standard agonistic SOAP and REST headers and include the requirements to aid in the re-association of these attachments with the claim or prior authorization transaction.

The operating rules have clear benefit to the industry by reducing costly back and forth communication. It provides uniformity too but does not replace the multiple formats used in the current exchanges. It aligns administrative and clinical language through the inclusion of LOINC.

Similar to the eligibility and benefits, resources for implementation are not insignificant. By most estimates, this project would cost a health plan slightly more than $2 million and it would take about two years for implementation of both attachment standards and the operating rules.

These costs would be all set, however, by a significant decrease in annual maintenance costs and reductio in attachments-related call center and facts volume. Fifty percent and 40 percent respectively for one plan.

Additionally, if mandated implementation dates for attachment standards and operating rules are aligned, organizations will be able to optimize their investments by doing a single implementation effort versus two separate efforts.

Given that 80 percent of attachments are conducted manually or via portal, the industry is predictably very excited about the prospect of attachment standards. My organization, like countless others, would be able to re-allocate vital human resources in the current environment that are very hard to come by towards patient care versus these countless hours of sending and receiving transactions manually.

As an example, our early implementer, using the X12 275 standards with the Attachment Operating Rules, is already showing promising results and is projected to save approximately $300,000 on an initial round of just 76,000 attachments over eight months.

I have alluded to the workflows generally, but I would like to get a little more specific on the next slide. Displayed across the top of this slide is a diagram depicting the attachment workflow, using the proposed X12 275 and HL7 C-CDA standards. Even with defined standards, a number of barriers are encountered throughout the process. These include unclear submission requirements, varying acknowledgement timeframes, system availability, and attachment de-association or rejections and requests for additional information among other complications.

The proposed operating rules effectively combat these barriers. While I have not touched on every single barrier and requirement, but the point I am trying to make is that the operating rules have been designed to address the most common pitfalls within this burdensome workflow.

On a final point, I would like to note that we respect the comments submitted by the standards organizations and the value of the proposed attachment standards. However, the CORE Board feels that with the potential of two named attachment standards, the operating rules are critical to maximize the effectiveness of the standards and minimize variation. This is the first time CMS has proposed more than one standard for the same transaction under HIPAA.

The proposed operating rules serve to unify the proposed standards and create a common set of rules of the road. We have the opportunity to act now to avoid any potential variation in the two new standards that the two new standards may cause by ensuring operating rules are implemented along with those standards.

Thank you very much. Now, I would like to turn it back to Erin.

Erin Weber: Thanks, Linda. Today, we have seen a comprehensive overview of the proposed operating rule requirements, their impacts, and their alignment with national interoperability goals. Throughout, we have illustrated the three key points that I shared at the beginning. First, operating rules are a proven, industry-developed tool for driving automation across health care business processes and are required for standard transactions under HIPAA.

Second, updates to the existing operating rules must be adopted to modernize and align requirements with advancements in health care since first mandated.

And third, we urge NCVHS to recommend inclusion of the Attachment Operating Rules in the final rule for the attachment standards. This is a rare opportunity to ensure robust electronic adoption and uniform implementation across industry.

These rules are built out of consensus. They align with current priorities and demonstrate innate value through the establishment of best practices and operational efficiencies.

In light of these arguments, I, on behalf of the CORE Board, ask NCVHS to unequivocally recommend the full set of proposed new and updated CAQH CORE Operating Rules for federal adoption to HHS. These rules represent a once-in-a-career opportunity to actively influence industry progress and provide a stable foundation for implementation of the landmark attachment standards.

Thank you so much for your time and attention today and for inviting us to present during this important process. Next, Linda, Tim, and I would love to hear your thoughts and comments on our presentation as well as answer any questions you might have.

Denise Love: Thank you to your board members and thank you for all the work put into these proposed operating rules. This is the time. We have some time, Subcommittee, for our own questions. I do not see any raised hands. That gives me the liberty to ask my own. I am not going to ask it of you. Is Dan Kalwa on the line?

Daniel Kalwa: Yes. I am still here.

Denise Love: Help me out, Dan, because I need some help. You have the proposed rules for attachments and prior authorizations. What is the policy or practice of adopting operating rules in the final rule if they are not included in the NPRM?

Daniel Kalwa: I think the best way for me to answer that would be I cannot comment on whether or not they would be. But I can say that it would require a recommendation from NCVHS.

Denise Love: Okay.

Daniel Kalwa: We cannot get around that requirement. Absent a recommendation from your board, that would not be an option.

Denise Love: Okay. That helps.

Are there any – I see Rich's hand up.

Rich Landen: I have a clarification question for Erin. Erin, if you could go back to your slide 12.

Erin Weber: The infrastructure requirements.

Rich Landen: The bottom line, the companion guides, the existing requirements. Can you talk a little bit more? I do not understand what really is changing between the existing requirements and the third column where you have requirements for a proposed mandate.

Erin Weber: The current CORE Master Companion Guide specifically references Version 5010 of the X12 Standards. The only change in the Companion Guide is to make it version agonistic. Rather than saying Version 5010, an implementer using the Companion Guide could say Version 6020, for example. That change was made in particular because the Attachment Operating Rules work with Version 6020 of the 275 transactions. It allows for flexibility in terms of the version of the X12 standard being referenced.

Rich Landen: Thank you. It was not clear to me when you went through it.

Denise Love: Jamie, I see your hand up.

Jamie Ferguson: Could you put the slides back up? I want to go back to – I think it was two slides before the one you were just showing. This is a question about security. I noticed here on the Envelope Metadata, you have SHA-1 as the secure hash algorithm. But SHA-1 actually was retired by NIST, fully retired last year. I think also ONC probably five years ago required SHA-2 in certified provider systems so providers who were using this Connectivity Rule to provide attachments or other things would not be able to use SHA-1. Could you just tell me why SHA-1 is in there?

Erin Weber: Thank you for that question. I appreciate you bringing it up. I will ask my colleague, Bob Bowman, who is our technical expert to respond. But I believe the rule says you can use SHA-1 or higher. Organizations are able to use SHA-2, given that that is the more current standard.

Bob Bowman: This is Bob Bowman. That is correct. We reference usually a base standard and its future iterations. This connectivity rule was written about two years ago. It may just be because of that lapse in time between its original publication and the edits that need to take place because of this current – I am sorry – because of NIST's recent activity. The reference should here on this slide be add SHA-1 or higher for the Checksum.

Jamie Ferguson: Thanks.

Denise Love: We have time for more questions or clarifications. I might take the liberty of asking Tim – a little deeper into the attribution rule, I see some real value as we move to value-based purchasing. But how does it affect payers who are not deep in the value-based purchasing mode at this time?

Tim Kaja: I would again probably defer back to Erin and Bob on this one but specifically around the requirement for use in every transaction, particularly if we are not in a value-based environment.

Erin Weber: That is correct. The rule only applies when there is an attribution model being used with that patient; otherwise, the rule does not apply.

Denise Love: Okay. That helps me. Thank you.

Any other comments or questions? Last call for the Subcommittee.

Margaret Skurka: This is Margaret Skurka. I just wanted to say thank you to these two presenters. They talked through their slides. They did not read them. And as a long-time educator myself, I get annoyed when people are reading their slides. I got good kernels of information from both Erin and Dan because of how they presented besides what they presented.

Denise Love: Thank you, Margaret.

I see Rich's hand up. And Tammy Banks then after Rich.

Rich Landen: I was trying to think through the implications of labeling the operating rules as standards agnostic, not because that it not a good idea but because under our scope, operating rules for adoption under HIPAA can only apply to transactions or implementation guides/implementation specifications that had been adopted under HIPAA. That limits them pretty much exclusively to X12. The conversation about applicability to the Health Level Seven and to the attachments in general is going to be one for some very good discussion among the Subcommittee members. And I am hoping others later today, will comment on that, particularly the SDOs, who are going to be speaking.

But my fundamental assumption is it is not within NCVHS' purview to make any recommendation for an operating rule that would apply to anything other than the X12 standards that have already been adopted under HIPAA for which there are operating rules. That is just a comment mainly focused at setting some discussion for the Subcommittee members in our deliberations after the hearing.

Erin Weber: I just respond to that only by saying CMS has proposed the C-CDA as the HIPAA standard as well for attachments. That is a non-X12 standard, but it would become a HIPAA-mandated transaction, which requires operating rules. But agree with your point otherwise. All the HIPAA standards right now are X12 standards and therefore the operating rules would only apply to the X12 components of those rules.

Denise Love: Tammy, I see your hand up.

Tammy Banks: Just adding on to Rich's comment, I think we have to – NCPDP includes the – the implementation guide includes the operating rules within it and I do not think we have had that conversation about HL7, their approach to their implementation guide. That will be a conversation point moving forward.

But in light of that conversation that needs to have, Erin, can you speak to the collaboration between HL7 since you were bringing this forward for their implementation guide as well as X12 and how you see the operating rules informing the next version of the standards, especially since X12 has brought forward a standard?

Erin Weber: Yes, absolutely. I just want to point out also that the CCD+, the EFT standard, is also a non-X12 standard that is mandated under HIPAA, back to Rich's previous point.

In terms of how we work with work with HL7 and X12, both organizations are set as advisors on the CORE board, so Cathy Sheppard and Viet Nguyen are both the representatives on the CORE board. They are regularly hearing updates on the work that we are conducting.

We also make a really big effort to engage across organizations and leadership that are working on the standards and the operating rules. For example, if you look at that list of co-chairs that we work with for our subgroups, you will see many of them are also co-chairs and leaders in X12. For example, the eligibility co-chair also co-chaired our eligibility update. Our connectivity co-chair also works on the FHIR taskforce for ONC and HL7. We try when we can to thread that needle to make sure that there is alignment across the work that we do.

I would also point out that as standards are updated, we understand the definition. Operating rules do not conflict or repeat with what is in a standard. For example, when we move from 4010 to 5010, we conducted a review of the operating rules and removed any requirements that had been adopted by the newer version of the standard. That would be the same process we would take moving forward if a new version were to be updated of any of the HIPAA-mandated standards.

Denise Love: Erin, how long in theory would a process to review take for CORE to do such an analysis?

Erin Weber: We engage with the standards development organizations. We understand what is included in the updated versions and have a good sense of the level of work. It depends. But typically, we can do it within a couple of months. It is a fairly straightforward analysis and presentation. If there are substantive updates, then we work with our participating organizations to make sure everyone is in agreement. But the fact is we cannot repeat or duplicate what is in the standards, so we have to take that information out for the operating rules to be within their definition.

Denise Love: Thank you. Tammy, is your hand up or just not down?

Tammy Banks: Just not down. Thank you.

Denise Love: We are doing really well on time. We caught up. I think we can move on to the next agenda item. I want to thank the CAQH CORE group for a good presentation. It helps us understand what you are moving forward, and we will move on to WEDI and receive feedback

from the survey. Rob Tennant will be presenting for WEDI. And thank you, all. I hope you can hang out.

Advisory Committee Report on Member Survey and Position Advisory Event Outcome

Robert Tennant: Thank you, Denise. Again, thank you to the Standards Subcommittee for inviting WEDI to present. I am Rob Tennant, VP Federal Affairs for WEDI.

Again, for those that are not familiar with our organization, we were formed by the US Department of Health and Human Service Secretary, Dr. Louis Sullivan, back in the early '90s where he invited leading health care stakeholders to come together to find ways to make health care data exchange more efficient and more secure. That led to WEDI developing a number of reports, which were then turned into legislative language, which made its way into the Health Insurance Portability and Accountability Act of 1996, better known as HIPAA. WEDI was named in HIPAA as an advisor to HHS and we have performed that role ever since.

We are a multi-stakeholder organization with health plans, providers, vendors, standards development organizations, and state and federal government. In fact, we have both CMS and ONC on our Board of Directors and we have all of the SDOs. We have CAQH CORE. We have HL7, X12, NCPDP, and ADA, all serve on our Board of Directors.

The vast majority of our work though is conducted through our workgroups/task groups, sub-workgroups. We do have both claims and remittance advice and payment sub-workgroups. They were instrumental in helping us understand the impact of these proposals on the industry. Our roles are of course to convene, to collaborate, to educate, and influence. I did want to recognize the wonderful partnership between WEDI and NCVHS. We really enjoyed working with you in understanding the impact of both the X12 and the CAQH CORE proposals on the industry.

We do have a Member Position Advisory of MPA process that we put into place. Whenever the government or a quasi-government body releases a proposal, a proposed rule, a request for comment, that sort of thing, it allows us to pull our membership together to understand the impact of the proposals and then advise our Board of Directors as it develops the official response from WEDI. In this case, it was the NCVHS request for comment where we gathered our team together to address the questions raised in the RFC.

We have three opportunities to gain input from the membership. One is through our workgroup and sub-workgroup discussions. The next is we hosted a four-hour virtual event on November 9. We had 75 WEDI members from all different stakeholder groups participate and share their perspectives, not just on the questions raised by NCVHS but also on some of the key implementation issues. Throughout the four hours, we conducted polls and will discuss some of the results of those polls today.

As well, we conducted a survey between September 28 and October 27 of last year. We received 58 responses. Again, as I said yesterday, we do not represent our MPA process nor the

survey as necessarily a scientific explanation of the perspectives of stakeholders but rather this is what we consider a snapshot of the industry and in particular, a snapshot of the perspectives from the WEDI membership.

With that caveat, we can go to the next slide and start talking about some of the results. I think it is important to recognize many of the survey respondents and were already members of CAQH CORE and they participated in the development of these updated new operating rules, about 40 percent. Another 20 percent plus had reviewed them. About 30 percent were not overly aware of the operating rules. We have to keep that in mind as we review the results of the survey.

We broke it down by the different rules. I will walk through the results from our survey. With the Connectivity Rule, we asked about their support and whether or not they agreed or disagreed with statements. The first one – 35 percent agreed or strongly agreed that the operating rules will reduce cost, enhance utility, and improve quality of care. Twenty-two percent said unsure. And 38 percent neither disagreed nor agreed.

As we walk through the results of our survey and our MPA polls, I think there are a lot of stakeholders that are not sure exactly what the impact will be. But I think as we will see, there is a fair amount of support for the operating rules.

Forty-six percent responded agreed or strongly agreed that the operating rules take an important step towards standardizing operational challenges within value-based payment models. Fifteen percent were unsure and 23 percent neither disagreed nor agreed.

In terms of the operating rules laying the foundation for creating common expectations to enhance the exchange of attachments to drive electronic adoption, 53 percent strongly agreed, 18 percent unsure, and 20 percent neither disagreed nor agreed.

We had a couple more questions. One was would they agree or not with the statement, this update to existing federally mandated rules will respond to immediate industry need to align requirements with current and emerging business, operational, security, and connectivity best practices. Fifty-eight percent strongly agreed. And 15 percent unsure and 18 percent neither disagreed nor agreed.

Finally, these operating rules laid the foundation for creating common expectations to enhance the exchange of attachments to drive electronic adoption. Almost 60 percent, 58 percent responded agreed or strongly agreed, 15 percent stating unsure, and 18 percent neither disagreed nor agreed.

A final one I will talk about is an additional poll we conducted during our MPA event and asking the overall benefits to the Connectivity Rule. Sixty-two percent answered that there would be significant or somewhat improved benefits. Fifteen percent replied no change in benefits, 4 percent saying somewhat decrease benefits, 4 percent saying significant decrease in benefits, and 15 percent stated do not know.

We will switch to the Infrastructure Operating Rules. Again, 36 percent responded agreed or strongly agreed that the operating rules will reduce cost, enhance utility, and improve quality of care. Thirty-nine percent agreed or strongly agreed that the operating rules take a very important step to standardized operational challenges within value-based payment models with 21 percent saying unsure and 21 percent not agreeing or disagreeing.

We also asked of the Infrastructure Operating Rule, would this update respond to immediate industry need to align requirements with current and emerging business operational, security, and connectivity best practices. Fifty-four percent agree or strongly agreed, 12 percent unsure, 21 percent neither disagreed nor agreed. Again, with the operating rules lay their foundation for creating common expectations to enhance the exchange of attachments, 56 percent agreed or strongly agreed, 15 percent were unsure and 15 percent neither disagreed nor agreed.

Again, we asked the overall benefits to the Infrastructure Operating Rules that are MPA event. Sixty-five percent said there would be significant or somewhat improved benefits. Thirteen percent indicated no change in benefits and 22 percent said do not know.

Switching to the Eligibility and Benefits Data Content Operating Rule. Again, 39 percent stated that the operating rule takes an important step to standardize operational challenges within value-based programs. Thirty-nine percent say that the operating rule will reduce cost, enhance utility, and improve quality of care. Fifty-four percent agreed or strongly agreed that the update to the existing mandated rules will respond to immediate industry needs to align requirements within current and emerging business operational, security, and connectivity best practices. Fifty-four percent stated that they strongly agreed or agreed that the operating rules lay the foundation for creating common expectations to enhance the exchange of attachments with 12 percent saying unsure and 21 percent neither agreeing nor disagreeing.

A couple more. We have the MPA poll asking to rate the level of potential improvement in efficiency that these Eligibility and Benefits Operating Rules would contribute to your organization. Forty-seven percent said there would be significant improvement or improvement in efficiency. Thirty percent indicated no change, 7 percent suggested decreased efficiency, and 17 percent stated do not know.

When asked to rate the level of potential benefits to value-based payments that would be associated with the new operating rules, 39 percent answered significant or somewhat improved benefits, 12 percent no change, 8 percent significant decrease in benefits and quite substantial 42 percent saying no opinion.

In terms of the Patient Attribution Data Content Rule, this got the lowest support of all of the proposed operating rules. I think that some of the issues came out in the last panel. But 27 percent stated that the operating rules will reduce cost, enhance utility, and improve quality of care where 27 percent said unsure and 30 percent neither agreed or disagreed.

Thirty-three percent agreed or strongly agreed that the rules would respond to immediate industry need to align requirements with current and emerging business, operational, security,

and connectivity best practices. Again, one-third said that the operating rules take an important step to standardize operational challenges within value-based payment models with 27 percent saying unsure and 27 percent neither agreeing nor disagreeing.

Thirty-six percent said that they lay the foundation for attachments with again 27 percent saying unsure and 21 percent neither agreeing nor disagreeing.

In terms of discussion on the Patient Attribution, I think we found that very few stakeholders have completed an analysis to really understand the value of this particular operating rule. I think it came out in the questions last panel that not all health plans are engaged with value-based care contracting. There may be a limit to the potential value. However, there was discussion that this rule is directionally correct. Although it may be a little ahead of the industry in terms of value-based purchasing, I think more and more health plans are moving to these models and therefore are looking for opportunities to improve data flow. I guess we would argue that I think these types of attribution rules should be explored for their potential benefit in the future.

Switching to the Attachments Operating Rules, 30 percent agreed or strongly agreed that these operating rules take an important step to standardize operational challenges within VBP models. Thirty-nine percent say that they would reduce cost, enhance utility, and improve quality of care.

Forty-two percent saying that they would respond to immediate industry need to align requirements and 45 percent said that they lay the foundation for creating common expectations to improve attachments with 15 percent saying unsure and 27 percent saying neither disagreed nor agreed.

Again, we asked our MPA participants to rate the level of potential benefits associated with the new Attachments Operating Rules. Fifty-five percent said that there would be significant or somewhat improved benefits. Very low percent said that there would be no benefits and 39 percent said that they do not know. I will say that it is important to remember that this poll and our survey was conducted prior to CMS releasing the proposed rule on attachments. Things could have changed dramatically had we done this after the rule was released.

And very important – we asked about whether or not the new Attachments Operating Rules should be mandated at the same time as the 275 Transaction Standard. Again, this was done prior to the rule actually coming out. You all can see here a pretty strong majority agreed or strongly agreed that they should come out at the same time. Twelve percent neither agreed nor disagreed with only six percent opposing.

I will say that during the conversation, during the event, many of the participants saw clear value in moving forward with an attachment standard and the supporting operating rules at the same time. Arguing that this could shorten the overall implementation process they said perhaps by a year or more and assist organizations as they try to scrounge up their resources both human and financial, necessary to implement these rules.

We asked overall, should WEDI recommend adoption of the operating rules with 32 percent saying yes, all of the operating rules, 20 percent saying all except the Attachments Operating Rule mainly because there was not a standard in place. I think those numbers would change dramatically. Only 20 percent said no, we should not recommend moving forward. And 28 percent said do not know.

With that, I just want to thank you again for the opportunity both to present today but also for the opportunity to collaborate closely with NCVHS. We greatly appreciate the close partnership.

Denise Love: Thank you, Rob. This partnership with WEDI is very helpful to the Subcommittee, recognizing that it is a snapshot of Quarter 4 of 2022. I think the most valuable thing perhaps was elevating the issues and the conversation across industry and getting those conversations going. I would imagine, as you said, some of those results might change if we were to conduct a similar survey in Quarter 1 or 2 of 2023.

Are there any questions or comments from the Subcommittee of Rob that you might have? Rich.

Rich Landen: Rob, thank you and WEDI very much for this. There was a lot of heavy lifting in there and a lot of the information that we were trying to get at was quite the challenge to really obtain. So kudos to WEDI and its members for completing the survey and the MPA.

I just have a technical question. I noticed in a lot of your summaries of the tallies that the percentages did not add to 100. I am wondering what is missing. There were categories for agree or strongly disagree, for unsure, and neither agree nor disagree. But there did not seem to be a category for disagree. Were the differences between the sum of the percentages reported in 100 – were those just non-respondents or were those disagrees or what were those?

Robert Tennant: We certainly rounded up to make it a little bit easier – rounded up to make it easier to report them. Any disagrees were included in the report.

Rich Landen: Where? If you want to go back to your Slide 14, we can use that as a case in point.

Rebecca Hines: Can we have Slide 14 up?

Rich Landen: The response highlights. You have 27 and 27 is 54 and 30 is 84. There is 16 percent – that seems too large for a rounding area. There is nothing in there about anybody disagreeing. Is disagreeing is 0 or was it – what is the 16 percent represent?

Robert Tennant: I will have to go back. I apologize. We can resubmit these, making sure that we have captured everything.

Rich Landen: It seems to be fairly consistent throughout all your different slides that the unexplained varies from a couple of percent as much as a little over 20 percent, so what is the missing component? Thanks. We will look forward to getting that.

Denise Love: Rob, this is Denise again. As far as WEDI as an organization, do you have a formal position or are you neutral, providing information? Where does WEDI fall on these proposals both operating rule and/or the standards?

Robert Tennant: I think we should not take a position on whether or not they should go forward. I think what we have tried to do is identify the perspectives from our membership. But as you can see, there is not a 100 percent agreement or disagreement on any of these.

I think one of the key factors that we learned was not everybody fully understands the impact of whether they be the standards or the operating rules. There are a lot of unsures and do not knows, because folks have not conducted analyses. But we did not hear a lot of disagreement with going forward and in particular with the operating rules. There is some unsure and some concern but overall, I would say the majority of our participants and our members support going forward.

Denise Love: Okay. Thank you. Again, as I assume some of that is a timing issue too because we move these questions along fairly, I guess, early in the process. That may be a function of that. We will be interested in learning more going forward.

Any other questions of the Subcommittee of WEDI? Hearing none – Rob, I want to thank you so much for your presentation today and yesterday.

With that, I will move to the net agenda item, which we are going to hear from X12. Again, we will hear from Cathy Sheppard. Today, we will hear in HL7 from Viet Nguyen. Cathy, you are up.

Panel 1: Presentations from Standards Development Organizations and Code Content Committees on CAQH CORE Operating Rules

Cathy Sheppard: Good morning, everyone. I would like to thank NCVHS for inviting us to participate in this panel today. It is always good to make sure that the information that we are providing to the industry is in sync.

As usual, X12 is neutral, related to Connectivity and Infrastructure Operating Rules. As was mentioned earlier, X12 does not address those activities in our implementation guide instructions.

Data Content Operating Rules do directly impact the instructions that we provided X12 implementation guides. But before I speak to the specific recommendations, I really want to do a little bit of level setting so that everybody understands what is going on in the background and sometimes in the foreground between CAQH CORE and X12.

First, we have a very collaborative and mutually supportive relationship between the organizations. We have worked really hard over the past seven or eight years to get in sync with each other and stay in sync so that we can ensure that the implementation guide instructions and the Data Content Operating Rules provide clarity to the industry instead of adding

confusion, which was not always the case. We are proud of that work that we have put in and we think that it is going to continue to bear fruit as we move forward.

Part of that cooperative agreement has already been referenced by Erin today. But I want to make sure that we are clear that we agree. We have effectively transitioned operating rules into new versions of X12's Implementation Guide over the years. The process that both organizations committed to at the beginning has been effective. When an operating rule instruction has made its way into the base implementation guide then that operating rule can go away.

We have done this informally in the past but we have recently agreed to put a little more formality into the transitions so that everyone in the industry understands the processes and how and when they are going to occur. Both organizations look forward to sharing more about that going forward.

X12 and CAQH CORE both received a significant amount of feedback over the past few years, including feedback provided at NCVHS hearings and working sessions. And that feedback indicated that it would be helpful for implementers if there was a more direct connection between X12's Implementation Guide instructions and CAQH CORE's related operating rules.

In response to that feedback, the organizations had some discussions. And what we agreed to is that our X12 Implementation Guides would include links or other callouts to related mandated operating rules so that implementers can see in context when there is something that is explained over both the organizations.

We have begun adding that cross-reference supporting information into the implementation guides and that has been very well received. Similarly, to how we are putting mapping to FHIR resources into our guides, those callouts are considered to be supporting information. If they need to be updated during the time that a particular implementation guide is in use, the updates will appear in our glass versions of those implementation guides so that we can provide that information to the implementation base as soon as possible.

Another thing that we are doing between the organizations is providing webinars that clarify the touch points between X12's EDI standards and implementation guides and CAQH CORE's Operating Rules. And those sessions have been well attended and very well received.

With that background in mind, X12 would like to say today that related to these specific data content rule recommendations, we have had representation with subject matter experts during CORE's development of these operating rules. Our input was given due consideration and we have no objection to these data content recommendations going forward. Just note that those recommendations are based on the content and the instructions, not based on feedback such as the feedback provided by WEDI and other organizations, just about the actual instructions themselves. Thank you.

Denise Love: Thank you, Cathy.

And Viet.

Viet Nguyen: Hello. Thank you. I am Dr. Viet Nguyen. I serve as the Chief Standards Implementation Officer for HL7 International, an ANSI-accredited standards development organization.

On behalf of HL7, I would like to thank the National Committee for Vital and Health Statistics for the opportunity to provide testimony regarding the proposed operating rules.

HL7 automates these clinical workflows by defining syntax and semantics of the information exchange, including requirements for authentication, authorization, and transport. The result is the exchange of data in a secure and reliable fashion. Implementation of HL7 Standards and underlying infrastructure do not require separate operating rules to make them effective and efficient.

HL7 International is a global, nonprofit organization founded in 1987. We are dedicated to providing a comprehensive framework and related standards for the exchange, integration, sharing, and retrieval of electronic health information. We are the developers and the stewards of three product families: FHIR, V3/CDA, and Version 2.

I want to mention that along with our members, we appreciate Congress' support for their ongoing support for FHIR and interoperability over the last three years, including funding contained in the fiscal year 2023 onto the spending bill.

We have members and affiliates in over 50 countries, and they are drawn from the largest health care provider, payer, and vendor organizations in the United States as well as federal agencies, international organizations, individuals, other standard organizations, and industry associations. Our members contribute their wide-ranging and invaluable subject matter expertise and business workflows and technical environments to our standards.

This timeline provides some historical context for my next statements regarding the proposed operating rules. The timeline marks significant events over the past 12 years since the creation of the first version of the Fast Healthcare Interoperability Resources of FHIR standard.

The red boxes highlight significant regulatory events that have been industry drivers in FHIR adoption. HL7 appreciates the leadership and support of the Office of National Coordinator and the Centers for Medicaid and Medicare Services throughout this journey.

On the left-hand side, you see the adjacent taskforce report and subsequent ONC requirements for open APIs provided the initial opportunity to develop and implement an early version of FHIR to provide a common method for patients to access their clinical data. We all carry this capability today in our mobile phones on both iOS and Android.

The ONC's Cures Final Rule in 2020 established FHIR in the US Core Data for interoperability as the foundations for health care interoperability into the future.

ONC rules and FHIR support seamless and secure access, exchange, and use of electronic health information for patients and providers. In 2020, CMS' Patient Access API Final Rule added payer-based data availability to covered patients via FHIR by leveraging the ONC Cures Final Rule and identifying HL7 Da Vinci's FHIR Implementation Guides.

Paraphrasing CMS, we all strive to establish a future where data flows freely and securely between providers, payers, and patients and to achieve truly coordinated care, improved health outcomes, and reduced costs.

As the committee can see, this timeline begins in 2011 with HL7's Fresh Look Taskforce. In 2011, the paradigm for HIPAA Transaction Standards adoption was focused on specifications requiring additional operating rules. Today's CAQH CORE's proposed operating rules reflect that need based on the historical exchange paradigm.

Regarding the proposed CAQH CORE Operating Rules, we ask the committee to refer to our detailed response in the RFC submitted in December. We believe that specifying an operating rule prior to CMS' Final Rule on Attachments would be premature.

Over the past 12 years, HL7 was built upon on its historical standards development process to a more comprehensive standards development life cycle. This life cycle engages the providers, payers, and vendors as well as policymakers throughout the life cycle standards development, an implementation guide development. Industry subject matter experts in business and clinical processes define the transaction and data requirements. They work in collaboration with FHIR experts and technical implementers to apply the FHIR standard to meet these requirements. We build reference implementations and test their feasibility. Most HL7 implementation guides and Da Vinci guides, in particular, are then put through a public, valid, and feedback process that is open to both members and non-members.

Published implementation guides and use case work products are freely available to the public. HL7 provides ongoing to the implementer community through chat.fhir.org, implementer community forums, our connect-a-thons, and other forums.

Most importantly, implementers are encouraged to submit comments or corrections that are addressed by the implementation guide authors and HL7 workgroups. The feedback and corrections are evaluated, discussed with the community in public forums, and incorporated into planned updates of the implementation guides following HL7's rigorous and open process. This process produces implementation guides that are led by and for the industry. The guides include implementation details and guidance necessary, precluding the need for operating rules.

This process has been successfully applied to 14 Da Vinci Implementation Guides and those of other FHIR accelerators, including the FAST FHIR Accelerator. As outlined in red, a number of implementation guides either align with federal regulations, are recommended in proposed rules, or have been identified in CMS final rules.

I would like to draw your attention to the collection of ideas on the top right of the slide. These three guides focus on the prior authorization process and were referenced in the recent CMS NPRM 0057 proposed rule. The prior authorization support implementation guide provides specifications for translation into and out of HIPAA-mandated X12 278 standard. HL7 worked directly with X12 to map the syntax and semantics of the X12 transaction to FHIR in order to accomplish this.

Additionally, the HL7 Da Vinci project members were granted a HIPAA exception to implement the FHIR Prior-Authorization Support Guide in production without this translation.

We appreciate X12 allowing us to use their code sets for testing of our implementation guides. I believe you will hear more from industry regarding their experience.

Health care data interoperability in the US is at a major inflection point. We have the opportunity to improve the care of patients, reduce the burden for clinicians, improve business workflow efficiencies by applying FHIR to use cases that need the most attention. FHIR implementation guides developed by HL7's vigorous processes and HL7 as an ANSI-accredited standards development organization obviate the need for operating rules by providing the information, security, and exchange standards needed by implementers.

Thank you to the Subcommittee for this opportunity and I am happy to take questions when appropriate. Thank you.

Denise Love: Thank you so much, Dr. Nguyen. I will open this up to the Subcommittee for comments or questions. Tammy Banks.

Tammy Banks: First of all, I just want to thank Cathy. I really appreciate the clarification of the work between X12 and CAQH CORE. Obviously, collaboration is what moves us forward. Deeply appreciate that report out.

Viet, I do not know how to ask this question. Pardon my incorrect technical language. I know that when you pass a C-CDA on X12 envelope for the 278 – that is one method and I think that is what we are talking about today with the operating rules. I also know that that envelope can carry FHIR – I think they are called artefacts – can carry different types of attachments as well. I also heard very clear and correct me if I am wrong that HL7 considers operating rules within their FHIR – it still would be implementation guides, correct?

Viet Nguyen: Correct.

Tammy Banks: Can you just walk through recognizing the different types of attachments that can go with these envelopes, and again we are looking at operating rules, how the coordination you see should occur between X12 and its operating rules for its standards and HL7 from the C-CDA and a more innovative FHIR artefacts that could possibly travel with that envelope? Is that a clear question?

Viet Nguyen: I will try to answer as best I can. We are talking about the envelope, or I will say the payload that goes in an attachment. As I understand it from the proposed rule that it is defined by the CDA and C-CDA standards and LOINC. I think that paradigm, creating a CDA record is well understood. It is widely in production. The challenges that the CDA documents are a snapshot in time, which is helpful when you are sending that information. But the paradigm of requesting just documents based on LOINC codes or labs based on LOINC codes is limiting. The transaction of sending the information is not necessarily the problem.

The benefit for the clinicians in a FHIR approach, as we have in our clinical document exchange implementation guide that will be published in the next few weeks, is that it supports both CDA because payers can request documents, but it also allows you to request other items that are available via FHIR and the US CORE FHIR profiles under US CDI. It allows more flexibility, and it allows –- the paradigm allows for the request to either be automatically fulfilled and returned to a payer or reviewed by providers as they desire. That lowers the burden on clinicians to look for, retrieve the data, put it into the RCM system and send it. We are looking for a more seamless process to do that and in the guide we will be having an opportunity for payers to actually do more expressive requests for information. It is not a great metaphor but say sending a form that they need returned because it has specific information and that process aligns well with our other FHIR implementation guides for quality measures, risk adjustment, and prior authorization.

It is using the FHIR paradigm to really lower the burden of identifying the information being requested, gathering that information using automated processes, and then returning that information in real-time APIs in a structured data.

That is, I think, in my opinion and our opinion and HL7 with APIs, is that it has greater flexibility and more opportunities for real-time interactions.

Tammy Banks: You gave clarity, and my intent with that question was I totally understand we are looking at X12 and the operating rules. And the only reason I ask for that clarification is I am wondering what the impact of looking at headers and footers if that would have an impact on the HL7 transactions as well as the movement of the C-CDA with – I call it an envelope.

Viet Nguyen: The creation of the CDA – I think industry has good experience at this point. It just does not have the level of flexibility we believe that more modern API approach would give both payers and providers.

Tammy Banks: Am I hearing that HL7 would support the operating rules tied to the X12 transactions? However, there needs to be flexibility to ensure that the more innovative – help me be clear – the position as we --

Viet Nguyen: As you will see in our RFC response, we are remaining neutral on the X12 paradigm and really encouraging the committee to consider the more modern API paradigms that do not require operating rules.

Tammy Banks: There really is no impact to be concerned with HL7 and the innovation movement with the operating rule as it gains to add standardization and clarity around C-CDA and the envelope exchange of information.

Viet Nguyen: Not specifically for CDA because industry can create the CDA. I think there has been concern raised yesterday and other places in industry about the implications about the breadth of the attachments rule whether it applies narrowly to just claims and claims attachments or other clinical attachments. If we limit ourselves in a way to only being able to use that approach, I think it may limit the opportunities for innovation later and require use of potential exceptions in order to test the innovations. We have some of these in our comments in the RFC.

Tammy Banks: Thank you, Viet. This is helpful. I understand the direction and the cautionary tale that you are providing.

Denise Love: Any other comments or questions from the Subcommittee of X12 or HL7?

Viet Nguyen: Thank you so much for the opportunity.

Denise Love: Thank you very much.

I think, Rebecca, that means we are ahead of schedule but just a little bit. We can go to break.

Rebecca Hines: We get an extra six minutes, and we will be back at 12:45 Eastern Time.

(Lunch Break)

Rebecca Hines: Well Tammy, Denise Love, are we ready to start the afternoon Panel 2?

Denise Love: I think Jamie is going to take The Master of Ceremonies duties for the next panel. Thank you, Jamie.

Panel 2: Presentations from Providers regarding CAQH CORE Proposals

Jamie Ferguson: Good afternoon everybody. In this panel we will hear presentations from the American Hospital Association, American Medical Association, MultiCare Connected Care, and Aspen Dental. And so I think without further ado, Terry, you're up first. Do we have slides for you? Lets get Terry's slides up.

Terrence Cunningham: Good afternoon everybody. My name is Terrence Cunningham, I am Director of Administrative Simplification Policy with the American Hospital Association, and I'm very pleased to be here to discuss the updated CAQH CORE Operating Rules and their application and how we see it for our members.

So today I want to give you a brief overview. My plan is to go through the various changes that these operating rules provide. So I'll go through the infrastructure rules, I'll go through the data

content for eligibility, I'll discuss the new patient attribution process, walk through our thoughts on the companion guide template and the connectivity rule, and then I'll give some perspective on the attachments operating.

So first up is the updated infrastructure rules for the eligibility, claims status, and remittance advice transactions. The AHA is extremely supportive of these updated operating rules, specifically the increased system availability requirements, from 86 to 90 percent per calendar week, is extremely important to our members.

As Erin touched on earlier, healthcare is a 24/7 365 industry. And so the need for systems to support that fact is extremely important. System downtimes frequently are going to lead to treatment disruptions.

And what this means is a provider generally can't schedule care without knowing a patient's coverage eligibility or coverage information, and then this could delay a patient's ability to schedule care and/or in certain cases downstream delay of receipt of care. So the ability to provide that extra hour per week, and the ability to give providers more understanding as to whether or not their patients are eligible and some of the specifics of that eligibility is extremely important.

Another aspect of this is the recently legislated, the No Surprises Act that was passed a couple years ago. As part of the No Surprises Act, eligibility is an essential step. Basically, when you do this price transparency process, you need to figure out is this person covered for this service up front.

And some of the granularity and some of the turnaround times really that are provided by these updates would greatly improve the ability for the providers to meet the tight turnaround times that are part of that regulation. Again, super supportive of this increased availability and decreased downtime for health plan systems.

Additionally, on the data content provisions of eligibility and benefits, we believe there are significant improvements in the quality and granularity of the information given to providers and subsequently to their patients. The four aspects that are really implicated are the ability to get better telemedicine eligibility, the remaining coverage benefits, the tiered benefits, and the procedure level information. All of these are extremely important.

Of particular note, that we've been hearing a lot from some of our members is this telemedicine eligibility. As many of you I'm sure are aware, given some of the changes to healthcare, and really our entire industry and system, over the last few years as a result of public health emergency, there has been a lot of upticks of telemedicine usage.

One of the concerns a lot of our providers have is it's unclear as to know often what services a particular patient might have eligibility for in telemedicine. There is not a standard way of doing this that's spelled out in the existing standardized HIPAA eligibility process. This updated OR does specifically spell out how that would be improved.

Again, this has been something a lot of our members have been scrambling and trying to work with their health plans, and so to have a standardized way of reliably knowing which services a patient can receive telemedicine for is extremely beneficial.

Additionally, the industry is focusing a lot on greater patient cost transparency. And the elimination of imprecise coverage information for patients is part of that. So if a patient needs to know kind of what their eligibility is and really have a better financial understanding as to what their cost of care will be, having such information such as the remaining coverage benefits, their idea of the tiered benefit structure, and procedure level information, is going to be extremely important for those patients. It is going to move the needle and help provide greater cost transparency to our patients.

Next I'll go over the patient attribution that Erin so well covered this morning. The patient attribution effectively improves the ability to identify if a patient you're treating is participating in value-based care. This is a longstanding identified problem for a lot of providers.

Basically, a patient will show up, you go to treat them, but you're not aware at that time when you're developing their care plan if they are part of a value-based care arrangement. And so it is helpful at that time to understand, and to really understand which patients are part of a value-based care plan. So to that extent that would solve an existing issue in our industry.

We will note that value-based care is still extremely limited. This has not necessarily taken a huge impact. So we do expect there to potentially be greater need for additional clarification, greater need for additional standardization around how value-based programs might work down the line, because again as these take more shape then we really see kind of the structure of a lot of these value-based care arrangements, there might be opportunity for additional work on this.

The Companion Guide Templates. I don't have too much to add about what hasn't already been said. But the establishment of applicability across standards is important for the companion guide. This is going to promote greater consistency. You don't want to have a loss of existing standardization of guides upon new versions of standards, or the implication of naming a different version such as the 6020 transaction that's named in the new attachment regulations.

So I think the ability to ensure that these companion guides are going to achieve the same level of standardization and greater uniformity amongst the various versions of companion guides that might exist is important for CAQH standards to apply not just to 5010 but to be able to apply as we move forward to different versions.

The Connectivity Rule. AHA remains super supportive of this rule. This is something we've been supportive of, we actually provided testimony two and a half years ago on this rule. And recognizing that it has been improved to meet specifications that then NCVHS spelled out at that time.

But we remain supportive of the way in which this rule would improve security and streamline the safe harbor methodology across transactions. Again, I think my core colleagues have done a better job of specifically delineating exactly how that occurs, but we remain supportive of the ability to improve security and streamline safe harbors.

The final aspect of the operating rules is the Attachments Operating Rules. I appreciate all the information that came out earlier. There are significant benefits of these Attachments Operating Rules. They establish long-awaited uniformity. As many of us are aware, the industry has not had standardization in attachments, and that has led to inefficient processing for some claims and prior authorizations.

Again, that often, especially in the prior authorization setting, could lead to delays in patient care, because if you can't process prior authorization quickly you can't proceed with care. And it has also led to a large impact on the effectiveness or ineffectiveness of the 278 Standard, because without the ability to consistently send clinical information along there has been a frequent kind of downside of the utility of the 278. And so this would go a long way for that.

Additionally, the rule establishes maximum response times and names an acknowledgment process. Both of these are extremely important because again this is going to speed up the delivery of care and make it more consistent and less resource draining for providers to receive approval to proceed with prescribed patient care.

And finally, we appreciate the ability that it spells out the utilization of LOINCs for the request of information for claims, and it names some of the reassociation specifics. Again, as the attachment rules are named these are important ways of further enhancing those standards.

With the attachments operating rules, we will note that there is not currently an approved HIPAA standard. We've heard this today. Unlike the other transactions we're going to talk about today, this rule would not be creating additional rules to improve an existing standard that is on the books. This is a standard that at the time we provided our comments had not been released, and at the time we're presenting now is only in NRPM form. We did see however that on December 21, HHS did release an electronic attachments standard. And these operating rules apply very well and do a great job of further enhancing that rule.

However, and Viet did a good job discussing this, but we have some concerns about the way in which the Electronic Attachment Standard harmonizes with the prior authorization standard that was released around that same timeframe.

The Prior Authorization Standard, maybe the word conflicts, but it seemingly conflicts or limits the benefits of some of the, the electronic attachment standard seemingly limits some of the benefits that could be derived from the Prior Authorization Rule.

And we think there might be a need for the attachments rule to be further reconsidered or tweaked before it's ready to go into effect. As a result of that we think it might be premature to establish an operating rule for a standard that might be in need of revision.

In conclusion, the AHA recommends that NCVHS approve the following: the Infrastructure Rules, the Eligibility and Benefits Data Content Rule, the Patient Attribution Rule, the Master Companion Guide changes, and the Connectivity Rule.

However, the AHA recommends delaying consideration of the Electronic Attachments Operating Rules until a time in which that transaction can be finalized, particularly because we think there might be a need for further revision of that standard prior to its finalization.

With that, I appreciate your time, I want to thank you for having me today, and welcome any questions from the committee. Thanks.

Jamie Ferguson: Thank you very much. What we will do is we will have a question-and-answer period after all the presentations. So committee members, please take note of your questions for AHA. And thank you for putting the slides up. And I will turn it over to you, Heather. Thank you for joining us today.

Heather McComas: Hi everyone. I am Heather McComas from the American Medical Association. Thank you so much for the invitation to participate in this discussion today. We are very passionate about this topic. I'm sure that most of you in the audience are familiar with the AMA, but just in case we are a national physician membership organization, and we convene over 190 state and specialty medical societies with a unified voice to advocate for the most important healthcare issues we are all facing today. And our mission is to promote the art and science and medicine and the betterment of public health.

And to that end we have long advocated for the adoption of electronic transaction and code set standards and operating rules to reduce administrative burdens on physicians and their staff.

If you talk to any of our physician members, they will say that they did not get into medicine to do paperwork or to conduct revenue cycle transactions. They got into practicing medicine because they care about people, and they want to take care of people and ensure their good health. And so we firmly believe that administrative simplification is an important piece of ensuring that our members can focus on doing what they love, which is taking care of patients.

We also think that administrative simplification is critical, because there is growing evidence connecting practice burdens to clinician burnout and issues with clinician wellbeing.

As others have noted today, operating rules are really important for increasing the consistency and uniformity and the implementation of electronic transactions. And because of this they really maximize the utility of the transactions. I would put it that the operating rules allow transactions to be the best that they can be. They really offer value. Because of this, the AMA has actively participated in the development of all of the CAQH CORE operating rules under consideration today, and overall, we do support adoption of these operating rules under consideration.

So as Erin and Terry and others have noted, healthcare is a 24/7 business, and I don't know if your family is like my family, it seems that healthcare issues in my household pop up in the evening or on weekends. And for that reason, it is really important for physician practices to be able to electronically communicate with health plans whenever care is being provided. And so it is key then that the updated infrastructure rule's increases in availability requirement from 86 percent to 90 percent.

For example, if a patient, I don't know, my husband, trips over a glass table on a Saturday night setting up for his band to rock and roll, and then ends up in urgent care Sunday morning to see if his bruises are serious, if there are broken bones or what have you, it is really important for the urgent care folks to be able to confirm that my husband has health insurance coverage.

And then again, the updated infrastructure rules support this system availability that's needed ensures that patient insurance coverage can be confirmed at any point in time, and as Terry indicated it ensures that patient care will not be delayed by scheduling delays.

I cannot leave this topic however without noting though that the AMA would strongly urge everyone to aim for higher system availability than 90 percent. We would say at least 95 percent system availability is really needed in the healthcare industry.

In our lives I don't think many of us would tolerate 90 percent system availability for banking, or I don't know, visiting our favorite online retailer. So the fact that we're settling for 90 percent is a little troubling to us, but we do fully support adoption of the infrastructure rule, because we really believe it is improving on the current status quo.

So along can needs and also to respond to recent emerging industry trends.

As Terry indicated there has been an explosion in telehealth due to the advent of the COVID-19 pandemic, and so we really need to have information about telehealth coverage and the eligibility response, and also there is an increasing complexity in insurance benefit plan design. So the revised eligibility and benefits data content operating rule adds key information to address these unmet needs.

And it addresses telehealth coverage, which is really important, I think particularly as we are hopefully moving a little bit out of the pandemic, and it's possible that plans might start adjusting the telehealth coverage, it is really important that clinicians can establish that a telehealth visit will be covered by a particular patient's plan before moving forward with scheduling.

As Terry indicated as well, the revised rule would require plans to return maximum benefit limitation information and remaining benefits for specified service types, and also to indicate tier network status and associated benefits.

We think that these additions to the eligibility response increase the value of the transaction, and we would expect that physician practices will increase their adoption of the eligibility

transaction because of this, when practice staff know that they can get these data from the eligibility transaction and do this electronically versus picking up the phone as they do today, they will turn to the 270-271.

I think that's really important for all of us, because all of us want to reduce phone calls because they're very expensive for all of us to manage and ensure staffing to cover the telephone communication.

I think it is important to note that I have two slides on the data content rule, because there is just so much juicy stuff in it. Along with the increasing volume of data, the operating rule would also increase data granularity and specificity in eligibility responses. And this would respond to current administrative burdens related to the No Surprises Act and also prior authorization requirements.

The updated rule requires health plans to provide coverage and patient financial responsibility for an expanded list of service type codes and certain procedure codes. As Terry indicated this would increase healthcare price transparency, which is a really important thing right now in our environment as we all know, and also would allow physician practices to determine if a particular service or procedure is covered by the plan, and if it's not, which means it is essentially going to be self-pay, we'll let the practice know that they need to prepare a good faith estimate for that patient to meet the requirements of the No Surprises Act.

And those of you who know me know that I cannot forsake an opportunity to opine about the need for improved transparency on prior authorization requirements. So I'm also very pleased that the revised data content rule would require health plans to indicate prior authorization requirements for a specified group of service types and procedures, which would take a major step forward in increasing the transparency of health plans' prior authorization requirements, which is something that's really important to us and to our members and patients as well.

So physicians need accurate, timely, and actionable patient information to successfully participate in value-based contracts and other innovative payment models. And we hear a lot of concern from our members right now about the ability to determine if a particular patient is attributed to them under specific value-based contract. And this impacts their ability to succeed and meet new payment models.

The new CAQH CORE Patient Attribution Rule requires health plans to provide patient attribution information in eligibility responses, and that would allow practice to take immediate action based on what they see. They could address a care gap, they could report on a quality measure, or they could contact the plan and say hey, I don't think this patient should be attributed to me, and deal with the issue right there and then, versus at the end of the year when there might be a possible ding on their payment due to the attribution issue.

As such we would argue that this rule really addresses emerging business needs. And as others have said, obviously we are still for the most part largely a fee for service healthcare system, but everyone says we are moving towards this value-based model. So this rule is a really

important part of that, because physicians need this information, and the eligibility response, to ensure that they can succeed in these new payment models.

Physicians also really need to protect the security, accuracy, and integrity of patient health information. This is a matter of liability, it's a matter of trust, and it's a matter of frankly their reputation in our communities and with our patients. And the revised connectivity rules provision supports modernized security authorization and authentication.

Others have mentioned the rule requires TLS 1.2 or higher, it requires digital certification, and OAuth 2.0. It also addresses new and emerging technologies, such as REST and APIs. While it does maintain safe harbor provisions that allow continued use of existing connections with mutual agreement between trading partners.

One other thing I wanted to note here, and I think it's important to point out, in the November 2020 recommendations NCVHS specifically gave CAQH CORE marching orders to enhance the security of their connectivity requirements and to address new and emerging technologies. And that is exactly what CORE has done with this operating rule, so I think that is another reason to support its adoption.

So the AMA along with almost every other stakeholder in the healthcare industry has long advocated for a standard way to electronically communicate supporting clinical documentation between physicians, other providers, and health plans. We have all been begging for an Apache standard for a very long time. We think that the operating rules that ACQH CORE is proposing do bring a lot of value, they bring much needed uniformity and efficiency to the implementation of electronic attachments.

Specifically, the infrastructure rules update the system availability and connectivity requirements, with the benefits that I have previously discussed. They ensure consistency in the minimum file size that would be accepted by health plans. This would help prevent rejection of files and reduce rework by practices, which is really important. And also there would be requirements for maximum response time acknowledgments and error handling. So those are all really great features.

The attachments and data content rules for both prior authorization and for claims would support reassociation of the clinical data, the attachment with the underlying prior authorization request or the claim. That's really important, we know that is a real challenge on the health plan side, matching up the claim or the prior auth with the associated documentation.

And also the rules recommending use of LOINCs to request supporting documentation, which again gets to the frequent concern we hear from our members that knowing what exact information they need to submit to a health plan to support a prior auth or a claim, or to get claim payment, is really a challenge. So we think this does go towards improving the transparency of the data requirements.

We do feel like these attachments operating rules have a lot of value, and we would recommend concurrent adoption of the transaction standards with the operating rules at the same time, because we think that, as we have been discussing this morning, operating rules bring uniformity, they bring structure and guidance, and promote consistent implementation. So to our minds it makes sense to adopt the standards for attachments with operating rules at the same time.

However, as others have noted, we kind of run this rapidly shifting environment with the terrain kind of moving under our feet as we speak here. There were two very pertinent proposed rules released right before the holidays, as others have indicated the CMS Prior Authorization and Interoperability Rule as well as the Attachments Rule. Very exciting developments. I know at the AMA we are still very much digesting these rules, and first of all trying to tease out how they interact with each other, how they align with each other, and are there things that perhaps suggest some things that are in conflict between them.

And because of that, we think that there might be a need to look at the core operating rules a little bit more closely before moving forward. Again, we think they have really valuable content, but the recent regulatory developments might give us pause and think that there needs to be some more validation before moving forward with adoption.

So to sum up, the AMA fully supports adoption of the proposed suite of operating rules because we think they address unmet business needs and emerging trends in the industry. We think that they will help patients and they will also reduce burdens for physician practices.

We would recommend immediate adoption of the infrastructure rules, the connectivity rule, the eligibility and benefits data content rule, and the patient attribution rule. We support adoption of the attachments, prior authorization, and claims rules, but as I indicated we think that it might make sense to take those rules along with those two proposed federal regulations out for comment right now and to see how they all work together to ensure that we're not leading to a messy situation in the future. So with that I will wrap up and welcome questions at the end of our panel. Thank you.

Jamie Ferguson: Thank you so much. I appreciate that. Next I would like to introduce Kirk and Anna, who are early adopters of the 278 exception process. And I think Kirk you're going to go first.

Kirk Anderson: So, good afternoon everyone. My name is Kirk Anderson, I'm the Chief Technology Officer for Regence Health Plans, which is a part of Cambia Health Solutions. I appreciate the opportunity from NCVHS to speak to you today from the vantage point of a technologist and an implementor.

And I'm excited to be joined by my colleague and partner, Anna Taylor, from MultiCare Connected Care, one of our largest provider partners, to share our real-world experiences as a payer and provider implementing RESTful API solutions using FHIR APIs and Da Vinci implementation guides.

By way of background, I have been working in healthcare for over 20 years as a Chief Information Security Officer, and for the last several years as a CTO. And while I am certainly no expert in the history of all of the healthcare data standards, X12, CAQH operating rules, I do appreciate the critical role that they have played to enable payers and providers to communicate meaningfully with each other in a world lacking in ubiquitous open standard APIs.

About a decade ago, as HL7 first began its work to create a uniform, open API standard for healthcare, today we know as FHIR, my company became very interested in that vision as a way to accelerate automation and transformation into healthcare. This led to me and others who are similarly passionate about APIs for healthcare to form the HL7 Da Vinci Project, which I currently chair.

Since that time, my company has been partnering directly with providers and EMR vendors to implement FHIR API based solutions for exchanging data in bulk for quality measure reporting, for patient attribution as my fellow panelists Terry and Heather just mentioned. And in the summer of 2022, for real-time end to end processing of prior authorization using FHIR APIs.

I wanted to give a little bit of that background, because as a technologist I believe that we are truly at an inflection point as an industry to embrace modern architectures and RESTful APIs and how we choose to invest our scarce technical resources from here forward is critically important.

So I know our discussion today is primarily focused on the role of operating rules across a myriad of topics and use cases. And as I said our company has relied upon operating rules from CORE in many areas. And we clearly understand the role and value of those operating rules, particularly in use cases like claims processing, where moving at the speed of nightly batch is sufficient. However, for other use cases, such as prior auth, the power of real-time API driven communications between provider systems and payers provides the opportunity for a huge and transformative leap forward for the industry.

As reflected in the vision of CMS's latest proposed rule for API powered prior auth, we now have an opportunity to address what has historically been a friction point for patients, providers, and payers alike, and in fact I have spoken to NCVHS about this previously, last year or the year before.

But in my opinion FHIR APIs will enable a paradigm shift in prior auth, processing prior authorization in real-time, allowing us to alleviate the administrative burden on providers and to get patients the speedy and accurate prior authorization they need for the best outcomes.

So why am I so bullish on this, why do I believe this? Well, RESTful APIs let computer applications communicate with each other directly without human intervention. That's the whole point of APIs. And this allows us as technologists, inside payers and providers, to look at prior auth as a single interoperable workflow process that transparently spans the organizational boundaries of payer and provider. So provider clicks a button inside their EMR system, and a payer system responds. That's what we're talking about.

The provider doesn't have to leave their AMR and go to a payer portal, which we know they don't love, we hear about it all the time. They don't have to create a task for their prior authorization staff. Whether a prior auth is necessary, and if so the ability to submit it and to upload automatically the clinical data required is all available to them within the EMR, even when the patient is still in their office.

And with this distributed process able to access care guidelines inside the payer, or medical policies and member benefits, all of it instantly, many prior auth requests can be answered in real-time, and those that do need human review, the status of that review can be communicated instantly to the member and the provider.

So what I'm describing here is not just a vision for the distant future. Using Da Vinci implementation guides, built in collaboration by payers, providers, and health IT vendors, and with a waiver from CMS to demonstrate end to end prior auth using FHIR APIs as part of a pilot, our company, Regence and Multicare have put that solution, have put that vision into production this past summer, serving real patients and real providers.

Ana is going to talk a little bit about the benefits and the results of this from a provider perspective, but as a payer I can attest that our ability to capture the data that we need to make PA decisions automatically allows us to greatly reduce the time to decision and to redeploy the human capital on our side to other high value tasks.

So again, I want to iterate that the work that we've done with this exception, which we feel can serve as a model for the industry, is operating without the use of a X12 278, and without accompanying operating rules. So why is that? And how are we able to do that in a way that is also going to provide consistency and uniformity for the industry?

Well, fundamentally the traditional role of operating rule is either defined in the FHIR standard we're using, it's automated in the functioning behavior of the FHIR API itself, and/or it's defined in detail on the Da Vinci implementation guides that we've used.

In other words, as healthcare is increasingly moving to RESTful APIs --

Jamie Ferguson: Kirk, if Anna is going to be speaking about this pilot also, we need to switch to her in the interest of time. Sorry.

Kirk Anderson: Let me just wrap up by thanking NCVHS again for the opportunity to share my company's experiences and perspectives. And with that I'll turn it over to Ana.

Jamie Ferguson: We are running a little bit behind. Can you stay within five minutes or less?

Anna Taylor: I'm going to try my best. Thank you for having me here today, it's an honor to be able to come and speak to our experience as a provider and what we're seeing in our industry and what is happening in these exciting times of being able to implement these technologies that are really enabling the change we want to see in our communities, which is the better health.

My name is Anna Taylor, I am the Associate Vice President of Population Health and Value-Based Care at MultiCare Connected Care. We are an accountable care organization that is owned by a health system called Multi-Care Health System. We have both community based and employed providers in our network. And I've spent 15 years serving this community at MultiCare, and I wouldn't have it any other way.

My background is in engineering. I was a human centered design and engineering graduate from University of Washington, and my master's is in clinical informatics and patient centered technologies, also from UW. And we're headquartered in Tacoma Washington, we have about 350,000 lives under risk that we manage, which is a very significant portion of our total revenue to the health system.

So I'm representing the voice of our communities that I serve, healthcare technology as an engineer, as an executive in healthcare and in value-based care, and also as a patient myself, because I only want it to get better. So I'll be discussing my experience as an early adopter of the Da Vinci implementation guide that we've had in production over the past two years. And these use those modern architectures and APIs that Kirk was discussing, and we have chosen to further invest in these things based on the results we received in our pilot.

So under value-based care, beyond our people, our most important asset is absolutely our information. And that information at the point of care, because that really makes the difference in us being able to care for our patients and our communities and to bring that joy to our staff that we always want to have when they come serve patients every day.

So what we have to deal with in this ecosystem is 25 plus payers in our marketplace that we have to interoperate, and 20 plus EMRs that are within our clinically integrated network. So to do all this we have to have scalable solutions, scalable standards, and those modern architectures and APIs are the way that we have found have proven the return on investment for us to get there.

So what I want to discuss today are the three use cases we have in production. And those are, one, quality reporting with a payer. Two, auto-authorization, prior authorization with a payer all the way through to approved or not approved. And then the foundation to everything, which is our member attribution, and receiving that in a way that we can get more real-time data to the point of care.

So both of those have proved to reduce administrative burden for providers overall, and they are highly correlated to our success in value-based care, because knowing who is responsible for, just as Heather and Terry and Kirk have said is very important to our success under value, especially since so much revenue is significantly associated with that. And under value we know we have better outcomes for our patients. So again, multi-care, significantly investing in those types of capabilities that enable us to do that successfully.

So under member attribution, we realized that we were able to get from two payers, not just Regence, also Premera, so scalable solutions that I did not have to redeploy or redevelop, I

could use the exact same API, different key, different token, and get that data to the same data pipeline that I have in place for other payers.

So slowly over the next couple months I hope to have a majority of our payers on this API, this API through Da Vinci that enables us to get that data within an eight-day period to the point of care, and with 90 percent accuracy rate or higher. And actually, we're performing at like a 3.3 accuracy rate, meaning we don't have to match those lives by hand with a human, we can tie them more discretely together because the API enables us to do that. So for patient safety it is also very important to us.

For quality reporting, we have put into place med reconciliation post discharge using the data exchange for quality measures IG from Da Vinci. We've seen 175 percent improvement in this measure. Why? Because we can mine the data more discretely and share the data more discretely with a modern API. And by doing so we get to do that on a daily basis for that API, so we know what our real patients that need a med reconciliation are.

And what is really powerful in that is that we eliminated chart chases which have calculated out to be about $50 per chart for us. And those chart chases now don't even have to happen, and we can push those resources more to the patient care and more to that care management service under value that's most important in managing the health of our members.

So very significant cost reduction, and I only have to develop it once. So under value I can afford that, because once I achieve that it costs the same amount as I get in return for the quality measures, and every year after that I'm achieving a return on my investment that I can now reinvest into care rather than trying to get data from point A to point B. Super powerful for us, and we continue. That's one measure, one payer, and now we want to multiply that by the 20, and the 120 measures that we have to report to our payers in the marketplace.

The last one is prior authorization, which we went live with just recently. We codified 10, or I should say our payers codified 10 surgical procedures. And of the 10 we found out that it only takes two to three minutes to get an answer back from Premera enter all the data, this is soup to nuts, enter all the data, get the answer back, approved, not approved, or pending, and have that data right there in the electronic medical record for our pre-service team to look at.

It also gives us - it reduces that time. So average time in the beginning was ten minutes at the mission and now we're reducing it down to two or three. Which some might say the portals do that too, but the portals are not within the EMR. They're not the one button. I'm on a one button campaign, I want to click a button, I want it to give you the auth and have it all there for the patient.

And most importantly, we only send what's needed for that auth. So having that identity as a service, ATR as a baseline and putting prior auth on top enables us to only send what is needed for that patient and that authorization to enable us to have a very more secure, most trust building between the patients and their data, because ultimately it is their health data that they own.

So all of these have been an immense return on investment for us. And I'll just say in closing that our patients', members', and our communities' health comes first.

That's what we're thinking about, what solutions can we do one to many because healthcare cannot continue to spend, we are not a venture capital tech company, we are a not for profit health system that's serving communities wanting to improve the health of them, and in order to do that we have to find solutions that reduce the burden to enable us to serve patients more than to get data from point A to point B.

I don't want to be talking about interoperability as a problem in my future, I want it to be a solution that enables us to change the way we can bring health to our communities.

So thank you guys so very much for your time and the space to speak to this. I do think this is the future, and we're already doing it, we're scaling it to multiple payers. And please let me know if I can provide any more data points that you would need as facts in how this is improving the way we're functioning as a value-based care company and as a health system.

Jamie Ferguson: Thank you. So, we will switch to Margaret Schuler from Aspen Dental.

Margaret Schuler: Thank you. I am going to take us back to the CORE operating rules and talk about how this impacts specifically the dental industry. So I am Margaret Schuler, very appreciative of being here. I'm the SVP of Revenue Cycle Management for Aspen Dental Management Incorporated, so ADMI.

My role is I oversee all the revenue cycle operations. We have 1000 dental offices across the country in 43 states. So I'm responsible for insurance eligibility processing and claims processing, and remits processing, et cetera. Denials management.

I wanted to share that I have 25 years of experience from revenue cycle management. I think some of you actually know me, I've had the pleasure of speaking at some of the prior NCVHS hearings. I've spent 23 years in the medical industry, and I've recently spent the last two years in the dental industry.

And let me tell you, I am outraged being in the dental industry. We are so far behind, and we have been left behind when it comes to administrative simplification. And so therefore I'm representing, I'm a voice today about the need to bring the operating rules forward for the dental industry.

Because we all know our dentists, our providers, our doctors, they need to be providing the care that they've gone to school to do, and what they do best, and our patients deserve the access to the right care at the right time. And so again the CORE operating rules so core to that mission vision.

Let me talk to you just a minute about, let me explain to you who ADMI is. ADMI, we're called a down-support organization, and we provide nonclinical business support and administrative services to again, like I shared, those 1000 dental offices across the country.

Our goal is to break down the barriers that doctors and patients face when it comes to dental care. And our overarching goal is to bring administrative simplification. And that's exactly what the CAQH CORE rules are doing. We are completely aligned with the proposed rules, insofar as the proposed rules moving forward.

So I'm going to highlight for you specifically, a little different from the prior presenters, around the dental industry. The dental industry, attachments are what we do day in and day out, claim attachments. CAQH CORE measured that there were 40 million attachments in '21 in the dental industry. 80 percent of those were manual. And the 20 percent that are electronic are dependent on third party solutions. So there is a real need to automate the attachments in the dental space, in the dental industry. And CAQH core has calculated for our investment this could be a savings of around $100 million for the dental industry alone, or three million hours of labor. So a lot of opportunities in this space.

A couple more callouts for you. On the minimum file size that is being proposed, that is important too for the dental industry. We send a lot of x-rays across to health plans, again to support why we're doing what we're doing to the patient, and those minimum file size, those operating rules, again we're very supportive, because that again helps with those attachments that we're sending across to health plans.

The other thing that I want to give a call out to, we believe that it is so important now that HHS has come out with the operating standard for the transaction, that the rules go forward as well together. We recommend to NCVHS that they do go forward together.

My biggest concern, again I've been in the business 25 years, I probably have maybe ten more years, I would like to see attachments go forward before I retire. I think before all of us retire. So I'm worried if we don't pair these together it's just going to be more delays in the space, and we can see the savings that the industry can benefit from.

Let's move on to the next slide, eligibility and benefits. Huge to the dental industry. And what CAQH CORE is putting forward as a recommendation is so important to us in the dental industry. Right now, the 271 is not value add for the dental industry. Basically, the only piece of information we get is do you have that particular health plan or not. We don't get detailed information to be able to give electronically be able to give our patients a solid price estimate.

So what we do, and I'm going to give you a real situation, is our office staff have to sit on the phone, call the health plans, are waiting for someone to answer, and then ask for a fax of coverage benefit information. They take that fax and they hand-key it into the practice management system.

This is hours and hours of work. And at ADMI we have over a million visits that we have to identify benefits on. So you can imagine the labor involved. And then having a patient be in the middle of all that, having to wait for what is this going to cost me out of pocket. So we have an urgency to get automation specifically around eligibility and benefits in the dental industry. And CAQH CORE is putting forward the service type codes specific to dental.

And you can see they're listed out on the slide here. This is really important to us, because there is benefit coverage information that's detailed depending on the service. A cleaning could be 100 percent covered, but maybe a tooth extraction is only going to be 50 percent covered, or a crown is 20 percent. We need that level of detail electronically.

So we, CAQH CORE has estimated that it costs $9 per manual transaction. So you can imagine the cost on the dental industry again around gathering that eligibility coverage information.

Game changer, this will leapfrog the dental industry, it's in the right direction. Certainly we probably won't completely get to where the medical industry is today, but this is absolutely in the right direction, and we completely support again these CORE operating rules in the space.

Infrastructure. So my peers at the AMA and AHA were completely aligned with what they shared. Being at 90 percent of up with system availability, 90 percent, it's a must have. And in fact we all want to be at 95 or even higher percent. But 90, we'll take it, to get us from 86 to 90. So for us this is a no-brainer. We also are open during weekends. We have people working claims and processing payments actually 24/7.

So we need system availability to do our job effectively. And for the dental industry to be effective, and again taking the cost out of the industry so when those systems are down and putting the patient in the middle of the healthcare industry, inconvenience with system availability. So completely aligned with moving forward from 86 percent to 90 from a provider perspective.

Let's move on to connectivity. My comment here is this is a just do it. Right now HIPAA covered entities are required to maintain outdated security protocols simply to remain compliant with an outdated regulation. So this is housekeeping. This needs to happen. This also, we have heard a lot about APIs. This starts to again provide that opportunity for emerging standards in our industry and is forward looking. So very supportive around the connectivity rule as well.

Key takeaways. The dental industry has been left behind. There are opportunities now for the dental industry to start catching up due to the CAQH CORE operating rule proposals. So we are again aligned with what is being put forward specifically to the dental industry.

NCVHS, again we would like to recommend that the attachment operating rules are aligned with the final rule for the attachment standard. And that goes for the call to actions now, before we're all going to retire.

And then finally, our overarching call to ADMI's administrative simplification so our providers can be providers and our patients can get the experiences that they need and deserve. And the CORE operating rules certainly aligns to our mission. That's all I have, thank you.

Jamie Ferguson: Thank you all for being here and presenting today. Now, I recognize that we are running late, but I do want to entertain questions from the committee, and I would like to lead off with a couple questions of my own.

For those of you who directly addressed the operating rules, we heard a lot about the expected benefits of the operating rules. But I think my first question will drill down into the potential consequences to providers if for some reason HHS does not adopt the proposed updated versions of the operating rules.

Specifically, I think a couple questions. One is what options do you have to communicate the good faith estimates required under the No Surprises Act in the absence of the operating rules. And also, how do you get the eligibility detail on telehealth today.

Kirk Anderson: I can field that. To be clear, the Good Faith Estimate is not something that this operating rule is going to facilitate. What it's going to facilitate is the ability to engage in determining how to handle a good faith estimate. What I mean by that is you will understand if the patient is eligible for a particular procedure. If they are eligible and they have insurance they are kind of sorted one way, if they are going to be self-pay they're sorted another way.

And you can only figure that out if you have procedure-specific information that tells you this patient's insurance covers this procedure. Without that you can't make that initial step of how do we treat this patient, as an uninsured patient, as an insured patient, which again there are two separate processes that go in, and I think the granularity just fosters better understanding at the provider up front.

And your second question was how is telehealth done today? Not consistently, would be my answer. It is a scramble. A lot of our members are saying there has been the specific method that was spelled out in these operating rules is something that X12 is also, the leadership of their eligibility group itself has also been saying this is the solution that we need to centralize around. But providers, health plans have not necessarily uniformly adopted it.

So you've got a lot of providers in a lot of large health systems trying to call their various health plans and say this is how we would like to deliver this information. Frequently it results in a phone call honestly and other inefficient ways of obtaining this information. So the telehealth is super, you say how would it happen if these weren't passed, there would continue to be these problems of trying to deliver information and expectations to your patients without having the requisite information.

Jamie Ferguson: Thank you. Let me go on to, I think it is really a related question about sort of the potential consequences of not passing these rules, the operating rules. And this is one about value-based payment models. How do you do patient attribution today, and if the operating rules were not adopted, then what methods would you use for patient attribution?

Anna Taylor: I am going to start with what methods would we utilize if we had patient attribution. And the one that we're utilizing today is the IT for ATR. And so we would use FHIR based APIs to exchange that identity between us, so that we can distribute that identity to multiple places.

Because in population health our operations and workflows involves more than one EMR, more than one place a transaction has to take place, and where that identity information has to get to, so that API enables us to hand off to multiple places that we need that data to go to, and that's what we utilize today and will be utilizing in the future to get attribution to our EMR, our population health engine, our financial engine, all of the things that help us be successful in managing the population.

Kirk Anderson: I would just add that's going to be based on whether or not the health insurer is supportive of that particular way of using it. So again, it would probably be varied and inconsistent if you didn't have an operating rule to centralize it.

Heather McComas: I will just jump in, and I welcome other folks with experience with it too, but I think a lot of times this information is shared in rosters you get every certain interval from the health plan. The value of the eligibility patient attribution rule is with your eligibility response right then and there for this patient you know if they're attributed, and if at that visit Heather is due for a foot exam because she has diabetes or whatever, let's get this done. Or she should be attributed, call the plan and get her off my list.

Versus like these rosters, lists of patients you have to manually track, and that information might be out of date by the time the patient comes in. So again, it's this idea that you're getting the real-time information when you can act that's so critical.

Jamie Ferguson: Thank you very much for those answers. Let me open it up to other committee members. Does anyone else have questions for this panel? I had a list of questions, but I'm going to cut it short just in the interest of time, because we are over time already. So once again I want to thank you all very much for participating here today. This has been extremely valuable. And thank you very much. I think now I'm going to turn it back to our federal officer, Rebecca Hines, for the public comment period.

Public Comment

Rebecca Hines: Thank you Jamie. We are now starting public comment. And as you can see on the slide there, if you are on Zoom, and I think we have two phone callers, but pretty much everyone else is on Zoom, please raise your hand if you would like to have your audio unmuted to make a comment. If you're on a phone, press star nine to request unmuting. And I just checked the email box and there's nothing in, but if you are so inclined and would prefer to send written comment, we receive them at ncvhsmail@cdc.gov.

So while we're waiting, I did want to say that Lorraine was suggesting maybe we could use the public comment time to finish the discussion with the panelists.

Unlike yesterday, it does not seem that we have any input from our listening audience. Thus I do believe public comment can wrap up now. And again, you can send your comments to that email address showing on the slide.

And Jamie, I don't know, before we turn it over to Tammy for panel three, or Denise, if you have any suggestions about using the next few minutes possibly to wrap up the previous panel. Denise?

Denise Love: Well, since we are going back to the provider panel, I have a question. And even if the rules are adopted the regulations are going to take a while. So what will the industry do in the 18 months, two years, or whatever, in the meantime, regarding these operating rules?

Terrence Cunningham: I can't speak definitely for the industry, but I think what these operating rules moving along would give is people a better impression of what's to come. So I think people would be more willing to start implementing a solution and updating their systems specifically for example, the telehealth benefits.

The solution is out there, it's moving its way through the regulatory process. You might have health plans start to coalesce around that, even though it's not mandated yet. They would have an idea as to what will be mandated. And then that could go a long way to funneling towards a standard. But I encourage my other panelists to give their thoughts as well.

Kirk Anderson: I'm happy to weigh in here, although I'm not a provider, I somehow snuck into this panel. Maybe coming back to the attribution use case that we were just talking about, the way that member rosters or attribution files are shared between payers and providers today, or historically, is a mess. It's spreadsheets, it's emails, no standardization, et cetera. What we've been doing with multiple providers is to move to a standards-based approach using the Da Vinci attribution use case.

And the benefit that operating rules historically provide, that is consistency, reusability, detailed specs, et cetera, exist in those Da Vinci implementation guides. And so that's why we're not going to wait for rules to pass, we've got a working model that has been tested in the community that is standard, repeatable, based on the fact that it's not using any proprietary technologies.

And as we have delivered that with the providers that we have that in production with we are seeing massive improvement. So we're not going to wait for rules, because the consistency is defined already in the APIs and in the Da Vinci IGs.

Anna Taylor: And in that we have expected timelines, and we are evolving within those timelines, and we know when changes are going to be made, we have a systematic process that enables us to maintain those for future use cases.

So for example we have the FHIR API BCDA with CMS that we utilize in our Medicare shared savings program, and the API had to evolve to meet those needs of BCDA, and we did that in community within the Da Vinci constructs, and it became very successful, and we had more adoption, and we knew when to expect those changes. So that is one thing that has enabled us to not wait and not have operating rules, just because we have these expected structures in place already that are making us successful.

Jamie Ferguson: And that is based on getting the exception, right?

Anna Taylor: That is for prior authorization. ATR we did not need an exception for.

Jamie Ferguson: Any other questions from committee members? Hearing none, I think I'm going to hand it off. Is this going to --

Rebecca Hines: It's going to Tammy, but Lorraine has her hand up.

Lorraine Doo: I just wanted to ask Margaret Schuler, because she shares a passion for dentistry, that I share and that Dr. Chalmers shares. I just wanted to say bravo. I know that you spent a long time in medical and now you're getting a bird's eye of the dental community, and I just wanted to thank you for that.

And then if I could, if you don't mind, make sort of a virtual introduction. I don't know if you heard Dr. Chalmers speak yesterday, I can't remember if you were on the call, but I would love to share her slides with you and make a virtual introduction for some ongoing communication.

We for the first time ever are going to be actually paying for dental services under Medicare in a new rule, just so the transactions and operating rules related to those, and I just think it would be a really nice kind of synergistic conversation, given what you shared with us today, if you don't mind.

Rebecca Hines: So, we are turning to Tammy for Panel 3.

Panel 3: Presentations from Health Plans regarding CAQH CORE proposals on operating rules

Tammy Banks: Thank you. We are going to be having presentations from the health plan perspective on the CAQH CORE operating rules. In this order, we will hear from Elevance Health, Christol Green, Blue Cross Blue Shield Association, Gail Kocher, Blue Cross Blue Shield North Carolina, Barry Hillman. So with no further ado, Christol, do you mind kicking it off?

Christol Green: Thank you. I want to thank the members of the NCVHS Subcommittee for allowing us to testify today considering the CAQH CORE proposed rules. We provide our testimony with the goal of improving NCVHS and to accomplish its task of assisting and advising the Secretary of the US Department of Health and Human Services in implementation of the administrative simplification act, health portability and accountability act, or HIPAA.

We have also filed a more inclusive written testimony with the subcommittee. So on behalf of Elevance health I would like to thank you for the opportunity to respond to the subcommittee questions and provide our perspective on the proposed operating rules. My name is Christol Green from Elevance Health. I work in the e-solutions area with an enterprise shared solutions team.

At Elevance Health we are elevating whole health and advancing health beyond healthcare. Our nearly 100,000 associates serve more than 119 million people at every stage of health. I've

been working on the HIPAA administrative simplification, and active in implementing and integrating electronic transactions for over 20 years.

We are current members of WEDI, X12, HL7, CAQH CORE, AHIP, Blue Cross Blue Shield Association, and other healthcare related industry organizations. Some of my engagements are liaison to CAQH CORE, liaison to HL7, also workgroup co-chair, US Realms steering committee, payer at large, and operating committee member for both the Da Vinci and FAST accelerators.

I also work with the E-Solutions Exchange on their steering committee, which is a Blue collaborative. New to the WEDI board and have been participating in X12 since 2004.

We hope that sharing our experience and recommendations with NCVHS will help improve efficiencies using electronic healthcare transactions, which ultimately supports improved healthcare experiences and outcomes for our members.

So in regard to CAQH CORE eligibility, benefits, and single patient attribution data content rule. Attribution rules may vary by model, and some of this information may not be contained in current eligibility systems. The majority of value-based care arrangements currently use retrospective attribution methods to assign patients to providers based on claim data, thus the status is unknown until the year in which the services were provided.

Other arrangements may prospectively identify the provider responsible for care. This could be based on purchase of a certain product, asking patients to choose, or any other analytic method in which the case, a population level list of patients is furnished to the providers at the start of the period.

Payers already have established methods to communicate to providers which patients are attributed to them, and patient by patient check is not useful in either of these cases. While some programs use tentatively attributed patient lists, that are later reconciled, they only refresh semi-annually or quarterly.

The resulting patient panels do not change with enough frequency to require re-running the analytics behind these files on a daily basis. Thus implementation of individual enrollee status checks like envisioned in these operating rules would only refer back to the latest file that could be almost a quarter old. Moreover, implementation will likely require more cost and burden than benefit.

Additionally, under the new rule payers will be impacted by the requirement to return maximum and remaining benefits for the ten service types. These requirements would require changes to payers, providers, EMRs, and clearinghouse systems that capture the information and create and receive the response.

Furthermore, the support of procedure code inquiries and the evaluation of the procedure code to a service type would require significant change to payer systems to respond at a procedure code level and map procedure codes to service types or vice versa. As such, we ask

NCVHS to recommend against adoption of this rule, and permit payers to rely on existing systems customized to specific contracts with their providers.

In the area of companion guides, currently the CAQH CORE companion guides are burdensome to create and may be of limited value. We recommend that NCVHS work with CAQH CORE to simplify and streamline these companion guides.

The updated connectivity rule references using HL7 fast healthcare interoperability resources, FHIR, for exchange. However, the HL7 FHIR implementation guides also address these aspects. We recommend NCVHS work with HL7 to crosswalk the FHIR IGs and update the connectivity rule to ensure consistency.

NCVHS should encourage CAQH CORE and HL7 to ensure alignment and harmonization in the connectivity rule and FHIR IGs. We also encourage NCVHS to work with CMS on alignment of the updated attachments proposed rule, in which we are in review for comments at this time.

Concerning the attachments, prior authorization infrastructure, and data content rule, and the attachment healthcare claims infrastructure and data content rule, we advocate that NCVHS not recommend adoption of operating rules at this time. Instead seek public comment after the relevant standards have been finalized.

We support the adoption of attachment standards, but note that as written, the operating rules will be burdensome and costly to implement and may conflict with the updated standards proposed in the current CMS and pending ONC proposed rule.

For healthcare claims attachment rule, the requirements for service level response will be challenging. We note that FHIR could allow for more flexibility. Likewise, for prior authorization attachments rule, listing the exact services will require the provider to have sufficient detail, and this will be expensive to build into workflows.

Of note, CMS has recently released the advancing interoperability and improving prior authorization process proposed rule. CMS has proposed the development of a FHIR based prior authorization requirement, document and decisions API, that automates the process for providers to determine if an authorization is necessary, what information is required, and facilitates the electronic exchange of both the request and the response.

While we recognize these requirements would only apply to federal plan programs, we support aligning requirements where reasonable with different insurance product lines. Lastly, NCVHS should work with stakeholders to identify when it may be most appropriate to use FHIR standards, versus when X12 standards may be applicable, and when or if either could be used. And with that I want to thank you for allowing me to give some testimony today.

Tammy Banks: Thank you Christol. Gail.

Gail Kocher: Good afternoon. I am Gail Kocher, Director of National Standards at Blue Cross Blue Shield Association. I'm going to dispense in the interest of time with the formal statement about the company, as I did read it into the record yesterday.

On behalf of BCBSA and the plans, we would like to thank you for the opportunity to respond to your questions and provide our perspective on proposed updates and new operating rules. We continue to strongly support the goals of HIPAA administrative simplification to promote efficiency and reduce the cost of administrative transactions.

Blue plans vary widely in size, markets, and geography. However, despite these differences plans report very little variation in experience for a particular transaction. The challenges and barriers to adoption of that transaction by trading partners and the overall adoption rate of mandated standards are fairly consistent across the plans. Therefore, our responses to the subcommittee's questions are applicable to Blue plans generally.

Before getting to the questions, I did want to just address three overarching points. We continue to uphold the adoption of operating rules that support the implementation of standards, not to supplement what is already defined by the standards organizations. Operating rules should replace neither their front matter nor conflict with general usage information contained in implementation guides.

The CAQH CORE operating rules appropriately focus on infrastructure requirements, meeting the objective of business rules, which are the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specification.

And we suggest that any information technology requirements, including these operating rules, must be considered in the context of the broader environment of mandates and requirements with significant IT implications, including the interoperability rules.

Regarding any value-add, what we have heard from plans over time is that implementing administrative simplification operating rules as well as standards requires time and resources that are incommensurate with the business value achieved. In part this is because of safe harbors which can result in plans having to implement something that may ultimately never be used by any of the trading partners that they have.

To free up resources while we accelerate other standards and specifications, which enable greater interoperability in the exchange of clinical data, the timing of any adoption of additional provisions of administrative simplification must be done with consideration to the timing of these other regulatory requirements. Consideration of value add must really be done looking at all mandates and requirements collectively, not just one standard or operating rule independent of the others.

Regarding the benefits of the connectivity rule and applicability to HIPAA standards, we appreciate that this version addresses the concerns that were noted back in 2020 regarding some of the provisions in the connectivity rule.

While we can support the current proposed rule minimum connectivity standards, we do continue to have concerns that health plans, our vendors, clearinghouses and other intermediaries that act as both a client and a server must implement both REST and SOAP while provider and provider vendors can implement one or the other. Again, having to implement something that in the end is not utilized, or utilized in a limited fashion, creates unnecessary cost and burden to those implementors.

Regarding the data content requirements for the eligibility operating rule, understanding that X12 does intend to move forward additional transaction standards for adoption consideration, we do not see that updating the data content of the operating rules against the current HIPAA mandated version. At this point in time is right for the industry. We would say that the best interest of the industry is that it is efficient to consider whether we update the current mandated transaction and then address the operating rules.

We have concerns that the current proposed rule was not necessarily developed with potential future changes to the eligibility standard, and there is a risk that implementors could be required to make changes now that would need to be removed or modified upon any movement to the next version of an X12 standard.

Regarding operating rules for claims and prior authorization, we believe it is premature to adopt operating rules for standards that are not yet adopted and implemented widely across the industry. Doing so assumes that the standard itself does not contain the business rules that are needed for implementation.

And even if after some period of implementation of these new standards for these business purposes it is determined that business rules are warranted, this really needs to occur after the standard to ensure that the operating rules are addressing the business aspects that are needed as opposed to rules based on assumptions that are made prior to real world implementation of those standards.

And whether we would support the recommendation to adopt. At this juncture we are not opposed to aligning the connectivity rule across the transactions that have mandated operating rules at this time, but we do not support moving forward with any data content operating rules for those currently mandated standards, or operating rules for the new business uses such as the attachments and member attribution at this time.

Even routine updates to systems and processes utilize budget and resources. So those resources and those changes need to be done with clear business need or gain, not just to make a change for the sake of making a change.

We support the work of NCVHS related to the adoption of standards and operating rules under HIPAA but again, we strongly encourage a roadmap to ensure that the private expenditures was well as government expenditures that are imposed on stakeholders are done so with all federal state mandates, things like CAA and consumer transparency, so that we're not creating bottlenecks and overlapping resource commitments for any of the stakeholder community. We appreciate the opportunity to supply comments today and are happy to address any additional questions. Thank you, Tammy.

Tammy Banks: Thank you Gail. I appreciate it. And our last presenter, Barry.

Barry Hillman: Hi everybody. I am Barry Hillman, and I'm a Director in our Digital Strategy Group at Blue Cross and Blue Shield of North Carolina, with responsibilities for the HIPAA transactions as well as our secure provider portal. I have over 20 years' experience in the healthcare data exchange space working in both clearinghouses and at Blue Cross Blue Shield of North Carolina.

And I will directly address the five guiding questions that were sent out, the first being the value add of the infrastructure and data content rules for eligibility and claim status. They are different for each transaction. For eligibility, the changes proposed in the data content rule will address items and services that are frequent call drivers.

As insurance providers have increased the usage of tiered concepts or carved out benefits and services that apply to physical therapy, occupation therapy, imaging and surgery, having those benefits more fully described in the eligibility response transaction will convey to the provider/user that information with the goal of eliminating a common phone call to the health plan provider call center.

CAQH has established over a series of years through the CAQH CORE survey that the benefit of electronic transactions versus calls is cents to dollars. If we can drive these types of requests for information to the electronic transactions, the administrative cost savings should be substantial over time.

This particular content is likely variable across insurers, and this will set a common floor and threshold for the content, thus benefiting all parties, and increased utilization of the transaction. It will present work for all. Certainly, more for some than others. But we believe the benefits will outweigh the work over the long run.

For claim status, the changes in the infrastructure rules apply the same common types of rules and expectations as was applied to eligibility for things like response time, availability, acknowledgments, which assures the provider/user that the claims service status will operate with clear and common expectations.

These expectations have served the eligibility transaction well, and our plan has seen significant growth in transaction volumes over the years. These same changes by extension should benefit the user community of the claim status transaction.

The second question, provide input on the benefits of the connectivity rule and applicability to the HIPAA standards, and if known provide information about the connectivity rule as it applies to the operating rules which are adopted as mandatory and those which may be used on a voluntary basis.

Our reply is as follows: The benefits of the connectivity rule and applicability to the benefit and transaction standards was that the HIPAA transaction standards did not specify connectivity methods, as are stated in the infrastructure rules. This created wide variability on how the various covered entities implemented these and required custom programming for connecting to each covered entity.

A common set of rules for connectivity allows software vendors to create products which can work with many different entities without custom programming. Thus, advancing and speeding utilization of these transactions. This lowers the cost of entry for all parties in the using of the HIPAA transactions, as well as off the shelf revenue cycle management products should be enabled to use the HIPAA transaction for data exchange and shift the work of development from an individual entity to software developers who create off the shelf software, thus creating a lower cost of implementation for performing these transactions, and moving the barrier of entry for those, where larger organizations would have the capabilities of doing custom programming but smaller entities would not.

The difference in voluntary versus mandatory in a rule like connectivity is that many more users will be enabled via the mandatory rule as opposed to the increased variability when connectivity solutions are voluntary. This should allow for movement away from a many and complicated approach to a few and common.

The third question was discuss the business impact of new data content requirements for the eligibility operating rule and its expected business process improvements. The business impact really should become present in the shift of volume of questions from the provider community to electronic transactions, from making phone calls and things of that nature.

Provider callers and insurer call representatives won't have to sit on lengthy calls when a transaction could be obtained for the same data content in three to five seconds, which is generally what our plan has as an expected response time for the real-time transactions.

The fourth question was provide commentary for your organization's perspective on the proposed rules for attachments for claims and prior auth. Our response is that an adopted attachment standard and related operating rules are long overdue in healthcare for both claims and prior auth attachments. Having these now available and implementing both the transaction standards and connectivity rules will allow full electronic workflow to be realized for these important functions.

Software products will be able to be built and available off the shelf, and instead of requiring extensive custom programming the adoption curve should show more rapid adoption than if we had the standard without the infrastructure rules. Increased ROI should be realized by all

parties as these functions switch from paper and fax and manual portal interactions to electronic system to system transactions. So EHR directly to the payer systems.

And the fifth question was indicate your association or organization supports the recommendation to adopt the proposed updated new operating rules, and if your organization does not support moving forward with either proposed, updated, or new operating rules, please explain why not.

And my response is Blue Cross and Blue Shield does support these operating rules. We have been a part of the development process and believe that CDQH CORE does a good job of soliciting multi-stakeholder input and feedback as part of the rulemaking process and has shown through the CDQH survey that the ROI in transforming these functions from manual methods, calls, faxes, et cetera, to electronic, is substantial over time.

CDQH CORE has shown that the electronic transactions cost cents versus manual methods costing dollars comparatively. We believe the investment will pay off over time, and the administrative cost savings and more transparent information being provided to the healthcare provider community who serves our insurance plan members. And thank you so much.

Tammy Banks: Thank you. Just for my clarification, Barry, I think your position was that you support all the operating rules as brought forward, is that correct?

Barry Hillman: That is correct.

Tammy Banks: Christol, you do not support any of the operating rules that are being brought forward, is that correct?

Christol Green: The ones that I mentioned, yes.

Tammy Banks: Which ones are you abstaining on?

Christol Green: I don't think we commented on the timing. The one on the response times are open, we didn't respond on that at all.

Tammy Banks: Gail, I think I got yours. You're neutral on the connectivity, and you don't support the data content, new attachments, or member attribution, and you remain silent on the rest?

Gail Kocher: We would be okay with connectivity, although we still have some concerns about it. The ones I didn't mention we're silent on, and the others we don't support it, at this point in time.

Tammy Banks: Before I jump into my questions, does anybody on the committee panel have any question for these fine presenters? Then I just have a couple. If I could, I'll ask you Christol but I'm sure the rest of you may have comments as well.

With the attribution, I personally realize that that is an extreme issue, especially as we move to value-based care, if providers do not know if a member is attributed during the middle of the year or at different points in time in the year, it is very difficult to get them in and meet the quality criteria. And I know Christol you were mentioning that it is very costly to convey that information through the eligibility.

I know you also mentioned the FHIR APIs. Can you speak to what your position is? You said you would rather have a different system respond to that. Does that mean you're leaning toward the FHIR API to solve that solution, and that you don't see the cost to get it in the eligibility a viable way of conveying that much needed information?

Christol Green: That is correct Tammy. (Inaudible) member attribution, that's not my area. So we have another area within Elevance on that. But we do have our folks involved in the Da Vinci ATR, we're looking at that right now. That's something we are heavily involved in in Da Vinci. But that guide particularly, we were looking at that just recently that we want to start looking at that attribution, member attribution.

Tammy Banks: So you understand the value of it, it just depends on the method of delivery, is what your organization is grappling with. Otherwise I think that was the main, I think you guys were very clear on your positions, and why your positions were what they were. Debra, do you have any additional questions or are you just ready to take on the next panel?

Debra Strickland: No, I am just waiting for you to hand it over.

Tammy Banks: I will hand over the baton. Thank you Deb.

Panel 4: Presentations from vendors regarding CAQH CORE proposals on operating rules

Debra Strickland: Thank you, and welcome to our vendors. So the next section we have Nora from athenahealth.

Nora Iluri: Thank you for having me. It is great to be here and thank you for letting me comment on these operating rules. So I am Nora Iluri, I head the revenue cycle for athenahealth. athena health, our mission is basically to create a thriving ecosystem that delivers accessible, high quality, and sustainable healthcare for all.

And we feel that this is very highly aligned in general with the CAQH CORE's vision, and as a result we participate in operating rule development as a member of the working group's straw poll and ballots and feel that we have been very much a part also of how this has been developed, as many others I know have also.

In terms of what we do, we have our revenue cycle solutions, we also have an EMR patient portal and a marketplace for vendors to connect with all of this to bring the industry together. We primarily solve the ambulatory practices in the market, and we operate on a single version of the code. So any integration we do, whether it's with a payer, whether it's with any other connection, serves every single one of our clients.

Currently we serve 155,000 providers, with Athena One, which is our primary solution, about 170 million unique patient records initially in our system, and 300 million claims built. So we do have quite a bit of scale. And all this through a single code base.

So in terms of our position on the operating rules, we do feel that these address the most impactful asks that help us serve patients better and reduce administrative cost for all. And I think every one of us, or at least most of us in healthcare, are here because we want to make the lives of our patients better.

And I think that's very important that we keep in mind that a lot of these rules are here to provide better more accurate information for them and to improve the care that they are given. It of course, when we can do these things quicker and higher quality that often means automation, and automation generally leads also to administrative cost savings in the longer term. Although there is an implementation cost, overall, I do believe that the cost savings go hand in hand with improvements in patient care.

There are four points I would like to make. Number one, I want to talk about how the adoption of the new and updated operating rules improve digital data exchange and transactions and driving the quality and timeliness of care and the cost reduction.

Also, number two, how attachment standards establish a necessary foundation for the electronic exchange of health information and operating rules ensure consistent construction of solutions.

Third, I want to talk about how operating rules directly support technology advancement and provide an on-ramp for industry driving adoptions.

And fourth, I want to talk about how federal adoption of infrastructure and connectivity operating rules help ensure consistency and fairness of resulting patient care, speed of adoption, and reduce the cost to maintain.

So with that I would like to give a little bit of background for number one, if you can go to the next slide. Just to again put it in perspective, we process about 700 million plus eligibility requests a year. And some of our top pain points that we run into while trying to process these eligibility requests is that many times there are insufficient automated means to communicate.

A lot of the communication is error prone and requires also expensive manual portal use or even voicework to do this. There is also insufficient or missing information in certain areas still, even with the evolving standards that we have to date. That gives practices, and what we really need is a lot more information to be able to give practices and patients a much clearer view of their coverage and costs.

And then also, very often, today we encounter lack of sufficient standards, where some of the critical information still comes in in things like message segments and other nonstandard ways

of using fields that make it very difficult to provide information that we need to provide patient care.

As a result, we support the data content rules. Given the goal is to better serve our practices and their patients, we recommend, we support eligibility and benefits recommendation, which continues the improved transparency into coverage and cost of our practices and their patients. We support attachments for prior auth and claims.

It helps the industry move towards attachment automation and improving quality and timeliness. Of course I would love it if we could do discrete data for everything, but the reality is that's not always going to be possible, and therefore we do need some level of standard on how to exchange attachments, which by the way we already do in many situations, but standards would go a long way.

Also, single patient attribution. We talked a lot about this. It is very critical to have that for value-based care, and to support that growing segment, and shift incentives from utilization to outcomes, so we are very much in support of moving that forward as well.

The most impactful requirements that we saw in these data content rules are around requiring the use of specific codes to indicate what service or benefit is available for telemedicine. We can see that telemedicine is here to stay, it is a part of how we serve our patients, and therefore this is quite important.

We also find the expansion of both the discretionary and mandatory STC codes and addition of procedure codes to get more accurate responses for coverage and cost highly beneficial. We are constantly trying to work on improving better visibility to practices and patients on what they are owing. And this is a step towards that, or a further step towards that.

We also find that indication of whether a prior authorization is required or not is valuable, although we have our own proprietary engine that is actually already pretty accurate to do this, we spend a lot of time maintaining that and updating that and trying to make sure that we get the right information to our practices.

It would be much easier if this would become a lot more of a standard way to have this information for all. And it would level the playing field because we can do this, others may not have the means to maintain such large engines and keep them up.

Requiring specific codes and reference data to improve data interoperability. Again, the more we can get this information the more accurate information we can provide to our patients and practices would help a lot in transparency.

And finally, I talked about the single patient attribution, that is definitely key to support our growing value-based care population.

So in terms of the second area, attachment standards, I've heard a lot of people debate this back and forth. The truth is there are a lot of potential savings here if we can adopt some level of standards and improve the way that we exchange these attachments.

Right now we still have literally truckloads of paper going back and forth. It would be great if we didn't still have to send paper in today's day, but we could actually have standards to exchange information for attachments. It would also speed obviously quality and turnaround time.

So as a result, athenahealth would like to ask NCVHS to recommend that HHS include attachment operating rules in the final rule for the attachment standards. We do understand that this is a step forward, there's anything and everything can have potential improvements, but let's not let perfect stand in the way of making progress and getting better. So we are actually very much supporting and hoping that we would be able to get the standards through.

Third, operating rules directly support technology advancement and yet provide an on-ramp for industry driving adoption. We already use obviously extensive X12 interfaces, but also have modern non-X12 using Da Vinci, they're using a lot of other things as well. We need a path to move over time to the more modern technologies, and therefore we definitely support these operating rules to both support the old and the new and pave that path for all of us to be able to move over.

And then finally, for the next slide, we also support the federal adoption of infrastructure and connectivity operating rules to help ensure the consistency and fairness of resulting patient care, speed adoption, and reduce the cost to maintain.

So we do serve practices nationwide. And we do see significant variations state to state in data connectivity and business processes. This does create a significant burden for payers, vendors, for everybody, and especially us as we work with our practices as well as we try to connect with payers on the other side.

It also creates unnecessary variations for the patients. So we would love to see all of this becoming more a national requirement.

As a result, we do support the federal adoption of infrastructure and connectivity rules. We would like to see those higher requirements and expectations also for industry. I think somebody said earlier going from 86 to 90 percent, we would love to see higher than 90 percent, but it is this movement in the right direction, and I think we keep charging forward and moving to bettering our capabilities, how we serve our practices and our patients, and do this nationwide. That's it for me, thank you.

Debra Strickland: Thank you so much Nora. Very informative. Next up, we have Arthur.

Arthur Roosa: Good afternoon everybody. I am Arthur Roosa, I am a member of the Healthcare and Business Management Association, which is a nonprofit professional trade association that

is a major voice, a major player in the revenue cycle management industry. I am a member of and the pass chair of their government relations committee.

I also have on the call with me today Steven Sundrud, who is the Vice President of Software Development for SyMed Corporation, which is an RFCM company headquartered in California that submits a little over a million or so claims per year. I will be calling on him if during the question-and-answer period I get a question that's too technical for me to handle. HBMA is generally supportive of the operating rules moving forward. And we think that they should be in fact moved forward.

We are particularly supportive of the 270-271 content, the addition of copay, deductible, maximum benefit data, that this sort of thing is a really important addition. And the eligibility by procedure code is a very valid and important addition to the content of 270-271. And telehealth is also valuable.

It concerned me a little bit that health plans were a bit hesitant about this particular aspect, that for them it seems to be somewhat of a burden. But I would like to proffer that it is a one-time change.

And although that change may be extensive and expensive, it is a one-time change whereas the benefit it provides is that it will prevent providers having to call multiple times a day, every day, going forward, to get the information that the 271 would now contain.

Also I would like to respond to the comment on patient attribution, and including that in the content of the 271. This is an emerging issue, and it has been emerging for the past 10 years. We really haven't gotten that far with it.

But currently that information is provided in proprietary ways, some of them as a literal paper list that comes to the provider, which they either must now keep at the front desk so the front desk folks can check to see if this patient has been attributed to them, or somebody has to key it in to be able to look that up.

So the ability to be able to do that and particularly, electronically, it's important. Particularly for RCM companies, who are responsible for doing the billing, if they have a question about it is much easier to run a 270 transaction and get that information than it is to try to obtain it in other ways.

With regards to the attachments, another thing that we support, another thing which is very useful to our workflow, and being able to have particularly uniformity in how attachments are transmitted to payers. Very often in the processing of a claim we are asked for additional information. And to be able to do that electronically and consistently would be a significant improvement to the current procedures.

We've had a number of people comment on the infrastructure update to require a 90 percent uptime. That certainly is a step in the right direction. Although I have to admit that most of our

trading partners, most of the folks that we communicate with as an industry are actually far exceeding that. It is unusual to attempt to access somebody's portal or access somebody electronically when you find that their system is down. Certainly, I recognize that it would be hard to write a recommendation that says they need to be up 99.9 percent of the time, but I think in general experience that is about where it is.

There was a comment earlier, I think it was Erin but I don't actually want to say that for sure, because I don't want her beating me up later if in fact it wasn't her that said it. But that supporting both SOAP and REST would provide flexibility for the provider.

The comment from Blue Shield had that meeting that payers had to support both SOAP and REST where providers only had to support one or the other. I think that needs to be clarified. I'm not in support of supporting both protocols, I think that there are people that the company certainly have made investments in SOAP and it's in common use, and so it would require more investment to move to REST, but I think that since this is a rule that would not go into effect until 2025 or 2026, I think that it would be probably more useful to move it up to REST.

As far as the other issues with the connectivity rule concern, the safe harbor thinking is really important. It is important that if we have a new payer that comes into a practice, or somebody that an RCM company hasn't communicated with in the past, that we know that there is a bottom line or floor at which if we are compliant in that area we can definitely communicate with that payer.

What that floor is or what that safe harbor is something which certainly can be discussed, and I don't think that we have a position on that, but simply that there is one, there are specifications in place that say if you are compliant here then you will be able to communicate.

And lastly, again, I mentioned this yesterday, but this will always come up, is that none of the above is important if there isn't an enforcement around it. Most of the players that are in healthcare will in fact follow compliance issues, and that not be a problem, but there are some that don't. And there is really no way in place to correct that. And often there is no penalty for them not doing so.

I have personal experience with this in attempting to get a couple of payers, I won't mention them because one of them is online, to actually correct a compliance problem that they had, and it took me a year and a half to do that, and I kept all the paper documentation, and it is literally five inches thick. So this is a necessary thing, I know NCVHS has no role in this, but again I do know that CMS is on the line, so as they say if you're listening. So those are my comments and thank you again for the opportunity to present them.

Debra Strickland: Thank you very much for your insightful comments. Next we have Pam Grosze from Cooperative Exchange.

Pamela Grosze: Thank you. I am Pam Grosze, I'm the Board Chair of the Cooperative Exchange of the National Clearinghouse Association, representing over 90 percent of the nation's

clearinghouse organizations, who process over six billion healthcare claims a year. Our function as clearinghouses is to enable nationwide connectivity between industry stakeholders, between payers, providers, and vendors, and facilitate exchange of data, both administrative and clinical data between those trading partners.

We support both real-time and batch standards, and we help enable interoperability by normalizing disparate data between our different trading partners, to ensure that each trading partner can send and receive the data that they need and get it to the right place in the right format.

And we give the opportunity to our stakeholders to enable their differing levels of technology ability. So we have some that are low tech, some that are high tech, and we act as a bridge between those to facilitate again the exchange of data across all of our industry stakeholders. So I appreciate the opportunity to provide comments on the updates to the operating rule.

So first I'll take a look at the infrastructure rules that currently are federally mandated and are being updated. Stakeholders have been operating under these rules for nearly a decade. So as has already been mentioned, increasing the system availability for eligibility and claim status is definitely a benefit and a logical step towards improving overall availability.

We also agree that the companion guide template is a benefit in the infrastructure rule. It enables standardized information flow and format. It enables payers and clearinghouses to convey their specific requirements around the implementation guide for their trading partners, and it has been a very effective means to communicate any trading partner specific information. And we agree that the updates that are made to the companion guide format would be very beneficial.

There are some concerns in the infrastructure rule, specifically the rule continues to include requirements for acknowledgment transactions which have not been adopted under federal regulation and were explicitly excluded in the current mandated rule. But the current publications don't reflect that. The rule updates also reference confusing language talking about certification versus the federally mandated requirement.

For example, CORE certified organizations are referenced in eligibility rule section 1.1, and then conformance requirements for HIPAA covered entities or their agents in section 1.2. So that is confusing to organizations trying to use the rule. References to voluntary certification requirements should be separate from the federally enforceable rule requirement mandates for HIPAA covered entities or their agents.

So in summary, the cooperative exchange generally supports the majority of what's included in the infrastructure rules, and we absolutely agree that the increased system availability time is definitely needed.

But because the updated infrastructure rules continue to include references to acknowledgment and voluntary core certification requirements, we don't support the proposed

update to the infrastructure rule as published, and we recommend that it be modified to exclude that information so that it is less confusing to the industry.

Looking at the eligibility and benefits data content rule, as has already been discussed there is a lot of additional information that is included in this new infrastructure rule and updating the data content operating rule would support all of the additional information that providers need to give a more robust eligibility response. It helps alleviate the burden on patients, providers, and payers by giving that information at the time of service. So we definitely support that additional information.

Obviously supplying additional information comes at a cost. Obviously that is a concern, that health plans would have to bear the burden of that cost, which includes the cost of modifying their systems. But assuming that there is a net positive benefit in providing that additional data versus the cost, the cooperative exchange does support the updates to the eligibility and benefit data content rule.

When we look at the connectivity rule, this is updated but also has some new information as well. It addresses known security vulnerabilities that are in the current core connectivity rule. And we support updating that information as outlined in question 5.A of the RFC. So the cooperative exchange does support updating the requirements to address those known security vulnerabilities.

There are some concerns in the rules, however. The core connectivity enhancements outlined in question 5B are directionally correct in accommodating the secure internet-based REST API and OOP2 connectivity in access. But the Cooperative Exchange does recommend that NCVHS solicit a wider perspective from healthcare industry stakeholders and the at large technical community regarding the specification of normative naming conventions for the API endpoints and the base set of metadata required to be used for the exchange of REST messages, to ensure that the rule will support advancements in technology and future standards updates. What is included in the rule today is fairly static and may not support additional advancements as technology and standards continue to move forward.

As such, the cooperative exchange does not support the inclusion of the naming conventions for API endpoints and base metadata as specified in the connectivity rule at this time, so that further review and interest from healthcare industry stakeholders and the at-large technical community can be solicited.

As the rule includes a mix of beneficial updates and these new requirements that both concern, the cooperative exchange does not support the federal adoption of the connectivity rule as published.

When we look at the patient attribution data content rule, in general clearinghouses already support the requirements of the new eligibility and benefits single patient attribution data content rule, and the exchange of patient attribution data content when present in eligibility workflow. Obviously as stated earlier, including more data content between providers and

payers does come at a cost, including the cost to modify systems. So while there is a benefit there also is a cost to include that.

And the cooperative exchange feels like providers, payers, and patients or patient advocate organizations and other interested stakeholders are better positioned to address the questions of administrative simplification improvement and potential adoption under federal regulations. So we are remaining silent on this one.

When we look at the attachments operating rule, it has been mentioned already, but the operating rules in general are provided to support standards that are part of HIPAA regulation. And because the attachment transaction standards have not yet been finalized in federal regulation, the cooperative exchange feels that it is premature to propose attachments operating rule for federal mandate consideration, and our recommendation is that SDOs and the Operating Rule Authoring Entity collaborate and coordinate to ensure that the regulated transaction standards and operating rules are aligned as appropriate and ensure industry adoption in a pragmatic and synchronized manner.

And just some suggestions for alternatives. Consistent with NCVHS recommendation number four in its July 2022 letter to the Secretary, the Cooperative Exchange recommends that establishment of or updates to the federally regulated operating rules be developed and deployed within a federally established SDO and ORAE guidance framework, and a known and predictable version update schedule.

As we discussed in our testimony yesterday, we feel that having a predictable update schedule for both standards and operating rules would benefit the industry in giving us the ability to plan, budget, and resource, ensuring that we can support any updates that are made.

As our industry is regulated under operating rules that were initially published over 10 years ago, the opportunity cost and risk of not accommodating innovation and change required to advance our industry forward can't be truly measured. The current process is unpredictable, and we need to collectively identify root cause and embrace change.

The Cooperative Exchange does recommend that federally mandated operating rules be published to include only the rule requirements under federal mandate, as I mentioned earlier. For example, rule publications or specifications that include requirements for acknowledgments which have been excluded in federal rulemaking is confusing to the industry at large.

CORE should be required to publish operating rules that are fully aligned with federal rulemaking requirements and can alternatively publish non-mandated certification requirements that include other requirements such as acknowledgments for purposes of voluntary certification.

Voluntary CORE certification requirements should be published separately from federally mandated operating rule requirements and should be clearly noted as such. This would greatly

decrease confusion within the industry about what is necessary for compliance and what is strictly voluntary. And that concludes my comment, thank you.

Debra Strickland: Thank you so much. Thank you for your comments. I'm going to open it up to the committee members. Does anyone have any questions for this panel? I do have one question for Pam. I know you have, Cooperative Exchange has some concerns about the rules as they are. Were the Cooperative Exchange members or a portion of them participating in the CORE activities?

Pamela Grosze: Yes, we do have members that are CORE members and participated in creation of the operating rule, and did provide input on some of these concerns during that process.

Debra Strickland: I do not have any other questions at this time. I am not seeing anyone else with their hand raised, unless I'm missing it. Rebecca, do you see anyone?

Rebecca Hines: I do not.

Debra Strickland: Alright. I thank you so much for this panel, this was very informative, and all of your opinions are very critical to our deliberation, so thank you so much.

Rebecca Hines: Thank you for facilitating. We are scheduled for a break. I wanted to consult with our co-chairs whether you wanted to take that break or just wrap up? How much dialogue do we have to go? I know there was some interest in some follow-up clarification with CAQH CORE. So Denise, Tammy, Rich, what would you like to do in terms of bringing this to a close?

Denise Love: I think we could do some follow up with CAQH CORE. There was some request for that. And then I think we could conclude. I'm saying maybe omit the break. And ask for clarification, and any wrap-up on our part.

Rebecca Hines: I think that is fine, because I think we are very close. So let's open it up to CAQH CORE and any other panelists who would like to contribute any final remarks before the committee closes out its final dialogue for today's hearing.

Erin Weber: I just want to touch on a couple points that have come up throughout the discussion today. We really appreciate the time and effort of all the presenters to review the rules and provide such detailed and thoughtful feedback.

With regard to the single patient attrition rule, payers do have established mechanisms for exchanging attribution, but they are all different, and create significant administrative burden for providers, and that's what this rule is addressing. Patients see many providers, and the plans only send rosters to the attributed provider, meaning other providers may not be certain if they're responsible for the patient or not. So adopting this rule would enable a common national approach to attribution.

Furthermore, rules don't specify the methodology that plans need to use for attribution. But when attribution is available it should be communicated in the eligibility transaction. For

example, if the plan does not attribute until six months into the plan year, to attribute based on claims, attribution would not be expected to be communicated in the first six months but would be expected to be communicated once attribution is known in the last six months.

I would also like to address some attachment comments that we have heard today. First, the CORE connectivity rule is payload agnostic. This just means that it allows for different attachments to be nested in the SOAP or REST message.

A provider can submit an X12 275, a 275 with a PDF, or a 275 with a CCDA. A provider could also send the CCDA nested within the SOAP and REST enveloping without an X12 275. These may all be dependent on the different systems or software that the provider uses, whether it be a practice management system, an EHR, care delivery app, et cetera.

When these attachments are submitted by the provider, the attachment operating rules ensure that no matter which system they use or which clearinghouse they have, or to which health plan they are submitting attachments to, and providers submit attachments to dozens of health plans, they can be assured that the health plan can accept that attachment no matter the standard and no matter the mode, direct through a vendor application or through clearinghouse.

The CORE connectivity safe harbor network allows for seamless interoperability between provider and health plan with clear expectations, and seamless access to data, and often images, where when each is needed for effective and streamlined administration of care.

Second, we've done an analysis of the proposed attachments and prior authorization proposed rules. We have not identified any conflicts with our attachments operating rules. However, we are happy to bring the industry together to consider additional attachment operating rules that could be added once the CMS rules are finalized.

And finally, I just want to emphasize again that over 140 organizations were involved in the development of these rules, and over 88 percent of our implementor organizations, meaning providers, vendors, clearinghouses, government entities, and health plans supported the rules, and they represent the vast majority of all stakeholder groups. This broad support was also well represented by the high levels of support from our presenters today and included in the comment letters NCVHS received on the proposed rules.

So I hope that clarifies some of the discussion that came up today, but I am happy to take any additional questions if you need them.

Denise Love: Thank you.

Tammy Banks: Do we have any other questions for Erin or any of the other panelists?

Denise Love: This may be risky to even ask because I haven't digested this day, it is too much. But it seems like there was quite a bit of support in general for many of the operating rules, but there were a few maybe glitches or fixes. So Erin, what would happen, how hard is it to address

thresholds or certain protocols? So the whole operating rule is not the problem, but maybe aspects of it. And what happens then?

Erin Weber: There are different approaches. If we were to actually modify our rule, it depends on whether it's a substantive or non-substantive adjustment, and a substantive adjustment is defined by us as when something needs to be adjusted in an organization's systems. And some of the issues you heard today were raised in our workgroups but not supported by the majority of our participants. So the rules stand as they were in the most supportive way.

That said, CMS, when we went through the first round of operating rules, found some creative ways to get around some of the challenges. For example, acknowledgments. In the currently federally mandated operating rules the requirements pertaining to acknowledgments are excluded from the federal mandate, and that's just a blanket understanding there.

And there is similar language around core certification requirements. So I don't remember it exactly, but if you go back and look at the final rule for the eligibility EFTRA and claim status operating rules, it specifically talks about how core certification is not required under the federal mandate.

Denise Love: So some of those concerns about lumping the certification language and the mandated language are easy fixes.

Tammy Banks: It has been a long two days, so please don't take lack of questions as lack of interest, because that's definitely not the case.

Erin Weber: No, we're happy. If you guys have questions in the coming weeks as you think through your recommendation, feel free to reach out to us, we're happy to help you understand or work through any thoughts.

Tammy Banks: Your presentations have been very clear, and this clarification has been very helpful, and Erin as always, we appreciate you presenting here over at NCVHS.

Rebecca Hines: I want to echo that the presentations today were so well done that I think that's why there aren't a lot of follow-up questions. So thank you all. I do believe all of the slide decks are now on the website, so if you don't see them, please refresh your browser. If you see any issues, don't hesitate to let me know. We do our best, but sometimes we don't get 100 percent perfection, so let us know if you see anything that needs adjusting.

Tammy Banks: Rebecca, I believe we can wrap-up unless Maya, Lorraine, you, have anything you want to add.

Rebecca Hines: I just want to thank the staff, Marietta Squires and Lorraine Doo for their incredible dedication to getting us to this point, and our contractor for getting all of the materials up on the website quickly today, and the smooth run of show.

And really to all of the members for the incredible amount of time you've all dedicated to get us to this point. There are a lot of details and a lot of opinions, and not necessarily all the perfect clarity you might want at this juncture. So I just want to thank everybody for coming to the table and contributing. That's how this work gets done.

And the real I think service of this committee is its capacity to convene.That is really one of the great benefits, I think ASPE would agree. It's just a great way to get as many opinions and perspectives factored in. So thank you all very much.

Lorraine Doo: Thank you for keeping us on track.

Jamie Ferguson: I want to thank every one of our panelists and presenters. Your preparation was excellent, slides were excellent, presentations were clear. That's why frankly we had fewer questions than I thought because part of our list of questions was already answered by your presentations.

Tammy Banks: With that, again, we will conclude.

Rebecca Hines: I did want to answer the question on the Q&A someone just asked. Thank you, Damon. So Damon just put it into the chat rather than the Q&A, all of the slides are on the website in the related items box to the side. You'll see all of the files there.

Maya Bernstein: I added it also to the Q&A. If you go to ncvhs.hhs.gov and you look at the top for meetings, you'll see the most recent meeting, and under there will be all the materials for this meeting.

Rebecca Hines: And all recordings will be posted at the same location next week.

Denise Love: As Co-chair I conclude the meeting. Any objection, co-chairs?

Rebecca Hines: Meeting adjourned.

(Whereupon the meeting was adjourned at 3:10 p.m.)