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December 15, 2022

Jackie Monson, JD
Chair
National Committee on Vital and Health Statistics
CDC/National Center for Health Statistics
3311 Toledo Road
Hyattsville, MD 20782-2002

Re: Request for Public Comment on Proposals for Updates to X12 Transactions and New and Updated CORE Operating Rules

Dear Ms. Monson:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am pleased to offer a response to the National Committee on Vital and Health Statistics (NCVHS) Request for Comment (RFC) on updated X12 transactions and new and updated operating rules. The AMA has long advocated for the adoption of electronic transaction and code set standards and operating rules to reduce administrative burdens for physicians and their staff and promote uniform communication between practices and the many health plans with which they do business. Growing evidence linking practice burdens to professional burnout for physicians and other health care professionals underscores the importance of addressing these issues.[1,2] We appreciate the opportunity to provide the physician perspective on the updated transactions and new and updated operating rules addressed in the RFC. More broadly, the AMA prides itself in actively participating in cross-industry, multi-stakeholder efforts to advance health information technology (health IT) to meet unmet business needs and build consensus on the best path forward for adopting these innovations in real-world settings.

Global Approach to RFC Response

Many physicians—**particularly those working in small or rural practices or serving minoritized or marginalized communities**—face challenges in updating their health IT systems due to limited resources. Acknowledging this reality, the AMA formulated its response to the NCVHS RFC based on the following core principles:

- Successful transaction/code set standards and operating rules should be recognized, preserved, and enforced.
- The industry should prioritize identifying and addressing unmet industry business needs.
- Any new transaction standards or operating rules being considered for adoption should be rigorously evaluated and tested prior to a federal mandate to ensure their maturity, viability in real-world settings across organizations of all sizes, and overall value.

[1] Rao SK et al. The impact of administrative burden on academic physicians: results of a hospital-wide physician survey. *Acad Med*. 2017;92:237-243.
[2] Shanafelt TD et al. Relationship between clerical burden and characteristics of the electronic environment with physician burnout and professional satisfaction. *Mayo Clin Proc*. 2016;91:836-848.

- Only one transaction standard for a particular business function should be adopted at a time; new or revised standards should replace previously adopted standards.

We urge NCVHS to use this approach when evaluating and recommending new or updated transaction standards or operating rules for federal adoption.

Updated X12 Transaction Standards

1. Costs.

The AMA is not currently able to provide information on the costs, benefits, or value of the Version 8020 837 and 835. We have done a preliminary query of some state medical associations and national medical specialty societies. At this time, none of them have begun an analysis of the extent of the changes, cost impact, or value to physicians to implement the updated transactions.

Based on previous experiences with the adoption of other Health Insurance Portability and Accountability Act (HIPAA) mandates, we know that costs to physicians vary widely. Costs will be dependent on whether a practice develops and implements changes internally, uses a vendor, or uses a combination of the two. The implementation strategy utilized by practices will result in different cost impacts and value. Costs will also depend on the specific changes in the Version 8020 837 and 835 and the extent to which a practice currently uses those functions or is in need of the new functions. We also note that there will be indirect costs involved in adopting the updated transactions, such as training and reduced productivity as staff become proficient with the new technology.

We believe that physicians, and the industry as a whole, require more real-world data about the changes, the necessary work to implement them, and their impacts on business operations and systems. We are aware that X12 will be conducting pilots of the Version 8020 transactions. **We urge NCVHS to hold any recommendation about the adoption of the Version 8020 837 and 835 until after results of the pilot testing are made available to the industry.**

2. Operational Impacts.

The AMA is not aware that any physician practices have completed enough analyses to draw any conclusions about the operational impacts of the changes. **We believe physicians, and the industry as a whole, require additional time to fully analyze the changes before making any assessment of the impacts they will have on their current operations and workflows.**

3. XML Schema.

The AMA is aware that some organizations currently use the XML schema internally within their systems, but it is unclear what the benefit would be to adopting it under HIPAA. Any use of the XML schema could be managed through trading partner agreements, if is to be used external to an organization for sending or receiving transactions. The EDI format should remain mandated under HIPAA. **We do not believe that covered entities should be required to support both the EDI format and XML schema for X12 transactions unless through voluntary agreement.**

4. Fast Healthcare Interoperability Resources (FHIR) Crosswalks.

The AMA does not support a requirement to include FHIR crosswalks of the 837 and 835 with the HIPAA-mandated transactions. It is unclear to us at this time what the value of these crosswalks would bring to the claim and remittance advice/payment transactions.

The intent of FHIR is to allow application program interface (API) exchange of data, which is typically employed in real-time exchange scenarios. The current Version 5010 837 and 835 support real-time exchange of the transactions, but this function is not used. From the physician's perspective, the true value of conducting a real-time claim transaction is getting a real-time adjudication of that claim in order to provide the information to the patient at checkout. Until this ability becomes prevalent, there is no point in developing and implementing FHIR crosswalks for these transactions. In addition, translation between X12 and FHIR via these crosswalks could introduce errors that result in physician payment delays. Mapping projects between other X12 and FHIR transactions (e.g., X12 278 and FHIR for the Da Vinci Prior Authorization Support Implementation Guide) have shown the potential for errors in crosswalk development, which further underscores our concerns.

5. Unique Device Identifier (UDI).

The AMA has serious concerns about the inclusion of the ability to report the device identifier (DI) portion of a UDI for high-risk implanted medical devices in the claim transaction. Overall, we do not believe that health plans' collection of the UDI in the claim transaction will improve the current surveillance on implantable medical devices.

We, along with many other organizations, presented our concerns on numerous occasions to X12 during the time that this request was under consideration. The following are risks and challenges that we raised to X12 if UDI is reported in administrative transactions.

- There is no standard definition of a "high-risk" implantable device.
- The UDI in administrative transactions is insufficient to evaluate device performance, since the clinical information included in the claim is extremely limited.
- As stated in the question, the U.S. Core Data for Interoperability (USCDI) already includes the UDI and supports both the device and production identifiers. Certified health IT therefore supports the full UDI and the corresponding clinical information necessary to evaluate device performance. There is a clear value proposition in leveraging an electronic health record (EHR) and its inherent interoperability rather than administrative transaction claims.
- The reporting of UDI will add administrative burden on physicians and other providers since each health plan will request a different list of devices to be reported.
- Data collected and analyzed by a health plan are a small subset of that health plan's members and provider networks and may not represent the full patient population and experience of a device.
- Implementation of UDI in systems and business workflows will be costly.
- Patients change health plans, resulting in health plans not having current patient information to participate in contacting patients for device recalls and follow-up care.
- There are technological challenges for system integrations to link supply chain and inventory systems to revenue cycle systems as well as the ability to pull information from the clinical record/EHR to the billing system.
- The inclusion of the UDI adds risks to normal claims processing if there are errors with its entry in the claim.

- Not all implanted devices will be reported in claims, since trading partners will agree to a limited number of devices to report, and there will be variation among the willing trading partners doing the reporting.

At this time, the AMA submits the following comment for consideration as a change to the Version 8020 Professional and Institutional 837 implementation guides:

The sections (front matter and data segment) in the Version 8020 Professional Claim (837P) and Institutional Claim (837I) describing the reporting of the Unique Device Identifier (UDI) should include language stating this is "not a HIPAA-mandated usage." The reason for adding these notes is because the UDI data are not necessary for the adjudication of the claim or a reimbursement and are therefore not part of the HIPAA-mandated use of the 837, per §162.1101 of the Transactions and Code Sets Final Rule.[3]

This language should be included in 1.12.7 Unique Device Identifier Reporting, similar to the language in section 1.4.2.3 Coordination of Benefits – Subrogation, which states:

> "At the time of this publication, subrogation is not a HIPAA mandated business usage of the 837 Health Care Claim; however, willing trading partner may use this Implementation Guide for this purpose."

The language should also be included in the High Risk Implanted or Explanted Device segment notes, similar to the TR3 note for the Property & Casualty Claim Number segment, which states:

> "This segment is not a HIPAA requirement as of this writing."

This added language to the front matter and segment UDI notes does not change the current instructions and intent that the reporting of UDI is done through willing trading partner agreement. The purpose of adding this language is to prevent payers from circumventing the willing trading partner agreement requirement and telling physicians and other providers they must report all HIPAA-mandated data, which would include UDI unless it is identified as not being a HIPAA requirement.

6. Alternative Payment Models (APM) and Value Based Purchasing (VBP).

The AMA is not aware of any specific alternative payment model needs that are met by the changes in the Version 8020 837 and 835.

[3] **§ 162.1101 Health care claims or equivalent encounter information transaction.**
The health care claims or equivalent encounter information transaction is the transmission of either of the following:
(a) A request to obtain payment, and the necessary accompanying information from a health care provider to a health plan, for health care.
(b) If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care.

7. Implementation Time Frame.

The AMA supports a two-year implementation timeframe if it is decided to adopt the Version 8020 transaction.

At any given time, there are numerous regulations impacting health IT and data exchange with differing requirements in various stages of development and implementation. We do not foresee an open window in which to schedule the Version 8020 implementation. Physicians and other providers must balance limited resources among the many regulatory requirements. It is important that these requirements result in a decreased administrative burden, return on investment, or improved business processes. Moreover, health IT vendors require at least 18 to 24 months from the time of a final rule to implement regulatory requirements. Any timeframe should be aligned with the development cycles of health IT vendors, including those that service small medical practices or themselves are less resourced.

8. Implementation.

The AMA has consistently advocated for the adoption of electronic transaction standards to reduce administrative burdens for physicians and their staff, particularly given the growing recognition that these practice hassles play a major role in professional burnout for physicians and other health professionals. **However, we are alarmed that NCVHS has significantly deviated from the original goals of the HIPAA administrative simplification provisions by recommending the concurrent use of multiple versions of a standard over an extended period of time and/or multiple standards for the same business function. The allowance of multiple versions of the same standard and/or multiple standards for the same business function will lead to increased costs, major inefficiencies, and patient care disruptions.**

While the AMA appreciates the spirit of innovation and flexibility underlying the NCVHS recommendations, we strongly object to the apparent abandonment of the basic tenets underlying HIPAA administrative simplification—namely, that physicians and other providers should be able to interact with all health plans using the same transaction standard and same format and enjoy the cost savings and improved efficiency resulting from this standardization. Indeed, NCVHS seems to be suggesting a reversion to the pre-HIPAA world, in which every health plan used its own proprietary format for revenue cycle functions. Allowing the use of multiple versions and/or standards would return the industry to our previous "Wild West" environment, where the lack of uniformity necessitated costly translation between formats to conduct business.

NCVHS had suggested that while health plans would be required to support all adopted standards for a particular business function, providers could choose which one to use. This leniency is not included in the final recommendation letter and suggests that physicians—many of whom are small business owners—would also be required to support multiple standards for a single business purpose. For small- and medium-sized practices, this is simply an untenable financial proposition, as these organizations do not have the resources to invest in duplicative technology to support multiple formats. Even if the intent is to allow providers to choose which standard to support, this presumes a level playing field in contracting relationships between physicians and health plans. While in theory providers could "choose" which standard to use, health plans could force use of a particular standard via network contracting arrangements, particularly for smaller practices with less negotiating power. Physicians could be forced to support one adopted standard for Payer A and another for Payer B due to contracting requirements. For physicians, this situation would be unworkable, extremely burdensome and costly—**especially for physicians serving marginalized and minoritized communities.** Moreover, such a change would go

against the underlying efficiency goals of administration simplification and electronic transaction and code set standards, which support uniform communication between health care professionals and health plans. To be clear, medical practices often contract with a dozen or more payers.

The AMA also harbors strong concerns about the consequences of allowing the use of multiple versions of the same standard for an extended period of time. **Indeed, allowing multiple versions of multiple standards could exponentially compound the issues we have already identified and lead to a *standards explosion*.** We stress that health IT is not a traditional marketplace, and physicians, particularly those in small practices, do not have the bargaining power to negotiate for their "standard or version of choice" in payer contracts, meaning that they could end up being required to support multiple versions of multiple standards for a *single business function*. We again reiterate the basic tenets underlying HIPAA administrative simplification—cost savings and improved efficiency resulting from stakeholder uniformity.

Beyond the high costs and burdens involved in supporting multiple standards/versions, we are concerned about the testing and orchestration of several health IT systems that would be required by a medical practice to support such a complex scenario. In today's world, a snag in an upgrade to a single health IT system can bring the entire medical practice to a crawl—leading to care delays. Support for multiple versions would astronomically increase the potential for these sorts of harmful impacts on patient care delivery. These unnecessary disruptions would be compounded in less resourced medical practices such as small, solo, and rural clinics, which often serve marginalized and minoritized communities.

We also strongly caution against viewing clearinghouses or other intermediaries as an easy solution to versioning issues for physician practices. While vendors offering translation services may on the surface appear to solve the problem of practices needing to convert versions in-house, this outsourcing comes at substantial financial and administrative costs to physicians and, indeed, the entire health care system. Moreover, allowing multiple versions could stall the forward momentum of interoperability we are experiencing today. Without controlling for different versions, health IT systems would receive incompatible software updates, breaking information exchange and creating backward compatibility issues. In fact, in its July 2022 recommendation letter, NCVHS envisions a future in which a cardiology practice would upgrade to a new version of the electronic claim while another specialty might not.[4] This could lead to interoperability challenges between practices (e.g., preparation of good-faith estimates to meet requirements of the No Surprises Act [NSA]), to say nothing of problems between different trading partners.

The decision to allow multiple versions should not be taken lightly. Yet, if NCVHS were to recommend adoption of multiple versions of the same standard, only the two most recent versions should be allowed at any one time, and it is essential that these versions be backwards compatible. This would provide the minimal protection for market stability while also supporting innovation. In addition, there would need to be firm federal control and transition planning to support use of multiple versions. The Office of the National Coordinator for Health IT's Standards Version Advancement Process registry could perhaps serve as a model for version control and transitioning.

The AMA wholeheartedly supports adoption of newer technologies to address unmet business needs. However, we believe that allowing the concurrent use of multiple versions and/or standards would increase costs, confusion, and inefficiency in our health care system. Given the limited resources

[4] July 28, 2022, letter from NCVHS to HHS. Available at: https://ncvhs.hhs.gov/wp-content/uploads/2022/08/Recommendation-Letter-Modernize-Adoption-of-HIPAA-Transaction-Standards-508.pdf.

available to invest in health IT, we urge NCVHS to use the approach outlined at the beginning of this letter when evaluating Version 8020 of the X12 standards, namely:

- Recognize successful transactions and code set standards to preserve/enforce (i.e., "don't break what's working"). For example, the CAQH Index reports a 97 percent adoption of the Version 5010 837 for electronic claim submission,[5] suggesting that development dollars could be much better spent on other business functions and transactions.
- Rigorously evaluate and test any new transaction standards/versions considered for adoption. A robust piloting program is needed to evaluate standards' maturity, viability in real-world settings across organizations of all sizes, and overall value.
- Adopt a single transaction standard and version for a particular business function at a time; new or revised standards should replace previously adopted standards. This will avoid stepping backward to the pre-HIPAA world of many proprietary formats and costly translation.

Following this approach will ensure that limited health IT resources are invested wisely to address the most urgent unmet business needs and avoid diversion of development time and dollars to duplicative efforts.

9. Simultaneity.

Again, the AMA is alarmed by the NCVHS recommendation to allow multiple versions of the same transactions in production for an extended period of time, for the reasons stated above. We have serious concerns about how the multiple versions of multiple transactions would function. For example, it is not clear how adoption of Version 8020 for claims and electronic remittance advice would impact use of the 5010 version of the post-adjudicated claims data reporting guides, which are used to transmit claims data to all-payer claims databases. We believe this approach would return the industry to the pre-HIPAA era and certainly add unnecessary cost, burden, and inefficiency to a system that is already stretched for resources. In instances where Version 8020 and 5010 data need to be reconciled, we are concerned with data fidelity issues resulting in data distortion or imperfections. This could result in delays in care, impact physician revenue and, at worst, lead to patient harms.

10. Alternatives Considered.

The AMA has reviewed a list of changes to the Version 8020 837 and 835 transactions but has not conducted any in-depth analysis of the impact of these changes with regard to reducing burden on physicians and other providers. Nonetheless, the following are specific points we have about some of the changes that were identified by X12 as benefits for the 837 and 835.

- The change from the Claim Adjustment (CAS) segment to the Reason Adjustment (RAS) segment for coordination of benefits will have a significant technical and business impact for all covered entities, although physicians and other providers may bear more of the burden with analyzing the adjustments and amounts. Moreover, the utility of this information to practices will ultimately depend on how it is presented by their vendors.
- The new functionalities for predetermination, UDI, factoring agent, and tooth segment have limited uses, and it is unclear what the industry adoption will be of them. It is worth noting that the predetermination is currently available in Version 5010, although it is in a separate implementation guide.

[5] 2021 CAQH Index. Available at: https://www.caqh.org/sites/default/files/explorations/index/2021-caqh-index.pdf.

- The revisions for reporting property and casualty data, allowing subrogation by non-Medicaid payers, and reporting drug information will likely have limited use by most physicians or other providers.
- Increasing the number of diagnosis codes and diagnosis pointers that can be reported will benefit social determinants of health (SDOH) and risk adjustment needs for those specialties where these are factors. However, it is not clear if health plans will accept or use this additional information, or how these changes will impact data storage needs.
- Additional clarifications and updated language are good, but not necessary for those that already know how to use the Version 5010 837 and 835.
- There are many qualifier changes and changes in lengths of data fields, which will have significant technical and business impacts.

In addition, Version 8020 added the ability to report remittance information for virtual credit card (VCC) payments. Of note, some physicians have expressed concerns that through addition of the ability to include VCC information, the Version 5010 835 will essentially serve as an "enabler" of VCC payments. **The AMA has offered numerous testimonies and comments to NCVHS, the Centers for Medicare & Medicaid Services (CMS), and the Department of Health and Human Services (HHS) over the past nine years expressing strong concerns regarding the harmful impacts and coercive business tactics associated with VCCs.**[6] The AMA recognizes that the Version 8010 835 would not require physicians and other health care professionals to accept VCC payment; as clarified in guidance released by CMS in March 2022, physicians may request, and health plans must offer, standard ACH electronic funds transfer instead of VCC payments.[7] In the absence of real-world implementation data, the AMA cannot definitively assert that adoption of the Version 5010 835 will lead to increased use of VCC payments by health plans. However, given that this change could lead to significant financial hardships and administrative burdens for physicians, **the AMA believes it is premature to recommend adoption of Version 5010 835 without a full understanding how this could impact physicians and other health care providers.**

We do not have a definitive opinion at this time on the benefits achieved by Version 8020 or the cost of remaining on Version 5010. We believe that real-world testing of Version 8020 is necessary to quantify its benefits.

11. General.

The AMA believes it is premature to support the implementation of the Version 8020 837 and 835. More industry-wide data is needed about the costs, benefits, and value before a realistic decision can be made. We also harbor strong concerns regarding the opportunity costs of implementing these updated transactions. Given the fact that the Version 5010 837 electronic claim is the most widely adopted HIPAA-mandated transaction—97 percent industry adoption per the 2021 CAQH Index[8]—we question if implementing the Version 8020 X12 837 is the best use of physician practices' limited resources for health IT updates, particularly when other revenue cycle transactions desperately need a viable standard technological solution that will likely require significant investments across the industry.

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[6] See documents posted on "Administrative Simplification Advocacy." Available at: https://www.ama-assn.org/practice-management/sustainability/administrative-simplification-advocacy.

[7] Guidance on health plans' payment of health care claims using Virtual Credit Cards (VCCs) and adopted HIPAA standards for Health Care Electronic Funds Transfers (EFT) and Remittance Advice (ERA) transactions. Available at: https://www.cms.gov/files/document/guidance-letter-vcc-eft-era.pdf.

[8] 2021 CAQH Index. Available at: https://www.caqh.org/sites/default/files/explorations/index/2021-caqh-index.pdf.

Specifically, CMS just released the Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule,[9] and while we anticipate that, if finalized, this regulation will streamline the prior authorization (PA) process, improve efficiency, and prevent patient care delays, stakeholders will need to devote substantial resources and time to meeting its technological requirements. It is also unclear what if any societal cost or benefit will result in the implementation of the Version 8020 837 and 835.

Committee on Operating Rules for Information Exchange (CAQH CORE) Operating Rules

1. Efficiency Improvements: Infrastructure Updates to the Adopted Eligibility and Benefits and Claim Status Operating Rules.

The AMA actively participates in CAQH CORE operating rule development and tirelessly advocated for increasing the system availability requirement beyond the current 86 percent per calendar week. Health care is a 24/7 industry, and our member physicians regularly express frustration when health IT systems are unavailable outside of strict "9 to 5" business hours. Patients do not stop falling ill or seeking care because it is after 5 p.m. or it is the weekend. **It is therefore imperative that physicians and their staff have reliable access to eligibility and benefits and claim status information whenever they are providing patient care.** Ideally, CORE would set system availability at 95 percent or higher, as the 90 percent threshold still allows health plan systems to be down over 16 hours per week. That said, **the AMA strongly supports adoption of the updated infrastructure rules, as this represents a major improvement from the status quo in system availability.**

In addition to the positive impact on physician practice efficiency, the updated infrastructure rules also will improve the timeliness of patient care. Practices regularly check a patient's insurance coverage using the electronic eligibility transaction prior to scheduling care. If coverage cannot be confirmed due to a health plan's system being down, scheduling will be delayed until practice staff can manually check the patient's benefits or the plan's system becomes available. Increasing system availability will prevent care delays and ensure that practices can check insurance coverage whenever the patient seeks treatment. **This direct benefit to patient care further solidifies the AMA's support for the updated infrastructure rules.**

2. Data Content Updates for Eligibility and Benefits Operating Rule.

The AMA actively participated in the revision of the Eligibility and Benefits Data Content Operating Rule and strongly supported changes that would increase **both the volume of information included in eligibility responses but also the granularity and specificity of the data.** Nearly every patient encounter with a physician or other health care professional begins with a confirmation of the patient's insurance benefits and specific details of coverage. The 2021 CAQH Index reports that medical providers can save 21 minutes per transaction by performing eligibility checks electronically,[10] clearly demonstrating the value of the electronic eligibility transaction. However, practice staff often have to resort to manual (e.g., phone) or partially electronic (e.g., proprietary plan portals) means to confirm eligibility if the information provided in the X12 transaction is unclear, confusing, or too general to be useful. While these other communication channels are time-consuming and burdensome, practices routinely default to their use when the data provided in the electronic transaction standard proves

[9] Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule CMS-0057-P. Available at: https://www.federalregister.gov/public-inspection/2022-26479/medicare-and-medicaid-programs-advancing-interoperability-and-improving-prior-authorization.

[10] 2021 CAQH Index. Available at: https://www.caqh.org/sites/default/files/explorations/index/2021-caqh-index.pdf.

insufficient or unreliable. The data content enhancements in the updated operating rule significantly increase the quality and quantity of the eligibility transaction's data. **As such, the AMA strongly supports adoption of the updated operating rule, as it addresses unmet business needs. Moreover, we expect that physician practices will increase utilization of the transaction due to the inclusion of valuable new information.**

This updated operating rule addresses several important recent trends in the health care industry. First, the rule requires health plans to indicate when a service is eligible for telehealth coverage. **The provision of telehealth coverage information in the eligibility transaction is crucial given the significant shift toward provision of care virtually during the COVID-19 pandemic and beyond.** Next, the revised operating rule addresses the increasing complexity of benefit design and requires health plans to include new details about a patient's coverage. Specifically, health plans must now provide a patient's maximum benefit limitation and remaining benefits for specified service types. In addition, health plans must return the tiered network status and the associated benefit information for that tier to the inquiring provider. **These valuable enhancements will allow physician practices to quickly ascertain the complexities of a particular patient's coverage and align the eligibility transaction's capabilities with today's more intricate health plan benefit designs.**

Another major improvement in the rule is the requirement that health plans provide coverage and patient financial responsibility for an expanded list of service type codes, as well as specific procedure codes for physical therapy, occupational therapy, surgery, and imaging. The availability of more granular data regarding coverage and patient responsibility in the eligibility transaction will support informed conversations between physicians and their patients about the cost of care and aligns with ongoing efforts to improve health care price transparency. By expanding the list of service type codes for which health plans must provide eligibility data, we anticipate that the rule will also reduce provider burdens by increasing uniformity of data sent across health plans. Finally, the provision of more specific coverage data in the eligibility transaction will allow physicians and other providers to determine if a service is not covered and, as required under the NSA, issue a good faith estimate for self-pay care. **As such, the operating rule addresses a currently unmet business need related to NSA implementation.**

Finally, the updated data content rule addresses one of physicians' priority concerns: the transparency of health plans' PA requirements. In the AMA's 2021 PA survey, 62 percent of physicians reported that it is difficult to determine whether a medical service requires PA.[11] Importantly, under the revised operating rule, health plans must indicate whether a specified group of service types and procedures require PA in the eligibility response, significantly improving transparency for physician practices. **While ideally health plans would provide procedure-level PA requirements across all services, the data content rule represents a major step forward to increasing transparency in PA programs.**

3. New: Patient Attribution. Content Rule Within the New Eligibility and Benefits Operating Rule (vEB.1.0).

Physicians need accurate, timely patient attribution information in order to successfully participate in value-based contacts (VBCs). Physicians face significant challenges in obtaining actionable patient attribution data, and AMA policy calls on health plans to "provide attribution information to physicians in a timely manner" and offer "mechanisms to allow physicians to verify and correct attribution data as

[11] 2021 Update: Measuring progress in improving prior authorization. Available at: https://www.ama-assn.org/system/files/prior-authorization-reform-progress-update.pdf.

necessary."[12] The new Single Patient Attribution Data Content Operating Rule offers exactly such a mechanism, as it requires health plans to provide information regarding a patient's attribution status in an electronic eligibility response. This allows practices to quickly and easily determine if the patient is included in the physician's panel for a particular VBC and take appropriate action, whether that be closing care gaps, engaging in quality reporting activities, or correcting any inaccurate attributions with the health plan. As our health care system increasingly transitions away from traditional fee-for-service payment towards VBCs and other innovative payment models, timely communication of accurate patient attribution will become even more important. **As such, the AMA strongly supports adoption of the patient attribution operating rule.**

4. Companion Guide Template.

Health plans publish companion guides to communicate the specifics of how they implement electronic transaction standards. Historically, companion guides have varied across health plans in format, structure, and content, which leads to confusion and wasted time for physician practice health IT staff who must review, interpret, and implement electronic transactions across the wide range of health plans with which a practice conducts business. CAQH CORE developed a companion guide template to increase document uniformity across health plans. The increased uniformity in companion guides' structure and format afforded by the CORE template has benefited practice health IT staff and other users by allowing them to quickly find information and more efficiently use the guides.

CAQH CORE updated its Master Companion Guide template to allow health plans to address newer (i.e., post-5010) versions of X12 transaction standards and non-X12 standards, such as HL7 FHIR. **Expanding the application of the Master Companion Guide to additional standards and versions should benefit physician practices by increasing documentation uniformity between plans and reducing administrative burdens.**

5. New Connectivity Rule.

The updates to the CAQH CORE Connectivity Rule reflect modern technology advances and IT best practices, and as such, should improve interoperability in the health care industry. Specifically, the rule requires Transport Layer Security (TLS) 1.2 or higher, thereby increasing the security of information exchange. The rule no longer permits use of outdated username and password authentication and instead requires digital certification based on X.509. In addition, the rule also supports stronger authorization standards based on OAuth 2.0. These updates save stakeholders the costs and other resources involved in maintaining outdated connectivity and security technologies that no longer represent best practices. More importantly, the new rule supports physician practices in ensuring the security, accuracy, and integrity of patient health information for which they are responsible for protecting. Physicians' business depends on the security and reliability of their health IT connections, without which they could lose revenue, experience increased costs, be exposed to significant liability, and suffer reputational harm. **The revised CAQH CORE Connectivity Rule modernizes security, authorization, and authentication requirements, and as such, protects physicians' vital business and professional interests.**

The rule also addresses new and emerging technologies, which further increases its value and utility. For example, the rule provides support for exchange of electronic attachments—a key unmet business need across stakeholder groups. In addition, this update incorporates REST standards and provides support for

[12] AMA Policy H-390.849 Physician Payment Reform. Available at: https://policysearch.ama-assn.org/policyfinder/detail/attribution?uri=%2FAMADoc%2FHOD.xml-0-3327.xml.

API integration, as well as instituting an API endpoint naming convention. Importantly, while the rule supports more modern technologies and standards, its safe harbor provisions ensure that existing connections do not need to be abandoned if continued usage is mutually agreed upon between trading partners. Moreover, it would likely be necessary for this rule to be adopted, implemented, and tested prior to moving trading partners off current claims systems and onto FHIR, APIs, and X12 mappings.

In a November 2020 letter to the HHS Secretary, NCVHS recommended against adoption of Connectivity Rule Version C3.1.0 and instead encouraged CAQH CORE to complete an updated connectivity rule with enhanced security requirements and inclusion of new and emerging technologies such as RESTful APIs and OAuth.[13] The updated Connectivity Rule achieves these goals and aligns with modern advancements in health IT. **The AMA anticipates that these changes will benefit physician practices, and as such, we recommend adoption of the rule.**

6. Implementation Costs.

The AMA does not have data regarding the projected costs to physician practices of implementing the updated eligibility and benefits and claims status operating rules. However, as detailed above, we strongly believe that the increased system availability and data content requirements offer significant value to our members. Increasing required system availability to at least 90 percent represents a meaningful improvement for our 24/7 industry and will prevent delays in scheduling patient care. Requiring inclusion of telehealth, tiered networks, and procedure-specific coverage information offers the potential for major efficiency improvements and costs savings for physician practices, as staff can obtain granular data needed to support today's complex benefits structure easily and within 20 seconds vs. relying on manual, costly, and burdensome telephone or portal benefit checks. Moreover, the updated eligibility data content rule brings much-needed transparency to health plans' PA requirements, a major pain point for physicians and their staff, as well as patients. These enhancements will drive further provider adoption of the electronic eligibility transaction and reduce administrative waste throughout our health care system. **The AMA strongly supports adoption of these operating rules due to the benefits they bring to both physician practices and patients.**

7. Alternatives Considered for Operating Rules.

The AMA strongly believes that federal adoption of the updated operating rules will benefit physicians and their staff through improved workflow efficiencies, reduced time spent on administrative tasks, increased time for patient care, and addressing unmet and emerging business needs. We further expect that the rules will positively impact patients. Please refer to our earlier responses for complete details on the anticipated value of these updated rules. Here we briefly identify the benefits of the rules for physician practices:

- Increased system availability better meets the 24/7 needs of the health care industry, avoids practice workflow disruptions, and prevents delays in scheduling and delivering care.
- Through the improved data content of the eligibility rule, practices will be able to ascertain more complex plan provisions, such as telehealth coverage, maximum benefit limitations and remaining benefits, and tiered network via the electronic transaction instead of time-consuming phone calls.

[13] November 23, 2020, letter from NCVHS to HHS. Available at: https://ncvhs.hhs.gov/wp-content/uploads/2020/11/NCVHS-recommendations-on-Operating-Rules-FINAL-11-24-2020-508.pdf.

- Health plans will be required to provide coverage information for additional service types and specific procedures, which will increase benefit transparency for both practices and patients, as well as support identification of self-pay services for NSA purposes.
- Provision of PA requirements for specific service types and procedures will significantly increase transparency and reduce administrative burdens.
- Inclusion of patient attribution data in the eligibility response will support physicians' success in VBCs, which will be increasingly important as our health system transitions away from a fee-for-service model.
- The update connectivity rule provisions enhance the security, integrity, and reliability of the electronic transactions that practices rely upon to run their business.

8. Attachments PA Infrastructure and Data Content Rules and Attachments Health Care Claims Infrastructure and Data Content Rules.

For years, the AMA, as well as many other health care stakeholders, has called for adoption of an electronic transaction standard for PA and claims attachments. In the absence of a standard, both providers and health plans waste considerable time and money on archaic faxes and snail mail to exchange medical documentation. In a 2021 AMA survey, 88 percent of physicians reported the burdens associated with PA as high or extremely high.[14] Beyond just the practice burdens associated with this process, clinicians overwhelming report that PA leads to care delays that can result in patient harm, with 91 percent of physicians saying that PA can lead to negative clinical outcomes. **Standardizing the electronic exchange of supporting documentation plays a key role in addressing both PA-related practice burdens and patient harms. The CAQH CORE attachments operating rules offer important and much-needed industry direction to support uniformity and efficiency in the implementation of electronic attachments.**

Of note, both attachments' infrastructure rules include the updated system availability and connectivity requirements previously discussed, bringing improved reliability, security, and data integrity to the exchange of electronic attachments. Importantly, the infrastructure rules require health plans and their agents to accept at least a 64-mb file size, creating important consistency between health plans and reducing initial rejections and costly resubmissions for physician practices. For X12 attachment transactions, the rule also sets requirements for maximum response times, acknowledgments, and handling of errors. **Taken in whole, these infrastructure requirements establish valuable uniformity and common expectations regarding the exchange of electronic attachments.**

The attachment data content requirements further enhance the benefit of this rule set. Specifically, the rules address a common workflow challenge related to clinical documentation exchange: the reassociation of attachments to the related claim or PA request. The rule includes requirements to support reassociation for both X12 and non-X12 attachment transactions and also recommends inclusion of reference data to further assist with association. In addition, the rule recommends that health plans use LOINCs when requesting supporting documentation to ensure that practices send the correct information. This provision addresses another common challenge for physicians and their staff, which is identifying the specific clinical data a particular health plan needs to complete claim adjudication or process a PA request.

[14] 2021 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

The AMA believes that the PA and claims attachments operating rules offer an important steppingstone to the health care industry's adoption of electronic attachments. By promoting uniform implementation, as well as addressing common workflow challenges such as reassociation, these rules will benefit physician practices and improve efficiency. **We urge NCVHS to recommend adoption of the attachment infrastructure and data content attachments operating rules.**

9. Attachments Operating Rules – General Question.

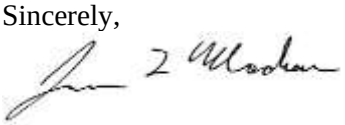
The AMA strongly recommends *concurrent adoption* of electronic transaction standards for attachments and associated operating rules. As previously stated, the health care industry has waited for many years for an attachments standard. In the absence of a standard, physician practices have been forced to use slow, expensive methods of transmitting clinical supporting documentation (e.g., faxes and mail) or faced with a myriad of proprietary, plan-specific solutions. Given the high costs associated with these inefficiencies, as well as the care delays associated with burdensome PA-related clinical data exchange, attachment standards and operating rules should be mandated together to avoid further implementation delays.

Beyond the long wait for an electronic attachment solution, there are other convincing reasons to simultaneously move forward with attachment transaction standards and operating rules. First, operating rules bring additional uniformity and conformance to transaction implementation by addressing business rules outside the strict purview of standards. For example, the CORE attachments operating rules establish a minimum attachment size limit, which sets common expectations across stakeholders and prevents failed transactions and costly resubmissions. Additionally, the operating rules provide critical support for attachment reassociation, which the industry has repeatedly identified as a workflow challenge. Having this additional structure and guidance in place during the initial implementation will increase conformance and consistency across the industry. **In turn, this uniformity will reduce confusion and improve efficiency, which we expect will increase physician practices' adoption of an electronic attachment transaction standard.** Finally, we expect that implementing attachment standards and operating rules simultaneously as one health IT project will be easier for most organizations and more efficient than addressing operating rule compliance at a later stage. **For these reasons, we believe that attachments transaction standards and operating rules should be simultaneously adopted and implemented.**

Summary

Thank you for the opportunity to provide comments on the proposed adoption of updated/new X12 electronic transaction standards and CAQH CORE operating rules. We look forward to continuing our dialog with NCVHS on how the health care industry can best leverage new technology to address unmet business needs without jeopardizing smoothly operating workflows or diverting limited health IT resources away from higher priority needs, such as PA automation. If you have any questions regarding our comments, please contact Margaret Garikes, AMA's Director of Federal Affairs, at 202-789-7409 or margaret.garikes@ama-assn.org.

Sincerely,



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