June 30, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Community Health Plans Request Flexibility to Meet Multiple Compliance Deadlines of Health Data Exchange Rules

Dear Administrator Brooks-LaSure:

On behalf of, the Alliance of Community Health Plans (ACHP) respectfully requests CMS evaluate the multiple regulatory compliance deadlines and pending actions directed to health plans on health data exchange. Prior to and during the pandemic, HHS and Congress issued a number of health data initiatives that require significant financial, workforce and resource investment by health plans. While nonprofit community-based health plans focus on a robust response to the COVID-19 pandemic and expanding access to affordable and comprehensive coverage, major regulatory requirements with fast approaching deadlines are putting significant strain on health plan operations. These include:

1. CMS Interoperability and Patient Access Regulation,
2. Transparency in Coverage Regulation, and
3. The No Surprises Act of the Consolidated Appropriations Act of 2021.

We urge the Administration to consider compliance and enforcement discretion as the health care industry and our regional, nonprofit health plans continue to prioritize vaccine administration, Affordable Care Act expansion and transitioning to post-pandemic operations. Additionally, the Administration should take the necessary time to revisit these policies which in many circumstances produce more burden on health plans and consumers than the benefit they derive.

ACHP represents the nation's top-performing non-profit health plans improving affordability and outcomes in the health care system. ACHP member companies are provider-aligned health organizations that provide high-quality coverage and care to more than 24 million Americans across 36 states and D.C. They are leading the industry in practical, proven reforms around primary care delivery, value-based payment and data-driven systems improvement.

ACHP supports interoperable health care data exchange to make it easier for individuals to access and use their health information. We fully support the necessary steps to implementing interoperability within health care systems and we appreciate the Administration recent delay of enforcement deadlines in response to the COVID-19 pandemic. While we are enthusiastic supporters of this next phase in health information exchange, we stress the importance of managing expectations in the midst of pandemic response and recovery with multiple demands on health plans. Key to the success of seamless health data exchange is consumer trust, which cannot be achieved unless the systems and processes in place are executed securely, accurately and appropriately. These steps require sufficient time to ensure that payers and providers are able to map and aggregate all administrative and clinical patient data and establish private and secure data exchange pathways.

Interoperability and Patient Access Regulation

ACHP members have spent the last year and a half making the necessary adjustments and investments, such as recruiting the right workforce and vendors, to be able to provide patients with seamless access to their health data on July 1, 2021, even while the pandemic forced ACHP members to shift resources away from non-emergency programs and initiatives to manage community, patient and provider needs. Pandemic response delayed numerous internal deadlines, resulting in compressed compliance timeframes and increased financial demands. In addition to developing and deploying the patient access API and meeting provider directory requirements, plans are simultaneously pivoting to planning and implementation of the January 1, 2022, payer-to-payer API requirements.

We ask the Administration extend the enforcement discretion for the patient access and provider directory requirements through January 1, 2022, and extend the enforcement discretion for the payer-to-payer API requirements until July 1, 2022. ACHP is grateful to the Administration for their initial enforcement discretion for the patient access and provider directory API requirements. However, the pandemic remained the pressing focus far longer than anyone hoped, and planning is also needed for many post-pandemic permanent transformative changes in the new health care marketplace. As previously noted, health plans are operating under compressed timelines to meet the first set of requirements by July 1, 2021. As a result, it is difficult to allocate personnel and resources to begin work on the second set of requirements. Many ACHP members are either undertaking these efforts internally with relatively small IT departments or relying on vendors with multiple other clients. Therefore, enforcement discretion is necessary to provide the adequate opportunity to be compliant with these complicated requirements.

A separate CMS rule pending final action, the *Improving Prior Authorization Processes and Promoting Patients Electronic Access to Health Information,* is another component of the interoperability initiatives that plans are considering without certainty of the regulation's status. While the rule appears to have been finalized January 15, 2021, the regulatory freeze enacted just five days later created some confusion as to the official status of the regulation.

ACHP requests the Administration provide clarity on the status of this Prior Authorization regulation and, should it be reissued, stakeholders should be given additional time to provide comments as the initial comment period was less than the requisite 30 days. If the Administration proceeds with this rule, the effective date should be set to accommodate the existing deadlines for the patient access, provider directory and payer-to-payer API requirements. For many ACHP member plans, implementation and compliance with this regulation will draw upon the same resources for the other regulations mentioned in this letter.

ACHP urges the Administration to consider additional, pressing aspects of interoperability, such as privacy protections of personal health information (PHI) within third-party applications. ACHP and our member companies raised our concerns over the insufficient protections to PHI once it leaves a HIPAA-covered-entity and is sent, at the direction of a patient, to a third-party application. ACHP is concerned that the consumer education requirements within the *Interoperability and Patient Access* regulation will be insufficient to prevent consumers from using unsecure applications. This places the onus on health plans rather than the application vendors and platforms that may lack privacy consumer education materials or notices and policies and practices for privacy, security and consent. In addition, when these applications fail to protect the privacy and security of personal health data, consumers may blame the health plan that released the data, undermining trust in health plans as reliable custodians of patient's private information – ultimately endangering consumer trust in health plans. While CMS and OCR have made it very clear that health plans will not be held liable for third-party application privacy violations, ACHP supports a new Federal Health Data Privacy Framework to ensure consistent standards for health data privacy and security spanning all government branches.

Transparency in Coverage Regulation

ACHP and our members strongly support transparency of cost information that is relevant, helpful, and specific to a consumer's individual benefit information. ACHP members aim to equip consumers with the price and quality information that will enable them to evaluate their health care options and make informed decisions. Individualized and tailored transparency will establish a more informed consumer base and help control total cost of care. ACHP member organizations already offer various pricing tools and information services to assist consumers with intensely personal medical decisions.

However, the *Transparency in Coverage* regulation, specifically the machine-readable files requirements and the January 1, 2022, effective date, is concerning. First, it is redundant for health plans to spend significant resources to produce these machine-readable files as many of them currently offer cost estimator tools for consumers. In addition, the data from these files will not be able to produce meaningful information when turned into applications. While application developers and health care researchers expect this data to provide high value to consumers, health plans use more sophisticated pricing and cost algorithms to predict consumer cost sharing, making the files an unhelpful source of cost and pricing information. Understanding individual benefit packages, contract

arrangements, historical claims data and other complex information used to estimate out-of-pocket costs, health plans are better suited to provide direct cost estimates to consumers, rather than rely on third-party applications.

Second, these machine-readable files are labor intensive and costly to produce. The cost to regional, nonprofit plans operating on thin margins of just 1-3 percent is significant when considering these health plans are also balancing investments in high-value, tailored benefits and care for their communities. It is also worth noting that other high-value consumer tools, like travel search engines, do not rely on machine-readable files.
In addition, health plans need additional guidance to compile the substernal and complex data for these files. While CMS has been using GitHub as a repository for technical details, there are numerous outstanding questions without guidance from the agency. For example, the schema currently posted on GitHub does not provide the level of detail that is contained in the final regulation and was only recently updated to include additional "billing code types" commonly used in provider contracts. The current schema does not account for complex combinations of code types or other intricate contract arrangements, such as contracts that use a percentage of billed charges as a default method for codes that might not be otherwise specified in the contract.

Lastly, as already mentioned, health plans are currently facing a significant amount of administrative burden to meet interoperability compliance requirements with overlapping deadlines. In many instances, the internal team responsible for implementing these requirements is also responsible for some, or all, of the interoperability requirements.

ACHP requests the Administration apply enforcement discretion to the Transparency in Coverage regulation and within that timeframe work with health plans to better understand how valuable cost and pricing information can be shared with consumers.
Our members support consumer access to pricing and cost information that is accurate and valuable to their health care decision making. To meet this goal, many of the requirements within the Transparency in Coverage regulation are unnecessary. We strongly encourage the Administration to consider an alternative pathway to providing consumers with accurate and valuable pricing information.

The No Surprises Act

The No Surprises Act passed within the Consolidated Appropriations Act of 2021 contains additional price transparency and health data provisions that overlap with existing regulations. The advance explanation of benefit (AEOB) for consumers, price comparison tool and provider directory provisions are all currently regulated in some form through the Patient Access and Interoperability regulation and the Transparency in Coverage regulation. The overlapping requirements, January 1, 2022, effective date, and additional provisions governing ID cards and broker compensation disclosures are concerning for health plans, which lack clarity on critical implementation details and the various competing regulatory and legislative effective dates.

ACHP urges the Administration delay the effective date for these provisions and to engage with health plans to assess feasible pathways towards achieving the goals of the No Surprises Act. The AEOB requirement, triggered by a provider notification, assumes existing and ready IT infrastructure and will involve significant investment to make this a seamless consumer experience. The requirement also assumes timely provider communications and accurate predictions of patient encounters and care needs. ACHP recommends that add an enrollee request to the criteria to trigger an AEOB. This would mean the AEOB requirement is triggered by a scheduled service, provider notification and enrollee request for a cost estimate. This would reduce inundating members with additional unwanted communications and avoiding member confusion for those that may mistake the AEOB as a bill.

In addition, there is no technical standard for providers when generating a good faith estimate. Health plans need further guidance and clarification regarding the "good faith" language in the legislation. ACHP is concerned that "good faith", while a flexible benchmark for plans, will ultimately disappoint and confuse patients should the actual services and costs differ from what was estimated in advance.

ACHP recommends that the Administration offer a phased-in approach to this requirement to allow for IT infrastructure modifications, starting with a narrower set of services, and gradually expanding those services over time. In addition, plans should be able to list a range of costs and exempt members on no-deductible copay-only plans, since the costs are fixed for those members. The Administration should also consider allowing plans to communicate AEOBs electronically by default, as using regular mail will prevent plans from meeting stated timelines and lead to estimates coming after member care or services.

ACHP requests the Administration align the overlapping requirements for a 'cost estimator tool' from the Transparency in Coverage regulation and a 'price comparison tool' from the No Surprises Act. The Transparency in Coverage regulation already requires health plans to provide a self-service tool showing personalized out-of-pocket costs for prospective items and services by January 1, 2023. It is unclear how the 'price comparison tool' in the No Surprises Act will provide additional meaningful benefit to consumers beyond the 'cost estimator tool' in the Transparency in Coverage regulation. The scope of these two requirements should be refocused to better provide consumers with valuable pricing information and avoid inundating consumers with information that may not be relevant to them or may vary from individual to individual.

ACHP requests the Administration clarify the overlap of provider directory requirements between the No Surprises Act and existing regulations. The specified updates to provider directories within the No Surprises Act differ from the Interoperability and Patient Access API requirements. The legislation requires a verification and update every 90 days and update information within 2 business days of being notified whereas the regulation requires an update every 30 days. As ACHP member plans are working towards the July 1, 2021, effective date within the regulation to meet the provider directory requirements, ACHP appreciates any guidance from the Administration as to potential overlap of these requirements. Maintaining and updating provider directories is

notoriously difficult and we encourage the Administration to refrain from requiring health plans to make updates within 2 business days of being notified of a change.

ACHP appreciates the Administrations ongoing efforts to ensure the health care industry has the appropriate resources and guidance to comply with the interoperability and patient access regulation. ACHP recognizes the need for rapid modernization of our health data exchange ecosystem, highlighted by the COVID-19 pandemic. However, with additional components of this health data exchange ecosystem still needing regulatory or administrative guidance, such as patient matching, TEFCA, HIPAA modifications and others, ACHP urges the Administration to weigh the significant amount of modernization already being undertaken by health plans and the basic need for time and flexibility before advancing new requirements.

We appreciate your consideration of our recommendations and look forward to discussing them further with you and your team. Please contact Michael Bagel, Director of Public Policy at mbagel@achp.org or 202-897-6121 if you have any questions or need any further information.

Sincerely,

Ceci Connolly
President and CEO, ACHP