CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase IV Rules/Technical Work Group (PIV RWG/TWG)
Call #2 Summary: Wednesday, September 11, 2019, 2:30-4:00 pm ET Conference Call

This document contains:

- Agenda items and key discussion points.
- Decisions and actions to be taken.
- Next steps.
- Call attendance.

Agenda Item	*Key Discussion Points*	*Decisions and Actions*
1. Antitrust Guidelines	• Erin Weber (CAQH CORE Director) opened the call and introduced Noam Nahary (Montefiore) and Rhonda Starkey (Harvard Pilgrim) as a CAQH CORE Phase IV Response Time Task Group (PIV TG) Co-chairs presenting on the call. She also introduced Bob Bowman (CAQH CORE Director), Emily TenEyck (CAQH CORE Senior Associate), Lina Gebremariam (CAQH CORE Manager) as speakers on the call. • Erin Weber (CAQH CORE Director) reviewed the Antitrust Guidelines, noting that they are published on the CAQH CORE Calendar along with the meeting materials.	*Discussion*
2. Roll Call and Administrative Items	• Erin Weber (CAQH CORE Director) reviewed the call document: o Doc #1: PIV RWG – TWG Call 2 Agenda 09.11.19 o Doc #2: PIV RWG – TWG Call 1 Summary 08.14.19 o Doc #3: PIV RWG –TWG SP Results 09.11.19 • Erin Weber (CAQH CORE Director) skipped roll call due to technical difficulties. [See call participant roster at the end of this meeting summary to view call attendees and affiliated organizations]. • Erin Weber (CAQH CORE Director) reviewed the focus of the call, which was to: o Review the straw poll results o Review the points of clarification and substantive feedback • **Summary of PIV RWG/TWG Discussion:** o No questions or comments were raised by the PIV RWG/TWG.	*Discussion*
3. Summary of 08/14/19 PIV RWG/TWG Call (Doc #2).	• **Summary of 08/14/19 PIV RWG/TWG Call:** o Erin Weber (CAQH CORE Director) reviewed the 08/14/19 call, in which the PIV RWG/TWG: – Provided a background and overview of CAQH CORE and role in prior authorization (PA). – Reviewed the Draft Phase IV CAQH CORE 278 Infrastructure Rule Update. – Reviewed Phase IV RWG/TWG roles and responsibilities. – Discussed next steps.	***Action*** - Motion to Approve by: Deb McCachern (Change Healthcare) - Seconded by: Sandra Jamison (Humana)
4. Straw Poll Overview (Doc #3).	• Emily TenEyck (CAQH CORE Senior Associate) provided an overview of the straw poll format and respondents. • **Summary of PIV RWG/TWG Discussion:** o No questions or comments were raised by the PIV RWG/TWG.	*Discussion*
5. Review Straw Poll Results: Draft	Rhonda Starkey (Harvard Pilgrim) reviewed the Point of Clarification from Part A of the straw poll.	*Discussion*

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Phase IV 278 Infrastructure Rule Update (Doc #3).	**Summary of PIV RWG/TWG Discussion:** ○ No questions or comments were raised by the PIV RWG/TWG. Rhonda Starkey (Harvard Pilgrim) reviewed the Substantive Comments from Part A of the straw poll. **Summary of PIV RWG/TWG Discussion:** ○ Rob Tennant (MGMA) stated that this call is timely because the house committee on small business just finished on the impacts to patient care that PA has, and they all mentioned timeliness. Rob argued that urgent is more important for CAQH CORE to address than non-urgent. The life expectancy of a patient can be dramatically affected by timeliness. Rob reiterated that efforts should be refocused on urgent care. ○ Rhonda Starkey (Harvard Pilgrim) responded urgent requests are handled in the exact same manner as emergent requests so Harvard Pilgrim look at it in a more expeditious way. Rhonda asked the group how other Health Plans dealt with urgent versus emergent services. ○ Diana Fuller (Michigan Department of Community Health) explained that Michigan Medicaid treats urgent the same way as we treat emergent. ○ Rhonda Starkey (Harvard Pilgrim) stated that the recommendation related to this comment is to address urgent PA requests during future efforts. ○ Heather McComas (AMA) responded that while some health plans may treat emergent and urgent PA requests in the same manner, the timeframe being discussed by the Work Group is still critical as when holidays and weekends are factored in, the timeframe can be five calendar days in some cases. Furthermore, the 278 transaction does not have an indicator for urgent requests. ○ Bob Bowman (CAQH CORE Director) stated one of the reasons CAQH CORE recommended not to address the urgent services in the Phase IV Rule Update as the 278 indicator for urgent requests falls under a data content update not an infrastructure update. As the Phase IV Update is specific to infrastructure, CAQH CORE recommended the definition of urgent be addressed in PV data content because it is different among entities etc. This work would include defining the indicator to be used to flag urgent requests. ○ Heather McComas (AMA) thanked Bob then asked whether CAQH CORE could reopen Phase V to address urgent requests. ○ Erin Weber (CAQH CORE Director) explained that work could be done concurrently as a task group but could not be done right now as all CAQH CORE Participants must have the chance to answer a call for participants to have their SMEs engage on different topics. A different call for participants would need to go out when addressing data content. ○ Bob Bowman (CAQH CORE Director) stated that this is important for the industry, but will need a new focus on the definition and the data content. This is a unique call to action so the industry can come together around the definition in the future.	

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	○ Bruce Bellefeuille (X12) stated that coming in the next version of the TR3 for the 278 will have another value for the Medicare expedited in addition to urgent and emergent. This is just something to take into consideration. ○ Bob Bowman (CAQH CORE Director): another point to advocate for as we look to specific data content for on the business processes and something CAQH CORE can look for in the future. Bob Bowman (CAQH CORE) reviewed Substantive Comments #1-6 from Part B of the straw poll. **Summary of PIV RWG/TWG Discussion for Substantive Comments #2 - #4:** ○ Chuck Veverka (Michigan Department of Community Health) said that the last bullet implies that just because some entities are experimenting with emerging technologies it means that all organizations can do it. But entities will need major system revisions. It is not readily adoptable by organizations in the healthcare industry. ○ Bob Bowman (CAQH CORE Director) agreed emerging technologies are in limited adoption today. CAQH CORE recommends not including those types of requirements in the rule at this time. ○ Rob Tennant (MGMA) agreed that FHIR and DSLR are forward looking but stated that every health plan on this call and in this nation already knows what is required to approve a service or medication. The templates are in place. One should not equate the simple transaction of letting a provider what is known with the prior auth. One can be done much faster than the other. Rob Tennant stated that the timeframe requirement for notifying a provider what additional documentation is required should be 24 hours, as the current two business days is too long. ○ Heather McComas (AMA) explained 2 business days is not 48 hours because of holidays and such. It could be a week and a half potentially before a patient is looking at being scheduled for treatment. Heather McComas noted that it was unclear why a plan would need two business days to identify the need for additional documentation unless the provider submitted unsolicited documentation. ○ Bob Bowman (CAQH CORE Director) clarified these pertain to 4.4.3 which is for real time. ○ Merri-Lee Stine (Aetna) said it would certainly be Aetna's goal to automate 278 requests to automatically spit out with a response that it is pended because X is needed and put that need in the response. Aetna does not anticipate being able to do this even though they use a real time 278 process. Several individuals are required to review these requests and identify the need for additional documentation. Furthermore, these are the same individuals that are reviewing urgent and emergent requests and will need to prioritize their workload. Aetna supports the two-day maximum timeframe to make sure all types of requests can be accommodated. ○ Diana Fuller (Michigan Department of Community Health) added that for a Medicaid, if there is a more cost-effective services, they are required to notify the provider which takes much longer than 2 business days. Diana Fuller also mentioned that a 15-business day timeframe requirement for providers versus 2 business days for health plans is unbalanced. Diana Fuller recommended that the timeframe requirement for both health plans and providers should be 15 business days.	

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	○ Bob Bowman (CAQH CORE Director) responded this rule is specific to the 278 and therefore the Work Group decided to move the provider requirement to the attachment initiative. ○ Heather McComas (AMA) asked whether health plans need to manually review the 278 transaction if it is just carrying administrative data? Does a manual review of the 278 need to occur before plans can request additional documentation? ○ Bob Bowman (CAQH CORE Director) responded that he knew from the attachments environmental scan, the review can include the need for additional data. ○ Merri-Lee Stine (Aetna) agreed with Bob Bowman. ○ Rob Tennant (MGMA) noted that there is flexibility built into the CAQH CORE rules for complicated requests, health plans only have to meet the requirement 90% of the time. How many of the authorizations are automated vs. manual review? ○ Diana Fuller (Michigan Department of Community Health) responded any procedure code that comes into Michigan Medicaid must receive a manual review. ○ Rhonda Starkey (Harvard Pilgrim) added that Harvard Pilgrim has 100% configured to respond with detail information if not highly specific information. If it is an inpatient admission and something else, Harvard Pilgrim may say it needs more generic patient history but 100% of our responses go back with information needed on a 278 response. ○ Megan Soccorso (Cigna) stated all of Cigna's PAs are manual. Cigna is in the process of automating some of them but not all of them so hopefully by the end of the year there will be some automation. At this point all of them are manual. ○ Bob Bowman (CAQH CORE Director) asked if all the PAs that come in drop to manual? ○ Megan Soccorso (Cigna) responded yes. ○ Merri-Lee Stine (Aetna) explained Aetna would like to automate all of it. Aetna is not currently using the LOINC codes, and would like to get to a place of automation, but is not there today. There is some auto-adjudication but no pending with request for specified additional documentation. ○ Bruce Bellefeuille (X12) stated it would be great as Merri Lee said to include the LOINC codes, etc. Aetna is waiting for the final Phase IV update and potential Attachments rules. Aetna does not have the ability to send back exactly what is needed. ○ Merri-Lee Stine (Aetna) added in today's world, if it is not certified, it is addressed manually. ○ Rob Tennant (MGMA) asked if there are deadlines that you place on your staff in terms of timelines? ○ Bruce Bellefeuille (X12) responded that the same staff that works on elective is those that work on emergent/urgent. They are looking at emergent/urgent first before those that are elective. There are a lot of internal turnaround times. There are plan/sponsor turnaround times and Medicaid turnaround times that the staff have to keep the commitments for. ○ Diana Fuller (Michigan Department of Community Health) explained they have never received a 278. Providers send the BDE, snail mail or fax. If they are not BDE, we have to enter that information in addition to the unsolicited or solicited.	

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	○ Heather McComas (AMA) responded saying that hearing about all the processes, weekends, holidays, she cannot underscore the need for urgent timeframe enough. If you are the patient in pain and suffering, industry cannot allow things to drag on if there are urgent situation. This highlights the need for an urgent use case. **Bob Bowman (CAQH CORE Director) explained other comments were similar for real time, and processed to Substantive Comment #5.** ○ Rhonda Starkey (Harvard Pilgrim) stated she was curious with providers and recipients, when you begin with the batch request, what would it mean for providers if health plans broke up that batch? How would the provider be able to track that they are getting the responses for the ones they need if some are received in 24 hours vs. 48 hours? ○ Noam Nahary (Montefiore) responded that we often get a few acknowledgements back. ○ Robert Tennant (MGMA) stated providers are looking for some improvement and this would improve some PAs. ○ Rhonda Starkey (Harvard Pilgrim) responded she was curious how many providers are looking at it as a batch vs. real time requests to ensure that the effort is get going as quickly as possible for the patient? Do we know or have data from the provider prospective? ○ Noam Nahary (Montefiore) responded the provider looking at the response isn't looking at the 278 batch. It is translated into what is needed for the provider to look at for the patient and there is this piece. Does that help? ○ Rhonda Starkey (Harvard Pilgrim) responded most of the folks she knows batch things and they got out at night. ○ Noam Nahary (Montefiore) stated yes, once a day or once a night. But at least once a day. ○ Randy Gabel (Ohio Health) explained they use the portal. It is all about timing and knowing if the PA is needed. ○ Bob Bowman (CAQH CORE Director) explained that some clearinghouses do something with the transactions and then send them back to the provider. The integrity of the batch is important for the tracking purposes of the clearinghouse. ○ Noam Nahary (Montefiore) asked do we want this requirement to be two separate items? ○ Bob Bowman (CAQH CORE Director) responded our suggestion was to keep it as one unless anyone has any significant reasons why not. **Bob Bowman (CAQH CORE Director) moved to Substantive Comment #6.** **Summary of PIV RWG/TWG Discussion for Substantive Comment #6:** ○ Heather McComas (AMA) asked, if plans need to review the 278 to know if a PA is required? ○ Bob Bowman (CAQH CORE Director) explained that Cigna said that any request that comes in needs a review but that most of those need a review. ○ Megan Soccorso (Cigna) stated that is right.	

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6. Next Steps for PIV RWG/TWG	• Given time constraints, the Co-Chairs and CAQH CORE staff recommended adding an additional call to complete review of the straw poll results. ○ Chuck Veverka (Michigan Department of Community Health) asked if rather than adding a second call if the next call could be extended by an hour. ○ Erin Weber (CAQH CORE Director) explained that it was a good idea, but the plan was to send the follow-up straw poll out after the next call which would cause a significant lag in timing. Erin Weber then asked participants to be on the lookout for an email from the CORE team regarding the next call. In the interim, she requested Work Group members reach out to the Co-Chairs and CAQH CORE staff on any key items. ○ Chuck Veverka (Michigan Department of Community Health) requested that the minutes from this meeting be sent prior to the next call.	*Discussion*

Call Documentation
Doc 1: PIV RWG – TWG Call 2 Agenda 09.11.19.pdf
Doc 2: PIV RWG – TWG Call 1 Summary 08.14.19.pdf
Doc 3: PIV RWG –TWG SP Results 09.11.19.pdf

CAQH CORE Contact Information

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Call #1 Summary: Wednesday, August 14, 2019, 2:30-4:00 pm ET Conference Call
Phase IV Response Time RWG/TWG Call #2 Attendance

CAQH CORE Participating Organization	Last Name	First Name	Attended
Accenture	Koul	Swati	
Aetna	Stine	Merri-Lee	X
Aetna	Bakos	Janice	X
Aetna	Myrhum	Melissa	X
Aetna	Neves	Amy	X
Aetna – X12 Representative	Bellefeuille	Bruce	X
AIM Specialty Health	Montesantos	Laura	X
American Medical Association (AMA)	Lefebvre	Celine	
American Medical Association (AMA)	McComas	Heather	X
Ameritas Life Insurance Corp.	Wordekemper	Lori	
Ameritas Life Insurance Corp.	Ninneman	Kyle	
athenahealth	Holtschlag	Joe	
athenahealth	Prichard	Emily	X
Availity, LLC	Wallis	Jason	
Availity, LLC	Weed	Michele	
Availity, LLC	Holman	Heather	
Blue Cross and Blue Shield Association (BCBSA)	Kocher	Gail	
Blue Cross Blue Shield of Michigan	Monarch	Cindy	X
Blue Cross Blue Shield of Michigan	Long	Susan	X
Blue Cross Blue Shield of Michigan	Turney	Amy	X
Blue Cross Blue Shield of Michigan	Rutherford	Darlene	X
Blue Cross Blue Shield of Michigan	McNeilly	Ann	
Blue Cross Blue Shield of North Carolina	Maness	Christine	X
Blue Cross Blue Shield of North Carolina	Wilson	Greg	
Blue Cross Blue Shield of Tennessee	Poteet	Brian	X
Blue Cross Blue Shield of Tennessee	Langford	Susan	X
CareFirst BlueCross BlueShield	Long	Lisa	
CareFirst BlueCross BlueShield	Zeigler	Karen	
CareSource	Moles	Mandy	
CareSource	Wilson	Angie	
CareSource	Takacs	Michael	
Centers for Medicare and Medicaid Services (CMS)	Pardo	Angelo	
Centers for Medicare and Medicaid Services (CMS)	Watson	Charles	X
Centers for Medicare and Medicaid Services (CMS)	Hunter	Michelle	
Centers for Medicare and Medicaid Services (CMS)	Kalwa	Daniel	
Centers for Medicare and Medicaid Services (CMS)	Cabral	Michael	X

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CAQH CORE Participating Organization	Last Name	First Name	Attended
Centers for Medicare and Medicaid Services (CMS)	Green	Denesecia	
Cerner/Healthcare Data Exchange	Hogan	Claire	
Change Healthcare	McCachern	Deb	X
Change Healthcare	Banks	Jodie	
CIGNA	Ikponmwosa	Davina	
CIGNA	Soccorso	Megan	X
Cognosante	Koduru	Andy	
Cognosante	Lambert	Dora	X
CSRA	Nair	Shilesh	X
DST Health Solutions	Lynam	Mary	X
DXC Technology	Daniel	Connie	
DXC Technology	Mills	Charles	
Epic	Barbieri	Andrew	
Epic	Pasumarthi	Vasu	
Epic	Carino	Santo	X
Experian	Wolskij	Beth	
Harvard Pilgrim Health Care	Kilrain	Katherine	
Harvard Pilgrim Health Care	Starkey	Rhonda	X
Healthcare Financial Management Association	Koopman	Chris	
HEALTHeNET	Gracon	Christopher	X
HMS	Wilcox	Beth	
Horizon Blue Cross Blue Shield of New Jersey	Fitchett	Kiana	
Humana	Peterson	Amy	X
Humana	Jamison	Sandra	X
Kaiser Permanente	Amiryan	Arpi	X
Kaiser Permanente	Crosby	Yolanda	
Kaiser Permanente	Belen	Aileen	X
Laboratory Corporation of America	Woodrome	Laurie	
Medical Group Management Association (MGMA)	Tennant	Robert	X
Michigan Department of Community Health	Fuller	Diana	X
Michigan Department of Community Health	Veverka	Chuck	X
Minnesota Department of Health	Haugen	David	
Montefiore Medical Center	Nahary	Noam	X
Montefiore Medical Center	Torres	Nysia	X
National Council for Prescription Drug Programs	Strickland	Teresa	
National Council for Prescription Drug Programs	Weiker	Margaret	
New Mexico Cancer Center	McAneny	Barbara L.	

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New Mexico Cancer Center	Bateman-Wold	Tonia	X
OhioHealth	Gabel	Randy	X
OptumInsight	Carty	Sintija	
Pennsylvania Department of Public Welfare	Valvo	David	
PNC Bank	Wood	Barbara	X
PNT Data Corp	Wiener	Amy	
Premera Blue Cross Blue Shield	McJannet	Kate	
Tata Consultancy Services Ltd	Kumari	Sushmita	
TrialCard	Mendez	Chris	
TRICARE	Amankrah	Leroy	X
TRICARE	Nawabi	Mostafa	X
TRICARE	Wilderman	David	
United States Department of Veterans Affairs	Tyra	Mary	
United States Department of Veterans Affairs	DeBacker	Anne	X
United States Department of Veterans Affairs	Knapp	Katherine	X
United States Department of Veterans Affairs	Matthews	Brian	
United States Department of Veterans Affairs	Annecchini	Frank	
UnitedHealthGroup	Shamsideen	Janell	
UnitedHealthGroup	Bleibaum	Angie	
Unitedhealthcare	Goel	Anupam	
Unitedhealthcare	Faulds	Sharon	X
Unitedhealthcare	Nordstrom	Alexandria	
Work Group for Electronic Data Interchange	Stellar	Charles	