CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase IV Response Time Task Group (PIV TG)
POST Call #4: Wednesday, August 07, 2019, 2:30-4:00 pm ET Conference Call
Call Summary for Phase IV Response Time Task Group (PIV TG) Call #4 – 08/07/19
Co-Chairs:
Randy Gabel, *OhioHealth*
Rhonda Starkey, *Harvard Pilgrim Health Care*

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 Rhonda Starkey (Harvard Pilgrim Health Care), CAQH CORE PIV TG Co-chair, Randy Gabel (OhioHealth), CAQH CORE PIV TG Co-Chair, Bob Bowman, CAQH CORE Director, and Emily TenEyck, CORE Senior Associate, as co-presenters 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 (Docs 1 & 2)	• **Erin Weber (CAQH CORE Director)** reviewed the three call documents: o Doc #1: PIV TG Call #4 Agenda 08.07.19 o Doc #2: PIV TG Call #3 Summary 07.10.19 o Doc #3: PIV TG Straw Poll Results 08.07.19 • **Erin Weber (CAQH CORE Director)** called roll. [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 Provide summary of straw poll respondents. o Review summary of support for each rule section straw polled. o Review comment categorization. • **Summary of Phase IV Task Group Discussion:** o Chuck Veverka (Michigan Department of Community Health) requested a correction to Doc 2: PIV TG Call #2 Summary 07.10.19. Instead of “greatly expanded or eliminated” it should read “greatly reduced or eliminated”. o Erin Weber (CAQH CORE Director) agreed that the change would be made to the call summary. o Chuck Veverka (Michigan Medicaid) then moved to approve Doc 2: Summary Call 3. o Megan Soccorso (CIGNA) seconded the motion to approve the call summary.	*Discussion*
3. PIV TG Straw Poll #2 Results (Doc 3; pgs. 2-3).	• **Emily TenEyck (CAQH CORE Senior Associate)** gave an overview of the straw poll and summary of respondents. • **Summary of Phase IV Task Group Discussion:** o No questions or comments were raised by the PIV TG.	*Discussion*

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4. Phase IV Task Group Straw Poll #2 Results (Part A) (Doc 3; pgs. 4-6).	• **Rhonda Starkey (Harvard Pilgrim Health Care)** reviewed the percent support for Part A: Scope. • **Rhonda Starkey (Harvard Pilgrim Health Care)** reviewed one point of clarification received on the Straw Poll pertaining to the scope section and provided clarification for the comment. • **Rhonda Starkey (Harvard Pilgrim)** reviewed two substantive comments received on the Straw Poll pertaining to the Scope of the draft requirements along with the CAQH CORE Staff & Co-chair recommendation on how to address the comments. • **Summary of Phase IV Task Group Discussion:** ○ Heather McComas (AMA) noted that the AMA has raised the issue that emergent, urgent and appeals use cases should be in scope before and understands that appeals go through a different use case than the rest but wants to push back on the urgent use case scenario because it follows the same workflow, just more quickly. She commented that while they would like timelines for all of these use cases addressed in the rule, the urgent use case would be something that CORE could address in this phase of the rule development because it requires the same reviews and data as what is currently in scope. ○ Rhonda Starkey (Harvard Pilgrim Health Care) replied that one thing she could point out from her plan's perspective is that if the request is for emergent or urgent status, it is converted to a notification process and an extensive medical review is not done, it is typically auto-approved. She asked if there are any other plans that function this way or if they would do the full review with an urgent PA? ○ Gail Kocher (BCBSA) commented that while she can't speak to what the plans are doing, part of the concern with urgent is that outside the federal rules the concept of urgent can vary based on state requirements so it would be difficult to establish an operating rule that would have state regulatory impacts without additional research at this point in time. Her recommendation is to leave the scope as is and take up the additional research/scope at a later date. ○ Erin Weber (CAQH CORE Director) agreed with Gail's comment and explained that part of the reason urgent use cases are not included is because we haven't seen a consistent use or definition of urgent requests across the industry. ○ Diana Fuller (Michigan Medicaid) asked if anyone has a 24-hour hotline or phone number where people can call if they are in an emergent situation or if a provider needs an answer immediately. After hearing no comments, she noted that Michigan Medicaid does have a phone line and asked if a phone call wouldn't be better than a 48-hour wait response. ○ Gail Kocher (BCBSA) stated that just because people didn't speak up to say they have a 24-hour hotline doesn't mean there aren't other opportunities available to the providers in that situation. She explained that other plans may not be speaking to it because the focus of this operating rule is on the electronic transactions and that this discussion is on electronic request/response for emergent and urgent situations. ○ Bob Bowman (CAQH CORE Director) noted that the Task Group may not be large enough to have details for every specific plan and whether they support other options. He agreed that many plans	*Discussion*

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	probably do support other options for emergent and urgent. Bob also reminded the group that this issue came up on the Phase V rule development while discussing the scope of the data content rule. However, Phase IV pertains to infrastructure and workflow, so we suggest not including requirements for emergent/urgent because that is mainly related to data content – a health plan has to see what type of 278 is coming in, whether it is an emergent, urgent, referral or simple PA request. We can to bring this discussion point up to the RWG/TWG level and relay to the group that it is still a point of concern. ○ Heather McComas (AMA) noted that Medicare Part D has different timing requirements for urgent and emergent coverage. She asked that the group consider this issue more at the next level of development. ○ Gail Kocher (BCBSA) replied that a lot of the Part D and pharmaceutical drug side are actually done through PBMs so the infrastructure is much more difficult than on the medical side, thus you aren't always comparing apples to apples when referring to Part D. ○ Heather McComas (AMA) said that was a fair point. ○ Erin Weber (CAQH CORE Director) told the group that CORE Staff would do their due diligence to research this topic further before the RWG/TWG launch. ○ Diana Fuller (Michigan Medicaid) transitioned the group to discuss the first substantive comment pertaining to scope and explained that she understands that the rules are currently voluntary, but CAQH expects them to become mandatory down the line, as discussed on the phone. She asked the group if it wouldn't be appropriate to adjust the rule now rather than down the line when the rule becomes mandatory. ○ Erin Weber (CAQH CORE Director) clarified that there is not an expectation but there is potential for the rule to go through the regulatory process. However, we do not know what the outcome will be based on public comment and other key components of the process. She further explained that if it does go through that process there would be time for it to go through the regulatory steps and then an additional 2-year implementation period following any mandate. ○ Rhonda Starkey (Harvard Pilgrim Health Care) asked if CAQH CORE has included any exclusions in other operating rules. ○ Bob Bowman (CAQH CORE Director) replied that we have not had exceptions aside from pharmacy, for NCPDP-related transactions. ○ Chuck Veverka (Michigan Medicaid) clarified that Michigan Medicaid's frustration over the wording of the rule is that we are talking about electronic submission of a 278 coming into an environment that is completely manually for all of the 278 transactions. The exception language is crafted to address this. He explained that it is inappropriate to expect an electronic response speed from a manual process and the wording, as it stands, will likely become mandated at some point in the future. If this will be a problem in the future for Michigan, they would like to address it now with an exception, however it can be worded. He noted that Michigan Medicaid is different than most other processors from the payers / health plan perspective.	

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	○ Rhonda Starkey (Harvard Pilgrim Health Care) asked if there were no other processes for any other administrative simplification transaction that Michigan Medicaid has the same issue with. ○ Chuck Veverka (Michigan Medicaid) confirmed that it is only with PA and until an electronic attachment capability is standardized, they do have the need to review the attachments issues in some cases on claims. ○ Gail Kocher (BCBSA) stated that the issue Michigan Medicaid faces is isn't as unique as they may think, but that her plan understand that those internal systems issues may need to be looked at in respect to an operating rule, if and when it is mandated. She commented that she struggles with supporting an exception that is based on an internal systems issue when we as an industry are trying to make the process better for the patient. ○ Bob Bowman (CAQH CORE Director) said that the intent of the PIV rule is to lay the groundwork for systems to become more automated even if it is just to receive the 278. He explained that CORE understand that systems today typically pend the transaction followed by a manual review and often a request for additional documentation. The current environment for many of these plans is very much a batch process but by setting the framework we hope to have more consistent exchange by trading partners. He noted that CAQH CORE understands that we aren't going to turn this into auto-adjudication tomorrow, but it is a pathway there and the intent is to help understand where entities are today and move phase by phase over time, with or without the intent of federal regulation. ○ April Todd (CAQH CORE Senior Vice President) commented, to close out the section, that in general, CAQH CORE approaches Operating Rule development as broadly as possible so that it can apply as many populations as possible that would be covered, whether it that may be Medicare, Medicaid or the commercial market. Unless there is another federal law that covers the rule in a certain way or another organization that the exemption would apply, for example pharmacy, our intention as the mission/vision of CORE is keep the rule development as streamlined as possible. She noted that we recognize that could be other topics to cover and will follow up with Michigan Medicaid. ○ Chuck Veverka (Michigan Medicaid) noted that Michigan Medicaid went offline with CAQH CORE and CAQH CORE suggested they draft the exemption language, which is now not being considered. ○ Erin Weber (CAQH CORE) mentioned that as discussed on the call, the decision is up to the participating organizations, not CORE staff. ○ Rhonda Starkey (Harvard Pilgrim Health Care) noted that she did not think we were hearing strong support for an exemption from the task group participants and asked if there were additional comments. ○ April Todd (CAQH CORE Senior Vice President) clarified that, to his point, it is something that CAQH CORE would like to discuss further and if it is something he would like to bring up for a formal vote we could do that at the Rules and Technical Work Group level. ○ Chuck Veverka (Michigan Medicaid) said thank you for your consideration.	

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5. Phase IV Task Group Straw Poll #2 Results (Health Plan Response Time Requirements) (Doc 3; pgs. 7-13).	• **Rhonda Starkey (Harvard Pilgrim Health Care)** gave an overview of the percent support for each of the Draft Health Plan Response Time Requirements as well as the percent support for the Health Plan Response Time Requirement Timeframes – Timeframes A & B. • **Rhonda Starkey (Harvard Pilgrim Health Care)** provided the CAQH CORE Staff and Co-chair recommendation to select 2 business days for both timeframes A and B, noting that support was split by stakeholder type. • **Bob Bowman (CAQH CORE Director)** reviewed 7 points of clarification comments received on the Straw Poll pertaining to potential Draft Phase IV Health Plan Response Time Requirements and provided clarifying answers to the group. • **Bob Bowman (CAQH CORE Director)** reviewed 5 substantive comments received on the Straw Poll pertaining to potential Draft Phase IV Health Plan Response Time Requirements and provided clarifying answers to the group. • **Summary of Phase IV Task Group Discussion:** ○ Heather McComas (AMA) asked the health plans what scenarios would lend themselves to not knowing what information was needed immediately – she noted that plans have rules for what information is needed readily available. The only scenario that the AMA could think of was if the provider submitted unsolicited information. She further explained that having a timeframe where plans get two days to tell the provider what information is needed adds time to the overall process because there is another timeframe until the final decision. ○ Gail Kocher (BCBSA) replied that while the health plan may return a response initially communicating that ABC information is needed, when that information is then submitted to the health plan the health plan may realize further information is needed from the provider. She agreed that the plan should be able to know what information is needed based on what was submitted, but that is not always enough information needed to make a final determination and additional information may be identified through further back and forth. ○ Bob Bowman (CAQH CORE Director) added that we don't want to assume that every plan has a front-end way to identify in the 278 from the provider what additional information is needed. If there is additional information needed, there must be time to make that assessment and pend the response. We are trying to address the scenario in Gail's example as well as plans that can auto-adjudicate. Michigan Medicaid, for example, pends everything because they know they will need additional documentation and will need to determine what documentation is needed. ○ Susan Langford (BCBST) agreed with Gail Kocher (BCBSA) and Bob Bowman (CAQH CORE Director) because they often find that PA requests are turned over to utilization management nurses for review. There are a small number of cases where they automatically know what is required – in most cases, nurses need to manually review each situation because cases are different. ○ Heather McComas (AMA) asked if this is because plans are not getting enough information on the 278 itself to make an immediate decision to determine what they need.	*Discussion*

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	○ Susan Langford (BCBST) replied that for BCBST, in many cases additional documentation is needed that isn't included in the PA request. She confirmed that, yes, it related to the additional documentation that isn't initially received and that nurses need to review. ○ Diana Fuller (Michigan Medicaid) transitioned to substantive comment number four and asked that in the case of PAs being sent out to a UMO, are there are two days for the UMO to return an answer to the health plan, or do the two days start once it comes back from the UMO? ○ Bob Bowman (CAQH CORE Director) said that the intent of the requirement for the final determination is that once all the information has been completed, review and the response is available to the health plan has two days to be communicated back to the provider. ○ Diana Fuller (Michigan Medicaid) clarified that the clock actually starts once the plan has received the determination, there is 48 hours to get it to the provider. ○ Erin Weber (CAQH CORE Director) stated that the clock starts once the health plan has received the information, not once you have made the determination – once the information is in hand. ○ Diana Fuller (Michigan Medicaid), confirmed that, in the scenario when all the information is in hand and it is given to the UMO, the UMO has 2 days to make a decision and return the information so it can be communicated to the provider, so a total of 48 hours. ○ Erin Weber (CAQH CORE Director) agreed that yes, that was the case. ○ Diana Fuller (Michigan Medicaid) stated that the way the CAQH CORE response reads in Doc 3, it seems like plans have 48 hours once the determination has been made to communicate the response to the provider, not once they have all the information. ○ Erin Weber (CAQH CORE Director) said the clock starts once you have all the information to make the final determination. ○ Bob Bowman (CAQH CORE Director) added that this a good point of clarity and noted we will address this in FAQs and also adjust the section headers. ○ Diana Fuller (Michigan Medicaid) agreed that this was a good approach. ○ Bob Bowman (CAQH CORE Director) commented that the group will see the draft rule language again at the RWG/TWG level and it will contain these adjustments for clarity. ○ Deb McCachern (Change Healthcare) noted that because the requirement says health plan *and its agent,* it seems like if the UMO is making decision on behalf of the health plan and they should communicate the decision. ○ Bob Bowman (CAQH CORE Director) agreed that in this example the UMO is making the decision of prior authorization and is the agent. ○ Diana Fuller (Michigan Medicaid) asked if, in the situation where a UMO or other agent is making a decision on behalf of a health plan – who would be held accountable to the standard, the health plan or the UMO? The health plan doesn't know the information because they aren't the one making the decision. Or is the health plan accountable after the UMO has made the decision? ○ Bob Bowman (CAQH CORE Director) noted that there is a requirement for if when a health plan has all the information it needs, and a timeframe for if there is additional documentation that is needed as well, like the scenario that Gail described previously.	

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	○ Erin Weber (CAQH CORE Director) commented that this was all good feedback and that we would clarify the language with the UMO language. ○ Bob Bowman (CAQH CORE Director) added that creating a workflow map may be helpful.	
6. Phase IV Task Group Straw Poll #2 Results (Close Out Response Time Requirements) (Doc 3; pgs. 14-16).	• **Randy Gabel (OhioHealth)** gave an overview of the percent support for each of the Draft Close Out Requirements as well as the percent support for the Close Out Requirement Timeframe – Timeframe C. • **Randy Gabel (OhioHealth)** provided the CAQH CORE Staff and Co-chair recommendation to select 15 business days for both timeframe C. • **Bob Bowman (CAQH CORE Director)** reviewed 2 points of clarification comments received on the Straw Poll pertaining to potential Draft Phase IV Health Plan Response Time Requirements and provided clarifying answers to the group. • **Bob Bowman (CAQH CORE Director)** reviewed 2 substantive comments received on the Straw Poll pertaining to potential Draft Phase IV Health Plan Response Time Requirements and provided clarifying answers to the group. • **Summary of Phase IV Task Group Discussion:** ○ Heather McComas (AMA) expressed concern about the requirement because health plans already have these requirements in place and providers are highly incentivized to get PAs completed as quickly as possible. She asked that the group better define 'close out' and what happens afterward as this requirement is developed at the next level. ○ Bob Bowman (CAQH CORE Director) agreed that these are valid concerns and that we can address them through FAQs and in discussions at the RWG/TWG level. He added that it would be beneficial for the industry to continue that education. ○ Heather McComas (AMA) said adding some kind of statement explaining that the close out doesn't imply that the patient can never get service approved would be helpful. ○ Bob Bowman (CAQH CORE Director) commented that as Heather mentioned, most plans already have systems and requirements on close outs, and that these requirements shouldn't infringe on those requirements, just inform how to communicate that response (via the 278). Most health plans today just cancel out requests in their system and the provider then has to make a phone call or go into the portal to figure that out, or a health plan has to generate a letter, when they should be able to send a standard transaction.	
7. Phase IV Task Group Straw Poll #2 Results (Provider Response Time Requirement) **8.** (Doc 3; pgs. 17-18).	• **Randy Gabel (OhioHealth)** reviewed the results of Part C: removing the provider response time requirement from the Phase IV 278 Infrastructure Rule Update. • **Randy Gabel (OhioHealth)** provided the CAQH CORE Staff and Co-chair recommendation to remove the requirement. • **Emily TenEyck (CAQH CORE Senior Associate)** reviewed the single substantive comment received on the Straw Poll pertaining to Part C. • **Summary of Phase IV Task Group Discussion:** ○ No questions or comments were raised by the PIV TG.	

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9. PIV Task Group Next Steps: Straw Poll #2 (Doc 3; pg.18)	• **Emily TenEyck (CAQH CORE Senior Associate)** thanked the group for joining the call and noted that task group participants are encouraged to stay involved in the rule development process at the RWG/TWG level. • **Emily TenEyck (CAQH CORE Senior Associate)** closed the call. • **Summary of Phase IV Task Group Discussion:** ○ No questions or comments were raised by the PIV TG.	**Actions/Responsibilities:** • Agreed to next steps

Call Documentation
Doc 1: Phase IV TG Call #4 Deck 08.07.19.pdf
Doc 2: Phase IV TG Call 3 Summary 07.10.19.pdf
Doc 2: Phase IV Straw Poll 2 Results 08.07.19.pdf

CAQH CORE Contact Information

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Phase IV Response Time Task Group Call #3 Attendance

CAQH CORE Participating Organization	Last Name	First Name	Attendance
Accenture	Anderson	Lisa	
Aetna	Bellefeuille	Bruce	X
Aetna	Egebergh	Heidi	
Aetna	Bakos	Janice	
Aetna	Lawyer	Amy	X
American College of Physicians	Rockwern	Brooke	
American Medical Association (AMA)	Scheid	Tyler	
American Medical Association (AMA)	McComas	Heather	X
American Medical Association (AMA)	Otten	Robert	
American Medical Association (AMA)	Celine	Lefebvre	X
Ameritas	Ninneman	Kyle	

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CAQH CORE Participating Organization	Last Name	First Name	Attendance
Anthem	Cioff	Chris	
Anthem	Gwinn	Kena	
Anthem	Reddick	Ryan	
athenahealth	Prichard	Emily	X
athenahealth	Holtschlag	Joe	
athenahealth	Pooler	Nikki	
Blue Cross Blue Shield Association (BCBSA)	Kocher	Gail	X
Blue Cross Blue Shield Association (BCBSA)	Cullen	Rich	
Blue Cross Blue Shield of Michigan	Turney	Amy	
Blue Cross Blue Shield of Michigan	McNeilly	Ann	
Blue Cross Blue Shield of Michigan	Larson	Carol	X
Blue Cross Blue Shield of Michigan	Monarch	Cindy	X
Blue Cross Blue Shield of Michigan	Long	Susan	
Blue Cross Blue Shield of North Carolina	Hillman	Barry	
Blue Cross Blue Shield of North Carolina	Maness	Christine	
Blue Cross Blue Shield of North Carolina	Wheatly	James	
Blue Cross Blue Shield of North Carolina	Zarate	Sal	X
Blue Cross Blue Shield of North Carolina	Howard	Wanda	
Blue Cross Blue Shield of Tennessee	Poteet	Brian	
Blue Cross Blue Shield of Tennessee	Langford	Susan	X
CMS	Meisheid	Anna	
CMS	Green	Denesecia	
CMS	Calvert	Emily	
CMS	Keyes	Katrina	
CMS	Combs-Dyer	Melanie	
Change Healthcare	McCachern	Deb	X
Change Healthcare	Denison	Mike	
CIGNA	Maisano	Marci	
CIGNA	Soccorso	Megan	X
DST Health Solutions	Lynam	Mary	
Harvard Pilgrim Health Care	Starkey	Rhonda	X
Health Care Service Corp	Harley	Melanie	
Health Care Service Corp	Washburn	Racheal	
HFMS	Koopman	Chris	
Humana	Zutterman	Michelle	
ioHealth	Marlow	Kristian	
Marshfield Clinic	Weik	Kari	

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CAQH CORE Participating Organization	Last Name	First Name	Attendance
Marshfield Clinic	Foemmel	Sara	
MGMA	Tennant	Robert	
Medical Mutual of Ohio	Headland	Carla	X
Medical Mutual of Ohio	Conklin	Deborah	
Michigan Department of Community Health	Veverka	Chuck	X
Michigan Department of Community Health	Fuller	Diana	X
Michigan Department of Community Health	Hinkle	Lori	
Montefiore Medical Center	Wasp	Eric	
Montefiore Medical Center	Kaufhold	Cynthia	
Montefiore Medical Center	Kelly-Manza	Sandra	
Montefiore Medical Center	Siena	Giuseppe	
NextGen Healthcare Information Systems	Hurgeton	George	
OhioHealth	Stratton	LeAnne	
OhioHealth	Gabel	Randy	X
Premera Blue Cross Blue Shield	McJannet	Kate	
Unitedhealthcare	Reigel	Jordan	
URAC	Merrick	Donna	
URAC	Adams	Robin	
Wells Fargo	St. John	June	
Wells Fargo	Birgenheier	Jason	X