CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase IV Rules/Technical Work Group (PIV RWG/TWG)
Call #3 Summary: Thursday, September 26, 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 Medical Center) and Rhonda Starkey (Harvard Pilgrim Health Care) as CAQH CORE Phase IV Response Time Rules/Technical Work Group (PIV RWG/TWG) co-chairs presenting on the call. She also introduced Bob Bowman (CAQH CORE Director) as a speaker 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 documents:
	  ○ Doc #1: PIV RWG – TWG Agenda Call #3 09.26.19
	  ○ Doc #2: PIV RWG – TWG Call #2 Summary 09.11.19
	  ○ Doc #3: PIV RWG – TWG SP Results 09.11.19 UPDATED
	• 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:
	  ○ Complete the review of the results of the straw poll on Draft Phase IV CAQH CORE 278 Infrastructure Rule Update and Draft Phase IV Certification Test Suite Update – 278 Infrastructure Test Scenarios (Doc #3).
	  ○ Discuss next steps, including the RWG/TWG Straw Poll #2.
	• **Summary of PIV RWG/TWG Discussion:**
	  ○ Celine Lefebvre (AMA) noted that on page 2 of the call summary there was a comment made by Heather McCommas (AMA) that states, 'does not' when it should say 'does'.
	  ○ Rhonda Starkey (Harvard Pilgrim) motioned to approve the 09.11.19 call summary, pending the change suggested by Celine Lefebvre.
	  ○ Amy Neves (Aetna) seconded the motion to approve the 09.11.19 call summary.
		Discussion

3. Brief Straw Poll Overview (Doc #3)	• Rhonda Starkey (Harvard Pilgrim Health Care) provided a summary of straw poll respondents and reviewed the percent support for each rule section that was straw polled. • Rhonda Starkey (Harvard Pilgrim Health Care) reviewed the comment categorization. • **Summary of PIV RWG/TWG Discussion:** ○ No questions or comments were raised by the PIV RWG/TWG.	*Discussion*
4. **Review Straw Poll Results: Draft Phase IV**	• Erin Weber (CAQH CORE Director) reviewed the points of clarification comments received for all Parts B of the straw poll beginning on page 9 before handing it to Bob Bowman (CAQH CORE Director) to review the remaining substantive comments in Part B.	*Discussion*

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278 Infrastructure Rule Update (Doc #3)	• **Summary of PIV RWG/TWG Discussion:** ○ No questions or comments were raised by the PIV RWG/TWG. • Bob Bowman (CAQH CORE Director) continued the review of the substantive comments received on straw poll Part B, beginning with Row 7. • **Summary of PIV RWG/TWG Discussion:** ○ Melissa Driscoll (Aetna) explained that she has a hard time believing that most carriers are auto-adjudicating 70% of their PA requests which generally require medical necessity or review. ○ Bob Bowman (CAQH CORE Director) thanked Melissa for her comment and noted that we have seen throughout the Work Group that there is significant variability in capabilities. Health plans have submitted comments indicating that they would like to see anywhere from less than two days up to 30 days, which speaks to the fact that a majority (63%) of the Work Group approved two business days as the timeframe for processing a final determination. ○ Melissa Driscoll (Aetna) said that two days is less than the Department of Labor gives a health plan to process a PA in an urgent situation. She further noted that 72 hours is the requirement for expedited requests and asked for confirmation that the rule requires two business days. ○ Bob Bowman (CAQH CORE Director) replied that, yes, the rule recommendation is two business days for 90% of a health plans' PAs requests. ○ Melissa Driscoll (Aetna) explained that going from 15 days for a non-urgent situation to a two day turnaround will be a heavy lift in terms of staffing requirements for carriers that do a medical necessity review on their PA requests. ○ Susan Langford (BCBS TN) offered that Blue Cross Blue Shield Tennessee was one of the plans who recommended a timeframe longer than two days. She agreed with Melissa and noted that while a significant number of PAs are systematically auto-adjudicated within BCBS Tennessee's portal, the turnaround time is not the issue. However, there are numerous situations where medical necessity review or utilization nurses must review information that's received with the PA request and they cannot get the buy-in from users to accommodate the two day turnaround. She stressed if the Phase IV rules are to be adopted or if the industry plans to continue implementing and certifying the rules, we need to start with three or four days then down the road and decrease the timeframe from three or four days to two days. She stressed that health plans would like to process PA requests in two business days, but the nurses who review medical records cannot accommodate two day response timeframes. She stated that we as an industry need to think about the timeframe in terms of adoption and emphasized that it will have improved adoption if the timeframe is longer than two days. ○ Rhonda Starkey (Harvard Pilgrim Health Care) reminded the group that two days was arrived at as the timeframe after a review of existing response time requirements in the industry. The analysis revealed that there are a large number of plans and states that require two day turnarounds.	

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	○ Erin Weber (CAQH CORE Director) agreed that the two day timeframe was found in the industry, including in Massachusetts. ○ Diana Fuller (Michigan Medicaid) said that according to PowerPoint shown on the first call only two states were polled, one with a 10 day requirement and one with a two day requirement. ○ Erin Weber (CAQH CORE Director) agreed that the vast majority of states do not require a two day turnaround time. ○ April Todd (CAQH CORE Senior Vice President) clarified that the PowerPoint shown on the first call was meant to illustrate the wide range of variation among states. She further noted that one of the things the rule is trying to mitigate is the wide variation when it comes to turnaround time for final determination. ○ Celine Lefebvre (AMA) commented that two business days is very generous considering payers are able to assign business days as they choose, including holidays, scheduled downtimes, and system availability, and that only 90% of PAs need to be adjudicated within the two day timeframe. She explained that PAs are a patient-facing issue and therefore stressed that the maximum amount of time for a final determination to be received from a health plan should be two business days. ○ Diana Fuller (Michigan Medicaid) asked Rhonda if Harvard Pilgrim has a two day turnaround time for PAs? ○ Rhonda Starkey (Harvard Pilgrim Health Care) replied that yes, from the time the additional documentation is received, the requirement in the state of Massachusetts is two days to make a final determination. ○ Diana Fuller (Michigan Medicaid) confirmed that the two days begins after all the information needed to respond to the PA is received, not when the request is initially received. ○ Rhonda Starkey (Harvard Pilgrim Health Care) stated that Diana is correct and that the same language is included in Section 4.5.4; the two day clock kicks in after all information is received. ○ Diana Fuller (Michigan Medicaid) asked Rhonda how many PAs are pended because additional documentation is needed. ○ Rhonda Starkey (Harvard Pilgrim Health Care) replied that she doesn't know the exact number but estimates that it is fewer than 30% of their PAs. ○ Rob Tennant (MGMA) echoed Celine Lefebvre (AMA)'s comment that two business days is a long time and that it often bleeds into weekends and holidays. He reminded the group that the two day final determination timeframe is after a health plan receives all the required information necessary to process the PA. He noted that there are medical necessity rules built into the engines and understands that there will be cases where the PA is a complicated clinical situation, but because only 90% of requests are required to comply with the rule requirement there is sufficient wiggle room to comply with the rule. He noted 30 days is too long from a patient care perspective.	

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	○ Diana Fuller (Michigan Medicaid) replied that the federal standard today for an elective service is 15 days, not 30 days. She asked how long it takes to see a patient and if all patients are seen within two days of their call to schedule an appointment. ○ Rob Tennant (MGMA) replied that if we are going to look at this question then staffing must be examined. He stated that the main concern about two days that he is hearing is around staffing but commented that some plans are able to accommodate two days. He further noted that the CAQH CORE rules should be aspirational in order to elevate the industry. ○ One PIV RWG/TWG participant explained that if the current standard is 15 days, the response timeframe shouldn't be decreased by 13 days, but cutting it by for example, seven days would be a good first step, while still aspirational without causing issues for staffing. ○ Diana Fuller (Michigan Medicaid) noted that while CAQH CORE recommends not adjusting the requirement because 63% of the Work Group agreed to two days, the stakeholder breakdown gives a broader picture of who makes up the 63% that voted for two days. ○ Lori Woodrome (LabCorp) shared that there are times in the lab world when they hold onto specimens until the PA processed and that, as an industry, we should do everything we can to protect patient care. ○ One PIV RWG/TWG participant stated that the 15 day turnaround time was meant to be for elective procedures and if something needs to be expedited there is a process under the current law. ○ Diana Fuller (Michigan Medicaid) said that we are trying to take the elective PA process and reduce a 15 days deadline down to a two day deadline, making elective PAs as important and necessary to process as urgent and emergent requests. ○ One PIV RWG/TWG participant agreed and noted that this puts cases that need to be expedited or that are actually urgent at a greater risk. ○ Diana Fuller (Michigan Medicaid) agreed and replied that urgent requests should come before elective request in the PA process. ○ Rhonda Starkey (Harvard Pilgrim Health Care) asked if the 15 day timeframe required by the Department Labor is 15 days from the date of receipt of the PA or the timeframe once all the information necessary to make a final determination is received. ○ One PIV RWG/TWG participant replied that she thinks it is the date from which all information is received but doesn't have the rules currently available. ○ Rhonda Starkey (Harvard Pilgrim Health Care) asked what the urgent and emergent requirements are under the Department of Labor. ○ One PIV RWG/TWG participant replied that it is 72 hours but that there is also latitude for receiving all the information needed. She clarified that it is not business days, rather a straight 72 hours.	

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	○ Rhonda Starkey (Harvard Pilgrim Health Care) asked Celine if, from point of the provider, there is a difference in turnaround times between a routine, non-emergent service and an emergent or urgent service. ○ Rob Tennant (MGMA) responded that there is absolutely a difference and that there should be no PA for emergent services and urgent PAs should be responded to in real-time or close to it. He reiterated that two days is generous for routine services. He also noted that part of the process is more transparency of rules. He explained that there is currently quite a bit back and forth with PAs because providers don't understand what's required by the health plans and the health plans don't receive the information they need. ○ Lori Woodrome (LabCorp) stressed that as an indirect provider, she often doesn't know the difference between routine and emergency and asked how to communicate that from the ordering provider to the indirect provider. She said that it is a moot point for LabCorp. ○ Celine Lefebvre (AMA) said that the AMA came out with guiding principles in 2017 which stated there should be no PAs for emergency services, 24 hours for urgent and 48 hours for regular/routine services. She echoed Rob Tennant (MGMA) in saying that these timeframes are important from patient perspective, even in non-urgent situations. ○ Rhonda Starkey (Harvard Pilgrim Health Care) asked if there would be another straw poll where people could comment on the timeframes. ○ Bob Bowman (CAQH CORE Director) said yes, there will be another straw poll following the call. He recommended moving to the next substantive comment for Work Group discussion. • Bob Bowman (CAQH CORE Director) continued to review the substantive comments received in Part B of the straw poll. ○ Celine Lefebvre (AMA) said that HL7 noted at the HL7 conference that it would be a security issue for payers close out a PA because it would require leaving the system open and notifications could be sent to the wrong place, causing HIPAA issues. She asked if anyone in the group had heard this as well because the AMA otherwise supports the requirement. ○ Gail Kocher (BCBSA) understands why the actual system wouldn't be left open but asked if we are talking about finalizing the notification, which is different than leaving the system open. ○ Rhonda Starkey (Harvard Pilgrim Health Care) replied that it's not finalizing the notification, but it is the point when a payer can close a request because it's still pended, and the provider never submitted the additional documentation needed to complete the request. ○ Gail Kocher (BCBSA) confirmed that this was her thought as well and thinks there may have been a misunderstanding in terms of leaving the system open versus leaving the notification open. ○ Rhonda Starkey (Harvard Pilgrim Health Care) agreed and said if that was the case, it would be a security risk to send out even the final notification or any unsolicited 278.	

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	○ Gail Kocher (BCBSA) said someone must have misunderstood between leaving a notification open and a system open. ○ Bob Bowman (CAQH CORE Director) directed the Work Group to the substantive comment in which an entity suggested developing an additional requirement that a payer must send a notification to the provider prior to the close out, warning the provider that the request will soon be closed out. He asked if any of the health plans include this in their current process. ○ Rhonda Starkey (Harvard Pilgrim Health Care) said that as a payer they do not have that type of process today. She said based on group discussion it doesn't seem like there is strong investment in the addition of this requirement. ○ Diana Fuller (Michigan Medicaid) stated that Michigan Medicaid does send out a notice, but that it is slightly different. If they receive a PA request and the necessary information is not included, they send back notice to send documentation required to prove medical necessity and close out the PA along with the statement. When the additional documentation is sent in, the PA process is started on that date. ○ Bob Bowman (CAQH CORE Director) asked if the notification sent to provider is through mail or online. ○ Diana Fuller (Michigan Medicaid) replied that once decision is made, Michigan Medicaid sends a letter by mail to adhere to legislative law. It is also available on the portal within 24 hours so provider or patient can review what is missing. ○ Diana Fuller (Michigan Medicaid) noted that the Work Group is working to determine if a PA should be closed out because information is not received within 15 days, but if this is about patient care, providers should be held to the same two day standard. ○ Lori Woodrome (LabCorp) responded that a specimen might be received but with genetic testing, for example, they often don't know what is needed because the patient has to be referred to a genetic counselor before the process can be finalized. If it is known upfront what is needed, they would be able to execute considerably faster. ○ Rob Tennant (MGMA) echoed Lori Woodrome (LabCorp) stating that it is out of the providers hands because each payer has different rules and regulations demanding different documentation for the same condition so there is a reason why the provider would need additional time. ○ Diana Fuller (Michigan Medicaid) replied that providers have fewer staff than large health plans, but not every health plan has ample staff. She noted that Michigan Medicaid uses the same people to review both routine and urgent PAs - there isn't staff that simply reviews routine requests. She further explained that their staff review all PAs and often need extra time because an urgent request comes in while a routine PA being reviewed, and the urgent request will be reviewed before continuing to review the routine request. She said that it makes sense for all stakeholders to have the same amount of time because everyone has staffing issues.	

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	○ Rob Tennant (MGMA) noted that unlike providers, payers know the rules because they make the rules and if there was perfect communication those stricter timelines could be met. ○ Diana Fuller (Michigan Medicaid) replied that they receive PA requests with no clinical information included, but it's understood by providers that there has to be some clinical information to back up a PA request. ○ Rhonda Starkey (Harvard Pilgrim Health Care) conducted a time check. ○ Bob Bowman (CAQH CORE Director) thanked Rhonda for the time check. He reminded the Work Group that they will be straw polled on the next iteration of the draft rule following this call.	
5. Next Steps for PIV RWG/TWG	• Bob Bowman (CAQH CORE Director) reviewed next steps including instructions, guidelines and a due date for the RWG/TWG Straw Poll. • **Summary of PIV RWG/TWG Discussion:** ○ No questions or comments were raised by the PIV RWG/TWG.	*Discussion*

Call Documentation
Doc 1: PIV RWG - TWG Call #3 Agenda 09.26.19.pdf
Doc 2: PIV RWG - TWG Call #2 Summary 09.11.19.pdf
Doc 3: PIV RWG - TWG SP Results 09.11.19.pdf UPDATED

CAQH CORE Contact Information

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Phase IV Response Time RWG/TWG Call #3 Attendance

CAQH CORE Participating Organization	Last Name	First Name	Attendance
Accenture	Koul	Swati	
Aetna	Stine	Merri-Lee	X
Aetna	Bakos	Janice	X
Aetna	Driscoll	Melissa	X
Aetna	Neves	Amy	X
Aetna	O'Connor	Elizabeth	X
Aetna	Lawyer	Amy	X
Aetna – X12 Representative	Bellefeuille	Bruce	X
American Medical Association (AMA)	Lefebvre	Celine	X
American Medical Association (AMA)	McComas	Heather	
Ameritas Life Insurance Corp.	Wordekemper	Lori	
Ameritas Life Insurance Corp.	Ninneman	Kyle	
AthenaHealth	Holtschlag	Joe	
AthenaHealth	Prichard	Emily	
Availity, LLC	Wallis	Jason	
Availity, LLC	Weed	Michele	
Availity, LLC	Holman	Heather	
Blue Cross and Blue Shield Association (BCBSA)	Kocher	Gail	X
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	
Blue Cross Blue Shield of Michigan	McNeilly	Ann	
Blue Cross Blue Shield of North Carolina	Maness	Christine	
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	
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	

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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
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	
Cognosante	Koduru	Andy	X
Cognosante	Lambert	Dora	X
CSRA	Nair	Shilesh	
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	
Humana	Jamison	Sandra	X
Kaiser Permanente	Amiryan	Arpi	
Kaiser Permanente	Crosby	Yolanda	
Kaiser Permanente	Belen	Aileen	X
Laboratory Corporation of America	Woodrome	Laurie	X
Medical Group Management Association (MGMA)	Tennant	Robert	X
Michigan Department of Community Health	Fuller	Diana	X
Michigan Department of Community Health	Veverka	Chuck	
Minnesota Department of Health	Haugen	David	
Montefiore Medical Center	Nahary	Noam	X
Montefiore Medical Center	Torres	Nysia	

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CAQH CORE Participating Organization	Last Name	First Name	Attendance
National Council for Prescription Drug Programs	Strickland	Teresa	
National Council for Prescription Drug Programs	Weiker	Margaret	
New Mexico Cancer Center	McAneny	Barbara L.	
New Mexico Cancer Center	Bateman-Wold	Tonia	
OhioHealth	Gabel	Randy	
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	
United States Department of Veterans Affairs	Knapp	Katherine	X
United States Department of Veterans Affairs	Matthews	Brian	X
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	X