CAQH CORE Operating Rules: Data Content/Infrastructure NCVHS Subcommittee on Standards Hearing August 25, 2020

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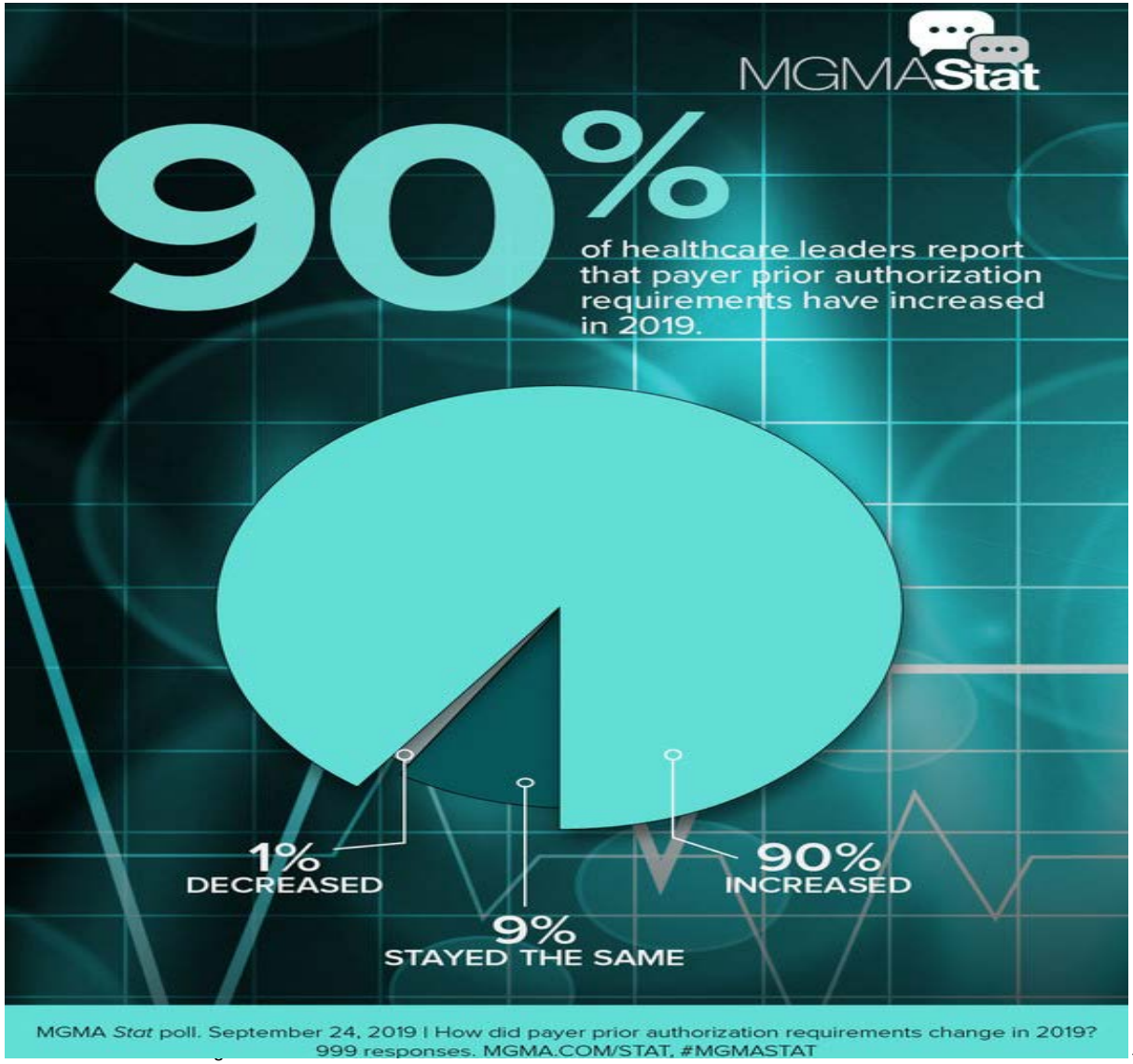
- MGMA is the premier association for professionals who lead medical practices.
- With a membership of more than 58,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 organizations of all sizes, types, structures, and specialties that deliver almost half of the healthcare in the United States.

Current Prior Authorization Environment

2019 MGMA Regulatory Burden Survey

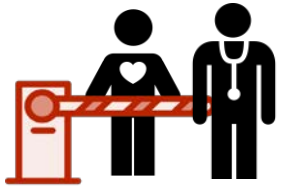
	Not burdensome	Slightly burdensome	Moderately burdensome	Very burdensome	Extremely burdensome	Very + Extremely
Prior authorization	2%	5%	10%	22%	61%	83%
Medicare quality payment program (MIPS/APMs)	4%	2%	17%	30%	47%	77%
Audits and appeals	1%	9%	23%	35%	32%	67%
Lack of EHR interoperability	5%	10%	20%	33%	32%	65%
Medicare Advantage chart audits	6%	10%	23%	26%	35%	61%
Translation and interpretation requirements	8%	14%	24%	26%	28%	54%
Medicare and Medicaid credentialing	4%	18%	31%	24%	23%	47%
HIPAA privacy and security	8%	15%	35%	28%	14%	42%
Federal fraud and abuse law	17%	22%	37%	18%	6%	24%

Prior Authorization



Excessive prior authorization requirements negatively impact our healthcare system.

Disrupts continuity of care



Interferes with physician-patient relationship

Increases costs and burden

Data Content Rule

Data Content Rule: Positives

There are content areas addressed in this Rule that could have a positive impact on the PA workflow. These include:

- Receipt and processing of diagnosis/procedure/revenue codes for specified categories of services and detection and display of all code descriptions.
- Consistent patient id and verification should reduce common errors and denials to ensure a better patient/subscriber match.
- Return of specific AAA error codes and action codes should improve communication between practices and plans and reduce the need for manual follow-up.

Data Content Rule: Positives

- Return of Health Care Service Decision Reason Codes should provide a clearer explanation of plan required next steps.
- Use of PWK01 Code should provide direction on status and what additional clinical information is needed for plan adjudication of the PA request.
- Detection and display of all code descriptions should reduce the burden of interpretation on the provider.
- “Requesting Additional Documentation for a Pended Response” has potential to improve the current workflow. Knowing what documentation the plan requires allows for the provider to determine the information that should be supplied.

Data Content: The Role of Operating Rules

- Optimally, a single entity should be responsible for data content, most likely the appropriate SDO.
- Yet this presupposes that the SDO will actively solicit input from providers, incorporate modifications that increase the usefulness of the transaction, and act quickly to meet industry needs.
- When these conditions are not met, it is imperative that operating rules be enacted to ensure that the transactions are responsive to the needs of practices and improved in a timely manner.
- We commend CAQH CORE for their diligence and professionalism in the development of these and other operating rules.

Infrastructure Rule

Infrastructure Rule: Positives

- **System Availability:** Sets provider expectations on standard system availability plus notifications of any down time. (We note, however, the permitted 24 hrs per week down time is excessive.)
- **Acknowledgements:** Allows for providers to immediately learn whether the plan has received the PA request, rather than needing to manually follow-up.
- **Consistent Companion Guide:** Standard Companion Guide format enables consistency across trading partners.

Infrastructure Rule: Positives

- **Two-Day Additional Information Request:** A health plan has two business days to review a PA request from a provider and respond with additional documentation needed to complete the request.
- **Two-Day Final Determination:** Once all requested information has been received from a provider, the plan has two business days to send a response containing a final determination.
- **Adoption Incentive**: Timeframe requirements could act as an incentive for practice adoption of the 278.

Infrastructure Rule-Enhancements Needed

- PAs deemed urgent should have a max response time of 24 hours once the plan with all the supporting documentation they require.
- Response times for initial plan response and final response of 2 “business” days should be changed to 48 hrs for each response. Healthcare delivery is not a Mon-Fri event. Bus days do not include weekends or federal holidays. In practical terms, 2 bus days could translate to a full 5 days between plan responses-leading to unacceptable delays in patient care.
- The maximum of 15 business days to respond to a plan request for additional supporting documentation before the request is closed by the plan should be extended to 30 bus days.

Implementation Timeframe

- All covered entities, regardless of their size or type, should be given 24 months to comply with this federal mandate-the same amount of time provided covered entities for implementing he operating rules for the 270/271, 276, 835, and electronic funds transfer transactions.

Summary

- MGMA is supportive of the CAQH CORE PA Data Content and Infrastructure Rules being federally mandated. Adoption of these operating rules will improve the current PA process by standardizing data content and requiring a max time for plans to respond to authorization requests.

- The two-bus day requirements were a necessary compromise between providers and plans during the Rule development process. While an improvement over the current lengthy and non-standardized plan response times, these max timeframes should be significantly shortened.

- These operating rules will help, but additional reforms are needed to substantially improve the PA process: (i) eliminating PA for services that are routinely approved and for providers in risk contracts; (ii) promulgating the regulation for attachments; (iii) exploring new standards to automate the authorization process; (iv) and stronger enforcement against non-compliant health plans.


Thank You!
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