Represented Provider Organizations

Today’s joint testimony is provided on behalf of the following organizations:

- American Hospital Association (AHA)
- American Medical Association (AMA)
- Medical Group Management Association (MGMA)
Background

- Existing operating rules have enhanced and improved electronic exchange of information
- Significant challenges as well as opportunities exist in reducing manual processes and improving efficiencies in health care
- Operating rules can be further leveraged to address barriers to administrative simplification and respond to changing business needs of all stakeholders
Overview of Recommendations

• Support more frequent updates to operating rules

• In addition to infrastructure requirements, address data content requirements in draft operating rules

• Analyze overall authorization/referral workflow and address gaps in standards to facilitate automation of the entire process
Frequency of Operating Rule Updates

- After initial operating rule development for each standard, there has not been the opportunity to revisit and revise rules in order to meet provider and health plan needs
- Current timeframe for development and implementation of new version of standards is 10+ years
- The rapidly evolving health care industry necessitates a more agile response to changes
  - Example: Health insurance exchange grace period notification in eligibility responses emerged as a business need after implementation of initial eligibility transaction operating rules
- An annual review/update of operating rules facilitated by the Review Committee would allow industry to more rapidly respond to and address issues
Need for Data Content Requirements

- Recent draft operating rules just address infrastructure requirements, not data content of transactions
- Connectivity, response times, and system availability are important to success of transactions, but **content** is also critical
  - Speed of transaction immaterial without exchange of *meaningful* data
- Previously established operating rules have successfully addressed data content and increased transaction quality, standardization, and adoption

*Examples:*
- Inclusion of real-time patient copay, coinsurance, and deductible information in eligibility response
- Uniform use of CARCs and RARCs in electronic remittance advice
Proposed Data Content: ASC X12 837 Claim

- Require support of all data elements in UB-04
- Require compliance with CPT guidelines
- Require acceptance and processing of all reported diagnosis codes
Proposed Data Content: ASC X12 278

- Require 278 response to indicate if prior authorization is not needed
- Require 278 response to indicate approval or denial of prior authorization if no additional information is required for processing
- Require 278 response to request additional information when needed for prior authorization processing
- Standardize data content of transactions by reviewing Companion Guides and developing operating rules to create uniformity in areas of greatest variability
Additional Proposed Data Content

Requirements for Existing Operating Rules

- Require procedure-specific eligibility response (X12 271) to procedure-specific eligibility inquiry (X12 270)
  - Enables providers to determine procedure-specific coverage restrictions (e.g., prior authorization requirements) using automated process vs. phone calls or payer portals
- Require standard reporting of health insurance exchange grace period information in mandated electronic transactions
  - X12 271 Eligibility Response
  - X12 277 Claim Status Response
  - X12 835 Claim Payment/Advice
- These suggested changes underscore the importance of frequent operating rule updates to respond quickly to emerging industry needs
Prioritize Prior Authorization Automation

- First and foremost: the current prior authorization process delays patient care and is also a major and ongoing pain point for providers

- Current manual prior authorization process represents significant administrative burden to the practice of medicine\(^1\)
  - 1.1 physician hours/week
  - 13.1 nursing hours/week
  - 5.6 clerical hours/week

- Payer prior authorization processes are also largely manual

- Any process that is such a significant drain on resources and impacts care quality deserves our full attention and prioritization for improvement

Current State of X12 278 Services Review Adoption

- The draft operating rule for the X12 278 correctly references the current manual nature of the authorization process and low industry adoption of the transaction
  - Consistent acknowledgment across stakeholders that the 278 transaction is not being widely used
- Today providers still make telephone calls and/or visit payer portals to identify when prior authorization is needed, to submit additional information, and to determine health plan’s final decision on their request
- Draft operating rule infrastructure requirements are **not sufficient** to automate process or drive industry toward adoption—need to **address data content** and any other issues impeding transaction’s adoption
Gap Analysis of X12 278 Services Review

• Need to require support of X12 278 responses other than AU (pended) or CT (contact payer)

• Major multi-stakeholder effort is needed to examine X12 278 and determine what other changes are needed or required in order for transaction to function well and be widely adopted

• Providers stand ready and willing to join this drill-down and problem-solving effort
Gap Analysis of Entire Authorization Process

- Mandated X12 278 transaction is just one piece of the authorization process
- Authorizations/referrals are a unique, multi-step, back-and-forth process, as illustrated by NCPDP ePA transactions
  - Provider inquires if authorization required
  - Payer indicates if authorization needed
  - Provider requests authorization
  - Payer requests additional information
  - Provider submits additional supporting documentation
  - Payer approves or denies authorization request
- All pieces must be in place for overall process automation
  - Need eligibility response to identify prior authorization requirement for specific service
  - Need attachment standard, as most authorizations/referrals require additional supporting clinical documentation for processing
- If these process gaps are not addressed—particularly the attachment piece—draft operating rules will not achieve promised automation or increase industry adoption
Summary

- Provider community appreciates efforts of CAQH CORE to improve efficiency and standardization through operating rule development
- Opportunities for operating rules to be increasingly leveraged to address current and future industry needs
- More frequent operating rule review and faster development will facilitate agile response to better meet provider needs
- Operating rules can be made more robust, meaningful, and impactful through inclusion of appropriate data content components
- Burdensome manual prior authorization processes merit close scrutiny to ensure complete automation and timely patient care
Questions?

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<th>Organization</th>
<th>Contact</th>
<th>Email</th>
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</thead>
<tbody>
<tr>
<td>AHA</td>
<td>George Arges</td>
<td><a href="mailto:garges@aha.org">garges@aha.org</a></td>
</tr>
<tr>
<td>AMA</td>
<td>Heather McComas</td>
<td><a href="mailto:heather.mccomas@ama-assn.org">heather.mccomas@ama-assn.org</a></td>
</tr>
<tr>
<td>MGMA</td>
<td>Robert Tennant</td>
<td><a href="mailto:rtennant@mgma.org">rtennant@mgma.org</a></td>
</tr>
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