Testimony by the Medical Group Management Association

To:

The National Committee on Vital and Health Statistics
Subcommittee on Standards

Submitted July 24, 2020

The Medical Group Management Association (MGMA) is pleased to submit the following testimony to the National Committee on Vital and Health Statistics on the issue of prior authorization. We commend the Committee for recognizing the need to improve prior authorization and for reviewing the Council for Affordable Quality Healthcare (CAQH), Committee on Operating Rules for Information Exchange (CORE) proposal to adopt the Prior Authorization (278) Data Content Rule, Prior Authorization (278) Infrastructure Rule, and Connectivity Rule Version PA 2.0 under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

MGMA is the premier association for professionals who lead medical practices. Since 1926, through data, people, insights, and advocacy, MGMA empowers medical group practices to innovate and create meaningful change in healthcare. 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.

Health plan prior authorization requirements are a significant burden for physician practices-costing time and money for the organization and delaying the delivery of patient care. Although HIPAA mandated and the Department of Health and Human Services implemented an electronic transaction standard for prior authorization, it continues to be woefully underused. Practices typically rely on fax, mail, or logging into proprietary web portals to conduct prior authorizations. As you will see from our testimony, while we are supportive of the three sets CORE operating rules under discussion, we assert that additional steps must be taken to improve the current prior authorization environment.

Key Recommendations

- MGMA is supportive of the CAQH CORE Prior Authorization (278) Data Content and Infrastructure Rules (PA Version 2.0) being federally mandated. We believe adoption of these operating rules will improve the current prior authorization by standardizing the data content of the electronic transaction and requiring a maximum time for health plans to respond to authorization requests.

- We recognize that the two-business day requirement for the plan to request additional information from the provider and the two-business day requirement for the health plan to provide a final determination was a compromise between providers and health plans. While an improvement over the current lengthy and non-standardized plan response times, we urge that these maximum timeframes be significantly shortened to improve the care delivery process.

- MGMA asserts that while these operating rules will impose important new requirements on health plans, additional reforms are needed to substantially improve the prior authorization process. These reforms include eliminating prior authorization for services that are routinely approved and for providers in risk contracts, promulgating the regulation for electronic attachments, exploring new standards to automate the authorization process, and increasing enforcement against non-compliant health plans.

MGMA Response to Committee Questions

1. *Participation in development of the rules: If your organization participated in identification and development of the proposed operating rules for prior authorization and/or connectivity, describe the skill set of the individuals involved (business or technical) and in what way they participated in the process.*

MGMA Response: MGMA was one of more than 125 organizations that collectively contributed to the development of the proposed operating rules. These entities represent a range of stakeholders including providers, health plans, vendors, clearinghouses, associations, standards development organizations, and government agencies.

MGMA staff participated on all calls and completed all of the polls throughout the development process for each of the operating rule sets. MGMA's representative for the CORE operating rules development process has more than 20 years' experience in standards development environment, leads industry administrative simplification efforts, and has participated in CORE since its inception in 2005.

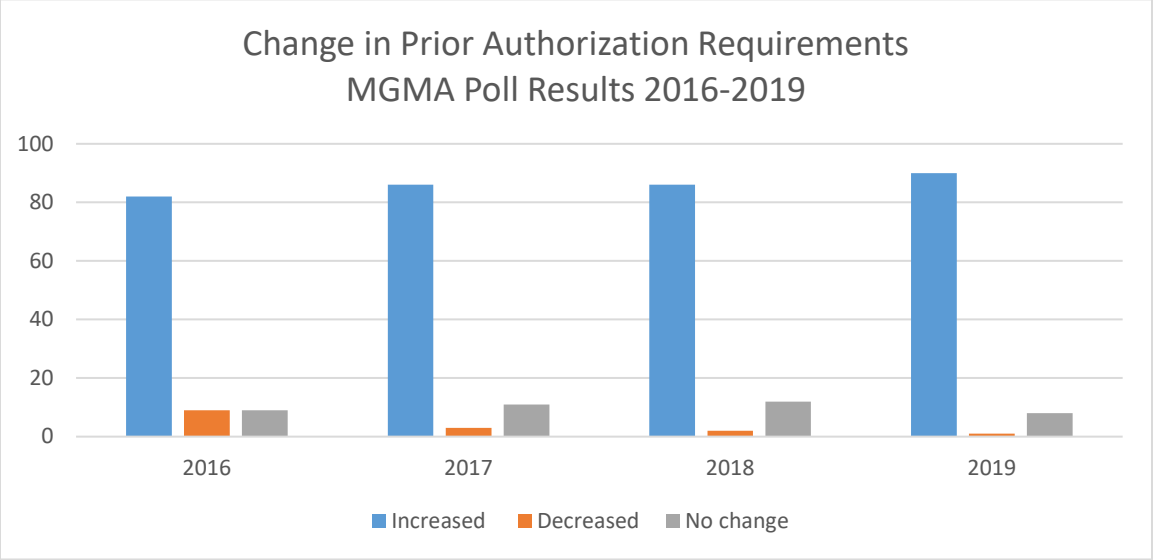
We want to commend CAQH CORE staff for their professionalism during the rule development process and for their willingness to engage and collaborate with impacted stakeholders. We also wanted to applaud CORE's recent revision of its operating rule structure and its transition to a business transactions-based model. This new approach structures the operating rules into logical categories and should facilitate a faster rule updating process.

2. *Workflow (prior authorization rules): In what way(s) will the proposed operating rules for prior authorization improve workflow for your organization's industry sector? Discuss the prior authorization data content and infrastructure rules and describe how the proposed requirements from each will impact your workflow, reduce burden (if relevant) and better support patient care.*

MGMA Response: Before we can discuss how new operating rules could impact physician practice workflow, it is important to understand the current prior authorization environment. Prior authorization continues to be one of the most onerous administrative processes faced by physician practices. As a cost-control process requiring providers to qualify for payment by obtaining approval before performing a service, prior authorization is overused, costly, inefficient, and can be responsible for delays in patient care.

Documentation requirements from health plans for items and services associated with prior authorization and ordering for certain medical services are also significant sources of administrative burden. Congress and the Administration can play an important role in evaluating and addressing administrative processes and clinical workflow factors contributing to this burden. While electronic health records, practice management system software vendors and other health IT solutions can also play a role in reducing this burden, prior authorization processes clearly suffer from a lack of standardization and common approaches from health plans.

Not only are prior authorization requirements challenging, but MGMA members also report that the requirements from health plans are actually increasing. In a poll conducted in September 2019 with almost 1,000 respondents, 90 percent reported that prior authorization requirements had increased in the past year, 9 percent stated that requirements had stayed the same, and one percent indicated they had decreased. Over the past few years, MGMA members have reported a consistent spike in prior authorization requirements (see below).



To put prior authorization into perspective and to compare this task with other administrative burdens facing medical practices, the 2019 MGMA regulatory burden survey asked practice executives to rate a number of administrative challenges from not burdensome to extremely burdensome. The survey results were released October 2019 and included responses from executives representing over 400 group practices.

Two-thirds of respondents are in practices with less than 20 physicians and 14 percent are in practices with over 100 physicians. Three-fourths of respondents are in independent practices. Survey respondents identified prior authorization as the leading regulatory burden facing their practice in 2019 (see below).

	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 approval rates and practice costs

The utilization of medical services and medications should not significantly increase if prior authorization requirements are relaxed due to the fact that the majority of authorization requests are ultimately approved. In October 2019, MGMA took a poll of almost 200 physician practice executives asking a series of questions regarding prior authorization requests. We received the following responses:

- Seventy-two percent of prior authorization requests submitted to their health plans are approved during the first submission.
- Seventy-five percent of prior authorization requests that are not approved during the first submission process and are subsequently appealed are approved by their health plans following the appeal.
- Eighty-five percent of prior authorizations that require a peer-to-peer (practice clinician to health plan clinician) discussion are approved by your health plans.

Respondents reported that the majority of authorization requests are approved by the health plan the first time they are submitted and for those that are appealed by the practice following a denial by the health plan, again, the majority are approved. In those cases where the appeal requires a peer to peer (direct discussion between the practice clinician and a clinician designated by the health plan) consultation, the vast majority of authorizations are approved by the health plan.

Practice costs related to prior authorization include:

- Clinical and administrative staff time spent determining if an authorization is necessary for a specific service, test, or medication. Each health plan has their own proprietary medical necessity requirements, thus adding additional burden for practice staff. Some

practices report they are forced to have staff assigned to specific health plans to conduct prior authorizations.
- Clinical and administrative staff time determining what documentation is required to support the individual plan's medical necessity requirements.
- Administrative staff time transmitting the prior authorization request and support documentation to the health plan (most often via mail, facsimile, or uploaded through a health plan's proprietary website).
- Clinical and administrative staff time spent responding to an authorization denial, which may include compiling and transmitting additional clinical documentation.
- Clinical staff time to engage in a peer-to-peer discussion of the clinical issues.

The 2019 CAQH Index reports that prior authorization is the costliest and most time-consuming administrative transaction for providers. On average, providers can save more than $9 per transaction by moving from fully manual to fully electronic transactions (X12 278) and more than $2 per transaction by moving from web portals to fully electronic.

It is important to note that the Office of the National Coordinator for Health Information Technology (ONC) final report "Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs," released February 21, 2020, also identifies prior authorization as a critical challenge facing clinicians. On page 14, the report correctly states "EHRs and other health IT solutions can also help to mitigate this burden, but prior authorization processes suffer from a lack of standardization and common approaches." The report makes recommendations aimed at alleviating the burdens associated with practices meeting health plan prior authorization requirements, including supporting automation of prior authorization processes through adoption of standardized templates, data elements, and real-time standards-based electronic transactions.

Support for the Proposed CAQH CORE Operating Rules

The CAQH CORE Prior Authorization (278) Data Content and Infrastructure operating rules take a modest step toward realizing the goals set out in the ONC final report by enhancing the X12 278 by closing automation gaps, reducing administrative burden, and reducing maximum adjudication timeframes. The Prior Authorization (278) Data Content Rule further standardizes the data shared between health plans and providers. The rule targets one of the most significant problem areas in the prior authorization process: the pending of authorization requests from health plans for what they claim is missing or incomplete documentation. The rule should reduce somewhat the unnecessary back and forth between providers and health plans that often occurs when confirming medical necessity, enabling shorter adjudication timeframes and less manual follow-up. We concur with CAQH CORE that there are content areas addressed in this Rule that could have a positive impact on the prior authorization workflow. These include:

- Receipt and processing of diagnosis/procedure/revenue codes for specified categories of services and detection and display of all code descriptions should assist in auto adjudication.
- Consistent patient identification and verification should reduce common errors and denials by providing a complete set of demographic data to ensure a better patient/subscriber match.
- Return of specific AAA error codes and action codes (used to identify security validation requirement issues and to indicate plan business edits) when certain errors are detected on the authorization request should improve electronic communication between practices and plans and reduce the need for manual follow-up.

- Return of Health Care Service Decision Reason Codes should provide a clearer explanation to the practice of plan required next steps.
- Use of PWK01 Code (or Logical Identifiers Names and Codes & PWK01 Code) should provide direction on status and what additional clinical information is needed for health plan adjudication of the prior authorization request.
- Detection and display of all code descriptions could reduce the burden of interpretation on the provider.
- "Requesting Additional Documentation for a Pended Response" has potential to improve the current workflow for the industry. Knowing, all at one time, what documentation the health plan requires to support the authorization request is beneficial. This allows for the downstream provider to determine the information that should be supplied by the ordering provider and submit just one request for information to that provider. Multiple requests for information decrease the likelihood that all requests will receive a response.

We do have a concern with the Patient Identification rule (4.1.1) that requires that when the patient is the dependent, the subscriber's last name, first name, date-of-birth to be supplied along with the dependents demographic information. Certain types of providers (i.e., laboratories) do not meet face to face with patients and are dependent on the ordering practice to supply the demographic information. Requiring the subscriber's date of birth for the authorization request would force the provider to find the information, including potentially reaching out directly to the patient. This would add considerable administrative burden, especially if the patient is reluctant to share that information over the phone.

There has been much discussion regarding what industry entity should be responsible for developing data content for the electronic transactions. Optimally, a single entity should be responsible for data content, most likely the appropriate Standards Development organization (SDO). Yet this presupposes that the SDO will exhibit certain characteristics, including actively soliciting input from providers, incorporating modifications that increase the usefulness of the transaction, and acting quickly to meet industry needs. When one or more of these characteristics are not met, it is imperative that another entity step up to ensure that the transactions are responsive to the needs of practices and improved in a timely manner. With the long gap between mandated transaction versions, it was important that CAQH CORE fill the void with its data content and infrastructure operating rules. We do note, however, that an improved standards development process would most likely negate the need for operating rules.

3. *Transaction exchange (connectivity rule): In what way(s) will the proposed operating rule for connectivity improve the processing of transactions, message payload, connectivity, security, etc. if adopted by HHS? What are the anticipated benefits that this operating rule offers vs. the current state (please provide examples if possible)?*

MGMA response: Updating the federally mandated connectivity requirements from vC1.1.0 and vC2.2.0 for the eligibility, claims status, and ERA transactions to an updated version for prior authorization could offer the following benefits:

- Moving to an updated CAQH CORE Connectivity version has the potential of enhancing interoperability, efficiency and security by defining technical requirements for the exchange of the electronic transactions between trading partners so entities can be assured of a common connectivity method–effectively creating a safe harbor.
- Mandating this updated version could assist in ensuring a common connectivity method for the exchange of eligibility, claim status, ERA and prior authorization transactions which reduces the need to support multiple connectivity methods.

However, we do not support the mandating of Connectivity Rule C3.1.0 at this time. CAQH CORE is currently working on an updated set of Connectivity operating rules (Version C4.x). CAQH CORE expects this version to be completed by the end of 2020. Rather than potentially require the industry to update an already outdated rule (C3.1.0), we recommend NCVHS wait until CAQH CORE finalizes and approves this new version before revisiting this issue and potentially including it in a set of federal mandates.

4. *Improving use of transactions and/or adoption of standards (all proposed operating rules): Describe how adopting the proposed operating rules will or could increase in the use of any of the adopted HIPAA transaction standards.*

MGMA response: We are optimistic that the requirements in the proposed rules will improve the value of the 278 transaction by specifying and standardizing the transaction infrastructure and the data shared between practices and health plans. Potential improvements include:

- The data content requirements could assist a practice more accurately request member-specific information needed for a prior authorization and enable a health plan to clearly communicate next steps in the prior authorization process to the practice, including what additional documentation is needed.
- The availability of enhanced data content has the potential of streamlining the review of prior authorization requests, facilitate faster response times, and provide for an automated adjudication of a final determination.
- Additionally, the timeframe requirements in the infrastructure rule could act as an incentivize for practice adoption as they can be more assured of a maximum response time when utilizing the 278 transaction. A federal mandate would also reduce the need for health plans to comply with varying state requirements.

5. *Connectivity rule implementation for your organization or industry wide (please specify):a. What are the implications, costs and benefits of implementing the new connectivity rule requirements for the prior authorization, eligibility & benefits, claim status and electronic remittance advice transactions? Providing generalized or high-level information will be helpful to the Committee. [Note, this question has been revised to remove reference to claims, enrollment/disenrollment, and premium payment transactions for which operating rules have not been adopted by HHS.] b. Can you provide general types of costs and benefits of meeting the processing mode requirements for both real time and batch submissions?*

MGMA response: CAQH CORE is proposing Connectivity Rule V PA 2.0 for the HIPAA-mandated eligibility, claim status, and ERA transactions. CAQH CORE is also proposing the CAQH CORE Connectivity Rule apply to the prior authorization transaction for federal mandate per the CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule.

As a result of the CAQH CORE Connectivity Rules vC1.1.0 and vC2.2.0 becoming federally mandated by the Department of Health and Human Services (HHS) in 2013, a large industry installed base of these connectivity rules exists among HIPAA-covered entities that exchange administrative transactions. The CAQH CORE Connectivity Rule vC2.2.0 includes requirements addressing the message envelope, corresponding envelope metadata, vocabularies and semantics, real time and batch processing modes, authentication, and transport security.

The only new processing mode requirements proposed by CAQH CORE are in the CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule. This rule requires that a health plan or its agent implement server requirements for either real time or batch processing mode

for the 5010X217 278 Request and Response transactions. Building off existing infrastructure for real time and batch processing in place for eligibility, claim status and ERA, implementation of the 5010X217 278 can be expediated given implementation of currently mandated operating rules. Leveraging existing efforts greatly reduces costs of implementation.

However, development of a revised version is currently underway at CORE. Updating the CAQH CORE Connectivity Rule to a more appropriate version will improve security and simplify interoperability across administrative transactions (see also the answer to Question 3).

6. *Implementation time frame for each proposed rule: a. What is the anticipated lead time needed by your organization to develop, test and implement the proposed operating rules? What are the dependencies that impact the timeline, e.g., vendors, trading partners and business associates? If possible, please provide an estimate of the amount of time your vendors would require to develop their component of the solution? b. Should considerations be given to size or organization type for the proposed implementation timeframe? Please discuss for each of the proposed operating rules (Prior authorization content, prior authorization infrastructure and connectivity*). 6 a. Should considerations be given to size or organization type for the proposed implementation timeframe?

Practices themselves will likely not be required to implement the technical portions of the Rules. For the Connectivity rule, practices will be heavily dependent on their EHR vendors to implement new system functionalities required to support system changes to optimize organization data/information integration. We expect some challenges to overcome from smaller EHR vendors and other trading partners related to implementing the proposed operating rules. Practices could be impacted by the data content and infrastructure provisions of the Rules and prior authorization workflows may need to be modified. However, we expect these changes will should not take very long to complete.

We note that the CAQH CORE Certification process typically takes between three to six months, depending on an organization's readiness and resources committed to the project. 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.

7. *Costs (Prior Authorization rules): Is your organization able to provide an estimate of the implementation cost for the requirements of the two prior authorization operating rules for data content and infrastructure? If not, how would you advise NCVHS and HHS to make a cost benefit determination about adopting these rules?*

MGMA response: While we are not able to provide an estimate of the specific implementation costs for the requirements of the two prior authorization operating rules for data content and infrastructure, we urge NCVHS to leverage data from the 2019 CAQH Index to determine the potential savings for the industry of the proposed rules.

We expect that adoption of the proposed prior authorization operating rules should accelerate increased use of the 278 transaction and somewhat reduced administrative costs. Prior authorization is the costliest and most time-consuming manual transaction tracked by the CAQH Index. According to the most recent Index, the industry could save $12.31 per prior authorization transaction by moving from manual processing to use of the HIPAA-mandated 278 Request and Response.

A cost-benefit determination could be calculated by potential improvement in the overall collection of payment for services and delivery of patient care. Streamlining and accelerating the process will result in reduced staff time processing authorizations. As many practices rely on retrospective authorizations to speed up patient care, moving more authorizations to the front of the delivery process should reduce accounts receivable.

8. *Costs (Connectivity rule): Is your organization able to provide an estimate of the implementation cost for the requirements of the connectivity operating rule? If not, how would you advise NCVHS and HHS to make a cost benefit determination about adopting this rule and its requirements?*

MGMA response: While we are not able to provide an estimate of the implementation cost for the requirements of the connectivity operating rule on covered entities we note that covered entities that were required to implement the CAQH CORE Connectivity Rule vC2.2.0 will not be required to fully implement all requirements due to commonalities in transport, envelope, authentication standards, and metadata. We expect that implementation costs for these organizations will be less due to only needing to support one submitter authentication standard.

9. *Additional comments: Given that the Connectivity Rule is highly technical, from an overall implementation and value perspective, do you have additional comments for the Committee's consideration?*

MGMA response: Updating the currently mandated CAQH CORE Connectivity requirements for eligibility, claim status, and ERA transactions will ensure a modern and secure connectivity method is available for industry and reduce the need for continued industry support for multiple authentication standards. Additionally, a single (appropriate) connectivity rule across all transactions is easier to update, reduces confusion, and promotes industry alignment on best practices.

10. *Additional comments: For the Prior Authorization operating rules, from an overall implementation and value perspective, do you have additional comments for the Committee's consideration?*

MGMA response: We are supportive of the proposed CAQH CORE Data Content and Infrastructure operating rules for prior authorization and believe they will help to streamline the current prior authorization process. However, we urge the Committee to consider the following recommendations for augmenting and improving these operating rules:

- Prior authorizations deemed urgent should have a maximum response time of 24 hours once the provider has supplied the health plan with all the supporting documentation they require.

- The CORE infrastructure rule PA Version 2.0 currently stipulates response times for initial health plan response and final health plan response as 2 "business" days. We assert that this should be changed to 48 hours for each response. Healthcare delivery is not a Monday through Friday event. Business days do not include weekends or federal holidays. In practical terms, 2 business days could translate to a full 5 days between health plan responses-leading to unacceptable delays in patient care.

- The CORE infrastructure rule PA Version 2.0 (Time Requirement for a 5010X217 278 Response Close Out Due to a Lack of Requested Information/ Documentation) currently stipulates that providers have a maximum of 15 business days to respond

to a health plan's request for additional supporting documentation before the request is closed by the plan. This timeframe does not adequately take into account the current care delivery process. For some authorizations, providers will be required to order additional tests, requiring patient action and follow up on the part of the practice. We urge the Committee to extend to 30 business days the maximum time providers have to respond to a health plan's request for additional supporting documentation.

- We also recommend the following modification to the CORE infrastructure rule PA Version 2.0. If a retrospective authorization request is received by the health plan, and the place of service code is "laboratory," the request should follow the same requirements for the operating rule as the ordering provider.

The NCVHS has, on numerous occasions, held hearings and issues recommendations to the HHS Secretary on prior authorization and related issues. As the Committee views these operating rules as a chance to modestly streamline the current prior authorization process, we offer the following recommendations for achieving more significant reform of prior authorization:

1. **Health plan transparency**. Health plans should be required to make available on a public section of its website a list of all items and services that are subject to a prior authorization requirement under the plan and a template of the clinical information the plan requires in order to fully adjudicate the prior authorization request for all items and services that are subject to a prior authorization requirement. Full transparency of what items and services require a prior authorization and the specific clinical documentation the practice is required to submit to support a prior authorization request will significant decrease the administrative burden associated with these processes.

   Further, access to this information will permit EHR and other vendors to develop automated prior authorization solutions that will decrease burden for the practice and reduce delays in the care delivered to patients.

2. **Establishment of programs excluding clinicians from prior authorization requirements**. Health plans should be required establish programs to exempt providers from the prior authorization process upon a provider's demonstration of compliance with the plan's coverage, coding and payment rules. Plans should exempt providers that achieve a prior authorization provisional affirmation threshold of at least 90 percent during a designated assessment period. Excluding clinicians who adhere to a plan's coverage, coding and payment rules from prior authorization requirements not only rewards those clinicians with decreased administrative burdens but can also serve as an incentive for other clinicians to more closely adhere to coverage, coding, and payment rules.

3. **Adoption of policies excluding clinicians who are participating in a risk-based contracts from prior authorization requirements**. Health plans should be required to establish programs exempting providers from any prior authorization requirements if they enter into a contract with the plan that requires the clinician take on one or two-sided risk.

   Excluding clinicians who have entered a risk-based contract from prior authorization requirements is appropriate for two reasons. First, clinicians who are in an at-risk contract are already inherently incentivized to furnish cost-effective, high quality care

and avoid overutilization of services. Second, waiving burdensome prior authorization requirements that are unnecessary in risk-based contracts will serve as an incentive to establish these contracts.

4. **Adoption of the X12 275 electronic attachments standard**. In four separate letters, NCVHS has recommended that HHS move forward with issuing a final regulation establishing a national standard for electronic clinical documentation attachments. Plan adoption and support of the X12 275 electronic attachment standard will significantly decrease administrative burden and cost for the practice and reduce delays in the care delivered to patients. Absent this electronic attachment standard, we assert widespread use of the 278 transaction will be significantly suppressed.

5. Enforcement of standards and operating rules. HHS

6. **Improvement of the standards development process.** The current process to develop and mandate electronic standards does not permit the rapid adoption of modifications necessary to keep up with the ever-changing healthcare environment. The NCVHS 2019 "Predictability Roadmap" outlined opportunities to improve the standards development process. We urge the Committee to continue working with the physician practice community and other impacted stakeholders to identify to HHS an appropriate pathway toward administrative simplification.

We thank you for your consideration of these comments and recommendations. We look forward to continuing to work with the Committee to identify opportunities to reduce the volume of prior authorization requirements and automate the remainder. Should you have any questions regarding this testimony, please contact Robert Tennant, Director of Health Information Technology Policy, at 202.293.3450 or rtennant@mgma.org.