CAQH CORE

Improving Prior Authorization: Operating Rule Update

Intersection of Clinical and Administrative Data Task Force

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CAQH CORE Mission/Vision & Industry Role

Industry-led, CAQH CORE Participants include healthcare providers, health plans, vendors, government entities, associations and standard-setting organizations. Health plans participating in CAQH CORE represent **75 percent of the insured US population.**

MISSION Drive the creation and adoption of healthcare operating rules that **support standards**, **accelerate interoperability and align administrative and clinical activities** among providers, payers and consumers.

VISION An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.

DESIGNATION CAQH CORE is the **national operating rule author to improve the efficiency, accuracy and effectiveness of industry-driven business transactions.** The Department of Health and Human Services (HHS) designated CAQH CORE as the author of national operating rules for the HIPAA-covered administrative transactions.

INDUSTRY ROLE **Develop business rules to help industry** effectively and efficiently use electronic standards while remaining technology- and standard-agnostic.

CAQH CORE BOARD **Multi-stakeholder.** Members include health plans, providers (some of which are appointed by associations such as the AHA, AMA, MGMA), vendors, and government entities. Advisors to the Board include SDOs (X12, HL7, NACHA, NCPDP) and WEDI.

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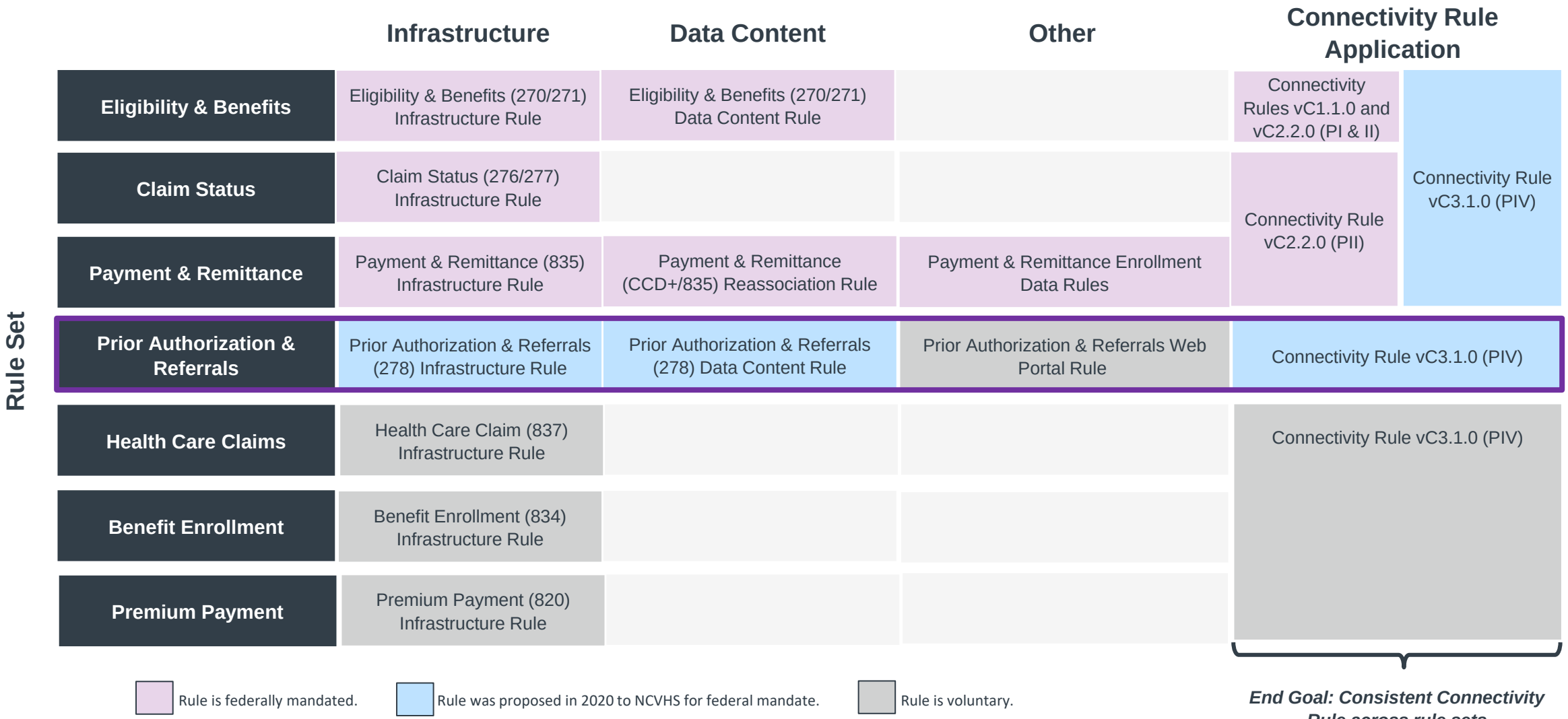
What are Operating Rules?

Operating Rules are the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted.
CAQH CORE is the HHS-designated Operating Rule Author for all HIPAA-covered transactions.

Industry Use Case	Standard	Operating Rule
Healthcare	Providers and health plans must use the ASC X12 v5010 270/271 Eligibility Request and Response transaction to exchange patient eligibility information.	When using the eligibility transaction, health plans must return patient financial information including copay and deductible in real-time.
Finance	Financial organizations must use ASC X9 standards in all ATM transactions with their clientele, standardizing layout, data content and messaging.	Financial organizations must use NACHA, the Electronic Payments Association, and the Federal Reserve operating rules for every automated clearinghouse (ACH) Transaction which allows consumers to use any debit card in any ATM around the world regardless of bank affiliation.

Operating Rules **do not** specify whether or how a payer/provider structures a business process supported by an electronic transaction. For example, operating rules do not specify when or how prior authorization is used by a health plan; if prior authorization is used, operating rules specify how information regarding that transaction is electronically exchanged.

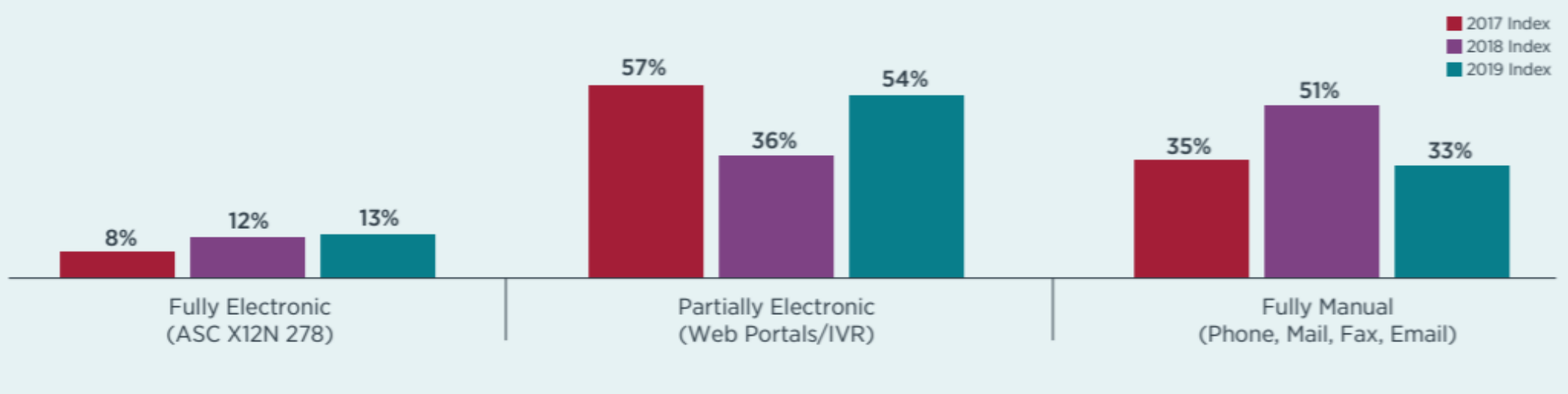
CAQH CORE Operating Rule Overview



2019 CAQH Index Report

Medical Industry Electronic Transaction Adoption

Medical Plan Adoption of Prior Authorization, 2017-2019 CAQH Index



Source: 2019 CAQH Index

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Barriers to Industry Adoption of Electronic Prior Authorization

Key barriers preventing full automation and auto-adjudication of Prior Authorization:

- There is **a lack of consistency** in use of data content across industry and electronic discovery of what information is required for an authorization request to be fully adjudicated.
- **No federally mandated attachment standard** to communicate clinical documentation.
- **Lack of integration** between clinical and administrative systems.
- **Limited availability** of vendor products that readily support the standard transaction.
- **State requirements** for manual intervention.
- **Lack of understanding** of the breadth of the information available in the 5010X217 278 Request and Response, and a lack of awareness that this standard prior authorization transaction is federally-mandated – particularly among providers.
- **Varying levels of maturity** along the standards and technology adoption curve, making interoperability a challenge.

CAQH CORE Key Findings

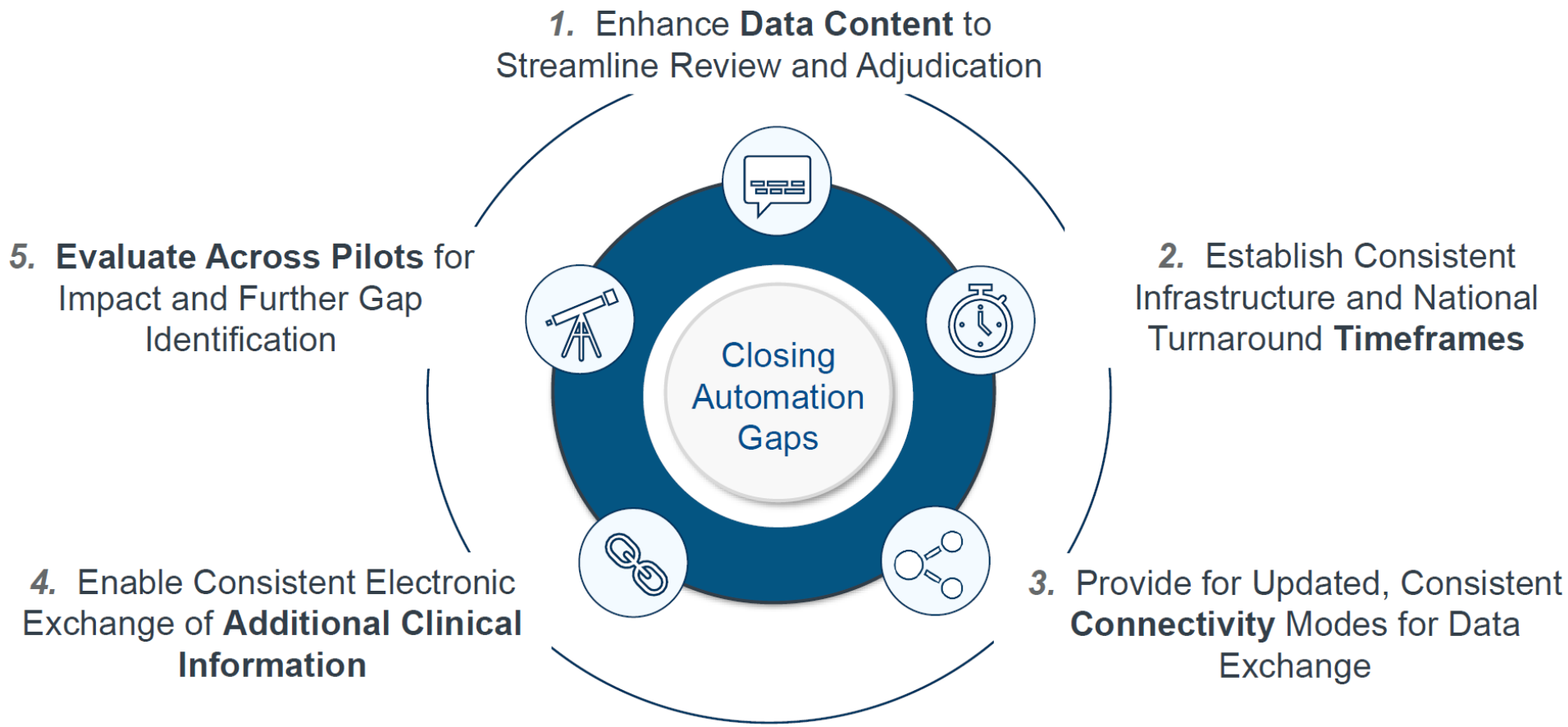
Engaged 100+ industry organizations to identify how they communicate status, errors, next steps, and additional information needs. **Wide variety creates confusion and delays additional steps** in the PA process.

Low vendor support: a supplement to the 2017 CAQH Index found that only 12% of vendors supported electronic prior authorization. For all other electronic transactions, vendor support was between 74% and 91%.

CAQH CORE environmental scans and industry polling reveal provider organizations are **unaware of the HIPAA mandated prior authorization standard** and that health plans are required to accept it.

Identifying & Closing Automation Gaps through Operating Rules

The CAQH CORE Approach to Accelerate Prior Authorization Automation & Reduce Burden



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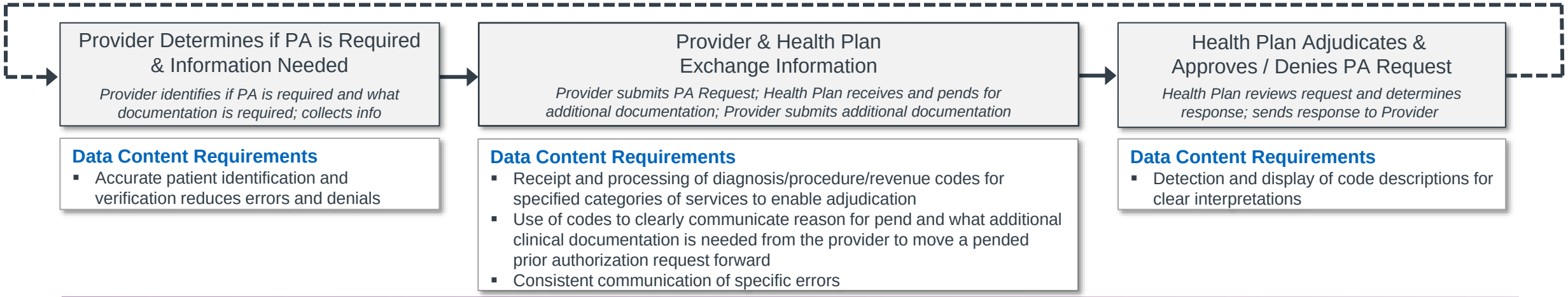
1. Enhance Data Content to Streamline Review and Adjudication

- **Proposed to NCVHS**
  - **The CAQH CORE Prior Authorization (278) Data Content Rule** targets one of the most significant problem areas in the prior authorization process: requests for medical services that are pended due to missing or incomplete information, primarily medical necessity information. The rule reduces unnecessary back and forth between providers and health plans and enables shorter adjudication timeframes and less manual follow up. Key rule requirements include:
    - > Consistent patient identification and verification to reduce to reduce common errors and denials.
    - > Return of specific AAA error codes and action codes when certain errors are detected on the Request.
    - > Return of Health Care Service Decision Reason Codes to provide the clearest explanation to the submitter.
    - > Use of PWK01 Code (or Logical Identifiers Names and Codes & PWK01 Code) to provide clearer direction on status and what is needed for adjudication.
    - > Detection and display of all code descriptions to reduce burden of interpretation.

- **Future Opportunities**
  - Operating rules can ensure **consistent use of existing and emerging standards**.
    - > For example, operating rules can establish and maintain common data and infrastructure requirements across standards, giving the industry flexibility to move forward without losing sight of the need for a common approach.



2. Establish Consistent Infrastructure and National Turnaround Timeframes

- **Proposed to NCVHS**
  - **The CAQH CORE Prior Authorization (278) Infrastructure Rule** specifies prior authorization requirements for system availability, acknowledgements, companion guides, and response timeframes. Rule requirements align with other federally mandated infrastructure rules.
  - In 2019, CAQH CORE Participants updated the rule to include new turnaround time requirements:
    - **Two-Day Additional Information Request:** A health plan, payer or its agent has two business days to review a prior authorization 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 health plan, payer or its agent has two business days to send a response containing a final determination.
    - **Optional Close Out**: A health plan, payer or its agent may choose to close out a prior authorization request if the additional information needed to make a final determination is not received from the provider within 15 business days of communicating what additional information is needed.

NOTE: Each HIPAA-covered entity or its agent must support the *maximum* response time requirements for at least **90 percent** of all X12 278 Responses returned within a calendar month.

- **Future Opportunities**
  - CAQH CORE infrastructure requirements that apply across transactions are updated over time to align with industry maturity and technology advancements (e.g., system availability).
  - Real time prior authorization is currently limited to requests that do not require additional documentation or complex backend adjudication processes. As standards and operating rules are identified to support the electronic exchange of attachments, new opportunities to expand real time capabilities will emerge.

3. Provide for Updated, Consistent Connectivity Modes for Data Exchange

- **Proposed to NCVHS**
  - **The CAQH CORE Connectivity Rule vC3.1.0** establishes a Safe Harbor connectivity method that drives industry alignment by converging on common transport, message envelope, security and authentication standards.
  - CAQH CORE proposed to NCVHS that the CAQH CORE Connectivity Rule vC3.1.0 replace current regulations mandating support for CAQH CORE Connectivity Rules vC1.1.0 and vC2.2.0 for the eligibility and benefits, claim status, and electronic remittance advice transactions in addition to prior authorization to promotes uniform interoperability requirements across administrative transactions.
- **Under Development**
  - The CAQH CORE Connectivity Work Group is currently **updating the CAQH CORE Connectivity requirements** to support administrative and clinical data exchange, including RESTful APIs to serve as a bridge between existing and emerging standards and protocols.
- **Future Opportunities**
  - Once a single Connectivity Rule is established across all CAQH CORE operating rule sets, CAQH CORE Participants will continue to update the rule to align with current interoperability, privacy and security standards.

Connectivity vC3.1.0

- Requires support of Simple Object Access Protocol (SOAP) based web services with specific metadata, message structure, and error handling.
- HTTPS (SSL 3.0, or optionally TLS 1.1 or higher. For compliance with FIPS 140-2 TLS 1.1 or higher in lieu of SSL 3.0) over the Public Internet TCP/IP.
- Digital Certificate X.509 Submitter Authentication (mutual authentication).

Draft Connectivity vC4.1.0

- Adds Representational State Transfer (REST) style web resources for X12 exchanges requirements.
- HTTPS (TLS 1.2 or higher) over the Public Internet TCP/IP.
- Real-Time/Sync and Batch/Async message interaction patterns to support Attachment Transactions.
- OAuth 2.0 (authorization).

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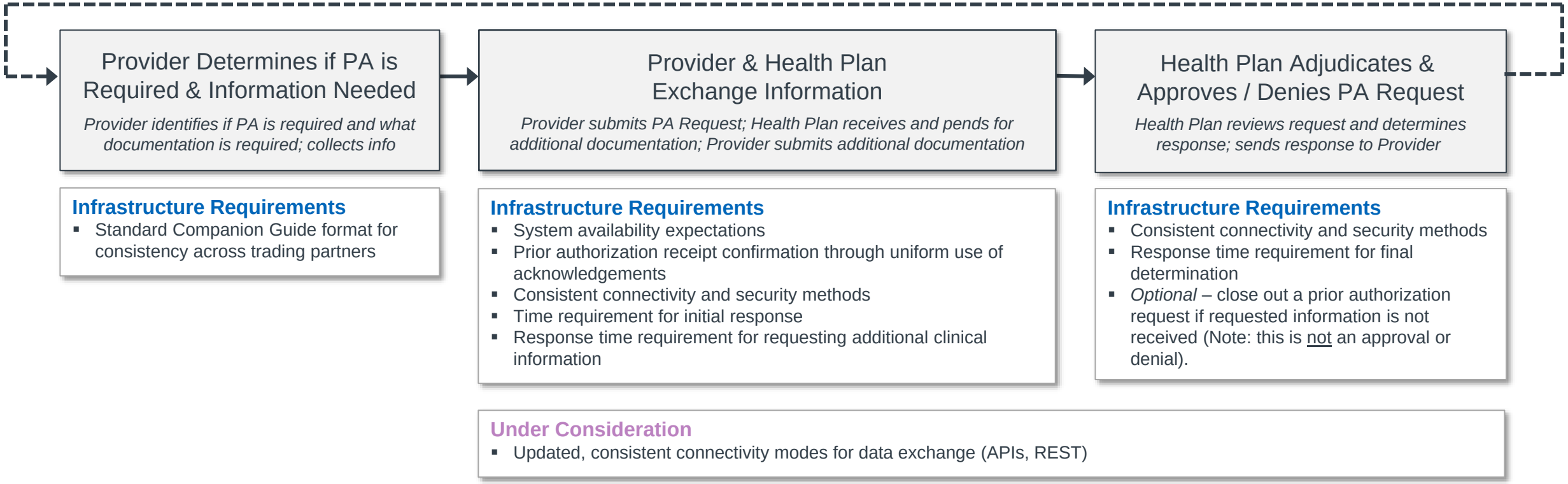
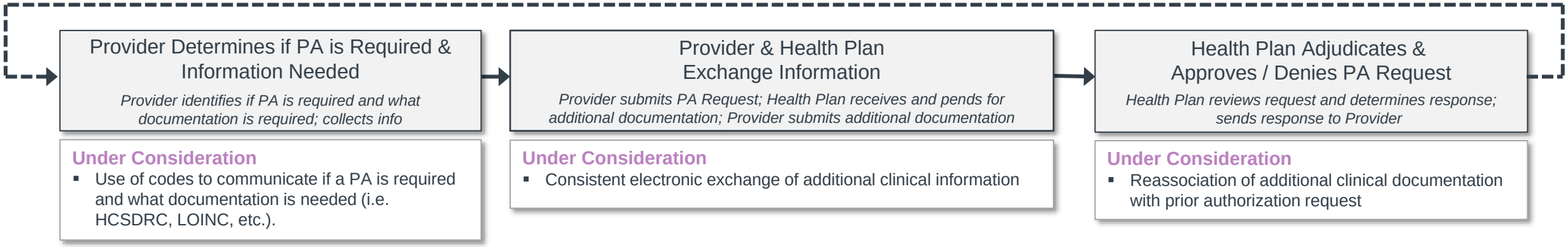
Application of Prior Authorization & Referral Infrastructure Rule + Connectivity



4. Enable Consistent Electronic Exchange of Additional Clinical Information

- **Under Development**
  - CAQH CORE is launching an **Attachment Subgroup** in July to draft operating rules to reduce administrative burden associated with the exchange of additional documentation/clinical information.
  - Rule requirements will align seamlessly with existing prior authorization data content and infrastructure operating rules.
  - Initial focus will be solicited attachments to support the **complete adjudication of a prior authorization request** either using the X12 275 or without the X12 275 (e.g. HL7 C-CDA).
  - Potential requirements could include:
    - > Standard system availability to ensure attachments can be received and processed, regardless of exchange format.
    - > Consistent acknowledgement of attachment to reduce confusion and probability of duplicate submissions.
    - > Clear reassociation requirements to ensure that a link between the prior authorization request and the additional information/documentation can be made.
    - > Use of specific data/code sets to enable electronic communication between the initial request, pends, requests for additional documentation/data, and error reporting, all to reduce manual follow-up (aligns with USCDI, LOINC, etc.).
    - > Uniform location to access/identify additional documentation requirements.
    - > Uniform companion guide to ease implementation burden and encourage adoption.

- **Future Opportunities:** The Attachments Subgroup will address claim attachment use cases after prior authorization.



5. Evaluate Across Pilots for Impact and Further Gap Identification

Initiative Vision: Partner with industry organizations to measure the impact of existing and potentially new CAQH CORE prior authorization operating rules and corresponding standards on organizations' efficiency metrics.

Identify Partners & Design Pilots

- ✓ **Met with over 25 organizations** to identify Pilot Groupings.
- ✓ **Solidified two distinct Pilot Groupings** – comprising at least five health plans, two prior authorization vendors, a major national health system, and other provider partners.
- ✓ **Three other distinct Pilot Groupings in the pipeline,** to potentially launch in second half of 2020.
- ✓ **Focus on diagnostic imaging** category of service.
- ✓ Can compare when the standard prior authorization transaction is **embedded in the EHR workflow vs. not.**
- ✓ **Crafted an ideal state timeline** for measurement, analysis, and reporting windows.

Prepare & Run Pilots

- ✓ **Established uniform measures** across Pilot Groupings to establish baseline.
- ✓ Conducted in depth **Requirements Applicability Assessments and Gap Analyses** to pinpoint where CORE Operating Rules already apply.
- ✓ Conducted an **on-site visit to national health system** with Pilot Grouping partners.

Collect, Analyze & Report

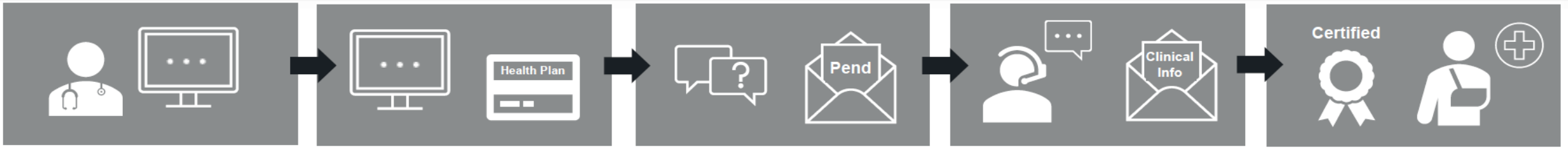
- ❑ **Ongoing meetings planned in Q2 2020 with pilot partners' analysts.**
- ❑ **Pilot partners interested in sharing with industry** through CAQH CORE Webinars, other industry partners and via report to NCVHS/Secretary of HHS, etc.

Sample Measures Across Pilots to Establish Baseline & Measure Impact

Tracking Changes in Volume	*Tracking Changes in Time*	*Overall Impact*
• PAs initiated by provider staff per day • Real-time PA approvals • PAs pended for additional information • PAs for peer-to-peer review • PA approved • PA denials • Patient appointment cancellations/reschedules due to waiting on PA response	• Staff initiating PA request • PA request submission to peer-to-peer review • Resolving pended PA for clinical information to final determination • Overall processing for PA final determination	• Annual savings • Increased provider staff satisfaction levels • Reduced time to patient care/treatment

Specific Example/A Day in the Life

How Operating Rules Improve Automation of Prior Authorization



Provider populates X12 278 Prior Authorization Request and sends to Health Plan for adjudication.

Provider includes information to identify the patient, servicing and rendering provider, and the service for which the PA is requested. This results in a complete set of demographic data to ensure a better patient/subscriber match.

Provider knows that Health Plan has standard system availability and will communicate any downtime.

Safe harbor connectivity method ensures Provider and Health Plan are capable and ready to exchange data.

Health Plan receives X12 278 Request.

Health Plan acknowledges receipt within 20 seconds when submitted via Real Time and two business days when submitted via Batch.

Health Plan normalizes the patient's name to ensure patient matching.

Health Plan communicates the most specific errors and associated reject reason codes back to the Provider if such occur.

Health Plan replies with pended 278 Response.

Health Plan returns specific reason codes to offer the most comprehensive explanation to the Provider, rather than a generic pend reason.

If the 278 Request is pended due to the need for additional information, the Health Plan must return codes to communicate what additional documentation is needed within two business days from receipt of the Request (Real Time and Batch). This includes the time it takes to acknowledge the Request.

Provider receives Health Plan's 278 Response.

Detect and display requirements enable Provider to see all code definitions, reducing interpretation burden.

Provider sends additional documentation to Health Plan.

Because Provider electronically received information about what additional documentation Health Plan needed, Provider did not need to manually connect with Health Plan to obtain the information, therefore reducing burden.

Health Plan receives additional documentation from Provider and makes a final determination.

Health Plan returns final determination to Provider within two business days following receipt of the complete Request from Provider. Patient is now authorized for care.

Note: If Provider does not respond to the request for additional documentation from Health Plan after 15 business days, Health Plan may choose to close the pended Request.

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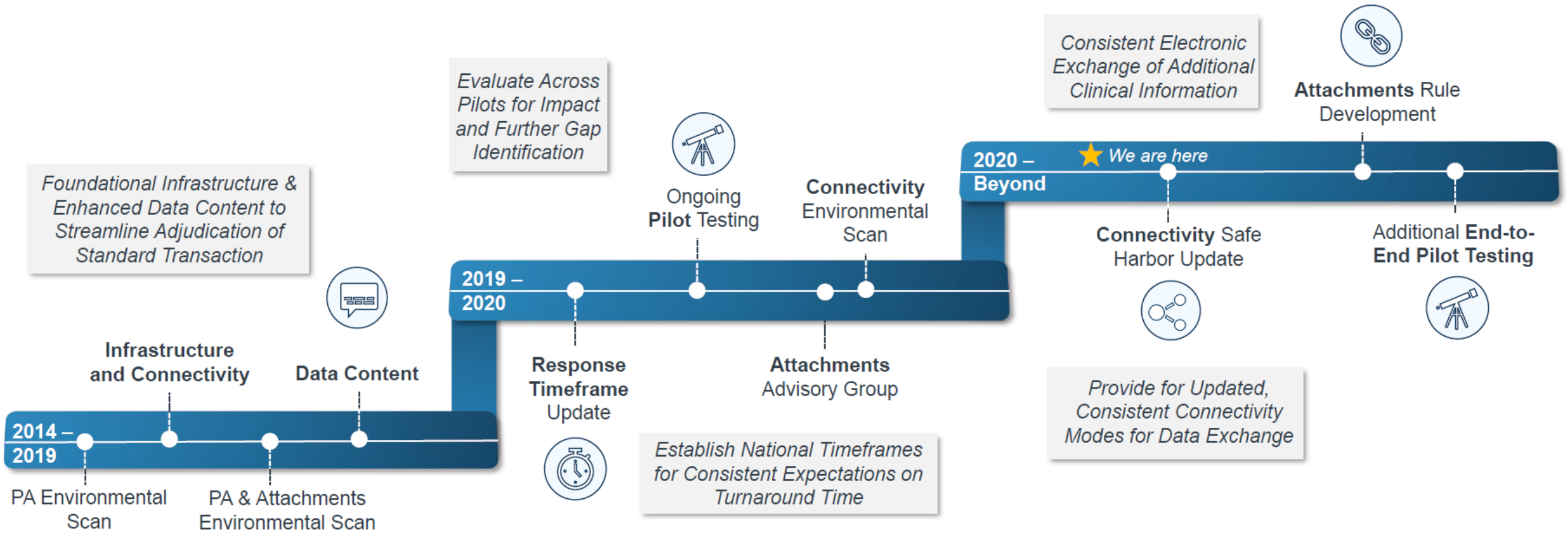
CAQH CORE Prior Authorization Roadmap

Focus on Aligning Clinical and Administrative Information Exchanges in 2020

The CAQH CORE Roadmap to Accelerate Prior Authorization Automation & Reduce Burden

Roadmap ensures that CAQH CORE Operating Rules and corresponding standards address the end-to-end prior authorization process, close critical automation gaps and support industry organizations at varying levels of maturity on the standards and technology adoption curve.



Thank you!

 @CAQH

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The CAQH CORE Mission

Drive the creation and adoption of healthcare operating rules that support standards, accelerate interoperability and align administrative and clinical activities among providers, payers and consumers.

Appendix

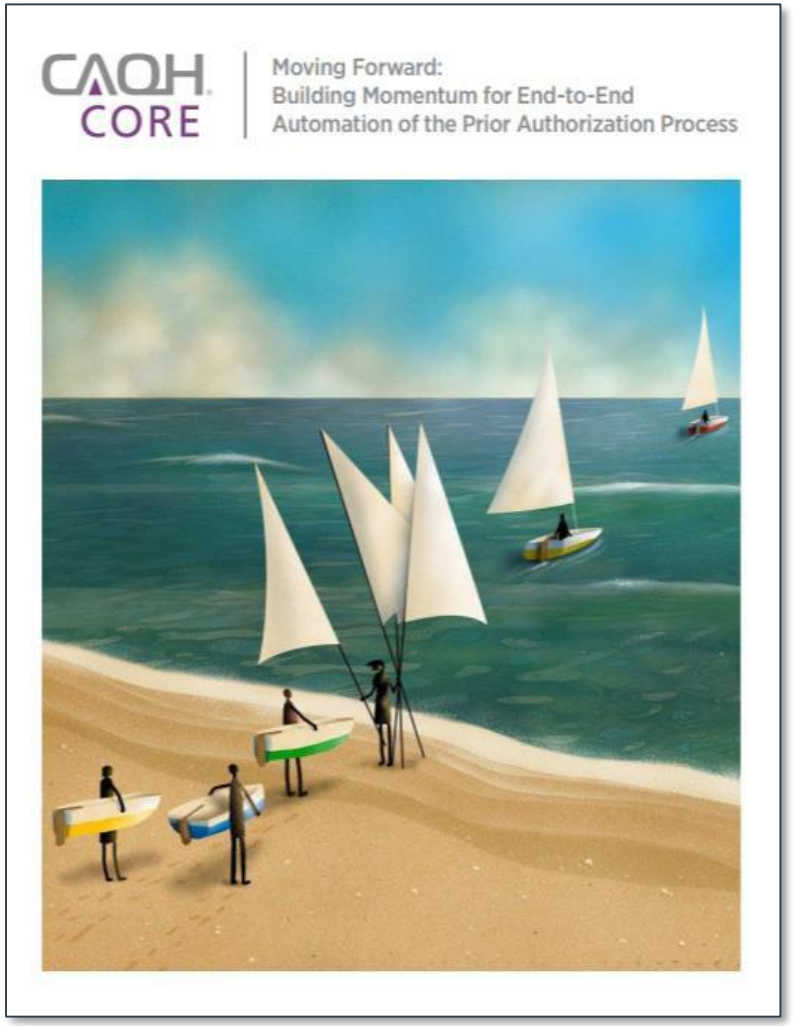
CAQH CORE Report on Prior Authorization

Moving Forward: Building Momentum for End-to-End Automation of the Prior Authorization Process, a CAQH CORE white paper published in July 2019, identifies six barriers to adoption of electronic prior authorization, and initiatives that leverage standards and operating rules to accelerate automation. Prior authorization has been used for decades and yet significant operational challenges still exist. This white paper outlines how we got to where we are today and offers a roadmap for collaborative solutions.

Full Report

Executive Summary

Press Release



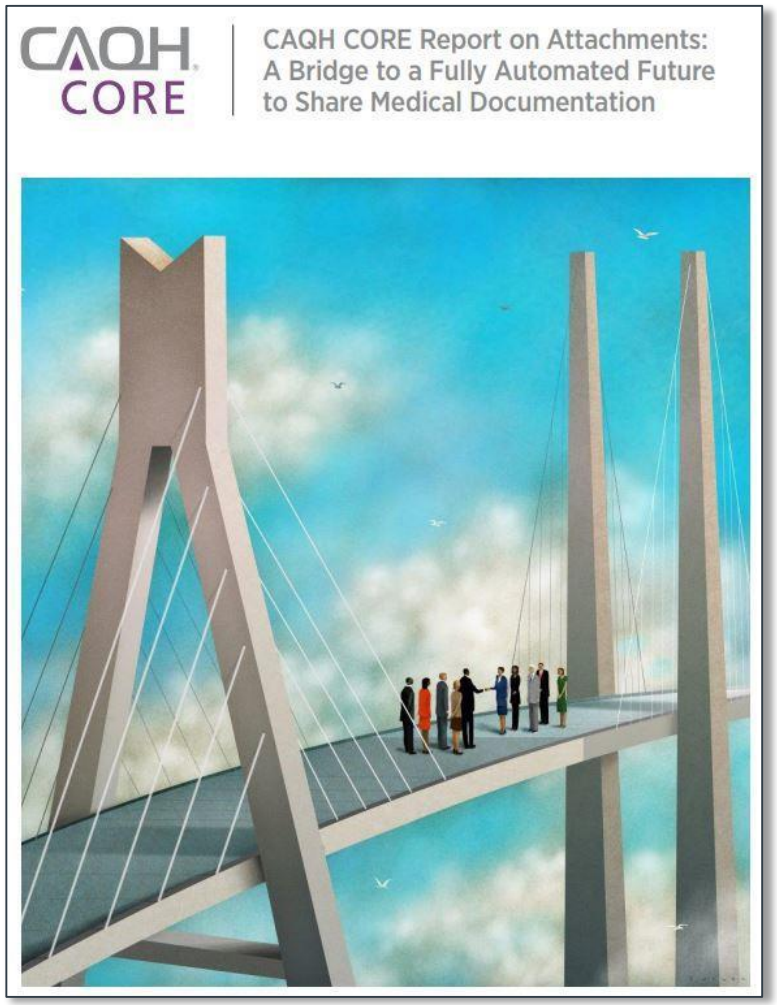
CAQH CORE Report on Attachments

The *CAQH CORE Report on Attachments: A Bridge to a Fully Automated Future to Share Medical Documentation*, published in May 2019, examines the challenges associated with the exchange of medical information and supplemental documentation used for healthcare administrative transactions. The report identifies five areas to improve processes and accelerate the adoption of electronic attachments.

Full Report

Executive Summary

Press Release

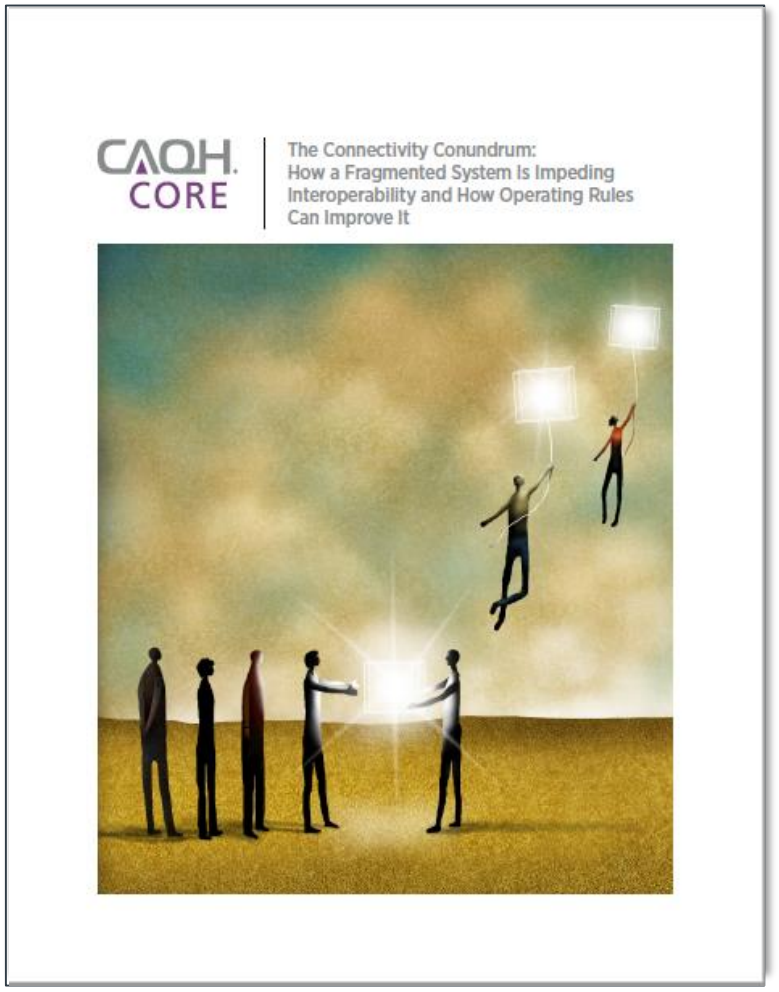


CAQH CORE Report on Connectivity

The Connectivity Conundrum: How a Fragmented System is Impeding Interoperability and How Operating Rules Can Improve It, published in December 2019, is an in-depth study of the challenges and opportunities associated with connectivity. Connectivity encompasses the capacity to connect applications, computers, systems and networks to one another in a coordinated manner, within and across organizations. Perhaps the most critical component of connectivity is the use of communication protocols, which are the set of rules and standards by which data is transported, messaged, secured, authenticated and acknowledged.

Full Report

Executive Summary



Status of CAQH CORE Operating Rules Related to Prior Authorization

Prior Authorization Operating Rules reduce administrative burden, close automation gaps and allow for patients to receive more timely care.

Provider Determines if PA is Required & Information Needed

Provider identifies if PA is required and what documentation is required; collects info

Existing

- Standard Companion Guide
- Accurate patient identification
- Application of standard data field labels to proprietary web portals

Under Consideration

- Use of codes to communicate if a PA is required and what documentation is needed

Provider & Health Plan Exchange Information

Provider submits PA Request; Health Plan receives and pends for additional documentation; Provider submits additional documentation

Existing

- System availability for standard transaction
- PA receipt confirmation
- Consistent connectivity and security methods
- Time requirement for initial response
- Consistent system availability for web portals
- Consistent review of diagnosis/procedure/revenue codes for adjudication
- Consistent communication of specific errors
- Display of code descriptions
- Use of codes to communicate reason for pend and additional documentation needed
- Response time requirement for requesting additional clinical information

Under Consideration

- Updated, consistent connectivity modes for data exchange (APIs, REST)
- Consistent electronic exchange of additional clinical information

Health Plan Adjudicates & Approves / Denies PA Request

Health Plan reviews request and determines response; sends response to Provider

Existing

- Consistent connectivity and security methods
- Detection and display of code descriptions
- Response time requirement for final determination
- *Optional* – close out a prior authorization request if requested information is not received (Note: this is not an approval or denial).

Under Consideration

- Updated, consistent connectivity modes for data exchange (APIs, REST)
- Reassociation of additional clinical documentation with prior authorization request

NOTE: All existing requirements are included in the rule package proposed to NCVHS in 2020 with exception of requirements related to web portals.

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CAQH CORE Rule Package for NCVHS/HHS Consideration

Prior Authorization & Connectivity Operating Rules Increase Value & Use of Electronic Transactions

- In February 2020, the CAQH CORE Board sent a letter to NCVHS proposing a CAQH CORE Prior Authorization and Connectivity Operating Rules package for recommendation to the HHS Secretary for national adoption under HIPAA that includes:

  - CAQH CORE Prior Authorization & Referrals (278) Data Content Rule vPA.1.0
  - CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule vPA.2.0
  - CAQH CORE Connectivity Rule vC3.1.0

- The Board proposed this rule package for federal mandate for three reasons:

  1. The prior authorization operating rules address a pressing need to improve automation and timeliness of the prior authorization process.
  2. The connectivity operating rule enhances security and promotes uniform interoperability requirements across administrative transactions.
  3. These operating rules set the stage for future operating rules to further enable the critical convergence of administrative and clinical data and support the use of new technologies with existing standards.

- An NCVHS Hearing on the proposed rule package is scheduled for August 25-26 in Washington, D.C. Public comments may be submitted to NCVHS by July 24.