CAQH CORE

Standards Subcommittee Meeting: Hearing on Request for NCVHS Review of CAQH CORE Operating Rules for Federal Adoption

April Todd

Senior Vice President, CAQH CORE & Explorations

Dr. Susan Turney

President and CEO, Marshfield Clinic Health System, Immediate Past Chair CAQH CORE Board

Tim Kaja

Chief Operating Officer of UnitedHealth Networks, UnitedHealthcare, Chair CAQH CORE Board

CAQH CORE Mission/Vision & Industry Role

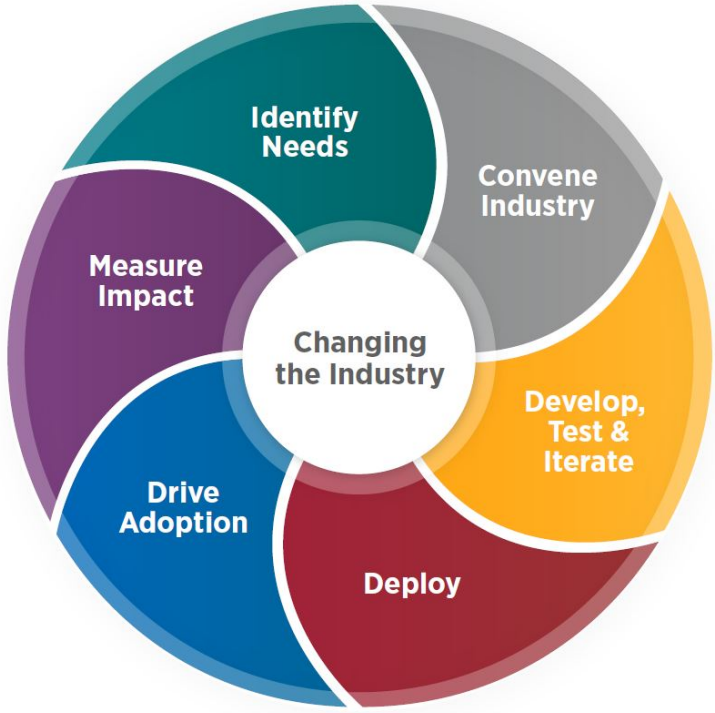
Industry-led, CAQH CORE Participants include providers, health plans, vendors, government entities, associations, and standard-setting organizations. Organizations participating in CAQH CORE represent over **75 percent of covered lives in the U.S.**

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.

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

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.



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.

Proposed Operating Rule Package

Rules Promote Auto-Adjudication, Improve Security, and Drive Electronic Data Exchange

Prior Authorization & Referrals Operating Rules Proposed to NCVHS for Federal Mandate

Prior Authorization (278) Data Content Rule vPA.1.0	Patient identification ▪ Error/action codes ▪ Clear communication of information needs, status, next steps, and decision reasons
Prior Authorization (278) Infrastructure Rule vPA.2.0	Processing mode and response times ▪ System availability ▪ Acknowledgements ▪ Companion guide
Connectivity Rule vC3.1.0	Single standard ▪ Enhanced security ▪ Additional transaction standard support ▪ Safe harbor ▪ Improved messaging and error reporting

CAQH CORE Board Members
Diverse, Engaged Board Drives CAQH CORE Priorities

VOTING MEMBERS

Kenneth L. Chung DDS, MPH; CEO	ComfortCare Dental
Marilyn J. Heine, MD, FACEP, FACP, FFSMB, FCPP	Drexel University College of Medicine (Proposed by AMA)
Linda Reed, RN, MBA, CHCIO, FCIME; Vice President and Chief Information Officer, *Board Vice Chair*	St. Joseph's Health (Proposed by AHA)
Stephen Rosenthal, Senior Vice President, Population Health Management and President of CMO, Montefiore Care Management	Montefiore Health System
Susan L. Turney, MD, MS, FACMPE, FACP; President and CEO, *Immediate Past Board Chair*	Marshfield Clinic Health System (Proposed by MGMA)
Renee Ghent, Chief Digitalization Officer	Aetna
Tim Kaja, COO of UnitedHealth Networks, *Board Chair*	UnitedHealthcare
Michael S. Sherman, MD, MBA, MS; Chief Medical Officer	Harvard Pilgrim Health Care
Troy Smith, Vice President, Healthcare Strategy and Payment Transformation	BCBSNC
Jennifer Weigand, MBA, Senior Vice President, Business Digitization	Centene
Paul Brient, MBA, Senior Vice President and Chief Product Officer	athenahealth
Vasu Pasumarthi, Software Development Group Lead–Registration, Eligibility, Referrals & Authorizations	Epic
Chris Seib, Chief Technology Officer and Co-Founder	InstaMed

NON-VOTING MEMBERS

- Federal Government - CMS: Christine Gerhardt, Director, National Standards Group
- State Government - *TBD*: *In Process*

NON-VOTING ADVISORS

- ASC X12: Cathy Sheppard, Executive Director
- HL7: Walter Suarez, Board Chair
- NACHA: Jane Larimer, President and CEO
- NCPDP: Lee Ann Stember, President
- WEDI: Charles Stellar, President and CEO
- *Emeritus:* Joel Perlman, Former EVP, CFO, Montefiore Medical Center

CAQH CORE Rule Development Process

Operating Rules Address Many Critical Barriers to Automated Prior Authorization

CAQH CORE Participants Collaborated to Address One of the Most Challenging Business Processes

- **Lack of detail and consistency** in the use of data content to identify patients, communicate errors, specify needed documentation, and inform on status and next steps creates confusion and delays the process.
- **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 transaction is federally-mandated – particularly among providers.
- **Limited availability** of vendor products that readily support the standard transaction. The 2017 CAQH Index found that only 12% of vendors supported electronic prior authorization, compared to 74-91% vendor support for all other electronic transactions.
- **Varying state requirements** for manual intervention and response times.
- **Varying levels of maturity** along the standards and technology adoption curve, making interoperability a challenge.
- **No federally mandated attachment standard** to communicate clinical documentation.
- **Lack of integration** between clinical and administrative systems.

Lack of automation leads to unnecessary delays in patient care and can impact outcomes.

Driving Industry Consensus on Prior Authorization

Given heightened industry concern and lack of solutions, **CAQH CORE Board prioritized rule development to address major automation gaps** in the industry.

Prior authorization **operating rule development was a challenging and contentious process**, but stakeholders with varied interests came together to compromise and make progress.

Although CAQH CORE Participants were not able to reach consensus on or address every issue, **the proposed rules are a significant step to drive automation today while allowing for future enhancements.**

Engagement in Prior Authorization & Connectivity Rule Development

Broad Industry Representation Provided a Diversity of Perspectives

Organizations that participated in the development of the prior authorization and connectivity rules included:

Health plans covering more than **208 million lives** in the U.S.

Provider organizations/ associations representing various provider types and care settings.

Medicaid agencies responsible for over **28 million enrollees**.

Federal agencies that provide services and benefits for Medicare beneficiaries and those that are or have served in the military.

Numerous **vendor, clearinghouse, and EHR organizations**.

Representatives from **standards development organizations** and other interested parties.

Individuals from these organizations represented business, clinical, technical, and leadership functions:

- Often multiple individuals from the same organization participated to represent different perspectives across departments/functions.
- These individuals then collaborated to submit a single response or vote on behalf of their organization.

CAQH CORE Rule Development Process

Intensive and Detailed Process Facilitated Compromise and Consensus

Identify Opportunities

Prior Authorization Advisory Group

Environmental Scans, Industry Surveys, and Advisory Groups were used to inform opportunities for rule development.

Develop Rule Requirements

Rules Work Group

- Prior Authorization Subgroup

Technical Work Group

- Connectivity Subgroup

Rule Writing Groups chaired by industry experts developed requirements using a consensus-based approach.

Ballot Rules

Formal Voting Process

CAQH CORE Voting Organizations voted on the proposed rules. Once quorum and approval levels were achieved, the CAQH CORE Board voted on final approval.

Robust Feedback and Support at Each Step

Held more than **75 Subgroup and Work Group meetings**.

Conducted **35 straw polls and ballots** to collect detailed feedback.

Each of the three rules received at least **80% support across participating organizations**.

Approval levels exceeded 69% within each stakeholder category including health plans, providers, government, and vendors.

Proposed Prior Authorization & Connectivity Operating Rules

1. The CAQH CORE Prior Authorization & Referrals (278) Data Content Rule

Enhances Data Content to Streamline Review and Adjudication

- **The CAQH CORE Prior Authorization & Referrals (278) Data Content Rule** targets one of the most significant problem areas in the prior authorization (PA) 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 CAQH CORE Rule Requirements Include:

1. Consistent patient identification and verification requirements.
2. Return of specific AAA error codes and action codes when certain errors are detected on the Request.
3. For specified categories of service* for diagnosis/procedure/revenue codes the following are required:
    a. Return one or more of the most specific Health Care Service Decision Reason Codes.
    b. Use of PWK01 Codes (or Logical Identifiers Names and Codes & PWK01 Codes).
4. Detection and display of all code descriptions.

*General Outpatient, Inpatient, Surgery, Oncology, Cardiology, Imaging, Laboratory, Physical Therapy, Occupational Therapy, & Speech-Language Pathology.
NOTE: Rule does not apply to urgent/emergent use cases; Affordable Care Act prohibits PA for emergency care.

Impact of Data Content Requirements on Prior Authorization Workflow

Provider Determines if PA is Required & Information Needed

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

Requirement	Workflow Impact
1. Consistent patient identification and verification requirements	Reduces common errors by providing complete set of demographic data to ensure better patient/subscriber match.

Provider & Health Plan Exchange Information

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

Requirement	Workflow Impact
2. Return of specific AAA error codes/action codes when certain errors are detected on the Request	Strengthens electronic communication, reducing need for provider to manually follow-up with health plan.
3. Specifies categories of service for diagnosis/ procedure/ revenue codes	Enables auto adjudication through support of use case driven system and application design.
a. Return one or more of the most specific Health Care Service Decision Reason Codes	Provides a clear explanation to provider to inform next steps.
b. Use of PWK01 Codes (or Logical Identifiers Names and Codes & PWK01 Codes)	Provides direction on status and what additional clinical information is needed for health plan adjudication of the PA request.

Health Plan Adjudicates & Approves / Denies PA Request

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

Requirement	Workflow Impact
4. Detection and display of all code descriptions	Reduces burden of interpretation on provider.

The proposed prior authorization operating rules will improve the exchange of attachments by clearly communicating what additional documentation is needed for final adjudication regardless of how it is exchanged. While a federally mandated attachment standard will be welcomed by the industry, it should not detract from reducing burden as soon as possible.

2. The CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule

Establishes Consistent Infrastructure and National Turnaround Timeframes

- **The CAQH CORE Prior Authorization & Referrals (278)** Infrastructure Rule aligns with other federally mandated infrastructure rules and specifies prior authorization requirements for:
  1. Standard companion guide template
  2. System availability expectations
  3. Uniform use of acknowledgements
  4. Processing mode and response timeframes
  5. Safe harbor connectivity and security

- In 2019, CAQH CORE Participants updated the rule to include new response requirements*:
  a. **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.
  b. **Two-Day Final Determination**: Once all requested information has been received from a provider, the health plan or its agent has two business days to send a response containing a final determination.
  c. **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.

Infrastructure Requirement	Prior Authorization
Processing Mode	*Batch OR Real Time Required*
Batch Processing Mode Response Time	*If Batch Offered*
Batch Acknowledgements	*If Batch Offered*
Real Time Processing Mode Response Time	*If Real Time Offered*
Real Time Acknowledgements	*If Real Time Offered*
Safe Harbor Connectivity and Security	✓
System Availability	✓
Companion Guide Template	✓

***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; does not apply to urgent/emergent prior authorizations.

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Impact of Infrastructure & Connectivity Requirements on PA Workflow

Provider Determines if PA is Required & Information Needed

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

Requirement	Workflow Impact
1. Standard Companion Guide format	Enables consistent access across trading partners.

Provider & Health Plan Exchange Information

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

Requirement	Workflow Impact
2. System availability expectations	Sets provider expectations on standard system availability plus notifications of down time.
3. Uniform use of acknowledgements	Allows for providers to immediately learn if health plan has received the PA Request, eliminating manual follow-up.
4a. Time requirement for initial Response including request for additional clinical information	Sets clear provider expectations on timeframe for initial response from health plan, reducing help desk burden and timeframe to communicate what additional information is needed to adjudicate Request.

Health Plan Adjudicates & Approves / Denies PA Request

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

Requirement	Workflow Impact
4b. Response time requirement for final determination using X12 278 Response.	Enables timely final determination, ensuring safety/ appropriateness of medical treatment and enables closure of pended PAs using the HIPAA-mandated 278.
4c. *Optional* – Close out a prior authorization request if requested information is not received (this is not an approval or denial).	Efficient close outs due to inactivity lead to less back and forth between plan and provider.

Requirement	Workflow Impact
5. Consistent connectivity and security methods using CAQH CORE Connectivity Rule vC3.1.0	Safe harbor connectivity method ensures providers and health plans are capable and ready to exchange data – reducing trading partner onboarding.

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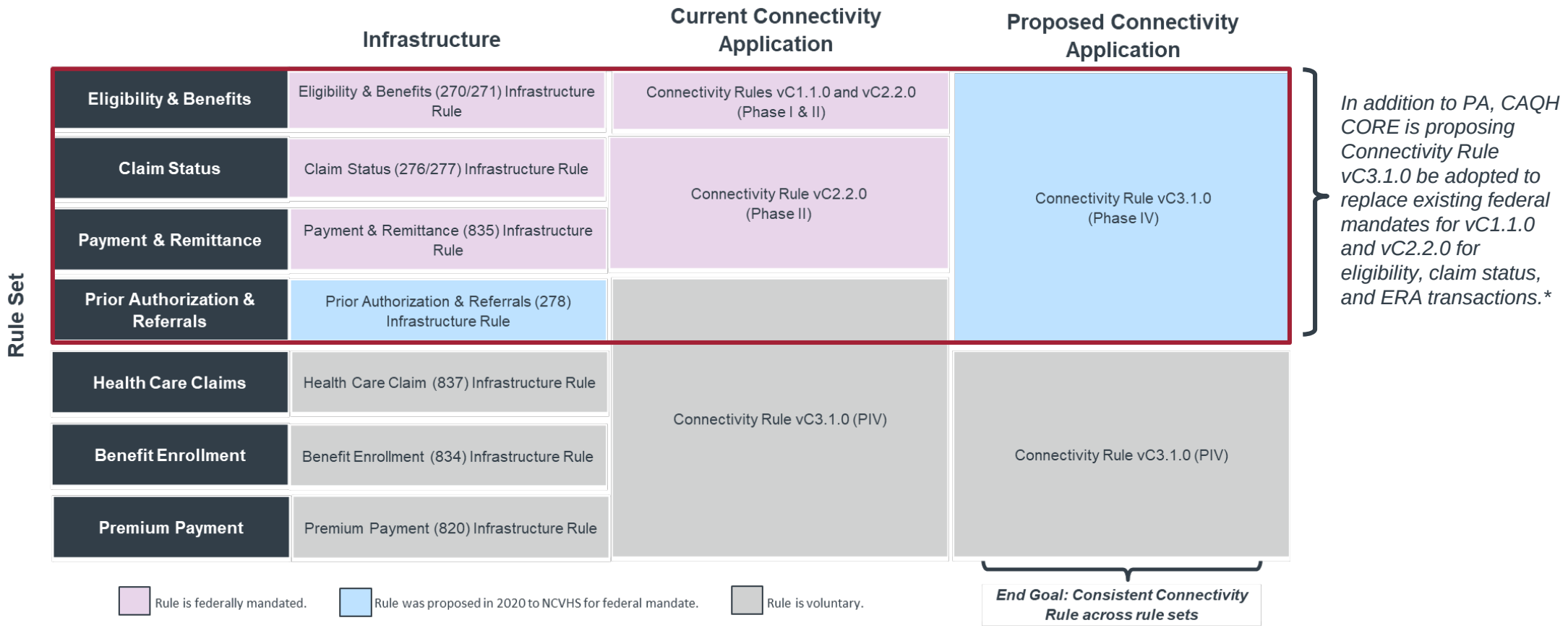
3. The CAQH CORE Connectivity Rule vC3.1.0

Provides for Updated, Consistent Connectivity Modes Across Transactions

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 will sunset the CAQH CORE Connectivity Rules v1.1.0 and v2.2.0 if CAQH CORE Connectivity Rule vC3.1.0 is federally mandated across eligibility, claim status, ERA, and PA.

Evolution of CAQH CORE Connectivity Requirements

Rule Evolved to Align with Industry Best Practices for Security and Connectivity

Given large install base of vC2.2.0 due to current federal mandates, implementation costs for vC3.1.0 will be limited due to commonalities in transport, envelope, authentication standards, and metadata. Implementation costs may be further reduced given the single submitter authentication standard.

Connectivity Rule Area	CAQH CORE Connectivity vC1.1.0 and vC2.2.0	CAQH CORE Connectivity vC3.1.0
Network	Internet	Internet
Transport	HTTP	HTTP
Transport Security	SSL 3.0 with optional use of TLS 1.x	SSL 3.0, or optionally TLS 1.1 or higher Entities that must also be FIPS 140-2 compliant or that require stronger transport security may implement TLS 1.1 or higher in lieu of SSL 3.0
Submitter (Originating System or Client) Authentication	Username + Password OR X.509 Digital Certificate	X.509 Digital Certificate based authentication over SSL/TLS *Removed Username + Password*
Envelope and Attachment Standards	SOAP 1.2 + WSDL 1.1 and MTOM (for Batch) OR HTTP+MIME	SOAP 1.2 + WSDL 1.1 and MTOM (for both Real Time and Batch) *Removed HTTP+MIME*
Envelope Metadata	Metadata defined (Field names, values) (e.g., *Payload Type, Processing Mode, Sender ID, Receiver ID*)	Metadata defined (Field names, values) (e.g., *Payload Type, Processing Mode, Sender ID, Receiver ID*) SHA-1 for Checksum FIPS 140-2 compliant implementations can use SHA-2 for checksum.
Message Interactions/ Routing	Real-time Batch (Optional if used)	Batch and Real-Time processing requirements defined for each transaction Generic push and pull interactions
Acknowledgements, Errors	Enhanced vC1.1.0, with additional specificity on error codes	Errors Codes updated
Basic Conformance Requirements for Client/Server Roles	Well specified	Well specified
Response Time	Maintained vC1.1.0 time requirements	Maintained vC1.1.0 time requirements
Connectivity Companion Guide	Enhanced vC1.1.0, with additional recommendations	Enhanced vC1.1.0, with additional recommendations

Use Case Driven Approach: Prior Authorization for Imaging

How the Proposed Operating Rules Improve Automation & Adjudication

1 Patient presents with abdominal pain and Physician requests PA for Imaging: CT scan with contrast.

Provider includes data identifying the patient, the provider, and the specific diagnosis code for the service.

Like a claim, the PA Request includes specific data that the health plan must have to accurately adjudicate.

2 Health Plan receives PA Request and completes adjudication process.

Health Plan acknowledges receipt of the 278 Request: 20 seconds for Real Time; two days for Batch.

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

As with claims, adjudication process includes member and provider look ups, eligibility and benefits review, specific procedure and revenue code analysis. Although many of these steps are manual today, with a use case driven approach, automation steps can be implemented.

3 Health Plan determines that the Patient had recently had a CT scan without contrast.

Health Plan must return specific codes to report errors, pends, status, and other processing and adjudication results; these assist the provider in making an informed decision on next steps.

When pending and requesting additional documentation – the health plan has two business days to return the pend and must include the most specific codes on next steps and documentation needed.

4 Provider receives pended PA response from Health Plan.

Detect and display requirements enables code definitions to be displayed to provider, reducing interpretation burden.

As with claim adjudication, when the health plan identifies specific data that must be supplied to support the review, the provider can easily identify the requested data and quickly return it to support the review.

Specificity allows for accurate and timely rework to remove the pend.

5 Provider remits CT scan without contrast for Health Plan review.

Health Plan receives original scan image, completes review, and returns final determination to provider within two business days.

Patient is now authorized, and the care can be scheduled.

Foundational infrastructure, connectivity and security requirements allow for Provider and Health Plan interoperability across the entire system.

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Operating Rule Impact

Operating Rules Drive Cost Savings

Approximately $18 Billion Saved to Date

$55 billion in cumulative savings associated with incremental improvements in automation since CAQH CORE Operating Rules started to be federally mandated in 2013.

Roughly **one-third** of cumulative savings ($18 billion) is estimated to be related to operating rule adoption.

In the year following CORE Certification, an organization reported a **19.5 percentage point one-time increase in electronic adoption** for eligibility and benefit verification.

For claim status, an organization reported a **37.4 percentage point one-time increase in electronic adoption** following certification.

Potential Savings

According to the 2019 CAQH Index, industry could save **$12.31 per prior authorization transaction** by moving from manual processing to use of the HIPAA-mandated 5010X217278 Request and Response. **Providers could save 17 minutes** on average per transaction.

Federal adoption of the proposed prior authorization and connectivity operating rules facilitates automation, requires faster response times, aligns on a single connectivity safe harbor, and reduces administrative costs and burden for industry.

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Case Studies: Benefits of Automation and Proposed Operating Rules

Insights from a Health Plan and a Provider

Harvard Pilgrim Health Care

- Harvard Pilgrim Health Care (HPHC) has **used X12 278 for PAs for nearly 20 years; now 70% of referrals and authorizations**.
- **Massachusetts requires** payers to respond to a prior authorization request within **two business days**; otherwise request is approved.*
- **HPHC consistently meets or exceeds this two-day response time requirement.**
- **HPHC exclusively utilizes CAQH CORE Connectivity vC3.1.0 for prior authorizations**; if mandated, HPHC will decommission additional methods for eligibility and claim status, a cost savings.
- Benefits to automation and shorter timeframes at HPHC include:
  - **Reduction of 14 FTEs** in referral and authorization administrative staff over time.
  - **85% of all requests received via the X12 278 result in a real time response** that the transaction is approved or partially approved, no plan action is required, or the request is denied (with denials at 1%).

With automation and operating rules for the X12 278, health plans can meet and benefit from the response time requirements.

Cleveland Clinic

- CAQH CORE **Prior Authorization Pilot & Measurement Initiative** with Cleveland Clinic and PriorAuthNow to measure impact of operating rules, initially related to imaging and diagnostic testing.
- Automated solution **uses X12 278, CAQH CORE Prior Authorization Operating Rules**, **and intersection with EMR workflow**.
- Initial results show **80% reduction in staff time (savings of at least 12 minutes)** on a prior authorization compared to web portals.
- Without an attachment standard, submission of clinical documentation is still manual, but **time saved from automating** other parts of **the workflow allows staff to address clinical documentation needs more effectively.**
- Satisfaction survey showed that most staff:
  - Saved time initiating a request, checking on status, waiting for next steps, and receiving a final determination.
  - Found it easier to determine next steps and documentation needs
  - Reported reduced job stress.

Providers experience significant reduction in resource use and improvement in staff satisfaction with greater prior authorization automation, regardless of an attachment standard.

*https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176O/Section25.

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Rules Will Drive Use of Electronic Prior Authorization & Promote Interoperability

Ultimately Rules Will Enable More Timely Delivery of Patient Care

Robust data content delivers actionable data between providers and health plans.

Improves member matching, provider matching, error messaging, and ability to specifically identify needed additional documentation to support the PA Request.

The “dialogue” nature of the standard is more fully implemented when roles, responsibilities, and expectations are clearly defined through use case driven approaches.

Infrastructure requirements incentivize adoption among providers as they can be assured of a maximum response time.

A federal mandate reduces need for health plans to comply with varying state requirements related to timeframes -- 30 states have PA response time requirements that vary from 24 hours to 15 business days with differences in definitions and applicability.

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A single, updated CAQH CORE Connectivity Safe Harbor ensures secure information exchange.

CAQH CORE Connectivity Rule vC3.1.0 reduces complexity and simplifies interoperability.

A single connectivity safe harbor method across administrative transactions will improve security, simplify onboarding, and reduce costs to support multiple connections.

Building on a Solid Foundation

Proposed Rules are an Impactful First Step; Future Efforts will Further Streamline Data Exchange

CAQH CORE will build on and further enable the critical convergence of administrative and clinical data. Regardless of the standard, data and infrastructure surrounding the exchange of information must be consistent to enable seamless transactions.

- **New Prior Authorization Attachments Operating Rules:** Reduce administrative burden associated with the exchange of documentation to support a prior authorization request.
- **Connectivity Rule Update:** Facilitate intersection of administrative and clinical data, including support for attachment/ clinical documentation needs. Bridge between existing and emerging standards and protocols to ensure industry interoperability needs are met.
- **Ongoing Pilot/ROI Assessment**: Continue to work with industry partners to measure the impact of current and potential future operating rules and corresponding standards on organizations' efficiency metrics.
- **CORE Certification:** Drive adoption of the CAQH CORE Prior Authorization and Connectivity Operating Rules.

Early Adopters of the Prior Authorization & Referral Infrastructure Operating Rule and Connectivity vC3.1.0 Represent 14% of Commercial Market

aetna™ Humana. TEXAS Health and Human Services HealthTrio® pokitdok The SSI Group, Inc. Availity™

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.