Improving Prior Authorization: Operating Rule Update

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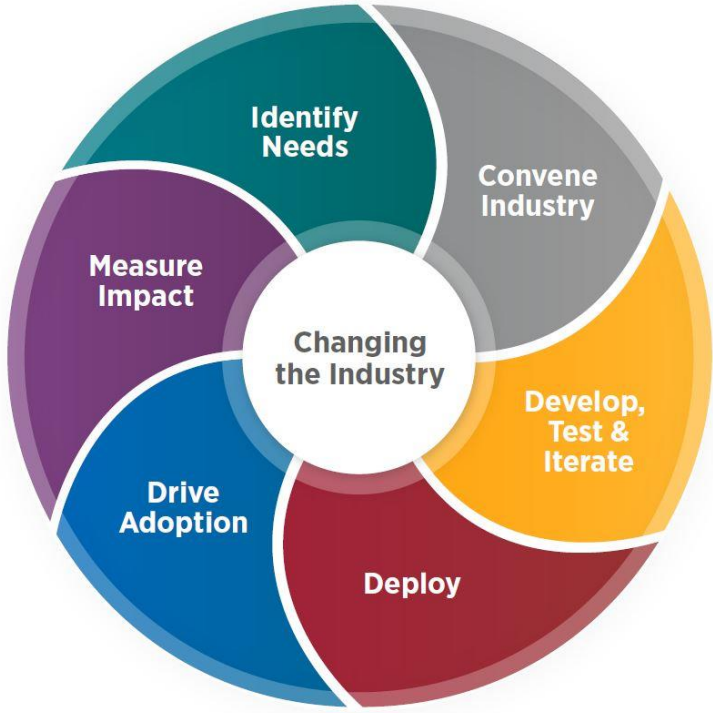
CAQH CORE Mission, Vision & Industry Role

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.

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

CAQH CORE Operating Rule Overview

CAQH CORE is designated by the Secretary of the Department of Health and Human Services (HHS) as the author for federally mandated operating rules for HIPAA-covered transactions.
HIPAA-covered entities conduct these transactions using the CAQH CORE Operating Rules.

	Phase I & Phase II	Phase III	Phase IV	Phase V	Phase VI
Transactions	Eligibility Claims Status	Electronic Funds Transfer Electronic Remittance Advice	Health Claims Referral, Certification and Authorization	Prior Authorization	Attachments
Manual to Electronic Savings per Transaction (2019 CAQH Index)	Eligibility: $7.55 Claims Status: $7.72	EFT: $1.59 ERA: $2.96	Claim Submission: $3.16 Prior Authorization: $12.31	$12.31	N/A
	Active				**In Progress**

Notes: (1) All Active Phases include requirements for acknowledgements, e.g., 999 Functional Acknowledgement, 277CA Claims Acknowledgement. (2) CAQH CORE is evaluating maintenance areas and opportunities to build on existing rules to support value-based payment.

CAQH CORE Rule Development

From Identifying Opportunities to Federal Mandate

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Identify Opportunities

Environmental Scans, Industry Surveys, and Advisory Groups are used to **research opportunities for a potential new rule and/or an update to an existing rule**.

Develop Rule Requirements

Rule Writing Groups develop requirements. New groups form as CAQH CORE rule writing focus changes. **Pilots and ROI assessment support quicker and broader market adoption**.

Ballot Rules

CAQH CORE Voting Organizations vote on the proposed rule(s). Once CORE Participants have achieved quorum and approval levels, the **CAQH CORE Board votes for final approval.**

NCVHS/HHS

CAQH CORE Writes Letter to NCVHS*

CAQH CORE writes a letter to the HHS Federal Advisory Committee (NCVHS)** explaining the industry need for the operating rules along with the CORE Board approved rules.

NCVHS Makes Recommendation to HHS

NCVHS sends a letter to the HHS Secretary regarding industry feedback given at the hearing, including a recommendation regarding whether the **operating rules should be mandated.**

Expedited HHS Interim Final Rule Making

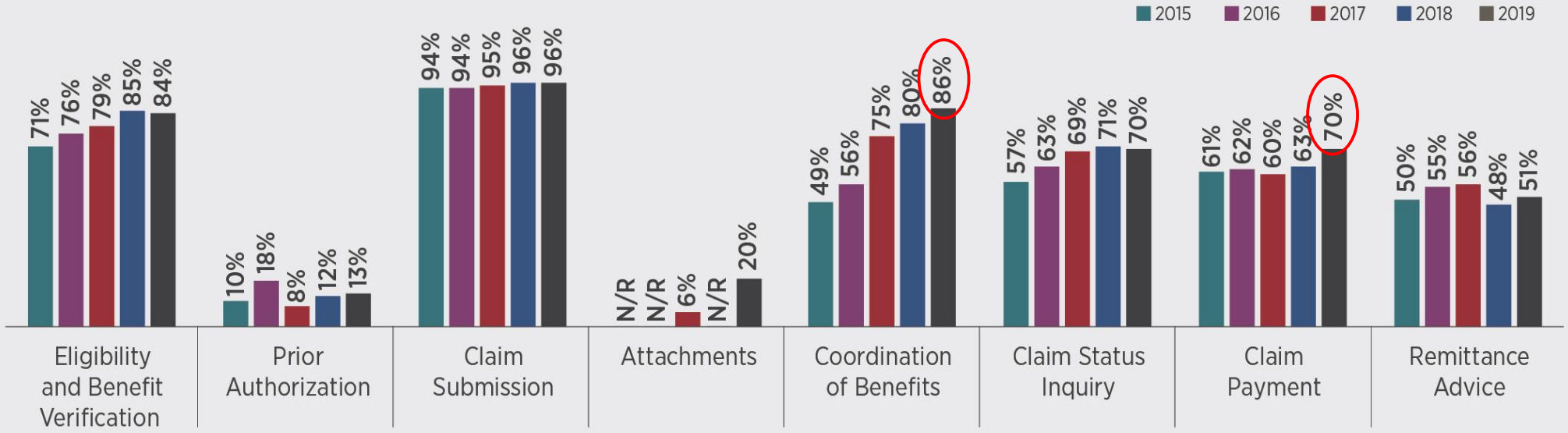
HHS issues Interim Final Rule (IFR) to the industry with a 60-day open comment period. With no major objections, **HHS adopts the final rule and mandates the operating rules.*****

Once HHS mandates an operating rule, industry is given 25 months to implement and adopt new rules.

Notes: *National Committee on Vital and Health Statistics (NCVHS) | ** Department of Health and Human Services (HHS) | ***HHS has the authority to judge whether comments are substantial and whether changes should be made to the final rule.

CAQH Index: Adoption Increased or Remained Relatively Stable

Figure 2: Medical Plan Adoption of Fully Electronic Administrative Transactions, 2015-2019 CAQH Index



N/R = Not Reported

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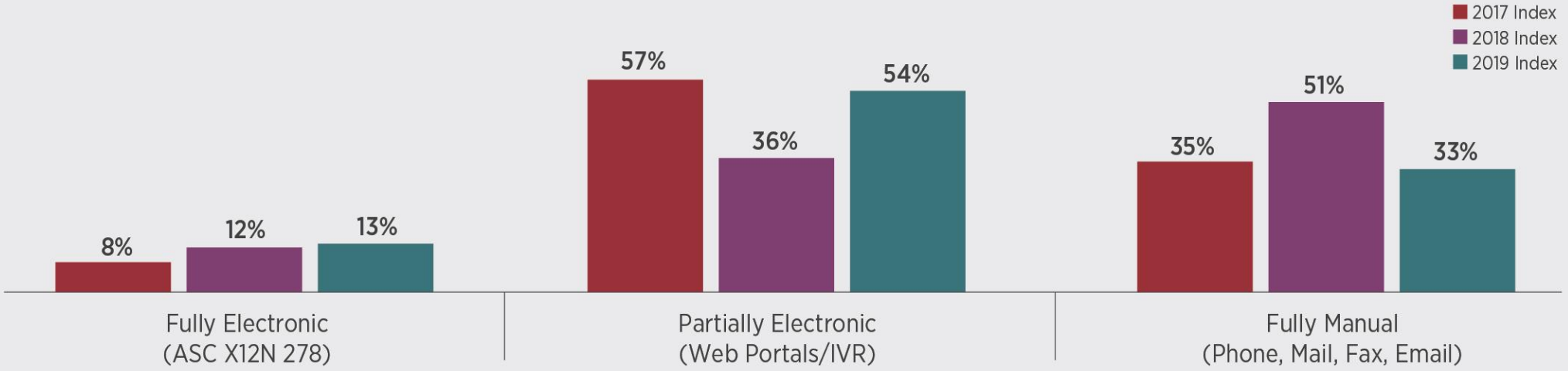
Prior Authorization: Medical Plan Adoption by Mode

Figure 10: Medical Plan Adoption of Prior Authorization, 2017-2019 CAQH Index



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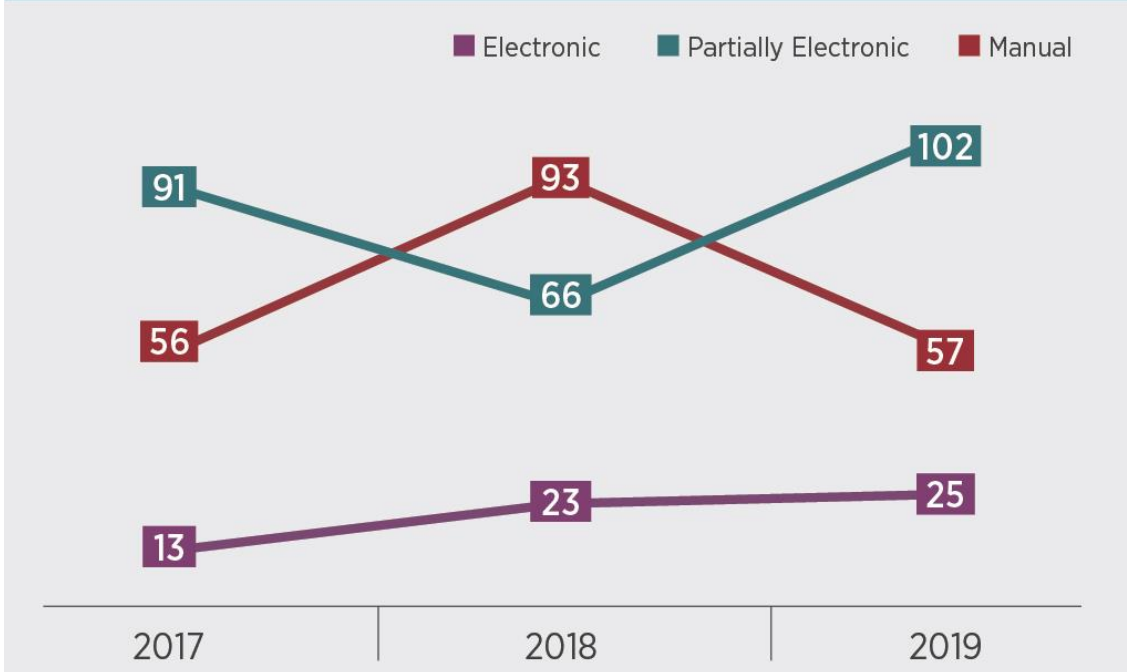
Prior Authorization: Medical Industry Estimated Volume by Mode

Figure 11: Estimated National Volume of Prior Authorizations, Medical, by Mode, 2017-2019 CAQH Index (in millions)



Note: Data represents plans and providers.

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Barriers to Industry Adoption of Electronic Prior Authorization

Top Barriers Identified Through CAQH CORE Research

1. 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.
2. No federally mandated attachment standard to communicate clinical documentation.
3. Lack of integration between clinical and administrative systems.
4. Limited availability of vendor products that readily support the standard transaction.
5. State requirements for manual intervention.
6. Lack of understanding of the breadth of the information available in the 5010X217 278 Request and Response, as well as lack of awareness that this standard prior authorization transaction is federally-mandated – particularly among providers.
7. Varying levels of maturity along the standards and technology adoption curve, making consistent interoperability a challenge.

Groundswell of Support at All Levels to Address Prior Authorization Challenge

Action in the Public Sector

- **Collaboration at HHS:**
  - Draft Strategy on Reducing Burden Relating to the Use of Health IT and EHRs
  - NCVHS and HITAC commitment to collaboration on prior authorization
  - CMS pilot Documentation Requirement Lookup Service Initiative
- **Activity in Congress:**
  - Improving Seniors' Timely Access to Care Act (H.R. 3107) bipartisan legislation to establish requirements for use of prior authorization under Medicare Advantage
- **Policy Activity at the State Level:**
  - More than 50 pieces of legislation from over 30 states

Industry Initiatives

- **Provider and Health Plan Association Efforts:**
  - Consensus Statement on Improving the Prior Authorization Process
  - American Medical Association research efforts
  - Coalition released a comprehensive set of 21 principles to reform the prior authorization process
- **Industry-wide Coalition Efforts:**
  - WEDI PA Council and Prior Authorization Subworkgroup
  - eHealth Initiative Prior Authorization Collaboration Project and Prior Authorization white paper
  - DaVinci project use cases and implementation guides using the HL7 FHIR standard

CAQH CORE Vision for Prior Authorization

Operating Rules Can Move Industry Towards an Optimized Prior Authorization Process

CAQH CORE Operating Rules enable a more optimized prior authorization process and drive industry-wide adoption to realize meaningful change. **The rules close automation gaps, reduce administrative burden and allow for patients to receive more timely care. By doing so, the prior authorization process can advance along the automation spectrum.**

Automation Spectrum

Manual

Entirety of provider and health plan workflows, including request and submission, is manual and requires human intervention, e.g., telephone, fax, email, etc.

Partially Automated

Parts of the prior authorization process are automated and do not require human intervention. Typically includes manual submission on behalf of provider which is received by health plan via an automated tool, e.g., health plan portals, IVR, 5010X217 278 Request and Response etc.

Optimized

Entire prior authorization process is at its most effective and efficient by eliminating unnecessary human intervention and other waste. Optimized PA process likely includes automating internal provider / health plan workflows.

Status of CAQH CORE Prior Authorization Operating Rule Development

CAQH CORE Prior Authorization Operating Rules

- Requires **consistent connectivity methods, safe harbor, allowable response timeframes, system availability**, and overall consistency with other mandated operating rules.
- Provides the foundation for healthcare organizations to **scale up their interoperability and electronic exchange efforts.**
- Data content requirements **enhance electronic communication** between providers and plans, **reduce manual back and forth** and **accelerate adjudication times**.
- Specifically requires **consistent use of codes** within the standard transaction to communicate errors, additional clinical information needs, status/next steps and decision reasons.
- Prior authorization **response time requirements**.

Under Consideration: Additional Operating Rules to Further Improve Prior Authorization

- Rules to support the **consistent electronic exchange of additional clinical information** needed for a prior authorization request.
- Potential updates to the Connectivity Rule to allow for **consistent modes for data exchange.**

Spotlight: CAQH CORE Prior Authorization Rule on Maximum Response Times

Rule Enables Consistency Across Industry

Approved by CAQH CORE Participants and published in 2015, the Phase IV CAQH CORE Prior Authorization (278) Infrastructure Rule response time requirement represented a **first step to setting national expectations for the completion of a prior authorization request and response exchange**.

CAQH CORE's analysis of national and state-level prior authorization response time requirements revealed that requirements across states and health plans are disjointed and inconsistent:

- Over 30 states have existing response time requirements in place, ranging from 24 hours to 15 business days and there is a wide variation in the definition of when the clock starts "ticking". Of these states, 11 have response time requirements of less than 3 business days, with the **most common being 2 business days**.
- Plans and providers that cover patients from multiple states are faced with **varying time requirements**, which can lead to timing disparities in care delivery.
- Response time requirements exist for provider submission of additional information/documentation when a request is pended and for final determination (approval/denial of a prior authorization) by the health plan once all information/documentation has been received.

Spotlight: CAQH CORE Prior Authorization Rule on Maximum Response Times

Summary of Rule 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.

CAQH CORE Prior Authorization Pilot & Measurement Initiative

The CAQH CORE Prior Authorization Pilot & Measurement Initiative ensures that operating rules and corresponding standards address the end-to-end process and continue to identify and close critical automation gaps.

Overview

CAQH CORE subject matter experts partner with industry organizations to **measure the impact** of existing and new CAQH CORE prior authorization operating rules and corresponding standards. Can be run in collaboration with organizations' existing automation projects. **Scoping targets high-burden categories of service.**

Goals for Initiative

- **Apply existing and test new operating rules** that support greater automation of the end-to-end PA workflow.
- **Ensure that operating rules support industry organizations** in varying stages of maturity along the standards (existing and emerging: X12, HL7 FHIR, etc.) and technology adoption curve.
- Identify opportunities to **refine existing rules and prioritize new rules** to further meet automation needs.
- Quantify impact to support potential rule recommendations for **national implementation** to NCVHS and HHS.

To date, CAQH CORE is in planning phases on multiple distinct provider / vendor / health plan groupings.

Prior Authorization Operating Rule Package for NCVHS/HHS Consideration

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

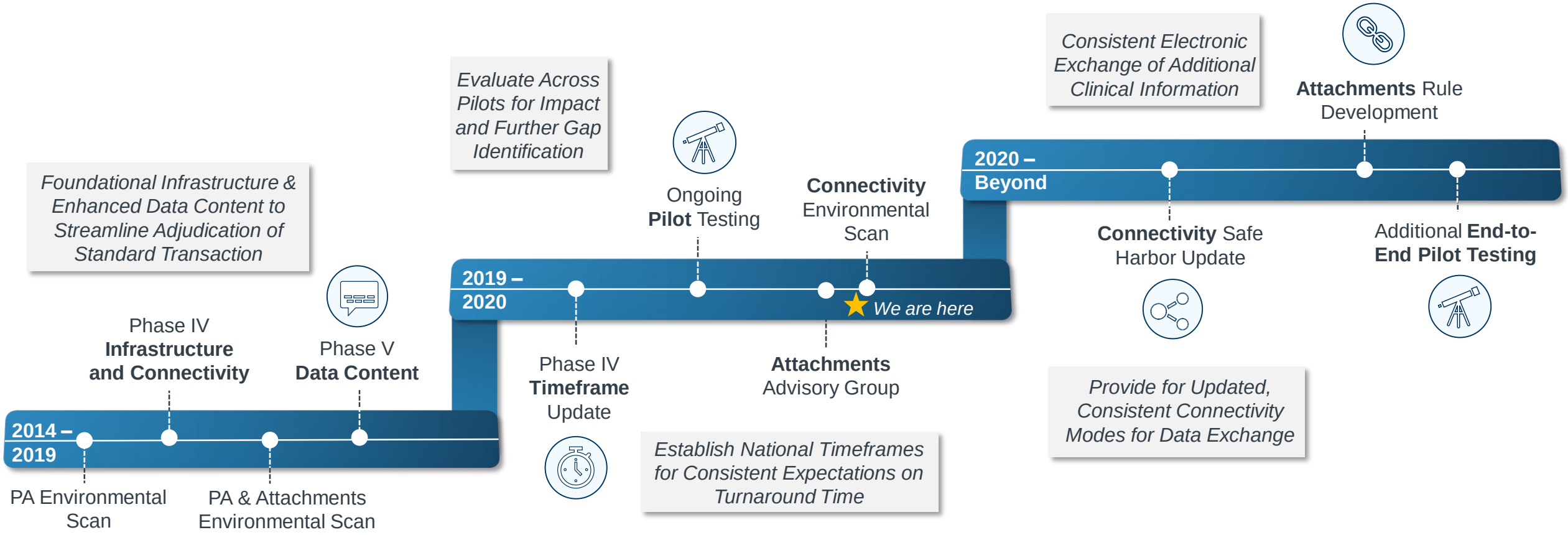
- In February 2020, the CAQH CORE Board proposed a CAQH CORE Prior Authorization and Connectivity Operating Rules package to the National Committee on Vital and Health Statistics (NCVHS) for recommendation to the HHS Secretary for national adoption under HIPAA that includes:
  - CAQH CORE Prior Authorization (278) Data Content Rule v5.0.0 specifies data content requirements for patient identification, error/action codes, communicating with providers regarding needed information and clinical documentation, status/next steps, and decision reasons to streamline the review and adjudication of prior authorization requests and facilitate faster response times.
  - CAQH CORE Prior Authorization (278) Infrastructure Rule v4.1.0 specifies prior authorization requirements for system availability, acknowledgements, companion guides, and response times including time limits for health plans to request supporting information from providers and make final determinations on prior authorization requests.
  - CAQH CORE Connectivity Rule v4.0.0 establishes consistent connectivity requirements for data exchange across HIPAA transactions, improves security through stronger authentication requirements, and reduces complexity by requiring a single envelope standard.
- The CAQH CORE Board is proposing this rule package for federal mandate for three reasons:
  - The prior authorization operating rules address a pressing need to improve automation and timeliness of the prior authorization process.
  - The connectivity operating rule enhances security and promotes uniform interoperability requirements across administrative transactions.
  - 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.

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.



Healthcare administration is rapidly changing.

Join Us

Collaborate across stakeholder types to develop operating rules.

Present on CAQH CORE education sessions.

Engage with the decision makers that comprise 75% of the industry.

Represent your organization in work groups.

Influence the direction of health IT policy

Drive the creation of operating rules to accelerate interoperability

Click **here** for more information on joining CAQH CORE as well as a complete list of Participating Organizations.

18