CAQH CORE Report on Attachments: A Bridge to a Fully Automated Future to Share Medical Documentation

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CONTENTS

Executive Summary

In the Health Insurance Portability and Accountability Act (HIPAA), the term "attachment" refers to the exchange of patient-specific medical information or supplemental documentation to support an administrative healthcare transaction. Attachments support the adjudication of claims, prior authorizations and other transactions. Similarly, the fluid exchange of clinical information and quality measure reporting documentation, essential for value-based payment success, hinges on a reliable, secure and efficient attachments workflow.

Most HIPAA-mandated electronic transaction standards have been federally adopted, and industry implementation is well underway. However, the healthcare industry continues to wait for an electronic attachments standard that can simplify the exchange of necessary medical information and supplemental documentation. In the interim, health plans, providers and vendors lack the direction needed to support broad use of automation in the attachment workflow, or for industry to coalesce around the use of even a small number of electronic solutions.

As the Department of Health and Human Services (HHS) designated author of operating rules for attachments, CAQH CORE® has gathered insights from more than 250 healthcare organizations via operating rule development input, industry webinars and surveys over the past few years to better understand industry needs. In 2018 CAQH CORE launched a formal environmental scan to identify major pain points and ways in which it can help the industry move toward a more automated attachments workflow by leveraging its collaborative, multi-stakeholder model.

The CAQH CORE Attachments Environmental Scan revealed that the majority of attachments today are submitted manually, as paper forms and records sent through the mail or by fax, presenting an enormous administrative burden. It also led to identification of five opportunity areas to move the industry towards a fully electronic future:

1. **Workflows –** Workflows map out chronological processes to accomplish complex tasks, often detailing sequential steps by parties in different organizations or locations. Research revealed opportunities to:

   - Enhance unsolicited process via electronic methods by embedding predefined documentation lookup requirements for use cases into workflows.

   - For solicited process via electronic methods, consider operating rules to enable real-time exchange of information between health plan and provider.

   - Engage with vendors to ensure industry participants have the tools and support necessary to implement end-to-end electronic workflows.

   - Educate industry participants about solicited and unsolicited workflows.

2. **Data Variability –** Attachments data shared between parties diverges from the expected structure to various degrees. Data may be non-uniform in specific dimensions of file format or size, for example. Or, data may diverge from the expected norm in its submission pattern, mode, timing, naming conventions, use of meta data and more. Research revealed opportunities to:

- Explore operating rules to streamline attachment documentation requests and re-association of attachments.
- Consider the creation of predetermined datasets for use as a transaction reassociation tracking mechanism.
- Develop data file format requirements for quality, readability and size efficiency.

3. **Exchange Mechanisms –** Data exchange between health plans and providers for a transaction lacks uniformity. Generally, these methods encompass manual processes, which include mail and fax, upload via the health plan portal or other proprietary solution and fully electronic transactions. Research revealed opportunities to:

- Standardize electronic attachment exchange methods to increase adoption. Consider web services, metadata requirements and industry standards to support the exchange of attachments; for example, standardize the use of X12 275 with PDF/CDA and/or the use of HL7 FHIR with CDA.
- Explore ways to bring greater uniformity to web portal transactions.

4. **Connectivity, Security and Infrastructure –** The fundamental instructions that every data exchange system needs to work - how to connect with other machines, negotiate security protocols and the basic expectations for each transaction require a common approach. Research revealed opportunities to:

- Define common connectivity and security frameworks so that, once in place, systems integration can facilitate mapping of administrative transactions and clinical data.
- Explore operating rules for attachment acknowledgements and response times.

5. **Resources–** "Single-source-of-truth" utilities maintained for the use of industry by a trusted party are capable of facilitating collaboration and driving consensus among stakeholders. Research revealed opportunities to:

- Create a uniform companion guide with flow and format sections to assist the vendor community in building systems and applications that can interoperate more easily with plans and other intermediaries and clearinghouses.
- Consider defining a common set of procedure or diagnosis codes or categories of service that most often trigger requests for additional documentation and the type of documentation typically required (i.e., cardiology, lab work, etc.).

If addressed, the opportunities identified in these five areas can help support and accelerate industry adoption of electronic attachment transactions by creating a more uniform approach.

CAQH CORE: Driving Automation

As stakeholders first began to implement HIPAA electronic transaction standards in the early 2000s, no operating rules existed to guide implementation. Importantly, industry also had no means of collaborating toward a solution. Health plans, providers and vendors were left to decide for themselves how to define key terms or the specific protocols for sharing data. Non-uniformity quickly became the norm. The use of proprietary systems and work-arounds had an effect opposite that intended by HIPAA administrative simplification measures. Administrative complexity rose sharply.

The industry solution was to establish CAQH CORE and task it with driving the creation and adoption of healthcare operating rules[1] that support standards, accelerate interoperability and align administrative and clinical activities among providers, payers and consumers. Beginning in 2005, the organization broke new ground with a consensus-driven process that brought multiple stakeholders together to iron out the "rules of the road" for implementing HIPAA and other standards.

In its first three phases of operating rules, CAQH CORE addressed eligibility and benefit verification, claim status, claim payment and remittance advice. It also launched a successful certification program. During this period, adoption of the rules was entirely voluntary, yet many organizations adopted the rules because they saw the value.

This experience led HHS to tap CAQH CORE in 2012 as the designated authoring entity for federally mandated operating rules under Section 1104 of the Affordable Care Act (ACA).[2] HHS also adopted the first three phases of CAQH CORE rules, originally voluntary, as mandatory under the ACA. Since that time, CAQH CORE has authored additional rules addressing claim submission, prior authorization, enrollment and disenrollment and premium payment.

Operating rule implementers have had a means through CORE Certification to voluntarily assure, validate and demonstrate that their systems are operating in conformance with the rules since 2007. CAQH CORE has now awarded more than 350 certifications to healthcare organizations. These organizations include health plans and payers that collectively cover 78 percent of commercially insured health plan members, 75 percent of Medicare Advantage beneficiaries and 44 percent of Medicaid enrollees in the United States.

Most recently, the scope of CAQH CORE has expanded to include improving the collective exchange needs of value-based payment. In 2018, the organization published results of an expansive study[3] drawing parallels between the administrative and operational challenges associated with value-based payment today and those experienced in the early 2000s associated with fee for service. CAQH CORE has launched an industry effort to facilitate needed collaboration to help ease these value-based payment administrative burdens.

Introduction

Attachments are a bridge between clinical and administrative data. They give health plans vital information for adjudication of a subset of claims, prior authorizations, referrals, post-adjudication appeals, audits and more. In value-based payment, attachments can be used for sharing clinical information and quality measure reporting documentation between health plans and providers.

The attachments workflow, however, is primarily manual and a source of significant administrative burden, largely because no federal standard has been adopted. For example, a regional health plan participating in the CAQH CORE Attachments Environmental Scan indicated that it takes 792 labor hours, the equivalent of nearly 20 people working full-time, to process the attachments it receives by mail, fax and web portal in the course of just one week. According to the 2017 CAQH Index, only 6 percent of attachments are processed using a fully electronic method.[4] The Index has estimated that adoption of electronic attachment transactions could reduce healthcare industry per-transaction costs for exchange of attachments by over 60 percent.[5]

Electronic attachments are also expected to reduce provider overhead costs by accelerating the provider revenue cycle and by eliminating the sources of some administrative costs altogether, such as the need for postage and other supplies when mailing attachments.[6] An electronic workflow would ease current health plan administrative burdens related to collection, processing, scanning and storage of documents received by mail.

In addition to the savings an improved attachments workflow can produce, healthcare has much to gain from such improvements. Importantly, attachments are essential to the success of value-based payment, which many believe can meaningfully increase the quality and reduce the overall cost of healthcare. Electronic attachments could make some of the hallmark features of value-based payment possible in a more streamlined and cost-effective manner. For example, a more fluid electronic exchange of clinical information and quality measure reporting documentation between health plans and providers could facilitate earlier identification of patient risk factors, reduce the time and effort associated with quality measure reporting and ease the adjudication of payment associated with value-based payment arrangements.

Industry has been waiting for action on an attachments standard for many years. In 1996, HIPAA mandated the adoption of an electronic standard for attachments, as well as for many other administrative transactions. For most cases, the HIPAA-mandated standards have been federally adopted, and companion operating rules have been developed to support these transactions. The extended wait for a federal attachment standard has fueled a sense of uncertainty, deterred vendor development of a standardized approach and resulted in numerous work-arounds that providers are asked to support.[7] In the meantime, CAQH CORE maintained a focus on attachments, collaborating with more than 250 healthcare organizations to provide education and gather insights on industry opportunities via operating rule development input, national webinars and surveys.

In a 2018 CAQH CORE Town Hall Webinar[8], 67 percent of participants responding to a poll said the wait for direction from federal regulators (44 percent) or industry (23 percent) was their biggest barrier, or reason for delay, in implementing electronic attachments. Interestingly, only 9 percent of participants named budget constraints as a reason for delay, suggesting funding may be available for adoption of electronic attachments.

Today there are indications that a federal attachments standard may be forthcoming. The Fall 2018 Unified Agenda of Regulatory and Deregulatory Actions, a semiannual report of regulations under development by federal agencies, indicates that a Notice of Proposed Rule Making (NPRM) is in development that would adopt standards for healthcare attachment transactions.[9] Given the urgent need to ease the attachments administrative burden, CAQH CORE launched an effort in advance of the anticipated NPRM to explore opportunities honoring its role as the HHS-designated operating rule authoring entity. The CAQH CORE Attachments Environmental Scan was a key step in this effort.

How Many Attachments Are Submitted to Health Plans Annually?

The volume of attachments received by health plans annually has proven a difficult number to track. For the environmental scan, CAQH CORE asked health plans to estimate the number of attachments received by method. 50 percent of health plans participating in the environmental scan were able to provide data.

Although none provided estimates of the number received by mail annually, 38 percent estimated the total number of attachments received by fax, web portal and electronic methods combined:

- One national health plan estimated it receives nearly 8 million attachments annually.
- Another national plan estimated about 5.4 million annually.
- A regional health plan estimated more than 200,000 attachments annually by these methods.
- Another national health plan reported that 35,000 attachments are received by web portal and other electronic methods.

The CAQH Index first studied claim attachments for its 2014 report. Due to a low volume of collected data in the first three years of study, it was unable to calculate or report benchmarks. The 2017 CAQH Index is the only report published to date with a meaningful sample size to report on attachments. It estimated a total of 204 million claim attachments were exchanged between healthcare providers and health plans nationally in calendar year 2017, 84 percent of which were conducted via mail or fax. The CAQH Index has also studied prior authorization attachments but has not yet been able to calculate and report benchmarks for this transaction.

More data is needed to fully articulate the scope of the attachments challenge. All health plans and healthcare providers are encouraged to participate in the 2019 CAQH Index study. The data collection effort has begun. For more information on contributing data to the CAQH Index, please visit https://www.caqh.org/explorations.

With its goal to accelerate the adoption of electronic attachment transactions and ensure these attachments flow seamlessly through the healthcare system, the CAQH CORE Attachments Environmental Scan probed how the industry currently exchanges medical information and supplemental documentation. It studied the current state of the industry to find opportunities for CAQH CORE to reduce burdens associated with attachments and to promote industry adoption of electronic attachments through operating rules.

For the environmental scan, CAQH CORE gathered insights from more than 40 organizations representing providers, health plans, vendors, clearinghouses and government. These organizations responded to online surveys and were interviewed by phone. Some hosted CAQH CORE representatives for onsite visits. All participants were given assurances that the data and information they shared with CAQH CORE would be used in aggregate only and that their organizations would not be identified in the report.

1 Opportunity Area: WORKFLOWS

Workflows map out chronological processes to accomplish complex tasks, often detailing sequential steps by parties in different organizations or locations.

INDUSTRY CHALLENGE: SOLICITED VERSUS UNSOLICITED ATTACHMENTS.

Health plans receive millions of attachments each year through various means of submission – mail, fax, upload via a health plan portal and a very small number as fully electronic transactions. The majority of attachments received by health plans from providers (60 percent) are unsolicited and often arrive with too much, too little or the wrong type of information. Regardless of whether an attachment is solicited or unsolicited, or if it is even useful, health plans process all attachments received, an enormous and costly administrative undertaking.

The attachments workflow also drives a significant administrative operation in healthcare provider offices. In anticipation of a request for additional information from the health plan, healthcare providers often send attachments proactively. For example, healthcare providers indicated that high-dollar claim submissions would prompt an unsolicited attachment. Also, healthcare providers send unsolicited attachments based on past experience with the provision of a specific service, the documentation needs of a certain health plan or both. A specialty group practice reported that two full-time employees are needed to manage and process the attachments generated on behalf of its patients. Similarly, a regional health system reported that 19 full-time equivalents (FTEs) are needed to process its attachments.

To ensure the inbound documentation is a better match with their needs, health plans indicated that they prefer to receive solicited attachments over unsolicited attachments. In a solicited claim attachment electronic workflow, the provider submits a claim (X12 837), then a health plan sends a request for additional information (X12 277 RFAI) to the provider. (Figure 1)[10] The RFAI defines the type of documentation needed to adjudicate the claim. The provider then sends the requested documentation, commonly as a Clinical Document Architecture (CDA) or a Portable Document Format (PDF) file, to the health plan (X12 275 + CDA or PDF).

Figure 1: Solicited Claim Attachment Electronic Workflow
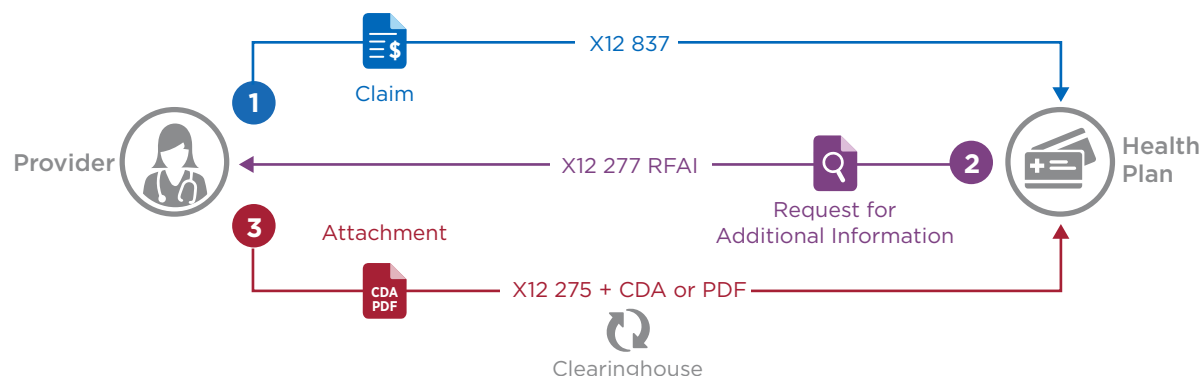
Today the solicited process does not occur in real-time. The provider submits a claim (X12 837), then the claim is pended awaiting review by the health plan. Once reviewed, the health plan sends a request for additional information to the provider, typically in a letter that is mailed and with the X12 277 RFAI. The time frame in which this process transpires delays the revenue cycle. For example, preparation and mailing of the letter and delivery by the post office may take several days followed by routing and processing by the provider.

In an unsolicited claim attachment electronic workflow, the provider submits a specific and pre-defined attachment document concurrently with the associated claim (X12 837 + X12 275 + CDA or PDF). (Figure 2)[11]

Figure 2: Unsolicited Claim Attachment Electronic Workflow
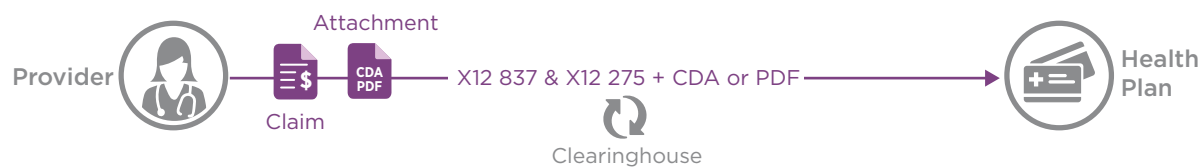
In addition, emerging electronic standards such as Health Level 7 (HL7) Fast Healthcare Interoperability Resource (FHIR) can simplify provider and health plan workflows, giving providers a means of looking up specific payer documentation requirements in real time for services rendered, then sending specific documentation to support a submitted claim. FHIR-enabled workflows also aspire to support care coordination as care delivery shifts from volume to value-based.

INDUSTRY CHALLENGE: PERSISTENCE OF MANUAL WORKFLOWS.

At least 80 percent of the attachments received by health plans from providers are paper-based forms that arrive in the mail or by fax. Yet only about 60 percent of attachments sent by healthcare providers to health plans are initiated using manual methods, indicating that health plans do not always receive a transmission by the same method the provider used to initiate it. (Figure 3) Providers use health plan web portals to upload roughly one in four attachments and use fully electronic methods for the small remainder.

Figure 3: Tracking Attachment Modes From Sent to Received

	Claims		Prior Authorization		Post-Adjudication Appeals		Referrals	
	Provider Sent	Payer Received	Provider Sent	Payer Received	Provider Sent	Payer Received	Provider Sent	Payer Received
Mail	35%	35%	15%	36%	25%	40%	33%	50%
Fax	29%	35%	39%	36%	25%	40%	33%	50%
Web Portal	24%	18%	31%	21%	25%	10%	17%	0%
Fully Electronic*	12%	12%	15%	7%	25%	10%	17%	0%

*Fully Electronic includes X12 275, HL7 CDA, practice management system, electronic health record system or other fully automated system.
Source: CAQH CORE Attachments Environmental Scan

For three of four types of attachments, providers sent a higher proportion of fully electronic and web portal transactions than health plans reported they had received. Except for claims, there was a loss in the proportion of attachment transmissions sent by fully electronic and web portal and an equal gain in the proportion of fully manual mail and fax attachments received by health plans.

Healthcare providers may have the capability to submit attachments using a web portal or electronically through another proprietary system or service. However, there is minimal support for the use of these submission methods by health plans and vendors.

Several health plans reported that although a web portal is available to manage claim or prior authorization submissions, these portals do not currently accept electronic attachments. Most health plans indicated that adding this capability is a priority, yet in the interim providers must use one method to submit claims and prior authorizations and another method to submit the necessary documentation to support claims and prior authorizations. This bifurcated process contributes to administrative burden, frustration and cost.

The environmental scan suggests numerous reasons for this disconnect, many of which are addressed in other areas of this report. For example, both health plans and vendors point to the lack of a federal standard as a reason for delaying investments in systems to automate the attachments workflow. Also, vendors indicate that, until there is a federal standard, variability in health plan attachment requirements makes development of a marketable electronic system problematic.

The 2017 CAQH Index[12] estimated that conducting a manual (mail or fax) claim attachment costs providers $1.68 each, electronic attachments cost an estimated $1.17 each. Health plans have an even greater cost savings opportunity with manual transactions at $1.74 each, a cost that falls to just 10 cents each when electronic methods are used.

OPPORTUNITIES: WORKFLOW

- ■ Enhance unsolicited process via electronic methods by embedding predefined documentation lookup requirements for use cases into workflows.

- ■ For solicited process via electronic methods, consider operating rules to enable real-time exchange of information between health plan and provider.

- ■ Engage with vendors to ensure industry participants have the tools and support necessary to implement end-to-end electronic workflows.

- ■ Educate industry participants about solicited and unsolicited workflows.

2 Opportunity Area:
DATA VARIABILITY

Data variability is the degree to which data shared between parties diverges from the expected structure. Data may be non-uniform in specific dimensions of file format or size, for example. Or, data may diverge from the expected norm in its submission pattern, mode, timing, naming conventions, use of meta data and more.

INDUSTRY CHALLENGE: RE-ASSOCIATION OF ATTACHMENTS AND ADMINISTRATIVE TRANSACTIONS.

When attachments are not submitted in parallel with a companion transaction, as is the case in the solicited claim attachment electronic workflow (Figure 1, page 7), the attachment and transaction must be linked, or re-associated. Given the scale of inbound attachment operations at health plans, matching an attachment to the correct administrative transaction can present a particular challenge. Also, while many transactions are now automated, most attachments arrive as paper documents, meaning the matching process often requires some level of human intervention.

An electronic workflow inherently brings significant improvements, because solicited transactions can often be flagged with a reference number to facilitate re-association. Beyond this, health plans and vendors called for greater uniformity in data content to improve re-association of attachments with administrative transactions and requests. Health plans and vendors agreed that use of meta data, code sets and data fields associated with patient demographics can help to re-associate attachments. Patient and provider demographic data, such as member identification number, National Provider Identifier (NPI) and claim reference number were recommended for linking by health plans and vendors alike.

Most vendor systems auto-populate provider and member demographic information. Although other vendor systems require providers to enter the information manually, use of data validation prevents providers from submitting an incomplete attachment in most cases.

Although there was strong agreement for the use of demographic data for re-association, there was less alignment for the specific code sets that would be useful beyond demographic data. However, vendors most often referred to Logical Observation Identifiers Names and Codes (LOINC) as useful for improving electronic workflows and strengthening the link between the attachment and its administrative transaction.

INDUSTRY CHALLENGE: USE OF UNSTRUCTURED FILE TYPES AND FILE SIZE.

Sometimes attachments are unreadable by the health plan due to poor quality in printing, faxing or due to errors in optical character recognition (OCR) and its supporting data entry validation. These and other issues cause breakdowns in the attachments workflow. An unreadable attachment may result in the inability to re-associate documentation with a companion administrative request or may lead to pended requests and delays in adjudication. Unreadable attachments are most often those that have been saved in one of several unstructured file types. These include PDF, image files (GIF or JPEG) and DOCs.

More than two-thirds of attachments received by health plans are saved in an unstructured file format. Vendors also receive a high proportion of PDFs, but far fewer image files and DOCs and a slightly higher proportion of structured files. (Figure 4)

Figure 4: Attachment File Formats Received by Health Plans and Vendors
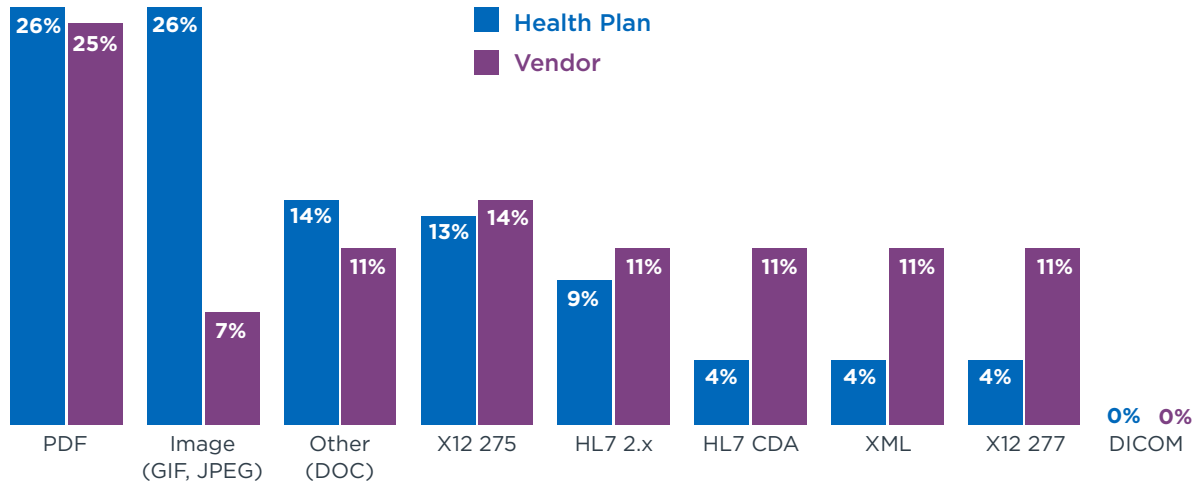
Source: CAQH CORE Attachments Environmental Scan

Health plans emphasized a preference for structured data, as it would support a transition to auto-adjudication. However, they also recognized that PDFs and image files are widely used by healthcare providers because many electronic health record (EHR) systems have the capability to export these file types. Despite their preference for structured files, health plans indicated strong support for continued use of PDFs, an unstructured file type, in addition to the structured file types, X12 277, X12 275 and HL7 CDA.

Inconsistency in file sizes has also created a problem for health plans, with some participants noting that storage capacity has become an issue. For example, one health plan participant representing an insurer with fully electronic capability indicated that limits have been implemented allowing its system to accept as many as six files totaling 35MB per transaction.

OPPORTUNITIES: DATA VARIABILITY

- Explore operating rules to streamline attachment documentation requests and re-association of attachments.
- Consider the creation of predetermined datasets for use as a transaction reassociation tracking mechanism.
- Develop data file format requirements for quality, readability and size efficiency.

3 Opportunity Area:
EXCHANGE MECHANISMS

Exchange mechanisms refer to the means of data exchange between a health plan and provider for a transaction. Generally, these methods encompass manual processes, which include mail and fax, upload via the health plan portal or other proprietary solution and fully electronic transactions.

INDUSTRY CHALLENGE: A MULTITUDE OF EXCHANGE OPTIONS.

The long wait for a federally adopted electronic attachment standard has led to a proliferation of options for attachment exchange. Only a small number of health plans have a fully electronic submission method available for providers. Although manual processes, such as mail and fax, continue to dominate, health plan web portals are playing a greater role. As mentioned earlier in this report, some health plans already have the capability to request and process attachments via a web portal, while others are prioritizing development of this functionality. Secure email, such as DIRECT messaging, is also emerging as a method of exchange.

The environmental scan also revealed that vendors may work directly with health plans and providers to develop proprietary solutions that automate the request for and submission of additional documentation. In the dental and workers' compensation markets, industry has worked with the vendor community to increase support for attachment exchange options that act as a pathway to fully electronic methods.

INDUSTRY CHALLENGE: LOW ADOPTION OF ELECTRONIC METHODS.

Although low, pockets of electronic attachment adoption have previously been identified by the CAQH Index.[13] Tracking both the X12 275 and HL7 CDA for claim attachment, the 2017 CAQH Index report indicated that 6 percent of attachments were exchanged electronically, all using the X12 275 transaction standard. No use of HL7 CDA was identified at that time.

More recently, most of the health plans participating in the environmental scan indicated that they were piloting at least one electronic transaction to automate the request and submission of additional documentation between health plans and providers. Some of the transactions mentioned include:

- X12 277 RFAI – Transaction used by a health plan to request additional information from a provider.
- X12 275 – Transaction used by the provider to respond to the health plan with requested information embodied in the transaction such as .pdf or CDA.
- HL7 FHIR – Use of profiles and APIs to establish real-time communication and data transference.

OPPORTUNITIES: EXCHANGE MECHANISMS

- Standardize electronic attachment exchange methods to increase adoption. Consider web services, metadata requirements and industry standards to support the exchange of attachments; for example, standardize the use of X12 275 with PDF/CDA and/or the use of HL7 FHIR with CDA.
- Explore ways to bring greater uniformity to web portal transactions.

4 Opportunity Area:
CONNECTIVITY, SECURITY AND INFRASTRUCTURE

Connectivity, security and infrastructure refer to the fundamental instructions that every data exchange system needs to work – how to connect with other machines, negotiate security protocols and the basic expectations for each transaction.

INDUSTRY CHALLENGE: LACK OF CLINICAL AND ADMINISTRATIVE SYSTEM INTEGRATION.

Attachments uniquely combine data from two disparate systems – clinical and administrative. Due to a lack of administrative and clinical system integration, an electronic attachment solution must resolve foundational interoperability challenges by establishing common rules for how the systems connect, share and secure data. The resolution of these issues establishes the environment in which all other requirements can operate.

For example, given attachment transactions contain protected health information (PHI), all vendors participating in the environmental scan stressed the importance of full mutual authentication and digital signatures when sending electronic attachments.

Phases I-IV CAQH CORE Operating Rules include infrastructure requirements addressing connectivity and security, acknowledgements, response times, processing modes, companion guides and system availability. Health plan and vendor participants, all of whom are familiar with these requirements, were asked to evaluate which would be most applicable in addressing electronic attachments. While all health plan participants thought all the requirements would be applicable and should be considered and evaluated, vendor responses were slightly more varied. For example, one vendor agreed with the health plans, saying all infrastructure requirements apply, yet another vendor said none apply until a mandatory federal standard is in place. Beyond that, a significant majority of vendors supported connectivity and security.

INDUSTRY CHALLENGE: LACK OF COMMUNICATION.

As part of resolving foundational interoperability issues, an attachment solution must address when and why clinical and administrative systems should communicate, such as to acknowledge receipt of an attachment.

Health plans indicated that they acknowledge receipt of attachments in 25 percent of cases. Half of the vendors participating in the environmental scan indicated that their systems support the ability to acknowledge the receipt of an attachment.

This is consistent with the experience of providers, who said they sometimes receive acknowledgements after responding to a request for additional information. More specifically, providers can see acknowledgements in their practice management and electronic health record systems when prescriptions and claims are sent electronically. Mail and web portal transactions, however, are seldom acknowledged but account for a large proportion of the volume of attachments submitted to health plans.

This variability may be due to differences in workflow capabilities. For example, health plans may not be capable of sending the acknowledgement. Or, providers may not be capable of receiving the acknowledgement, which might prevent health plans from initiating the acknowledgement in the first place.

In either case, when there is variability in the use of attachment acknowledgements, providers are often left in the dark, not knowing if the information sent was successfully received. This situation may lead to resubmissions of additional documentation, phone calls or uncertainty of adjudication time frames.

INDUSTRY CHALLENGE: VARIABILITY IN TIME FRAMES.

Common expectations are also lacking as a foundational component of the attachments workflow. Response times vary greatly, yet there is strong alignment around the value of fully electronic transactions.
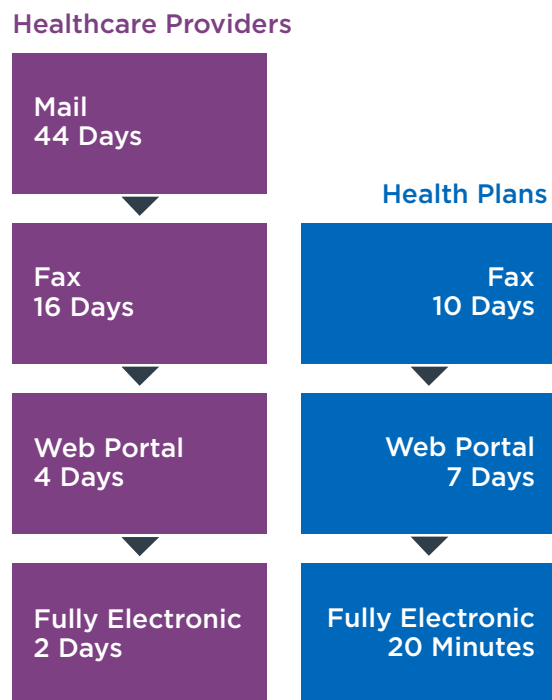
The CAQH CORE Attachments Environmental Scan found that, although stakeholders rarely have common expectations for specific attachment adjudication turnaround times, healthcare providers and health plans do share a common belief in the ability of an electronic workflow to significantly reduce adjudication time and improve efficiency. (Figure 5)

Health plans reported a seven-day adjudication time frame for electronic attachments sent as an X12 275 or uploaded via a web portal. When submitted via fax, they said the adjudication cycle increases to 10 days and that fully automated electronic transactions reduce the adjudication time significantly. Illustrating the value of a fully electronic workflow, a regional health plan with such a capability indicated that it can adjudicate attachments received electronically in just 20 minutes.

Interestingly, CAQH CORE asked providers to estimate health plan adjudication turnaround time based on their experiences. They were asked to estimate time for an adjudication with attachment sent by each of the four methods studied. Providers estimated a two-day wait for adjudication when the attachment was sent using a fully electronic method, two times as long (four days) when uploaded via a web portal, eight times as long as electronic (16 days) if by fax and 22 times as long as electronic if by mail (44 days).

Figure 5: Attachment Adjudication Turnaround Time by Method, As Estimated by Healthcare Providers versus as Reported by Health Plans

Source: CAQH CORE Attachments Environmental Scan

In addition to the delays in adjudication and uncertain time frames, providers noted claims can be denied. In these cases, the provider initiates an appeal process for the claim to be reconsidered for payment. In an appeal, claims and all associated data from the medical record are often submitted through the mail or fax a second time.

Although most providers interviewed for the environmental scan said delays in adjudication of claims-related transactions with attachments had not delayed patient care, other providers disagreed, particularly related to attachments required for prior authorization. A behavioral health provider indicated that patient care is delayed in about 40 percent of cases as a result of additional documentation requests for prior authorization use cases.

OPPORTUNITIES: CONNECTIVITY, SECURITY AND INFRASTRUCTURE

- Define common connectivity and security frameworks so that, once in place, systems integration can facilitate mapping of administrative transactions and clinical data.
- Explore operating rules for attachment acknowledgements and response times.

5 **Opportunity Area:**
RESOURCES

Resources are "single-source-of-truth" utilities maintained for the use of industry by a trusted party are capable of facilitating collaboration and driving consensus among stakeholders.

INDUSTRY CHALLENGE: NON-UNIFORM DOCUMENTATION REQUIREMENTS.

Healthcare providers and vendors reported that it is difficult to keep up with health plan attachment requirements. Documentation requirements change and are non-uniform from plan to plan or even within the same plan, as various insurance products from the same plan have different requirements (e.g., commercial product versus Medicare Advantage product). This variability and lack of transparency in health plan attachment policies and the frequency with which these policies change pose an administrative challenge for providers and vendors.

Health plans may require or request additional documentation, or attachments, to verify the service being billed or requested (in the case of a prior authorization) is consistent with patient insurance benefits, demographics (e.g., age and sex), the general medical policies of the health plan, level of service being performed or specific condition/diagnosis. The type of documentation requested varies by health plan. For example, a health plan may request operative notes, progress report notes, diagnostic images/radiographs, laboratory results, previous health plan explanations of benefits (EOBs), contract type and more.

Vendors believe these issues not only cause problems for providers, but also cause unique challenges for the support and maintenance of their own products. In the environmental scan, they lamented that the non-uniformity and lack of transparency makes it more difficult to develop solutions that support electronic attachment exchange.

OPPORTUNITY: RESOURCES

- Create a uniform companion guide with flow and format sections to assist the vendor community in building systems and applications that can interoperate more easily with plans and other intermediaries and clearinghouses.

- Consider defining a common set of procedure or diagnosis codes or categories of service that most often trigger requests for additional documentation and the type of documentation typically required (i.e., cardiology, lab work, etc.).

Industry Call to Action

Healthcare leaders have long worked to more closely align administrative and clinical systems. While many believe the capacity for greater interoperability is now within reach, data in clinical and administrative systems has remained siloed. The electronic exchange of attachments to communicate medical information and supplemental documentation between health plans and providers is an opportunity to change this in a significant way.

Electronic attachments open a line of communication between administrative and clinical systems and hold the key to unlocking the next level of interoperability by making the use of integrated data routine. The exchange of clinical information and quality measure reporting documentation through more standardized use of electronic attachments is also crucial for value-based payment models to operate efficiently.

Achieving this vision, however, first requires industry to collaborate in an effort that addresses and overcomes a range of challenges. This report is a starting point. It identifies many of the specific challenges preventing greater adoption of electronic attachments and suggests opportunities to address these challenges. The commitment of industry stakeholders, including health plans, healthcare providers, vendors, standards development organizations and federal and state governments is needed.

Working through its integrated model of rule development, CAQH CORE will launch work groups in 2019 to identify potential operating rule opportunity areas that can accelerate the adoption of electronic attachment transactions and help ensure these attachments flow seamlessly through the healthcare system. In addition, CAQH CORE continues to educate industry participants about the need for action and on the progress of these efforts.

To become involved with this initiative, please contact core@caqh.org.

Appendix

INDUSTRY EFFORTS TO IMPROVE ATTACHMENT EXCHANGE

Many organizations are working to reduce the administrative burden associated with attachment exchange, workflows and interoperability. CAQH CORE, as the HHS-designated author of operating rules for attachments, engages and collaborates across these initiatives. In many cases, these groups are CAQH CORE Participants, and some hold non-voting advisory positions on the CAQH CORE Board.

- **X12 –** As part of an effort to update standards, X12 is expected to publish an updated 275 transaction, the X12 v7030 275. Providers use this transaction to respond to the health plan with requested information embodied in the transaction, such as in a .pdf or CDA.

- **Health Level 7 (HL7) –** HL7 standards include Version 2.x (V2), CDA (clinical document architecture) and HL7 FHIR® (Fast Healthcare Interoperability Resources). Also, the Da Vinci Project is a private-sector initiative facilitated by HL7 that applies the HL7 FHIR platform to address the needs of the value-based care community. Da Vinci is focused on driving standards for the exchange of information critical to patient care, such as prior authorization, attachments / additional documentation and others.

- **Work Group for Electronic Data Interchange (WEDI) –** WEDI continually leverages its platform to draw attention to the administrative burden associated with exchange of information in healthcare.

- **The P2 FHIR Task Force –** An Office of the National Coordinator (ONC)-convened group of payers, health information technology and healthcare organizations, collaborating on a focused effort to accelerate development of a joint HL7 FHIR application program interface (API) and to reduce variability in industry implementation, has proposed that certified health information technology applications use a specific API based on FHIR.

- **Integrating the Healthcare Enterprise (IHE) –** An initiative by healthcare professionals and industry to improve the way computer systems in healthcare share information. The IHE promotes the coordinated use of established standards such as DICOM and HL7 to address specific clinical needs in support of optimal patient care. Systems developed in accordance with IHE communicate with one another better, are easier to implement and enable care providers to use information more effectively.

Endnotes

1   "Operating rules" are defined by the ACA as "the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications," https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Operating-Rules/OperatingRulesOverview.html

2   CAQH CORE website, letter designation CAQH CORE as the operating rule authoring entity, accessed April 15, 2019, https://www.caqh.org/sites/default/files/core/hhs-response-to-ncvhs-12122009.pdf.

3   CAQH CORE, "All Together Now: Applying the Lessons of Fee-for-Service to Streamline Adoption of Value-Based Payments," accessed April 9, 2019, https://www.caqh.org/core/value-based-payments.

4   The CAQH Index tracks both the X12 275 and HL7 CDA (Clinical Data Architecture) for claim attachment. https://www.caqh.org/sites/default/files/explorations/index/report/2017-caqh-index-report.pdf.

5   CAQH, 2017 CAQH Index, 2018, https://www.caqh.org/sites/default/files/explorations/index/report/2017-caqh-index-report.pdf.

6   HIMSS, "Electronic Attachments Tell a Comprehensive Health Story," accessed March 31, 2019, https://www.himss.org/library/electronic-attachments-tell-comprehensive-health-story.

7   NCVHS, "Attachment Standard: The Physician Perspective," NCVHS Subcommittee on Standards, Feb. 16, 2016, American Medical Association, accessed March 31, 2019, https://www.ncvhs.hhs.gov/wp-content/uploads/2016/01/Part-2-McComas-Slides.pdf.

8   CAQH, CAQH CORE Town Hall National Webinar, accessed April 9, 2019, https://www.caqh.org/about/event/caqh-core-town-hall-national-webinar-10.

9   "Adoption of Standards for Health Care Attachments Transactions, Acknowledgments Transactions, Electronic Signatures, and Modification to Referral Certification and Authorization Standard (CMS-0053-P)," https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201810&RIN=0938-AT38.

10   Figure 1 offers a visual representation of one potential workflow. It is for illustration purposes only. Other standards and workflows are possible.

11   Figure 2 offers a visual representation of one potential workflow. It is for illustration purposes only. Other standards and workflows are possible

12   CAQH, 2017 CAQH Index, 2018, https://www.caqh.org/sites/default/files/explorations/index/report/2017-caqh-index-report.pdf.

13   CAQH, 2017 CAQH Index, 2018, https://www.caqh.org/sites/default/files/explorations/index/report/2017-caqh-index-report.pdf.

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