CAQH CORE

CAQH CORE Call on Prior Authorization

FOR CAQH CORE PARTICIPANTS ONLY

July 27, 2017

2:00 – 3:00 PM ET

Logistics

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- **A copy of the slides and the webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.**
- The phones will be muted during the presentation.

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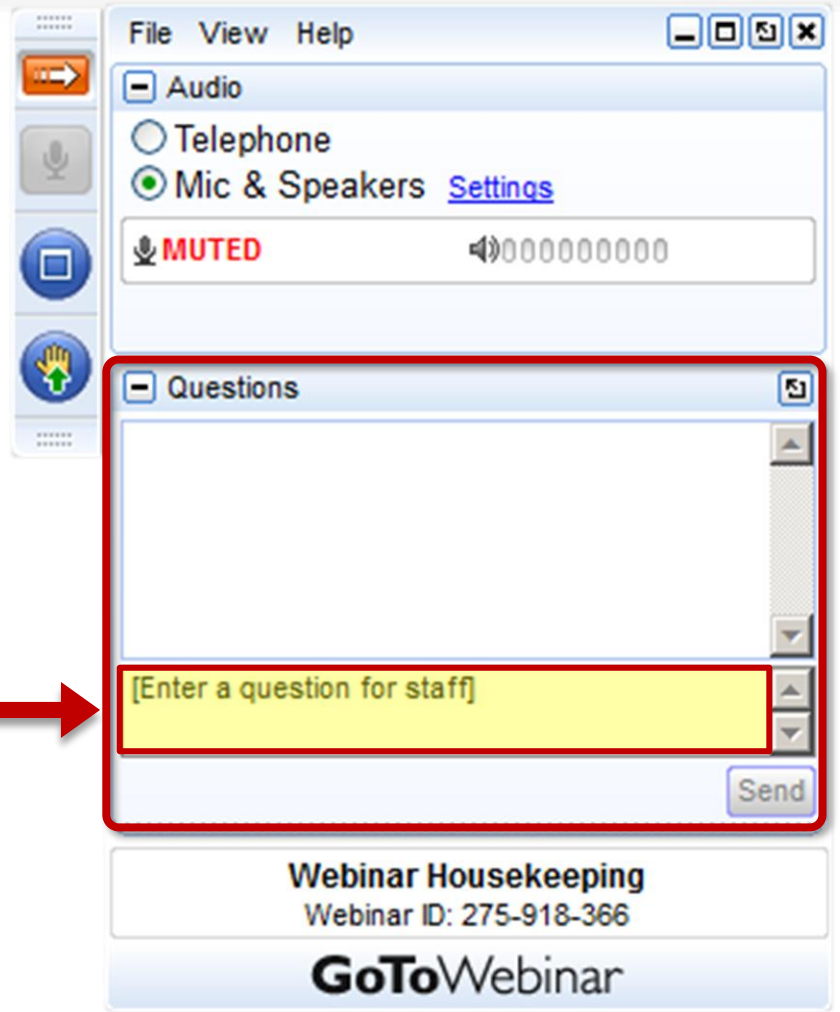

CAQH CORE

Thank You!

CAQH CORE would like to thank our guest speaker.

Kim Peters
Process Owner, Provider Process Implementation

Session Outline

- Background & CAQH CORE Role in PA
- CAQH CORE Advisory Group Activities in PA
- Creation of CAQH CORE PA Subgroup

Background & CAQH CORE Role in PA

Rachel Goldstein
CAQH CORE Manager

Prior Authorization

The Prior Authorization Challenge

Prior authorization (PA) is a process to manage utilization of healthcare resources, i.e. unnecessary use and cost. A PA requires approval for a service or prescription prior to delivering care to the patient, with the intention of validating appropriateness and value.

Each step of the prior authorization process is **labor-intensive and generates time-consuming and costly administrative burden** on both provider organizations and health plans, and can result in delays to patient care.

Fast Facts

PA within the Context of Other Administrative Transactions

The PA process is separate from the patient eligibility claims processes. Siloed processes can jeopardize provider reimbursement and/or result in unintended patient out of pocket costs

Example 1. Even if a PA is approved, the patient's eligibility may not be confirmed, or may have changed

Example 2. Even if a PA is approved, edits may be applied to the claim, and the service may still be denied

Volume*

At least 71 million submitted and responded to per year (in commercial market alone)

Submission Method*

35% manual (phone, fax, email); 65% partially automated (web portal, Interactive Voice Response (IVR), ASC X12N v5010 278 Prior Authorization Request and Response (278))

Approvals & Appeals**

Approx. 80% of PAs are eventually approved. Approx. 28% are denied on initial request and must be submitted again for appeal.

Time & Cost*

For Providers

Approx. 20 minutes per request prepared and submitted manually.
Approx. 6 minutes per request prepared and submitted via partially automated methods

Approx. **$454M per year**

For Health Plans

Several hours to 26 days

Approx. **$94M per year**

90% of Providers surveyed by the AMA reported that the PA process **delays patient care.****

Sources: * CAQH Index (2016); commercial market figures only | ** AMA PA Physician Survey (2016)

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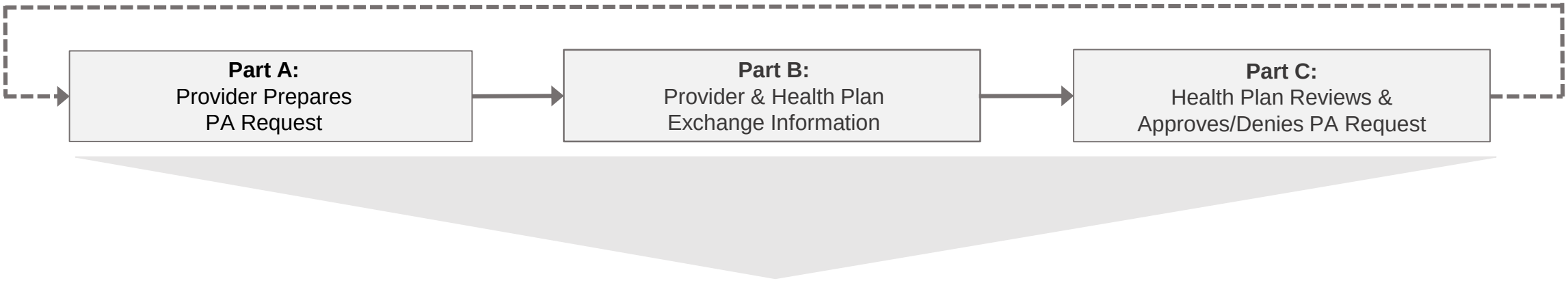
Prior Authorization

Major Parts of PA Process & Spectrum of Automation

Major Parts of the PA Process*



Each major part of the PA process currently sits somewhere along a spectrum from *manual* to fully *optimized*.
Moving these steps towards optimization will reduce administrative burden and costs across stakeholders, and ultimately improve timely delivery of patient care.

Automation Spectrum

Manual

Entirety of provider and health plan workflows, including request and submission, is manual and requires human intervention. Tools used may include telephone, fax, e-mail etc.

Partially Automated

Certain steps of the PA process are automated and do not require human intervention. Typically this includes a manual submission on behalf of the provider which is received by the health plan via an automated tool (e.g. health plan portals, IVR, ASC X12 278 etc.).

Optimized

The entire PA process is at its most effective and efficient by eliminating unnecessary human intervention and other waste. An optimized PA process would likely include automating internal provider and health plan workflows.

* Major parts of process have been truncated. Slide 17 displays a more detailed view.

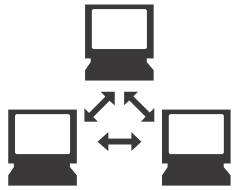
CAQH CORE

CAQH CORE Efforts on Prior Authorization

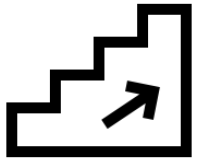
Phase IV Laid the Foundational Infrastructure

CAQH CORE Vision for PA

Introduce targeted change to propel the industry collectively forward to a PA Process optimized by automation, thereby reducing administrative burden on providers and health plans and enhancing timely delivery of patient care.



The Phase IV Operating Rule* established foundational infrastructure requirements such as connectivity, response time, etc., and builds consistency with other mandated operating rules required for all HIPAA transactions.



CAQH CORE not only develops operating rules to optimize the PA process, but also drives adoption to realize meaningful change.

Highlights of Phase IV Infrastructure Requirements

- Connectivity Requirements Facilitate Electronic Information Exchange between Providers and Health Plans
- Real-time and Batch Processing of PA Requests
- Acknowledgement of Receipt of PA Request
- Responses within Specified Timeframe

* Phase IV Rule is currently underway. Complete rule available here: Phase IV CAQH CORE 452 Health Care Services Review – Request for Review and Response (278) Infrastructure Rule v4.0.0.

Prior Authorization Landscape

CAQH CORE Alignment with Industry

Organization	Description of Organization's PA Efforts	Expected Deliverable(s)	Alignment with CORE
American Medical Association (AMA)	AMA surveyed providers to gather data on issues related to PA. The results also informed development of the Prior Authorization and Utilization Management Reform Principles, which were issued in collaboration with the American Hospital Association and other key industry groups.	21 reform principles for industry adoption	CAQH CORE's work on PA (Phase IV rules; current opportunity areas) support/align with 7 of the 21 Reform Principles (in the Transparency and Timely Access categories).
Healthcare Administrative Technology Association (HATA)	Prior Authorization was identified at HATA's 2016 strategic planning meeting as one of three key areas on which to focus. Survey was sent to HATA members to identify barriers to adoption and provide recommendations to address them.	Recommendations on Best Practices for Improved Vendor Solutions	CAQH CORE presented during a HATA webinar on PA, reviews HATA's survey findings as available, and provides updates on CAQH CORE efforts.
Healthcare Information and Management Systems Society (HIMSS)	HIMSS17 Annual Meeting included a panel session focused on resolving prior authorization pain points.	TBD; determining next step	CAQH CORE participated in a HIMSS17 Annual Meeting panel on resolving PA pain points, as well as discussed current work to build on the Phase IV foundation.
Workgroup on Electronic Data Interchange (WEDI)	Convened Prior Authorization Sub-workgroup to evaluate barriers/challenges, business cases, current workflows, and return on investment (ROI) related to electronic data exchange for medical services prior authorization. CORE Staff participating in workgroup. Also convened a Prior Authorization Council with the goal of identifying synergies across the unique industry groups working on PA.	TBD; white paper expected	CAQH CORE participates in the WEDI PA Sub-workgroup and the WEDI PA Council. There is overlap with issues the PA Sub-workgroup has addressed and the CAQH CORE opportunity areas.
X12	Draft of updated X12 standards includes a draft X12 v7030 278 Prior Authorization standard; public review period for this standard has not yet occurred.	Updated transaction standards for potential regulatory adoption	CAQH CORE PA Subgroup will review v7030 of the X12 278 being issued in Sept 2017 for public comment.

CAQH CORE will also continue to monitor **state policy development and potential legislation related to PA**, especially developments that align with the opportunity areas pursued by the PA Subgroup.

Audience Poll #1

As a provider or health plan, would you be willing to be interviewed by CAQH CORE staff about best practices and challenges in your PA processes?

1. Yes.
2. No.
3. Unsure.
4. Already interviewed.

CAQH CORE Advisory Group Activities in PA

Kim Peters
Process Owner, Provider Process Implementation, Humana Inc.

Robert Bowman
CAQH CORE Associate Director

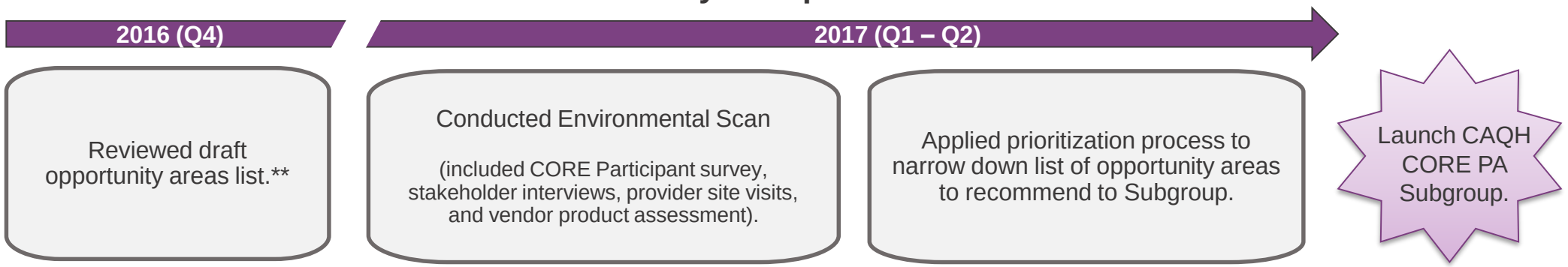
Prior Authorization Advisory Group

Development of High Priority Opportunity Areas for Potential Rule Development

Advisory Group Roster

Entity Type	CORE Participating Organization	Name	Title
Health Plan	**Humana**	Kim Peters	Program Manager
	Anthem	Mary Jo Baughman	Director Administrative Connectivity
Provider	**Mayo Clinic**	BJ Venhuizen	Electronic Eligibility Coordinator
	American Medical Association (AMA)	Heather McComas	Director "Admin Simp" Initiatives
	Veterans Health Administration (VHA)	Robert Huffman	Miscellaneous Administration & Programs
Vendor	**athenahealth, Inc.**	Joe Holtschlag	Operations Manager
	Transunion	Kimberly Young*	Senior Business Systems Architect, Healthcare Solutions

Advisory Group Activities



* Advisory Group member from November 2016 until May 2017.

** Included thorough review and analysis of: X12 v5010X217 278 TR3; NCVHS testimonies; CAQH CORE industry surveys; Industry forum discussions and initiatives; CAQH CORE Phase IV Subgroup discussions

Prior Authorization Advisory Group

Environmental Scan Findings: Pain Points

CAQH CORE, with guidance from the PA Advisory Group, conducted a multi-stakeholder Environmental Scan with over 100 entities to **identify industry barriers to adoption of electronic PA and pain points with the PA process.** The scan revealed pain points in each major part of the PA process, as well as overall pain points.

Pain Points in PA Process

Part A:
Provider Prepares PA Request

- Difficulty initiating a PA
- Access to clinical data
- Lack of integration between clinical and administrative systems
- Inconsistencies across health plans
- Inaccuracy of information
- Importance of the X12 270/271*

Part B:
Provider & Health Plan Exchange Information
[Provider submits PA Request; Health Plan receives; Health Plan requests additional documentation (if needed); Provider submits]

- Lack of adoption of the X12 278
- Ubiquity of health plan portals
- Inconsistencies across health plans
- Lack of additional documentation standard
- Lack of electronic method of submission for additional documentation

Part C:
Health Plan Reviews & Approves/Denies PA Request

- Lack of adoption of the X12 278

Overall Pain Points

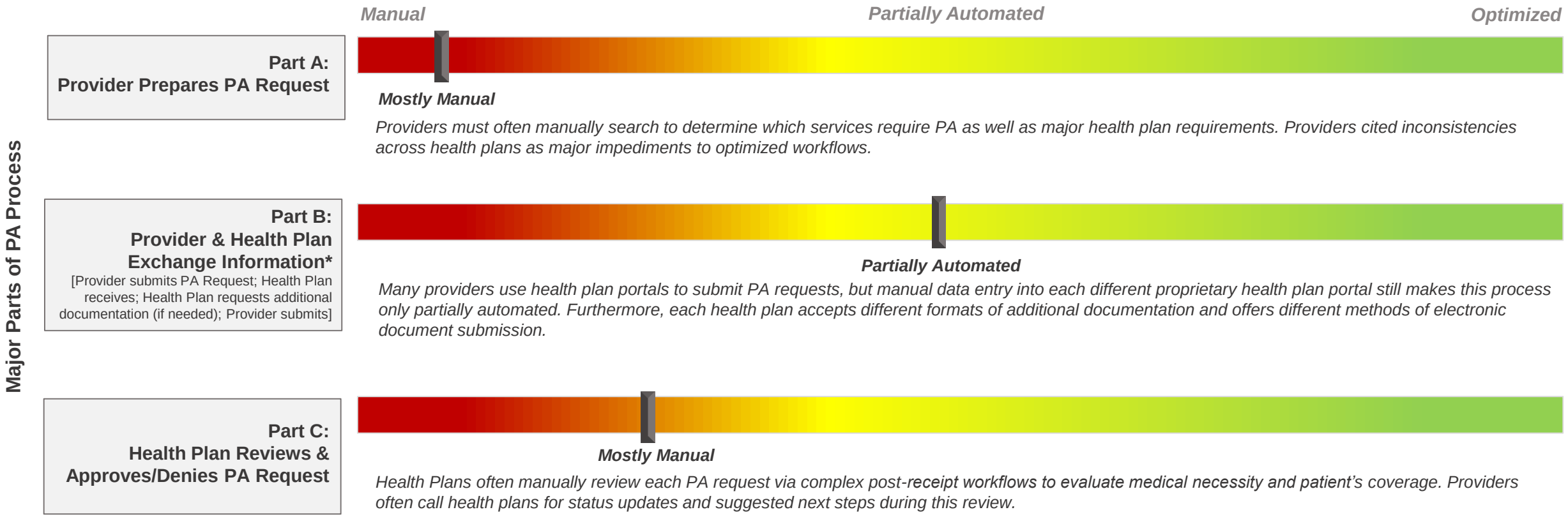
- Impact to patient care
- Impact to revenue cycle
- Persistence of manual processes
- Length of time to final adjudication

* ASC X12 v5010 270/271 Eligibility Request and Response

Prior Authorization Advisory Group

Environmental Scan Findings: Current State of Automation of Major Parts of the PA Process

The Scan findings also informed the below depiction of each major part of the PA process plotted on the automation spectrum.



* Phase IV CAQH CORE 452 Health Care Services Review – Request for Review and Response (278) Infrastructure Rule v4.0.0 established the foundational infrastructure necessary for Part B.

Prior Authorization Advisory Group

Environmental Scan Findings: Pain Points by Stakeholder Type

PROVIDERS

- Must manually check for lists of services requiring PA, which differ by Health Plan. Lists may be outdated or ambiguous, requiring further clarification via phone.
- Information needed to prove medical necessity for service often varies by Health Plan.
- Must manually collect patient information from disparate systems to populate a PA request.
- PA submission methods vary widely by health plan. Some of these methods are partially automated (e.g., health plan-specific web portals, IVR, X12 278, etc.) and could save time and money, but providers still rely heavily on manual submission methods (e.g., fax, phone, etc.). Providers cite lack of uniformity of web portals and the start up and maintenance costs of the X12 278 as barriers to adoption.
- There is little transparency into the status of the PA request. When Providers receive a "pending" status, it is unclear whether the pend is due to health plan review of request or if additional documentation is required.
- Providers usually manually fax information rather than utilizing electronic methods, due to inconsistency across health plans.

VENDORS

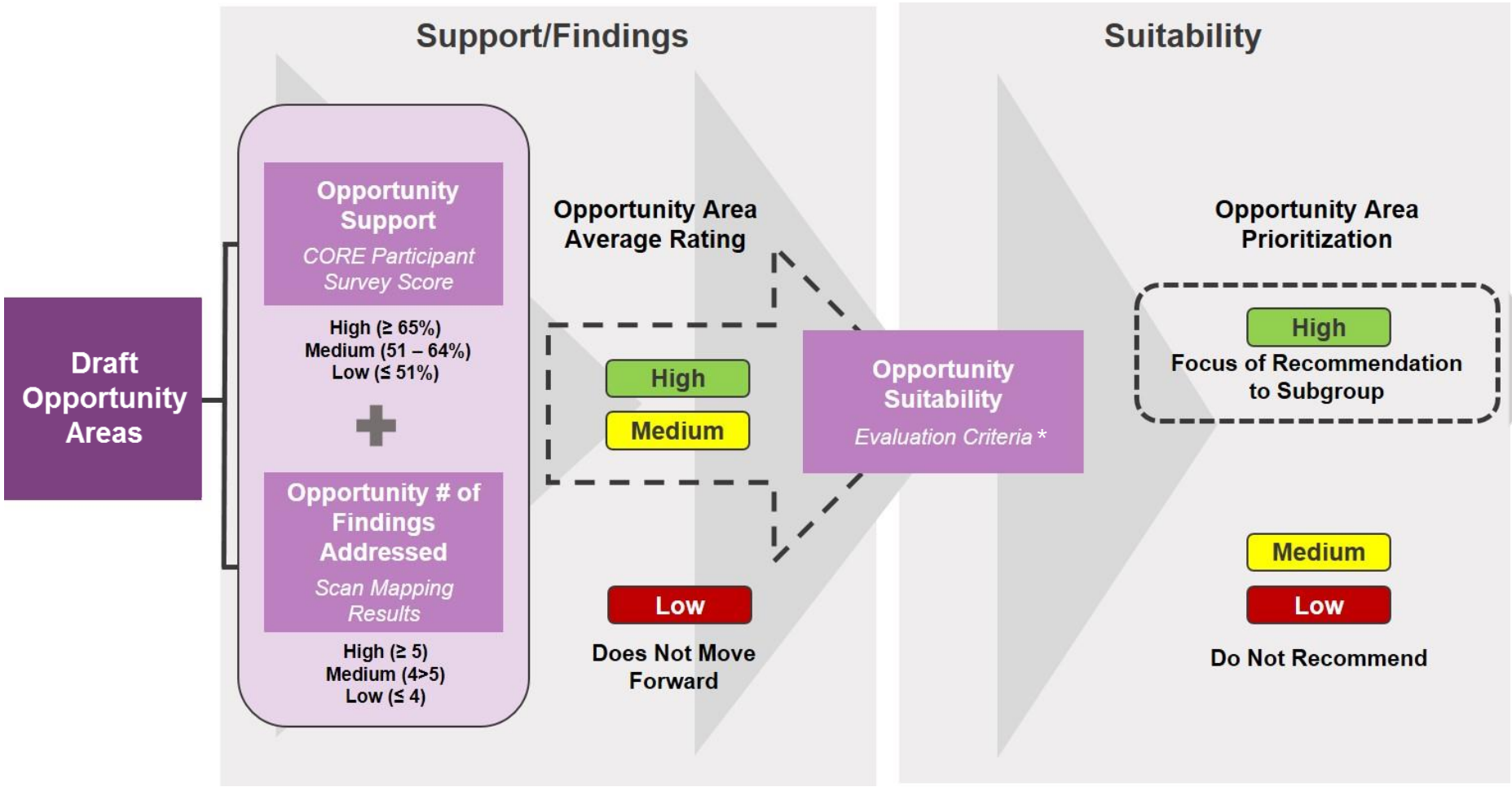
- Roadblocks to vendors' solutions often due to: low adoption of X12 278, lack of uniform and consistent standards for exchanging information, and inconsistencies in health plan requirements.

HEALTH PLANS

- While most health plans receive PA requests via an electronic method, most must use a manual process to determine medical necessity and patient coverage and reach a final decision.
- Receipt of additional documentation from providers is often via fax, resulting in additional time and cost compared to electronic methods.

Prior Authorization Advisory Group

Process to Prioritize Draft Opportunity Areas



Top Six Opportunity Areas

- Robust data content requirements for mandated v5010X217 278 PA request and responses.
- Uniform and consistent robust data sets for initiating a PA.
- Uniform and secure transport methods and uniform electronic document formats for submission of additional documentation.
- Uniform electronic document formats for submission of additional documentation.
- Best practices for automation of provider pre-submission process and health plan adjudication process.
- Capability of the ASC X12 v5010 271 to notify provider of PA requirement at time of mandated eligibility response.

* See Appendix (slide 32) for full names and descriptions of evaluation criteria used.

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Prior Authorization Process

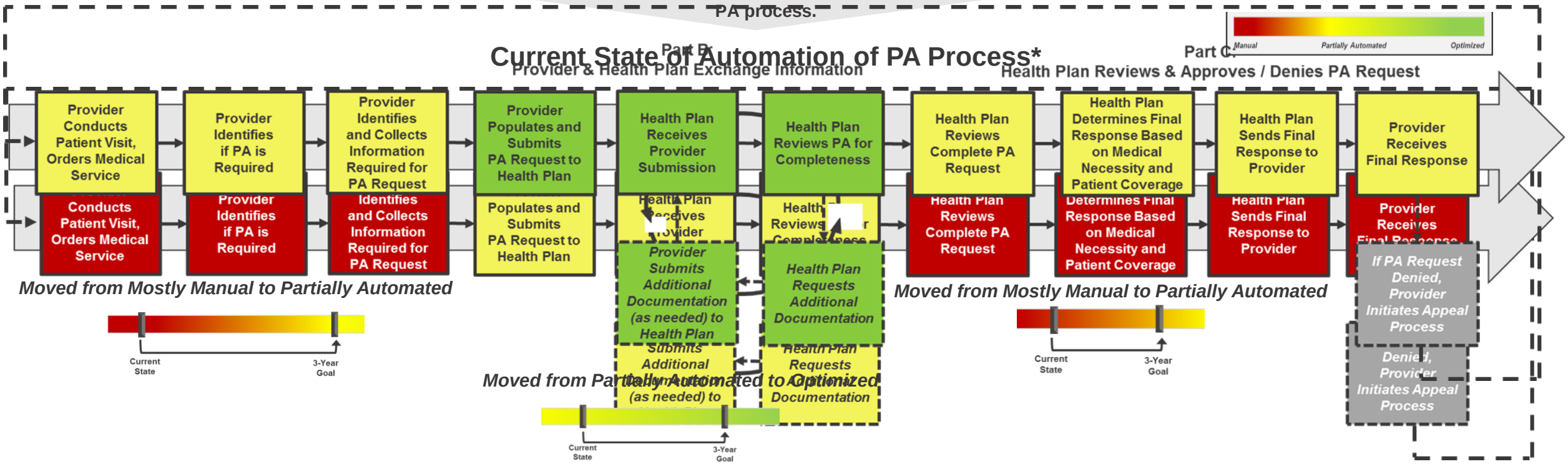
CAQH CORE Vision to Move the Needle Toward Optimization

CAQH CORE Vision for PA

Introduce targeted change to propel the industry collectively forward to a PA Process optimized by automation, thereby reducing administrative burden on providers and health plans and enhancing timely delivery of patient care.

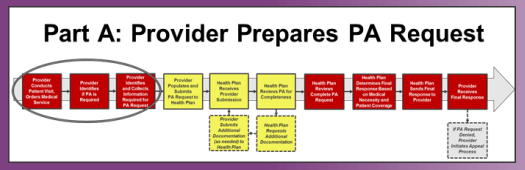
Expected Impact of Opportunity Areas on PA Process*

CAQH CORE and the PA Advisory Group identified six potential opportunity areas to move the needle towards optimization for each major part of the PA process.



* Depicts the most common path for the PA process to follow.

PA Process Part A:
Provider Prepares to Submit PA Request



Part A: Provider Prepares to Submit PA Request

Provider Conducts Patient Visit, Orders Medical Service

Provider Identifies if PA is Required

Challenge
Providers manually check for lists of services requiring PA, which differ by Health Plan. Lists may be outdated or ambiguous, requiring further clarification via phone.

Opportunity to Move the Needle
Notify provider of PA requirement for patient service at time of ASC X12 v5010 271 Eligibility Response.

Provider Identifies and Collects Information Required for PA Request

Challenge
Information needed to prove medical necessity for service often varies by Health Plan.

Opportunity to Move the Needle
Standardize the information required for a PA request.

Challenge
Providers must manually collect patient information from disparate systems to populate a PA request

Opportunity to Move the Needle.
Research best practices for automation of provider pre-submission process.

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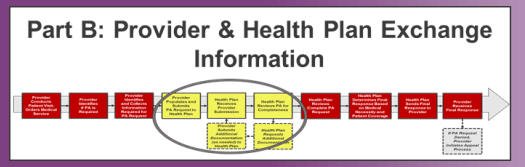
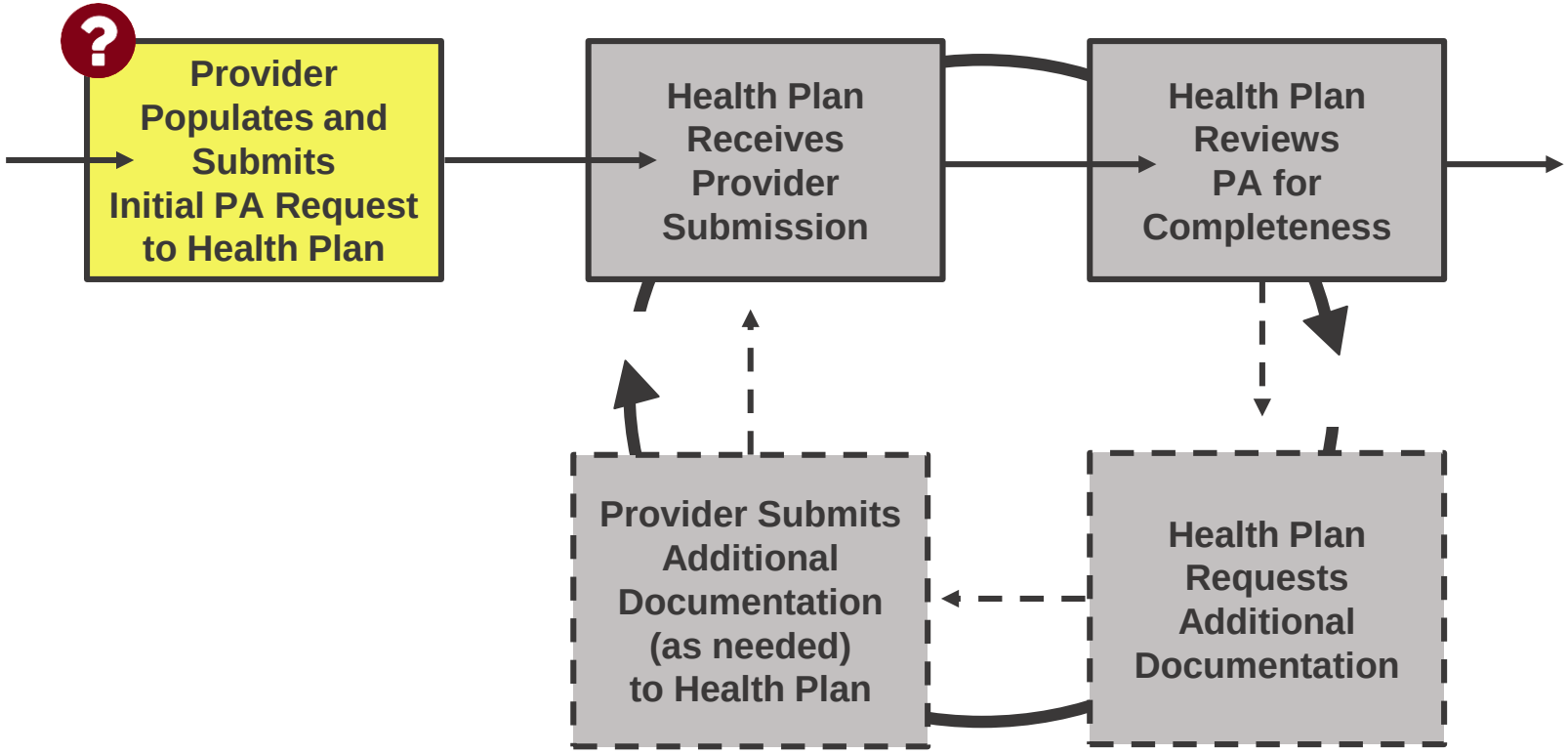
PA Process Part B:
Provider & Health Plan Exchange Information



Part B: Provider & Health Plan Exchange Information

Challenge
PA submission methods vary widely by health plan. Some of these methods are partially automated (e.g., health plan-specific web portals, IVR, X12 278, etc.) and could save time and money, but providers still rely heavily on manual submission methods (e.g., fax, phone, etc.). Providers cite lack of uniformity of web portals and the start up and maintenance costs of the X12 278 as barriers to adoption.

Opportunity to Move the Needle
Standardize the information required for a PA request.



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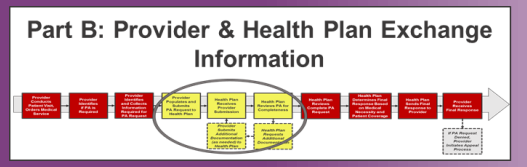
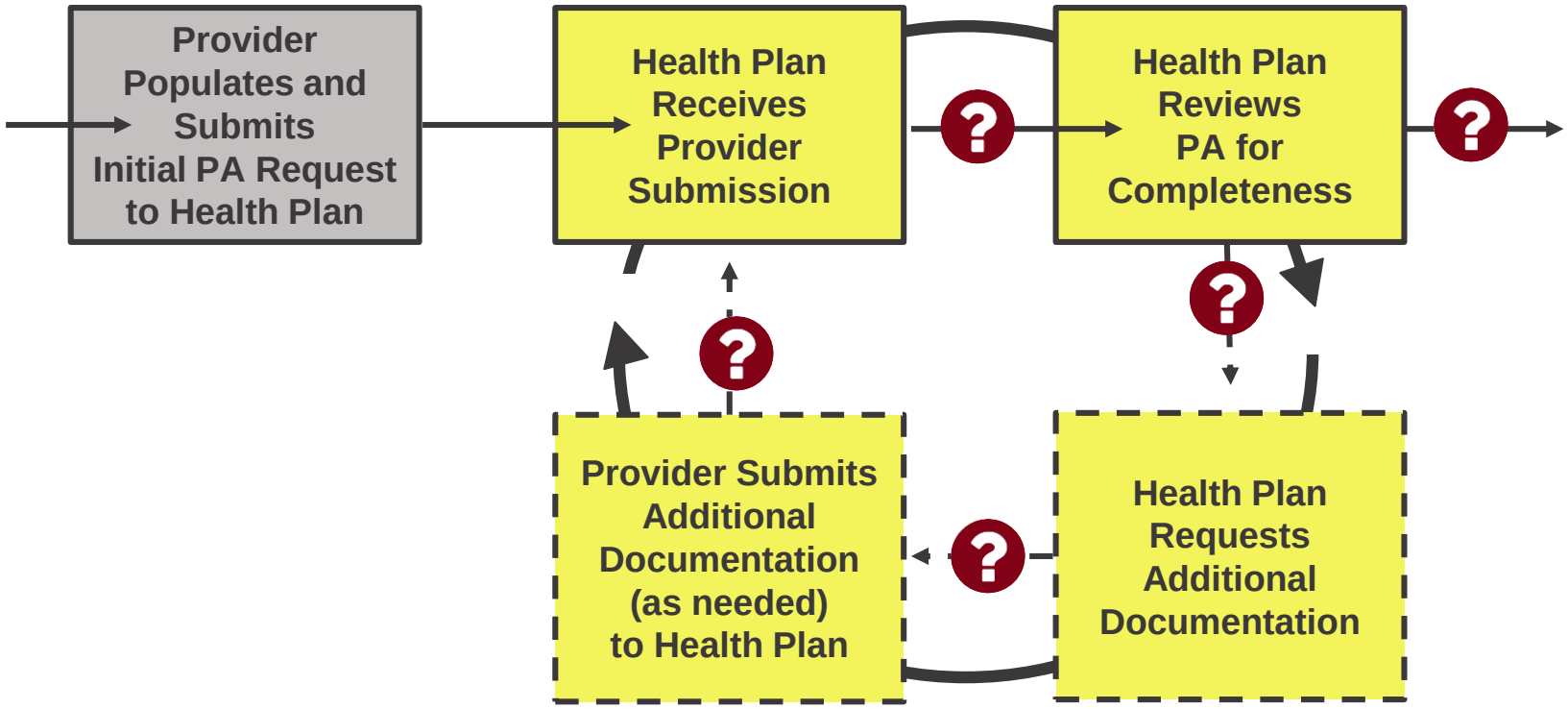
PA Process Part B:
Provider & Health Plan Exchange Information (continued)



Part B: Provider & Health Plan Exchange Information

Challenge
There is little transparency into the status of the PA request. When Providers receive a "pending" status, it is unclear whether the pend is due to health plan review of request or if additional documentation is required.

Opportunity to Move the Needle
Provide explanation for "pending" status in mandated X12 278, and appropriate next steps for Provider to receive final approval.



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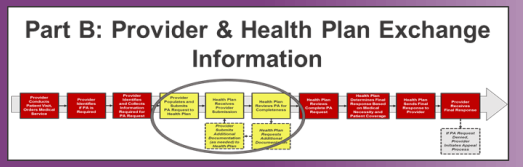
PA Process Part B:
Provider & Health Plan Exchange Information (continued)

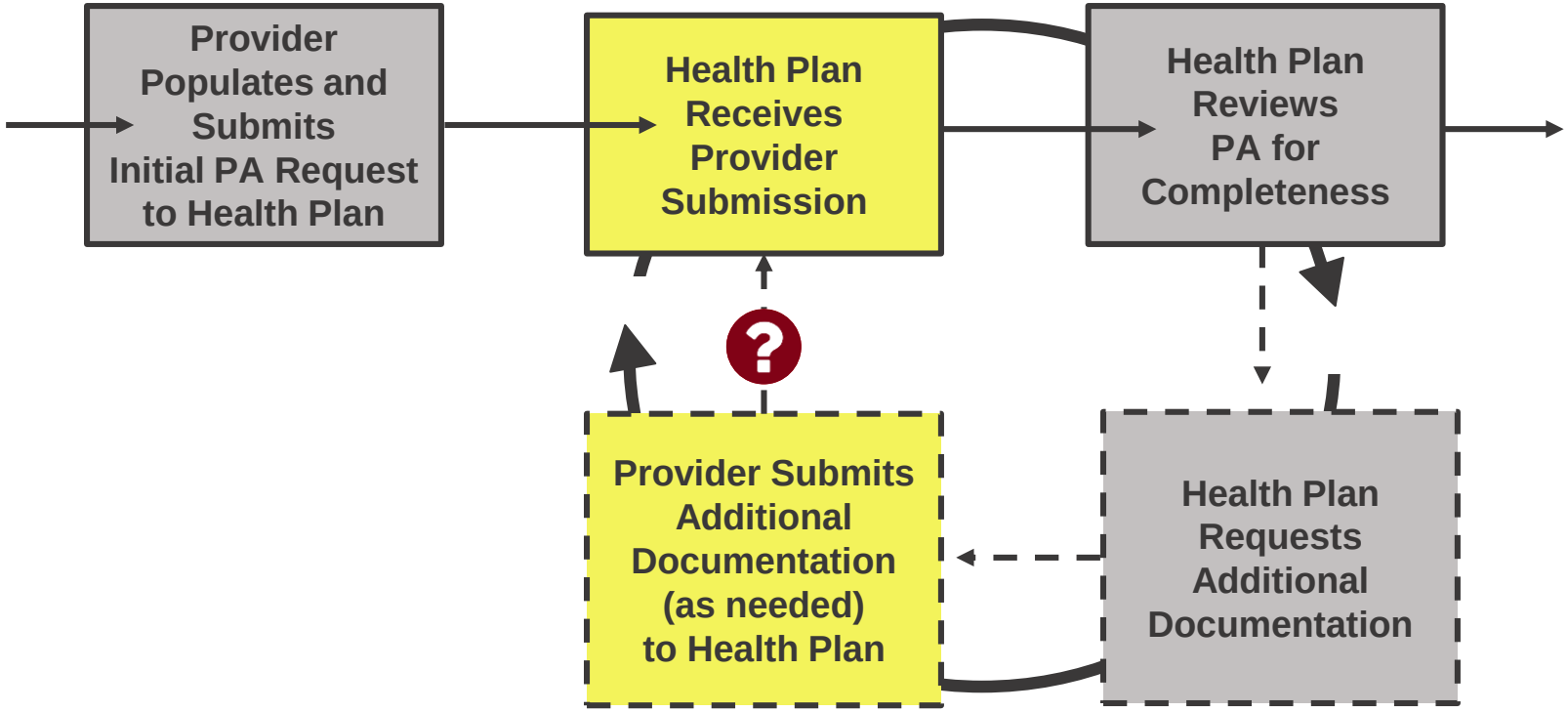


Part B: Provider & Health Plan Exchange Information

Challenge
Health plans often require additional documentation to make a determination. Providers usually manually fax information rather than utilizing electronic methods, due to inconsistency across health plans**.**

Opportunity to Move the Needle
Define a uniform set of accepted formats for additional documentation.

Opportunity to Move the Needle
Ensure health plans offer an electronic method of additional documentation submission.



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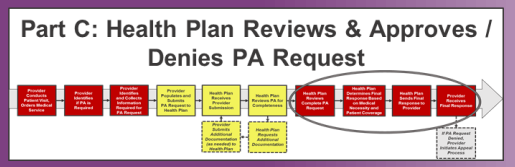
PA Process Part C:
Health Plan Reviews & Approves/Denies PA Request



Part C: Health Plan Reviews & Approves/Denies PA Request

Health Plan Reviews Complete PA Request

Health Plan Determines Final Response Based on Medical Necessity and Patient Coverage

Health Plan Sends Final Response to Provider

Provider Receives Final Response

If PA Request Denied, Provider Initiates Appeal Process

Challenge
While most health plans receive PA requests via an electronic method, most must use a manual process to determine medical necessity and patient coverage and reach a final decision.

Opportunity to Move the Needle
Research best practices for automation of health plan adjudication process.

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Audience Poll #2

Which opportunity area would be most beneficial to your organization? (Select all that apply.)

1. Robust data content requirements for mandated v5010X217 278 PA request and responses (e.g., explanation of “pending” status”, appropriate next steps for provider to receive final approval, etc.).
2. Uniform and consistent robust data sets for initiating a PA.
3. Uniform and secure transport methods and uniform electronic document formats for submission of additional documentation.
4. Best practices for automation of provider pre-submission process and health plan adjudication process.
5. Capability of the ASC X12 v5010 271 to notify provider of PA requirement at time of mandated eligibility response.

Audience Poll #3

In addition to the mandated use of Service Type Codes (STC), is your organization currently supporting/planning to support eligibility transactions (X12 270/271) using procedure codes?

1. Yes, we currently support eligibility inquiries/responses using procedure codes.
2. Yes, we are planning to support eligibility inquiries/responses using procedure codes.
3. No, we do not support eligibility inquiries/responses using procedure codes.
4. Unsure.
5. Does not apply.

Creation of CAQH CORE PA Subgroup

Robert Bowman
CAQH CORE Associate Director

CAQH CORE Prior Authorization Efforts

Impacts of Opportunity Areas

Top Opportunities

- **Change sequence of transactions**: Notify provider of PA requirement at time of Eligibility Response.
- Standardize and enhance the information required for a PA **request and response.**
- Provide explanation for "pending" status in mandated HIPAA transaction, and **next steps for Provider to receive final approval.**
- Ensure health plans offer an **electronic method for additional documentation** submission.
- Define a uniform set of accepted **formats for additional documentation**.
- Identify **best practices** for automation of provider pre-submission process and health plan adjudication process.

How Provider & Health Plan Experience Improves

Providers

- Reduces unnecessary delays in patient care due to shortened time to final adjudication.
- Simplifies preparation and submission of PA request due to consistent requirements.
- Increases PA request status transparency and next steps to get request approved.
- Simplifies submission of additional information (Attachments) to support PA request.
- Reduces resources (clinical and administrative staff time, cost) spent on administrative tasks, through increased automation PA process steps.

Health Plans

- Makes it easier to receive and process PA request due to receipt of more complete data.
- Encourages electronic receipt and processing of additional information (Attachments) to support PA request, thus saving labor costs.

Vendors

- Ability to offer stronger products (reduced turnaround time, more data content, ability to exchange several requests/responses on same PA, electronic attachments).

Current State → **Future State [Phase IV + Top Opportunities]**

Manual *Partially Automated* *Optimized*

CAQH CORE PA Subgroup Information

Join Today!

Why join a Subgroup?

Contribute to the development of implementable operating rules for targeted industry change, resulting in meaningful improvements for providers, health plans, and patients.

Goal	Expand on the foundation set by the Phase IV Operating Rules to develop additional voluntary operating rules and move the needle towards an optimized PA process.

Deliverables	Rules will be drafted and made ready for implementation *incrementally over a two year period, starting now*. • Draft high-level requirements for select operating rules by end of 2017. • Interim report summarizing research on potential best practices for automation of parts of the PA process expected Q2 2018. • Continued rule development addressing aforementioned opportunity areas to continue throughout 2018.

Timeline & Commitment	• Subgroup launch: September 2017 • Short-term, mid-term, and long-term timelines for deliverables • Commitment: Approx. 90 minute calls every other week

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Audience Poll #4

Are you and/or your organization interested in participating in the CAQH CORE PA Subgroup?

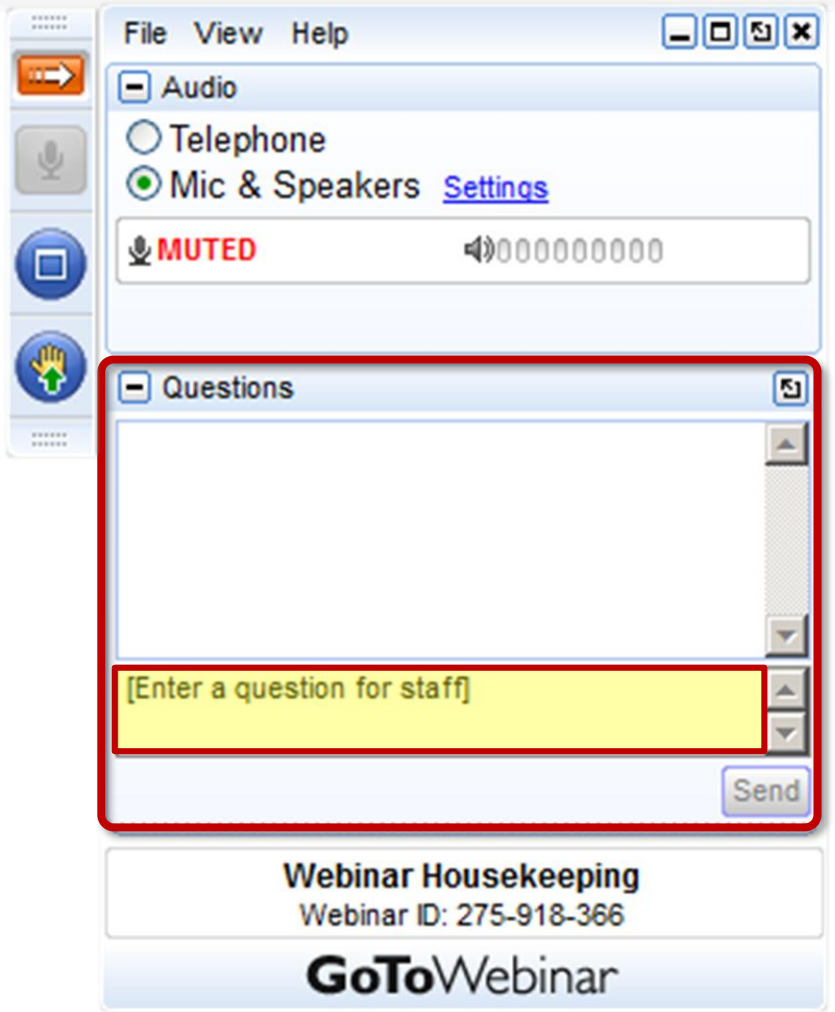
1. Yes, please reach out to me.
2. Unsure, would need more information.
3. No, not at this time.

CAQH CORE Participant Q&A

Please submit your questions and comments:

Submit written questions or comments on-line by entering them into the **Questions panel on the right-hand side of the GoToWebinar dashboard.**

Attendees can also submit questions or comments via email to core@caqh.org.



Thank you for joining us!

@CAQH

Website: www.CAQH.org/CORE

Email: CORE@CAQH.org

The CAQH CORE Mission

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

Appendix

Prior Authorization Advisory Group

Prioritization Process: Suitability Criteria

The Advisory Group identified PA specific criteria to assess the suitability of each draft opportunity area. These will be applied along with the CAQH CORE Guiding Principles and Board Evaluation Criteria, which apply to all CORE rule writing, to reach agreement on high priority areas for recommendation.

#	CAQH CORE Guiding Principles*
1.	CAQH CORE will not create or promote proprietary approaches to electronic interactions/transactions.
2.	Whenever possible, CAQH CORE has used existing market research and proven rules. CAQH CORE Rules reflect lessons learned from other organizations that have addressed similar issues.
3.	CAQH CORE will suggest migration steps to promote successful and timely adoption of CAQH CORE Rules.
4.	All CAQH CORE recommendations and rules will be vendor neutral.
5.	Rules will not be based on the least common denominator but rather will encourage feasible progress, promote cost savings, and efficiency.
6.	To promote interoperability, rules will be built upon HIPAA, and align with other key industry initiatives.
7.	Where appropriate, CAQH CORE will address the emerging interest in evolving standards.
8.	CAQH CORE will not build a switch, database, or central repository of information.
9.	CAQH CORE participants do not support "phishing."
10.	CAQH CORE Rules address both Batch and Real Time, with a movement towards Real Time (where/when appropriate).
11.	All of the CAQH CORE Rules are expected to evolve in future phases.

#	CAQH CORE Board Evaluation Criteria
1.	Strategic and organizational fit (CORE guiding principles)
2.	Goal and expected impact/accomplishment
3.	ROI: Benefit to provider, health plan and system (immediate or long-term)
4.	Ability to drive participation/adoption/ease of implementation
5.	Timing considerations

#	PA Evaluation Criteria	Description
1.	Effective Approach	Opportunity must be an effective approach to increasing electronic PA adoption, minimizing manual processes, and/or incentivizing automated final adjudication of PA requests.
2.	Broad Set of Clinical Services	Affects a broad set of clinical services that require PA.
3.	Benefits Across Stakeholder Types	Opportunity should offer business benefits or ROI across stakeholder groups.
4.	Does Not Pose Barrier to Existing Federal or State Regulations	Opportunity area does not pose a barrier to existing federal or state regulations.
5.	Supports Attachments (Additional Documentation)	Supports adoption of electronic additional documentation through multiple formats and delivery mechanisms.
6.	Advances Interoperability	Supports interoperability between clinical and administrative systems.
7.	Patient Centric	Supports the patient experience and the delivery of timely care.

*__NOTE:__ The CORE Guiding Principles were updated prior to review by the PA Advisory Group to remove outdated refences (e.g., support for HHS's National Health Information Network (NwHIN)).