CAQH CORE Town Hall

September 30, 2020

2:00-3:00 pm EST

Agenda

- CAQH CORE Overview & Industry Update
- NCVHS Hearing Summary
- CAQH Operating Rules in Development
  - Value-based Payments
  - Connectivity
  - Attachments
- Spotlight: CAQH CORE Pilot & Measurement Initiative
- Q&A

Logistics

Presentation Slides and How to Participate in Today's Session

- Accessing webinar materials
  - You can download the presentation slides now from the "Handouts" section of the GoToWebinar menu.
  - You can download the presentation slides and recording at www.caqh.org/core/events after the webinar.
  - A copy of the slides and the webinar recording will also be emailed to all attendees and registrants in the next 1-2 business days.
- Questions can be submitted ***at any time*** using the **Questions panel on the GoToWebinar dashboard.**

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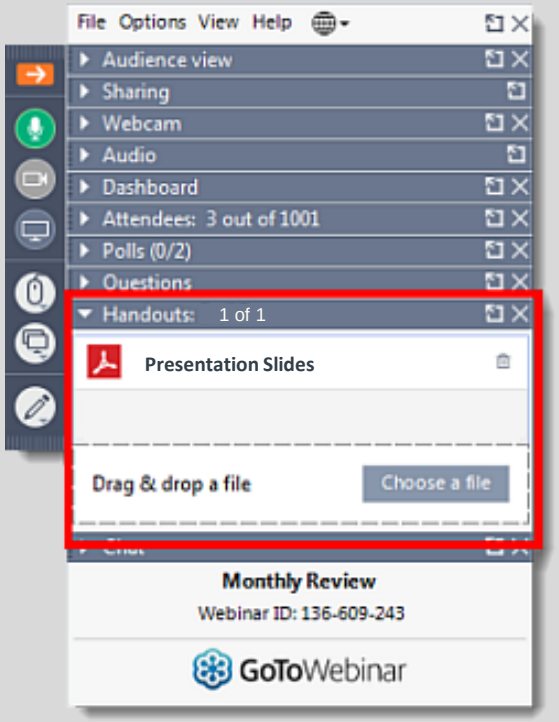


CAQH CORE

CAQH CORE
Overview & Industry Update

April Todd
CAQH CORE and Explorations Senior Vice President

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.

CAQH CORE

CAQH CORE Operating Rule Overview

Revenue Cycle Business Processes Supported by Operating Rules

Rule Set	Infrastructure	Connectivity Rule Application	Data Content	Other
Eligibility & Benefits	Eligibility (270/271) Infrastructure Rule*	Connectivity Rule vC.1.0 (PI)* Connectivity Rule vC.2.0 (PII)*	Eligibility (270/271) Data Content Rule*	
Claim Status	Claim Status (276/277) Infrastructure Rule*	Connectivity Rule vC.2.0 (PII)*		
Payment & Remittance	Claim Payment/ Advice (835) Infrastructure Rule*		EFT/ERA 835/CCD+ Data Content Rule*	EFT/ERA Enrollment Data Rules*
Prior Authorization & Referrals	Prior Authorization (278) Infrastructure Rule**	Connectivity Rule vC.3.0 (PIV)**	Prior Authorization (278) Data Content Rule**	Prior Auth Web Portal Rule
Health Care Claims	Health Care Claim (837) Infrastructure Rule			
Benefit Enrollment	Benefit Enrollment (834) Infrastructure Rule			
Premium Payment	Premium Payment (820) Infrastructure Rule			

* Rule is federally mandated. ** Rule was proposed in 2020 to NCVHS for federal mandate.

CORE Certification

CORE Certification program was developed **by industry, for industry** by CAQH CORE Participating Organizations including health plans, providers, vendors, government agencies and associations.

CORE Certification program allows organizations to **certify on specific transactions** related to their products or solutions.

Many health plans **require** their vendors to be CORE-certified prior to contracting.

Recertification enables ongoing conformance when rule requirements are updated over time to align with market needs.

381
certifications have been awarded.

aetna™ | Harvard Pilgrim HealthCare | MAYO CLINIC | CHANGE HEALTHCARE | HealthTrio® LLC
DELTA DENTAL | GEORGIA DEPARTMENT OF COMMUNITY HEALTH | U.S. Department of Veterans Affairs | CVS caremark™ | athenahealth

CAQH CORE 2020 Goals

1

Continue to successfully serve as the national operating rule author to improve the efficiency, accuracy and effectiveness of industry-driven business transactions.

- Prior Authorization
- Attachments
- Value-based Payments
- Connectivity
- Value Enhancement

2

Effectively serve as the "Gold Standard" industry certifier for operating rules and underlying business standards.

- Targeted effort to increase certification for Phase III, IV, V and Medicaid.
- Launch re-certification efforts.

3

Evolve CAQH CORE Integrated Model (rule writing, certification, industry relations) to drive future multi-stakeholder value.

- Transition from phase-based to business transaction-based rule sets.
- Evaluate and launch processes to update/expand existing rules as needed.

Polling Question #1

What business processes should CAQH CORE prioritize for operating rule development in 2021? (Check all that apply)

- Eligibility and Benefits
- Healthcare Claims
- Prior Authorization
- Attachments/Medical Documentation
- Value-based Payment

Federal Update

Office of National Coordinator
Advancing Standards: Standards Version Advancement Process (SVAP) and Interoperability Standards Advisory (ISA)

- The inaugural **Standards Version Advancement Process (SVAP)** comment period allows health IT developers in the ONC Health IT Certification Program to voluntarily update their products to include National Coordinator-approved, newer versions of adopted standards.
- The annual **Interoperability Standards Advisory (ISA)** review and comment period is an opportunity to provide comments, suggest revisions, and propose additions to the ISA before we publication of the 2021 ISA Reference Edition. The ISA is a dynamic, coordinated catalog of the standards and implementation specifications that can be used to meet interoperability needs in healthcare.

Comments due November 9, 2020

Initial Compliance Dates for Federal Interoperability Rules Approaching

CAQH Endpoint Directory Supports Compliance

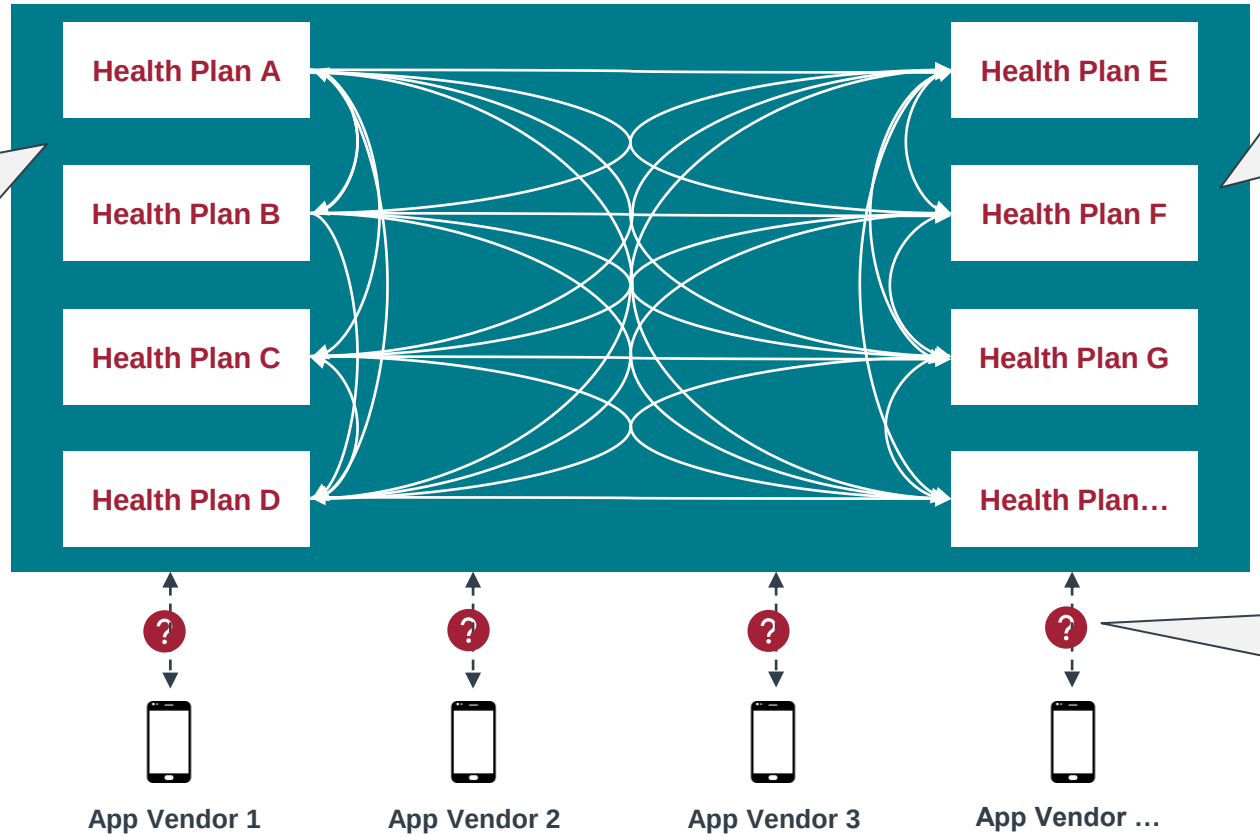
- CMS released the Final Rule on Interoperability and Patient Access, requiring that CMS-regulated plans:
  - Implement and maintain openly-published **HL7® FHIR® -based APIs in order to provide patients access** to their health information.
  - **Permits access to data by third-party applications**, with approval from patient (effective Jan 1, 2021; enforceable Jul 1, 2021).
  - Support electronic **exchange of data for care coordination as patients move between plans** (effective and enforceable Jan 1, 2022).
  - Also encourages impacted payers to ask **third-party app developers to attest to having certain provisions in their privacy policy**, giving patients warnings if app vendors have not attested or agreed to privacy policies.
- ONC's FHIR at Scale Task Force (FAST), Da Vinci, and other organizations have identified **endpoint directories as a critical solution to overcome scale barriers.**
- Feedback indicates that a **solution that securely publishes validated payer FHIR endpoints and third-party apps would close an industry gap.**

CAQH Endpoint Directory

Challenge: Unwieldy volume of one-off trusted connections required for plan-to-plan and app vendor-to-plan interaction

For health plans to implement and comply with the CMS Final Rule…

Assuming 689 CMS-regulated payers alone, there are over **237k possible plan-to-plan trusted connections** that need to be established.*



Trusted connections must address:

- security, privacy,
- adherence to and conformance with standards,
- access,
- use cases,
- modalities,
- technical frameworks,
- governance

Plans are required to grant access to third-party app vendors. Plans may notify members if an app does not seem trustworthy but cannot reject the request unless there is a security threat.

NOTES: *237k calculated using 689!/(2!x(689-2)!) combination formula. Assumes that every health plan would need a connection to every other health plan. This connection count excludes endpoint discovery that may have to occur for payer-provider and payer-patient connections that may occur.*

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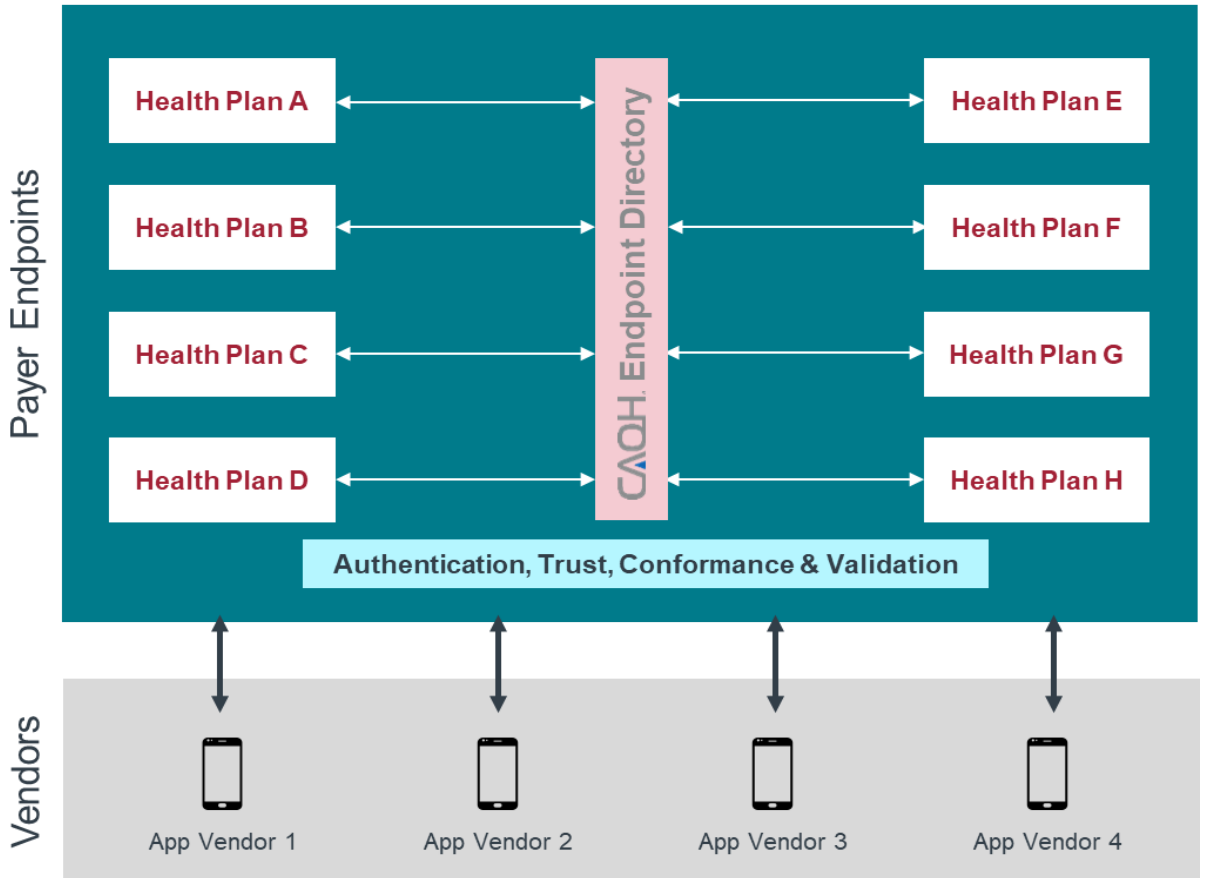
CAQH Endpoint Directory

Solution Concept: A National Utility for Payer Endpoints & Third-party App Registry

A national source of truth for validated payer endpoints and third-party apps that:

- Allows payers to **share information about endpoints**, including capability statement imports. Simplifies, automates manual processes.
- Allows payers and third-party apps to **query payer endpoints** for multiple use cases.
- **Validates identity** of payer and third-party app participants.
- **Facilitates connection request** between parties.
- **Confirms privacy and security attestations** and/or privacy policy, data use agreements.
- **Ensures conformance testing and validation** of FHIR endpoints and ability to work with endpoints.
- Allows **third-party apps to upload information about themselves** to make available to payers.

Phase 1 Solution Concept



Beta Launch Q4 2020 | **Phase 1 Full Launch** Q2 2021

CAQH CORE

NCVHS Hearing Summary: CAQH CORE Prior Authorization & Connectivity Rule Set

Erin Weber
CAQH CORE Director

Proposed Operating Rule Package to NCVHS

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

- On August 25th and 26th NCVHS held a hearing to review and hear industry feedback on the proposed rules.
- NCVHS plans to finalize its recommendation to the Secretary of HHS at its November 18-19th meeting.

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

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

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

Enhances Data Content to Streamline Review and Adjudication

- **The CAQH CORE Prior Authorization & Referrals (278) Data Content Rule** targets one of the most significant problem areas in the prior authorization (PA) process: requests for medical services that are pended due to missing or incomplete information, primarily medical necessity information.

- The rule reduces unnecessary back and forth between providers and health plans and enables shorter adjudication timeframes and less manual follow up.

Key CAQH CORE Rule Requirements Include:

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

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

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

Establishes Consistent Infrastructure and National Turnaround Timeframes

- Specifies prior authorization requirements for:
  1. Standard companion guide template
  2. System availability expectations
  3. Uniform use of acknowledgements
  4. Processing mode and response timeframes
  5. Safe harbor connectivity and security

- In 2019, CAQH CORE Participants updated the rule to include new response requirements*:
  1. Two-Day Additional Information Request
  2. Two-Day Final Determination
  3. Optional Close Out

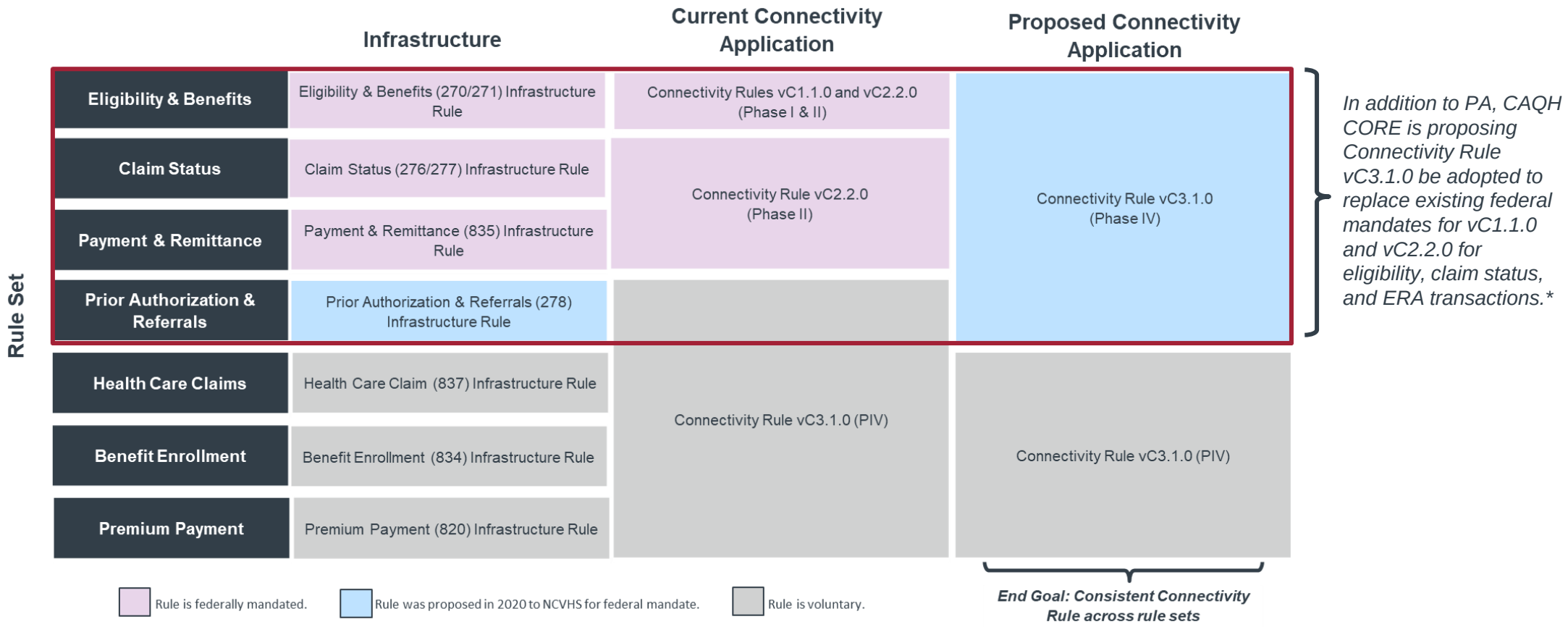
Infrastructure Requirement	Prior Authorization
Processing Mode	*Batch OR Real Time Required*
Batch Processing Mode Response Time	*If Batch Offered*
Batch Acknowledgements	*If Batch Offered*
Real Time Processing Mode Response Time	*If Real Time Offered*
Real Time Acknowledgements	*If Real Time Offered*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

***Each HIPAA-covered entity or its agent must support the *maximum* response time requirements for at least **90 percent** of all X12 278 Responses returned within a calendar month; does not apply to urgent/emergent prior authorizations.

3. The CAQH CORE Connectivity Rule vC3.1.0

Provides for Updated, Consistent Connectivity Modes Across Transactions

The CAQH CORE Connectivity Rule vC3.1.0 establishes a safe harbor connectivity method that drives industry alignment by converging on common transport, message envelope, security and authentication standards.



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

Use Case Driven Approach: Prior Authorization for Imaging

How the Proposed Operating Rules Improve Automation & Adjudication

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

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

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

Health Plan receives PA Request and completes adjudication process.

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

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

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

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

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

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

Provider receives pended PA response from Health Plan.

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

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

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

Provider remits CT scan without contrast for Health Plan review.

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

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

Prior Authorization & Connectivity Rule Set

Implementation Update

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

- **Implementation and certification on these operating rules address key infrastructure challenges** related to the prior authorization transaction, such as connectivity, processing times and system availability.
- The operating rules are a critical step in **reducing the time-consuming phone and fax communication in the prior authorization process** conducted by providers to send information and obtain approvals for procedures.
- Visit the **CAQH CORE website** to learn more about the CORE Certification process.

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Case Studies: Benefits of Automation and Proposed Operating Rules

Insights from a Health Plan and a Provider

Harvard Pilgrim Health Care

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

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

Cleveland Clinic

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

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

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

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CAQH CORE Operating Rules in Development

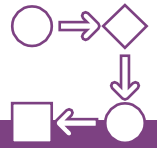
- **Value-based Payments**
- **Connectivity**
- **Attachments**

Helina Gebremariam
CAQH CORE Manager

Value-based Payments Subgroup Initiative

Patient Attribution

Attribution matches individual patients in a population with providers, which ultimately determines the patients for which a provider (as an individual or as a group) is responsible. Attribution forms the basis of analysis for metrics underpinning VBP, such as total costs of care and quality measures.* While health plans supply attribution information on a regular basis, providers are often left with several questions:



Why are they in my population?

VBP contracts between health plans and providers may include information on the methodology for assigning patients to a population. However, clinicians providing care often do not have insight into those contracts and **may not know why a patient is in their population**, especially if it is a patient without a prior relationship.

Who is on first?

Patients may be attributed to a singular provider or a group of providers which may leave **ambiguity as to who is the primary care provider (PCP) responsible for the patient.** Furthermore, patients with chronic conditions such as heart disease may have a specialist who acts as their PCP which may or not be reflected in the attribution model.

Who else is involved?

In some VBP models, providers are penalized when patients in their population visit other providers. **Providers may not have insight as to where else their patient is seeking care.** Preventing "leakage" is a large incentive in VBP contracts, but without visibility into patient utilization, providers are often unaware when this occurs until after the contract period.

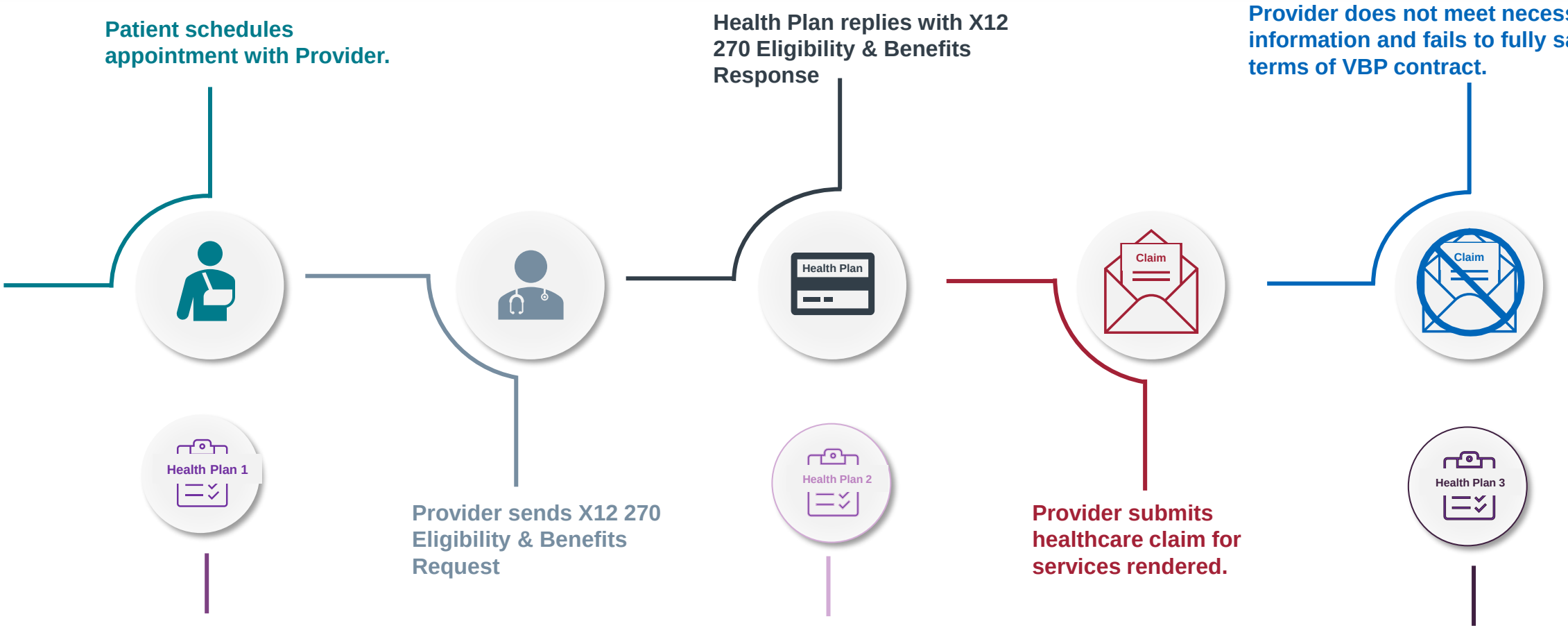
Provider success under VBP models requires knowing the answers to all these questions,
but before asking these questions a provider needs to know the answer to the most important question:

IS THIS PATIENT IN MY ATTRIBUTED POPULATION?

*National Quality Forum, 2016

Value-based Payments Subgroup Initiative

Current State of Exchanging Attribution Information



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Value-based Payments Initiative

Overview of Draft CAQH CORE VBP Attribution Data Exchange Operating Rules

There are currently no industry standards for the exchange of attribution information. To streamline this business process, the VBP Subgroup drafted two sets of rules to reduce provider administrative burden and bring critical information to the point of care. The rule references aligning data across standards including FHIR. CAQH CORE has engaged with leadership from DaVinci to enable alignment.

Single Patient Attribution Status Data Content Rule

- Builds upon the CAQH CORE Eligibility & Benefits (270/271) Data Content and Infrastructure Rules which include real-time and batch response time, system availability and companion guide requirements.
- **Data content rule** requires a health plan (or its agent) to return the following attribution data in the Eligibility & Benefits Request transaction:
  - Attribution Status
    - Yes, No, Partial (i.e. is attributed to provider requesting Eligibility & Benefits verification and one other provider) and N/A (i.e., attribution does not apply to patient).
    - Effective dates of attribution status.
    - Attributed provider if different than requesting provider and if deemed permissible by health plan.

Attributed Patient Roster Rule Set

- Contains one infrastructure rule and one data content rule that standardize the use of the X12 00510X318 834 Plan Member Reporting transaction for the exchange of patient rosters.
- **Data content rule** standardizes the minimum data elements a health plan must return to identify patients within the VBP population, including a VBP contract name and effective dates of attribution.
- **Infrastructure rule** standardizes expectations for exchange, including system availability and companion guide requirements. The rule also requires health plans to send providers an updated attributed patient roster (including updated dates of effective attribution) at least once per month.

Value-based Payments Subgroup Initiative

Impact of Draft Rules

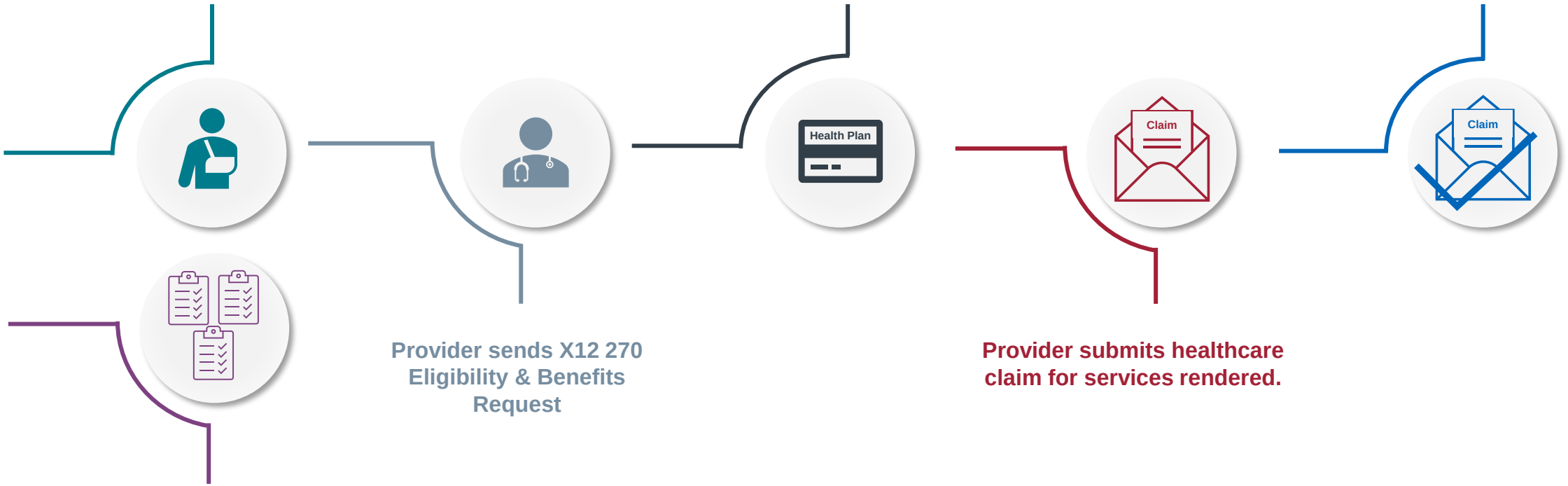
Patient schedules appointment with Provider.

Provider sends X12 270 Eligibility & Benefits Request

Health Plan replies with X12 270 Eligibility & Benefits Response conforming to the Single Patient Attribution Status Data Content Rule.

Provider submits healthcare claim for services rendered.

Health Plan adjudicates claims payment at end of fiscal year.



Provider receives monthly patient rosters via a standard format from health plans in conformance with Attributed Patient Roster Rule Set.

Uniform format enables data to be easily integrated into the provider system.

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CAQH CORE Operating Rules in Development

- Value-based Payments
- **Connectivity**
- Attachments

Emily TenEyck
CAQH CORE Manager

CAQH CORE Connectivity Initiative

The CAQH CORE Connectivity Rules address connectivity and security of administrative and clinical data exchange and establish a national base guiding healthcare communication.

CORE Connectivity Roadmap: Increased Interoperability and Improved Connectivity & Security

Existing

CAQH CORE Connectivity Versions C1 & C2
Federally Mandated for *CORE Eligibility and Claim Status Transactions*

Standardized transport allowed for greater online access due to uniformity in transport protocols.

Requirements were developed more than ten years ago; no longer align with industry best practices for connectivity and security.

CAQH CORE will sunset vC1 and vC2 if vC3 is federally mandated.

Currently Before NCVHS

CAQH CORE Connectivity Version C3
Applies to *all transactions currently addressed by CAQH CORE Operating Rules*

CAQH CORE has proposed vC3 for federal mandate to replace vC1 and vC2 for eligibility, claim status and ERA and support prior authorization.

Mandate would create a base connectivity protocol across all transactions; requires single transport & envelope standard, robust authentication and security standards and specific metadata.

Future Update

CAQH CORE Connectivity Version C4
Under Development
Will Apply to *all transactions addressed by CAQH CORE Operating Rules including claim and PA attachments rules in development.*

Supports clinical and administrative data exchange. Updates and aligns CAQH CORE connectivity & security requirements to support REST and other API technology.

CAQH CORE Board may propose future updates to the federally mandated connectivity requirements to align with vC4.

CAQH CORE Participants will continue to **update and maintain the Connectivity Rule at regular intervals** over time to align with current interoperability, privacy and security standards**.**

CAQH CORE Connectivity Initiative

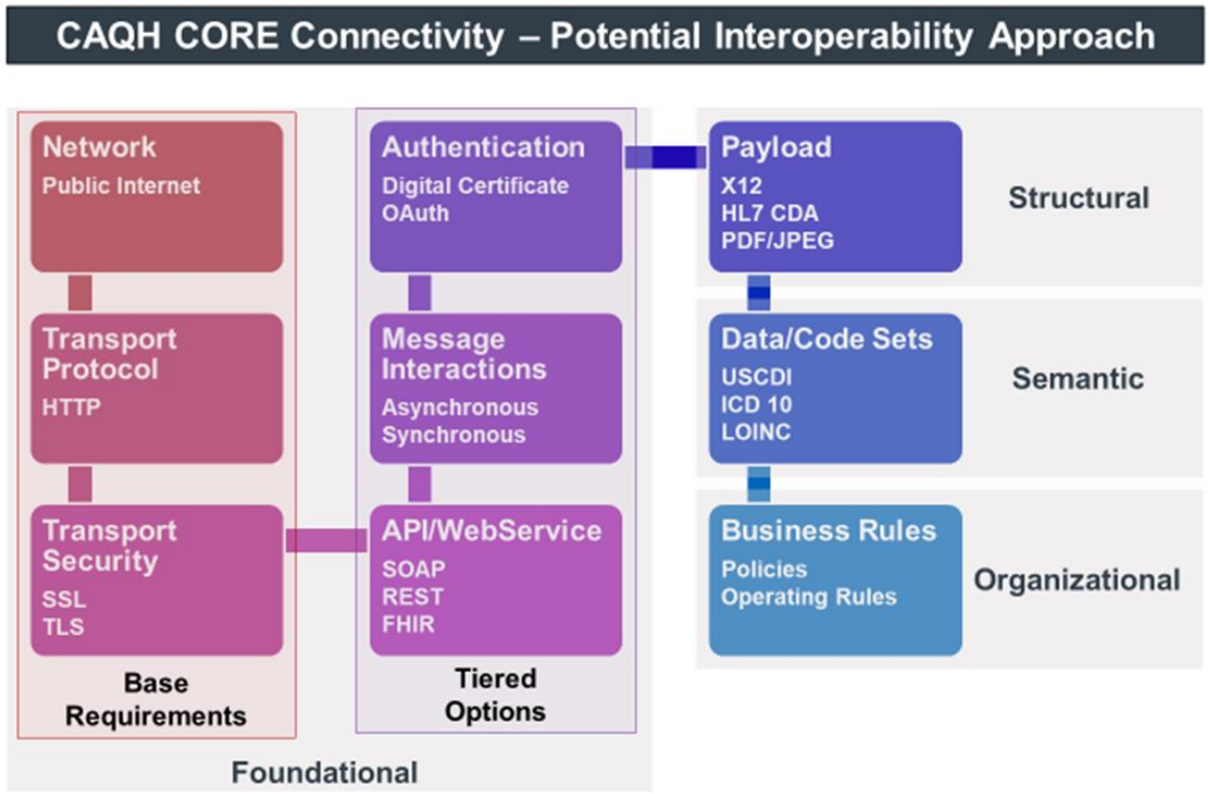
Connectivity Enables the Transport of Information to Support Data Exchange

CAQH CORE Connectivity Rule vC4 Goals:

- Align the CAQH CORE Connectivity Rule vC4 to support frameworks proposed in the **CMS and ONC interoperability rules.**
- Establish a **Safe Harbor** that aligns with existing IT implementations and supports emerging approaches for exchanging data.
- Develop **single, uniform Connectivity Rule** that support the intersection of administrative and clinical data exchange.

Draft Enhancements to CORE Connectivity Requirements:

- Require the use of **TLS v1.2 higher for security** over the public internet for increased security.
- Define **authentication and authorization methods** to establish trust within an exchange including the addition of **OAuth 2.0** as an authorization standard.
- Add support and requirements pertaining to **REST APIs** including specifying **API endpoint naming conventions and versioning** to ensure CORE Connectivity serves as a bridge between existing and emerging standards.
- Add support for the exchange of **attachments transactions** to advance the intersection of clinical and administrative interoperability.



CAQH CORE Operating Rules in Development

- Value-based Payments
- Connectivity
- **Attachments**

Bob Bowman
CAQH CORE Director

CAQH CORE Attachments Initiative

Attachments refer to the exchange of patient-specific **medical information or supplemental documentation** to support an administrative healthcare transaction and are a **bridge between clinical and administrative data.**

- While attachments can be exchanged electronically, partially electronically and manually, exchanging medical documentation for prior authorization and claims is **often highly manual** and a source of significant administrative burden.
- A range of **standards and specifications currently support the exchange of attachments** (e.g., X12 275, HL7 C-CDA, HL7 FHIR, SOAP, REST, etc.)
- **A HIPAA-mandated standard for attachments has not been named**, resulting in lack of industry direction on a uniform approach in the supporting clinical documentation requested by health plans.
- CAQH CORE launched an Attachments Subgroup in July 2020. **The Subgroup has begun its work addressing the Prior Authorization Use Case; will be followed by Claims Use Case in early 2021.**

NOTE: The HHS Unified Agenda announced that an **Attachments NPRM** may be published in September 2020. The NPRM is expected to adopt standards for health care attachments transactions and electronic signature used with the transaction, among other standard and operating rule adoptions.

CAQH CORE Attachments Initiative

Prior Authorization Use Case Scope

Scope: CAQH CORE Attachments Subgroup (PA Use Case)

Exchange Formats
X12 275 and Non-X12 275

Infrastructure
Acknowledgements, Response Times, Processing Modes, System Availability

Data Content
Data Error Handling, File Size, Reassociation

Other
Master Companion Guide Template, Attachment Electronic Policy Access

Additional CAQH CORE Operating Rules that Support Attachments

Covered by CAQH CORE Connectivity Rules*

Method of Transport (Web Services)
SOAP & REST Exchanges

Transport Layer Messaging
HTTP Status/Error Codes, SOAP & REST Metadata, and Message Interaction Patterns

Security, Authentication & Authorization
TLS 1.2 or higher, OAuth 2.0, X.509 Digital Cert

Covered by CAQH CORE Prior Authorization Rules

Structured Data and Codes Sets
Use of LOINC, and
Health Care Decision Reason Codes

Timeframes
Timeframes for requesting attachments when pending a Prior Authorization.
&
Timeframes for communicating a Final Determination on a Prior Authorization once all attachments have been received.

*Updated CAQH CORE Connectivity Rules are currently under development and will be balloted by CAQH CORE Participating Organizations in November 2020.

Spotlight: Pilot and Measurement Initiative

Bob Bowman
CAQH CORE Director

CAQH CORE Pilot & Measurement Initiative

Overview

VISION

Work with industry organizations to measure the impact of existing and potentially new CAQH CORE operating rules.

GOALS

Apply existing and test new potential operating rules that support greater automation.

Support industry organizations' efforts to track and articulate the impact of workflow improvements, using standard metrics.

Ensure that operating rules support industry organizations in varying stages of maturity along the standards (existing and emerging: X12, HL7, etc.) and technology adoption curve.

As appropriate, recommend rules for national implementation to federal bodies (NCVHS and HHS).

CURRENT FOCUS AREAS

Prior Authorization (Ongoing). Measure the impact of prior authorization data content and infrastructure operating rules and potential attachments operating rules on efficiency metrics, including impact on time, provider staff experience, and overall savings.

Quality Measures Reporting (Launching 2021). Test the use of expanded code sets (e.g., LOINC or CPT II Codes) with healthcare claims to convey non-service-related clinical information, such as outcomes measures, to reduce physician reporting burden.

CAQH CORE Pilot & Measurement Initiative

New Pilot Launching 2021: Quality Measure Reporting

Challenge Overview:

As healthcare dollars are increasingly linked to the value and quality of care, quality measure reporting has become a substantial source of physician administrative burden.

- Claims used to request payment for services rendered currently do not capture the *outcomes* of services performed. This often leaves large gaps in reporting requirements and requires physician follow-up to report progress on process measures, outcomes measures and other gaps in care outside of typical workflows.

- Providers and their staff spend approximately 15.1 hours per physician each week on filling those gaps in external quality measure reporting.*

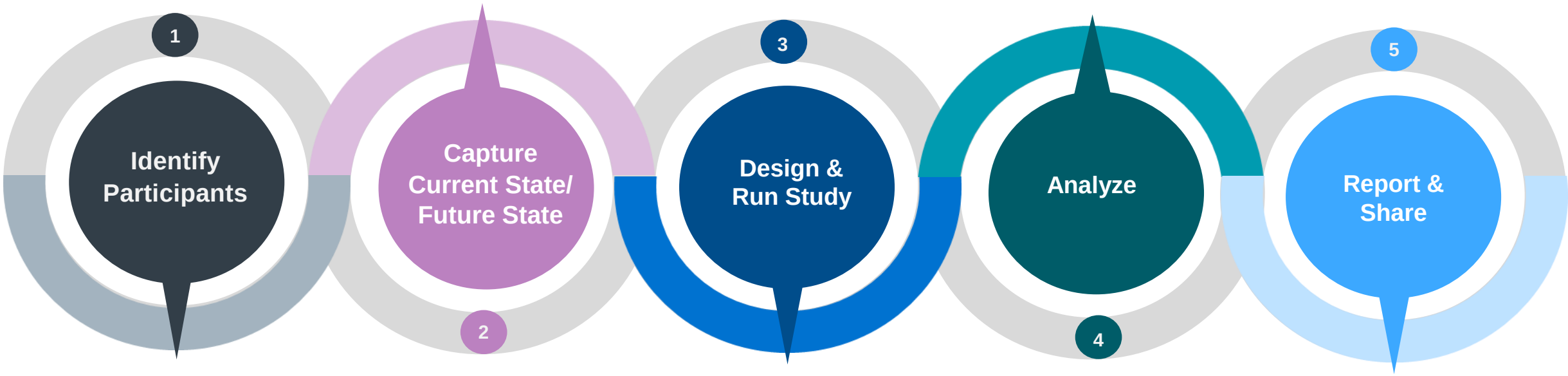
Pilot Description:

Test the use of expanded code sets (e.g., LOINC, SNOMED, CPT Codes, etc.) with healthcare claims to convey non-service-related clinical information, such as outcomes measures, to reduce physician reporting burden.

*Health Affairs, 2016

CAQH CORE Pilot & Measurement Initiative

Engagement Model



Meet with industry organizations to identify Pilot/ Study Grouping (at least two organizations that are trading partners).

Appoint Executive Sponsor & SMEs to work with CAQH CORE & Explorations.

Review of technical specifications to pinpoint where operating rules and standards apply (both current and future).

Interviews/shadowing.

Identify appropriate comparison groups, service categories, priority measures, measurement method, timeline.

Support for organizing baseline information prior to launch.

Data analysis & articulation of key findings.

Recommendations on how to further streamline with operating rules & standards.

Opportunity to share successes with a national audience, via conference/webinar collaborations and potential issue briefs.

Input into suggestions for national implementation, via CAQH CORE's role.

Polling Question #2

Are you interested in participating in the CAQH CORE Quality Measures Reporting Pilot?

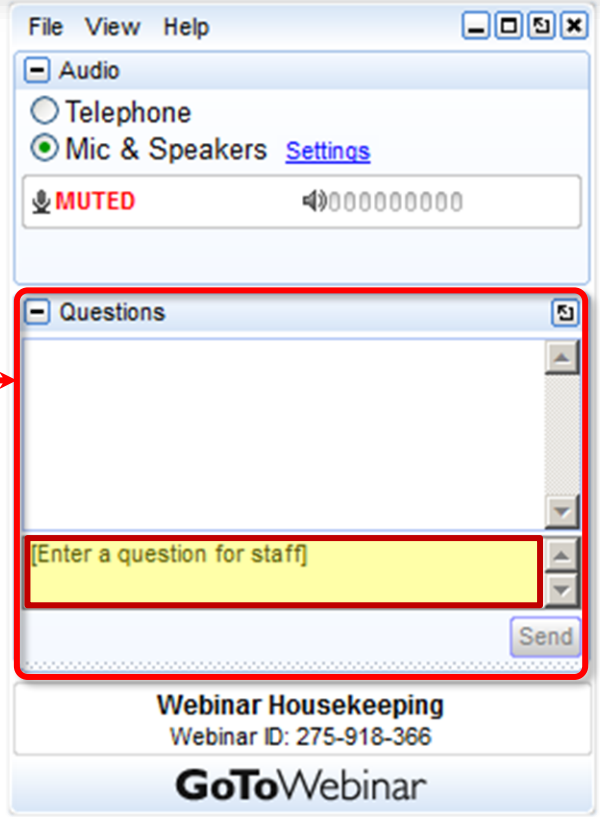
- Yes, I'm interested in getting involved
- Unsure, I would like to learn more about it
- No, I am not interested

Audience Q&A

Please submit your questions

Enter your question into the “Questions” pane in the lower right-hand corner of your screen.

You can also submit questions at any time to CORE@caqh.org



Download a copy of today’s presentation slides at caqh.org/core/events

- Navigate to the Resources section for today’s event to find a PDF version of today’s presentation slides.
- The slides and webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.

CAQH CORE

Upcoming CAQH CORE Education Sessions and Events

CAQH CORE & WEDI Webinar:

HIPAA Standards Exceptions Request Process with CMS

October 15, 2020 2:00-2:30 PM EST

WEDI National Conference

October 16 – October 22, 2020

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.

CAQH CORE

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.