CAQH CORE

CAQH CORE Participant Webinar

Phase IV CAQH CORE 278 Infrastructure Rule Update

November 21, 2019

Logistics

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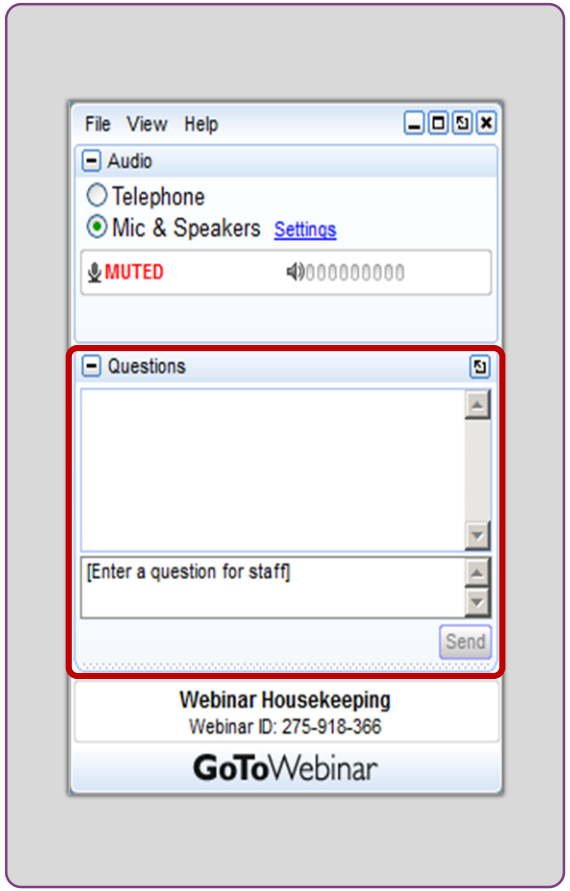
- The slides and the webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.
- Questions can be submitted ***at any time*** using the Questions panel on the GoToWebinar dashboard.



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Session Outline

- CAQH CORE Approach to the Prior Authorization Challenge
- Draft Phase IV CAQH CORE 278 Infrastructure Rule Update Package Overview
  - *Phase IV CAQH CORE 278 Infrastructure Rule Update*
  - *Phase IV CAQH CORE Certification Test Suite Update – 278 Infrastructure Test Scenario*
- Next Steps: Final CAQH CORE Vote
- Q&A

Thank You to Our Speakers

Noam Nahary

Senior Director, HSR

Montefiore Medical Center

Rhonda Starkey

Director, eBusiness Services

Harvard Pilgrim Health Care

Erin Weber

Director

CAQH CORE

Emily TenEyck

Senior Associate

CAQH CORE

CAQH CORE Approach to the Prior Authorization Challenge

Barriers to Industry Adoption of Electronic Prior Authorization

Even when portions of the prior authorization process are conducted electronically, many points along the workflow still drop to manual intervention. Today, 51% of prior authorizations are submitted and responded to manually (phone, fax, email), 36% are partially electronic (portal, interactive voice response system), and 12% are electronic* (5010X217 278 Prior Authorization Request and Response).**

Top Barriers Identified Through CAQH CORE Research

1. There is a lack of consistency in use of data content across industry and electronic discovery of what information is required for an authorization request to be fully adjudicated.

   Engagement with over 100 industry organizations revealed that health plan/vendor use of codes to communicate status, errors, next steps, and additional information needs varies widely. Lack of robust information results in confusion/delays.

2. No federally mandated attachment standard to communicate clinical documentation.

3. Lack of integration between clinical and administrative systems.

   A research supplement for the 2017 CAQH Index found that only 12% of vendors supported electronic prior authorization. For all other electronic transactions, vendor support was between 74% and 91%.

4. Limited availability of vendor products that readily support the standard transaction.

5. State requirements for manual intervention.

6. Lack of understanding of the breadth of the information available in the 5010X217 278 Request and Response, as well as lack of awareness that this standard prior authorization transaction is federally-mandated – particularly among providers.

   Recent industry polling, as well as CAQH CORE environmental scans, reveal that provider organizations may not be aware of the federal prior authorization standard or that if they want to conduct prior authorization using the standard transaction, health plans are required to accept it.

7. Varying levels of maturity along the standards and technology adoption curve, making consistent interoperability a challenge.

***** 2018 CAQH Index.

** Hereafter referred to as “5010X217 278 Request and Response”.

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Groundswell of Support at All Levels to Address Prior Authorization Challenge

Action in the Public Sector

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

Industry Initiatives on Prior Authorization

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

CAQH CORE Vision for Prior Authorization

Operating Rules can Move Industry Towards Optimized Prior Authorization Process

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

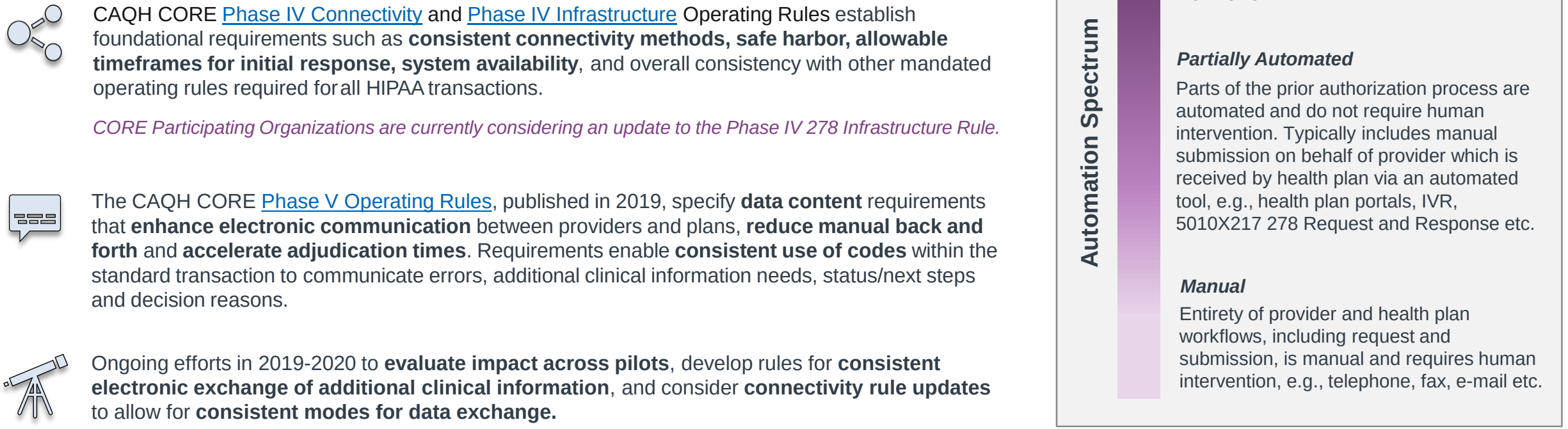
Existing Rules & Current Efforts

CAQH CORE Phase IV Connectivity and Phase IV Infrastructure Operating Rules establish foundational requirements such as **consistent connectivity methods, safe harbor, allowable timeframes for initial response, system availability**, and overall consistency with other mandated operating rules required for all HIPAA transactions.

CORE Participating Organizations are currently considering an update to the Phase IV 278 Infrastructure Rule.

The CAQH CORE Phase V Operating Rules, published in 2019, specify **data content** requirements that **enhance electronic communication** between providers and plans, **reduce manual back and forth** and **accelerate adjudication times**. Requirements enable **consistent use of codes** within the standard transaction to communicate errors, additional clinical information needs, status/next steps and decision reasons.

Ongoing efforts in 2019-2020 to **evaluate impact across pilots**, develop rules for **consistent electronic exchange of additional clinical information**, and consider **connectivity rule updates** to allow for **consistent modes for data exchange.**

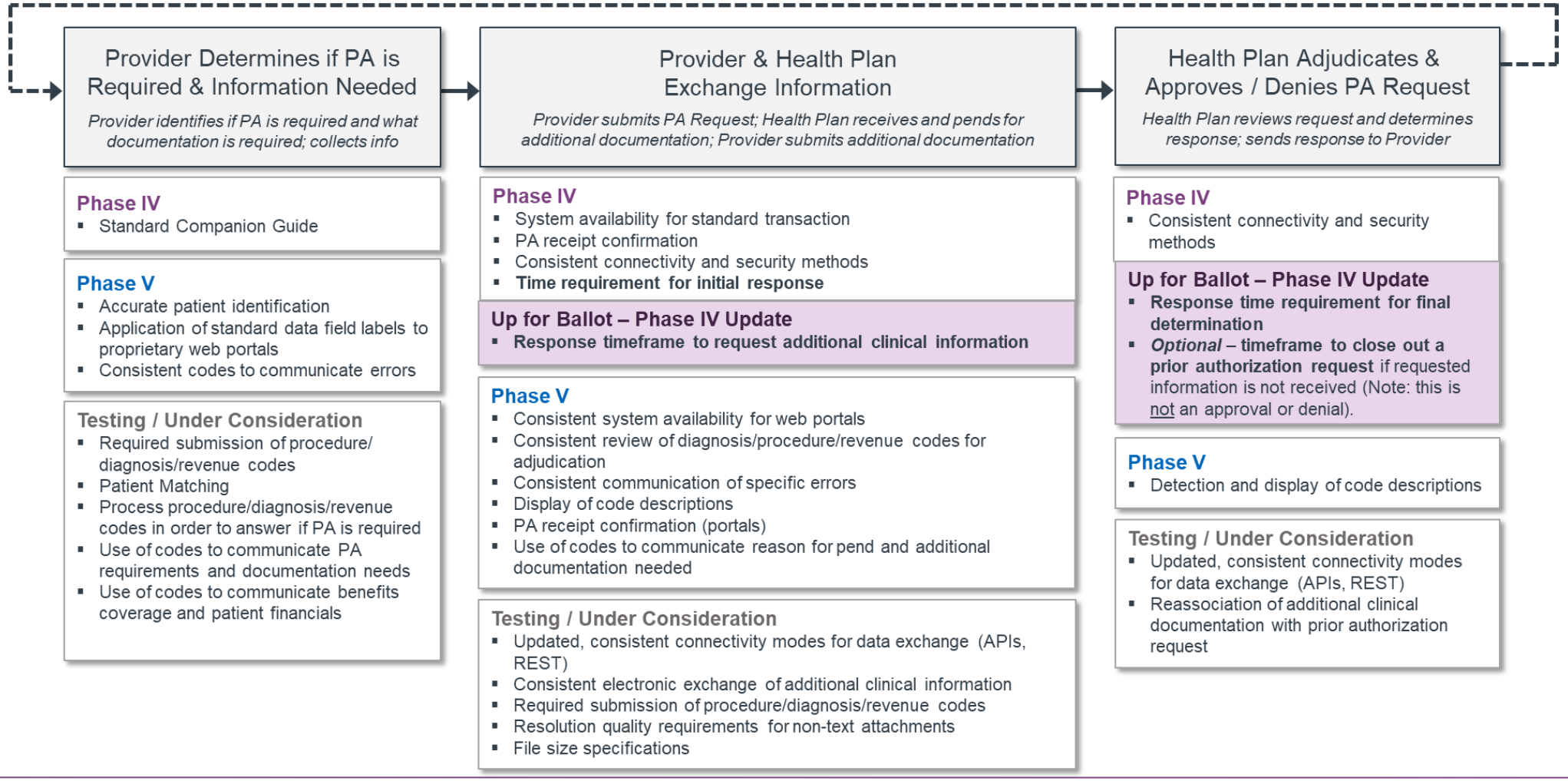


Note: The Department of Health and Human Services (HHS) designated CAQH CORE national operating rule authoring entity for HIPAA administrative transactions.

Status of CAQH CORE Prior Authorization Operating Rules

Updates to Response Time Requirements in Prior Authorization Process

Proposed updates to the Phase IV 278 Infrastructure Rule apply consistent national response time requirements at key stages of the prior authorization process. This enhancement enables shorter adjudication timeframes and more timely delivery of patient care.



Ongoing Interest to Enhance the CAQH CORE Phase IV Operating Rules

Updating the Phase IV Response Time Requirements

Approved by CAQH CORE Participants and published in 2015, the Phase IV CAQH CORE 452 Health Care Services Review – Request for Review and Response (278) Infrastructure Rule response time requirement represented a **first step to setting national expectations for the completion of a prior authorization request and response exchange**. Since then, industry commitment towards improving prior authorization response times has only strengthened.

1. A poll of CAQH CORE Participating Organizations engaged in Phase V prior authorization rule development indicated 73% of participants support pursuing development of additional time requirements, building on the Phase IV 278 Infrastructure Rule.

2. CAQH CORE performed an extensive analysis of national and state-level prior authorization response time requirements. The analysis revealed:
   - Over 30 states have a response time requirement, ranging from **24 hours to 15 business days** and there is a **wide variation in the definition of when the clock starts "ticking"**.
   - Plans and providers that cover patients from multiple states are faced with **varying time requirements**, which can lead to timing disparities in care delivery.
   - Response time requirements exist for **provider submission** of additional information/documentation when a request is pended as well as for **final determination** (approval/denial of PA) by the health plan once all information/documentation has been received.

3. CAQH CORE conducted interviews with a diverse mix of industry experts representing CAQH CORE Participating Organizations to gather more details on the feasibility and impact of the Phase IV Update.

CAQH CORE Phase IV 278 Infrastructure Rule Update

Special Thanks to our Co-chairs

CAQH CORE CO-CHAIRS – PHASE IV RULE UPDATE GROUPS		
Harvard Pilgrim Health Care	Rhonda Starkey, *Manager, Provider eBusiness Operations*	Task Group, Rules/Technical Work Group
Montefiore Medical Center	Noam Nahary, *Senior Director - HSR*	Rules/Technical Work Group
OhioHealth	Randy Gabel, *Senior Director Revenue Cycle*	Task Group

Over 50 CAQH CORE Participating Organizations, consisting of a diverse set of stakeholder types, participated in the Phase IV 278 Infrastructure Rule Update development process.

Timeline for the Phase IV 278 Infrastructure Rule Update

2019

Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec

Phase IV PA Task Group Drafts Updated Requirement & Certification Test Suite

Formal CAQH CORE Voting Process

Phase IV Task Group **Recruitment**	Phase IV Task Group **Launches**	Phase IV Task Group **Chooses** Rule Requirement Options for Update	Phase IV Task Group **Drafts** Updated Rule Requirement & Updated Test Suite	Combined Rules Work Group/ Technical Work Group **Finalizes & Ballots** Updated Rule Requirement & Updated Test Suite	**We are here** **Final CORE Participant Vote**	**CAQH CORE Board Vote**

- Over 50% of voting organizations participated in the Task Group and/or Work Group.
- All Task Group and Work Group calls were co-chaired by CAQH CORE Participating Organizations.
- Quorum and approval levels were exceeded at the Rules/Technical Work Group level to pass the Draft Phase IV 278 Infrastructure Rule Update Package to the Final CAQH CORE Vote.

For the Draft Phase IV Update to be forwarded to the CORE Board Vote:

- **Quorum of 60%** must be achieved.
- **Approval of at least 66.67%** must be exceeded.

The Final CAQH CORE Vote is open from: **Monday, 11/11/2019 until Wednesday, 12/04/19 end of day.**

Overview: *Draft Phase IV CAQH CORE 278 Infrastructure Rule Update*

Overview of Draft Phase IV 278 Infrastructure Rule Update

Limitations of Current PIV 278 Infrastructure Rule: The existing requirements only specify a maximum timeframe for a health plan to return an initial 5010X217 278 Response (batch or real time) to a 5010X217 278 Request, which can be an approval, denial or pend. The requirements DO NOT apply to timeframes for subsequent 5010X217 278 Responses, including what additional documentation is needed to complete the Request to reach a final determination for the prior authorization.

Three key enhancements are included in the Phase IV 278 Infrastructure Rule Update to enable more timely sending and receiving of batch and real time prior authorizations that are pended for additional information/documentation:

1. **Time Requirement for Health Plan to Request Additional Information/ Documentation:** The health plan or its agent has **two business days** to review the 5010X217 278 Request and respond with additional documentation needed to complete the Request.

2. **Time Requirement for Final Determination (Approval/Denial):** The health plan or its agent has **two business days** to review the additional documentation, once it has received all information from the provider, and send a 5010X217 278 Response containing a final determination.

3. **Time Requirement for a 278 Close Out:** The health plan or its agent *may choose* to close out a pended 5010x217 278 Request if the additional information needed to make a final determination is not received from the provider within **15 business days** of communicating what additional information is needed.

NOTE: Each HIPAA-covered entity or its agent must support the *maximum* response time requirements for at least **90 percent** of all 278 Responses returned within a calendar month.

Draft Phase IV 278 Infrastructure Response Time Requirements

Response Time Requirements - Workflow

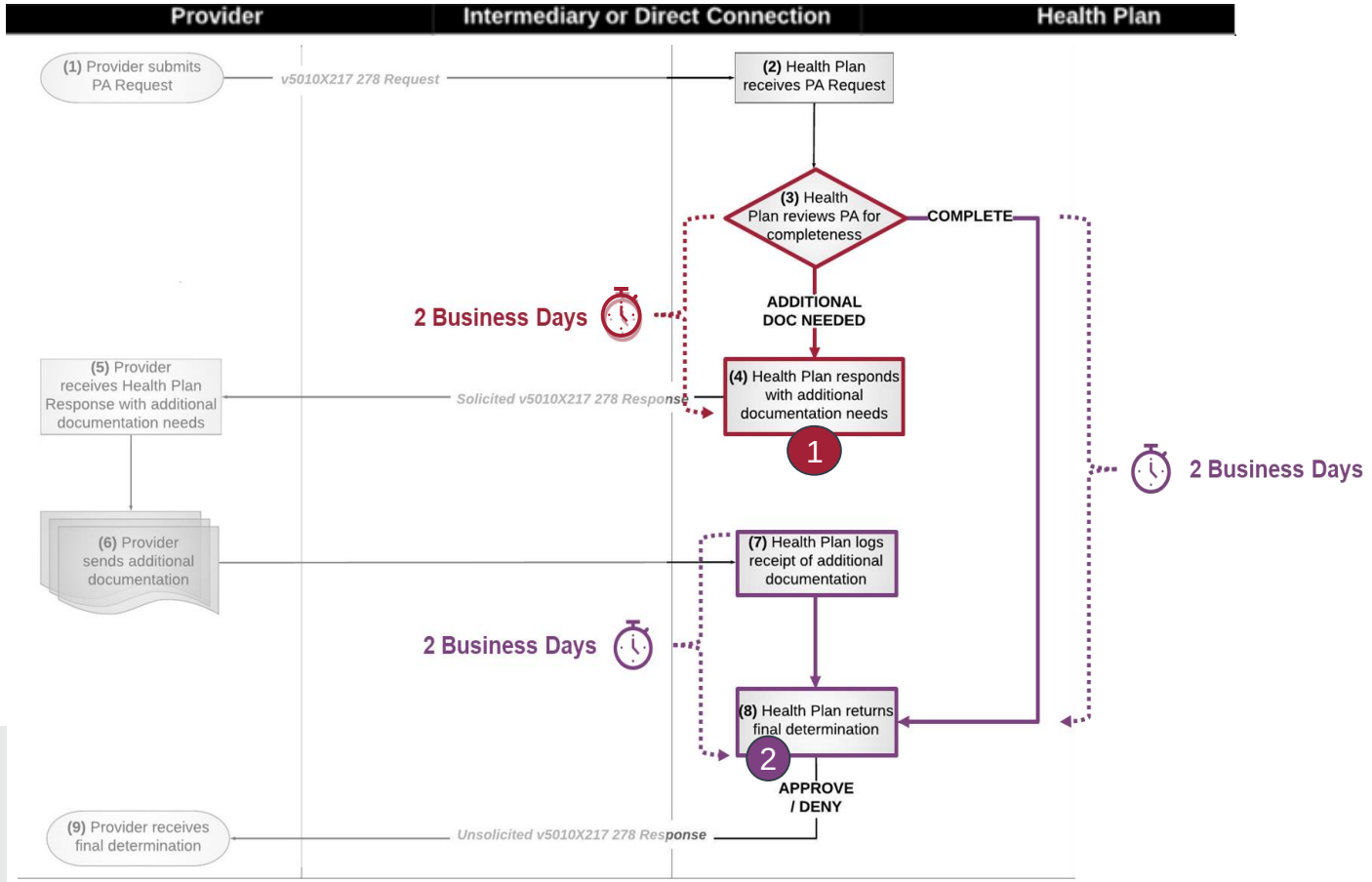
Three new requirements were added to the existing Phase IV 278 Infrastructure Rule Time Requirement* to facilitate more timely sending and receiving of prior authorizations that have been pended for additional information/documentation and to establish a maximum timeframe for final determinations (i.e. approval/denial):

1 Time Requirement for Health Plan to Request Additional Information/ Documentation

- Batch Processing
- Real Time Processing

2 Time Requirement for Health Plan to Send Final Determination to Provider (Approval/Denial)

- Batch Processing
- Real Time Processing
  - Additional documentation needs immediately know vs. unknown timeframes



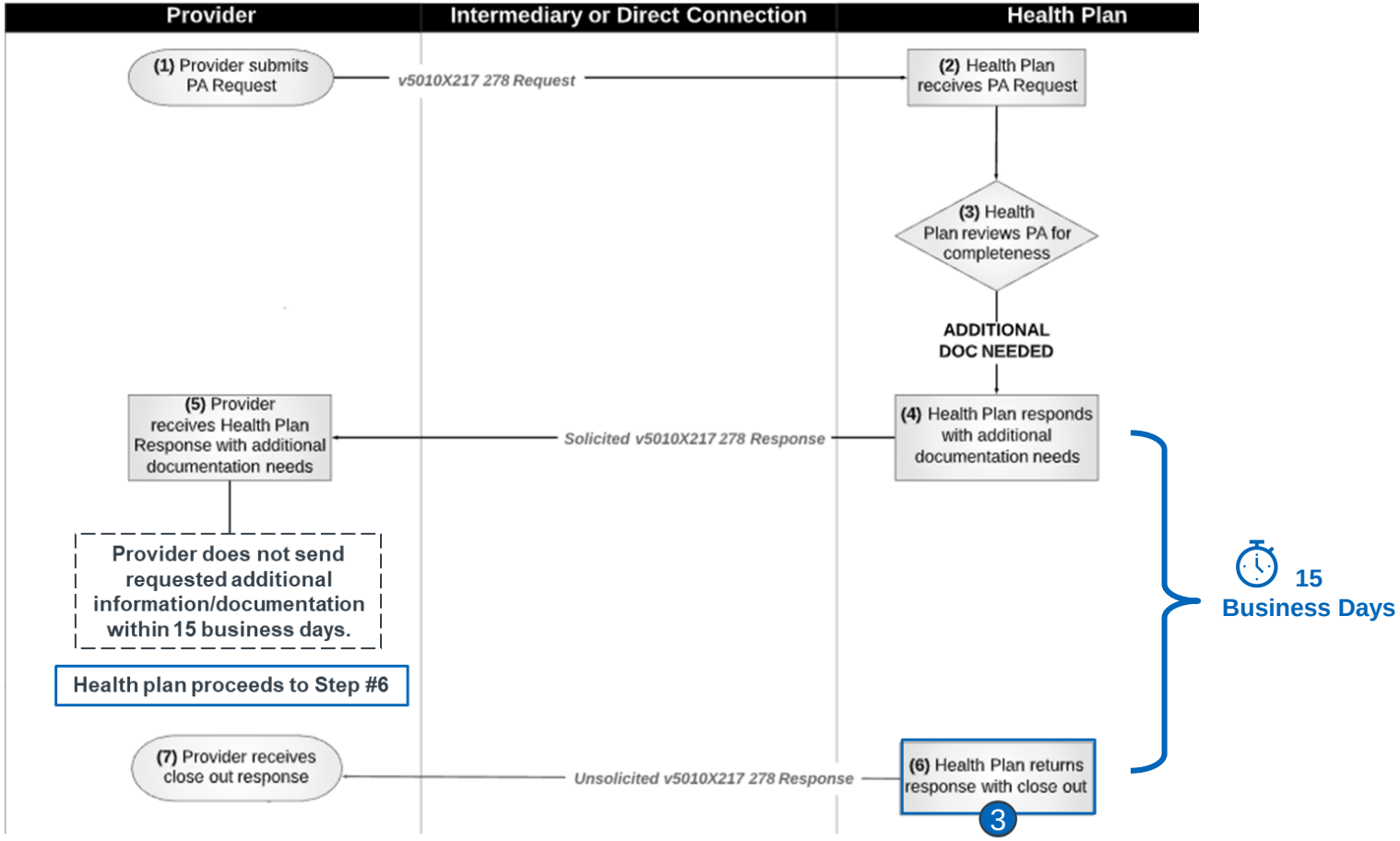
* The existing 278 Initial Response Time Requirement (Batch Mode) was updated to a maximum timeframe of 2 business days to align with the new requirements. The existing 278 Response Time Requirement has a timeframe of 3 business days.

NOTE: There were no adjustments to the existing 278 Initial Response Time Requirement (Real Time) maximum time frame of 20 seconds.

Draft Phase IV 278 Infrastructure Response Time Requirements

Time Requirement to Close Out a 278 Request - Workflow

3 **Time Requirement for Health Plan to Optionally Close Out a 278 Request Due to Lack of Requested Information from Provider**



Draft Phase IV 278 Response Time Requirements Update

Scope Updates

NOTE: The existing Phase IV 278 Infrastructure Rule applies when any HIPAA-covered entity or its agent uses, conducts, or processes the 278 Request and Response transactions.

Updates to Section 3.4: Outside the Scope of this Rule

- Sections 4.4 *Health Care Services Review – Request and Response Real Time Processing Mode Response Time Requirements* and Section 4.5 *Health Care Services Review – Request and Response Batch Processing Mode Response Time Requirements* do not apply to:
  1. Emergent[10] review request and associated responses.
  2. Urgent review request and associated responses.
  3. Review request and associated responses conducted retrospectively (i.e. neither prospectively[11] nor concurrently[12]).
  4. Review request and associated responses undergoing the Appeals Review Process (internal or external).

Urgent, emergent and appeal prior authorization use cases often follow different workflows than non-urgent or non-emergent prior authorization requests because they are typically conducted **retroactively**. Section 3.4: Outside the Scope of this Rule was updated to place these use cases **out of scope** for the Phase IV timeframe requirements only. CAQH CORE Participants will consider the urgent use case for future rule development and/or pilot inclusion.

[10] The ACA prohibits requirements for prior authorization to access emergency services under section 29 CFR 2590.715-2719A, patient protections. In line with federal law, a growing number of state laws set additional limits around prior authorizations for emergency and urgent care.
[11] In the context of this CAQH CORE rule "prospective review" is defined as a utilization review conducted before an admission or a course of treatment including any required preauthorization or precertification, including extensions of outpatient treatment.
[12] In the context of this CAQH CORE rule "concurrent review" is defined as a utilization review conducted during a patient's hospital stay or course of inpatient treatment.

Deep Dive: *Draft Phase IV CAQH CORE 278 Infrastructure Rule Update*

1. **Batch Processing Mode**
   - *Time Requirement for Requesting Additional Information/Documentation*
   - *Time Requirement for Final Determination*

2. Real Time Processing Mode
   - *Time Requirement for Requesting Additional Information/ Documentation – When Known vs. When Unknown at Time of Request*
   - *Time Requirement for Final Determination*

3. *Time Requirement to Optionally Close Out a 278 Request*

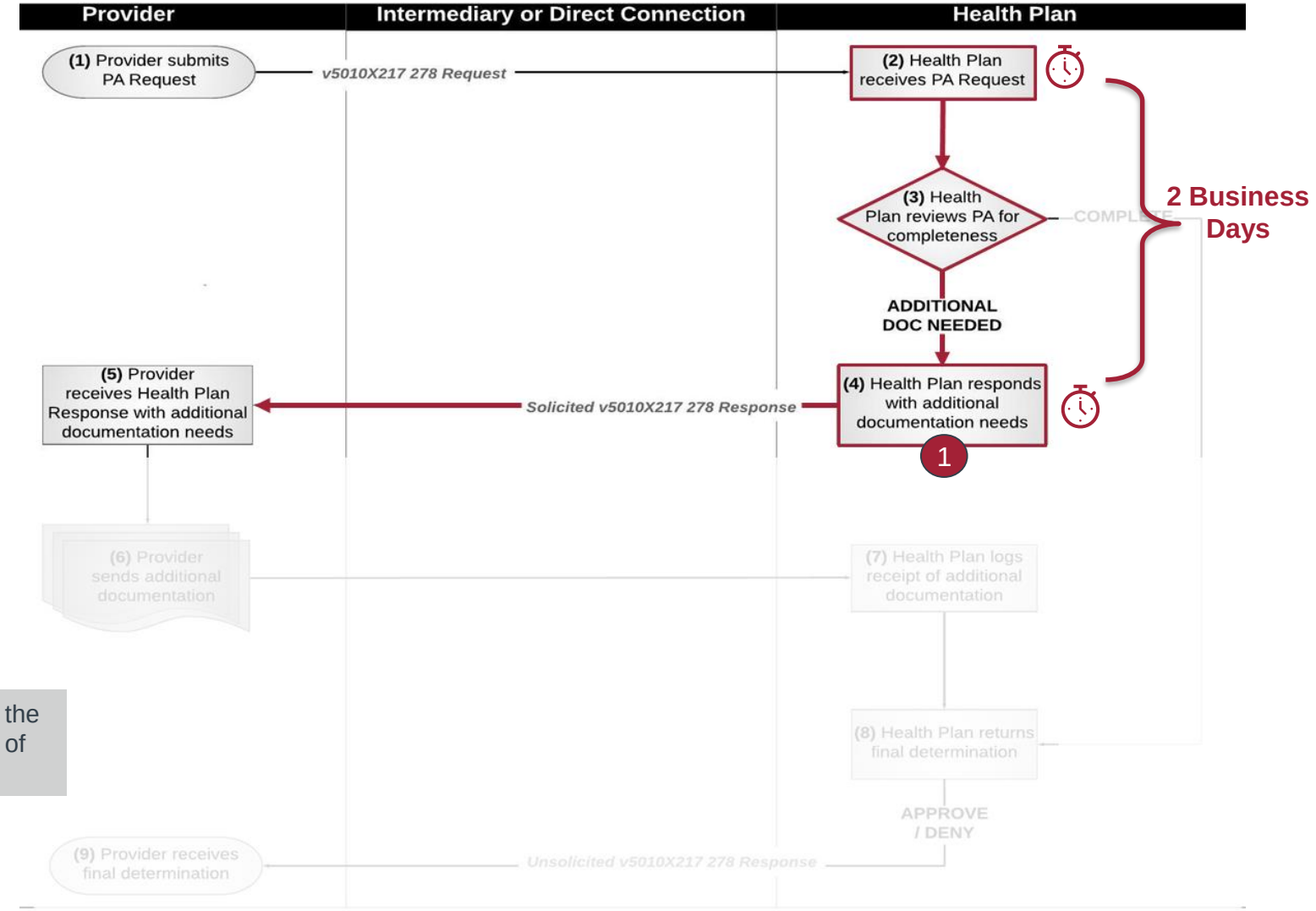
1 Draft Health Plan Response Time Requirement: Health Plan Request for Additional Information/Documentation (Batch Mode)

1

Section 4.4.3: *Time Requirement for Requesting Additional Information/ Documentation (Batch Mode)*

"When a health plan or its agent pends an ASC X12N v5010 278 Request due to a need for additional information/ documentation from the provider or its agent, a health plan or its agent must make available an ASC X12N v5010 278 Response specifying what additional information/documentation is needed to reach a final determination within **two business days** following submission of the ASC X12N v5010 278 Request."

NOTE: Each HIPAA-covered entity or its agent must support the *maximum* response time requirement for at least **90 percent** of all 278 Responses returned within a calendar month.



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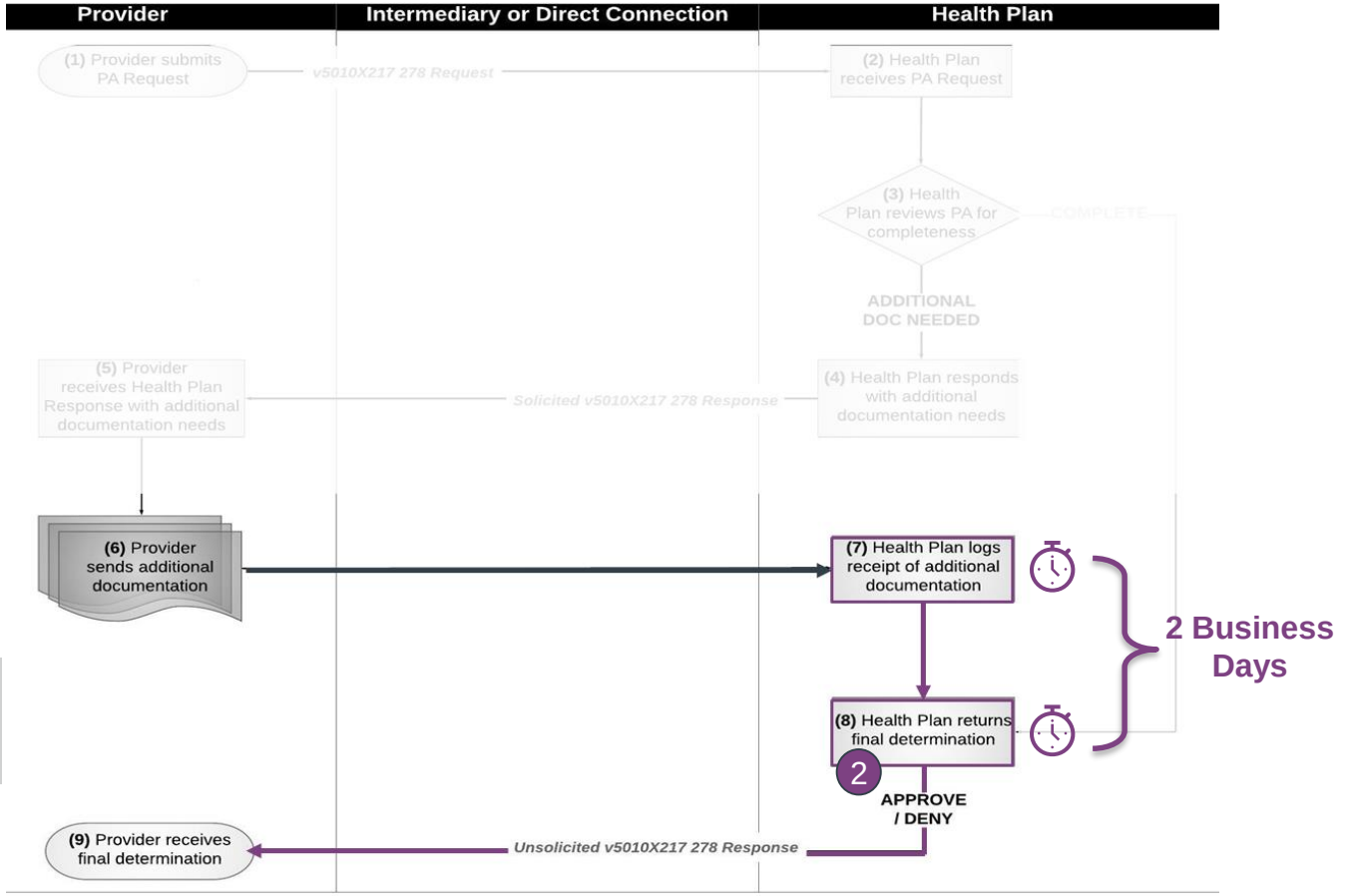
2 Draft Phase IV Time Requirement: Health Plan Sends Final Determination to Provider (Approval/Denial – Batch Mode)

2

Section 4.4.4: *Time Requirement for Final Determination (Batch Mode)*

"Once a health plan or its agent receives a complete prior authorization request with all information and documentation necessary, including peer to peer medical reviews conducted prior to a final determination,[17] the health plan or its agent must return a solicited or unsolicited ASC X12N v5010 278 Response containing an approval or denial within **two business days** following receipt of the completed prior authorization request."

NOTE: Each HIPAA-covered entity or its agent must support the *maximum* response time requirement for at least **90 percent** of all 278 Responses returned within a calendar month.



[17] Peer to peer medical reviews conducted after the final determination are part of the appeals process, which is out of scope for this rule, per Section 3.4 *Outside the Scope of this Rule.*

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Deep Dive: *Draft Phase IV CAQH CORE 278 Infrastructure Rule Update*

1. Batch Processing Mode
   - *ASC X12N v5010 278 Initial Response Time Requirement*
   - *Time Requirement for Requesting Additional Information/Documentation*
   - *Time Requirement for Final Determination*

2. **Real Time Processing Mode**
   - *Time Requirement for Requesting Additional Information/ Documentation – When Known vs. When Unknown at Time of Request*
   - *Time Requirement for Final Determination*

3. *Time Requirement to Optionally Close Out a 278 Request*

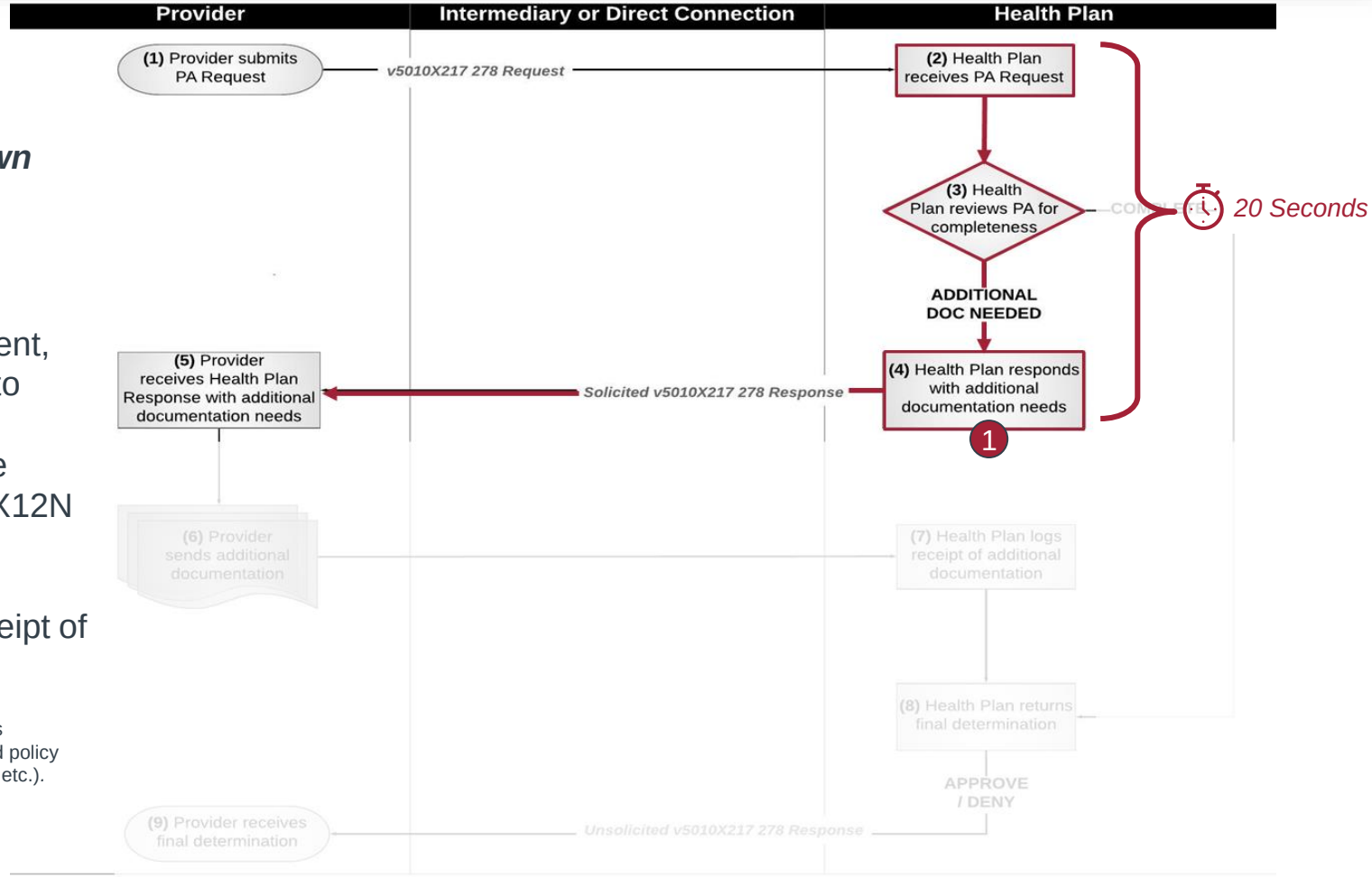
1 Draft Health Plan Response Time Requirement: Health Plan Request for Additional Information/ Documentation when Known (Real Time Mode)

1

Section 4.5.2: *Time Requirement for Requesting Additional Information/Documentation when Known at Time of Request (Real Time Mode)*

"When a health plan or its agent pends an ASC X12N v5010 278 Request due to a need for additional information/documentation from the provider or its agent, and additional information/documentation necessary to complete the ASC X12N v5010 278 Request is immediately known by the health plan or its agent, the health plan or its agent must return the pended ASC X12N v5010 278 Response specifying what additional information/documentation is needed to reach a final determination within **20 seconds** from the time of receipt of the ASC X12Nv5010 278 Request.[18]"

[18] A health plan or its agent must communicate what additional information/documentation is needed to complete the PA request in real time if the health plan or its agent has a published policy that references the required documentation (e.g. companion guide, provider billing manuals, etc.).



NOTES: (1) The Draft Phase IV 278 Infrastructure Rule Update DOES NOT require a health plan or its agent to return a 278 Response to a provider using real time processing mode, if it does not already utilize real time processing **(2)** Each HIPAA-covered entity or its agent must support the *maximum* response time requirement for at least **90 percent** of all 278 Responses returned within a calendar month.

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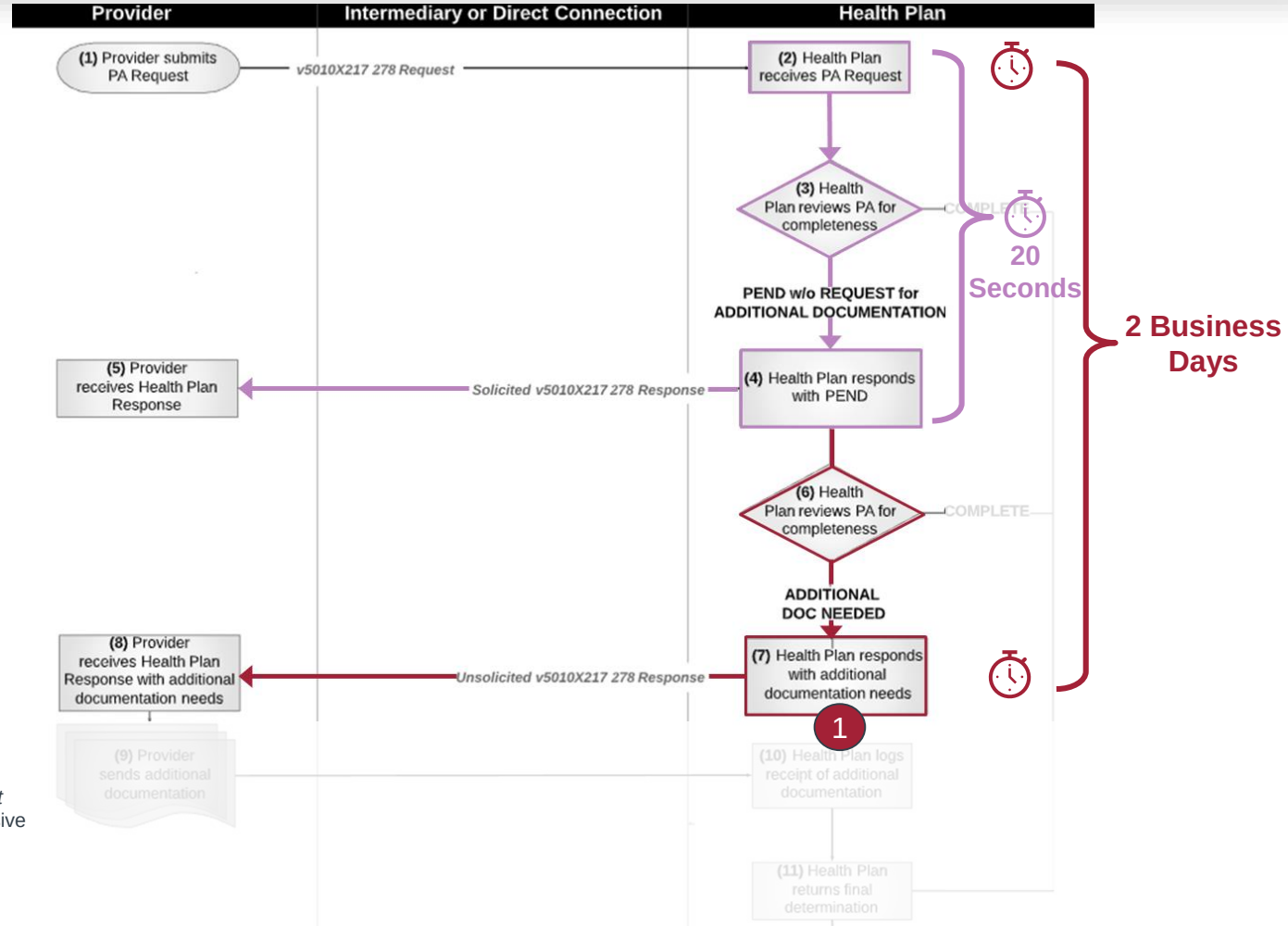
1 Draft Health Plan Response Time Requirement: Health Plan Request for Additional Information/Documentation when Unknown (Real Time Mode)

1

Section 4.5.3: *Time Requirement for Requesting Additional Information/Documentation when Unknown at Time of Request (Real Time Mode)*

"After a health plan or its agent has pended the initial ASC X12N v5010 278 Response within 20 seconds from the time of submission due to a need for additional information/documentation, a health plan or its agent must return an unsolicited ASC X12N v5010 278 Response specifying what additional information/documentation is needed to reach a final determination within **two business days** of the initial ASC X12N v5010 278 Request.[19]"



[19] An unsolicited ASC X12N v5010 278 Response specifying what additional information/documentation is needed to reach a final determination is only required in cases when the health plan or its agent did not immediately know the information/documentation necessary and return that information with a solicited ASC X12N v4010 278 Response within 20 seconds. Therefore, Section 4.5.2 *Time Requirement for Requesting Additional Information/Documentation when Known at Time of Request* and Section 4.5.3 *Time Requirement for Requesting Additional Information/Documentation when Unknown at Time of Request* are mutually exclusive of one another.

NOTES: (1) The Draft Phase IV 278 Infrastructure Rule Update DOES NOT require a health plan or its agent to return a 278 Response to a provider using real time processing mode, if it does not already utilize real time processing **(2)** Each HIPAA-covered entity or its agent must support the *maximum* response time requirement for at least **90 percent** of all 278 Responses returned within a calendar month.

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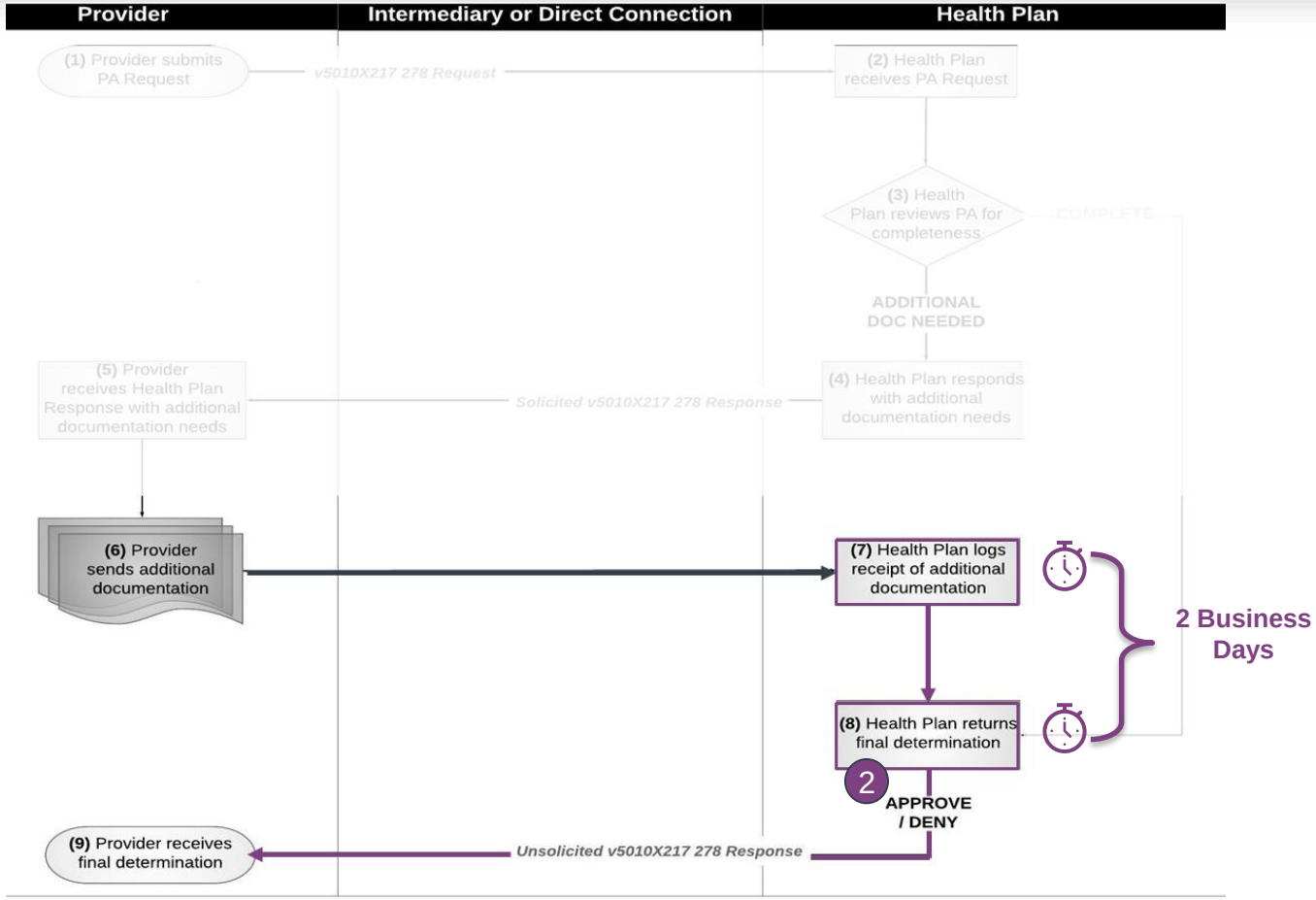
2 Draft Phase IV Time Requirement: Health Plan Sends Final Determination to Provider after Initial Pend (Approval/Denial – Real Time Mode)

2

Section 4.5.4: *Time Requirement for Final Determination after an Initial Pended Response (Real Time Mode)*

"After a health plan or its agent has sent an initial pended ASC X12N v5010 278 Response via Real Time Processing Mode, whether within 20 seconds in scenarios when additional information/documentation is immediately known or within two business days when additional information/documentation is not immediately known, a final determination must be sent via an unsolicited ASC X12N v5010 278 Response. Once a health plan or its agent receives a complete prior authorization request with all information and documentation necessary, including peer to peer medical reviews conducted prior to the final determination, the health plan or its agent must return an unsolicited ASC X12N v5010 278 Response containing an approval or denial within **two business day** following receipt of the complete prior authorization request."



[19] Peer to peer medical reviews conducted after a final determination are part of the appeals process, which is out of scope for this rule, per Section 3.4 Outside the Scope of this Rule.

NOTES: (1) The Draft Phase IV 278 Infrastructure Rule Update DOES NOT require a health plan or its agent to return a 278 Response to a provider using real time processing mode, if it does not already utilize real time processing **(2)** Each HIPAA-covered entity or its agent must support the *maximum* response time requirement for at least **90 percent** of all 278 Responses returned within a calendar month.

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Deep Dive: *Draft Phase IV CAQH CORE 278 Infrastructure Rule Update*

1. Batch Processing Mode
   - *ASC X12N v5010 278 Initial Response Time Requirement*
   - *Time Requirement for Requesting Additional Information/Documentation*
   - *Time Requirement for Final Determination*

2. Real Time Processing Mode
   - *Time Requirement for Requesting Additional Information/ Documentation – When Known vs. When Unknown at Time of Request*
   - *Time Requirement for Final Determination*

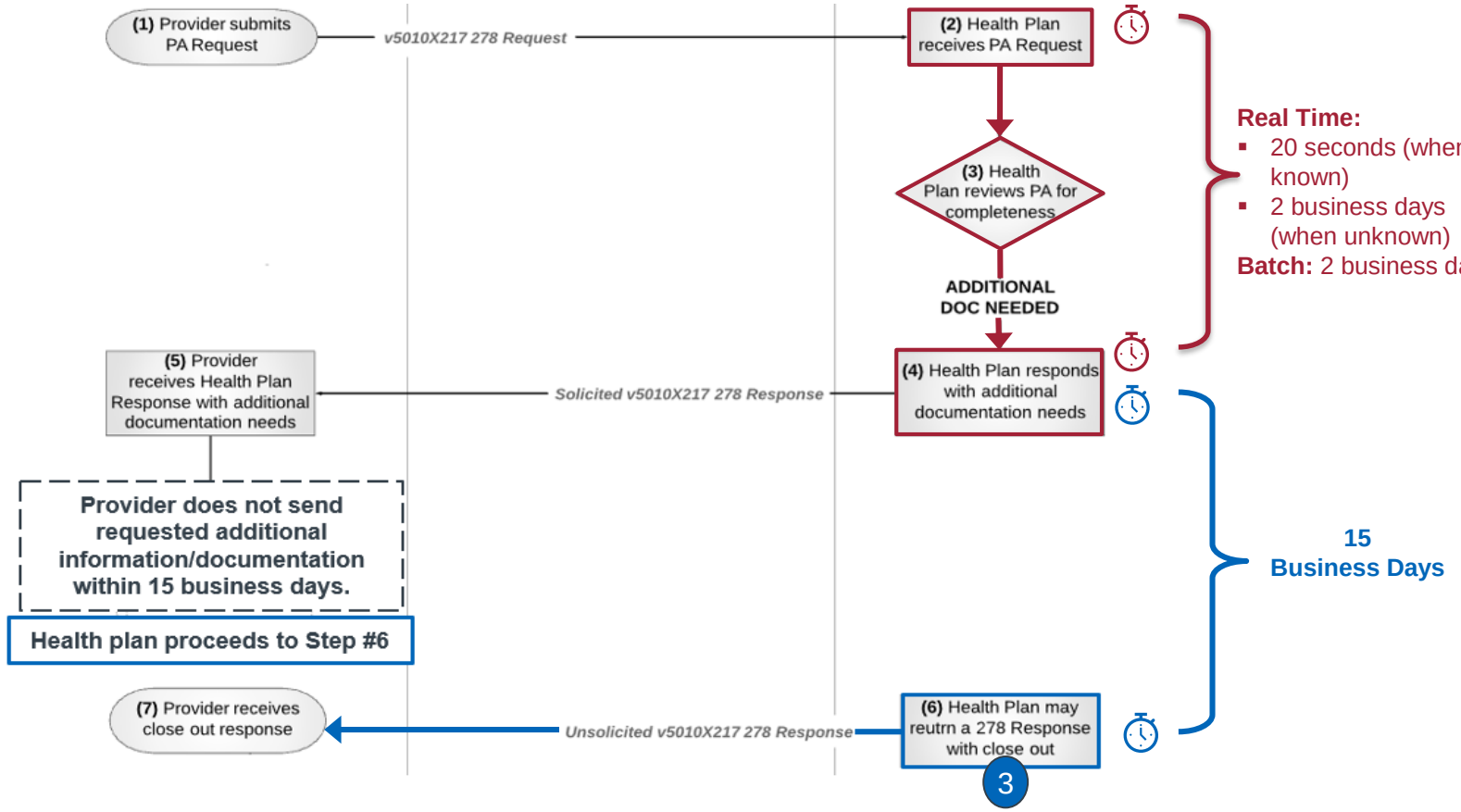
3. Time Requirement to Optionally Close Out a 278 Request

3 Draft Optional Close Out Response Time Requirement

3

Section 4.6.1: Time Requirement for an Optional ASC X12N v5010 278 Response Close Out Due to a Lack of Requested Information/ Documentation

"A health plan or its agent may choose to close out an ASC X12N v5010 278 Request if a provider or its agent does not respond to a request for additional information/ documentation from the health plan or its agent after a minimum of **15 business days** following the return of a pended ASC X12N v5010 278 Response requesting the additional information/ documentation necessary to adjudicate the pended ASC X12N v5010 278 Request."



[21] A health plan or its agent should specify the processes for the close out and resubmission/appeal of an ASC X12N v5010 278 Response and any other provider notification in their Companion Guide, provider billing manual, or other organization policy manual to ensure business and technical processes are clearly articulated to its trading partner.

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Summary of Draft Phase IV 278 Infrastructure Rule Update

Three key enhancements are included in the Phase IV 278 Infrastructure Rule Update to enable more timely sending and receiving of batch and real time prior authorizations that are pended for additional information/documentation:

1. **Time Requirement for Health Plan to Request Additional Information/ Documentation:** The health plan or its agent has **two business days** to review the 5010X217 278 Request and respond with additional documentation needed to complete the Request.

2. **Time Requirement for Final Determination (Approval/Denial):** The health plan or its agent has **two business days** to review the additional documentation, once it has received all information from the provider, and send a 5010X217 278 Response containing a final determination.

3. **Time Requirement for a 278 Close Out:** The health plan or its agent *may choose* to close out a pended 5010x217 278 Request if the additional information needed to make a final determination is not received from the provider within **15 business days** of communicating what additional information is needed.

NOTE: Each HIPAA-covered entity or its agent must support the *maximum* response time requirements for at least **90 percent** of all 278 Responses returned within a calendar month.

Phase IV CAQH CORE Certification Test Suite Update – 278 Infrastructure Test Scenario

CORE Certification – Industry Gold Standard

Developed by CAQH CORE Participants for Industry to Promote Adoption

The CORE Certification program was developed by **CAQH CORE Participants,** including health plans, providers, vendors, government agencies and associations, to promote industry-wide adoption of operating rules for the HIPAA-covered administrative transactions.

CORE Certification provides **assurance** to organizations that their IT systems/products conform to operating rules and deliver value afforded by the rules.

CORE Certification provides an end-to-end testing suite that is **robust**, **comprehensive** and **complementary** across all operating rules.

370

certifications have been awarded.

aetna

Harvard Pilgrim HealthCare

MAYO CLINIC

CHANGE HEALTHCARE

DELTA DENTAL

Georgia Department of Community Health

Department of Veterans Affairs

CVS caremark

athenahealth

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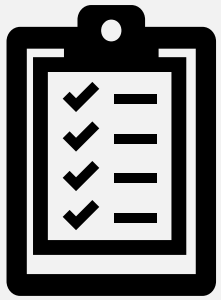
Phase IV CAQH CORE Certification Test Suite Update

278 Infrastructure Test Scenario



The CAQH CORE Certification Test Suite defines testing and evaluation criteria for organizations seeking to demonstrate that they have successfully implemented operating rule requirements.

Phase IV CAQH CORE Certification Test Suite:

- The Phase IV CAQH CORE Certification Test Suite meets industry needs for certifying organizations conducting the v5010X217 278 transaction with specific infrastructure rules such as connectivity, processing modes, response times, acknowledgments, system availability, and companion guide.

Update to 278 Infrastructure Test Scenario:

- The Phase IV CAQH CORE Certification Test Suite – 278 Infrastructure Test Scenario has been updated to include certification testing requirements for maximum response times for final determination.

Certification Testing for these updates will be available January 2020.

Next Steps:
CAQH CORE Participant Vote

Final Vote for Full CAQH CORE Voting Participating Organizations

Due by Wednesday 12/04/19

Vote Overview:

- ❑ **Who:** Primary representatives and contacts engaged in Phase IV Rule Update Development from Full CAQH CORE Voting Participating Organizations (i.e. entities that create, transmit, or use healthcare administrative data) in good standing received the Official Final CORE Vote Ballot.

- ❑ **What:** For the Draft Phase IV CAQH CORE 278 Infrastructure Rule Update Package being balloted, organizations will be asked to select “Support", “Do Not Support", or "Abstain" to indicate whether or not your organization **supports the Rule Package**:
  - Draft Phase IV CAQH CORE 278 Infrastructure Rule Update
  - Draft Phase IV CAQH CORE Certification Test Suite Update – 278 Infrastructure Test Scenario

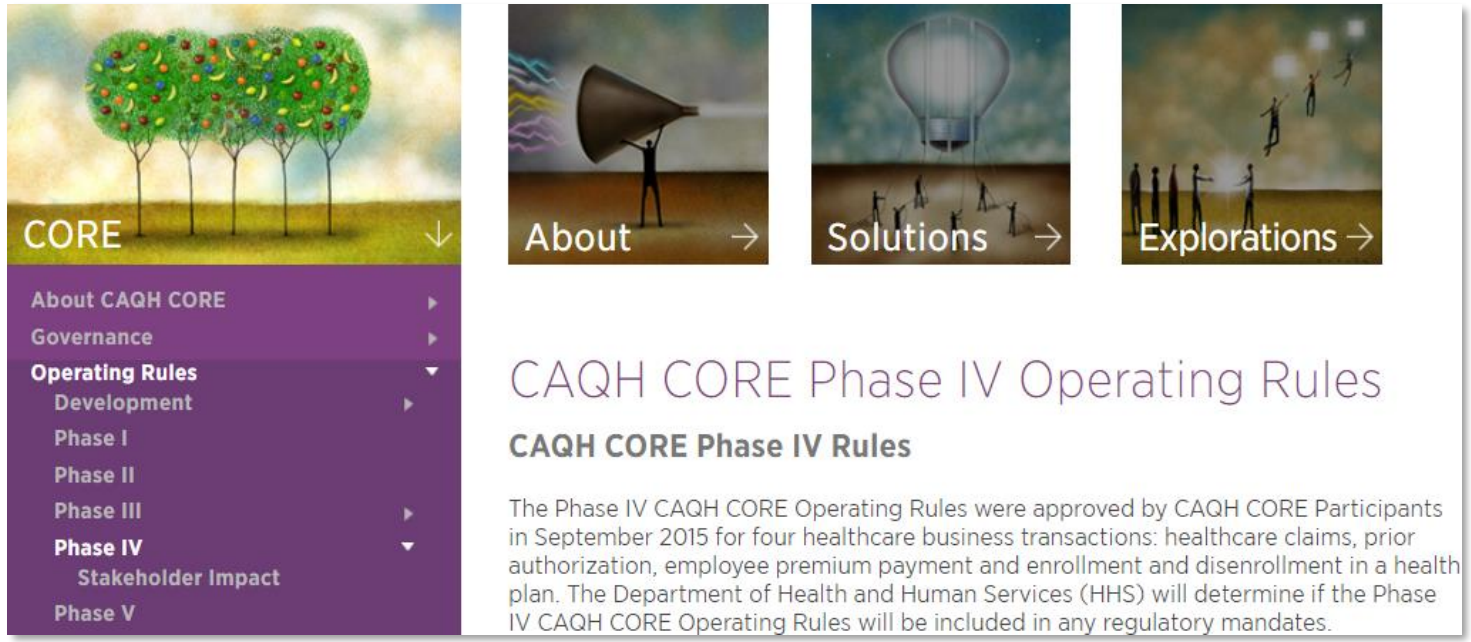
- ❑ **When:** Voting representatives from each voting participating organization in good standing received the Official Final CORE Vote Ballot **Monday 11/11/19.** The ballot will be open until **close of business Wednesday 12/04/19.**

How to Complete your Organization’s Ballot:

- Submit your organization’s Final CAQH CORE Vote via the online submission **link** **by close of business Wednesday 12/04/19.**
- Participants should reference the *Draft Phase IV 278 Infrastructure Rule Update Package* (i.e. rule and certification test suite update) and the Two-page Summary of the *Draft Phase IV 278 Infrastructure Rule Update Package* while completing the ballot.
- The vote is to be submitted by CAQH CORE Participants only; please coordinate to submit one response for your organization.
- The results of the Final CAQH CORE Vote will be shared via email following the balloting period.
- NOTE: In accordance with CAQH CORE Policy, all responses will be kept strictly confidential and will be reported in aggregate.

If you have any questions please contact us at CORE@CAQH.org.

Additional Resources



NOTE: The CAQH CORE Calendar, available to all CAQH CORE Participants, contains all materials developed at the Task Group and Work Group Levels.

- Two-page Summary: Draft Phase IV 278 Infrastructure Rule Update
- Draft Rule Update: Draft Phase IV CAQH CORE 278 Infrastructure Rule Update
- Draft Certification Test Suite Update: Draft Phase IV CAQH CORE Certification Test Suite – 278 Infrastructure Test Scenario
- Final CAQH CORE Vote: Submission Link

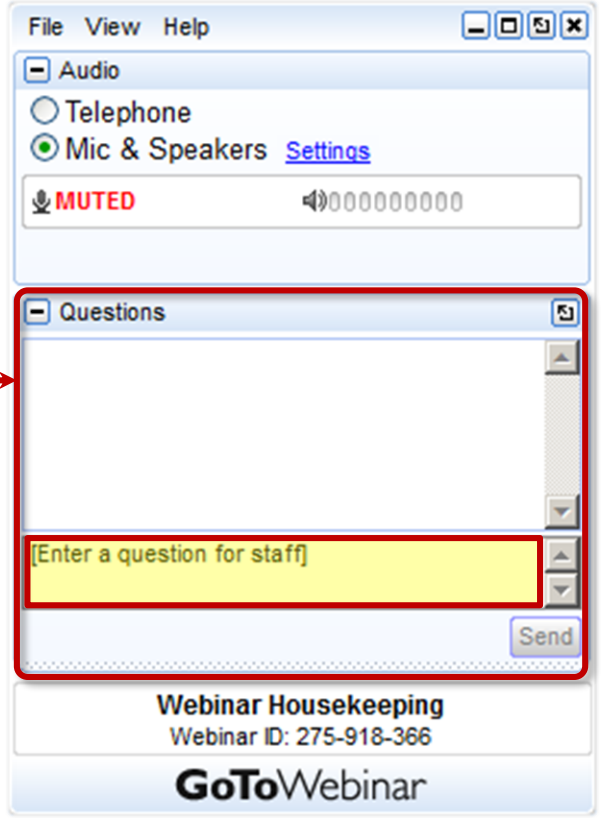
Please contact CAQH CORE Staff & Co-Chairs with any questions or concerns: CORE@CAQH.org

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



- The slides and webinar recording will be emailed to attendees and registrants in the next 1-2 business days.

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: List of Voting Participating Organizations*

Voting Participating Organizations are entities that create, transmit, or use healthcare administrative data.

- AccuReg Inc.
- Aetna
- Allscripts
- Ameritas Life Insurance Corp.
- Anthem Inc. / AIM Specialty Health
- Arizona Health Care Cost Containment Sys
- athenahealth
- AultCare
- Availity, LLC
- Blue Cross Blue Shield of Michigan
- Blue Cross Blue Shield of North Carolina
- Blue Cross Blue Shield of Tennessee
- California Dept of Health Care Services
- CareFirst BlueCross BlueShield
- Centers for Medicare and Medicaid (CMS)
- Cerner/Healthcare Data Exchange
- Change Healthcare
- CHRISTUS Health
- CIGNA
- Conduent
- CSRA Inc.
- DST Health Solutions
- DXC Technology
- Edifecs
- Excellus BlueCross BlueShield
- Experian
- Federal Reserve Bank of Atlanta
- Florida Agency for Health Care Administration
- Government Employees Health Association
- Harvard Pilgrim Healthcare
- Health Care Service Corporation
- Health Net Inc. / Centene
- Health Plan of San Joaquin
- HEALTHeNET
- Highmark, Inc.
- HMS
- Horizon BCBS of New Jersey
- Humana
- InstaMed
- Jopari Solutions
- Kaiser Permanente
- Laboratory Corporation of America
- Louisiana Medicaid – Molina
- Marshfield Clinic / Security Health Plan
- Mayo Clinic
- Medical Mutual of Ohio, Inc.
- Michigan Department of Community Health
- Minnesota Department of Health
- Missouri HealthNet Division
- Mobility Medical, Inc.
- Montefiore Medical Center
- New Mexico Cancer Center
- NextGen Healthcare Information Systems
- North Dakota Medicaid
- OhioHealth
- OODA Health
- Oregon Dept of Human Services / Health Authority
- Ortho NorthEast (ONE)
- PaySpan
- Pennsylvania Department of Public Welfare
- PNC Bank
- Tampa General Hospital
- The SSI Group, Inc.
- TIBCO Software, Inc.
- TransUnion
- TrialCard
- TRICARE
- TriZetto Corporation, A Cognizant Company
- Tufts Health Plan
- United States Department of Veteran Affairs
- UnitedHealth Group / Optum / Unitedhealthcare
- Virginia Mason Medical Center
- Waystar
- Wells Fargo

*Only voting participating organizations in good standing (current on 2019 CORE participant fees) are eligible to vote in the Final CORE Vote.

CAQH CORE Prior Authorization

Suitability Evaluation Criteria

The CAQH CORE Board Evaluation Criteria (which include the CAQH CORE Guiding Principles) apply to all CORE rule development. For Prior Authorization rule development, PA-specific criteria are also used. The PA-specific criteria were developed by the CAQH CORE PA Advisory Group.

#	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.

#	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.

#	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.