CAQH CORE℠

Provider Perspectives: Implementation of CMS 0057-F Prior Authorization Requirements

January 23, 2025

Webinar Logistics

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  - All attendees and registrants will receive a link to the recording after the webinar.
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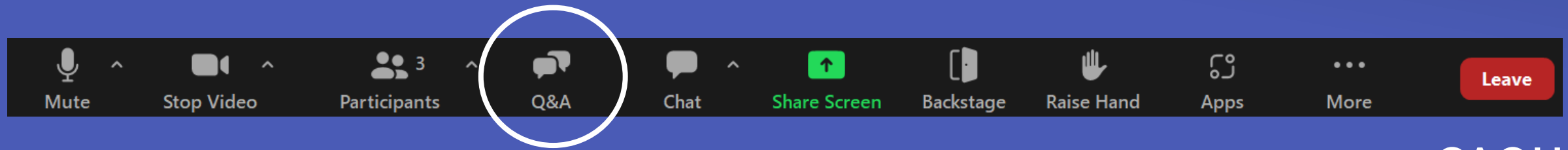


CAQH CORE℠

January 2025

- CORE & NAHAM Overviews
- Opportunity and State of Implementation
- Key Considerations for Implementation
- Get Involved & Next Steps

CAQH℠

SPEAKER INTRODUCTION

Michelle Fox

Michelle Fox is the Director of Revenue Operations/Patient Access at Health First in Brevard County, FL. She is responsible for directing the revenue cycle front end operations of the Patient Access department supporting four not for profit hospitals, fifteen diagnostic centers, and a 300+ employed physician group. Michelle is nationally certified in Healthcare Access Management.

She is a Past President of NAHAM and is currently serving as the NAHAM Ambassador to CORE. She holds a Bachelor of Health Science Education, a Master of Hospital Administration and a Master of Business Administration from the University of Florida as well as a Doctor of Business Administration from Apollos University.

CORE & NAHAM Overviews

CORE accelerates automation and interoperability

10

CORE Operating Rules Mandated Under HIPAA

CORE is the **trusted, independent author of operating rules**, offering both mandated and voluntary rule sets.

$46B

Annual Industry Cost Savings Attributed to CORE Operating Rules

Using CAQH Index® data, CAQH Insights identified annual savings of $26 billion for providers and $20 billion for health plans resulting from implementation of the mandated CORE Operating Rules.

100+

Multi-stakeholder Participating Organizations

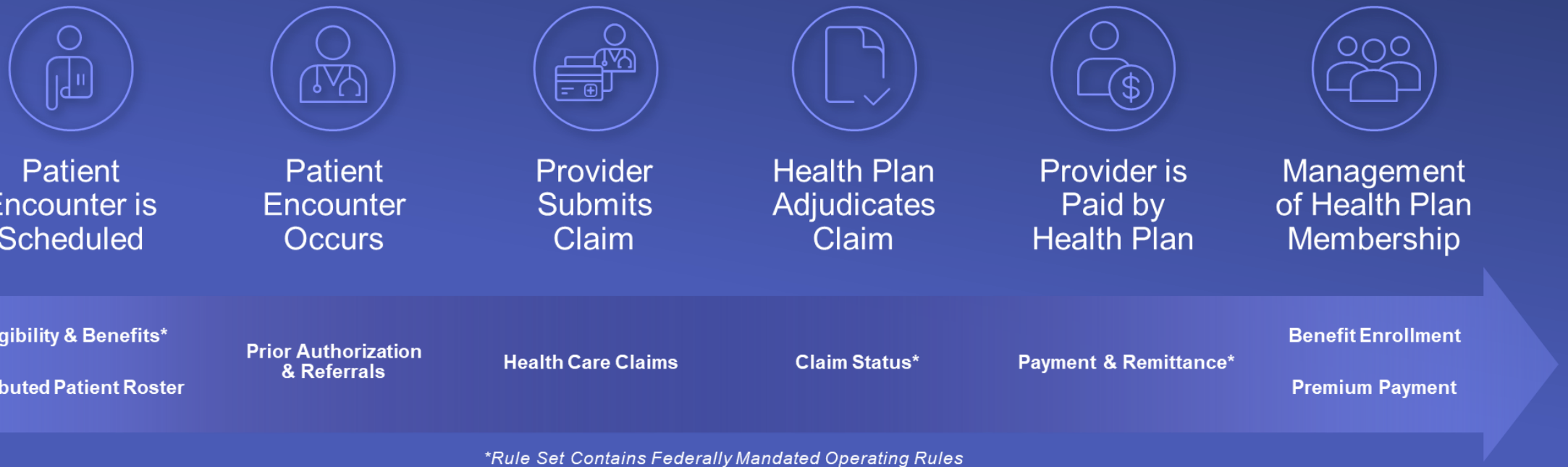
From small provider organizations, to national health plans, CORE has the **unique ability to bring diverse industry stakeholders to the table** to tackle complex administrative problems together.

Committee on **O**perating **R**ules for Information **E**xchange

CORE OPERATING RULES SUPPORT KEY HEALTHCARE ADMINISTRATIVE FUNCTIONS

CORE facilitates an industry-driven, consensus-based process to advance interoperability

Operating Rule Definition: The "necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications."



Rule Set Contains Federally Mandated Operating Rules

WHO ARE WE?

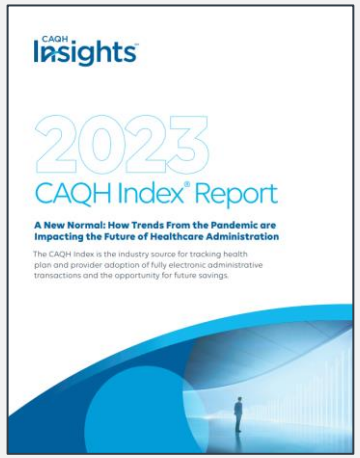
National Association of Healthcare Access Management (NAHAM)

NAHAM is the preeminent association for patient access professionals

- Establish best practices and subject matter expertise
- Provide an array of networking, education, and certification opportunities
- Enable our members to influence and promote high quality delivery of Patient Access Services

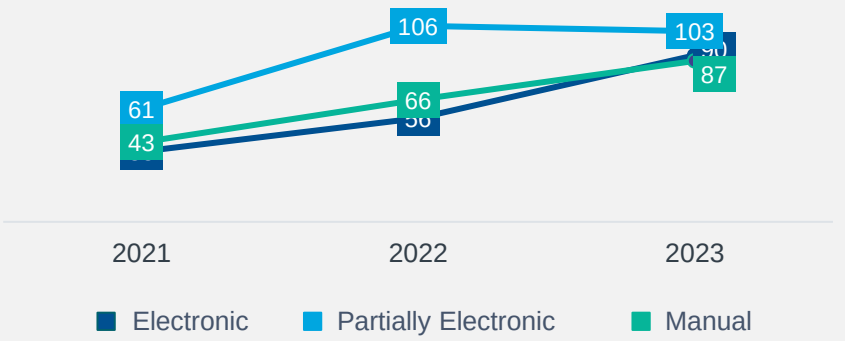
Opportunity and State of Implementation

State of the industry: prior authorization opportunity

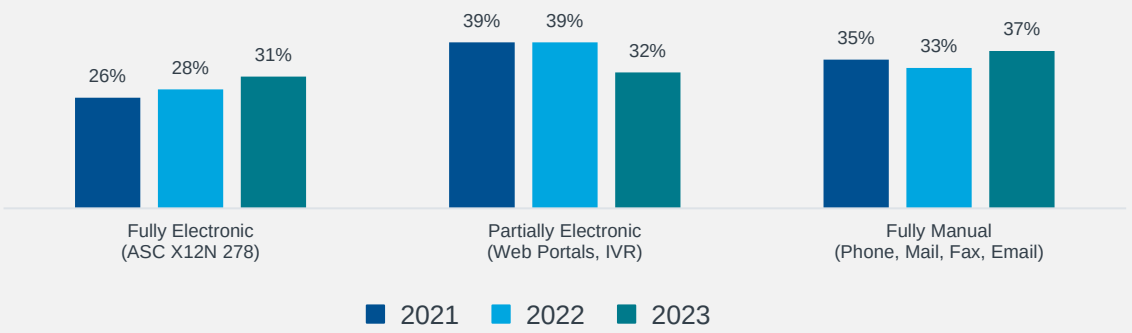


- A National Benchmarking Survey
- A Tool to Track and Monitor Industry Progress
- A Collaborative Initiative

Estimated National Volume of Prior Authorization by Mode (in millions)



Medical Plan Adoption



By transitioning to fully electronic prior authorizations, **the healthcare industry could save**:

$494 Million annually

11 Minutes per transaction for providers

HOW CORE SUPPORTS ePA ADOPTION

Convening industry to close gaps in prior authorization automation

Research and Environmental Scanning

CORE collaborates with industry stakeholders to reveal inefficiencies and pain points for myriad topics, including prior authorization.

Methods include primary source research, environmental scans, and advisory groups.

Operating Rule Development

Industry feedback informs the development of new and updated operating rules to support the conduct of electronic standards.

- CORE Prior Authorization Data Content Rules
- CORE Prior Authorization Infrastructure Rules
- CORE Prior Authorization Attachments Rules
- CORE Connectivity Rule

Tracking and Monitoring Return on Investment and Value

CORE partners with industry organization to quantify the value of interoperability efforts.

CORE, Rhyme (formerly PriorAuthNow), and Cleveland Clinic demonstrated the efficiency of automated prior authorization.

CMS 0057-F: Interoperability and Prior Authorization Final Rule

- Sets technical and content requirements for a set of FHIR-based APIs with a go-live deadline of January 1, 2027.
  - Patient Access API *(updates to existing build)*
  - Provider Access API
  - Payer-to-payer API
  - **Prior Authorization API***
- Requires prior authorizations to be conducted electronically through the **Prior Authorization API** and establishes streamlined response time requirements for **prior authorization** workflows.
  - 7 days for standard requests
  - 72 hours for expedited requests
- Creates provider accountability through provider attestation of using the prior authorization API in the **CMS Quality Payment Program (QPP)**.

*The National Standards Group (NSG) and Office of Burden Reduction and Health Informatics announced enforcement discretion for the HIPAA-mandated 278 allowing impacted entities to conduct electronic prior authorizations for all product lines using FHIR-based protocols.

Health Plans

- Medicare Advantage Organizations
- State Medicaid and CHIP Fee-for-Service
- Medicaid Managed Care Plans
- CHIP Managed Care Entities
- Qualified Health Plans offered on FFEs

Providers

- MIPS Eligible:
  - Clinicians
  - Hospitals
  - Critical Access Hospitals

Provider inputs are key early in the implementation process

Year	Health Plans & Vendors	Providers & Vendors
2024	▪ Evaluation of regulatory requirements ▪ Preliminary business planning & decision-making	▪ Evaluation of requirements ▪ PA workflows largely not impacted
2025	▪ Finalized business plans ▪ Initial build-out and adherence to regulation	▪ Anticipated no or low impact workflow changes
2026	▪ Requirements to for public reporting and adherence to decision timeframes go into force	▪ Observable shortening of time-to-decision timeframes.
2027	▪ **Requirements to launch FHIR-based API for electronic Prior Authorization for select product lines**	▪ **Requirements to use electronic Prior Authorization APIs; tied to quality performance**
2028	ASTP/ONC certification criteria for payer and provider-facing health IT [**proposed**]	

Engaging the Provider in Implementation

Provider organization insights must be accounted for early in implementation, otherwise the advantages of automation may not be fully realized

Data Collection Overview

Survey Audience – NAHAM Membership: Patient access leaders nationally across health systems, hospitals, clinics, ambulatory centers, etc.

2023 Prior Authorization Survey

- Surveyed NAHAM members to gather insights into the current state of prior authorization among patient access professionals
- Participation
  - 280 responses received
  - Approximately 165 organizations represented
  - 87 comments received on solutions to address aspects of prior authorization

2025 CMS 0057-F Survey

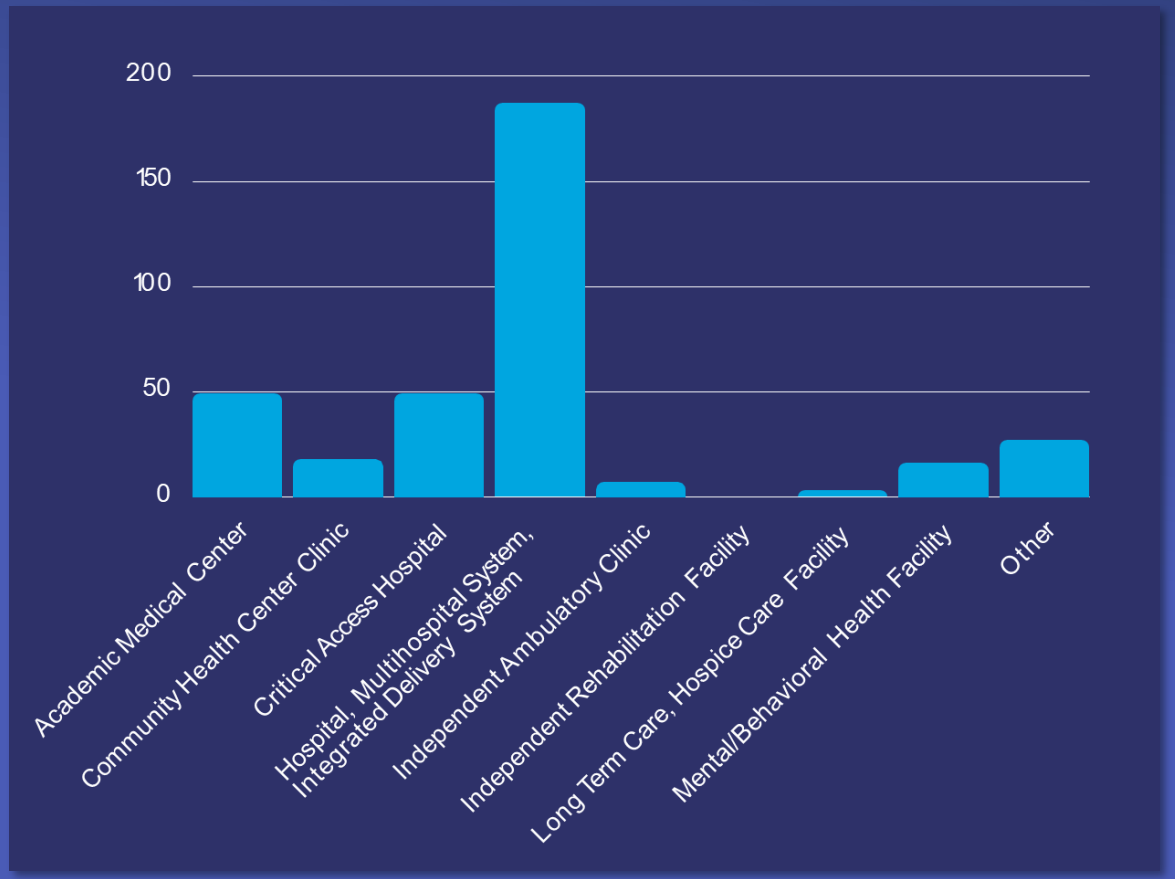
- Brief, 5 question survey assessing CMS 0057-F requirement awareness and engagement:
  - Familiarity of how requirements will impact workflows and intended benefits of requirements
  - Involvement in discussions with stakeholders on how user experience may change
  - Interest in learning more about becoming involved with implementation of requirements
- Participation
  - 32 responses received

NAHAM membership: awareness and knowledge of CMS 0057 requirements

Please indicate your knowledge level of how these requirements will impact your workflow and day-to-day.

NAHAM respondents (n=32) were quite familiar with the requirements of CMS 0057 and the potential impact on their workflows and operations.

CMS 0057 requirements have broad impact on providers of all types



Automating and streamlining prior authorization positively impacts:

- Patient safety,
- Provider satisfaction,
- Access to care, and
- Administrative efficiency

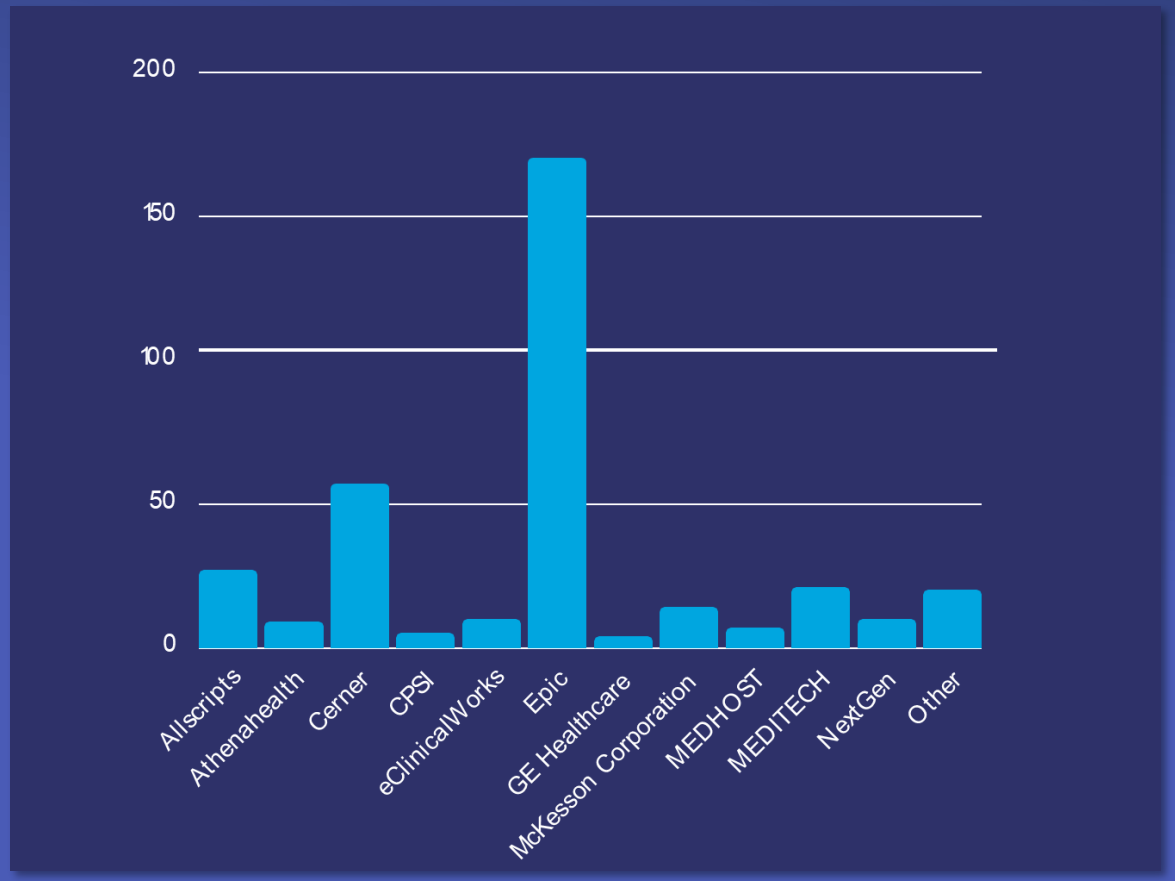
CMS 0057 requirements can improve the provider and patient experiences across care settings.

Solutions traditionally are vendor-driven and proprietary – there is opportunity to align best practices with mandate

- Automated eligibility checks assist with prior authorization requirement discovery.
- Automation and data standardization using standards reduce errors and FTE time.
- Education and training programs allow workflows to be managed effectively.

Proprietary, vendor produced solutions have demonstrated the benefit health IT has for prior authorization

Regulation sets approaches for vendors and health plans – the provider voice is critical



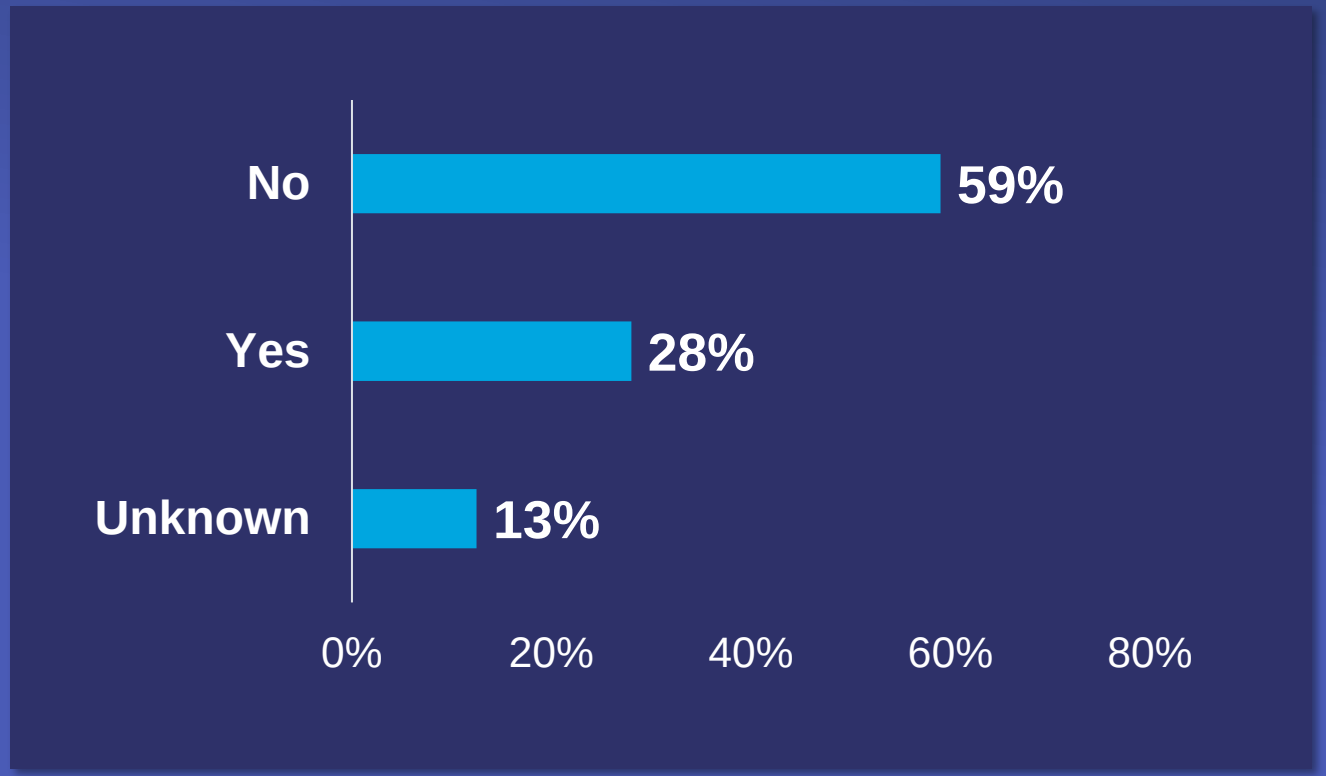
CMS 0057 can bring unprecedented uniformity to prior authorization workflows – but deployment requirements are disproportionately centered on health plans and vendors.

Providers, health plans, and their vendor implementation partners must proactively collaborate to ensure solutions are aligned with providers' needs and expectations.

1. Engage EHR/PMS vendors to ensure systems seamlessly access health plan APIs.
2. Work with health plans to understand what product lines will be using the new system and clarify the need for a single platform solution.
3. Convene internally to educate about the regulatory requirements and timelines to secure fluency among access management staff.

Despite a need for provider engagement, to date, NAHAM membership reports low interaction

Have you or anyone from your department been involved in discussions or initial feedback sessions with your Electronic Health Record (EHR) or Practice Management Software (PMS) vendor(s) on how your user experience may change due to these requirements?



Only **28%** of surveyed NAHAM members report engagement from other non-EHR & PMS stakeholder groups, including:

- Government agencies (i.e., CMS)
- Health plans
- Other provider offices

Key Considerations for Implementation

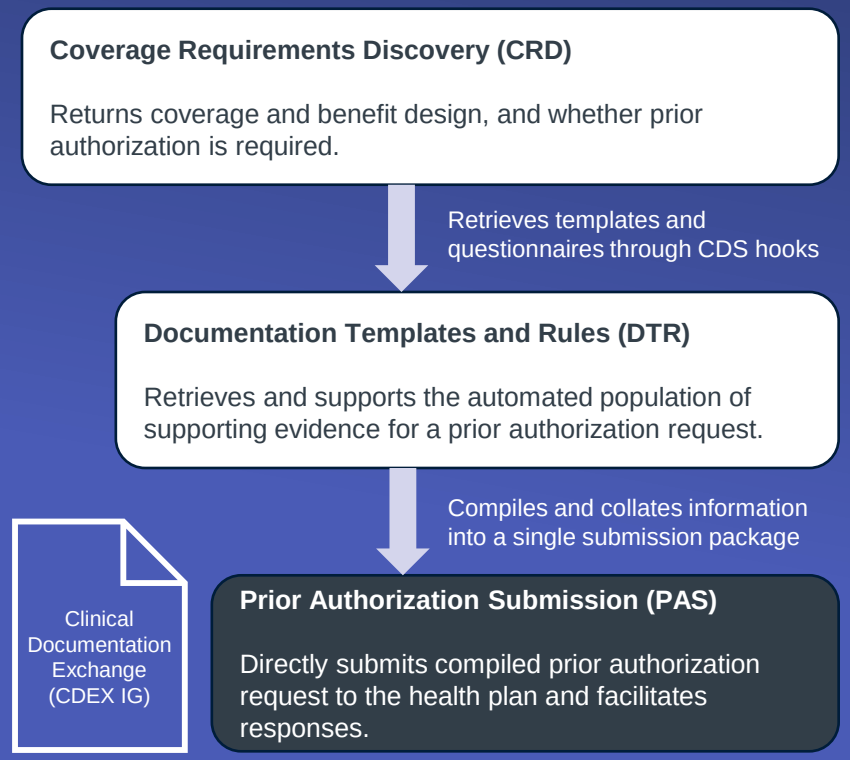
CORE supports **required** use of HL7 Da Vinci IGs with some key augmentation

Consideration		Description
1	**Security Requirements**	Implementation guides do not require a single authentication and authorization protocol.
2	**Questionnaire / Form Automation**	Full automation of prior authorization requires implementation of CQL.
3	**Exchange of Attachments**	Implementers should consider implementation of CDEX to automate document exchange
4	**Data Element and Exchange Standardization**	Elements like status, error reporting, names, and response times are not contemplated in the rule.
5	**Phased Implementation**	Benefit should be realized early across named and optional product lines.

Automation can be achieved when optional levers are pulled in the Burden Reduction Implementation Guides

Ideal Implementation

- **Pre-population:** CRD and DTR work in concert to automate retrieval of required prior auth. information.
    - Achieved through a combination of fully implemented CDS Hooks and Clinical Quality Language (CQL)
- **CDEX attachments:** Attachments are pulled in and collated using the optional CDEX implementation guide.
- **Minimal follow-up:** Automated collection and submission using the Burden Reduction Implementation Guides leads to few or no submission errors/follow-up.



Potential Limitations

- **Partial population:** Results of CRD and DTR population must be manually inspected and remediated prior to submission.
    - Complex prior authorization requirements may lead to lagged CDS and CQL implementation.
- **Variable attachments:** Materials are likely to be collected and collated by human staff and sent in variable formats.
- **Maintained follow-up:** Any breakdown in the ideal implementation of the Burden Reduction Implementation Guides will perpetuate manual follow-up.

Operating Rules Enhance CMS 0057 Requirements

Operating Rule Requirements seamlessly extend CMS 0057 Requirements to support the conversational nature of PA, **ensuring next steps are clear and actionable and that patient care is not delayed**

REQUIREMENT	CMS 0057	OPERATING RULES
ELIGIBILITY VERIFICATION & PATIENT FINANCIAL RESPONSIBILITY	• **Recommended** return of coverage information	+ **Real-time notification** of patient's co-pay, deductible info, remaining procedure allowances, and if the service requires PA
ERROR CODE REPORTING	• Standard, **non-specific** web-based error code reporting	+ **Specific error code guidance** (AAA codes), so next steps are immediately clear
PATIENT ID AND NORMALIZATION	× ***Not included***	+ **Normalized patient name and ID requirements** to avoid common errors that lead to costly delays in patient care
STANDARD STATUS REPORTING & DECISION REASON	• **Recommended** use of Health Care Services Decision Reason Codes (HCSDRCs) for status	+ **Required** Health Care Services Decision Reason Codes (HCSDRCs) at **event and service levels** to ensure providers have a clear decision, with clear, standard meaning; also requires action code
IDENTIFICATION AND EXCHANGE OF ADDITIONAL CLINICAL DOCUMENTATION	× ***Not included***	+ Inclusion of **attachment report type codes** and standard agnostic format and exchange requirements to clearly articulate what additional clinical documentation is needed to prove medical necessity
TIMEFRAMES: ADDITIONAL DOCUMENTATION REQUEST	× ***Not included***	+ **2 business days for health plan to review a PA request and ask for any missing documentation**
TIMEFRAMES: FINAL DETERMINATION	• **7 calendar days** (standard) / 72 hours (expedited)	+ **2 business day turnaround for standard requests** (once provider has submitted required information), ensuring timely communication of next steps and decisions
TIMEFRAMES: OPTIONAL CLOSE-OUT	× ***Not included***	+ **14-day option** for health plan close out **if requested medical documentation not received**
INFRASTRUCTURE AND CONNECTIVITY	• **Varies** by implementation guide	+ **CORE real-time and batch requirements** and alignment to most recent CORE Connectivity to ensure smooth submission
CLAIM SUBMISSION, REVIEW, & PAYMENT	× ***Not included***	+ **Specific details from PA are included in the claim** to ensure claims linking, proper payment, and compliance with reporting requirements

IMPACT OF IDEAL IMPLEMENTATIONS

Full value can only be achieved through expanded implementation

Achieving the **$494 million of annual medical industry cost savings** associated with prior authorization requires more than meeting only the minimum requirements of CMS 0057.

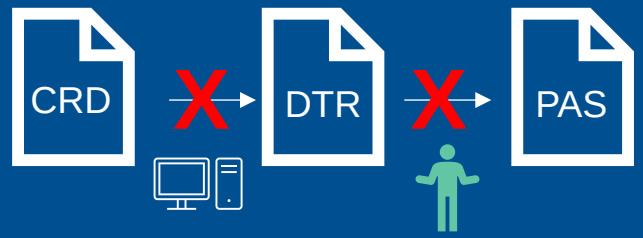
Expansion to All Products

50-60%

of covered lives are in plans that require prior authorization but are not named in CMS 0057

Expansion to all products lines assists in unifying and streamlining prior authorization workflows.

DTR Automation Through Clinical Quality Language (CQL)



Investing in CQL programming **aids in the fully automated the population of templates and forms** used for prior authorization requests.

Exchange of Attachments

+$140 million

Annual cost saving opportunity for providers and plans

Automating the exchange of attachments can capture additional cost saving opportunity.

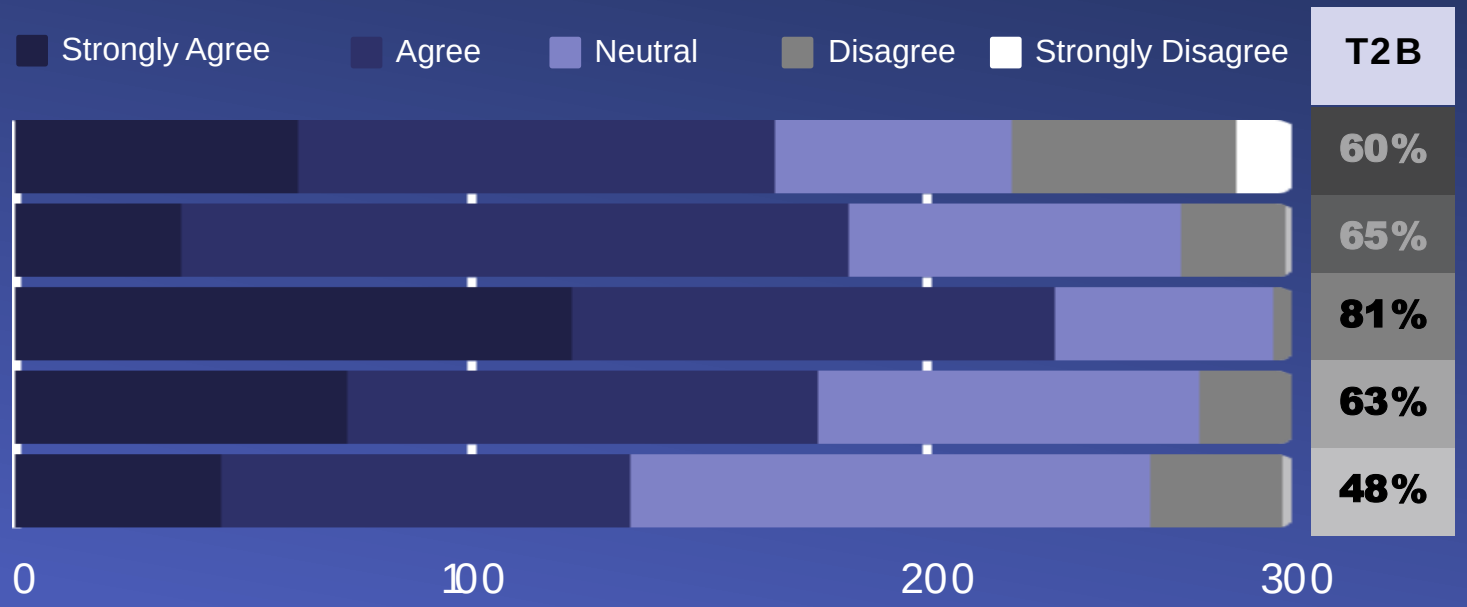
Assumes 54% of Medicare beneficiaries are enrolled in Medicare Advantage. Based on KFF estimates.

KFF (2023). Health Insurance Coverage of the Total Population.
KFF (2024). Medicare Advantage in 2024: Enrollment Update and Key Trends.

A lack of uniformity places burden on the providers and access managers supporting the workflow

Please rate the degree to which you or your patient access department agrees or disagrees with these statements:

- Patient care is delayed as a result of current PA policies.
- Initial denials are often approved following appeal and/or peer-to-peer meetings.
- Documentation required to obtain PA has increased in the past 2-3 years.
- Denials of PA lack consistency in reasoning.
- PA technology is successful in improving the efficiency of PA.



T2B = Top two (2) boxes. Percentages displayed in this column represent the total of the percentages representing "strongly agree" and "agree".

NAHAM membership: perceived benefits of CMS 0057 requirements

Please indicate how familiar you are with the intended benefits of these new PA requirements.

NAHAM respondents (n=32) are optimistic about the benefit CMS 0057 have in standardizing and automating their prior authorization workflows.

Get Involved

Partner with CAQH to create a durable measurement framework that supports ideal implementation of CMS 0057 requirements

Preparedness and Implementation Guidance

Assess preparedness for CMS 0057 implementation requirements.
Identify ideal implementation of ePA requirements.

Projections and Tracking of Value and Return on Investment

Establish durable measurement strategies for key data points.
Quantify cost and time saving opportunity of adopting CMS 0057 and related requirements.

Industry Influence and Thought Leadership

Generate opportunities to share implementation best practices in collaboration with CAQH.
Inform the development of industry resources for the ideal implementation of ePA requirements.

Industry Blind Spot

"Automation" does not fully consider human involvement. Projections and guidance must account for the maintenance of manual workflows.

Return on investment and value measurement

Keep track of the value associated with implementation by monitoring the following domains.

Measurement Domains

Implementation Impact: Articulation of the **success of the implementation effort**, measured by projected annual cost savings, **staff satisfaction levels**, and impact on patient care.

Workflow Efficiency: Recognition of overall **time savings** due to efficiency gains from streamlined process, including reduced staff time performing prior authorization tasks.

Workflow Accuracy: **Changes in volume** of real-time prior authorization approvals accepted without error.

Benefits of Tracking Implementation Value

- ✓ Articulation of operational cost and resource savings
- ✓ Support for scalability and future growth
- ✓ Empowers future interoperability “asks” to leadership
- ✓ Strengthens identification of improvement areas and influence for policy refinements.

Recommendations for Provider Organizations

- ❑ Connect with your EHR/PMS vendors to ensure systems seamlessly access health plan APIs and gain an understanding about how these changes will impact your workflows
- ❑ Work with health plans to understand what product lines will be using the new system and clarify the need for a single platform solution
- ❑ Plan for internal education about the regulatory requirements and timelines for access management staff
- ❑ Reach out to core@caqh.org if your organization is interested in partnering with CAQH to measure the impact of ePA implementation

Questions

Appendix

Without Operating Rules, the Prior Authorization Process is Manual and Burdensome for Providers & Delays Patient Care

Checking Eligibility & PA Requirements

Patient presents with abdominal pain. Provider determines an Imaging: CT scan with contrast is necessary for the patient.

- Provider manually checks the list of services requiring PA for the patient's health plan, but the list is outdated and ambiguous.
- Provider must call health plan for eligibility check and to understand if the service requires PA, as each health plan's requirements differ. Provider is put on hold and does not get timely clarification of requirements.

Submitting the PA Request

Provider submits the PA request for Imaging: CT scan with contrast for the patient.

- Provider takes extra time to complete the PA request: each plan requires different information, and the provider must retrieve information from multiple different systems.
- Once the Provider manually faxes the PA request, they do not receive acknowledgement of receipt from the health plan and must call the health plan to ensure the PA was received.

Adjudicating the PA Request

Health plan reviews PA. Determines that the Patient recently had a CT scan. Sends generic "pend" response.

- While the provider waits for a response, they have little to no transparency into the status of the request.
- After weeks of waiting, health plan sends the provider a non-specific error code and/or generic "pend" without any direction on next steps. Provider must call the plan to identify if additional information is required.

Proving Medical Necessity & Resubmission and Approval

Health plan tells Provider via phone that they require additional information to prove medical necessity for the service.

- Provider must manually call the plan to identify what additional medical information is required. There are no standard codes provided; the provider must spend extra time searching the patient record for the report type needed.
- Provider manually faxes in additional clinical documentation.
- After a couple of weeks, Provider must call to find out that PA was approved. Patient can now schedule and receive the service.

Claim Submission & Payment

Provider submits claim for the service rendered.

- Details from the approved PA are not included in the claim, and the claim is denied.
- Patient receives an alarmingly high bill for the service.
- Provider's payment for the service is delayed due to claims denial.
- Claim must be appealed and resubmitted.

Operating Rules Improve Prior Authorization and the Overall Provider and Patient Experience

From Eligibility Verification to Claims Adjudication and Payment

Checking Eligibility & PA Requirements

Patient presents with abdominal pain. Provider determines an Imaging: CT scan with contrast is necessary for the patient.

- Provider electronically submits eligibility check to the health plan.
- Provider is notified in real-time of the patient's co-pay, deductible info, and remaining procedure allowances. They are also notified that the service requires PA.

Submitting the PA Request

Provider submits the PA request for Imaging: CT scan with contrast for the patient. Health Plan acknowledges receipt.

- Provider includes data identifying the patient, the provider, the specific diagnosis code for the service, and data that the plan requires to accurately adjudicate.
- Health plan acknowledges receipt of the Request within 20 seconds. Health plan normalizes the patient's name to ensure patient matching.

Adjudicating the PA Request

Health plan adjudicates PA. Determines that the Patient recently had a CT scan, and requests more documentation from the Provider.

- 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.
- The health plan has two business days to return the pend and must include the most specific codes on next steps and documentation needed to prove medical necessity.

Proving Medical Necessity & Resubmission and Approval

Provider receives pended response and request for more documentation to prove medical necessity. Provider submits info, and health plan approves.

- 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.
- Health plan receives required medical data, completes review, and returns final approval to provider within two business days.
- Patient is now authorized and can receive care without delays or avoidable out of pocket costs.

Claim Submission & Payment

Provider submits claim for the service rendered.

- Specific details from the approved PA are included in the subsequent claim to ensure claims linking, proper payment, and compliance with reporting requirements.
- Health plan approves claim due to all required information being included and PA approvals.
- Provider receives payment for the service.