Prior Authorization Reforms

NCOIL Health Insurance & LTC Issues Committee

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CAQH

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CAQH Board and Member Health Plans

CAQH, a non-profit alliance, is the leader in creating shared initiatives to streamline the business of healthcare. Through collaboration and innovation, CAQH accelerates the transformation of business processes, delivering value to providers, patients and health plans.

Board Members:

CAQH

CAQH Initiatives

CAQH CORE — COMMITTEE ON OPERATING RULES FOR INFORMATION EXCHANGE	Maximizes business efficiency and savings by developing and implementing national operating rules. More than 140 participating organizations.
CAQH Explorations — INDEX®	Benchmarks progress and helps optimize operations by tracking industry adoption of electronic administrative transactions.
CAQH Solutions — COB SMART®	Quickly and accurately directs coordination of benefits processes.
CAQH Solutions — PROVIEW®	Eases the burden of provider data collection, maintenance and distribution for more than 1.4 million providers 800 participating organizations.
CAQH Solutions — VERIFIDE™	Streamlines credentialing by consolidating and standardizing primary source verification.
CAQH Solutions — DIRECTASSURE™	Increases the accuracy of health plan provider directories.
CAQH Solutions — SANCTIONSTRACK®	Delivers comprehensive, multi-state information on healthcare provider licensure disciplinary actions.
CAQH Solutions — ENROLLHUB®	Reduces costly paper checks with enrollment for electronic payments and remittance advice for more than 500,000 providers.

CAQH

CAQH CORE Rule Development

CAQH CORE Mission & Vision

Industry-led, CAQH CORE Participants* represent **75 percent of the insured US population** and include health plans, healthcare providers, vendors, government entities, associations and standard-setting organizations.

MISSION

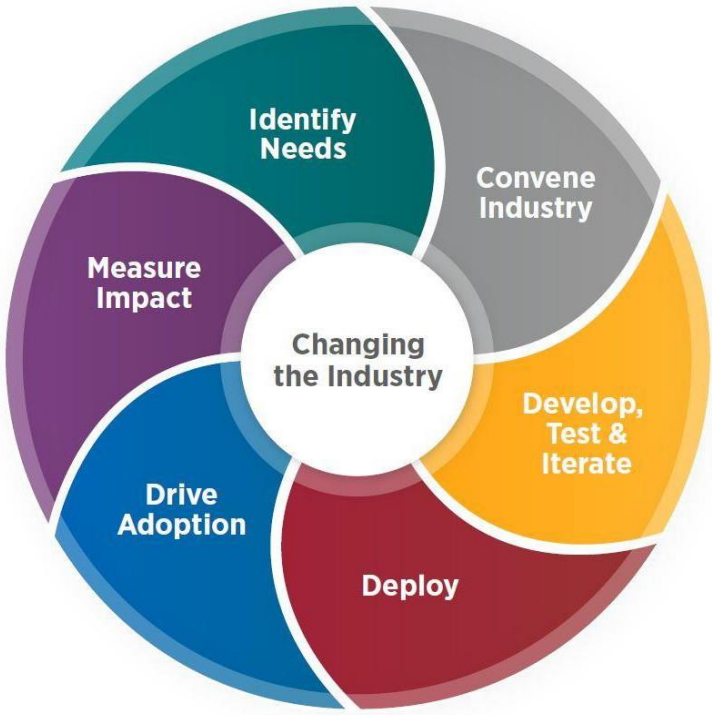
Drive the creation and adoption of healthcare operating rules that **support standards**, **accelerate interoperability and align administrative and clinical activities** among providers, payers and consumers.

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.

* See full list of CAQH CORE Participating Organizations here.

What are Operating Rules?

Operating Rules are the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted.

Industry Use Case	Standard	Operating Rule
Healthcare	Providers and health plans must use the ASC X12 v5010 270/271 Eligibility Request and Response transaction to exchange patient eligibility information.	When using the eligibility transaction, health plans must return patient financial information including copay and deductible in real-time.
Finance	Financial organizations must use ASC X9 standards in all ATM transactions with their clientele, standardizing layout, data content and messaging.	Financial organizations must use NACHA, the Electronic Payments Association, and the Federal Reserve operating rules for every automated clearinghouse (ACH) Transaction which allows consumers to use any debit card in any ATM around the world regardless of bank affiliation.

Operating Rules **do not** specify whether or how a payer/provider structures a business process supported by an electronic transaction. For example, operating rules do not specify when or how prior authorization is used by a health plan; if prior authorization is used, operating rules specify how information regarding that transaction is electronically exchanged.

CAQH CORE Vision for Prior Authorization

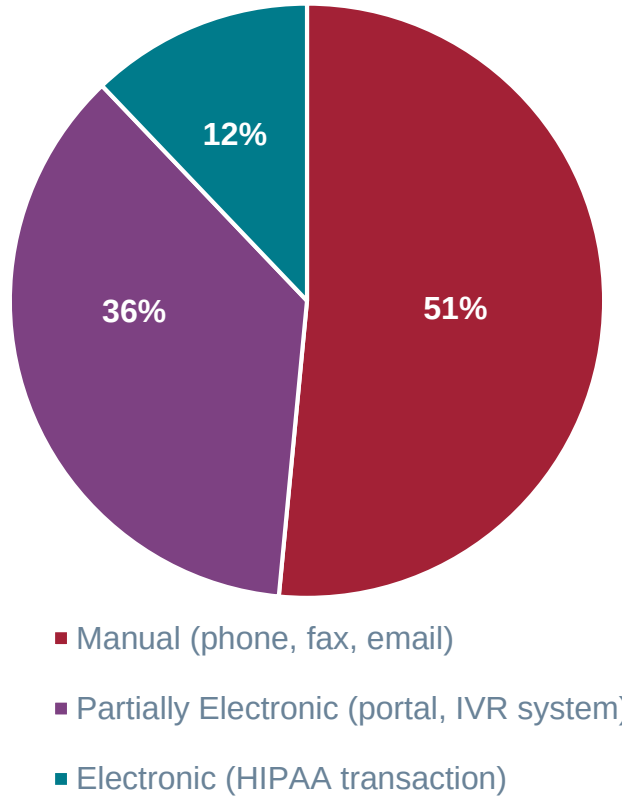
Operating Rules can Move Industry Towards a More Automated Prior Authorization Process

CAQH CORE Operating Rules close automation gaps, reduce administrative burden and allow for patients to receive more timely care.

- Barriers to automation include **lack of awareness** and support of the electronic standard, **state requirements** for manual intervention, **challenges of integrating clinical and administrative data**, and varying levels of industry maturity.
- CAQH CORE Operating Rules enable a more optimized prior authorization process and drive industry-wide adoption to realize meaningful change through:

1. **Enhanced data content** in the standard prior authorization transaction to streamlines review and adjudication.
2. Proposed **national timeframes** for consistent expectations on turnaround time.
3. Updated, **consistent connectivity modes** for data exchange.
4. Future rules enabling consistent electronic exchange of **additional clinical information.**
5. Pilots to **evaluate impact** and further gap identification.

Electronic Adoption of Prior Authorization*



* 2018 CAQH Index.

CAQH CORE Rule Spotlight: Prior Authorization Response Times

Rule Currently Under Review to Enable Consistency Across Industry

Phase IV CAQH CORE Rule Update – Currently In Voting Process*

Disjointed Prior Authorization Timeframes Across States

Prior authorization response time requirements across states and health plans are disjointed and inconsistent:

- Over 30 states have response time requirements, ranging from 24 hours to 14 business days.
- Wide variation in the definition of when the clock starts "ticking" and to which parts of the process the time requirement applies.
- Plans and providers that cover patients from multiple states are faced with varying time requirements, which can lead to timing disparities in care delivery.

Establishing Consistent National Timeframes

(Applicable to use of the HIPAA-mandated prior authorization transaction)

Draft rule enhancements focus on establishing **maximum timeframes** for health plans at key stages in the prior authorization process:

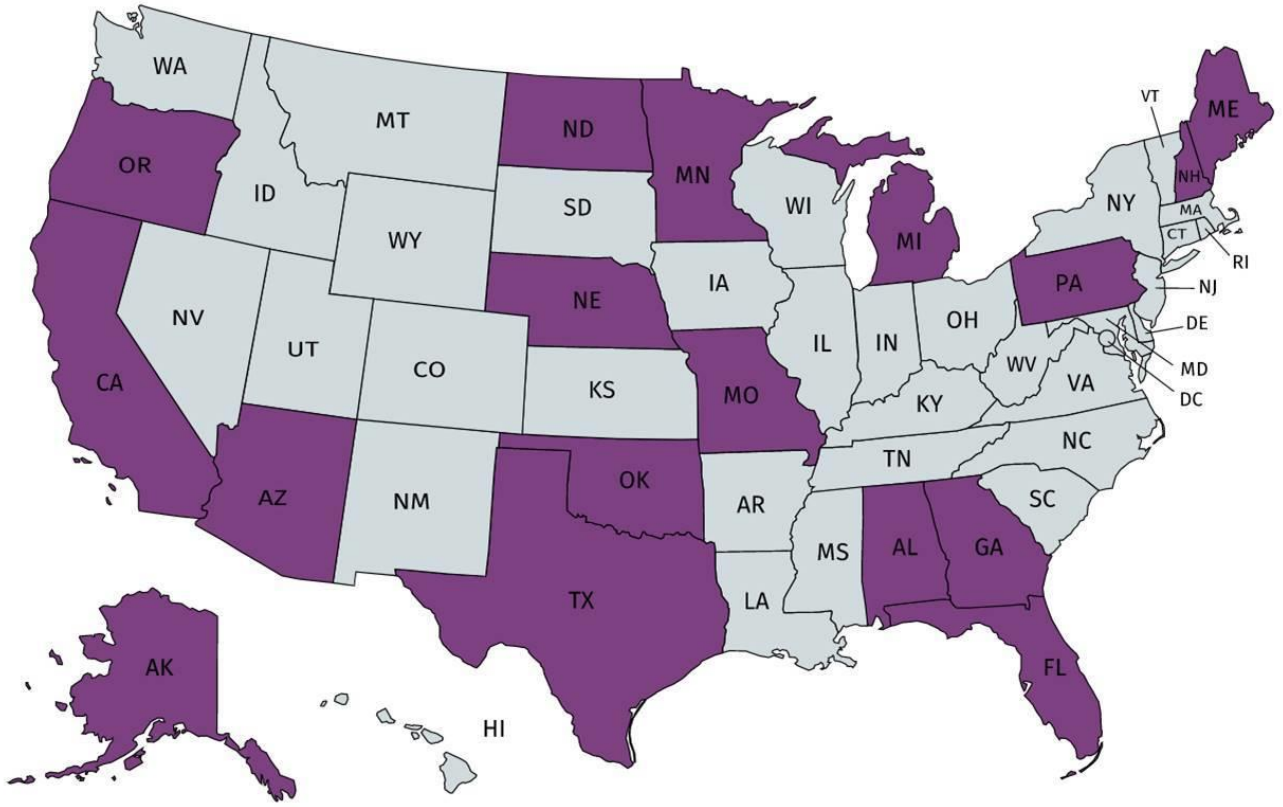
- Time requirement to request **additional clinical information** from provider.
- Time requirement to send **final determination** to provider once all information has been received.
- Optional time requirement to **close out** a prior authorization request if requested information is not received from a provider.

Applying a **national response time** for greater uniformity and consistency is critical to enabling shorter time to final adjudication and more timely delivery of patient care.

***** This rule enhancement is an update to the existing Phase IV CAQH CORE 278 Prior Authorization Infrastructure Rule that was initially approved via the formal CAQH CORE Voting Process in 2015. CAQH CORE Participating Organizations are currently voting on the draft rule update, per formal voting procedures.

State Governments Involved with CAQH CORE

Agencies Contribute to Development of Business Rules and Certify Conformance



CAQH CORE Participation and Certification is free for state agencies. To learn how to get involved or who is participating from your state, email CORE@caqh.org.