Prior Authorization
Industry Landscape

Tuesday, September 25, 2018
3:00 – 4:00 pm ET
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- A copy of the slides and the webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.

Questions can be submitted *at any time* using the Questions panel on the GoToWebinar dashboard.
Session Outline

- Prior Authorization Level Set
- Industry Efforts on Prior Authorization
  - American Medical Association Perspective
  - WEDI Perspective
- Overview of CAQH CORE Scope & Draft Phase V Operating Rules
- Q&A
Acknowledgments

CAQH CORE thanks the guest presenters for today’s webinar.

Heather McComas
Director, Administrative Simplification Initiatives
American Medical Association

Stephanie (Geihe) Bronshvayg
Healthcare Transactions Manager
athenahealth

Rhonda Starkey
Director, eBusiness Services
Harvard Pilgrim Health Care
The Prior Authorization Challenge

Prior authorization (PA) began as a means to manage the utilization of healthcare resources: people, time and dollars. PA requires providers to request approval from a health plan before a patient can be referred to another provider (e.g., specialist), or before a specific procedure, service, device, supply or medication is provided to the patient. Each step of the prior authorization process is labor-intensive and generates time-consuming and costly administrative burden in the industry.

Fast Facts

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

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

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

Volume

Over 150 million* PAs per year (in the medical, commercial market alone).

Submission Method*

35% manual (phone, fax, email); 57% partially automated (web portal), 8% fully electronic (ASC X12N v5010 278 Prior Authorization Request and Response (278)).

Wait Times**

Approx. 64% of physicians report waiting at least one business day for a PA response, and 30% report waiting at least 3 business days. 92% of Providers surveyed by the AMA reported that the prior authorization process delays patient care.**

Potential Savings

Full adoption of the standard prior authorization transaction (X12/v5010 278 Request and Response) by health plans and healthcare providers could result in a savings of $6.84 per transaction, for the portions of the prior authorization process included in the X12/v5010 278 Request and Response.

Sources: *CAQH Index (2017); commercial market figures only. | **AMA PA Physician Survey (2017).
Continued Industry Engagement to Address Prior Authorization

- The Phase IV CAQH CORE Operating Rule for prior authorization represents the CAQH CORE Board and Participants’ commitment to promoting uniformity and accelerating industry adoption of electronic prior authorization.

- The National Committee on Vital and Health Statistics (NCVHS) recommended:
  - Additional research to understand barriers to improving the prior authorization process.
  - Development of additional operating rules to address these barriers.
  - “Encouragement of payers and providers to standardize across all systems to ensure consistency in transmitting and receiving information. This would include payer portals, service request systems, etc.”

- Significant public and private sector interest in addressing challenges throughout the prior authorization continuum.
  - July 31, 2018 Senate Health, Education, Labor and Pensions (HELP) Committee hearing on "Reducing Health Care Costs: Decreasing Administrative Spending" was the third in a series of hearings the committee has held on reducing health care costs – prior authorization was a key topic in multiple testimonies.
  - Multiple industry statements and guiding principles from multi-stakeholder and provider coalitions.
    - CAQH CORE Board open letter to the authors of the Consensus Statement on Improving the Prior Authorization Process.
    - Other complementary work efforts include AMA research, WEDI PA Subworkgroup, HL7, HATA, DaVinci Project use case, etc.

*Letter to the Secretary - Findings from Administrative Simplification Hearing, Letter to the Secretary - Recommendations for the Proposed Phase IV Operating Rules, Review Committee Findings and Recommendations on Adopted Standards and Operating Rules.
Prior Authorization Industry Landscape: AMA Perspective

Heather McComas
Director, AMA Administrative Simplification Initiatives
CAQH CORE Webinar
September 25, 2018
Setting the Stage: Discussion Roadmap

1. **Building the case for change**
   - Research
   - Grassroots stories

2. **Reform efforts**
   - Principles
   - Consensus statement
AMA Prior Authorization Research
2017 AMA Survey Overview

• 1000 practicing physician respondents
• 40% PCPs/60% specialists
• Web-based survey
• 27 questions
• Fielded in December 2017
Average PA Response Wait Time

**Question:** In the last week, how long on average did you and your staff need to wait for a prior authorization (PA) decision from health plans?

- Under 1 hour: 6%
- A few hours: 10%
- More than a few hours but less than 1 business day: 12%
- 1 business day: 16%
- 2 business days: 18%
- 3-5 business days: 23%
- More than 5 business days: 7%
- Don't know: 9%

**Total does not equal 100% due to rounding.**

- 64% report waiting at least one business day
- 30% report waiting at least three business days
Care Delays Associated With PA

Question: For those patients whose treatment requires PA, how often does this process delay access to necessary care?

- Always: 15%
- Often: 39%
- Sometimes: 38%
- Rarely: 6%
- Never: 1%
- Don't Know: 1%

92% report care delays
Treatment Abandonment Associated With PA

Question: For those patients whose treatment requires PA, how often do issues related to this process lead to patients abandoning their recommended course of treatment?

78% report that PA can at least sometimes lead to treatment abandonment.

Total does not equal 100% due to rounding.
Impact of PA on Clinical Outcomes

Question: For those patients whose treatment requires PA, what is your perception of the overall impact of this process on patient clinical outcomes?

- **61%** report **Significant NEGATIVE impact**
- **31%** report **Somewhat NEGATIVE impact**
- **7%** report **No Impact**
- **2%** report **Somewhat or significant POSITIVE impact**

92% report that PA can have a negative impact on patient clinical outcomes.

Total does not equal 100% due to rounding.
Physician Perspective on PA Burdens

Question: How would you describe the burden associated with PA for the physicians and staff in your practice?

- High or extremely high: 84%
- Neither high nor low: 12%
- Low or extremely low: 4%
Change in PA Burden Over the Last 5 Years

Question: How has the burden associated with PA changed over the last five years for the physicians and staff in your practice?

- 51% Increased significantly
- 35% Increased somewhat
- 11% No change
- 3% Decreased somewhat or significantly

86% report PA burdens have increased over the past five years
Additional PA Practice Burden Findings

• **Volume**
  • **29.1 average total PAs** per physician per week*
    • 13.9 average prescription PAs per week
    • 15.1 average medical services PAs per week

• **Time**
  • Average of **14.6 hours** (approximately two business days) spent each week by the physician/staff to complete this PA workload

• **Practice resources**
  • **34%** of physicians have staff who work exclusively on PA

*Total PAs per week rounded after combining prescription and medical services PAs.
Prior Authorization Grassroots Stories
New AMA Grassroots Website: FixPriorAuth.org

Prior authorization hurts patients and physicians. It’s time to #FixPriorAuth.

Click below to discover how prior authorization affects you.

- Physician and patient tracks
- Social media campaign drives site traffic and conversation
- Call to action: Share your story
- Most impactful stories collected in site gallery
Your prior authorization stories matter

"The authorization was not initially approved because of the co-payment, so I appealed. It was rejected again, even though I pointed to the agent on the phone that the patient met the criteria."

– Dr. Sussana L.

My daughter had ALS. Her doctor ordered a PET scan of her brain. The appointment was set, medical transportation was set, co-pay was paid. The day before the test the hospital called to say the prior authorization had not been received. My daughter passed away the day before we were supposed to go for the rescheduled test.

– Kathy M.

Read More >
"I have had to make multiple calls and wait as long as 2 weeks trying to obtain authorization for an MRI when there were abnormal mammogram or pelvic sonogram findings. The patients become increasingly anxious about their condition and sometimes angry at me because they think I’m either withholding care or not concerned about their needs.

– Dr. Nina S.

"I have to do a prior authorization and wait as long as 2 weeks trying to obtain authorization for an MRI when there were abnormal mammogram or pelvic sonogram findings. The patients become increasingly anxious about their condition and sometimes angry at me because they think I’m either withholding care or not concerned about their needs.

– Dr. Nina S.

"I have had to make multiple calls and wait as long as 2 weeks trying to obtain authorization for an MRI when there were abnormal mammogram or pelvic sonogram findings. The patients become increasingly anxious about their condition and sometimes angry at me because they think I’m either withholding care or not concerned about their needs.

– Sherri H.
"Now the surgery to remove thyroid, 2 masses, 14 lymph nodes, and a parathyroid has been denied, pending questionable medical necessity. My 8-year-old had 2 large masses on the thyroid. It took a month and a half to finally get the approval and paperwork sent to the hospital. We had our first appointment and then 5 days later a biopsy that took hours and hours on the phone to get the prior authorization. Then the results came back cancerous. After hours and hours of phone calls after meeting with the surgeons, surgery was scheduled after the prior authorization was received. Now the surgery to remove the thyroid, 2 masses, 14 lymph nodes, and a parathyroid has been denied, pending questionable medical necessity. More info has been sent in and still is kicking back denied. Results from the removed items - cancer."

– Megan T.

"Prior authorizations take up 14 of 47"

– Megan T.

"Some damn nerve doctors' wishes for patients!"

thleen G.

"A patient die due to prior authorization need for axetil for a UTI."

– Dr. Philline K.
Prior Authorization Principles and Consensus Statement
Prior Authorization and Utilization Management Reform Principles

- Underlying assumption: utilization management will continue to be used for the foreseeable future
- Sound, common-sense concepts
- 21 principles grouped in 5 broad categories:
  - Clinical validity
  - Continuity of care
  - Transparency and fairness
  - Timely access and administrative efficiency
  - Alternatives and exemptions
Prior Authorization Reform Workgroup

- American Medical Association
- American Academy of Child and Adolescent Psychiatry
- American Academy of Dermatology
- American Academy of Family Physicians
- American College of Cardiology
- American College of Rheumatology
- American Hospital Association
- American Pharmacists Association
- American Society of Clinical Oncology
- Arthritis Foundation
- Colorado Medical Society

- Medical Group Management Association
- Medical Society of the State of New York
- Minnesota Medical Association
- North Carolina Medical Society
- Ohio State Medical Association
- Washington State Medical Association

Over 100 additional organizations have signed on as supporters of the Workgroup efforts following the January 2017 release of the Principles.
PA Principles and Electronic Prior Authorization

Principle #12
A utilization review entity requiring health care providers to adhere to prior authorization protocols should accept and respond to prior authorization and step-therapy override requests *exclusively through secure electronic transmissions using the standard electronic transactions for pharmacy and medical services benefits*. Facsimile, proprietary payer web-based portals, telephone discussions and nonstandard electronic forms shall not be considered electronic transmissions.
Outreach Targets for Principles

- **Utilization management entities**
  - Health plans
  - Benefit managers
- **State legislators/regulators**
- **Health plan accrediting bodies**
  - URAC
  - NCQA
- **Standards organizations**
- **Media**
Consensus Statement on Improving the Prior Authorization Process

- Released in January 2018 by the AMA, AHA, AHIP, APhA, BCBSA, and MGMA
- Five “buckets” addressed:
  - Selective requirements to reduce volume of providers subject to PA
  - Regular review of services/drugs requiring authorization
  - Improved transparency and communication
  - Protections for continuity of care
  - Automation to improve efficiency transparency
Consensus: Automation to Improve Transparency and Efficiency

**Agreement to:**

- Encourage health care providers, health systems, health plans, and pharmacy benefit managers to accelerate use of existing national standard transactions for electronic prior authorization (i.e., National Council for Prescription Drug Programs [NCPDP] ePA transactions and X12 278)

- Advocate for adoption of national standards for the electronic exchange of clinical documents (i.e., electronic attachment standards) to reduce administrative burdens associated with prior authorization

- Advocate that health care provider and health plan trading partners, such as intermediaries, clearinghouses, and EHR and practice management system vendors, develop and deploy software and processes that facilitate prior authorization automation using standard electronic transactions

- Encourage the communication of up-to-date prior authorization and step therapy requirements, coverage criteria and restrictions, drug tiers, relative costs, and covered alternatives (1) to EHR, pharmacy system, and other vendors to promote the accessibility of this information to health care providers at the point-of-care via integration into ordering and dispensing technology interfaces; and (2) via websites easily accessible to contracted health care providers
Providers and Health Plans Agree on PA Automation

• Health plans, benefit managers, and providers should all accelerate adoption of the standard electronic transactions for pharmacy and medical services PA (NCPDP ePA transactions and X12 278)

• All intermediaries – EHR vendors, clearinghouses, etc. – should also support these transactions, as PA automation is not possible without the support of these stakeholders
AMA Resources and Links
AMA Prior Authorization Weblinks

• AMA Prior Authorization Resources:  www.ama-assn.org/prior-auth

• AMA Prior Authorization Grassroots Advocacy:  FixPriorAuth.org
Questions

Heather McComas

• Director, AMA Administrative Simplification Initiatives
  heather.mccomas@ama-assn.org
Prior Authorization Landscape

Stephanie (Geihe) Bronshvayg
What is WEDI?

WEDI (Workgroup for Electronic Data Interchange) is a nonprofit organization focused on the use of health IT to improve healthcare information exchange—enhancing quality of care, improving efficiency and reducing costs.

Created by the Secretary of Health and Human Services (HHS) in 1991 and named in the HIPAA Legislation as an advisor to the Secretary of HHS, WEDI continues to be the place where the leading health plans, providers, vendors, and government agencies come for information, education, and innovation on health IT.

Website: www.WEDI.org
How Does WEDI work?

Health care Information exchange areas broken into workgroups and sub-work groups

To participate, members join regular calls

Anyone can join – just need to sign up on the WEDI website: www.WEDI.org

WEDI also hosts regular conferences where members interact
Sub-work group Focus: Developing a multi-stakeholder lead white paper on the guiding principles that should be implemented to drive adoption and value of the Prior Authorization Health Services Review transaction (x12 278)

The white paper is intended to:
- Outlines the Prior Authorization terms and various workflows
- Identifies barriers to transaction adoption
- Develops best practices to overcome each barrier
Health Services Review (ANSI x12 278) transaction is a standard electronic transaction that has the ability to put a Prior Authorization on file with the payer and to check the status of a pended Prior Authorization request.

However, transaction adoption has been low due to various challenges.
The Prior Authorization White Paper

**Goal:** Drive industry adoption of the transaction by articulating best practices to overcome the various high-level barriers of adoption

**Method:** Meet virtually every other week to discuss various parts of the paper

- Diverse group of active participants across the industry
- Every voice can be heard
How can you get involved?

Go to www.WEDI.org and sign up!
Overview of CAQH CORE Scope & Draft Phase V Operating Rules
CAQH CORE Vision for Prior Authorization

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

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

The **Draft Phase V Operating Rules** address needed data content in the PA transaction and enable greater consistency across other modes of PA submissions.

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**Automation Spectrum**

**Manual**

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

**Partially Automated**

Parts of the PA process are automated and do not require human intervention, but some parts still require human touch. Typically includes manual submission on behalf of provider which is received by health plan via a more automated tool (portals, ASC X12 278).

**Optimized**

Entire PA process is at its most effective and efficient by eliminating unnecessary human intervention and other waste. Optimized PA process includes automating internal provider/health plan workflows.
CAQH CORE Participating Organizations play a critical role in all aspects of the rules lifecycle. All Groups are open to and chaired by CAQH CORE Participants.

**Identify Opportunities**
- Advisory Groups
  - e.g., Attachments (Additional Documentation) Advisory Group.

**Develop Rules**
- Rules Work Group (RWG)
- Subgroups
  - e.g., Prior Authorization Subgroup, Claim Status Subgroup, etc.
- Technical Work Group (TWG)
- Subgroups
  - e.g., Connectivity & Security Subgroup, Certification/Testing Subgroup, etc.

**Maintain & Enhance Rules**
- Task Groups
  - e.g., CORE Code Combinations Task Group, EFT/ERA Enrollment Data Sets Maintenance Task Group.
From Fall 2016 through Summer 2017, a multi-stakeholder CAQH CORE PA Advisory Group vetted potential PA operating rule opportunity areas against agreed-upon evaluation criteria.

- The initial PA opportunities list was developed via thorough review and analysis, such as NCVHS testimonies, ACA Review Committee, industry forums and discussions, CAQH CORE industry surveys and X12 v5010X217 278 TR3.
- The PA Advisory Group conducted an environmental scan to hone in on pain points and understand the potential benefit of the various opportunity areas.

The resulting opportunities list was used by the CAQH CORE PA Subgroup, which represents more than 50 multi-stakeholder organizations, to specify operating rule draft requirements.

Over the past six months, the PA Subgroup defined key rule requirements related to the data content of the X12 278 Request/Response Transaction and Prior Authorization Web Portals. This was achieved by participating in surveys, feedback forms, straw polls and industry discussion.
The Draft Phase V Prior Authorization Rules focus on standardizing key components of the prior authorization process, closing gaps in electronic data exchange to move the industry toward a more fully automated adjudication of a request. These efficiencies enable shorter time to final adjudication and more timely delivery of patient care.

- Consistent patient identification to reduce common errors and associated denials.
- Consistent review of diagnosis, procedure and revenue codes to allow for full health plan adjudication.
- Consistent use of codes to indicate errors/next steps for the provider, including need for additional documentation.
- Detection and display of code descriptions to reduce burden of interpretation.
- Application of standard X12 data field labels to web portals to reduce variation in data elements to ease submission burden and encourage solutions that minimize the need for providers to submit information to multiple portals.
- Confirmation of receipt and acknowledgment of PA submission to reduce manual follow-up for providers.
- System availability requirements for a health plan to receive a PA request, to enable predictability for providers.

**NOTE:** The CAQH CORE Prior Authorization Subgroup is currently reviewing and refining these draft rule requirements prior to sending to the Rules Work Group. While in the review process, draft rule requirements are subject to change.
The Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule requirements target one of the most significant problem areas in the prior authorization process: requests that are pended due to missing or incomplete information, primarily medical necessity information.

These enhancements reduce the unnecessary back and forth between providers and health plans and enable shorter adjudication timeframes and reduced staff resources spent on manual follow-up.

The rule requirements reduce barriers to adoption by:

- Strengthening the data submitted by the provider and the communication of next steps by the health plan.
- Easing the burden of interpretation on the provider by standardizing code use through uniform use and requiring display of code descriptions.
- Allowing for more efficient review and adjudication of requests, by focusing on key aspects of the prior authorization process that can most benefit from systems and application development.
The Phase V CAQH CORE Prior Authorization Web Portal Rule builds a bridge toward overall consistency for the prior authorization request and response by addressing fundamental uniformity for data field labels, ensuring confirmation of the receipt of a prior authorization request and providing for system availability.

The rule reduces administrative burden and encourages pathways to automation by:

- Requiring use of the X12/v5010 278 Request and Response TR3 implementation names for the web portal data field labels, which supports the HIPAA-mandated standard transaction.

- Adhering to the requirements outlined in the Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule when the portal operator maps the collected data from the web portal to the X12/v5010 278 Request and Response transaction.

- Reducing variation in data elements to ease submission burden and encourage technology solutions to minimize the need for providers to submit information to multiple portals.
# Phase V CAQH CORE Prior Authorization Operating Rule Development Timeline

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**Phase V Rule Development**
- PA Subgroup (PASG) Develops and Refines Rule Options.
- PASG Develops Draft Rules.
- **Rules Work Group (RWG) Reviews Draft Rules.**

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<th>Phase V Certification &amp; Testing Development</th>
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**Phase V Certification & Testing Development**
- Certification & Testing Subgroup (CTSG) Develops Test Suite.
- Technical Work Group (TWG) Reviews Test Suite.

**CAQH CORE Phase V Voting**
- All CAQH CORE Participant Vote.
- CAQH CORE Board Vote & Approval.

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We are here
### Why join a CAQH CORE group?
Contribute to the development of implementable operating rules for targeted industry change, resulting in meaningful improvements for providers, health plans and patients.

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<th>CAQH CORE Group Name</th>
<th>Group Focus</th>
<th>Current Group Objectives</th>
<th>Target Launch &amp; Meeting Cadence (Tentative)</th>
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| Phase V Rules Work Group              | Rule Review                        | Review the Draft Phase V Operating Rules developed by the Prior Authorization Subgroup; participate in ballot to approve the draft rules to move on to an All CORE Participant Vote. | ▪ Launched September 2018.  
▪ Cadence: Once monthly; September-November 2018 period.                                                                 |
| Phase V Certification & Testing Subgroup | Test Suite Development             | Develop the Certification Test Suite for the Phase V CAQH CORE Operating Rules.            | ▪ Target Launch: Q4 2018.  
▪ Cadence: Once monthly; targeted for the October 2018-January 2019 period.                                                                 |
| Phase V Technical Work Group          | Test Suite/Technical Specification Review | Review technical rules (when applicable); review the Certification Test Suite for Phase V CAQH CORE Operating Rules (developed by the Certification & Testing Subgroup). | ▪ Target Launch: Q1 2019.  
▪ Cadence: Once monthly; targeted for the January-March 2019 period.                                                                 |

### CORE Certification and CORE Endorsement
Organizations can demonstrate adoption of the CAQH CORE operating rules and electronic transactions through CORE Certification, including prior authorization.
Polling Question

Are you interested in getting involved in the CAQH CORE Prior Authorization effort?

- I am a CORE Participant interested in joining the Phase V Rules Work Group.
- I am a CORE Participant interested in joining the Phase V Technical Work Group.
- I am a CORE Participant interested in joining the Phase V Certification Testing Work Group.
- I am interested in learning more about CORE Participation.
- I am interested in learning about possible rule adoption pilot projects to measure return on investment.
**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

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- Navigate to the Resources section for today’s event to find a PDF version of today’s presentation slides.
- Also, a copy of the slides and the webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.
Thank you for joining us!

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.

Website: www.CAQH.org/CORE
Email: CORE@CAQH.org