CAQH CORE

Moving Forward: Building Momentum for End-to-End Automation of the Prior Authorization Process

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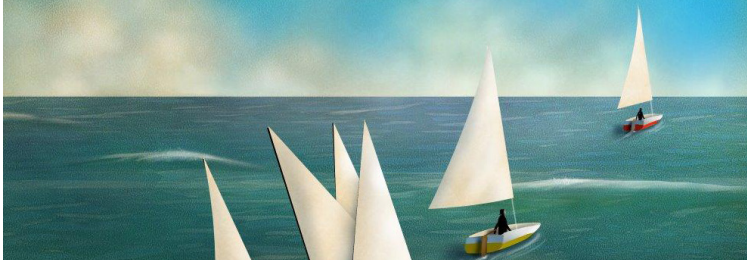


Executive Summary

Prior authorization, a tool used as a gateway to certain benefits of a patient's health plan, originated from a desire to ensure high quality of care while concurrently controlling healthcare spending. The prior authorization process itself, however, is labor-intensive and has become a significant source of administrative burden for healthcare providers and health plans alike. Administrative prior authorization processes have been estimated to contribute as much as $25 billion annually[1] to the cost of healthcare in the United States and have been linked to negative effects on patient care[2,3,4] and provider morale.[5]

Despite longstanding efforts by industry and government to improve the prior authorization process through greater automation, manual processes remain dominant. As demonstrated by the successful automation of other essential healthcare administrative processes, prior authorization can be made more efficient, predictable and uniform using operating rules to tie together the end-to-end workflow leading to greater adoption of federally mandated electronic HIPAA standards and use of emerging standards.

CAQH CORE® Operating Rules codify common business practices to simplify the sharing of data among many parties. Operating rules support standards and specify the business actions for which each party must adhere to ensure a high volume of reliable data exchanges can occur smoothly, making it easier for stakeholders to uniformly implement and benefit from standards, creating a comprehensive solution.

A standard electronic method for conducting at least part of the prior authorization process has been federally mandated since the early 2000s.* However, adoption of electronic prior authorization has remained low compared to other administrative transactions for which an electronic standard is required. According to the 2018 CAQH Index[6], a survey of progress to simplify healthcare administrative functions, only 12 percent of prior authorization transactions were conducted using the electronic standard. In the same report, adoption of electronic standards increased substantially for several other transactions over the past few years.

Numerous barriers have prevented or slowed the adoption of electronic prior authorization. These barriers are wide-ranging, encompassing the nature of the transaction itself, the lack of operating rules to support use of the electronic transaction standard, a lack of infrastructure supporting electronic submission of supporting clinical documentation, vendor readiness, the ubiquity of web portals and a myriad of state laws. In addition, some components of the prior authorization workflow occur outside the scope of the electronic standard.

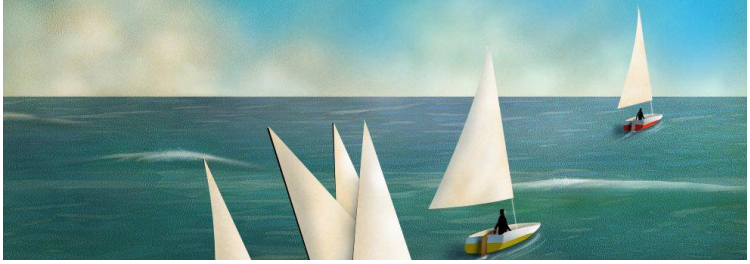
A groundswell of momentum to reduce the prior authorization administrative burden has sparked innovative collaborations, state laws and broad policy discussions to help the industry move toward more efficient prior authorization processes. As a result of a prioritized effort by over 100 CAQH CORE participating

* The adopted standard for prior authorization and referrals is the X12/005010X217 Health Care Services Review – Request for Review and Response (278) transaction, hereafter referred to as "5010X217 278 Request and Response".

organizations, the Phase V CAQH CORE Operating Rules for prior authorization were released in May 2019. These rules include the Prior Authorization (278) Request / Response Data Content Rule and the Prior Authorization Web Portal Rule. They join the Phase IV CAQH CORE Prior Authorization Infrastructure Operating Rule to form the foundation of a roadmap to move the industry toward an end-to-end automated workflow for prior authorization adjudication.

To address the full end-to-end workflow, CAQH CORE is collaborating with standards development organizations focusing on the interplay of existing and emerging standards and operating rules to close automation gaps and optimize the prior authorization process. CAQH CORE participating organizations are starting pilots to measure the impact of these new operating rule opportunities to drive further automation along the end-to-end workflow.

With a cadre of collaborative efforts starting to gain traction, industry stakeholders are striving to reduce the administrative burden of prior authorization for providers and health plans and create a system that serves the needs of patients by assuring the provision of timely, safe and effective care.



CAQH CORE: Driving Automation

As stakeholders first began to implement HIPAA electronic transaction standards in the early 2000s, no operating rules existed to guide implementation. Health plans, providers and vendors were left to decide for themselves how to define key terms or the specific protocols for sharing data. Non-uniformity quickly became the norm. The use of proprietary systems and workarounds had an effect opposite that intended by HIPAA administrative simplification measures. Administrative complexity rose sharply.

The industry solution was to establish CAQH CORE and task it with driving the creation and adoption of healthcare operating rules[7] to document industry agreement for common business practices and support standards by ensuring their uniform implementation. Operating rules tie together the end-to-end administrative workflows across common transactions such as prior authorization to support a comprehensive solution. Operating rules accelerate interoperability and align administrative and clinical activities among providers, payers and consumers.

Beginning in 2005, CAQH CORE broke new ground with a consensus-driven process that brought multiple stakeholders together to iron out the "rules of the road" for implementing HIPAA and other standards. In its first three phases of operating rules, CAQH CORE addressed eligibility and benefit verification, claim status, claim payment and remittance advice. It also launched a successful certification program. During this period, adoption of the rules was entirely voluntary, yet many organizations implemented the rules because they saw the value.

This experience led the Secretary of the Department of Health and Human Services (HHS) to tap CAQH CORE in 2012 as the designated authoring entity for federally mandated operating rules under Section 1104 of the Affordable Care Act (ACA).[8] HHS also adopted the first three phases of CAQH CORE rules, originally voluntary, as mandatory under the ACA. Since that time, CAQH CORE has authored additional rules addressing claim submission, prior authorization, enrollment and disenrollment and premium payment.

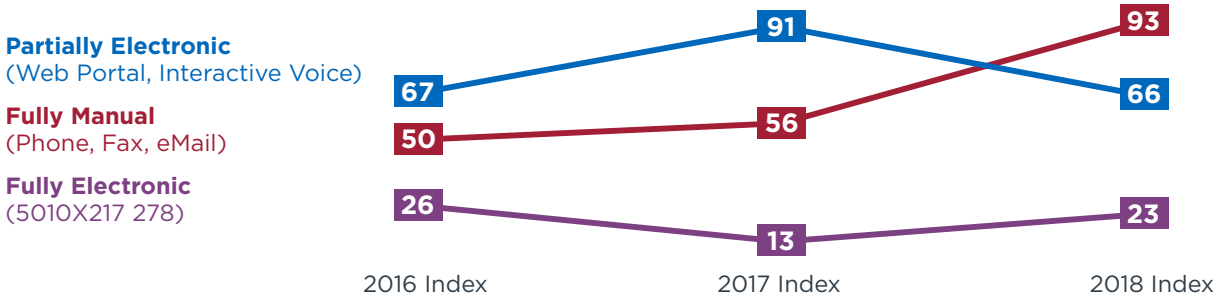
Most recently, the scope of CAQH CORE has expanded to include improving the collective exchange needs of value-based payment. In 2018, the organization published results of an expansive study[9] drawing parallels between the administrative and operational challenges associated with value-based payment today and those experienced in the early 2000s associated with fee-for-service. CAQH CORE has launched an industry effort to facilitate needed collaboration to help ease these value-based payment administrative burdens.

Operating rule implementers have had a means through CORE Certification to voluntarily validate and demonstrate that their systems are operating in conformance with the rules since 2007. CAQH CORE has now awarded more than 360 certifications to healthcare organizations. These organizations include health plans and payers that collectively cover 78 percent of commercially insured health plan members, 75 percent of Medicare Advantage beneficiaries and 44 percent of Medicaid enrollees in the United States.

1 The Prior Authorization Process: A Fractured Workflow

Prior authorization is a process to obtain health plan approval for provision of specific healthcare services to a patient covered by the health plan. The process is intended to manage utilization of healthcare resources, reduce overuse or misuse of services, improve the quality of care and control healthcare spending. Today, prior authorization is used by most health plans as a pathway to access certain benefits of a patient's health plan, such as surgeries, diagnostic tests, procedures, medications and other categories of service. The number of prior authorizations conducted nationally is estimated to have increased by 27 percent over a two-year period, growing from 143 million in 2016 to 182 million in 2018, according to the 2018 CAQH Index[10] (Figure 1). The expansion in its use has drawn the attention of providers, patients and lawmakers.[11]

Figure 1: Estimated National Volume of Prior Authorizations, Medical, by Mode, 2016-2018 CAQH Index (in millions)



The CAQH Index: A Resource for Stakeholders and Policymakers

The CAQH Index is the industry resource for benchmarking progress to reduce a portion of healthcare industry administrative complexity. Since 2013, the CAQH Index has tracked adoption of routine electronic administrative transactions, including those mandated through HIPAA and other transactions. These transactions include verifying a patient's insurance coverage, obtaining prior authorization for care, submitting a claim, sending and receiving payments and more. It also estimates the annual volume of these transactions, their cost and the time needed to complete them.

By benchmarking progress, industry and government can more easily identify barriers that may be preventing stakeholders from realizing the full benefit of electronic administrative transactions. These insights can prompt new initiatives to address and reduce barriers.

The CAQH Index is available for complimentary download at www.caqhindex.org. This website also offers a savings calculator, an on-demand webinar about the most recent report and information about how stakeholders can participate. All health plans and providers, as well as vendors and clearinghouses, are encouraged to participate in CAQH Index. For more information, contact explorations@caqh.org.

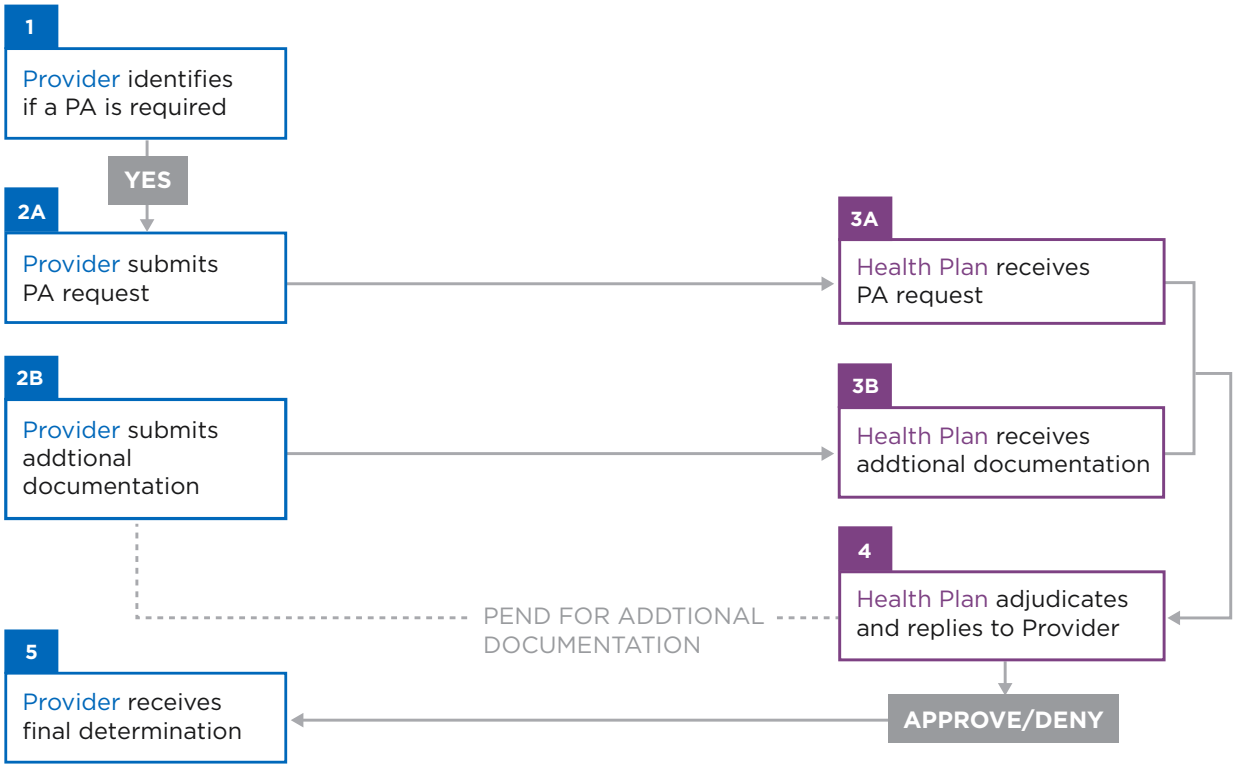
Although the use of prior authorization has increased, the level of automation remains low. Even when prior authorizations transactions are initiated electronically using the 5010X217 278 Request and Response, there are many points along the process where these transactions can fall to partially electronic (web portal tools and interactive voice response systems) and even to manual processes (phone, fax and e-mail).

ACCESS TO SUBMISSION REQUIREMENTS

The prior authorization process begins when a provider determines that a patient needs a medical service, special medical equipment, medication or related supplies. To understand if a prior authorization is required for provision of that service, provider staff often manually review lists of services requiring prior authorization. These lists differ by and within health plans, can lack uniformity and specificity and may be out of date, which often results in the need for clarification by phone. Provider-facing web portals also offer access to the lists of services requiring prior authorization. However, while these lists may be more frequently updated than lists available via other look-up methods, outdated information may still be an issue.

Once a provider confirms that a prior authorization is required, portals may also allow the provider to look up the requirements for that specific request and submit the request from a single web-based application. Some health plans use a more manual PDF look-up process, while others employ a search capability to find the prior authorization requirements by procedure code. The retrieval of clinical information required to accompany a prior authorization request is also mostly manual. Due to the relative lack of integration between clinical and administrative systems, providers often rely on manual methods of data retrieval or toggle between applications. Some providers may have a solution in place that provides integration between systems and allows for time savings from reduction in manual keystrokes.

Figure 2: High-Level Prior Authorization Workflow



REQUEST SUBMISSION PROCESSES

Providers currently use a range of processes - manual, electronic and partially electronic - for submitting prior authorization requests to health plans. While manual options, such as phone, are generally more burdensome and cost the industry $7.28 more per transaction[12], providers report that this method frequently results in the most clarity regarding requirements, status and next steps given the lack of automation across the entire prior authorization workflow.

Web portals are generally thought to be less efficient for the provider than the 5010X217 278 Request and Response given their nonuniformity and the staff time required to manage unique logins for each health plan. Moreover, the 5010X217 278 Request and Response, while federally mandated under HIPAA, is not a viable option if the provider does not have the system to support it. This is common given that vendor solutions do not always offer it.

In general, even when providers are ready to submit a prior authorization request electronically, a system to receive the request is not always available at the health plan, and it is difficult to determine such availability. Finally, once a provider submits the request, there may be no acknowledgement that the submission was successfully received.

ADJUDICATION AND COMMUNICATION OF NEXT STEPS

Once the health plan receives a prior authorization request, most are routed through a manual internal review rather than an automated adjudication process. This especially pertains to requests that require medical documentation.

Health plans have been limited by a lack of robust electronic communication channels to update the provider in a timely fashion to communicate errors, indicate the need for additional information and to identify next steps. Providers routinely call the health plan to determine the status of the request, as well as any next steps to get the request approved. Missing or incomplete information, including proof of medical necessity, is one of the most common reasons for a health plan to pend a request. Providers are not always able to include this information on the request itself, either because it is not known or they need to transmit it separately, lengthening the time to final adjudication and delaying patient care.

When the health plan has collected the information needed to render a decision, it delivers the decision back to the provider. This decision is usually communicated to the provider via a decision notice letter, a returned provider review letter, a web portal notification or over the phone.

CLINICAL DOCUMENTATION TO PROVE MEDICAL NECESSITY

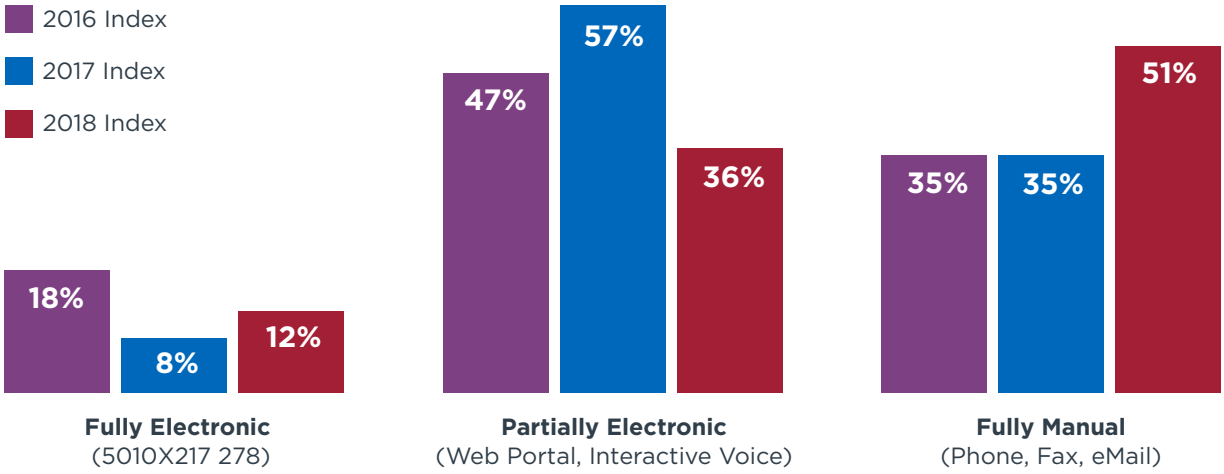
Providers are often asked to share clinical documentation with the health plan to demonstrate medical necessity for the services being requested. This documentation is submitted in the form of an attachment. Attachments are a bridge between clinical and administrative data. They give health plans vital information for adjudication of a subset of claims, including prior authorizations.

The attachments workflow is primarily manual and a source of significant administrative burden. To date, a HIPAA-mandated standard for attachments has not been named, resulting in a lack of direction needed to support broad use of automation in the attachment workflow or for the industry to coalesce around the use of even a small number of less manual solutions.

2 Barriers to Adoption of the HIPAA-mandated Electronic Prior Authorization Standard

Although an electronic standard for automating part of the prior authorization process has been in place since the early 2000s, industry adoption is limited in contrast to other federally mandated HIPAA electronic transactions. The 2018 CAQH Index[13] found that only 12 percent of the 182 million medical sector prior authorization transactions were conducted using the federally mandated HIPAA standard 5010X217 278 Request and Response. Roughly half (51%) of these transactions were performed manually by phone, fax, or email, and more than a third (36%) were conducted using a web portal or interactive voice response system (Figure 3).

Figure 3: Adoption of Electronic Prior Authorization, Medical, 2016-2018 CAQH Index



Numerous barriers have prevented or slowed healthcare industry adoption of the existing prior authorization electronic standard. These barriers are wide-ranging, encompassing the nature of the transaction itself, the lack of operating rules to support use of the electronic transaction standard, a lack of infrastructure supporting electronic submission of supporting documentation, vendor readiness, the ubiquity of web portals and a myriad of state laws. Notably, these barriers share a common theme, demonstrating that many components of today's prior authorization workflow occur outside the scope of the 5010X217 278 Request and Response.

- **The Need for Consistency in Data Content.** A major impediment to a fully electronic prior authorization process is inconsistency in how codes are used to communicate status, errors and next steps, including the need for clinical documentation to prove medical necessity. In a landscape where requirements for authorizations differ across (and within) health plans, providers do not have an efficient way to identify what critical information to submit in the request. Lack of uniformity in code use – and use of overly generic codes that do not provide clear direction and next steps – further limit adoption of the standard transaction on the provider side. The recently released Phase V CAQH CORE Operating Rules for prior authorization provide support for data content consistency (see page 13 for more detail).

- **No Federally Mandated Attachments/Clinical Documentation Standard.** The standard prior authorization request contains data fields in which clinical information is inserted about the patient; however, health plans often require an additional level of granularity. The lack of an attachment standard or uniformity in the supporting clinical documentation requested by health plans fuels a sense of uncertainty about investments in various solutions, deterring vendor support for the 5010X217 278 Request and Response on its own, resulting in numerous work-arounds that providers are asked to support.[14]
- **Lack of Integration Between Clinical and Administrative Systems.** Electronic prior authorization requests are typically initiated by a practice management system (PMS), but require the use of clinical information. This clinical information is usually housed in the electronic health record (EHR) system. Because integration between PMS and EHR systems is uncommon, most providers must retrieve clinical information from the EHR and manually enter it into the prior authorization request. This process can be not only an obvious source of human error, but also a frustrating drain on productivity and efficiency. Similarly, adjudication of a prior authorization often requires health plans to manually access and use information from numerous systems and databases.
- **Limited Availability of Vendor Products that Readily Support the Standard Transaction.** A research supplement in the 2017 CAQH Index[15], which examined vendor products to assess their level of support for processing HIPAA electronic transactions, found that only 12 percent supported electronic prior authorization. For all other electronic transactions, vendor support was between 74 percent and 91 percent. Some vendors indicated that, while their systems do currently support prior authorization, this functionality is not part of the core product offering to providers. That is, prior authorization functionality may be available in some vendor systems, but only in a premium configuration.
- **State Requirements for Manual Intervention.** In cases of more complex prior authorization requests, peer-to-peer reviews may take place that cause the process to drop to manual phone calls. Some state legislatures have mandated that certain steps of the prior authorization process be handled manually. In Minnesota, when health plans do not certify a prior authorization request, they are required to notify providers by phone, fax or secure email.[16] In both Colorado and Rhode Island, health plans are required to give providers an opportunity to speak directly by phone or in person with a qualified medical professional before issuing an adverse determination. [17,18] Some of these manual requirements are in place because a phone call or written letter may be a more trusted mode of receiving communication regarding determinations. Additionally, disparate requirements across states makes automation even more difficult for health plans and health systems that work in multiple states.
- **Lack of Provider Awareness.** Despite the above challenges, the industry is coming together to automate the prior authorization workflow. Solutions like operating rules make the 5010X217 278 Request and Response more robust and less likely to drop to manual processes. Operating rules will also bring greater consistency to the electronic exchange of clinical documentation (attachments). However, many providers are still unaware that HIPAA requires health plans to offer the 5010X217 278 Request and Response to conduct prior authorizations electronically. Greater demand from providers can incent broader use of the 5010X217 278 Request and Response and encourage development of vendor products to support its exchange.

These substantial barriers, which affect all stakeholders, demonstrate the unique and valuable opportunity that eliminating barriers to automation along the end-to-end workflow for prior authorization presents. It also helps explain why organizations and entities representing a diverse array of healthcare industry participants have stepped forward to collaborate toward solutions.

3 Public and Private Sector Commitment to Improve Prior Authorization

Given the opportunities for process improvements, cost savings, provider experience and patient care, industry momentum to address the challenges of prior authorization has never been greater, and there are reasons to be optimistic about the prospect for improvements. In both the public and private sectors, initiatives are underway that promise to effect real change, and standards organizations are working to meet the industry need.

ACTION IN THE PUBLIC SECTOR

Collaboration in the Department of Health and Human Services

Within the public sector, HHS is taking the lead through the Office of the National Coordinator for Health IT (ONC) and the Centers for Medicare and Medicaid Services (CMS). In the draft "Strategy on Reducing Burden Relating to the Use of Health IT and EHRs,"[19] CMS and ONC jointly call out the challenges associated with the prior authorization administrative and clinical workflows, acknowledging the need for agency alignment on the topic.

Additionally, the National Committee on Vital and Health Statistics (NCVHS) and Health Information Technology Advisory Committee (HITAC), federal advisory committees to CMS and ONC respectively, have demonstrated a commitment to collaboration on this issue and to the convergence of clinical and administrative standards. Each of these organizations have made meaningful contributions to the other's meetings and hearings on the topic.[20]

Medicare Documentation Requirements Lookup

One example of the Centers for Medicare and Medicaid Services (CMS) commitment to ease the provider prior authorization burden is its development of a Medicare Fee-for-Service (FFS) Documentation Requirement Lookup Service.[21] The initiative enables providers to discover prior authorization and documentation requirements at the time of service within the electronic health record (EHR) or practice management system (PMS) using Application Programming Interfaces (APIs) and solutions based on Health Level Seven (HL7) Fast Healthcare Interoperability Resources (FHIR).

Movement in Congress

Awareness of challenges related to prior authorization and attachments continues to build in Congress. Committees in both the Senate and the House have either held hearings or introduced legislation to address prior authorization. Multiple witnesses at a July 2018 Senate Health, Education, Labor and Pensions (HELP) Committee hearing focused their testimony on the burden of prior authorization.[22] During the summer of 2019, bi-partisan legislation was introduced in the House Ways and Means Committee.[23] In advance of this legislation, the committee chair, Rep. Richard A. Neal (D-MA), urged HHS Secretary Alex Azar "to move forward with electronic transaction standards to reduce administrative burden for physicians and other providers who are subject to health plan prior authorization requests."[24]

Policy Activity at the State Level

Many states have developed requirements related to prior authorization in recent years, with more than 50 pieces of legislation from over 30 states to date.[25] State legislative actions represent a wide variety of approaches and measures to reduce burden, control costs and improve the timeliness of patient care. For example, many states have established requirements around response times for health plans and providers, including a maximum response time requirement for a final determination on a prior authorization request. Other common themes include transparency for which services require prior authorization, use of standardized forms, use of electronic systems and processes, as well as peer-to-peer reviews with providers of the same specialty area.

A GROUNDSWELL OF INDUSTRY SUPPORT

In addition to public sector engagement, several industry initiatives have helped to frame the prior authorization discussion and point to an increase in support for its optimization.

Provider and Health Plan Associations Work Toward Consensus

The American Medical Association (AMA) has championed research on prior authorization, shedding more light on the impact the process has on physicians.[26] The AMA was also instrumental in a coalition of 17 organizations representing providers, medical groups, patients and pharmacists that asked health plans, benefit managers and others in January 2017 to reassess prior authorization programs. The group offered 21 principles to guide the industry reassessment in categories that included clinical validity; continuity of care; transparency and fairness; timely access and administrative efficiency; and alternatives and exemptions.[27]

A focused effort by a coalition of six organizations in July 2018 released a Consensus Statement on Improving the Prior Authorization Process.[28] In it, the American Hospital Association, America's Health Insurance Plans, AMA, American Pharmacists Association, Blue Cross Blue Shield Association and Medical Group Management Association identified five opportunity areas for prior authorization improvement and agreed to support certain principles advancing each of the five areas. The CAQH CORE Board published an open letter in support of this statement.[29]

Industry Work Groups Increase Focus on Prior Authorization

Meanwhile, numerous industry coalitions are facilitating industry dialogue and documenting best practices.

The Work Group for Electronic Data Interchange (WEDI), an industry coalition with a mission to improve healthcare information exchange, focuses on prior authorization in several ways. WEDI collaborated through its Prior Authorization Council to develop a February 2019 white paper, making recommendations for policy development, standardization and gap identification.[30] It proposed the need for a work group to set expectations for vendors of EHR systems, health information systems, PMS and others supplying software and services to payers and providers. It also called for harmonization of standards development efforts, including FHIR, Consolidated Clinical Document Architecture (C-CDA) and X12. An earlier WEDI white paper provided guidance on exchange of electronic attachments, including for prior authorization.[31] In addition, the WEDI Prior Authorization Subworkgroup continues to build a guiding principles document for a fully electronic prior authorization process.

The eHealth Initiative (eHI), which convenes executives from healthcare industry groups to share best practices, launched the Prior Authorization Collaboration Project[32] in 2018 and published a white paper on the topic in 2019.[33] In the paper, industry executives agreed that transparency of requirements, reduction in volume, use of standards and exploration of alternative payment models are key to improving the prior authorization process.

Private Sector Organizations Commit to Standardization

The Da Vinci Project, an initiative working to accelerate the adoption of HL7 FHIR as the standard to support value-based data exchange, was founded in 2018 by private sector healthcare companies, including health plans, providers and vendors.[34] Notably, these companies pledged their commitment to minimize development of unique solutions – including for prior authorization – and some have committed to test, pilot and refine use of the emerging standards for various use cases.[35]

Health plans are now experimenting with new policies to ease the provider prior authorization burden, including reducing the number of services that require authorization[36] or exempting some providers from the process altogether.[37] Providers who qualify for this exclusion program already have high approval levels for past prior authorization requests with insurers or have agreed to use clinical decision support tools.[38,39] Value-based payment arrangements, where risk is often shared between providers and payers, offer additional opportunities to rethink prior authorization requirements. The use of artificial intelligence (AI) to auto-approve some prior authorization requests for routine services and procedures and to identify critical patient information in the EHR[40] is also underway.

4 Evolving Standards and Operating Rules

Standards and operating rules for healthcare information exchange serve as a critical foundation for a more efficient, predictable and uniform prior authorization process. Leading organizations in this space are prioritizing development of standards and operating rules that support the end-to-end prior authorization process and help close the automation gap.

- As a designated standards development organization, X12 continually works to ensure that HIPAA electronic transaction standards meet the evolving needs of the industry. Most recently, X12 added two new codes to its Health Care Service Review Decision Reason Codes list. This move was in response to industry feedback calling for additional codes to communicate the reason for a healthcare services review outcome, including for prior authorization.[41] This code list is maintained externally to the 5010X217 278 Request and Response base standard to allow for flexibility when needed.[42]
- HL7, also a designated standards development organization, is demonstrating its commitment to improving the prior authorization process via two separate but related paths. The Financial Management Work Group and Additional and Supporting Information - Payers/Providers (ASIPP) Work Group work closely together on HL7 standards and FHIR resources that support the intersection of clinical and administrative data exchange. In addition to Work Group efforts, HL7 officially hosts the Da Vinci Project and serves as a founding member alongside the private sector companies. Its FHIR standard serves as the basis for the Da Vinci Project use cases. Da Vinci members and HL7 have prioritized use cases related to prior authorization, including Documentation Templates and Coverage Rules, Coverage Requirements Discovery and Prior Authorization Support.[43]
- CAQH CORE Operating Rules support and add value to these existing and emerging standards by offering specific business rules that close common automation gaps. CAQH CORE participating organizations, representing providers, health plans, vendors and government have produced two phases of operating rules that lay the foundational infrastructure and data content requirements needed for the standard prior authorization transaction. For example, a recently published rule outlines how plans can communicate status, next steps and information needs to providers – all using the standard electronic transaction rather than phone or email. The rule points to use of standardized code sets to flag what additional documentation is needed and is in concert with subsequent workflows for exchange of attachments, including those that leverage existing X12 and/or HL7 additional documentation standards.

CAQH CORE Prior Authorization Operating Rules

The Phase IV CAQH CORE Prior Authorization Infrastructure Rule establishes foundational requirements that build consistency with other operating rules for HIPAA transactions. These foundational requirements include receipt acknowledgement, connectivity methods, required response times, minimum system availability and a common companion guide format. The rule ensures electronic prior authorization information is shared in an organized, trusted and consistent way.

The Phase V CAQH CORE Prior Authorization Operating Rules were released in May 2019 and build on the Phase IV Operating Rules. These rules standardize data content related to the exchange of information for procedures, laboratory testing, medical services, devices and medications within the medical benefit. Addressing one of the most significant problem areas in the prior authorization process - requests for medical services that are pended due to missing or incomplete information - the rules give health plans a more robust electronic means of communicating with providers about missing clinical information and documentation. The rule requirements are expected to reduce the unnecessary back and forth between providers and health plans, accelerate adjudication timeframes and reduce provider resources spent on manual follow up.

As part of its integrated model, CAQH CORE continually measures the impact of operating rules, including maintenance and updates to meet evolving industry business needs. For example, CAQH CORE participating organizations are currently evaluating an update to requirements in the Phase IV Prior Authorization Rule. The update under consideration includes a timeframe for final determination of a prior authorization request, a measure that would set national expectations for how long it takes to adjudicate a prior authorization request.

A COLLECTIVE PUSH TO CLOSE GAPS IN AUTOMATION

Each standards and operating rule development organization holds a piece needed to complete the puzzle and to collectively integrate clinical and administrative data. Recognizing the meaningful opportunity to optimize the prior authorization process, these organizations are working more closely than ever before. Emerging initiatives are focusing on the interplay of standards and operating rules to close automation gaps.

In collaboration with its participating organizations, CAQH CORE is launching prior authorization pilot tests designed to identify opportunities to refine existing and develop additional rules, and measure the impact of operating rules and corresponding standards on the pilot organizations' efficiency metrics (Figure 4). Pilot workflows address the intersection of CAQH CORE Operating Rules, X12 standards and HL7 standards, including FHIR, to ensure operating rules support industry organizations in varying stages of maturity along the standards and technology adoption curve. As the industry awaits a federally mandated standard on attachments, the pilots are also an opportunity to address the critical role of clinical documentation in the prior authorization

workflow via testing combinations of exchange methods and their impact in reducing manual intervention. CAQH CORE, in its role as designated authoring entity for federally mandated operating rules[44], may report findings to NCVHS and HHS as part of a recommendation for national operating rule implementation.

Figure 4: CAQH CORE Pilots to Measure Value of Prior Authorization Operating Rules & Existing and Emerging Standards

Pilots apply existing and potential new Prior Authorization Operating Rule Requirements to the Components that participants choose to test. Pilot participants select underlying standards and technologies based on capabilities and interest.

PROVIDER SYSTEM*

CAQH CORE Operating Rule Requirements for Providers

NOTE: May not apply to all exchange options

- Security/Authentication; Connectivity/Transfer; System Availability
- CORE Connectivity
- Submission of information needed to answer query/adjudicate request
- Detection and display of codes
- *Re-association of PA Request with additional information*
- *Resolution quality requirements for non-text attachments; File size specifications*

Component A: Infrastructure

Overarching: Connectivity, Security and Data Transfer
(e.g. CORE PIV Connectivity / REST Web Services / DIRECT; Acknowledgments; Response Time, etc.)

Component B: Is a PA required?

Query 1: Is a PA Required?

Options for Exchange: X12 278 / X12 271 / HL7 FHIR

Answer 1: Rejected (missing / inaccurate information)

Answer 2: No, PA Not Required

Answer 3: Yes, PA Required

Answer 4: [278 / FHIR only]: Yes, Required; no Additional Information needed

Answer 5: [278 / FHIR only]: Yes, Required; Additional Information needed

Component C: Is this PA authorized?

Query 2: Is this PA Authorized?**

Options for Exchange: X12 278 / HL7 FHIR

Answer 1: Rejected (missing / inaccurate information)

Answer 6: PA Approved

Answer 7: PA Denied

Answer 8: PA Pended (if applicable, Additional Information needs are communicated)

HEALTH PLAN SYSTEM*

CAQH CORE Operating Rule Requirements for Health Plans

NOTE: May not apply to all exchange options

- Security/Authentication; Connectivity/Transfer; System Availability
- Acknowledgement of receipt within set timeframes
- Patient Matching and processing of certain codes
- Consistent communication of errors
- Use of codes to communicate reason for pend and additional doc needed
- Initial response time requirement
- *Use of codes to communicate PA requirements and doc needs*
- *Use of codes to communicate benefits coverage and patient financials*
- *Re-association of docs with PA Request*
- *Final determination response time*

Italics text represents potentially new or reusable Operating Rule Requirements under consideration
*Could be direct connection or via intermediary
**Provider may submit Additional Clinical Information concurrently

The X12 and the Da Vinci Project cooperative effort to map Da Vinci FHIR resources to the X12 5010X217 278 Request and Response is reason for optimism about standards interoperability. The initiative will ultimately ensure that the process for using FHIR resources to conduct prior authorization activities will support the data in the 278 transactions and enable information to transition between the FHIR bundle and the HIPAA-mandated 278 transaction where needed. This approach allows for flexibility surrounding the standards, while still providing structure. The combination of these standards and the CAQH CORE Operating Rules, informed by real-world testing and implementation, can support the end-to-end electronic prior authorization process.

5 Where Do We Go from Here?

Today, all healthcare stakeholders are motivated to help resolve the administrative burdens associated with prior authorization. Indeed, a groundswell of industry support for initiatives to call attention to and improve prior authorization is converging with encouraging signs of action in the public sector, including at HHS, in Congress and at the state level. Also, standards development organizations and operating rule authoring entities are collaborating to close gaps.

The opportunity for operating rules and existing and emerging standards to remove silos, find common ground and achieve alignment is vast. By introducing and leading targeted change via operating rules, CAQH CORE aspires to propel the industry toward a more optimized and automated prior authorization process. Although operating rules cannot resolve all the issues of prior authorization, adoption of the Phase IV and V CAQH CORE Operating Rules and participation in CAQH CORE's prior authorization pilots provide meaningful steps that healthcare stakeholders can take to support the move toward automation of prior authorization.

The CAQH CORE rule development process itself also is an important forum for collaboration. It gives the industry a way to agree on common expectations. Importantly, operating rules can also ensure consistent use of existing and emerging standards. For example, they can establish and maintain common data and infrastructure requirements across standards, giving the industry flexibility to move forward without losing sight of the need for a common approach.

As demonstrated in this report, a range of industry initiatives have already begun to take root, making substantial improvements in the prior authorization process. This renewed spirit of collaboration is the pathway to reducing prior authorization administrative burden. It is imperative for all stakeholders to actively encourage and participate in this collaborative momentum toward a more automated prior authorization end-to-end workflow.

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