MAINE ASSOCIATION OF HEALTH PLANS

Report to the Committee on Health Coverage, Insurance and Financial Services on Efforts to Develop Standards for Secure Transmission of Prior Authorization Requests

Public Law c. 273 (*LD 705 An Act Regarding the Process for Obtaining Prior Authorization for Health Insurance Purposes*), includes the requirement that health insurers and the Maine Association of Health Plans (MeAHP) submit a Report to the Committee on Health Coverage, Insurance and Financial Services (HCIFS) on efforts to develop standards for secure electronic transmission of prior authorization requests no later than January 1st, 2020.[1]

Why prior authorization is important

Health insurance providers are committed to ensuring patients receive clinically effective, evidence-based, high value care. Utilization management tools, including prior authorization (PA), help accomplish these goals by requiring advance approval of coverage for a medical service. PA is applied to less than 15 percent of treatments.[2],[3]

While many studies have shown that Americans continue to receive wasteful, inappropriate and potentially harmful care at a significant cost, prior authorization helps to minimize these discrepancies. The estimated cost of waste in the U.S. healthcare system ranges from $760 billion to $935 billion, or about 25% of total healthcare spending according to a report in the Journal of the American Medical Association issued October 7th, 2019.[4] PA can eliminate unnecessary tests—such as certain imaging tests that are commonly overused and may expose patients to potentially harmful radiation, undue surgical procedures or added stress.

---

[1] P.L. c. 273, **Sec. 5. Report on electronic transmission of prior authorization request for medical services; authorization to report out legislation.** No later than January 1, 2020, health insurance carriers, in cooperation with the Maine Association of Health Plans, shall report to the Joint Standing Committee on Health Coverage, Insurance and Financial Services on efforts to develop standards for secure electronic transmission of prior authorization requests that meet requirements of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. The committee may report out legislation to the Second Regular Session of the 129th Legislature related to the electronic transmission of prior authorization requests for medical services.

[2] https://www.ahip.org/wp-content/uploads/AHIP-BCBSA-Small-Business-Committee-Prior-Auth-Statement-Sept2019.pdf

[3] https://www.ahip.org/myths-and-facts-ma/

[4] https://www.healthcaredive.com/news/waste-gobbles-up-25-of-us-healthcare-spending-jama-study-finds/564433/

An article published in the International Journal for Quality in Health Care in January 2019, reports that 30-60% of diagnostic imaging for three common conditions in Massachusetts was inappropriate.[5] Moreover, according to America's Health Insurance Plans (AHIP), Plans report that up to 25% of PA requests they receive from clinicians are for care that is not supported by medical evidence.[6] Plans report that PA is critical to identifying potential overuse, misuse, and safety issues before care is delivered.[7] Examples include opioids prescribed for patients also receiving benzodiazepines and MRIs for low back pain without documentation that the patient received 6 weeks of conservative therapy, which is recommended by leading medical societies. A majority of Plans also credit PA with improving physician performance, promoting dialogue between the Plan and clinicians and with helping to trigger action by the Plan to monitor care coordination.

Utilization management tools, including PA, ensure a well-functioning health system, however, both insurers and providers acknowledge that data interoperability is a challenge and that communication processes can and should be improved. In recent years, providers, health plans, electronic health record vendors and federal agencies have worked together to seek greater simplification and efficiency through automation.

Barriers to automation of prior authorization

Although slow progress is being made - which is described later in this report – there are significant barriers to full automation. Accomplishing "end to end" automation of PA includes accessing submission requirements, the request process, adjudication and communication of next steps, and the provision of clinical documentation to prove medical necessity.

A key element underlying automation is the ability for interacting parties to understand each other using a common data language of sorts. To share and use data from multiple institutions, data must be built upon common words (data elements and terminology), structures, and organization. In the world of information technology (IT), this requirement is called interoperability and it means that the support of common functions and procedures as well as the language of communication must be understandable by a computer at both ends of a transaction.[8]

---

[5] Stephen Flaherty, E David Zepeda, Koenraad Mortele, Gary J Young, Magnitude and financial implications of inappropriate diagnostic imaging for three common clinical conditions, *International Journal for Quality in Health Care*, January 23, 2019, https://doi.org/10.1093/intqhc/mzy248

[6] www.healthit.gov. 2019-03-20 Public and Private Payer Perspective AHIP Kate Berry.pdf

[7] AHIP State Issues Conference Presentation by Kate Berry, Senior Vice President of Clinical Affairs, AHIP, September 27, 2019

[8] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.24.5.1205, The Making and Adoption of Health Data Standards, W. Ed Hammond, 2005

The need for interoperability drove the development of an electronic transaction standard (5010X217 278 Request and Response[9]) that can be used to conduct at least part of the PA process. Although this standard has been federally mandated for over 10 years, according to a 2018 survey only 12% of PA transactions were conducted using the electronic standard.[10] According to the same survey, a full 51% were submitted fully manually, by phone, fax or e-mail.

The slow adoption by providers is driven by several factors including the lack of formal operating rules to support use of the electronic transaction standard, the absence of a HIPAA-mandated standard for attachments, and lack of infrastructure (electronic medical records system capabilities) to support the submission of clinical documentation supporting PA requests. Minimal vendor support and a lack of awareness and training capacity among providers are also problems. Fundamental to the array of challenges is the lack of integration between administrative and clinical data systems.

Clinicians use an electronic health record for clinical work and a separate administrative system to bill an insurer. Even though PA is an intrinsically clinical task, it is governed by an administrative standard mandated by HIPAA that leaves no room for medical notes, test results and patient history found in the electronic health record and no way for the insurer and doctor to exchange that data efficiently.[11]

Electronic PA requests are typically initiated by a practice management system, but require the use of clinical information which is housed in the electronic health record system. Integration between the two is uncommon so most providers must retrieve and enter clinical information manually, increasing chances of human error and administrative costs. Similarly, adjudication of a PA can require health plans to manually access and use information from numerous systems and databases. This toggling between applications and systems can create delays for both providers and carriers.[12]

Several national multi-stakeholder efforts are currently underway to develop the structure and processes to make PA more efficient and less costly while preserving its essential function and role.

Maine Association of Health Plans (MeAHP) member Plans are active participants in these efforts. Three of our Plans have representatives who lead portions of the projects described below including co-chairing subcommittees.

---

[9] https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Downloads/esMD_X12_278_Companion_Guide_AR2017010.pdf

[10] https://www.caqh.org/sites/default/files/explorations/index/report/2018-index-report.pdf, pg. 10

[11] https://www.modernhealthcare.com/insurance/momentum-builds-fix-prior-authorization, 10/5/2019

[12] https://www.caqh.org/sites/default/files/core/white-paper/CAQH-CORE-Automating-Prior-Authorization.pdf

Industry momentum towards electronic prior authorization

Health plans, providers, electronic health record venders and federal agencies are diligently working together in several forums to reduce the burden of prior authorization. A recent article published October 5th, 2019 in Modern Healthcare reports that momentum is building behind those efforts.[13]

Efforts include collaborations that:

- Publicly report multi-stakeholder commitments around PA
- Ensure consistent and reliable data interoperability standards so systems can communicate with each other
- Develop common operating rules to support and guide prior authorization
- Engage the vendor community to assist parties to operationalize the new standards and rules

In addition to these multi-stakeholder efforts, America's Health Insurance Plans (AHIP), the national trade association for health insurers, is conducting an industry-wide survey on the prior authorization landscape, challenges, and opportunities including use of automation efforts to streamline prior authorization. AHIP is also conducting a Prior Authorization Automation Demonstration Project that seeks to streamline PA processes for all stakeholders and has engaged an independent organization to evaluate impact and produce a report. The project has set forth guidelines requiring multiple approaches be considered, that all efforts must be based in medical standards and be scalable, the approach must be agnostic to payor (work across payors), and must integrate into existing practice work flow.

More information on each of the multi-stakeholder initiatives is provided below.

1. Publicly report multi-stakeholder commitments around prior authorization

In January 2018, the American Hospital Association (AHA), America's Health Insurance Plans (AHIP), American Medical Association (AMA), American Pharmacists Association (APhA), Blue Cross Blue Shield Association (BCBSA) and Medical Group Management Association (MGMA) announced a Consensus Statement "Collaboration to Streamline PA and Improve Timely Access to Treatment" outlining their shared commitment to industry-wide improvements to prior authorization processes and patient-centered care.[14] One of the five areas of commitment is accelerating movement towards electronic automation of prior authorization.

The statement calls for making prior authorization requirements electronically accessible to health care providers at the point-of-care in electronic health records (EHRs) and

---

[13] https://www.modernhealthcare.com/insurance/momentum-builds-fix-prior-authorization, 10/5/2019

[14] https://www.ahip.org/wp-content/uploads/2018/01/Joint-News-Release-Prior-Authorization-Consensus-Statement.pdf

widespread technology adoption by all involved stakeholders, including health care providers, health plans, and their trading partners/vendors of standard electronic prior authorization processes.

Signatories agree to accelerate use of existing national standard transactions for electronic prior authorization, advocate for adoption of national standards for the electronic exchange of clinical documents (i.e., electronic attachment standards), advocate that health care provider and health plan trading partners and 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 requirements at the point of care and via websites easily accessible to contracted health care providers.[15]

Progress being made towards these public commitment goals is being principally led by three collaborative efforts - the Da Vinci Project, CAQH CORE, and WEDI – each of which is described more fully below.

2. Ensure consistent and reliable data interoperability standards so systems can communicate with each other

Interoperability challenges have limited many stakeholders in the healthcare community from achieving better care at lower cost. The dual challenges of data standardization and easy information access are compromising the ability of both payers and providers to create efficient care delivery solutions and effective care management models.

Founded in 1987, Health Level Seven International (HL7)[16] is a not-for-profit, ANSI-accredited standards developing organization dedicated to providing a comprehensive framework and related standards for the exchange, integration, sharing, and retrieval of electronic health information that supports clinical practice and the management, delivery and evaluation of health services. HL7 is supported by more than 1,600 members from over 50 countries, including 500+ corporate members representing healthcare providers, government stakeholders, payers, pharmaceutical companies, vendors/suppliers, and consulting firms.

The Da Vinci Project[17] is a private sector initiative hosted under the umbrella of HL7 and represents a diverse body of stakeholders with experience across the specific value-based care business challenges, emerging Fast Health Interoperability Resources (FHIR) standards and practiced at agile development. Founding organizations are drawn from payers, providers and vendors.

The objective of Da Vinci is to minimize the development and deployment of unique solutions between trading partners (e.g. a payer and provider), to promote interoperability

---

[15] Ibid.
[16] https://www.hl7.org/about/index.cfm?ref=common
[17] http://www.hl7.org/about/davinci/

across value-based care stakeholders, and to guide the development and deployment of interoperable solutions on a national scale.

The Da Vinci Project facilitates the definition, design, and creation of use cases based upon established data interoperability standards. Da Vinci's business model enables payors, health systems and others to identify and enumerate use cases that involve managing and sharing clinical and administrative data between partners. The Project validates the readiness of use cases through field tests and makes implementation guides and sample code publicly available at no cost.

Since November of 2018, Da Vinci members have been working through Prior Authorization use cases.[18] The goal of the use cases is to enable providers, at point of service, to request authorization (including all necessary clinical information to support the request) and receive immediate authorization.

3. Development of common operating rules to support and guide prior authorization

CAQH CORE® (Council for Affordable Quality Health Care Committee on Operating Rules for Information Exchange)[19] is an industry-wide collaboration committed to the development and adoption of national operating rules for electronic business transactions. Technical standards and the supporting operating rules specify the business actions required for each party to ensure a high volume of reliable electronic transactions.

CAQH CORE gives participating entities a direct voice in the development and maintenance of operating rules and represents the interests of healthcare providers, health plans, government agencies, vendors, associations, and standards development organizations. The effort is governed by a multi-stakeholder board to address the interests of more than 130 participating organizations. Health plans participating in CAQH CORE represent 75 percent of the insured U.S. population.

CAQH CORE has been named by the Secretary of the U.S. Department of Health and Human Services as the author of operating rules for HIPAA-mandated standards for electronic transactions. To date, CAQH CORE has developed operating rules for eligibility, claim status, electronic funds transfer (EFT), electronic remittance advice (ERA), healthcare claims, prior authorization, enrollment and disenrollment, as well as premium payments.

The federal government currently requires all HIPAA-covered entities to adhere to operating rules for eligibility and claim status under the Phase I and II CAQH CORE Operating Rules. In June 2019, CAQH released Phase V CAQH CORE Operating Rules for

---

[18] Da Vinci Prior Authorization Support, February 22, 2019

[19] https://www.caqh.org/sites/default/files/about/marketing/caqh-overview-fact-sheet.pdf?token=lePz1QNd

PA.[20] These rules focus on standardizing components of the prior authorization process, closing gaps in electronic data exchange to move the industry towards a more fully automated adjudication of a request. The Department of Health and Human Services (HHS) will determine if the Phase V CAQH CORE Operating Rules will be included in any regulatory mandates, however, as a federally designated authoring entity, CAQH will report its findings as part of a recommendation for national operating rule implementation.[21]

The Phase V CAQH CORE Prior Authorization Operating Rules are a significant step towards addressing the prior authorization challenge. In particular, the rules:

- Build on the Phase IV CAQH CORE Operating Rule which ensures electronic prior authorization information is shared in an organized, trusted and consistent way.
- Enhance and standardize the data shared between plans and providers, eliminating unnecessary back and forth.
- Enable the health plan to clearly communicate next steps in the prior authorization process, including what additional documentation is needed.
- Apply to procedures, laboratory testing, medical services, devices, supplies and medications within the medical benefit including cancer drugs and other complicated conditions.
- Support an interim strategy to bring greater consistency to web portals given current widespread industry use, with a long-term goal of driving adoption of standard transactions.

Beyond Phase V, CAQH CORE will continue to focus on prior authorization including potential requirements to reduce the timeframe for a prior authorization determination, improve accessibility of health plan requirements, and enhance the way supplemental clinical information and attachments are exchanged.

CAQH CORE has also undertaken piloting workflows to address the intersection between operating rules and electronic data standards to ensure support for industry organizations in varying stages of maturity and technology adoption and seek to test their impact on reducing manual intervention.

4. Engage the vendor community to assist parties to operationalize the new standards and rules

The Workgroup for Electronic Data Interchange (WEDI[22]) is the leading authority on the use of health information technology to improve healthcare information exchange in order to enhance the quality of care, improve efficiency and to reduce costs of the American healthcare system. Formed in 1991 by the Secretary of Health and Human Services (HHS),

---

[20] https://www.caqh.org/core/caqh-core-phase-v-operating-rules
[21] https://www.caqh.org/sites/default/files/core/caqh-core-overview.pdf
[22] https://www.wedi.org/about-us/

WEDI was named in the 1996 HIPAA legislation as an advisor to HHS and continues to fulfill that role today.

Serving as a private and public industry solution to critical healthcare problems, WEDI is a coalition comprised of a cross-section of the healthcare industry: doctors, hospitals, health plans, laboratories, pharmacies, clearinghouses, dentists, vendors, government regulators and other industry stakeholders.

WEDI established a multi-stakeholder Prior Authorization Council (PAC) in the spring of 2017.[23] It's purpose was to build a cross-stakeholder view of PA in the US and identify recommendations on addressing gaps relative to the critical components of any plan to provide future industry direction (by WEDI or HHS) that will significantly reduce the administrative burden associated with PA.

This group issued a White Paper[24] in 2019 that, among other things, endorsed a targeted effort to engage the Electronic Health Record (EHR) vendor community. The goal of the effort is to elicit a commitment on the part of EHR vendors to support the full automation of the industry PA process. The effort seeks to leverage the work of all the constituent groups (such as those in this report) to articulate a formal request to EHR vendors.

Conclusion

These serious, credible and interconnected efforts are all currently underway and collectively expected to result in the adoption of formal, mandated standards around the automation of prior authorization including data interoperability and operating rules. Vendor expertise and products to support the adoption of full automation are critical and emerging. Health plans are actively at the table for each of the initiatives and publicly and visibly committed to working towards the goal of full automation.

With several robust multi-stakeholder efforts underway at the national level, state legislation should be tied to those solutions rather than establish a state-specific standard or process. There is risk and cost to premature adoption of a specific standard or process before it is widely accepted. Recall Maine's experience with electronic toll collections – Maine was an early adopter of Transpass and had to subsequently transition to E-Z Pass for consistency with the East Coast.[25]

Electronic standards for clinical attachments will likely be formally adopted at the national level. While progress is being made, we believe it is too soon to require an all-electronic system for medical prior authorization for either providers or health plans.

---

[23] https://www.wedi.org/2019/02/05/the-wedi-prior-authorization-council/

[24] https://www.wedi.org/2019/02/05/wedi-releases-industry-white-paper-authored-by-newly-chartered-prior-authorization-council/

[25] https://www.mainebiz.biz/article/take-it-e-z-the-maine-turnpike-authority-gets-set-to-introduce-e-z-pass