Considerations for a Transition to Electronic Prior Authorization

Most parties agree that today's prior authorization (PA) processes are too burdensome. The use of automated tools to share needed information between health plans and providers, often referred to as electronic prior authorization (ePA), could be one way to simplify this process and create efficiencies. To better understand the view from the ground, AHIMA contracted with Alazro Consulting to conduct structured interviews with a range of payers, providers, and experts from the field to understand the current PA landscape and key considerations that would need to be addressed as part of a transition to ePA. This issue brief summaries PA and ePA basics before turning to the interview findings.

Prior Authorization Basics

Prior authorization generally involves a health care provider seeking advanced approval from a health plan (or its designee) before providing a specific service, procedure, medicine, or item to a patient.[1] Health plans use PA as an important tool to be a good steward of health care premium dollars, effectively manage health care utilization, ensure patient safety, and guard against fraud.[2] Providers and others have noted that PA can delay access to care, result in patients abandoning a recommended treatment, and lead to higher out-of-pocket costs.[3] Not all medical services require PA, but failure to obtain an authorization when needed can result in a claim denial.

Generally, PA includes the following steps, each of which involves sharing of information between payers and providers:

- Verification by the provider that the payer requires an authorization for a given patient and service
- Submission of required clinical data by the provider
- Consideration of the clinical data by the health plan (which could include a request for additional information)
- Communication from the health plan as to whether a service is pre-authorized
- Possible provider appeal of a denied authorization (which could include a peer-to-peer consultation between the health plan's medical director and the provider)

Today, providers often use web-based payer portals to submit their PA requests, upload required clinical data, and track a payer's decision-making. These portals are unique to each payer and may also vary according to the specific plan (a given payer may have dozens of individual plans, each tailored to a specific employer or other plan sponsor). As currently configured, these portals are not fully automating the process, as clinical data needs to be abstracted from the medical record and uploaded into the portal, generally in the form of a pdf. Providers may also default to manual processes, including phone and fax if they have questions about needed information or the status of an authorization.

[1] For a more complete definition, see: WEDI Prior Authorization Electronic Inquiry: Guiding Principles (Oct. 16, 2023).
[2] https://www.ahip.org/resources/prior-authorization-promotes-evidence-based-care-that-is-safe-and-affordable-for-patients
[3] Consumer Problems with Prior Authorization: Evidence from KFF Survey | KFF
and https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

Electronic Prior Authorization Basics
The goal of standards-based ePA is to lessen the burden and decrease the time needed to know if a service requires an authorization, share clinical data, receive a response from the payer, and check the status of a PA request. Additional functionality can also give patients visibility into the status of a request made on their behalf. The two standards-based approaches to ePA currently receiving consideration are:

HIPAA Administrative Transaction Standard. HIPAA required the U.S. Department of Health and Human Services (HHS) to adopt a series of standards to support claims submission and other administrative transactions in health care, including prior authorization. The Centers for Medicare & Medicaid Services (CMS) has adopted the X12 278 Health Care Services Review Request for Review and Response standard for ePA. However, use is limited. According to the 2023 CAQH Index, only 31 percent of PA transactions were done using the HIPAA X12 278 ePA standard in that year. One challenge to using this standard is the lack of adoption by CMS of a national standard for electronic attachments that could share clinical information needed by the payer.[4]

HL7 FHIR-based Standard. An initiative within the HL7 standards community, the Da Vinci Project, has used the internet-based Fast Healthcare Interoperability Resources (FHIR) standard to create a set of application programming interfaces (APIs) designed to share electronic health information between payers and providers to facilitate and automate aspects of the PA process. This approach to ePA has been considered in rulemaking by both CMS and the Office of the National Coordinator for Health IT (ONC), which is now under the Assistant Secretary for Standards and Technology (ASTP) at HHS.[5]

Interview Findings
Interviewees: The interviewees represented nine organizations with provider, payer, vendor and subject matter expert (SME) roles, often with multiple individuals participating in an interview. The majority of interviews were with AHIMA members. Healthcare provider respondents ranged in size from small, independent hospitals to large, multi-state health systems. Payer respondents offered both commercial and government-sponsored plans.

Views of PA: Interviewees acknowledged the role of prior authorization, with payers emphasizing the use of evidence-based guidelines in making medical policies and their responsibility to ensure health care dollars are spent wisely and guard against fraud. Providers generally stated that managing prior authorization is time-consuming and has increased in burden in recent years. Key provider concerns included variability in medical policy rules and PA processes across payers/plans and over time, as well as the impact of delays in PA on scheduling and patient care. Providers also noted that an authorization is not a guarantee of payment, as a claim can subsequently be denied for lack of medical necessity.

Interviewees generally had strong views on prior authorization that diverged across payers and providers.

Current Approaches to PA. Interviewees described four approaches used to conduct PA (Table 1). Providers reported using multiple modes to communicate with payers, leading to workflow and operational challenges that can be costly and impact patients. No provider organization had a single workflow for processing prior authorizations and all interviewees agreed that the PA process needs improvement. As the health care field and policymakers consider ePA, it will be important to avoid automating existing processes that are inefficient and administratively burdensome.

[4]Note that these standards are for medical services. Authorization for prescription drugs is handled separately.
[5]CMS has provided an exception and enforcement discretion to the HIPAA mandated standard for the use of the HL7 DVP API Standards.

Table 1. Prior Authorization Processes Are Multi-Modal

Mode	Operational Implications
Payer portals	• Portal is specific to a payer/plan combination • Number of portals varies by size of provider, but most manage across 10+ portals, each with unique log-ins and user interfaces • Clinical documentation generally uploaded to the portal as a pdf
Manual Efforts	• Follow-up phone calls to clarify requirements and check status • Clinical documentation may be faxed • May need to schedule a peer-to-peer discussion between payer medical director and ordering clinician
Proprietary Payer Platforms	• Some, but not all, payers and providers are beginning to use proprietary payer platforms, such as those offered by Epic or Rhyme • However, given current limited uptake across payers and their plans, providers report workflow challenges, stating that this is one more approach rather than a single solution
ePA Approaches	• Those that have participated in HL7 DVP pilots report successful results. However, pilots are limited and do not yet encompass the full range of medical services • Outside of pilot sites and SMEs, interviewees had little to no understanding of DVP and related regulatory proposals • The X12 278 has limited adoption so far, given the lack of a national standard for electronic attachments

Considerations for Operationalizing ePA

As noted in Table 1, outside of HL7 Da Vinci Project pilot sites and SMEs, interviewees had little to no understanding of the FHIR-based API approach to ePA or the related regulatory proposals. However, when asked about factors that must be considered to support a move to ePA, interviewees identified workflow, technology, operational, and privacy issues.

Workflow: Providers expressed a concern that ePA would be yet one more option for PA, rather than a single solution. A shift to ePA would ideally become the only PA workflow, with a single interface that works across multiple payers/plans.

Technology: Interviewees with an understanding of ePA noted that payers will likely need to make large investments to create APIs and turn their medical policies into computable resources. Doing so may require a layer of intermediaries that could reduce the efficiency gains associated with ePA. Others expressed concerns about whether ePA decisions will be accurate, given unique patient situations and the complexity of both health care and payer rules.

Operations: Interviewees noted that medical records may not be sufficiently standardized to support automated data retrievals, and there will likely still be a need to be able to work through issues via phone call. They also expressed concern that smaller providers and payers (particularly those serving governmental programs) will find it more challenging to adopt ePA, given constrained resources. Some providers also expressed concern that ePA could lead to increased volume of PAs, and possibly increased denials.

From the provider point of view, a key goal is to have "a single workflow for all" prior authorizations, across payers and plans.

Patient privacy: Healthcare providers noted that they have an obligation to protect patient data and ensure that they are following HIPAA requirements to share with payers only the minimum necessary data to make a prior authorization. Providers would want to be able to review and approve the information shared via ePA before it goes to a payer.

Policy Considerations

There was general agreement among provider interviewees that ePA will not, on its own, solve all of the challenges currently faced in processing PAs, such as the growing volume of PAs or the variability in medical policies and processes across payers/plans. Other factors that go beyond automation include transparency into payer practices and timeliness of approvals, which have been the subject of recent CMS rulemaking.

"Adding technology on a poor process isn't going to fix anything."

As the policy conversation continues, key issues to be addressed include:

- Business rules for prior authorization, such as timeliness of payer decisions, transparency metrics, and more standardization of medical policies
- Maturity of standards for ePA, and whether multiple standards should be used at the same time
- Real-world testing of ePA approaches in a range of payer types and clinical settings and specialties, with public reporting of the results prior to being adopted into regulation
- Timing, scope and incentives for adoption of ePA approaches

Conclusion: As policymakers and industry leaders consider adoption of ePA approaches, they must also address workflow, technology, operational, and patient privacy factors that go far beyond automation.