



# Electronic Prior Authorization RFI Task Force 2022 Recommendations

Sheryl Turney, Task Force Co-Chair

Tammy Banks, Task Force Co-Chair

March 10, 2022

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Health Information Technology Advisory Committee

The Office of the National Coordinator for Health Information Technology



# Task Force Recommendations and Report

- Task Force Charge, Membership, and Process
- Task Force Recommendations
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# Task Force Charge, Membership, and Process

# Electronic Prior Authorization RFI Task Force 2022

ONC issued a [request for information](#) that seeks input from the public regarding support for electronic prior authorization processes. ONC is requesting comments on how the ONC Health IT Certification Program could incorporate standards and certification criteria related to electronic prior authorization.

**Task Force Charge:** Provide input and recommendations in response to the RFI on Electronic Prior Authorization to inform future rulemaking and other actions in this area.

**Timeframe:** Provide recommendations by March 10, 2022.



# Electronic Prior Authorization RFI Task Force 2022 Roster

Name	Organization
Sheryl Turney (Co-Chair)	Anthem, Inc.
Tammy Banks (Co-Chair)	Individual
Hans Buitendijk	Cerner
Dave DeGandi	Cambia Health Solutions
Rajesh Godavarthi	MCG Health
Jim Jirjis	HCA
Rich Landen	NCVHS
Heather McComas	AMA
Patrick Murta	Humana
Eliel Oliveira	Dell Medical School, University of Texas at Austin
Debra Strickland	NCVHS

## Task Force Process

- Reviewed the charge, the RFI, and the scope. Initiated a discussion on the capabilities that need to be in place to enable electronic prior authorization and asked members to share comments.
- Additional subject matter expertise was identified and secured to support the Task Force's deliberations.
- Invited the following speakers to present information to the Task Force to help frame discussion on specific topics:
  - Viet Nguyen, HL7 Da Vinci Project – presented overviews of the three Implementation Guides (IGs) mentioned in the RFI:
    - CRD – Coverage Requirements Discovery
    - DTR – Documentation Templates & Rules
    - PAS – Prior Authorization Support
  - John Kelly, WEDI – presented an overview of X12 and attachment standards for prior authorization.
  - Hans Buitendijk, Cerner – presented an overview of the health IT ePA landscape and an overview mapping the Da Vinci IG functional capabilities to a bundled process view of the ePA process.

## Task Force Process (continued)

- Summarized comments and continued discussion on capabilities. Assigned Task Force members to update wording and provide input on each section of the RFI.
- Reviewed the questions in each section of the RFI and solicited draft input from the Task Force members.
- Compiled and reviewed regulatory resources and citations related to the Da Vinci IGs, FHIR, the C-CDA, and related ONC and CMS resources, including the report of the Intersection of Clinical and Administrative Data Task Force report.
- Mapped maturity and adoption readiness to the bundled view of the Da Vinci IGs to help support Task Force comments on certification and readiness for adoption.
- Reviewed the Task Force's early progress with HITAC during the February 17, 2022, meeting.
- Developed overarching recommendations, input on capabilities and responses to the RFI questions for submission to HITAC.
- Prepared our final report and presentation to HITAC.







# Task Force Recommendations

## Task Force Recommendations – High Level

1. Suite of Certified Health IT Capabilities to Support the Prior Authorization Workflow
2. Readiness of Implementation Guides to Support Functional Capabilities
3. Patient-Centered Inclusion in ePA
4. Prior Authorization Roadmap to FHIR
5. Adoption at Scale
6. Regulatory Coordination
7. Attachments
8. Prior Authorization Proving Ground For FHIR
9. Establishment of an Advisory Process
10. Accessibility of Health IT for ePA at Scale
11. Innovation around ePA Integration
12. Innovation around ePA Bundles
13. Multi-Stakeholder Engagement

## Recommendation 1: Suite of Certified Health IT Capabilities to Support the Prior Authorization Workflow

The Task Force recommends that ONC create a suite of ePA health IT certification criteria for health IT systems supporting both providers and payers that can enable health IT developers (e.g., developers of EHRs, RCM/PMS systems, SMART Apps or other solutions), to certify to one or more specific functional capabilities that together, across participating health IT systems, enable the full ePA workflow.

- 1.1 All parties, including intermediaries, should use certified health IT to minimize the additional contractual obligations that might exist for electronic prior authorizations.
- 1.2 The ePA process should support prior authorization functional capabilities occurring in different systems and be capable of integration to allow for different systems to provide an integrated solution. Specific steps in the ePA process may not always involve interactions between payer and provider HIT systems but may instead involve intermediaries and applications. Health IT certification should encompass all these systems.
- 1.3 ONC should ensure new certification criteria for ePA provide for health IT systems that perform prior authorization on behalf of payers to ensure that their solutions are compliant to the standards and able to send and receive the information needed to meet the prior authorization business case and are therefore scalable.
- 1.4 ONC should ensure that systems and tools certified to support ePA processes allow capabilities to be incorporated within the existing provider workflow where appropriate.
- 1.5 ONC should develop criteria in a staged and tiered approach, providing initial baseline functionality that evolves through an iterative roadmap.
- 1.6 ONC should update the “e-prescribing” certification criterion in 45 CFR 170.315(b)(3) to change NCPDP SCRIPT transactions related to prior authorization from “optional” in the criterion to “mandatory,” to better support ePA processes for drugs covered under a prescription benefit.

## Recommendation 2: Readiness of Implementation Guides to Support Functional Capabilities

ONC should work with the Da Vinci Project and key healthcare stakeholders (i.e., providers, developers, patients) to develop appropriate health IT certification criteria that incorporate key functional capabilities for prior authorization.

- 2.1 ONC should use the Task Force's Health IT ePA Functional Criteria RFI Specifications guidance document (Attachment B) to assess maturity and readiness for adoption of the Implementation Guides for CRD, DTR and PAS and functional capabilities.
- 2.2 ONC should not be limited to requiring certification to a full IG or all IGs by one system, e.g., EHRs, rather we encourage ONC to define certification criteria that only require compliance with parts of the IGs initially.
- 2.3 HHS should work with Da Vinci Project leads and key healthcare stakeholders (e.g., payers, providers, HIT developers, patients) to determine functional requirements for health IT vendors acting on behalf of the payer to ensure that their solutions are compliant to the IGs and be able to send/receive the information needed to meet the prior authorization business case and therefore scalable.
- 2.4 Privacy and security of the data should be considered in criteria development along with the functional capabilities.



## Recommendation 3: Patient-Centered Inclusion in ePA

The Task Force recommends that ONC work with SDOs and other key stakeholders to build out standards to meet patient use cases and provide transparency.

- 3.1 Capabilities supported by standards for ePA should include: the ability for patients to opt-in to participate in the prior authorization process including status information related to making a prior authorization request; prior authorization status including relevant descriptions of where the prior authorization is in the process through to decision; and the ability to obtain the cost of the medical care connected to the prior authorization based on health plan coverage, including relevant cost information related to in-network status of treating physician(s), ancillary services related to the prior authorization, and desired place of care.
- 3.2 Stakeholders should develop additional IGs or modify existing IGs, such as IGs supporting the Patient Access API policy finalized by CMS, to enable the prior authorization status updates for the patient and allow for voluntary patient inclusion in the ePA process.
- 3.3 Stakeholders should consider whether the Blue Button 2.0 API IG (and related IGs, such as PDex) should be amended to add the ability for patients to have access to prior authorization status and final determinations. Patients should also have access to the information that will guide them on how to handle denials and appeals.
- 3.4 Standards should be developed for electronic ID cards to support exchange requirements for patient matching.
- 3.5 The ONC roadmap should include plans within future ePA processes to enable patients to have the ability (but not be required) to submit to a payer a request for a prior authorization, participate in the prior authorization process, make a request, and obtain the cost of the medical care based on their health plan coverage, provider network and desired place of care.

## Recommendation 4: Prior Authorization Roadmap to FHIR

HHS should create and update a “Health IT ePA Roadmap” for health IT systems supporting providers, payers, and consumers that lays out an iterative path forward to move stakeholders to an integrated, automated prior authorization workflow.

The roadmap should describe:

- 4.1 How capabilities and specifications should be mapped to the Da Vinci IGs.
- 4.2 A timeline that aligns the maturity of the capabilities within the Da Vinci IGs and the speed of the industry’s ability to comply. The timeline should be informed by an environmental scan that assesses the readiness of the IGs and identifies the functionality that provides value to patients, providers, and payers.
- 4.3 A path for information exchange (i.e., C-CDA to FHIR) to lead stakeholders to move from a document-driven approach to an event-based and data-driven approach.
- 4.4 A strategy for certification criteria to be adopted in a tiered and staged approach, providing baseline functionality as well as a roadmap for cutting-edge organizations.
- 4.5 A certification strategy only based on FHIR-to-FHIR endpoint transactions.

## Recommendation 5: Adoption at Scale

HHS should develop an informed and vetted iterative roll-out plan for certification and adoption in collaboration with CMS, SDOs, and other healthcare stakeholders. The plan should allow for adoption and maturity at scale of a fully functional prior authorization workflow by setting/service, with no requirements rolled out until the standard has been tested in that practice setting and for that type of service (e.g., imaging).

- 5.1 Initially roll out ePA for procedures that are most commonly subject to prior authorization and are being pilot tested through Da Vinci. Over time, additional procedures can be added that may take longer for less mature health IT systems to adopt.
- 5.2 Recommend that any provider requirements imposed by CMS or other payers to enforce use of ePA be put in place after the standard(s) have been tested and adopted in that practice setting (e.g., ambulatory practices), and for that type of service (e.g., imaging).
- 5.3 Roll out individual components as they are ready and fully tested leading to implementation of the CRD, PAS, DTR and related IGs.
- 5.4 ONC should focus certification initially on the source of the information (e.g., payers for coverage determination and documentation requirements, and providers for access to supporting information).

## Recommendation 6: Regulatory Coordination

Given the emergence of new standards to support ePA, HHS should ensure that regulations allow multiple standards to at least temporarily co-exist as they are tested and used by stakeholders to meet specific business needs, while preserving widely used existing standards and addressing gaps.

- 6.1 The Certification Program should address the complete prior authorization workflow across one or more payer, provider or third-party HIT system(s). However, the individual components can be certified, implemented incrementally, and structured to allow both ONC and HIPAA regulations to update/change independently but remain harmonized with strong consideration of the status of the other regulations.
- 6.2 Certification requirements that allow a FHIR-enabled process for prior authorization transactions should not require the use of translation to X12.
- 6.3 An amendment should be made to the HIPAA exception approval process for testing emerging standards to be less burdensome for beta testers and more proactively supportive of innovation.
- 6.4 CMS should ensure compatibility with HIPAA transaction and code set regulations.
- 6.5 ONC should collaborate with CAQH CORE to add response times as contained in its Prior Authorization Operating Rule for the critical interactions that the ePA implementation guides are introducing.



## Recommendation 7: Attachments

In considering standards for attachments, the Task Force emphasized the need to move the healthcare industry from a document driven to data driven information exchange.

- 7.1 ONC should prioritize criteria based on the PAS IG that allows data, C-CDA or FHIR documents be provided in a FHIR construct that is:
  - certifiable and testable as a unique process regardless of what larger workflow it is supporting.
  - developed based on movement of all stakeholders toward FHIR-based interactions that can include the variety of supporting information necessary to support an authorization request in the short term and aim for a more automated approach based on FHIR-based APIs to gather all relevant data.
- 7.2 Both the CDA Attachments IG and/or FHIR documents require further maturation and sufficient testing to be considered as an ePA minimum standard for adoption at scale before mandates should be established.
- 7.3 ONC should consider a “soft” timeline, e.g., when a specific quantitative testing threshold is reached, a specified timeline for adoption could kick in if there is still a need for document-based submission of attachment data.
- 7.4 Providers should have the option to either compile an attachment document that includes all supporting data or exchange the requested data gathered individually.
- 7.5 Any certification criterion addressing a CDA attachment functional requirement certification criterion should remain optional; innovators not be locked down to the payload using a CDA Attachment IG approach only.

## Recommendation 8: Prior Authorization Proving Ground for FHIR

ONC should develop and fund a proving ground to support maturation of IGs supporting ePA. This effort would:

- 8.1 Encourage and monitor the continued testing of these IGs in real-world settings to validate and improve the standards and the use of human-centered design to ensure patients would benefit from these advancements.
- 8.2 Require pilots and early implementers of the Da Vinci IGs to publicly report key metrics. Metrics examples include provider time spent on prior authorization before and after adoption; percentage of prior authorizations that were completed digitally (e.g., automatically); time to care delivery before and after adoption; cost savings; percentage of payer denials and both direct and indirect cost to providers of implementing the Da Vinci IGs. This will provide valuable data to the industry regarding the overall value of investing in this technology.
- 8.3 Require independent review of return on investment (ROI) and analysis to demonstrate improved metrics related to the ePA process.



## Recommendation 9: Establishment of an Advisory Process

ONC should establish a review and advisory process that advises on the ePA adoption lifecycle. This process should:

- 9.1 Evaluate ePA readiness and the maturity of the ePA implementation guides (CRD, DTR, PAS and others) and make recommendations for certification enhancements to support adoption, standard maturity, scalability from a multi-stakeholder perspective.
- 9.2 Identify gaps in current capabilities and encourage development of additional capabilities, such as patient-centered transparency.
- 9.3 Increase collaboration and extend federal funding to accelerate the movement toward adoption at scale (e.g., FHIR Accelerator).
- 9.4 Ensure standards and criteria are addressed and incorporated into the Interoperability Standards Advisory. Following adoption in the Certification Program, recommend updates to standards be addressed through the Standards Version Advancement Process.
- 9.5 Enable stakeholders to come together and match to the same requirements and ensure API conformity.



## Recommendation 10: Accessibility of Health IT for ePA at Scale

The Task Force recommends HHS explore additional incentives and supports to ensure ePA processes are effectively adopted and implemented across the care continuum.

- 10.1 ONC should partner with other agencies to establish positive incentives for stakeholder groups (providers, payers, other health care stakeholders) to reach adoption at scale and enable stakeholders to choose preferred system/systems, internal/external app, or other solutions to manage or initiate an ePA.
- 10.2 To ensure the widest beneficial impact of ePA technology and protect against further exacerbation of current health disparities, HHS should explore incentives to support smaller, under-resourced providers in adopting and implementing standard ePA technology.
- 10.3 The Certification Program (i.e. ONC's CHPL) should inform and support providers' ability to mix and match components they use in their practice setting. Many providers will be unaware of which health IT products are necessary to fully support ePA. The CHPL should clearly identify and group together complementary health IT products into suites of modules that support ePA.
- 10.4 Supporting overall reduction in the volume of prior authorization requirements will also be necessary for widespread ePA implementation. Exploring policies such as a trust and verify framework for prior authorizations that are routinely approved (e.g., gold carding), can help to reduce overall burden and ensure uptake of ePA for high priority procedures, services, and items.

# Recommendation 11: Innovation around ePA Integration

ONC should require health IT systems to provide inter-provider communication and workflows associated with the ePA certified processes with the goal to allow “pass-offs” between physicians and other practice staff and ability for physicians to save an initiated PA to complete later and/or delegate to staff.

- 11.1 Tools should be made available to trigger a new/renewal PA that may be submitted by an expanded group of stakeholders to enable ePA processes based on best practices (e.g., patients, DME providers, etc.).

## Recommendation 12: Innovation around ePA Bundles

HHS should encourage expansion of authorizations from a single procedure or service within a “single medical episode” to one where authorizations cover services performed concurrently that may be bundled into an established protocol or complex treatment plan to improve transparency, reduce complexity/administrative burden, and improve coordination of care.

- 12.1 Encourage further study of the required capabilities/additional code options for concurrent care authorizations that need to be included in the future Da Vinci CRD IG to meet the business need.
- 12.2 Encourage payers through various levers to continue to move toward episode of care, complete treatment plan or bundled services including ancillary services required to complete the service for prior authorizations review and decision.

## Recommendation 13: Multi-Stakeholder Engagement

ONC should solicit multi-stakeholder feedback, including feedback from other departments, agencies, programs across HHS (i.e., CMS), and key stakeholders, throughout the development of the health IT certification criteria and roadmap for the acceleration and adoption of the ePA process.



# Discussion