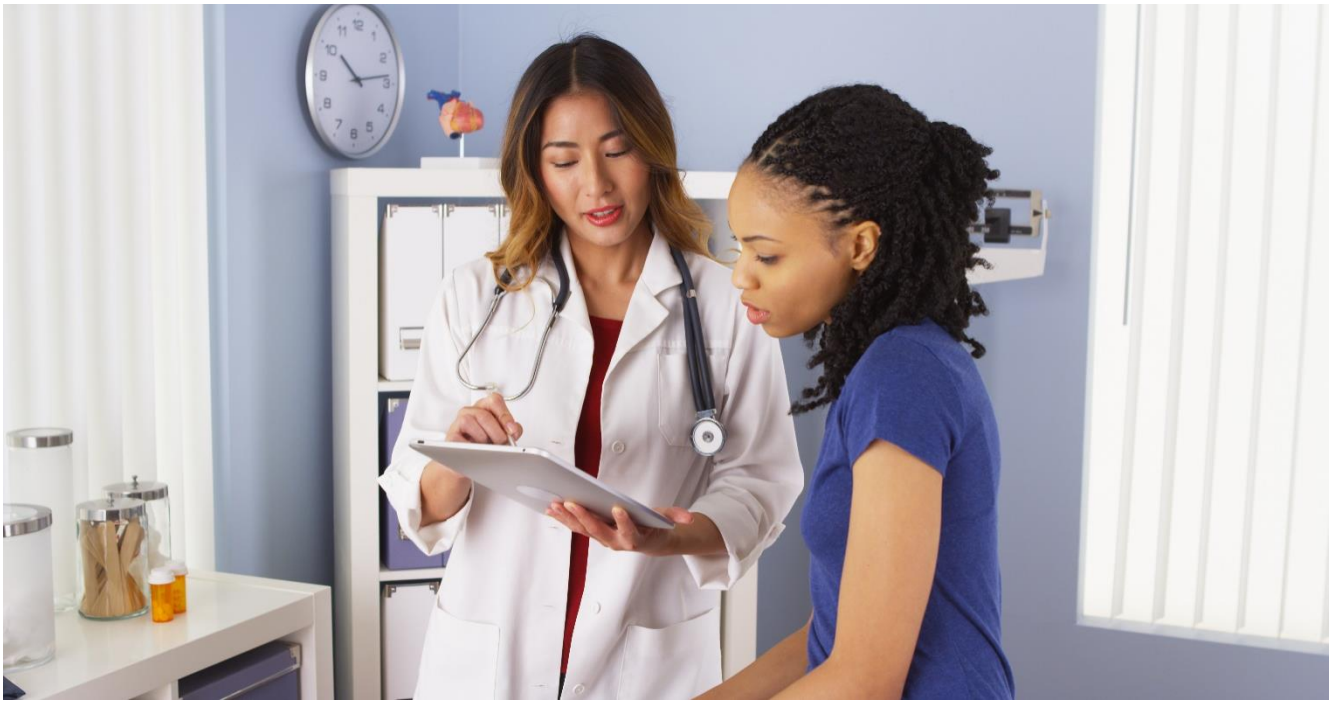
# Considerations for Improving Prior Authorization in Healthcare



eHEALTH INITIATIVE

**An eHealth Initiative Collaborative Project | 2019**

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## Introduction

In 2018 and 2019, eHealth Initiative (eHI) convened a series of prior authorization workshops with representatives from key stakeholder organizations across healthcare. The goal of the workshops was to establish a set of recommended practices to help improve the current prior authorization environment and to respond to the widespread challenges and dissatisfaction healthcare professionals have with prior authorization.

United States healthcare spending grew to $3.5 trillion by the end of 2017,[i] and approximately 1 in 3 dollars of those expenditures do not actually improve health.[ii] Experts estimate that about 30% of health spending is wasted on unnecessary services, excessive administrative costs, fraud, and other problems.[iii] Prior authorization is also meant to optimize patient outcomes and protect their safety. Healthcare payers utilize prior authorization to keep costs in check while reducing waste; error; and unnecessary procedures, treatments, and prescriptions.

The prior authorization process has, however, proved burdensome for healthcare professionals (clinicians, nurses, physicians, and others who provide care directly to patients) and can result in delayed or denied patient care. A recent American Medical Association (AMA) survey revealed that 86% of physician respondents feel that the burden associated with prior authorization in their office is either "high or extremely high" and that they and their staff spend an average of 14.9 hours each week to complete the prior authorization workload.[iv]

These delays may then result in patients abandoning care and/or a significant negative impact on patients' clinical outcomes. Ninety-one (91%) percent of respondents in the AMA survey reported that for patients whose treatment requires prior authorization, the process delays access to necessary care. In a survey of insured Americans through the Doctor-Patient Rights Project (2017), respondents whose payer denied coverage of a prescribed treatment reported their median wait time to seek approval and be denied was greater than one month. Almost a third (28%) shared that the approval process took three months or longer. While waiting for a payer to consider an authorization request, another third (29%) experienced a worsening of their condition due to delayed treatment.[v]

Streamlining prior authorization would improve the patient experience and also offer potential cost savings to both healthcare professionals and payers. The 2018 CAQH Index reported that the medical industry could save as much as $7.28 per transaction in transitioning from manual prior authorization processes to electronic prior authorization, resulting in $417 million annual savings for the medical industry. Electronic prior authorization would also reduce time spent on the process by the staff of healthcare professionals by seven minutes per transaction.[vi]

**STAKEHOLDERS**

Workshop participants agreed that vendors, healthcare professionals, payers, patients, and others should work cooperatively to create a prior authorization process that is as seamless and burden-free as possible. When communicating clinical information, healthcare professionals and payers should be able to leverage technology and have ready access to clinical guidelines and payer rules in order to request and execute prior authorization for procedures, imaging, labs, consults, medications, durable medical equipment, and any other service required for patients.


Participants acknowledge that prior authorization will continue to be used, for the foreseeable future, as a utilization management tool. Due to the complex nature of medicine, guidelines are unavailable for many conditions, therefore prior authorization will still be required by payers. The focus should be on improving, reforming, and streamlining the prior authorization process to reduce physician burden, improve outcomes, and increase patient satisfaction. Stakeholders discussed the following four concepts to achieve meaningful improvements in the prior authorization process:

## 1 Transparency of payer policy and evidence-based clinical guidelines available at the point of care may, in many cases, reduce the need for prior authorization and minimize care delays.

- The availability of eligibility, benefits coverage, clinical guidelines, payer documentation requirements, and patient financial responsibility at the point of care would facilitate the most appropriate decisions made by healthcare professionals and their patients. It should, however, be done in a way that reduces the burden on ordering healthcare professionals.

- When evidence-based clinical guidelines are presented within electronic health records (EHRs), healthcare professionals are more likely to order tests concordant with the published guidelines.


- If payers were to designate certain evidence-based guidelines for integration into EHRs, prior authorization could be reduced to instances where healthcare professionals recommend services inconsistent with or not addressed by the evidence-based guidelines. Identification of such gaps in indication coverage will facilitate expansion of available guidelines.

- The American College of Radiology, American College of Cardiology, and other physician-led organizations have published evidence-based guidelines to help healthcare professionals determine the most appropriate tests to order in specific instances. The consultation of Appropriate Use Criteria (AUC), even when unneeded for coverage and if no procedure/treatment is performed, should be documented for system analysis and improvement when it is performed.

- Additionally, integrating medical and pharmacy benefits information into vendor systems improves the transparency of that information for healthcare professionals and for administrative staff who are responsible for securing prior authorizations. Accomplishing this task is incumbent on all stakeholders as no single stakeholder can do this alone.

- Improvements in data interoperability and data science should facilitate processes and data sharing that reduce or eliminate the friction associated with the prior authorization process and enable monitoring of transactions. Any potential out-of-pocket costs for which the patient would be responsible should also be included at the point of care.

## 2 Reducing the overall volume of services and drugs requiring prior authorization could decrease administrative burdens and costs for all stakeholders. As long as care continues to be consistent with evidence and the person's insurance coverage, prior authorization may not be needed (or needed as frequently) for:

- Patients who are taking medications chronically.

- Patients undergoing repeat procedures and deemed by their healthcare professional to be medically stable.

- Medications and procedures with low denial rates.

- Healthcare professionals who historically meet prior authorization criteria regularly (sometimes referred to as "gold carding") with monitoring for continued qualification.

- Healthcare professionals who are participating in risk-based payment contracts.

## 3 Payers, healthcare professionals and vendors should use existing, industry-endorsed standards whenever possible and explore incorporating new electronic standards that have the capability to improve the prior authorization process.

- The incorporation of industry-accepted standards (e.g. LOINC, Direct Messaging, CORE operating rules, and EDI (x12 278)) into payer-healthcare communication should be promoted.
- At the same time, payers, healthcare professionals, and vendors should responsibly and effectively transition to new technologies (e.g. SMART on FHIR, CDS Hooks). Payers, healthcare professionals, vendors and/or their business associates should work together to develop a clear implementation roadmap and timeline to incorporate new standards and operating rules as they emerge and are ratified by their governing bodies.
- Stakeholders urge the government to enhance current standards to support transmission of data and encourage the development and implementation of new standards that will improve the prior authorization process.

## 4 Payers and healthcare professionals should explore alternative payment models that promote bundled authorization for procedures, medications, and durable medical equipment that are associated with a particular episode of care.

- Bundled authorizations, mirroring alternative payment models that encompass episodes of care where healthcare professionals share responsibility for cost and quality outcomes, could reduce the volume and burden of prior authorizations. For example, payers could design bundled authorizations to acknowledge the most frequent components of care associated with an episode, based on AUC, rather than asking healthcare professionals to request authorization for each individual procedure, medication, or durable equipment.
- Bundled authorizations may require payers and pharmacy benefit managers to coordinate their approvals to reduce the need for healthcare professionals to manage separate authorization processes for treatment of the same clinical condition.

**Stakeholders**

American Academy of Family Physicians (AAFP) ✱ America's Health Insurance Plans (AHIP) ✱ American College of Cardiology (ACC) ✱ American College of Radiology (ACR) ✱ American Heart Association (AHA) ✱ Automated Clinical Guidelines ✱ CAQH ✱ Change Healthcare ✱ Delaware Health Information Network (DHIN) ✱ DirectTrust ✱ EnableCare, LLC ✱ eHealth Initiative ✱ eviCore Healthcare ✱ GE Healthcare ✱ Haven Health Solutions ✱ Highmark ✱ Health Level Seven International (HL7) ✱ Kaiser Permanente ✱ Marshfield Clinic ✱ Medical Society of Delaware ✱ Medical Group Management Association (MGMA) ✱ National Alliance of Healthcare Purchaser Coalitions ✱ Office of the National Coordinator for Health Information Technology (ONC) ✱ Point-of-Care Partners ✱ Stratametrics, LLC ✱ UnitedHealthcare ✱ Virence Health ✱ Workgroup for Electronic Data Interchange (WEDI)

## About eHealth Initiative

eHealth Initiative and Foundation (eHI) convenes executives from every stakeholder group in healthcare to discuss, identify, and share best practices that transform the delivery of healthcare, through technology and innovation. eHI, and its coalition of members, focus on education, research, and advocacy to promote the use of sharing data to improve healthcare. Our vision is to harmonize new technology and care models in a way that improves population health, consumer experiences and lowers costs.

eHI serves as a clearinghouse and has become the go-to resource for industry through its eHealth Resource Center. For more information, visit ehidc.org. To join the conversation on Prior Authorization, follow eHI's Prior Authorization showcase page and connect with us on LinkedIn, Facebook, and Twitter.

## Citations

[i] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html
[ii] http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2012/Best-Care/bestcare_infographic.png
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