



**Prior Authorization:
Current State, Challenges, and Potential Solutions**

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THE CASE FOR FIXING PRIOR AUTHORIZATION

The prior authorization (PA) process is entrenched in today's healthcare system. Prior authorization is a decision by a payer that a healthcare service, treatment plan, prescription drug, or durable medical equipment is medically necessary and is included in a member's coverage.¹ Although PA is meant to ensure appropriate, cost-effective healthcare, it often creates barriers and administrative burdens for providers, payers, and patients. In a world where rovers roam capably on Mars, PA is still a broken process. Fixing PA will alleviate stress for patients and providers and reduce costs for healthcare as a whole.

In Fall 2018, eHealth Initiative (eHI) and Virence Health (now a part of athenahealth) embarked on a project to find practical solutions for fixing PA. eHI began the endeavor by gathering feedback from high-level executives during structured interviews, specifically:

- Provider perspectives on PA and appropriate use criteria in the workflow
- Organizational approaches to implementing PA
- Strategic organizational goals around PA
- Barriers limiting the automation and implementation of PA
- Actions that policymakers, payers, and patients could take to improve PA

These interviews set the groundwork for two roundtable discussions that convened multiple stakeholders throughout healthcare. Stakeholders were well versed in the subject of PA, representing the issue from various perspectives with hundreds of years of collective experience in the health IT sector. As a component in eHI's Prior Authorization Initiative, this brief discusses the current state of PA, and offers examples of initiatives, from the field, that are working to address PA.

THE CURRENT STATE OF PRIOR AUTHORIZATION

There are numerous examples of delayed patient care because of arduous PA processes. Anecdotes about denied coverage for critical care or treatment are abundant. One salient example that highlights the problem with PA tells the tale of a double leg amputee unable to easily replace a broken wheelchair because of PA. Meanwhile, payers are concerned about stories of Medicare fraud and providers recommending unnecessary treatments or services. From the interviews to the roundtables, executives elucidated the point that insurers find PA beneficial, considering it a necessary evil to guarantee healthcare spending stays on track, while providers find it burdensome, viewing PA as a hinderance to patient care.

According to a 2017 physician survey from the American Medical Association (AMA), PA issues are associated with 92% of care delays and contribute to patient safety concerns and administrative inefficiencies.² The survey collected responses from 1,000 practicing physicians—40% of respondents were Primary Care Physicians and 60% were specialists:

- 64% waited at least 1-business day for PA decisions from health plans
- 30% reported waiting at least 3-business days for PA decisions from health plans
- 84% said the PA burden was high or extremely high

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- 86% said the burden associated with PA *increased* over the last five years

PA is particularly burdensome for practices, which spent an average of two business days per week to complete the workload, 14 hours were spent on prescription PAs, and 15 hours spent on medical service PAs. Overall, 34% of physicians have staff that exclusively work on PA. PA forces providers, who are good stewards of healthcare, into a workflow that does not add value. Instead of thinking about the actual pathways that may make PA beneficial, providers find themselves asking what diagnosis they need to record, each time, so a request is approved.

Interestingly, even when under the same financial umbrella, insurers often still require PA systems of their providers. Insurers find value in tracking services, and sometimes fear providers will overutilize services without a PA system. Recently, Marshfield Clinic in Wisconsin moved to a capitated payment system—physicians are paid based on outcomes rather than fee-for-service. Physicians are already financially at risk through the capitated system, therefore requiring PA is a redundancy as physicians, in effect, are already financially responsible. Practically speaking, it would make sense to simply eliminate the administrative burden and bureaucracy associated with PA. Despite the move to capitation, the organization has not abandoned PA. The processes are engrained into the culture and administrative workings of the healthcare system. Even progressive organizations like Kaiser Permanente have struggled with the PA issue since its inception. Kaiser’s business model has always included physicians and their health plan under the same entity. Yet the tension between physicians wanting to end the burden of PA and the health plan still finding value in the practice exists.

Prior authorization issues are associated with 92% of care delays and contribute to patient safety concerns.

—American Medical Association

The image shows a medical claim form with a large, bold, red 'DENIED' stamp diagonally across the center. The form is titled 'Medical Claim Form' and contains various fields for patient information, provider details, and claim specifics. The text on the form is small and partially obscured by the stamp.

Part of the issue with the current state of PA is the lack of consensus around appropriate clinical standards, which creates a conundrum. Although standards provide a framework for PA to function, often times they lack nuance for differing circumstances. For example, some hysterectomy claims require physicians to choose a claim code associated with the weight of a uterus, meaning a weight must be selected on the PA *before* the uterus is removed from the body. If a physician provides an incorrect code, the claim for the procedure could be denied. Clearly, there is no way for a physician to know the weight prior to surgery, but this fact is not a consideration in the PA process.

When it comes to standardization, some radiologists objected to the Protecting Access to Medicare Act (PAMA) regulations that required the same standards across the board. Pharmacists were concerned that standards were not flexible enough for varying circumstances of their profession. The American College of Cardiology does not put forth a standard on how to diagnose chest pain because there are simply too many variables for such a diagnosis, especially across the country. There is doubt within the healthcare industry that consensus can be met among and between groups of health plans and physicians for certain clinical standards, but there is promise for more agreement on technology standards, such as FHIR® and APIs for value-based care, which could be helpful for PA. The possibility exists that a technological solution could easily resolve the hospital’s PA issue with hysterectomies,

making it unnecessary to know the weight of the uterus *prior* to the procedure. **The right amount of utilization, with the right content and context, time, and cost within the right workflow is needed for a PA formula to function correctly.**

FEDERAL, STATE, AND ORGANIZATIONAL INITIATIVES ADDRESSING PRIOR AUTHORIZATION

American Medical Association Prior Authorization Initiatives & Collaborations



In an effort to track the current state of PA and advocate for reform, the AMA started a grassroots campaign and website, #FixPriorAuth and www.FixPriorAuth.org, that allows both patients and providers to tell their PA stories. The AMA also created a Prior Authorization Reform Workgroup and Prior Authorization and Utilization Management Reform Principles. Following the January 2017 release of the principles, over 100

organizations signed on as supporters of the workgroup efforts. The 21 principles are grouped in five overarching categories³:

- Clinical validity
- Continuity of care
- Transparency and fairness
- Timely access and administrative efficiency
- Alternatives and exemptions

Additionally, the AMA partnered with the American Hospital Association (AHA), America's Health Insurance Plans (AHIP), American Pharmacists Association (APhA), BlueCross BlueShield Association (BCBSA), and Medical Group Management Association (MGMA) to identify opportunities to improve the PA process.⁴ The healthcare leaders are working together to:

- **Reduce the number of health care professionals subject to prior authorization requirements** based on their performance, adherence to evidence-based medical practices, or participation in a value-based agreement with the health insurance provider.
- **Regularly review the services and medications** that require prior authorization and eliminate requirements for therapies that no longer warrant them.
- **Improve channels of communications** between health insurance providers, health care professionals, and patients to minimize care delays and ensure clarity on prior authorization requirements, rationale, and changes.
- **Protect continuity of care for patients** who are on an ongoing, active treatment or a stable treatment regimen when there are changes in coverage, health insurance providers, or prior authorization requirements.
- **Accelerate industry adoption** of national electronic standards for prior authorization and improve transparency of formulary information and coverage restrictions at the point-of-care.

The six organizations developed a ***Consensus Statement on Improving the Prior Authorization Process***, which outlines five areas they believe would lead to meaningful PA reform.⁵

- Selective Application of Prior Authorization
- Prior Authorization Program Review and Volume Adjustment
- Transparency and Communication Regarding Prior Authorization
- Continuity of Patient Care
- Automation to Improve Transparency and Efficiency

Smart Prior Authorization Project

Smart Prior Authorization (SPA) is a specific solution that directly addresses the five areas of opportunity for improvement as outlined in the *Consensus Statement* by the AMA, AHA, AHIP, APhA, BCBSA, and MGMA. SPA's premise is that it is time for medical societies to lead through action, at the physician level, instead of relying on legislation or payer concessions alone. According to Mark Thompson, Executive Director of the Medical Society of Delaware (MSD), most states introduced bills to address PA, however individual bills varied greatly on requirements such as standard PA forms, electronic prior authorization (ePA), and response time. Several bills stalled in committee or changed significantly in scope. PA legislation in every state does everyone a disservice. SPA is a unification process that began in the mid-Atlantic and is designed to invert the paradigm to give physicians control, transparency, and relief from the PA process; provide better outcomes for patients; and present a unified approach on behalf of physicians.

“The potential for prior authorization cost savings is huge.”

—Mark Jacobs, CIO
Delaware Health
Information Network

Additionally, SPA maintains:

- A performance value for each physician and procedure, which is matched against a threshold and allows performing physicians to fast-track the process
- A permanent register of past requests, thereby fast-tracking repetitive requests
- Criteria on a shared blockchain owned and accessible by all stakeholders; the blockchain powers outside services with a simple, industry-standard way to communicate over a common data set and allows untrusting parties to participate in a protected, yet open manner
- Performance data at a granular physician and procedure level because adjusting requirements for risk-based payment contracts requires turning the fast track on or off at the detail level

SPA was created because of leadership and collaboration between MSD, Delaware Health Information Network (DHIN), a Health Information Exchange (HIE), and Haven Health Solutions, a technology vendor. The group used the state of Delaware as a pilot to create a viable PA solution. The SPA model is gaining traction at medical societies across the country and is concurrently partnering with HIEs. SPA is the embodiment of industry working together.

In the DHIN, between 87-92% of PAs are approved within 24-48 hours, with no fallout. Rejections are associated with a lack of clinical data, procedures that are not medically necessary, and care that can

be provided in alternative settings. Haven Health Solutions supports the ongoing development of PA national standards and is an active member of DirectTrust, another collaborative. DirectTrust is a non-profit association of 121 health IT and healthcare provider organizations that support secure, interoperable health information exchange via the Direct Message protocols.

CAQH CORE's Operating Rules for Prior Authorization

CAQH's Committee on Operating Rules for Information Exchange (CORE) regularly brings together 130 organizations from across the healthcare industry to "drive the creation and adoption of healthcare operating rules that support standards, accelerate interoperability, and align administrative and clinical activities among providers, payers and consumers."⁶ Phase IV and V of CORE's operating rules create common infrastructure and data content for PA. The aim of the operating rules is to reduce unnecessary manual interventions and, ultimately, improve the timely delivery of patient care, while reducing the costs associated with manual claims management for both providers and payers.



Phase IV CAQH CORE Operating Rules establish requirements to address real-time batch processing and response times, connectivity, and acknowledgements, setting industry expectations for how the PA transaction is exchanged. Implementation of the phase IV infrastructure requirements has been adopted among regional, national, and Medicaid plans, as well as vendors and clearinghouses.

Phase V CAQH CORE Operating Rules build on Phase IV and are near completion. This phase focuses on standardizing key components of the PA process with the goal of closing gaps in the data required for electronic data exchange. Phase V moves the industry toward a more fully automated adjudication of requests. By helping providers understand what data is required to successfully submit a PA request and what subsequent steps are needed for a request to be approved, the time to receive the payer's final decision is also shortened. Ideally, these rules would be adopted by all payers to ensure a uniform and consistent PA process for the provider.



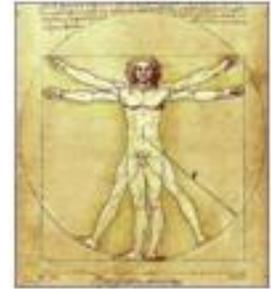
CORE offers a voluntary certification to entities and products/services that create, transmit, or use the administrative transactions addressed by the operating rules.⁷ Currently, organizations involved with CORE are voluntarily adopting Phase IV and are advocating that others do the same. CORE is specifically calling on the six leading healthcare organizations that signed onto the *Consensus Statement on Improving the Prior Authorization Process* to encourage PA automation as part of their efforts to improve the entire PA process⁸ and recommends that organizations add CORE-certification to their PA improvement efforts. CORE is working toward identifying industry consensus on streamlining final determination requirements, including

research on current state and employer group requirements, interviews and site visits with providers and payers, and a potential pilot to assess the effectiveness of their requirements in helping providers efficiently determine whether PA is required for a variety of services and medications.

HL7® Da Vinci Project

The Da Vinci Project is hosted under the umbrella of Health Level Seven International (HL7®) as a privately funded initiative that operates independently, but collaboratively, with HL7's workgroups.⁹ The goal of Da Vinci is to develop Fast Healthcare Interoperability Resources (FHIR®) Implementation Guides and sample code that:

- Support the fast development and deployment of interoperable services to enhance provider-payer exchanges
- Reduce provider burden and improve the quality of data required to fuel value-based care arrangements



For 2018, the Da Vinci Project identified several use cases and project deliverables linked to “high-volume, manual activities that would benefit from automation of portions of the workflow that collect critical data to improve outcomes.” The Da Vinci Project will validate the readiness of use cases through field tests and make implementation guides and sample code publicly available at no cost. Additionally, the Da Vinci team will bring select implementation guides into the HL7 standards development process to be balloted as standards. Two use cases in process that can impact and improve current challenges surrounding PA are “coverage requirements discovery” and “documentation templates and coverage rules”.¹⁰

- **Coverage Requirements Discovery** enables a provider to request and receive payer coverage requirements at the point-of-care. In-workflow coverage details allow providers to make both clinical and administrative decisions about orders, treatments, and referrals mid-encounter. A FHIR®-based API gives providers the ability to discover specific payer requirements in real-time, bringing important benefit details in context for providers.
- **Documentation Templates and Coverage Rules** aims to reduce provider burden, clearly define documentation requirements at point-of-service, and where possible, share medical necessity criteria across trusted partners. The ability to inject benefit information in context of clinical decision support modules (CDS), leveraging existing FHIR® constructs like CDS hooks, enables partners to expose rules prospectively at the point-of-service reducing errors, missing information, and waste.

ONC P2 FHIR® Task Force

ONC is convening groups from across the industry to collaborate on accelerating the development of FHIR® on a national scale and reducing variability in industry implementations as part of the ONC Payer and Provider (P2) FHIR® Task Force. The Task Force is complementary to the HL7® Da Vinci Project. Both initiatives seek to solve payer-provider and provider-provider interoperability problems by leveraging HL7's FHIR® Standard, and to reduce provider burden and transition to value-based care payment models.

CMS Documentation Requirement Lookup Service

The Centers for Medicare and Medicaid Services (CMS) is collaborating with the P2 FHIR® Task Force and the Da Vinci Project as part of its Documentation Requirement Lookup Service Initiative. The initiative is an ongoing effort to streamline workflow access to Medicare requirements.¹¹ The Task Force will help CMS identify and solve infrastructure barriers that could prevent providers' use of the Medicare Fee-For-Service (FFS) Documentation Requirement Lookup Service on a wide scale. CMS will then incorporate the results of the two DaVinci use cases, Coverage Requirements Discovery and Documentation Templates and Coverage Rules, into the Medicare FFS Documentation Requirement Lookup Service.¹²

“The key word on the P2 FHIR Task Force is scalability.”

—Stephen Konya,
Senior Innovation
Strategist Office of
National Coordinator
of Health IT, HHS

American College of Radiology's Appropriateness Criteria

“CDS can say more than just ‘right or wrong test’. It includes the additional benefit of immediate educational feedback.”

—William Thorwarth,
MD American College of
Radiology

The Protecting Access to Medicare Act of 2014 has made it more likely that organizations will adopt clinical decision support (CDS) solutions. According to the bill, a radiologist's claims will only be paid if the claim includes evidence that the ordering physician consulted appropriate use criteria (AUC) prior to ordering advanced diagnostic imaging services such as CT, MRI, NM, and PET scans for Medicare patients. PAMA defines AUC as “criteria that are evidence-based (to the extent feasible) and assist professionals who order and furnish applicable imaging services to make the most appropriate treatment decisions for a specific condition.”¹³ The legislation goes into effect on January 1, 2020, at which point a CMS approved qualified clinical decision support mechanism (qCDSM) using AUC from qualified provider led entities (qPLE) must be used. The tool must also provide immediate feedback to the ordering clinician on

appropriateness guidance, allowing for referrer education and avoiding the delay that occurs in PA. It is important to note that ordering clinicians are only required to *consult*, not *adhere*, to the AUC.¹⁴

The American College of Radiology (ACR) is one national medical specialty that supports AUC policies as an evidence-based, point-of-care alternative to PA. Ordering clinicians prefer CDS to PA programs from radiology benefit management companies, as CDS avoids delays, protects patients from unnecessary or inappropriate tests, educates referring providers, and empowers referring providers to address patient insistence. The ACR has developed their own evidence-based guidelines to assist providers in choosing the most appropriate imaging or treatment decision for a certain clinical condition. By 2018, the ACR Appropriateness Criteria® had 179 diagnostic imaging and interventional radiology topics with over 898 variants. Their diagnostic imaging topics had over 1,560 clinical scenarios. Medical providers can actually consult ACR Appropriateness Criteria to fulfill impending PAMA requirements because CMS named ACR as a qPLE in 2016.¹⁵

The ACR has partnered with technology vendor National Decision Support Company (NDSC) to develop and deploy ACR Select™, a module contained within CareSelect Imaging that delivers a web-based CDS system that includes ACR Appropriateness Criteria recommendations. Organizations can access ACR

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Select through a web portal or integrate it into existing computerized physician order entry (CPOE) and electronic health record (EHR) systems. ACR Select scores the appropriateness of an exam based on patient data entered into the system by the clinician. The system displays a numerical appropriateness rating for the test and a list of other possible exams with their appropriateness ratings. The more often ordering clinicians use the system, the more they improve their ability to identify appropriate exams on the first try.¹⁶



THE PRIOR AUTHORIZATION FORMULA — POSSIBLE SOLUTIONS

When booking airline tickets evolved from travel agents to websites like Travelocity, airlines were forced to expose their business services, radically changing how tickets are booked. Healthcare is going to have to expose their business services in a similar manner, which will allow for a fundamental change to PA.

Electronic Prior Authorization



Providers are apprehensive about ePA because in their attempts to use it, they are failing on specific questions and end up reverting back to their old non-electronic ways. As industry moves to value-based care, the role of authorization is changing. Change management is difficult. Providers may be leery about ePA, but it is the future. E-prescribing did not become legal nationwide until 2010, however almost a decade later, 77% of all prescriptions and 90% of prescriptions for non-controlled substances are e-prescribed, which has helped reduce prescription abuse, particularly in states that have whole-heartedly accepted the practice.¹⁷ ePA has the potential to transform PA in the way e-prescribing transformed healthcare.

In another tangible example, one provider might get three PA faxes for the same patient and the same drug, but from three different entities: the plan, the physician, and the pharmacy. ePA can streamline and centralize requests. Principle #12 of the AMA's Prior Authorization and Utilization Management Reform Principles calls for PA "exclusively through secure electronic transmissions using the standard electronic transactions for pharmacy and medical services benefits," and specifically states that, "facsimile, proprietary payer web-based portals, telephone discussions and nonstandard electronic forms shall not be considered electronic transmissions." "Automation to improve efficiency and transparency" was the fifth area that the healthcare organizations signing the consensus statement believed would lead to meaningful PA reform.

"Change management is hard."

*—Jocelyn Keegan,
Senior Strategy
Leader, Point of
Care Partners*

Data-Driven Decision Making & the Gold Standard

The idea that insurers should use data they have collected on physicians to create a "gold card" for those with a successful track record of PA approval is a popular option with some providers for reducing

the PA burden. Providers with a proven track record of efficiency and cost-effectiveness particularly support the idea. The “gold card” entitles the physician to eliminated or relaxed PA requirements,

Data-driven decision-making is key to solving prior authorization.

compared to doctors with less successful track records. The data will also be able to identify which PA items are almost 100% approved and those items could be gold carded as well. More organizations are looking into gold carding as a means to better integrate clinical guidelines in the PA process. Pharmacy is a great example of data-driven decision making. The industry is already practicing ePA and uses data to remove PA for certain entities. The gold standard allows organizations to think through PA for specific priority areas, instead of blanketly.

Vendor Agnostic Platforms & Solutions that Work Across Plans

Vendor agnostic platforms that support standards are another solution for PA. Organizations strongly feel that PA platforms should not be propriety. Electronic Health Records (EHRs) were supposed to be the holy grail of healthcare but were not built to communicate with one another, which created new silos and was contradictory to the purpose of truly accessible patient records. Industry members working on PA solutions do not want to repeat this mistake. If PA solutions work across plans, patient data follows the patient no matter the health plan. PA could be set up as a single clearinghouse that follows the patient, if industry is vested in creating this system.

Setting Standards & Building Trust and Transparency

While the industry is dubious that health plans and clinicians will reach consensus, the only way health plans can determine the appropriate standards for PA is through conversations with physicians. When payers agree, problems are solved, and administrative hassles alleviated. Vendors believe they play a role in taking administrative burdens away from providers. For instance, vendors can work with providers to define the right language for CDS. Some ideas suggested to help set standards and avoid collusion were:



- FHIR® technology that provides the opportunity to check the PA requirements of various plans
- Linking coverage alternatives to PA requests, for instance informing providers when a certain pill requires PA and suggesting three similar pills that do not
- Legislative support for payers in order to alleviate the potential for collusion as more entities collaborate
- Putting the back office and front office back together, either at the point-of-service or afterwards

CONCLUSIONS

Although PA has been troublesome for healthcare stakeholders across the board, there is a light at the end of the tunnel. eHI’s Prior Authorization Initiative demonstrates the willingness of industry to work together to find tangible solutions for fixing PA. Potential solutions have coalesced around ideas

formed in collaboration. For instance, the *Consensus Statement on Improving the Prior Authorization Process* is key to both CORE and SPA processes. Technological solutions such as FHIR® and CDS are at the forefront of agreement about healthcare IT's contribution to fixing PA. A collaborative approach is the only way to tackle the issue. eHI will continue to convene industry around PA until the process improves.

“It’s not rocket science, it’s social science.”

—Jon Zimmerman,
athenahealth

ENDNOTES

- ¹ <https://www.healthcare.gov/glossary/preauthorization/>
- ² [2017 AMA Prior Authorization Physician Survey. \(American Medical Association, 2017\)](#)
- ³ <https://www.ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf>
- ⁴ <https://www.ama-assn.org/health-care-leaders-collaborate-streamline-prior-authorization>
- ⁵ <https://www.ama-assn.org/sites/default/files/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf>
- ⁶ <https://www.caqh.org/core/caqh-core-overview>
- ⁷ <https://www.caqh.org/core/core-certification-process>
- ⁸ <https://www.caqh.org/sites/default/files/core/caqh-core-board-prior-auth-response.pdf>
- ⁹ <http://www.hl7.org/about/davinci/index.cfm>
- ¹⁰ <http://www.hl7.org/about/davinci/use-cases.cfm>
- ¹¹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/LookupServiceInitiative.html>
- ¹² <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/LookupServiceInitiative.html>
- ¹³ <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/index.html>
- ¹⁴ <https://www.ehidc.org/resources/presentation-imaging-appropriate-use-criteria-proven-replacement-prior-authorization>
- ¹⁵ <https://www.acr.org/Clinical-Resources/ACR-Appropriateness-Criteria/About-the-ACR-AC>
- ¹⁶ <https://www.acr.org/Practice-Management-Quality-Informatics/Imaging-3/Case-Studies/Information-Technology/Digital-Guidance>
- ¹⁷ <https://www.ehidc.org/resources/ehi-explains-epcs>