PRIOR-AUTHORIZATION SOLUTIONS

Automating workflows to reduce the burden on clinicians and patients

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Inefficient prior-authorization processes, slow turnaround times, lack of transparency and inconsistent requirements by payers can lead to dangerous delays in patient access to needed care and are a significant burden on physicians and patients. Making the prior-authorization process more transparent and connecting it to the point of service enables clinicians to determine whether prior authorization is necessary at the point of care. Some hospitals and health systems are working to automate parts of the authorization process, but they face significant challenges that can only be addressed by working jointly with payers. One of the most frustrating aspects for providers and patients is the variation in prior-authorization submission processes. Ensuring standardization across payers is crucial to automating authorization processes.

KEY FINDINGS

1. Authorization requirements differ by payers and often differ at the individual plan level vs. the payer level. **Existing prior authorizations are not portable across health plans.** The challenge of keeping up with prior-authorization variations places excessive time demands on physicians and their staff, disrupts patient care and increases administrative costs.

2. **Accountability and transparency by payers** around service-authorization requirements would help providers operationalize requirements. Make the kinds of medical documentation required and the types of services it requires accessible to providers and patients.

3. **Innovations in technology and electronic prior authorization** can reduce administrative inefficiencies and promote real-time decisions for services, making health care more efficient and patient-centered.

4. **By automating and moving the authorization process upstream** in the care delivery process, physicians can be alerted when certain criteria apply and prior authorization is required.

5. A **standard transaction** that can be submitted across the payer spectrum by the provider's billing systems would streamline workflows and reduce denials.

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MODERATOR *(Lindsey Dunn Burgstahler, American Hospital Association):* **The AHA is closely following regulations regarding electronic prior authorization from our members' standpoint. I wanted to give John Travis, who provides guidance on regulatory requirements for Cerner's business units and clients, a chance to share Cerner's perspective on the issue, and then we'll hear from all of you about the challenges and opportunities.**

JOHN TRAVIS *(Cerner Corporation):* Thank you, Lindsey. I have a few context-setting remarks to keep in mind as we go through the discussion. The prior-authorization transaction, among all the HIPAA standard transactions, stands out for its low adoption rate even after almost 20 years of existence. In CMS rulemaking proposed at the end of the Trump administration, the Centers for Medicare & Medicaid Services cited that only about one in seven providers use the existing transaction in anything that would approach full implementation. Even for those that have implemented it, it's still troubled by issues around the lack of transparency. What are the service-authorization requirements? What kinds of medical documentation are required? What services require it? Then, how to operationalize these types of requirements?

In its recent rulemaking, CMS tried to get at some of that with its proposals around using new interoperability requirements based on application programming interfaces. These requirements would call for FHIR APIs (Fast Healthcare Interoperability Resources application programming interfaces) similar to the certification criteria that support the Promoting Interoperability Programs, which replaced Meaningful Use. That rule is awaiting rework and reissue by the Biden administration. A lot of work remains to make prior authorization a useful end-to-end process without much human intervention. The process is disjointed from the clinicians and from their workflows. The American Medical Association and others have conducted surveys to point to prior authorization as one of the most burdensome of administrative requirements with Medicare and Medicaid as well as with commercial payers. I think we're getting close to a tipping point in addressing the burden of the transaction.

MODERATOR: **Thanks John, we appreciate those comments. Let's hear some of your experiences on the challenges of automating the prior-authorization process.**

ALLYSON KELLER *(Piedmont Healthcare):* We have been working to automate the prior-authorization process. One of the biggest challenges we have is being able to validate requirements at the plan level vs. the payer level.

Another challenge is internal — our staff's willingness to trust the determination because sometimes they find what is being returned to them is not what the requirements have been historically. When they call, they may get a different answer or when they go to a portal, they may get a different answer.

Every plan or insurance company does it differently and has different requirements. Not having a standard form to complete makes automation difficult. A lot of payers also are blocking bots and not allowing for the automation of the determination.

MODERATOR: **Allyson, in your comments around bots, are you trying to automate pieces of it on your end while payers are not accepting that approach?**

KELLER: The service with which we're working has bots that try to gather information and the payers are blocking them.

MARY BOURLAND, M.D. *(Mercy Health):* We have been using bots internally. Also, we have been trying to use them with our larger payers by visiting

their websites to see if the bot is even required, to decrease the number of times we need to have a prior authorization performed. Some vendors are succeeding and others aren't, so it is vendor-specific. Sometimes it's not the payer but the third-party vendor that gets their authorizations. It is frustrating. Groups like this can come together and suggest how to standardize the authorizations because it's such a big problem. If we don't bring a solution to the table, then we're not going to be able to move the payers off square 1.

MODERATOR: Good comment, Mary. I should add that we share an after-action report with our public policy team that leads our work around administrative burden in prior authorization, so we'll be taking this in on our end as well.

ELIZABETH WIKOFF *(Mercy):* I also work for Mercy and I echo what Dr. Bourland said. We have language in our payer agreements that prohibits us from being able to give credentials to bots. That's why we struggle with bots being able to access the payer websites.

Has anybody worked with payers regarding presumptive authorization where instead of having to obtain authorization, they just give it to you automatically? However, they can then go back and audit clinical documentation on the back end to validate that what was ordered and performed was truly medically necessary.

MODERATOR: Anyone with success on presumptive authorizations?

SAMI BOSHUT *(Jamaica Hospital Medical Center):* There should be a clear definition and the payers should adopt one standard for prior authorization.

BOURLAND: For inpatient vs. observation status pre-authorizations, once Medicare Advantage plans have approved pre-authorization, they are required by law not to deny payment later. That does not hold true for outpatient procedures, imaging and drugs where pre-authorization is not a guarantee of payment. So often when they give pre-authorization, they deny it on the back end for lack of medical necessity. You'll be denied 100% if you don't have a pre-authorization, but even if you get it, you may still be denied.

MODERATOR: Other challenges?

RON CHRISTENSON *(Morris County Hospital):* Our electronic health record (EHR) does not offer an automated solution to prior authorizations now, and we have a manually driven process. Our staff is either on the phone or on payers' websites trying to obtain prior authorizations every day. You might be placed on hold for extended periods and the websites aren't necessarily updated with plan changes as promptly as they should be. You can receive varying answers from the website vs. telephone follow-ups.

We are appealing a number of patient claims because they first told us, "Oh, yes. You don't need a prior authorization for that service," and then, "Sorry, you do." It's a cumbersome process and many payers are unclear as to what they require or don't require. When you receive multiple answers from the same payer, it's frustrating.

We're looking at having to add more staff just to take care of the issues at hand, which is driving up the cost of health care again. We're a 21-bed critical access hospital; smaller hospitals don't have the sophisticated systems that big health systems do. We have many tedious, cumbersome manual processes, and staff are becoming tired of it.

DENISE WELCH *(Arbuckle Memorial Hospital):* We face similar difficulties; we're also on the phone getting different answers. One of our struggles is when we have someone taken to the emergency department who needs to be admitted. Many insurance companies want patients to go into observation instead of into an acute care stay, because the patient has more liability and the insurance

company has less. We have a number of frustrated physicians who have had to make the peer-to-peer calls with the insurance company's physicians.

KELLER: The recurring and more complex procedures are really challenging; for instance, infusion services, chemotherapy, rehab, outpatient physical therapy and speech. We haven't even attempted to automate those. We're still trying to automate on the imaging side and then move to the procedural side, which has its own complexities pertaining to inpatient vs. outpatient.

MODERATOR: There are many challenges. What are some of the opportunities if we were to be successful in moving this more upstream in the care delivery process? How would it potentially affect treatment planning and workflows?

WIKOFF: If we could have a model in place like presumptive authorization, it would allow more patient self-scheduling. We've been talking about having patients be able to self-schedule for a lot of these tests, but we need all the restrictions built into the system based on preset requirements. We couldn't have a patient schedule for tomorrow if it takes us 72 hours to get a pre-certification from a payer. We're trying to solve for some of that, to be able to automate more of our other processes like scheduling.

JEENY JOB, D.O.: *(SBH Health Systems)* Ideally, getting that information at the point of care might prevent the prior-authorization process to begin with. Physicians would know what medications/procedures are available to the patient and can order accordingly. In the current state, clinicians are finding about a denial after the patient has left the office, creating issues with the patient and provider experience.

THOMAS MCILWAIN, M.D. *(Charleston Area Medical Center):* The standardization issue is paramount because, if you're dealing with 20 different payers that have 20 different approaches, 20 different timelines, 20 different forms and 20 different criteria sets, whether it be for a prior authorization for a medication, a test or a procedure, then all of this is wasted effort. We can't do it on our end as a provider in the absence of a level of agreement across all payers. It's just too much of a challenge.

KELLER: By being able to empower providers at the point of ordering the service, they know what they're ordering, whether it will be authorized or even meets medical necessity. This is key in the future. It's frustrating for providers because so many items end up going to peer-to-peer review with the payers, which requires our providers to be on the phone with payers. Providers don't understand this and, in a lot of cases, it's because it doesn't meet the criteria.

Without having standardization, it's hard to give providers a level of regularity to say, "Well, that's because either something wasn't documented," or "A step was skipped." Ultimately, if we can get information at the point of ordering, we can get authorization or the provider would know that this doesn't meet the criteria and may need to provide additional justification. We wouldn't want to stop clinicians from ordering, but they need knowledge at that point.

MODERATOR: John, this is an issue your team thinks a lot about. Let's hear your perspective.

TRAVIS: One of the things that garnered some discussion and that the rulemaking team put out was the idea of exposing the medical documentation requirements through a public-facing resource. The idea is to promote the transparency of the information required to have a successful authorization, even to provide a submission template for what needs to accompany the prior-authorization request at the point of service.

Part of the focus was to make available what services require authorization and what services do not. If we were talking about denials, we might be

discussing complex and simple denials or technical denials, things that would require follow-up. There's a corollary to the authorizations where the process could be more or less automated through bots to streamline simple authorization scenarios that do not require extensive review. CMS imagines using application-programming interfaces from an interoperability perspective not only to support that, but also to tighten down the communication timelines for how long it would take a payer to communicate a decision on a prior authorization and to provide a more fine-grained response to such questions as: Why a denial? What caused it? What was missing? What was defective about the authorization request?

While we're still waiting for that rulemaking, it was aimed exactly at making the process more transparent and enabling it to be connected to the point of service, rather than having it be such a disjointed process to the provider clinically or from the revenue-cycle perspective.

"The idea is to promote the transparency of the information required to have a successful authorization, even to provide a submission template for what needs to accompany the prior-authorization request at the point of service."

— John Travis —
Cerner Corporation

MODERATOR: Going back to the upstream discussion, technology only goes so far. It doesn't mean much if it's not incorporated as seamlessly as possible into workflows. Let's hear your thoughts around that workflow issue.

KELLER: For imaging, appropriate-use criteria have already been developed by CMS and are going to be a requirement. If it meets CMS-appropriate use, why could that not apply to other payers? In addition, since that presents to the provider at the time of ordering, that certainly would be a step in the right direction.

TRAVIS: CMS was trying to push the idea that there are a standard set of services that require prior authorization and that prior authorization is portable. Specifically, they were looking at the case of a patient who changes health plans. An open authorization that was approved by Medicaid, a fee-for-service plan or Medicaid managed care plan could be portable to the health insurance product that was purchased through the federally facilitated exchange. CMS was aiming to have a durable, or portable, authorization. If the authorization had already been active and approved, why go through it again? Similarly, you could have a single authorization work for a whole series of services.

MODERATOR: What about the friction from a patient's standpoint? How does this make access to treatment and patient care more challenging, Denise?

WELCH: We do experience frustration from the patient because, while we're waiting for those prior authorizations, it delays treatment.

KELLER: We are evaluating different ways to approach it. Do we delay how far out we're going to put someone on the schedule because of the authorization; do we delay scheduling until after it's been authorized; or do we schedule and then notify them that they're going to be canceled, which never goes well.

Patients expect that we're going to be the ones to get the authorizations and make sure everything is taken care of. It puts us in a tough, no-win situation. However, I agree with Denise that, ultimately, it's about patient care, and not being able to provide it in a timely manner or in a way that is best for the patient is because of the restrictions we have.

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