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The Prior Authorization Challenge

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secure exchange solutions

Prior authorizations (PA) within the U.S. healthcare system were created to improve patient safety and reduce unnecessary costs through the application of evidence-based care best practices.

Typically involving communication and collaboration among patients, providers, third-party administrators and payers (to name just a few of the key actors), the PA process is handled many different ways depending on the policies, processes, tools and capabilities of those involved.

The industry as a whole has acknowledged that the current methods for managing PAs are marked by a lack of standardization and a dearth of widely adopted technologies and processes, which have had a significant negative impact on patient care.

Industry research reveals that:

- 76 percent of physicians said they've switched treatments at least once because of the PA process.
- Physicians spend an average of 20 hours per week on PA activities — and some doctors say this figure is too low.[2]
- Two-thirds of physicians reported common waits of several days to receive preauthorization from an insurer for drugs; 10 percent waited more than a week.[1]
- For prescriptions requiring a PA, as many as 40 percent of patients forego treatment altogether.[1]

Beyond the impact on patients, current PA processes represent an estimated $23 to $31 billion administrative cost on the U.S. health system annually.[1]

Some payers are developing new policies to address issues of administrative burden, including waiving some PA requirements or conducting retrospective reviews on provider practices to create "teaching moments." However, PA requirements will persist in many circumstances, especially in cases where high-cost treatments are involved. Thus, the challenge to the industry is how best to meet the original intent of PAs while finding ways to minimize adverse cost and patient care outcomes.

Untangling the Complexity

The healthcare industry as a whole has made significant progress in streamlining and automating various other transactions critical to how our third-party payer insurance model works today. For example, benefit-eligibility determinations and claim submissions can be processed at high volumes with generally increasing efficiency through standards and automation.

So why has streamlining the medical PA process through technology remained elusive? Part of the answer lies in the complexity of the transactions. Many other healthcare transactions, while complex in their own right, involve a more finite amount of detail and data that need to be transmitted per payer policies. Additionally, there are well-defined standards for what's generally required to share among payers and providers for strictly administrative functions around eligibility and payment.

By contrast, PA often demands an exchange of more detailed and varied information — data that can vary by provider type, treatment type, payer review requirements, and other factors. Often, additional clinical information is required for medical review, necessitating back-and-forth communication between parties either at different locations or at different entities within a location. Moreover, differences between preauthorization requirements for medical treatments versus durable medical equipment, pharmacy and behavioral health create further complications including adding into the equation additional third-party administrators and systems.

As one family practitioner stated, "Finding the correct point of contact, calling the payer, waiting to get someone on the line, waiting for the form to be faxed, shuffling through a patient's medical records, filling out forms — all these steps add up. It can take upwards of four hours to finalize a PA request." [1]

Another important factor is the involvement of the providers themselves. Unlike routine administrative transactions that can be handled by a practice's front office, a PA originates with a provider prescribing a course of treatment. Already operating on tight timelines in their daily routine, providers often don't have the time or inclination to work outside of their electronic health record (EHR) systems — something they would have to do if a payer has their own portal for collecting online PA requests. Often, providers don't know if a PA is even required. Further complicating the matter is that payer systems are more likely to integrate with a provider's revenue lifecycle management system, not their EHR, where patient and treatment information resides.

Partial Solutions

To help address the problem, some payers are eliminating PAs for certain referrals, treatments, procedures and tests. Instead, they are setting policies based on evidence-based care data and reviewing for compliance. If they learn that certain providers are routinely working outside policy parameters, payers can take appropriate action, including removing repeat offenders from their network.

This approach is only a partial solution, however, because prior authorization often is still required for high-cost treatments and medications, and in other situations where payers want to be informed of a treatment plan.

When PAs are still required, providers face a daunting array of disparate technologies and processes. For larger practices or facilities, the opportunity to invest in automation between their systems and payer systems depends on having enough volume to justify the cost of the integration. Even then, that investment will probably be applicable only to a single payer's membership and not extensible to other payers that providers work with.

So for most providers, it often comes down to the choice of learning and using each payer's portal — or working the old-fashioned way with phone calls and faxes.

A Better Path Forward for Prior Authorizations

Patients, physicians and payers all have shared interests in creating a connected and automated infrastructure to reduce the administrative and care costs associated with the current PA system.

What would the ideal solution look like? Most industry experts agree that it starts with letting providers work within the EHR they already use today.

Consider a situation in which a provider and patient are discussing new medications and a treatment plan involving a specialist referral. Currently, the medication and referral must be approved by the patient's insurer, requiring administrative time and expense and a delay of several days or even weeks.

Imagine, instead, that the provider requests a PA directly from their EHR system. The request is immediately routed to the payer for instant approval when possible, or for a speedy and streamlined review by the appropriate decision-maker at the insurer. In addition to the payer's response, the provider would receive information about in-network, recommended prescriptions and other suggested options. This allows the provider to immediately advise the patient on next steps — confident that all administrative necessities are handled so they can focus their attention on patient care and the treatment plan.

From a technical perspective, the solution would capture the real-time, end-to-end flow of information made possible by standards-based integration. All participants could implement the solution methods and patterns without having to worry about proprietary technology lockout. When providers are able to spend considerably less time on preauthorization paperwork, the result is improved patient care, satisfaction and outcomes. The savings from reduced administrative costs would be significant, particularly for large organizations requiring tens of thousands of preapprovals.

Because formats and transport methods are standardized, the solution could scale across the industry and be leveraged by all. As more and more EHR vendors and payers adopt these methods and standards into their solutions, the cost of adoption would decrease so that these streamlined processes can be made available to smaller practices. Eventually, providers throughout the industry and at all scales would have these solutions embedded as part of the EHR software packages.

Innovation also offers cost-savings for payers, who could rely more heavily on the standardized authorization technology they have invested in and less on training providers on the use of new, proprietary systems. Additionally, long term costs would drop due to a reduced need to maintain large call centers, which are currently supporting physicians' staff who prefer to call in for approval rather than learn to navigate various payer portals.

Where to Start

Today's healthcare industry is operating far away from this ideal state. The solutions that do exist are still largely proprietary and often the result of a concerted integration effort between the largest provider systems and the largest payers. While some solutions being rolled out and piloted do make use of existing and emerging standards and technologies, most industry participants agree that we're not at the point where there's a clear path to solutions that can be widely adopted by all, particularly for medical treatments and referrals.

A clear barrier to adoption is the amount of investment that EHR vendors and payers need to make in a solution that will work on a broader scale. Many payers have invested in provider-facing portals for electronic communications and have connected those to their internal medical management systems. These payer portals put a burden on providers to learn and maintain accounts on multiple systems, and to manually transfer data from their EHRs. Although deploying these capabilities as a module within the EHR solution would streamline the provider experience, integrations with multiple payers has not been a focus of EHR vendors.

The good news is that many of the potential foundational components for a solution are in place and currently in use by EHR vendor and payer systems. Direct Secure Messaging (DSM), for example, is a secure messaging protocol for exchanging patient information that came into wide adoption by EHR systems due to CMS Meaningful Use requirements. Similarly, there are existing and emerging standards for exchanging patient data, including X12 schemas for common health care transactions (e.g. 278, 277, and 275), X12 semantic XML, HL7 CDA, and FHIR. Ultimately, it may be a matter of surfacing and combining the right mix of technologies, tools, and methods to achieve the critical mass needed to fully automate and streamline the PA process. In order to achieve this goal, participation and collaboration from organizations across the industry is imperative.

An example where the industry has seen success is in the area of e-prescribing where payers and providers that have adopted the NCPDP SCRIPT standard have been able to streamline the preauthorization process significantly. In cases where end-to-end integration has been implemented between EMRs and payer systems, preauthorizations can be completed in a matter of seconds.

You Can Be Part of the Solution

The Innovation Messaging Group (IMG) is in the process of aligning with the X12 organization, which has been chartered by the American National Standards Institute (ANSI) for more than 35 years to develop and maintain the EDI standards and XML schemas that drive business processes globally. A number of leading EMR vendors, payers, and health care vendors and consultancies have joined together on the IMG to begin this process of discovery and forward movement.

The IMG seeks to develop scalable, efficient and affordable solutions to the challenges posed by prior authorizations. Moreover, we plan to facilitate and support pilots of these solutions and share lessons learned with the industry. As part of a vendor-neutral standards organization, we want to make certain that the solutions provide clear guidance on standards that can be easily adopted by all players, leading to cost-effective solutions as ubiquitous as the other types of transactions routinely flowing among organizations across the industry.

We invite payers, provider groups, health technology vendors, third-party administrators and governmental agencies to get involved, especially by participating in pilots. Given the complexity and breadth of the problem, multiple pilots will be conducted to experiment and learn about how to build solutions that satisfy core business needs in an economical manner through standards-based technologies and methods.

At the January meeting of the IMG in Portland, Oregon, the group commissioned a pilot for an important aspect of the end-to-end PA process around request-response transactions between payers and providers. Specifically, the group intends to use the 277 Request for Additional Information and 275 Response flow as an initial test case for streamlined information exchange. Aspects of the pilot include:

- Using X12 semantic XML for representing 277 and 275 information
- Providing routing information within the XML to channel the data to the correct reviewing entity within the payer organization
- Using HL7 CDA as the container for patient information exchanged
- Using the Direct Secure Messaging protocol as a means of secure messaging

Contained within the pilot are several hypotheses that will be tested:

- From a business perspective, did the pilot save time and effort over solutions currently in place?
- Did the technologies used meet the business requirements with regard to routing the information and providing the right data to satisfy the target use cases?
- Was the right version of X12 semantic XML used?
- What could be added and improved to support better routing, tracking and transaction success rates?

1 The Impact of the Prior Authorization Process on Branded Medications: Physician Preference, Pharmacist Efficiency and Brand Market Share. Frost & Sullivan.

2 Standardization of prior authorization process for medical services white paper. American Medical Association.

This whitepaper is the first in a series that will track the progress being made by the IMG and its partner organizations. Additional white papers will focus on key learning from pilots and efforts to drive forward toward standards-based solutions that can be adopted by industry participants.

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