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Formerly AHC Media

MAY 2018 Vol. 37, No. 5; p. 49-56

Surprise Medical Bills Trigger Disputes, Dissatisfaction With Patient Access

Surprise medical bills from out-of-network providers are making headlines and angering patients. They also cause some pretty big problems for patient access.

"We have had issues with patients getting 'surprise' medical bills," says **Maria Lopes-Tyburczy**, CHFP, director of patient access at HackensackUMC Palisades in North Bergen, NJ. Typically, multiple bills arrive because the ED physician group bills separately from the hospital. "Patients dispute the bills, stating that they should have been told upfront that the physician is out of network," Lopes-Tyburczy explains.

Hands-off Attitude

The primary source of surprise billing is when patients go to hospitals that are in network, but are seen by physicians who are out of network. "Some hospitals take a hands-off attitude toward this problem, thinking that it's really an issue for the physicians but not for the institution," says **Mark Hall**, JD, who authored a recent white paper on the topic.[1] However, patients see things a little bit differently. "They are not aware of the fine points of distinction among employed physicians, contracted physicians, and independent medical staff members," says Hall, director of the Health Law and Policy Program at Wake Forest University School of Law. Hall is author of *Making Medical Spending Decisions: The Law, Ethics, and Economics of Rationing Mechanisms* (Oxford University Press).

In Lopes-Tyburczy's experience, "patients feel that it is the hospital's responsibility to let them know that physicians are not in network." Most often, it happens in the ED setting. However, surprise bills also come from outpatient ancillary services because physicians bill separately for their professional fees.

Despite patients' outrage, surprise bills remain common. About one in five (22%) ED patients receive such bills, according to the authors of a recent study.[2] In that investigation, the patients were seen at in-network hospitals, but were treated by out-of-network physicians.

"Hospitals should be aware of the potential for surprise billing situations to arise, especially when a facility is in network but particular physicians are

HOSPITAL ACCESS MANAGEMENT

Hospital Access Management™ (ISSN 1079-0365) is published 12 times annually by
AHC Media, a Relias Learning company
111 Corning Road, Suite 250
Cary, NC 27518-9238

Periodicals Postage Paid at Cary, NC, and additional mailing offices.

POSTMASTER: Send all address changes to:
Hospital Access Management
Relias Learning
111 Corning Road, Suite 250
Cary, NC 27518-9238

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Back issues: $80. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.
GST Registration Number: R128870672.

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not," Hall warns. Hospitals could include network participation as one of the conditions for medical staff membership, or make it a condition of contracts with physician groups. "Hospitals have significant influence on whether their physicians join the same insurance networks as the hospital," Hall adds.

Inflated Charges

It's not only that patients are billed for out-of-network care without notification. It's also that that the amounts charged are inflated, according to a recent analysis.[3]

"Surprise bills have reached headlines all over the country, and have caused real hardship to both insured and uninsured consumers of healthcare," says **Barak Richman**, JD, PhD, the paper's lead author and Bartlett Professor of Law and Business Administration at Duke University in Durham, NC.

Researchers found that chargemaster rates impose significant financial burdens on uninsured and out-of-network patients while inflating healthcare costs. "When hospitals negotiate with insurers and decide whether to be in network or out of network, they tend to threaten insurers that they will charge chargemaster prices for all out-of-network care," Richman explains.

This makes it costlier to keep hospitals out of network, making insurers more likely to accede to pay hospitals' demands to bring them in network. "This is best described as an extortive negotiation tactic that raises the cost of health insurance and the cost of healthcare," Richman notes. "It is a deeply unfair way to charge for healthcare."

The obvious question is: If hospitals change these practices, how will they make up for lost revenue? "The short answer is, they have to set prices the way everyone sets prices: transparently, in advance," Richman offers.

This is contrary to how the healthcare industry operates. "But hidden prices are not real prices. And 'discounts' from prices to which no one agrees are not discounts," Richman adds.

Negotiation With Carriers

Patients have a right to know where medical charges come from and how much they will be responsible for, says **Peter Kraus**, CHAM, CPAR, FHAM. "Ultimately, it's a matter of transparency."

Unfortunately, ED registrars don't know what services a given patient will receive, let alone which services are out of network for the patient's insurance plan. "EMTALA regulations don't make things any easier," says Kraus, business analyst for revenue cycle operations at Emory Healthcare in Atlanta. He suggests these two approaches:

- Hospitals should negotiate contracts with carriers so that all procedures deemed emergencies and ordered in an ED setting are covered at the negotiated rate, regardless of where they are performed. "Insurance companies can tout this as a benefit to the insured," Kraus says.
- ED registrars should advise patients, at the time when insurance information is collected, that not all services are performed and billed by the hospital; and that some services may end up out of network. "This includes services that were already performed as part of the emergency treatment the patient received," Kraus notes. ■

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Underinvestment in Patient Access? Lack of Compelling Data Could Explain

Hospitals don't invest in patient access the way facilities invest in clinical areas. One reason is lack of data. Understandably, hospital executives want to see more data that can support these financial decisions.

"The absence of that data makes it hard to drive the investments in resources. Investments in clinical processes sometimes come at the expense of patient access," says **Jason Considine**, senior vice president of patient collections and engagement for Experian Health.

Narrow profit margins and widespread layoffs also make it hard to justify investments in patient access. "I don't know a hospital that's not talking about operational reductions in staff and being asked to do more with less," Considine laments.

Patient access has been affected more than other hospital departments. "It's an area people look to cut," Considine notes.

Investing in patient access can result in significant return on investment for the organization. But departments struggle for the numbers to prove it. "One of the things that patient access departments need to improve processes is simply to improve visibility," Considine offers.

Here are some reasons for underinvestment in patient access:

1. Patient access departments lack business intelligence tools.

Patient access leaders know intuitively that things that happen in their departments, such as receiving the incorrect insurance information, affect when and if a claim gets paid. This highlights the need for resources such as training. Yet, there often is no way to show how registrars repeatedly botching the insurance plan ultimately resulted in late or denied payments. "Those can be difficult data elements to tie together," Considine says. "That is a big challenge to solve."

2. Some patient access departments don't have tools to help registrars or schedulers obtain the necessary information to ensure "clean" claims are sent on the back end.

"Patient access is all about collecting and verifying data upfront so back end claims are successful," says **Jason Wallis**, senior vice president of patient access for Experian Health. Without data to support the link between the front end and back end, it's an uphill battle to get needed resources.

3. Patient access lacks data on satisfaction.

The patient experience is a top priority at virtually every organization. Unfortunately, patient access struggles to obtain specific metrics on how they're faring beyond vague organization-wide survey scores.

"With the increase in consumerism, patient access [departments] need the ability to be customer-facing," Wallis underscores.

Back when the role of patient access consisted mainly of obtaining the correct subscriber ID, name, and date of birth, satisfaction metrics didn't matter much. With complex financial conversations calling for top-notch service expertise, satisfaction has become paramount.

"Those soft skills are creeping into the patient access space. But they are hard to quantify," Wallis notes.

It may seem like a no-brainer that patient access needs training to achieve high levels of patient satisfaction. Without numbers to justify the

connection between the two, though, obtaining resources becomes a losing battle. "It's somewhat of a struggle to get that kind of data," Wallis acknowledges.

4. Patient access usually can't compare themselves to patient access departments at other facilities.

Key performance indicators are becoming available to establish industry standards for patient access. The Healthcare Financial Management Association's revenue cycle MAP Keys are one example.

Some benchmarking tools require hospitals to share their own data to see how they compare against peers. This poses a problem for some patient access departments.

"Some hospitals are averse to sharing data," Wallis explains.

Patient access makes do by measuring their own improvement over time. For instance, departments can point out that registration accuracy increased by 20% over the previous month. But it's not cause for celebration if every other hospital in the area is twice as accurate.

"Without the ability to compare against peers, patient access has no way of knowing how they're really doing," Considine says. "That's what you lose with a close-minded approach to your data." ■

Assess Service Skills by Asking How Applicant Handled Difficult Customers

When **Lolita M. Tyree**, MSW, CHAM, asks, "Can you tell me about a time you dealt with a difficult customer," she hopes to hear some great anecdotal stories that reveal a patient access candidate's excellent customer service skills. Occasionally, she finds out the complete opposite is true.

One applicant couldn't stop yawning as she struggled to answer the question. Her body language — full of shrugs and slouches — sent a message that she couldn't care less about the customers she'd interacted with. Others have blatantly rolled their eyes to show just how frustrated they'd gotten with a particularly annoying customer.

"I look for those things that are unsaid. I also listen for the words they use to describe their customers," says Tyree, patient access manager for the ED at Riverside Regional Medical Center in Newport News, VA.

Body Language Counts

Some applicants get visibly tense talking about previous customers they've served. That's not encouraging. "When they are searching for anything in the room to look at other than me, that's a sign they are not comfortable at all with what they are sharing," Tyree notes.

One candidate played with the hem of her pants while trying to explain how she had helped a customer with a coupon issue. "I could not tell if she were looking for the answers in her pant leg, or just grasping at any scenario to give as an explanation," Tyree recalls.

On the other hand, another applicant described in detail how she was cursed out at her previous job at a call center by a customer. The problem was that a package — a family heirloom — had not arrived. "She went to the lost items room herself outside of her normal work hours and found the package, which had been misrouted, for the customer," Tyree says.

Another applicant spoke about a time she calmed down a patient who was so over a physician's bedside manner that she wanted to leave without completing her treatment.

"She realized there was a big miscommunication, and saved the relationship between the patient and physician," Tyree reports. Sometimes, applicants' work experiences outside patient access or even healthcare. Yet, they convey the kind of customer service that's very applicable to the registrar role.

One was a veteran whose previous job was transitioning military personnel to civilian life.

"One in particular gave them a really hard time, declaring they didn't know how it felt to not have any idea what to do after being in one career for so long," Tyree says. The candidate didn't take it personally. Instead, he put the service member in touch with a support group and a vocational counselor.

"The best responses are those that show the candidate went above and beyond the expectation to help the customer," Tyree offers. The worst response to a "difficult customer" story: "I just got my manager."

"That usually shows that they either can't, or won't, try to resolve issues independently," Tyree notes. ■

SOURCE

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Poor Productivity? It's Often Outside Patient Access Control

Payer updates or provider processes often are to blame for inefficiency in patient access. This makes it very tough to measure or improve productivity for anyone.

"Understandardization is both internal and external to the revenue cycle," says **Brett Light**, PMP, director of optimization for patient access and financial clearance services at Stanford Health Care in Palo Alto, CA. Here are some examples:

- Payers vary significantly as to what is and is not covered based on location and provider type, and which facilities are in network;
- Inconsistent payer requirements result in some patients arriving for scheduled visits without an authorization in place;
- Providers use different scheduling templates, documentation, and forms;
- Clinical documentation frequently arrives incomplete or unsigned from physicians' offices, causing registration delays. "When we expect our patient access staff to navigate these inconsistencies, we are setting them up for frustration, burnout, stress-related workers comp, and turnover," Light explains. Most registration areas are far less productive than they could be. "The total cost of this decreased productivity is significant," Light laments. "But most importantly, it is a key driver for decreased patient satisfaction scores." Fairly or not, patients frustrated because of delayed care and registration wait times will blame patient access.

To assess productivity, patient access leaders usually rely on work queue reports such as missing registration fields, ancillary order verifications, and observation status notifications. "But it is equally important to look at indicators that patient access *cannot* control to see the full story on productivity issues," Light says. Some examples:

- Plan benefits changes that aren't current in the registration system;
- Tests that are medically necessary to complete before the number of days required by payers to give an answer on authorization requests.

"For many patient access leaders, tackling these external challenges can feel overwhelming," Light notes. He suggests these three approaches:

1. Start with what you know is your biggest obstacle to productivity. "Expand from there one step at a time, using a gap analysis tool," Light offers. First, ask registrars to name some obstacles to productivity. Next, identify which of those originated outside the patient access department.

2. Ask information technology to help you to automate reporting into a dashboard. Light says this makes it far easier to spot problem areas. "Use this tool to sit down with your clinical and payer partners monthly," he suggests. "Discuss ways to reduce registration issues that are within their control."

3. Don't rule out hiring some outside help. "An experienced consultant can tackle these issues quickly," Light says. "The ROI will more than justify the investment." ■

SOURCE

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Patients Converted to Medicaid: Uninsured Now Under 2%

Many patients have come to The Ohio State University Wexner Medical Center in Columbus uninsured — but left with Medicaid coverage. "Prior to 2014, our uninsured population was around 6%. Today, it's under 2%," says financial counseling supervisor **Kylie Sokol**.

In 2017, the department worked 1,676 patient accounts for Medicaid, compared to 451 that were outsourced to a vendor. In-house financial counselors obtain the needed verifications for pending Medicaid applications. "This avoids having to outsource cases to a Medicaid vendor that can easily be worked internally," Sokol says.

Financial counselors routinely enroll all types of patients into Medicaid. This includes women and infants, trauma patients, and psychiatric patients.

"In addition to increasing our revenue and lowering our A/R, Medicaid expansion provides coverage for discharge needs," Sokol explains. Patients no longer have to worry about obtaining durable medical equipment, prescriptions, or nursing home placements.

Financial counselors work in two groups. The pre-registration financial counselors take these steps:

1. Screen patients prior to service for financial assistance, Medicaid, and Ohio's Hospital Care Assurance Program (HCAP), a financial assistance program for income-eligible uninsured patients;

2. Explain benefits to the insured patients;

3. Inform patients of their estimated out-of-pocket responsibility prior to service.

"The patients that we preregister tend to be insured, making most of our work dealing with copays and deductibles," Sokol reports.

Uninsured and out-of-network patients also are pre-registered. These patients often pay very high out-of-pocket costs.

"Our pre-reg team completes estimates to give the patient a close idea of their patient responsibility," Sokol notes.

Staff found that a simple change in the way they ask for deposits greatly increases the likelihood of payment. Asking, "Would you like to pay today?" usually gets a flat "No." Instead, staff advise patients of the requested deposit amount and ask, "Would you like to put this on your credit card today?"

"This results in a higher percentage of collections," Sokol adds. Inpatient financial counselors perform these tasks:

1. Screen for Medicaid programs, HCAP, and financial assistance;

2. If patients aren't eligible for any of these, they request deposits and set up payment plans.

"This can be more challenging, as the patients are already in a bed, receiving services," Sokol says.

Scripting for inpatients begins with an introduction and explanation of why the employee is there.

"Perhaps insurance coverage termed during their stay, or they changed insurance plans," Sokol offers.

If it's determined that the inpatient is uninsured, staff go on to explain that they would like to see if the patient qualifies for assistance to help them with their bill.

"Simultaneously, we are also screening for Medicaid, or determining how much [of] a deposit to ask for," Sokol explains. During open enrollment, or when the patients experience a qualifying event, the counselor discusses the possibility of enrolling in Affordable Care Act plans.

Most inpatients are instructed to leave wallets or purses containing insurance cards, recent paychecks, and other important documents at home. This creates an obstacle for financial counselors who want to assist patients, but have no way to verify coverage or income.

Sometimes, patients are unable to communicate due to medical conditions. "In these cases, getting family to cooperate with obtaining verifications can be time-consuming," Sokol laments. Here are three issues financial counselors face commonly:

1. Insured patients often are shocked by their high deductibles.

"Patients think they did all the right things by purchasing insurance, only to find out they have a large patient responsibility," Sokol says.

For these people, some basic insurance education is provided. "We have an internal document that explains their healthcare benefits," Sokol notes.

This scripting is used: "I'm showing that with your insurance, it looks like you have a deductible of $4,000 and a maximum out-of-pocket cost of $8,000. That means you will be responsible for the first $4,000. Then, your insurance will pay at 80% for any services."

"At this point, we listen to the patient," Sokol says. "If they want to apply for assistance, they can. Or, we offer to put them on a payment plan."

2. Patients expect financial assistance to cover both the hospital and physicians, but this is not always the case.

In Ohio, there is a non-Medicaid type of assistance that covers hospital services only. For this reason, hospital and physician financial assistance application processes are handled separately.

"Patients may have only been approved for one or the other. Or, one approval may have expired before the other," Sokol says.

If the patient is a walk-in, or calls the department, staff review the accounts and explore all options. For some patients, financial assistance is available for both the hospital and physicians on their outstanding accounts. "Then, we educate the patient to the difference in the financial assistance programs in order to help them understand bills going forward," Sokol explains.

3. Patients are confused by multiple bills.

Surgical patients often are bombarded with bills — one from the hospital for time, equipment, and supplies used in the OR; another from the surgeons on the same statement; and still another from anesthesia.

To head off dissatisfaction, financial counselors take an upfront approach about this.

"Our scripting for both pre-service and post-service includes a reminder that anytime you have services done at the hospital, you can expect more than one type of bill," Sokol says. ■

SOURCE

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Prior Auth Reform Underway: 'The Problem Is Real, and It Continues to Get Worse'

We recently spoke with **Jack Resneck, Jr.**, MD, chair-elect of the American Medical Association (AMA) and a practicing dermatologist, about prior authorization reform:

• On the AMA's recent survey: ***(See key findings in the sidebar box below.)***

"It really did confirm what each of us on the front lines taking care of patients is experiencing. It's just as bad as each one of us feels that it is in our daily practice. The problem is real, and it continues to get worse."

• On how patient care is affected negatively:

"I hear from my own patients every day about their frustration with the authorization process. I'm writing a prescription for them that I think will be helpful. Whenever possible, I try to be a good steward of resources and use affordable options. Then, to their surprise and my surprise, often times the patient will show up at the pharmacy and find that the medication has a prior authorization, or has a much larger copay than anticipated, or isn't covered at all. This is frustrating for both patients and doctors.

"It's very hard for me as a physician at the point of care, writing a prescription, to know: Is this one going to require a prior auth? It used to be much more predictable. For very expensive or new medications, you could anticipate they were going to be needed, and you could get the authorization in advance. But nowadays, I can be writing for a generic topical cream that has been around for 30 years, and when the patient shows up at the pharmacy, we find out it needs a prior auth.

"The system to get medications to patients, and the system to get prior authorization, has gotten more opaque for everybody. Not only do you have the health plan involved, you have pharmacy benefits managers that are sometimes in the middle. It's tough for all of us to know in any given case where the problem lies. Is it the drug manufacturer, or the pharmacy benefit manager, or the health plan? The AMA has tried to draw attention to the lack of transparency around how drug pricing and prior authorization processes work.

"Physicians are the closest point of access, so we hear a lot of that frustration. When a patient finds out the drug I prescribed isn't covered without a prior auth, we usually get it submitted that same day. I may not hear from the health plan for a few days, and when I do hear back, it's just the first go around. You seem to almost get an automatic rejection. Then, you have to do another level of appeal, which either means more paperwork or spending a lot of time on hold.

"Sometimes we hear, 'We will not cover that, but here are some alternatives.' And those are coming from somebody who clearly doesn't know the patient's condition. Sometimes, the things they suggest are way out of bounds and inappropriate for what patients have. And while we are back and forthing with the health plan, the patient is waiting.

"Physicians spend all that time fighting these battles because they want patients to get access to the care that they need. But all the time I spend doing that is time that I'm not spending with another patient. At the end of the day, that affects access to care and my availability to everybody else.

"Sometimes, we get the prior authorization for a drug, and the patient's condition is getting better because they finally found something that works for them. But months later, either they change health plans, or something about the health plan's formulary changes. Then, you have to repeat the prior auth process for the same drug and the same patient. It's especially scary for the patient when their condition is getting better. Now, the patient can't maintain continuity when they've finally found something that works."

• On the managed care backlash of the 1990s, when many states passed legislation restricting the cost-cutting measures that managed care firms could use:

Prior Auths Hurt Patients' Clinical Outcomes

Prior authorizations are more than just an administrative burden — they're harming patients' clinical outcomes by delaying necessary care, according to 92% of 1,000 physicians surveyed in December 2017 by the AMA. Other key findings:

- About one-third of physicians reported waiting three business days or longer for prior authorization decisions;
- Most (78%) reported that the authorization process "sometimes, often, or always" led to patients abandoning a recommended course of treatment;
- The vast majority (86%) believe burdens associated with prior authorization have increased during the past five years;
- Medical practices complete 29.1 prior authorization requirements per physician each week on average. These take an average of 14.6 hours to process. ■

"What these two situations have in common is that at the end of the day, they create access to care frustrations for patients. The frustrations are a little bit different. In the first go around with managed care, a lot more attention was directed on access to individual physicians and referrals.

"This prior authorization quagmire that we find ourselves in now is driven partly by the cost of pharmaceuticals. In the last decade, there is no doubt we've seen increased costs. It's not just because there are exciting new treatments out there that we expect to be expensive. We are seeing prices increase even on generics and branded drugs that have been out for several years and don't have recent R&D involved with them. In some cases, the health plans have increased these prior auth requirements in response to these increasing costs. My guess is that's been driving some of this."

• On what's underway currently with prior authorization reform:

"We assembled a group that included pharmacists, hospitals, doctors, and health plans to talk about what next steps will be. We actually had some health plans in the room that signed on to an agreement to try to make progress in this area.

"I think we are going to see a continued variation in health plans. Some will come to the table to work collaboratively earlier than others. Those conversations are ongoing.

"There is a lot of low-value work that is affecting our side and the health plan side as well. There are certain medications and tests, where the overwhelming majority eventually get approved, after a lot of work on both sides. We feel those are a good place to start in terms of reducing the numbers of drugs and tests that are subjected to prior auth.

"Obviously, there will continue to be some very expensive and new things that will continue to be on the list. Even if a high percentage are approved, from the health plan standpoint there may be some savings that are motivating them to keep them on the list. The reality is that physicians and payers are going to need to work together on multiple issues related to affordability and access and quality of care. Reducing this burden would help that collaborative relationship, and help us work together on other things.

"We also think that if individual clinicians have demonstrated a pattern of using evidence-based medicine and having all of their prior authorizations approved over a period of time, that healthcare plans should actually exempt them from many of the requirements. You can imagine a sort of gold-carding process where physicians who demonstrated good prescribing would therefore have lower hurdles.

"One thing we are working with health plans on is being able to see, at the time that we prescribe, what things are covered and not. You'd think that would be pretty straightforward with computers these days. But you'd be surprised at how little that information they share with us at the time we're prescribing as to what's covered — or if it requires a prior auth, what are the requirements, so I know if it's something they will agree to approve or not. If that's something that showed up right in my EHR when I'm prescribing, that would be really helpful.

"Not only that, but if it requires a prior auth, it would be nice if I could just put that information right into my EHR. It could be sent electronically, rather than filling out old-fashioned paper forms and logging into a proprietary system that just that insurance plan uses, so you have to have a second screen up on the computer and track how that goes separately. It just doesn't feel like we are using 21st century technology here to solve this important problem. ■

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