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INSIDE

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Evidence Shows Prior Auth Requirements Hurt Patient Care

Complying with health insurance companies' prior authorization requirements is demanding ever-increasing resources from patient access. The authors of multiple recent studies found these requirements also stop patients from receiving needed — and sometimes life-saving — medical care.

"Some patients may not have time to waste while waiting for responses from insurance companies," notes **Zachary Wallace**, MD, an assistant professor of medicine at Harvard.

As a practicing rheumatologist and clinical researcher, Wallace was in a unique position to understand how prior authorization requirements affected patient outcomes. "I have spent countless hours on the phone doing peer-to-peer discussions and providing literature supporting my treatment decisions," Wallace recalls.

After seeing prior authorizations become an obstacle to treatment repeatedly, Wallace and colleagues decided to analyze the issue closely. They reviewed the care of 225 patients for whom an infusible medication was ordered between July 2016 and July 2018.[1] Of this group, 71% required a preauthorization. For patients who did not require an authorization, the median time to first infusion was 27 days, compared to 31 days if the auth was required. In cases where the auth was denied initially, it took much longer (50 days). Most (79%) authorizations were approved on the first try. Of the 21% that were denied initially, 82% were approved after appeal. Overall, 96% of the infusible medications were approved. "The findings certainly have significance for revenue cycle leaders," Wallace notes.

There are two important roles for patient access employees, according to Wallace. One, identify alternative payment options if patients cannot wait for the payer to respond. Two, warn patients upfront that prior authorization delays could affect their care. "This sets expectations early on," Wallace adds.

Many other studies have linked prior authorizations to treatment delays, emotional distress, and worsening symptoms. Some recent findings:

- Delays in securing prior authorization for high-priced outpatient antibiotics were common, and caused delays in discharge;
- Prior authorization delayed the start of a new antiepileptic drug, or caused coverage lapses in drugs currently used. The delays resulted in more seizures in some patients and caused one patient to be hospitalized;
- Of 137 medication prior auth requests for pediatric oncology patients, 98.5% were approved. However, clinic staff spent a median of 46 minutes on each

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SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421
customerservice@reliasmedia.com
ReliasMedia.com

AUTHOR: Stacey Kusterbeck
EDITOR: Jonathan Springston
EDITOR: Jason Schneider
EDITORIAL GROUP MANAGER: Leslie Coplin

request. Researchers then set out to learn whether providers believed prior authorization hassles were resulting in inferior care.[2-5]

"Medication deviations and delays due to prior authorization requirements are frequent for children with cancer and blood disorders," says **David Dickens**, MD, FAAP, clinical director of pediatric oncology services at the University of Iowa Stead Family Children's Hospital.

Half the oncologists Dickens and colleagues surveyed believed treatment delays negatively affected care. Two-thirds of oncologists surveyed said delayed treatment caused emotional distress for patients or families.[5] The findings were not at all surprising, says Dickens — "not to healthcare providers responsible for preventing deviations or delays in the care of pediatric cancer patients, nor to the parents who must wait for the adjudication process to resolve."

The study findings point to the need to define medically necessary therapy for children with cancer, and agree on terms for prior auth requirements. This kind of payer/provider collaboration, says Dickens, "represents an opportunity to reduce wasteful spending and specious nonpayments."

A typical scenario: A 2-year-old girl is admitted for urgent, standard chemotherapy for a new diagnosis of leukemia. Two weeks into therapy, her parents receive a letter from their insurer, indicating the treatment will not be covered because a prior authorization was not obtained. "I have now worked at two institutions where there is a standard line item for nonpayment due to prior auth not in place, and considered as an acceptable and ongoing loss," Dickens shares.

It seems simple to patients: Their doctors order tests, so patients need to undergo those tests. Stress levels soar if payers stand in the way of that happening. "There is an overall feeling of frustration about the process," says **Kaylin Fogarty**, director of patient access and financial coordination at Tufts Medical Center in Boston.

Typically, payers take five to 15 business days to give an answer. In reality, neither the hospital nor the payer has enough resources to quickly manage the countless requests for authorization. "Just as staffing impacts our ability to work days out, the same issue can occur with the payers," Fogarty explains.

Registrars are stuck explaining all of this to patients who just want to undergo a test or procedure. "Payers ultimately control whether they approve or deny a case — and when," Fogarty notes.

Registrars do their best to manage expectations, since delays are going to happen even if everything on the front end is handled perfectly. "If the payer is reviewing cases only within two days of the expected date of service, it doesn't matter if we submitted it weeks in advance," Fogarty says.

EDITOR'S NOTE

This is a special issue on how prior authorizations are affecting patient access departments. The cover story explores hard data showing the process hurts patient care. We also report on attempts to automate the process that technology departments are considering, a policy that stops authorization delays from interfering with scheduled care, current trends in prior authorizations, and state legislation to avoid unfairly denied claims when additional authorizations are needed.

For patient access, the main focus is on putting all clinical documentation in place to justify that the service is medically necessary. Even so, says Fogarty, "we are still stuck waiting for the response." Some frustrated patients end up calling their health plan directly to speed up the process. "This often causes more harm than good," Fogarty cautions.

Sometimes, payer reps inaccurately claim the hospital just submitted the auth request one day ago. This makes it look like patient access was sitting on it for days without taking action. "The payer doesn't always explain that the claim is in a peer-to-peer because more clinical information is needed," Fogarty observes.

Meanwhile, patient access does everything it can to avoid a worst-case scenario. No one wants to call someone the night before a scheduled procedure to tell them it is not going to happen because the payer did not give an answer. "We do everything in our power to make sure if it does happen, it was not because of a delay or error on our side," Fogarty says. ■

REFERENCES

1. Wallace ZS, Harkness T, Fu X, et al. Treatment delays associated with prior authorization for infusible medications: A cohort study. *Arthritis Care Res (Hoboken)* 2019; Sep 10. doi: 10.1002/acr.24062. [Epub ahead of print].
2. Bianchini ML, Kenney RM, Lentz R, et al. Discharge delays and costs associated with outpatient parenteral antimicrobial therapy for high priced antibiotics. *Clin Infect Dis* 2019; Oct 31. pii: ciz1076. doi: 10.1093/cid/ciz1076. [Epub ahead of print].
3. Wirrell EC, Vanderwiel AJ, Nickels L, et al. Impact of prior authorization of antiepileptic drugs in children with epilepsy. *Pediatr Neurol* 2018;83: 38-41.
4. Dickens DS, Pollock BH. Medication prior authorization in pediatric hematology and oncology. *Pediatr Blood Cancer* 2017;64.
5. Kelly MJ, Sung L, Dickens DS. Barriers to medication access in pediatric oncology in the United States. *J Pediatr Hematol Oncol* 2019;41: 286-288.

Automation, Artificial Intelligence Future of Patient Access Authorizations

Spending hours on hold and transmitting information by fax are business practices from a bygone era. Yet the prior authorization process depends on these costly, inefficient manual processes.

Shawn Tienken, MHA, director of revenue cycle operations at Stanford Children's Health in Palo Alto, CA, sat with *Hospital Access Management* to discuss his department's progress toward automation. *(Editor's Note: This conversation has been lightly edited for length and clarity.)*

HAM: How are prior authorizations affecting your department?

Tienken: We are seeing an increasing number of requirements, particularly for services considered to be high cost. The development of targeted, bioengineered pharmaceuticals has been accompanied by stringent authorization requirements, since these therapies are so expensive. As a pediatric specialty institution, we perform a lot of high-cost services. It might be hitting us harder than your average community hospital. There has been more control implemented over access to specialty services. That also has increased the authorization burden. All of those things have made it more time-consuming.

HAM: What progress have you made toward automation of auths?

Tienken: Our organization has looked very closely at automating authorizations for the past three years. Our views on the best ways to do this have evolved over time.

A lot of payers have instituted portal-based authorization and online options, as opposed to [making] phone calls or [sending] faxes. Strangely, we still have to submit a decent number of faxes. Probably 10% to 20% of authorizations are done via fax. There have been some opportunities, either through using a portal or e-faxing, to generate an automated submission. But where we see the opportunity for automation to really make an impact is less on the initial submission than on follow-up. We submit the request, but then we have to follow up. Usually, we can just log into a portal to do it, but it still requires somebody to do that. We were particularly interested in automation for status updates, and there were vendors in the marketplace saying that they could do that.

What we found was that a lot of those vendors could really only do that for a certain subset of payers, or for a certain subset of services. Or, they can do it for the hospital side, but not the professional side.

Some didn't integrate well with our EMR. All of a sudden, the value we were realistically going to get was shrinking pretty rapidly.

HAM: What about artificial intelligence (AI) or machine learning solutions?

Tienken: We've talked to firms that offer these solutions. These seem to offer much greater flexibility in what services they can perform, because the systems learn and adapt over time. We haven't implemented an AI solution yet. That's because we are still trying to figure out

what's real and what's marketing. We are trying to do that by talking to existing customers. The problem is that firms don't have real track records of actually doing this yet. They say they've done it on a small scale, and that it should work theoretically. But we are trying to evaluate what they can really do, and then what the best approach is for actually doing it.

Our decision has been much more about how do we implement something that has the ability to scale and grow over time. Instead of just putting one piece of duct tape on the problem, and then needing more duct tape for other problems, we want to cover the whole issue. Every one of those implementations requires an investment of IT, operational, and project management resources. If you do it piecemeal, implementation costs can become prohibitive. What we've learned is there are certain areas where hospitals can get value. If you want to just focus on imaging, and your organization does a lot of that, that's pretty straightforward. What you have to submit is pretty consistent from payer to payer. That would be a good opportunity to automate. But if that's a small slice of what you do, the question is: Is it really worth it to invest and get enough of a return?

HAM: How have you made the prior authorization process more efficient?

Tienken: We've worked to maximize the efficiency of auth rules within our existing EMR. There's a good chunk of things we do that don't require authorization. We want to make sure we only route those things to people ... who actually require it. We have made rules in our system that automatically bypass the whole authorization workflow if payers don't require it.

But one of our biggest challenges is making sure we align those front end rules with the back end rules we've set up for billing and claims. The worst-case scenario is that we bypass the workflow for something that we say doesn't need an auth, but our claims people on the back end say it [needs an auth]. They stop it when we are trying to send out a bill. We've missed the chance to get an auth beforehand, and we're chasing it after the fact. We've come across areas where the rules we initially set up on the front end weren't matching up with our back end rules. Our front end rules were too broad. They basically said: All visits of this type, for this payer, don't require authorization. While that may have generally been true, for a certain subset of those usually higher-dollar services, or services with other specific components within that general category, the payer did require authorization. Our front end rules weren't that nuanced.

We also were paying highly skilled people to follow up on the status of an already submitted authorization. We outsourced that component so we are able to do the follow-up at a much lower cost. We are now focusing our highly trained front end people on initial submissions rather than follow-up. It takes fewer resources to get the submission accurate and complete in the first place than it does to fix things on the back end. The authorization gets approved faster, so payment is faster — with lower cost to collect. ■

Patient Care Goes Forward as Planned: 'You're Good to Go'

Patients tend to become anxious when scheduled care is cancelled due to authorization holdups. This happened so often at Stanford Children's Health in Palo Alto, CA, that a decision was made to change the process.

"We've had to go so far as to implement a policy that says, 'If the auth is still pending, we'll still schedule you for service,'" reports **Shawn Tienken**, MHA, director of revenue cycle operations at Stanford Children's Health in Palo Alto, CA

If the payer takes too long to give an answer one way or the other, things go forward as planned anyway. Patients are responsible only for their copay, coinsurance, or deductible that they would have paid anyway.

"We tell them, 'We won't hold you liable if it gets denied,'" Tienken explains. Cancelling services at the last minute puts the hospital in a difficult position. "We had all the resources we put into that space that we suddenly are not able to fill," Tienken says. "We don't want a pre-eminent surgeon standing around with nobody to operate on."

The revised policy takes the worry off patients, and makes scheduling more predictable. Although it is a financial risk for the organization, it is a calculated one.

"We've got a front-end process that's increasingly precise," Tienken shares. "It's a risk that we can afford to take."

More than 90% of requests end up authorized. "If it doesn't, our appeals process is also pretty good," Tienken adds. The total dollars that end up written off because of denied auths are tiny compared to overall cash collection.

For registrars, changing the policy helped morale. Registrars can schedule services confidently without cautioning patients it is not a sure thing until the payer says so. Instead, they tell patients,

"Assume that you are good to go. You will only hear from us about the auth if it gets denied." To some, this sounds too good to be true. Many still worry about receiving an expensive bill if the payer ends up denying the authorization. "Our experience is that people still don't believe us. They call us anyway, worried about whether it's been approved yet," Tienken observes.

Registrars assure patients there is no need to worry; the hospital is taking the risk, not the patient. For many, the prior authorization policy gives them one less thing to worry about. "The whole reason we did it was to relieve the patient's stress — and relieve the provider's stress," Tienken says. ■

The Pushback to Burdensome Authorization Requirements Has Begun

It is hard to dispute the fact that prior authorization requirements place a heavy burden on both patients and providers. Yet the number of services and medications requiring auths continues to increase.

"Overall, the authorization list is growing," says **Kevin Thilborger**, managing director of value-based care, strategy, and transformation at Chicago-based Huron Consulting Group. There are some trends worth noting:

• Payers are more frequently asking for documentation of care plans before approving surgery or complex imaging. The goal of payers, says Thilborger, is to ensure lower-cost treatments were tried first.

• The number of services allowed in a hospital setting is declining. "Place of service is a current focus area for payers," Thilborger reports.

This increases the complexity of the authorization process. "There is the added nuance of authorizing the where in addition to the what," Thilborger adds.

However, some large employers are pushing back against this. They argue quality of care is more important than a cheaper site of service. "These employers are demanding that the service be performed in the best-quality location — the hospital," Thilborger observes.

• Payers are adding more medications and services to the list of those that require authorization. "Payers, vendors, and especially providers report that prior authorization is increasing," says **Ani Turner**, codirector of sustainable health spending strategies at Altarum Center for Value in Healthcare in Ann Arbor, MI.[1,2]

"Hospitals are seeing prior authorizations expand to cheaper, generic drugs," adds **Tom Lytle**, senior vice president of operations, digital transformation, and patient experience at Chicago-based R1 RCM Physician Advisory Solutions.

The number of prior authorizations continues to increase at the beginning of each year. "This is due to changes in prescription coverage, formula modifications, and renewal requirements," Lytle explains.

• Prior authorizations are cropping up even in traditional Medicare coverage. The Centers for Medicare & Medicaid Services (CMS) started testing limited prior auth requirements for nonemergent services back in 2012. These included certain power mobility devices, nonemergent hyperbaric oxygen, and repetitive, scheduled nonemergent ambulance transport.[3]

"CMS is now going a step further," says Lytle, noting auths will be required for five hospital outpatient services often considered cosmetic.[4,5] CMS Administrator **Seema Verma** said in a February speech, "While prior authorization is an important utilization management tool, we believe we can use automation to make the process more efficient."[6]

It is clear more changes are coming. "It's unclear what those changes will look like," Lytle adds. Hospitals struggle to manage the sheer volume of authorization requests. There are costs to payers, too. "But payers appear to believe that the benefits are worth the administrative costs," Turner observes. "They continue to invest in the staff and technical infrastructure to implement prior authorization."

On the other hand, there are some encouraging signs that the tide is turning when it comes to prior auths:

• Some payers are reducing requirements for providers who have a high percentage of authorization requests that are approved.[7] "Insurers may have a hard time implementing this 'gold card' status in practices with multiple providers who may not all have the same track record," Turner notes.

• Federal legislation to curtail prior authorization has not been enacted. "Despite bipartisan support, there has been little traction," Thilborger notes. "We have not yet encountered anything that has a broad, successful impact."

Some proposed healthcare legislation does include prior authorizations. "Most bills designed to limit balance billing by out-of-network providers also prohibit requiring prior authorizations for emergency medical services," Lytle notes.

Surprise billing initiatives include requirements for insurance providers to respond to authorization requests in a timely manner, and to make their requirements publicly available.[8] "There is a building movement to address the use of prior authorizations by Medicare Advantage plans," Lytle adds. While traditional Medicare covers most

services without authorizations, Medicare Advantage plans do require prior authorization for inpatient hospital stays and certain procedures, labs, and tests. Yet more than half of audited Medicare Advantage organizations inappropriately denied requests for prior authorization of services, according to a 2018 report.[9]

The Improving Seniors' Timely Access to Care Act of 2019 (HR 3107) would limit prior auth requirements by Medicare Advantage plans and mandate that health plans report on how often they approve or deny prior auth requests.[10]

Private insurance companies claim prior authorization prevents excessive testing and treatment. Still, a legislative solution is likely to limit prior auths in Medicare Advantage, Lytle predicts. "There is widespread agreement among healthcare providers and private insurance companies that changes are necessary," he says.

• Payers are questioning the amount of resources expended on responding to authorization requests. "The question becomes: How effective are these authorization requirements?" Thilborger asks.

Some payers are conducting a cost/benefit analysis on certain types of care that require prior authorizations.

"If they are always approved, or they create more barriers than protections, they may remove the requirement," Turner says.

For example, some payers are removing prior auth requirements for medications used to treat opioid use disorder.[11,12]

• The money spent on authorizations is coming up during contract negotiations between hospitals and payers. "Providers are increasingly taking the opportunity to calculate and present the administrative cost of their revenue cycle operations," Thilborger says.

Facing increasingly tighter margins, some hospitals are bringing up the financial burden of prior authorizations when negotiating. "It can prevent future demands that seem unreasonable or can detract from your bottom line," Lytle says. ■

REFERENCES

1. American Medical Association. 2018 prior authorization (PA) physician survey. Available at: http://bit.ly/2uPILek.
2. Workgroup for Electronic Data Interchange (WEDI). WEDI prior authorization survey highlights. Available at: http://bit.ly/3ajTc92.
3. 80 FR 81673. Medicare program; prior authorization process for certain durable medical equipment, prosthetics, orthotics, and supplies.
4. 85 FR 7666. Medicare program; update to the required prior authorization list of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items that require prior authorization as a condition of payment.
5. 84 FR 61142. Medicare program: Changes to hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs.
6. CMS.gov. Remarks by CMS Administrator Seema Verma at the American Medical Association National Advocacy Conference, Feb. 11, 2020. Available at: https://go.cms.gov/3clr1Z8.
7. eHealth Initiative. *Prior authorization: Current state, challenges, and potential solutions.* February 2019. Available at: http://bit.ly/3amVlAU.
8. Robeznieks A. Insurers are a roadblock to proven reforms on surprise medical bills. American Medical Association, July 24, 2019. Available at: http://bit.ly/2uMaNqZ.
9. U.S. Department of Health and Human Services, Office of Inspector General. Medicare Advantage appeal outcomes and audit findings raise concerns about service and payment denials. September 2018. Available at: http://bit.ly/2uKB8FR.
10. Congress.gov. H.R.3107 - Improving Seniors' Timely Access to Care Act of 2019. Available at: http://bit.ly/2Vzf0cJ.
11. Michigan.gov. Starting today, Michigan eliminates prior authorization for medications used to treat opioid use disorders, Dec. 2, 2019. Available at: http://bit.ly/2PDW0Wy.
12. Beetham T. Buprenorphine prior authorization removal: Low hanging fruit in the opioid epidemic fight. *Harvard Public Health Review* 2019;25.

When It Is Life and Death, No Time to Wait for Authorization

A patient underwent a chest MRI with contrast. While studying the results, the radiologist determines an abdominal MRI would give the better view needed for proper diagnosis.

"Imagine having the patient either wait for the additional authorization or scheduling [the test] for another date. This is not healthcare at its finest, when patient care is driven by mandates for payment," says **Catherine M. Pallozzi**, CHAM, CCS, director of patient access at Albany (NY) Medical Center Hospital. The same is true if a surgeon encounters unexpected complications during

a procedure. Requiring any medical professional to secure an authorization right in the middle of possibly life-saving treatment "is an absurdity," Pallozzi says.

Denied claims for urgent, medically necessary procedures are no laughing matter. Patient access staff have to appeal each denial, a time-consuming and expensive process.

New York state recently enacted a law that aims to stop "no auth" denials for urgent and medically necessary procedures and treatments. The law states that if a patient presents with unexpected complications or requires additional services in the course of treatment, a health insurer will no longer be able to deny payment due to lack of prior authorization.

"The legislation is long overdue," Pallozzi says. "It will provide the physician the ability to do what is best for the patient."

The department will save the equivalent of almost one full-time equivalent due to far fewer claims denials having to be appealed. "It will remove inefficiencies and additional labor costs in the revenue cycle," Pallozzi predicts.

Tamara C. Imm, CPA, vice president of front end revenue cycle at Rochester (NY) Regional Health, says the legislation is "a great concept, removing authorization requirements from potentially interfering with medically necessary care being rendered."

If authorization was obtained for an excisional biopsy of the breast, that patient could end up undergoing a mastectomy because of what the surgeon finds during the procedure. Since no authorization was obtained for the mastectomy, "in the past, the hospital risked nonpayment due to payer policies," Imm says.

With the new law in place, the payer would have to cover the mastectomy since the initial procedure was authorized. Imm expects her department will see far fewer "no auth" denials, which currently cost the health system more $1 million a year. "Despite having multiple resources dedicated to managing this process, there is still no guarantee," Imm adds. The legislation does not cover all "no auth" denials. It specifies an authorization must be in place for the first procedure. "It does not appear to address the situations in which we have not already obtained authorization for the procedure initially scheduled, since it wasn't required," Imm says. If no auth was needed for the first procedure, there is a chance payers will still deny the additional procedures that do require prior authorization.

While the law does not specifically address that kind of situation, it does cover a common problem with chemotherapy drugs. Cancer patients often start on one drug, with authorization obtained, but the medication may not work. Starting a new drug normally required another authorization. "This sometimes delayed medically urgent care," Imm says. It also caused claims denials if the drug was ordered without the auth in place. For hospitals, says Imm, "this has been extremely costly."

Now, the new drug could be started immediately without needing to wait for authorization. "The legislation will be a win for chemotherapy patients who require immediate treatment," Imm says.

(Editor's Note: Read more about the recently enacted New York law at: https://on.ny.gov/32NpYNp.) ■

Automating Auths: Not as Simple as It Sounds

Spending an hour or longer on hold trying to find a straight answer on whether a medication needs authorization is not the best use of any registrar's time. Neither is sending faxes back and forth to prove the drug is medically necessary. In the patient access world, these inefficient practices are common. That is because most authorization requests are handled manually: by mail, fax, phone, web portals, or a combination of these. "The percentage of prior auths that are done electronically today is pretty low. We've been tracking it at about 13%," says **April Todd**, senior vice president of the committee on operating rules for information exchange (CORE) and explorations for CAQH.

CAQH, a nonprofit that seeks to streamline healthcare business practices, recently approved two sets of standards: one for consistent use of data content, and a second for response times, which health plans, providers, vendors, and governmental entities have agreed on.[1] "Getting everyone to come together on those two things is pretty significant," Todd shares. CAQH CORE is in the process of recommending rules to Health and Human Services (HHS) for federal mandate under the Health Insurance Portability and Accountability Act (HIPAA). If HHS mandates these recommendations, all HIPAA-covered entities would have to follow them. "Hopefully, things should start to change and move in a good direction," Todd says. The authors of a July 2019 white paper[2] identified these barriers to automating the auth process:

- **Clinical and administrative systems used within health systems often are not integrated.** When payers request clinical information before agreeing to authorize a service, there is no easy way for patient access staff to obtain it. "This continues to be a problem. Providers have to essentially copy and paste information from their EMR to the other systems," Todd explains.
- **There are no federally mandated standards on how providers communicate clinical information to health plans.** "The industry has been waiting

for HHS to set this standard for a long time," Todd says. The currently agreed-upon rules go only so far. Once HHS sets the standard, "we'll be ready to act very quickly to fill this gap that is making prior authorization more complicated," Todd adds.

• Vendors are not offering products that solve the problem. Some patient access departments turn to vendors in the hopes they can automate auths, only to find the products are not there yet. Vendors are hesitant to develop solutions that they will have to change later. "We are hopeful that these rules going into place — that will create some standardization, will give vendors the impetus to develop products to comply with it," Todd says. Despite many obstacles, there is a great deal of momentum toward finally fixing the problem of prior authorizations. The timing is right for automation, according to Todd. "If you look historically at how the healthcare industry has moved to automate things, prior authorization is the next logical place to go," she says.

The vast majority of high-volume processes in healthcare are automated, according to the 2019 CAQH Index.[3] Almost all (96%) claim submission, 84% of eligibility and benefits verification, and 86% of coordination of benefits are conducted electronically.

According to the 2019 CAQH Index, it takes providers an average of 21 minutes to submit authorization requests manually. This compares to four minutes if it's handled electronically. "If you add up that savings of 17 minutes for every transaction, it's a lot of time saved," Todd shares.

Prior authorization practices for medications at eight community providers in Tucson, AZ, are in urgent need of modernization, according to the authors of a recent analysis.[4] "We did this study to provide some empiric evidence about the process. We hope that this information will be used to improve the system," says **Terri Warholak**, PhD, one of the study's authors. None of the providers used electronic prior authorization solutions at the time of the study. Staff were largely unaware these existed. Some college students who collected data for the study, most of whom were millennials without a healthcare background, were shocked that prior authorization requests are handled via fax. "Many of them had never seen this antiquated technology in use before," Warholak says. If electronic prior authorization was implemented fully, "the extra hours, and hence the cost, put in by the providers and their staff can be reduced significantly," says **Sandipan Bhattacharjee**, MS, PhD, the study's lead author.

Many patients have no idea about all the work that happens to obtain an auth. "Currently, patients are largely shielded from the process," says **Anita C. Murcko**, MD, FACP, another of the study's authors. Providers and patient access employees are left to update patients on the status of the auth. "There is a slow movement toward transparency, standardization of questions and formats, and improving EHR integration," Murcko adds. ■

REFERENCES

1. CAQH CORE phase V operating rules. Available at: http://bit.ly/2TALoc6.
2. CAQH CORE. *Moving forward: Building momentum for an automated prior authorization adjudication process.* Available at: http://bit.ly/2Igrhus.
3. 2019 CAQH Index. *Conducting electronic business transactions: Why greater harmonization across the industry is needed.* Available at: http://bit.ly/38iBEZk.
4. Bhattacharjee S, Murcko AC, Fair MK, Warholak TL. Medication prior authorization from the providers perspective: A prospective observational study. *Res Social Adm Pharm* 2019;15:1138-1144.

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