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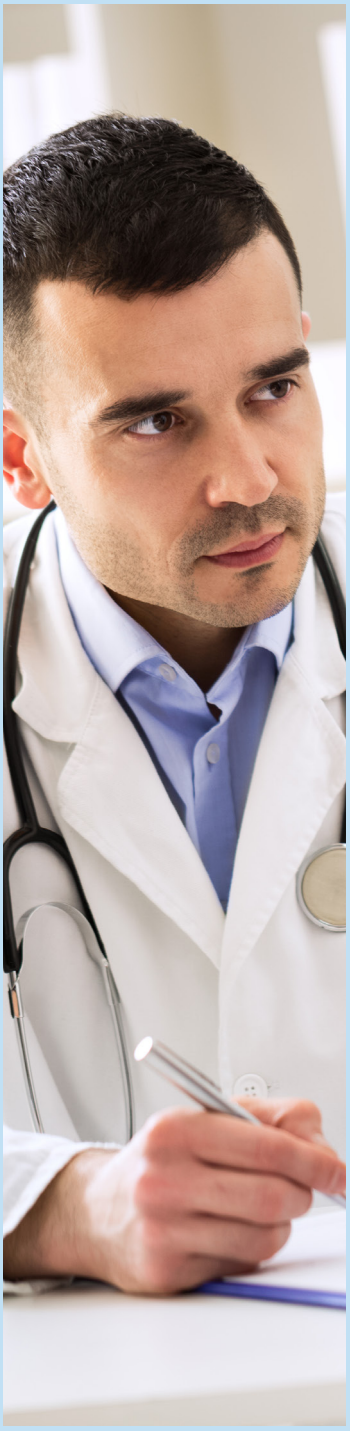

RE-IMAGINING PRIOR-AUTHORIZATION AS A CARE ACCELERATOR!

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Prior-Authorization is one of the most complex and tedious processes from patient perspective when it comes to the urgency of care. While the process is an added step in the care journey, it is one of the most important functions that not only determines the service coverage eligibility for the patient but also helps patient and all the care stakeholders plan for the costs involved. Eventually, this process helps determine right care pathway decisions. Thus, it is not as administrative as it sounds but can be a catalyst towards efficient care. However, if we look at studies, this process of prior-authorization is one of the most high-cost and low efficiency processes today due to its complexity. According to an AMA study, 91% of patients face significant delay in getting care due to the prior authorization process. One of the main reasons for the delay is the manual prior authorization which is prone to lower turnaround times and human errors. When compared to other medical transactions, prior authorization has the lowest electronic adoption rate of 21% and this needs to change.

Cost inefficiency, manual overheads and poor turnaround times are the key drivers behind recent mandates that have been laid out by CMS and 21st Century Cures Act. Having said that, the focus is not just cost control but also stakeholder satisfaction – patient & provider experience uplift as well.

Digital transformation of the whole process has become the need of the hour and will drive the efficiencies as it becomes a care catalyst instead of being a hurdle. The key capabilities to focus on to address the transformation & compliance needs are:

- Provider Experience uplift with Paperless workflow
- API-led interoperability between payer-provider systems
- Patient data accessibility
- Data driven actionable insights & Decision support system for process optimization

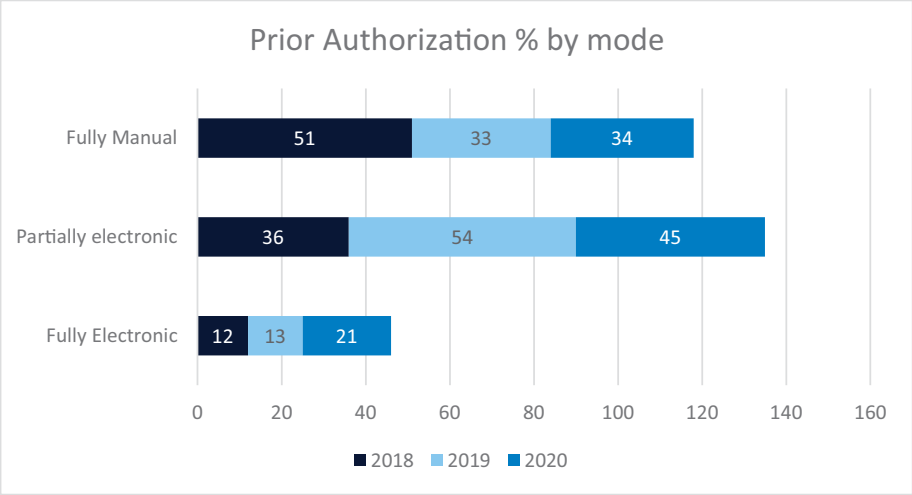
In this perspective, we discuss about transformational capabilities for prior-Authorization process digitalization, while addressing the mandate's compliance needs.

The need for an uplifted Prior-Authorization Process…

Given that the process involves multiple stakeholders, the empathy wall is bigger for this process. Patients are looking for an easy, quick authorization process to ensure care continuity without process impediments.

Provider admins/nurses are the main users who must work on lengthy forms and ensure gathering of the data which is time consuming process, and the overall experience is bad with all paperwork and administrative tasks. They expect simplified, prefilled forms with data accessibility for both clinical as well as coverage information.

Further when the requests go to payer organization, it is important to ensure completeness & consistency of the forms data and eliminate the straightforward cases from manual review through automation. The clinicians and MDs on payer side also need to look at lot of other references like Plan contracts, Clinical notes, medical policies, and history of authorizations and claims etc. which are all in silos in different systems. They need a unified information desktop with all the information handy for decision support.



Source: 2020 CAQH Index

Note:

Fully Electronic	ASC X12N 278
Partially Electronic	Web Portals, IVR
Fully Manual	Phone, Mail, Fax, Email

Electronic prior authorizations cost more than 85% less than manual ones on average

The Recent Mandates around prior-Auth Process – Another driver for prior-auth process transformation…

To reduce unnecessary burden and improve interoperability in healthcare, CMS formulated 'The Interoperability and Patient Access Final Rule (CMS-9115-F)'. It came into effect this year and encourages high degree of interoperability and provides patients the right to access their health information. Building on to this rule, CMS has proposed 'The Interoperability and Prior Authorization proposed rule (CMS-9123-P)' to focus on prior authorization and improving the electronic exchange of health information among payers, providers, and patients. This proposal is set to be mandated effective January 1, 2023, and it has many components some of which need to be implemented on top of the CMS-9115-F rule.

- Include pending and active authorization information in Patient Access API
- Maintain Provider Access API for payer-to-provider data sharing
- Build APIs for document lookup and FHIR-enabled electronic Prior Authorization Support
- Include reason for denial in Prior Authorization responses
- To maintain shorter prior authorization timeframes (72 hours for urgent requests and 7 calendar days for standard requests)
- FHIR based Payer-to-Payer exchange

In addition to this, CAQH has established a set of CORE Operating Rules focusing on prior authorization process and it gives direction on:

1. Data content requirements for patient identification, error/ action codes, communicating with providers
2. Infrastructure requirements for response time and connectivity requirements for data exchange. This standard helps reduce complexity and simplifies interoperability for prior authorization transactions.

Digital Transformation of Prior-Authorization Process

The transformation objectives to be addressed with the process while complying with the mandates are:

Enhanced Healthcare Infrastructure.	Safe Harbor connectivity rule or even working through existing transmission channels
Reduced Back and Forth between Provider and Health Care organization.	Changes in error codes and better descriptions
Enabling Quick Turnaround time.	2 days for final determination, once documentation is complete
Reduced burden on Healthcare Organizations for unattended cases	Ability to do optional close out, if provider does not respond within 15 days of communicating what additional information is required
Operational efficiency.	The timeframes must be met 90% of time in a calendar month
Harmonized exchange of documentation.	New operating rules can streamline exchange of medical documentation
Enabling Decision support system for care & utilization management.	Building digital capabilities that can drive the authorization decisions systemically and reduce manual interventions/efforts for medical necessity reviews as well as care pathway integrations

To address the above objectives, it is essential not only to focus on building the digital core but also ensure provider staff experience uplift through a simplified process which in turn will help boost patient experience given the quick turnaround and coherent patient centric process.

API Led Interoperability is essential to drive the automation. EDI led transactions processing has been widely adopted by health plans however the key is to extend this EDI-ecosystem to further integrate with provider systems for better patient data accessibility. Now, it is anyways a mandate to have all the prior-auth transactions in EDI X12 278 format. While there is no one common standard API that helps achieve the systems integration for the end-to-end process, FHIR along with EDI smart gateways will help ensure required pipeline set up to automate the submission as well as review process. The gateway would cater to the data needs around patient clinical, provider, coverage information as well as authorization recommendations. This interoperability can help fulfill the aspiration of having real-time prior authorizations as much possible and eliminate need for manual interventions through guided automations.

Provider experience can be enhanced by ensuring **simplified integrated process** for prior-auth submission. FHIR API-led enterprise ecosystem can help providers with quick data access which is needed to submit the complex prior-authorization forms in an easier and faster manner. This will save time and reduce the paperwork for the request submission. Further to enhance the experience, it is important to reduce their paperwork. Still, many of the providers are using manual paper-based forms and have their records in papers. While with regulations electronic request submission has been mandated, there is a need for **NLP processing or unstructured data processing** for PDF forms and supporting clinical notes. This will help with the move towards paper-less workflow and in turn enhance the provider experience further. An efficient prior-Auth process identifies the authorized services and reviews similar cases for holistic care needs. Hence it can also provide medical necessity and care pathway inputs to care management processes which helps the providers.

Patient Data Accessibility is the key for both provider as well as payer clinical staff for request as well as medical necessity determination and final recommendation on service authorization. The request processing requires patient clinical details, provider details and the service details, however the medical necessity determination would need access to patient medical history and utilization patterns as well. Besides Medical policy and coverage information will drive the rules for authorization process. From payer perspective it is also important to ensure monitoring and prevention of fraudulent transactions. For an optimized workflow, having quick at-desk references to all the data and history is critical. **Unified patient view** will play a vital role in decision making systemically as well as clinician interventions. Further having data accessibility can drive correlation with care pathways and care management programs associated with the patient condition and service and further drive the value for patient care.

Making the data available in an accelerated manner from across diverse systems drives a lot of automation opportunities. Digitalization of the process can be further achieved through AI/ML capabilities on the data for not just driving the request routing automation but also the clinical recommendations. It can further support in driving coordination and personalization in care management based on the medical necessity of condition in the context. **Data driven actionable insights** can help with guided automation of approval vs denial of the prior-auth process and help move towards real-time authorization. The decision support system can also help detect data anomalies, inconsistent patterns, and further support adjudication process streamlining & optimization too. This will further drive down the costs of process.

This decision support system can be designed on the base of past prior-authorization experiences as well as patient medical conditions and policy.

ML & NLP techniques can also be leveraged for **virtual assistance around medical policies** which can help automate and centralize knowledge management.

Conclusion

CAQH Index 2020 says that prior authorization costs $13.40 per manual transaction and $7.19 per partially electronic web portal transaction. This is the highest spend compared to any other medical transaction and causes unnecessary burden on healthcare. With an optimized and automated real-time process, the costs and efforts can come down by more than 30-40% at a minimum. Today more than 30-40% of requests are manually decided and have manual subjectivity associated with decision, thus are unpredictable from plan to plan. Digitalization can help bring in objective, policy driven and evidence-based decision making which can further help improve the overall efficiency. Lastly the process is one of the crucial inputs for care management and if the transformational capabilities can help accelerate the care management process while also improving efficiency. It can provide care pathways recommendation to ensure elimination of medical waste and care effectiveness as well which is more important particularly given the rising cases of chronic conditions in the entire population.

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Triveni is healthcare consulting practice delivery manager & Industry principal with about 22 years of experience in insurance and healthcare IT. Triveni has led and supported several healthcare digital transformation, mandates and interoperability engagements across geographies. She is also managing several industry specific innovations and CoEs.

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