# Solve prior authorization challenges today

## Implement fast, intuitive and transparent prior authorization processes now

Prior authorization is supposed to save healthcare dollars. Too often instead, it's a cost sink—consuming invaluable time, money and resources. Errors, rework and frustration that hurt timely delivery of care, erode patient trust in their health plans and cause friction between payers and providers all add to healthcare's nearly $1 trillion in annual administration costs.[1] The friction should especially concern payers because satisfaction ratings will weigh heavily on success in value-based care. Prior authorization is far from the seamless, intelligent experiences that are the hallmark of modern businesses.

Many payers may expect their Interoperability compliance work to fully address prior authorization challenges. Yet electronic health record interoperability was first mandated by the Affordable Care Act 13 years ago and is only now becoming a reality.

In contrast, solutions for streamlining prior authorization -- from submission through decision -- exist today.  Yet merely deploying a tool doesn't truly solve prior authorization challenges. That requires a complete analysis of the end-to-end process to identify gaps, manual and extraneous work and resources used. The next step is exploring disruptive

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solutions to streamline the process, increase efficiency and reduce costs.

At Cognizant, it's our mission to help reduce healthcare costs and improve experiences by helping payers and providers collaborate wherever their workflows intersect across the care continuum. In our experience, payers that have intelligent, automated prior authorization workflows supported with improved processes achieve these benefits:

- Free budget and time to reallocate resources to higher value and more complex issues by eliminating much of the analysis required to manually coordinate and manage authorization requests and approvals.
- Greatly improve member and patient experiences by making prior authorization fast and transparent so patients receive care sooner.
- Increased provider satisfaction as they save time and money and are equipped to help patients explore options under clear clinical guidelines.

- More effective care management by reducing authorization-related administrative work so utilization teams work at the top of their licenses and focus on complex cases.
- Success under value-based contracts with improved provider and patient satisfaction scores and helping providers succeed in reducing their administrative burden.

Here's a look at what to do about prior authorization today.

## Move before the regulators do

Waiting for prior authorization solutions to emerge out of Interoperability and additional rules from the Centers for Medicare & Medicaid Services (CMS) will take too long to satisfy consumers. Patients and members rarely perceive any benefit to prior authorization, and regulators increasingly scrutinize it. In 2018, the Office of the Inspector General (OIG) analyzed Medicare Advantage plans' prior authorization and payment denials and found the plans themselves overturned 75% of their own denials on appeal.[2] Further analysis showed that 13% of those denials in fact met Medicare coverage rules.[3] The OIG concluded the Medicare Advantage plans used different clinical criteria than those in the Medicare coverage rules.[4]

That 75% represents wasted time and effort and likely frustration among providers, patients and members. The 13% underscores the need for solutions that make medical necessity criteria transparent. Today's technology can deliver solutions that automate the prior authorization process with accuracy and support more transparent clinical decisions. This is especially valuable for payers who have analyzed their entire prior authorization process. They can implement a comprehensive solution or deploy a modular solution to make immediate progress in key areas. For example, a payer could initially deploy prior authorization automation with provider organizations that work with specific patient populations.

Whatever their approach, payers that implement these solutions now will be ahead of regulators, yet have the flexibility to adapt to new CMS regulations. They'll also have practical experience with automated prior authorization decisions they can draw on to help shape future rules.

## Reduce authorization time to minutes

Prior authorization systems aren't exactly new. But portals provide little value when they function only as request submission mechanisms and don't expedite decisions. In contrast, intelligent portals auto-populate data, restrict drop down menu options and have "help" and "alert" features to assist providers as they fill out authorization request forms. These portals automatically review requests and flag missing components before the providers submit for approval. Such features help reduce review times, resubmissions and appeals by ensuring that providers deliver all required data and documentation in the first request submission. Providers estimate they can save up to 16 minutes per transaction with automation.[5]

Prior authorization intelligent portal technology with automated business rules and an intuitive, guided user experience can guarantee consistent decision outcomes, managing the complexity of intersecting clinical protocols, plan policies, enrollment, benefit contracts and various systems storing all this information.

Medical necessity criteria and clinical guidelines can be tightly integrated into the prior authorization workflow to trigger refined, very granular business rules that enable high auto-approval rates. Even challenging decisions about genetic testing, durable medical equipment (DME) and skilled nursing can be automated. The process may also incorporate rules for redirecting patients to preferred providers and facilities, such as having an MRI done at a third-party facility vs. in hospital.

On average, plans with automated prior authorization processes are achieving up to 88% auto-approval rates.[6] One plan saw its 11-day prior authorization turnaround time drop to 4.5 minutes on average.[7]

## Engage stakeholders in new ways

Automating prior authorization is not simply about digitizing existing processes. Laying the groundwork for better stakeholder relations and success with value-based contracts requires rethinking operations and clinical decision processes. The latter likely includes liberalizing clinical approvals and standardizing them so that the rules can be codified and automated. Many payers we work with worry their costs will balloon if they adopt more liberal approval standards. However, based on the OIG data, many payers eventually approve many of the authorization requests they originally deny. Each of these denied-then-approved transactions represents wasted time, effort and costs as well as unhappy providers and patients.

By exposing the right clinical criteria through a prior authorization portal in just a few seconds as providers make their requests, payers give providers the opportunity to evaluate a care plan against the standards. Increasing adoption by improving the provider experience is perfectly aligned with CMS' direction.

Automated prior authorization solutions also enable payers to offer providers interactive online training tutorials for education and engagement. Those are even more effective when coupled with local support services and a dedicated support team. These tools strengthen working relationships with providers while also improving efficiency by reducing authorization submission errors.

UM teams and medical directors can make decisions about pended authorizations more efficiently when prior authorization automation workflows include richer data, such as attachments uploaded through the portal and clinical guideline responses. One payer even saw its pended decisions turnaround time decrease to just under 48 hours.[8]

Further, with today's analytics tools, it's possible to easily track costs on a near real-time basis. When necessary, payers may walk back decision trees that led to costs out of line with projections. What's more, with this data in hand, payers have proof of the problem and can collaborate with providers to address it. That enables a more positive working relationship and improves the process for both payers and providers.

## Improve success under value-based contracts

Payers that automate prior authorization decisions help providers reduce their administrative burden and reduce their low-value spending. Automatic approvals for care that meets standards can speed the time to quality care for patients/members. Prior authorization is then part of the toolset that supports value-based care, enabling UM professionals to focus on the complex needs of populations vs. paperwork.

It can also include processes for monitoring outlier cases over time. This data can help reveal the outcomes and efficacy of high-cost and rarely performed treatments and procedures. This information can inform future decision-making criteria and treatment pathways.

## An Example: Modern prior authorizations in action

At Cognizant, we offer proven, flexible solutions for automating prior authorizations, including:

- **CareAdvance® Utilization Management,** available as part of a larger population health and care management offering.
- **TriZetto® Touchless Authorization Processing** (TTAP), available as a stand-alone, SaaS-based prior authorization solution that can augment any payer's utilization management workflow.

In one example of these tools in action, one of our clients was overwhelmed by cumbersome UM workflows and increasing resource costs. In addition, the cost of IT maintenance on its proprietary UM technology was unsustainable. We collaborated with this payer to redesign its UM clinical operations and systems, implementing an integrated solution based on TTAP. Our clinical experts worked with the payer's UM team to codify policies, guidelines and best practices. The solution's easily modified criteria enabled the team to quickly tailor processes to specialized areas of care. We also delivered a custom integration between TTAP and the payer's core systems. The solution automates the prior authorization process between provider and plan, from start to finish, all within seconds. The outcomes include:

- **76% automation expedited revenue capture across all types**
- **86% automation specific to surgery**

When state, federal or organizational policies change, the payer may use self-service tools to quickly customize guidelines. The solution also streamlines maintenance by providing additional self-service tools that allow payers to control the timing and speed of updates.

## No regrets investing in prior authorization automation

In a study we recently commissioned, health plan executives said these were the features they most valued in a prior authorization solution:

- **Automated decisions.** Built-in criteria should be standardized and evidence based.
- **Analytics/reporting.** Features should include up-to-the-minute status displays and customizable data tracking and reports.
- **Machine learning (ML).** ML should be focused on predicting future trends by forecasting membership size and patient care needs.
- **Data integration.** Solutions should retrieve information from electronic medical records (EMRs) and share data across other systems and tools, including core administrative platforms, UM systems, quality systems, etc., to enable revamped and streamlined processes.
- **Portals and connectivity.** Provider portals should be easy to navigate and have reliable uptime.

Investments payers make today in prior authorization systems with these features will provide immediate benefit and long-term value, as long as they are based on open, extensible technology architectures. Open, standards-based systems should be flexible enough to incorporate the proposed CMS rule for FHIR-based prior authorization interoperability. Complying with that rule requires a solution that supports EMR integration; payer-provider authorization mandates; and FHIR integration.

Payers should not stop at satisfying CMS regulatory obligations. Inefficient prior authorization processes that leave behind dissatisfied patients and members are a problem for all health plans and providers. Prior authorization portals and other electronic data exchange, already in place in varying degrees in many health plans, provide a rich opportunity to reduce administrative burdens and improve time to care. Automated prior authorization enables payers and providers to collaborate on providing care seamlessly, with the speed of intuition. That's an excellent foundation for delivering new member experiences and business strategies fit for the era of value-based care.

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1 mckinsey.com/industries/healthcare-systems-and-services/our-insights/administrative-simplification-how-to-save-a-quarter-trillion-dollars-in-US-healthcare
2 Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials Report (OEI-09-16-00410) 09-25-2018 (hhs.gov)
3 Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care OEI-09-18-00260 04-27-2022 (hhs.gov)
4 Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care OEI-09-18-00260 04-27-2022 (hhs.gov)
5 https://www.caqh.org/sites/default/files/explorations/index/2021-caqh-index.pdf, pg. 17
6 Client reported data
7 Client reported data
8 Client reported data

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