



Digital Operations

Automated Prior Authorization: A High-Value Opportunity

In the face of manual PA proliferation and pressure from the value-based care model, the need is growing for real-time electronic PA systems that will ease the administrative burden on stakeholders throughout the healthcare ecosystem.

Executive Summary

Though prior authorization (PA) is an important tool for controlling the rising cost of U.S. healthcare, it also represents a common pain point for both payers and providers in terms of cost and administrative burden. These burdens can also act contrary to organizations moving toward value-based care and a consumer-centric healthcare system. Electronic and automated PA systems can lower the costs and burdens of the PA

process for all parties, but not all solutions are created equal or deployed effectively. To identify and understand current and future trends, obstacles and opportunities in PA, Leavitt Partners conducted a series of interviews with medical and pharmacy directors from payers, including health plans and pharmacy benefit managers (PBMs), across the U.S. regarding their PA process, challenges and best practices.

The administrative and cost burden of PA

As healthcare costs have continued to rise, payers are increasingly focusing on PA as a utilization management tool. The percentage of medical claims referencing PA increased on average by 2.3% from 2011 to 2013, with some payers doubling and tripling the number of care events that require authorization.¹ These statistics do not include pharmaceutical PAs, so the number is most likely much higher when factored in.

Eighty-six percent of physicians report that the burden of PAs has increased over the past five years. One study estimated that on average, PA requests consumed about 20 hours a week per medical practice: one hour of the doctor's time, nearly six hours of clerical time, plus 13 hours of nurses' time.² On the payer side, PA systems can require a substantial investment both in the initial

development of a system and in human capital to have qualified experts review and make decisions on PA submissions.

PA costs quickly compound into a significant burden. One study estimated that when time is converted to dollars, practices spent an average of \$68,274 per physician per year for interacting with health plans. This equates to between \$23 billion and \$31 billion annually.³ About one-third of doctors are using dedicated data-entry staff to handle PA requests, which incurs an extra cost; for the other two thirds of doctors, the PA process reduces the time available to see patients.⁴ Care interruptions caused by PA delays are also costly. A cancelled appointment or procedure due to a missing or denied PA results in lost revenue, and expensive staff and equipment sit unused.

“For large providers, it's possible to achieve an effective PA process, but only with a lot of dedicated manpower, a specialized team, and a relatively high level of investment. Smaller organizations would find it much more difficult to develop the needed staff and expertise to interact with all the payer systems in a timely manner for patients.”

► Interviewee

The opportunity cost of electronic PA

The high cost burden of PAs presents an equally large opportunity. A 2018 study found that electronic PA could save as much as 416 hours per year for a physician and his or her staff.⁵ Additional research estimated that the average cost to a provider for a fully electronic PA was \$1.89, compared to \$7.50 for an entirely manual authorization.⁶ PAs with attachments have shown a high savings opportunity per transaction, with savings estimates upward of \$45 per transaction.⁷ In one report, providers that exclusively used electronic PAs for medication requests reduced their administrative workload by 2.5 hours each week. Modernizing the system can lower cost not only in terms of manpower and time, but also through other considerations like devices, space or toner usage over the long term.

But for some, the move to electronic PA systems has yet to result in significant cost savings and/or personnel reduction. Many interviewees seemed to fall into a dissatisfactory “middle ground” of investing in an expensive, and sometimes unwieldy, electronic solution that had not yet resulted in being able to relieve staff due to automation. Several interviewees reported having to increase the size of their PA teams in recent years despite the introduction of electronic tools, saying that the tools hadn’t become sophisticated or tailored enough to save time or personnel. Additionally,

“ We have seen a high level of success with a highly automated PA system based on clinical pathways, and we’ve been able to pass the savings from this system on to consumers in the form of lower premiums, enabling us to stay competitive in our market.”

▶ Interviewee

several interviewees reported that PA/electronic health record (EHR) systems often remain incompatible, so providers must manually pull the necessary records to submit as part of a PA.

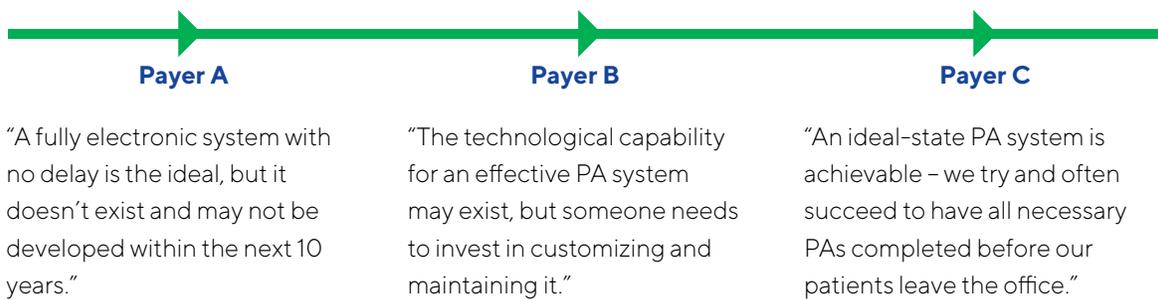


Lack of agreement about what is possible in terms of PA

Currently, the vast majority of payers (96%) are committed to implementing electronic PA solutions as a way to address administrative problems with procedures.⁸ But actual adoption of electronic systems has lagged far behind other transaction types, as the percentage of plans and providers that use fully electronic systems remains in the single digits (see Figure 1). Over one third

of PA systems are still fully manual.⁹ The variance across systems compounds this problem – 76% of providers report working with a combination of fax, phone and electronic channels.¹⁰ There is a lack of industry consensus around what is even possible in terms of a real-time automated PA solution.

Quotes from three interviewees illustrate the broad difference of opinions among payers:



Further, all interviewees wanted a more automated system, but many expressed concern that critical decision-making is needed for patients who might

have a complex case or be exceptions to the rule. They worried that a fully automated system would see these patients slip through the cracks.

Adoption of Electronic PA by Medical Plans and Providers

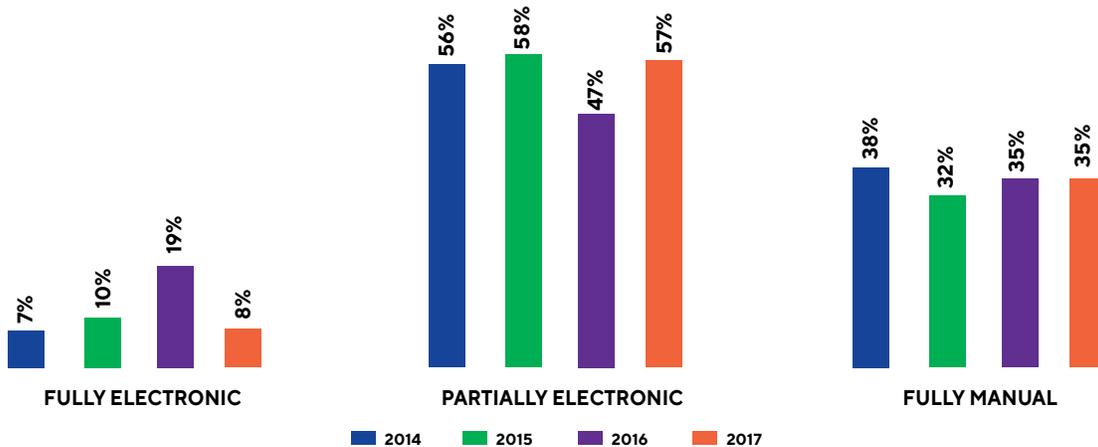


Figure 1
 Source: 2017 CAQH Index



The potential of automation

A transition to automation presents new opportunities. Though electronic solutions have proved they can save significant time and money, even processes that use electronic aspects often include manual components either on the provider or payer end, especially with many diverse and non-interoperable systems. For example, some providers send PAs manually to a clearinghouse or another partner that then converts these records to an electronic format for the payer. Conversely, a provider may have to manually submit information using a payer web portal; while the process is “electronic” on the payer end, the transaction still takes time and resources for manual input on the provider end. These manual inputs can create bottlenecks that leave PAs taking days to process.

Automated PAs would use a solution that automatically matches the request to parameters set by the payer to ensure accuracy. Once eligibility, benefits design and clinical guidelines are met, the authorization can be instantly adjudicated and returned to the provider while the patient is still in office. Those requests that contain errors or do not conform to payer rules would be flagged and returned to the provider just as quickly for correction. Effectively leveraging the power of real-time automation can be a key solution for payers and providers who feel they are investing in electronic PA systems without seeing a high enough ROI, as well as opening the current bottleneck of care for patients.

The responsibility of making PA work for patients

The statistics on PA turnaround time can be staggering and have real implications for effective care delivery:

- 64% of physicians report that they have waited at least one business day for a PA decision and 30% say they have waited three or more business days.
- 79% of providers report that they are sometimes, often or always required to repeat PAs.
- 92% of physicians say that PA programs have a negative impact on patient clinical outcomes.
- Patients often become discouraged by the PA process, with 78% of doctors reporting that PA can at least sometimes lead the patient to abandon treatment.¹¹

These challenges can interfere with provider care plans, especially as physicians might not immediately know that a delay has occurred. For example, a consumer may be prescribed a medicine and expect to be able to enter the pharmacy and pick

it up right away, only to discover that a PA was not yet approved. Patients can become confused and frustrated with their payer, pharmacist and physician.

The PA process and its associated delays present significant problems for pharmacists and patients. The majority of prescriptions (66%) rejected at the pharmacy require PAs, amounting to about 300 million PA requests per year.¹² Of those prescriptions, 36% are abandoned. Resolving PAs can cost pharmacists just as much time as physicians, and many patients will associate that delay with the pharmacist, while the pharmacist feels the issue rests with the payer. One interviewee, a director at a specialty pharmacy, reported that it typically takes one to three days to get a PA, which in her view is most often an unnecessary delay. The high volume of PAs processed by her pharmacy has allowed her to determine with relative certainty which PAs are merely a formality (i.e., approval is almost always given) and which are clinically justified.

Patient Impact of PA

About 1 in 10 prescription claims are rejected at the pharmacy.

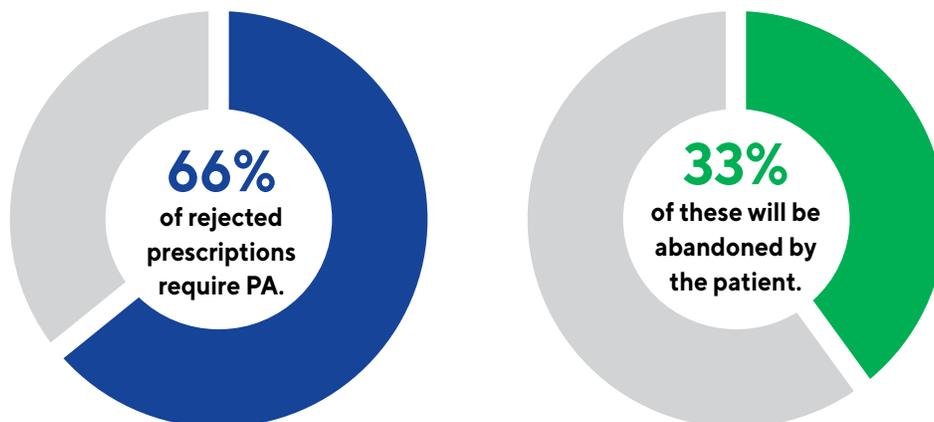


Figure 2

Source: CoverMyMeds Analytics



This implies that an automated PA system could significantly reduce the time burden for patients and the cost burden for providers by drastically decreasing PA turnaround time. This would also result in increased patient satisfaction and better medication adherence.

While parties agree that PAs take too long, payers and providers often disagree on whose responsibility it is to tackle this problem. Some payers prefer to rely on the “sentinel” effect of PAs to avoid delays – expecting physicians to learn the medication formularies or clinical guidelines for all the payers they work with and avoid prescribing drugs or procedures they know to be PA-

dependent. Physicians may not regard this as their responsibility, and they feel that payers should be accountable for creating an efficient PA system so their members do not experience care delays.

At the bottom line, an effective PA system requires buy-in on both sides of the equation. While it can be difficult to make changes to an entrenched PA system, doing so can improve payer-provider synergies. An ideal-state PA solution requires an initial investment on the part of payers, but over time it can broker trust with physicians by limiting their administrative burden and helping to ensure that their patients’ well-being is a priority.

“ Net promoter score is critical, and physician satisfaction is hugely important to the net promoter score. A PA system that providers are happy with affects that a great deal. Net promoter score is also linked to a patient’s relationship with their doctor, so when care is more seamless, scores go up. ”

▶ Interviewee

PA and the transition to value

The growing shift to value-based care is driving demand for improved PA tools and processes. Value-based care introduces more financial stress for providers,¹³ and a PA system causing care delays that interrupt clinical pathways affects a patient's satisfaction with their provider, or affects patient adherence to treatment guidelines that can present a risk for organizations participating in value-based care.¹⁴ When flaws in the PA system have detrimental effects on patient care, this affects quality outcomes that are important to value-based contracting. A truly effective PA system can help value-based care and PAs work to achieve similar goals of cutting cost and eliminating unnecessary utilization while maintaining positive health

outcomes. Interviewees agreed that the more satisfied providers are with their PA system, the more likely they are to change their behavior over time based on PA feedback, rather than consider PAs as a flawed system or a barrier to effective care.

One pharmacy director at a regional, provider-owned health system reported that risk-bearing entities tend to have a significantly lower number of PA denials despite having seemingly similar systems and decision-making processes. The interviewee suggested that the decrease in both PA requests and denials from value-based organizations can be attributed to incentives that encourage doctors to avoid using PAs altogether. These incentives may



align with explicit organizational mandates (e.g., prescribing cheaper drugs where possible to save money), but may also be the result of physicians' desire to avoid the added expense and hassle of the PA process for which they receive no additional compensation.

The ongoing transition to value will present opportunities for payers and providers who are looking to mutually improve the PA process and align incentives and risks. A 2018 Consensus Statement by the AMA, AHA, AHIP and other organizations stated that while PA can help to

maximize the value of healthcare spending, improving the process is critical for patients and doctors. The statement recommended that healthcare leaders "reduce the number of healthcare professionals subject to prior authorization requirements based on their performance, adherence to evidence-based medical practices, or participation in a value-based agreement with the health insurance provider."¹⁵ Physicians who are willing to participate in agreements where they are held accountable for cost and performance will likely welcome reform to a PA process that supports them in these goals.



Looking ahead

PA is poised to undergo a major transformation as both payers and providers struggle to fully make the switch to electronic models. As PAs will continue to be an important cost-containment tool for payers and plan sponsors, the importance of a system that works for today's providers and patients only grows. Value-based care arrangements and rapidly developing health information technologies will also drive motivation and capability to make the change.

There is a key opportunity for payers and providers to reduce administrative and cost burden through the implementation of electronic and automated solutions. As accountability for patient outcomes and costs becomes increasingly important across healthcare stakeholders, an effective PA system can also play a role in bringing value to the point of care. A real-time automated solution has the potential to tackle administrative and clinical requirements, increase payer-provider cooperation and ensure that patients get the proper care when they need it.



Endnotes

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World Headquarters

500 Frank W. Burr Blvd.
Teaneck, NJ 07666 USA
Phone: +1 201 801 0233
Fax: +1 201 801 0243
Toll Free: +1 888 937 3277

European Headquarters

1 Kingdom Street
Paddington Central
London W2 6BD England
Phone: +44 (0) 20 7297 7600
Fax: +44 (0) 20 7121 0102

India Operations Headquarters

#5/535 Old Mahabalipuram Road
Okkiyam Pettai, Thoraipakkam
Chennai, 600 096 India
Phone: +91 (0) 44 4209 6000
Fax: +91 (0) 44 4209 6060