TRIARQ HEALTH

PRIOR AUTHORIZATIONS:

The Struggle Is Real

(But So Is the Solution)

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Prior Authorizations Create Abrasion between Payers, Providers, and Patients

Every doctor across every specialty has dealt with the headaches of prior authorization, and each has plenty of anecdotes about the negative impacts it has on them, their staff, and, most importantly, their patients.

The American Medical Association (AMA) has made numerous attempts at changing the system.[1] Only after years of work have their efforts been recognized with established change, including the passing of reform laws in 9 states (with another 20 in process). Most importantly, the AMA was a proponent of the latest CMS Interoperability and Prior Authorization rules, which are estimated to generate $15 billion in savings for practices over the next 10 years.[2]

But what about the here and now?

Practices need to act now. Waiting until 2026 or 2027, when the CMS rules go into effect, equates to years of administrative burden.[3] However, there are things physicians can do now to work toward alleviating the prior authorization burden.

Your specialty practice can't wait around for imposed deadlines to change broken prior authorization processes—you need solutions that benefit your practice today and prepare you for the future.

[1] American Medical Association, Advocacy in Action: Fixing Prior Authorization, Jan 2024

[2] American Medical Association, $15 Billion Win for Physicians on Prior Authorization, Jan 2024

[3] American Medical Association, Toll from Prior Authorization Exceeds Alleged Benefits, Say Physicians, May 2023

By the Numbers: The Impact of Prior Authorizations

Prior authorizations are more than just a day-to-day challenge. They chip away at your time and profits and impact patient care.

Practice Impacts

Increased administrative burden. Every procedure that requires prior authorization entails proper paperwork that must be completed, reviewed, and submitted—not to mention the follow-up phone calls and additional work of managing the denials.

The average physician practice completes 45 prior authorizations per physician per week, with doctors and staff spending nearly two business days a week completing such authorizations.[4]

Increased time dealing with inconsistent payment policies. Practices train staff to handle variations and inconsistencies across payer requirements, keep pace with updates, manage peer-to-peer reviews, and interpret vague rules.

Since 2016, healthcare leaders have reported increases in prior authorization requirements year over year.[5]

Denial of routine items and services. Even specialty practices submitting nearly identical authorizations are routinely denied for various unknown reasons, driving additional administrative churn.

Out of the 35 million prior authorization requests submitted to Medicare Advantage in 2021, 2 million were fully or partially denied, and of those that were appealed, nearly all resulted in a fully or partially overturned denial decision.[6]

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[4] American Medical Association, Advocacy in Action: Fixing Prior Authorization, Jan 2024

[5] MGMA, Prior Authorization Burdens for Healthcare Providers Still Growing During COVID-19 Pandemic, May 2021

[6] KFF, Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021, Feb 2023

Decision delays. Decisions come in anywhere from 3 to 10 days after submission, depending on the payer. This creates operational roadblocks that make scheduling and resource allocation a chore—not to mention the impact this can have on patient satisfaction.

89% of physicians believe that the prior authorization process has a negative impact on patient clinical outcomes.[7]

Unnecessary resource strain. All of these factors cause ongoing resource strain on practices. For example, one patient can need prior authorization that requires an appointment and associated paperwork. That initial prior authorization can be denied, forcing another appointment with more paperwork. Meanwhile, decision delays can cause an adverse event, leading to additional appointments or emergency services. Multiply that by a practice's entire patient cohort, and that's a lot of wasted resources.

86% of physicians think that prior authorization "sometimes, often, or always" leads to higher overall utilization of healthcare resources.[8]

Patient Impacts

Limited doctor-patient interaction. There are only 24 hours in a day, and the ongoing administrative burdens of prior authorization and other medical programs mean physicians spend more hours punching keys and fewer hours giving patients face time.

Doctors spend nearly twice as much time doing administrative work as actually seeing patients.[9]

Preventable adverse events. It is a consistent feeling among doctors that prior authorizations can compromise patient outcomes. Whether prior authorization processing takes too long or care is denied, there is no arguing that patients seldom benefit from these policies.[10]

One-third of doctors have seen a prior authorization lead to a serious adverse event.[11]

[7] American Medical Association, 2022 AMA Prior Authorization Physician Survey, Mar 2023
[8] Fierce Healthcare, Surveyed Physicians Say Prior Authorization Harms Patient Outcomes, Burdens Healthcare Resources, Mar 2023
[9] Annals of Internal Medicine, Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties, Sep 2016
[10] New York Times, 'What's my Life Worth?' The Big Business of Denying Medical Care, Mar 2024
[11] American Medical Association, 1 In 3 Doctors Has Seen Prior Auth Lead To Serious Adverse Event, Mar 2023

Prior Authorizations Are Not Going Away

Despite the negative views and outcomes of prior authorizations, they aren't going anywhere.

How We Got Here

Utilization Review

Before prior authorization, there was utilization review (UR). The UR process was established in the 1960s at the beginning of Medicare and Medicaid legislation. It was used to verify hospital admissions by validating the need for treatment based on a confirmed diagnosis from two doctors. The goal was to limit unnecessary hospital stays, cut costs, and protect patients from receiving care they don't need.[12]

Expensive Treatment and Medication

Over the years, UR evolved into today's prior authorization system. When initially created, the process was intended to limit the use of brand-new, expensive medications or treatments. It was a cost-control measure for payers and was easily managed by practices because it was limited to a few novel treatments.

While the prior authorization system was initially used to audit hospital admissions, it has morphed into a system that determines whether a specific treatment is appropriate.

The Real Cost of Today's Prior Authorization Process

Outside of the care and cost implications for patients, prior authorizations put serious financial strain on the US healthcare system.

$35 Billion
is spent in the US each year in administrative costs for prior authorization.[13]

It costs
$11,000
per clinician per year to handle prior authorizations (and clinicians include support staff like PAs and NPs).[14]

$20-$30
per prior authorization
submission, with the average practice submitting around 45 prior authorizations each week.[15, 16]

[12] ACMA, The Evolution of Prior Authorizations, Dec 2021
[13] New York Times Opinion, 'What's My Life Worth? The Big Business of Denying Medical Care, Mar 2024
[14] Physicians Practice, How Much Do Prior Authorizations Cost You?, Aug 2023
[15] HealthAffairs Scholar, Active Steps to Reduce Administrative Spending Associated With Financial Transactions in US Health Care, Nov 2023
[16] American College of Physicians, Toolkit: Addressing the Administrative Burden of Prior Authorization, Feb 2024

Payers Do Have Legitimate Interests

While the system has evolved over the years, the goals have not. Cost containment is a top priority for payers, and the pressure to achieve that goal will only increase as healthcare becomes more expensive. Between 2022 and 2031, the average growth across the National Healthcare Expenditure (NHE) is projected to be 5.4%, which will outpace average GDP growth of 4.6%.[17]

In healthcare, a single bad player can have an outsized adverse impact on cost. Medicare and Medicaid fraud in the US costs upward of $100 billion per year.[18] With all of this, payers have a legitimate interest in cutting costs and maintaining control over the care they are willing to pay for.

Prior Authorization Is Not Bad in Principle—Its Implementation Needs Improvement

All of this is to say that prior authorization isn't inherently bad but needs to be balanced for the sake of patients and providers. There are cases in which it makes sense. Doctors agree that going through these processes for routine treatment or generic prescriptions is not only a waste of time but an infringement on their expertise.

Prior authorization requests are often evaluated by people with little or no medical training or by computers running strict algorithmic terminology-matching rules.[19]

One investigation found that an insurance company was denying hundreds of thousands of prior authorizations every month, spending an average of just 1.2 seconds per case.[20]

Doctors, not payers, should be the ones making decisions about patient care—it's the only way to ensure that treatments are based on clinical expertise and not profit interests.

[17] Centers for Medicare & Medicaid Services, NHE Fact Sheet
[18] CNBC, Inside the Mind of Criminals: How to Brazenly Steal $100 Billion from Medicare and Medicaid, Mar 2023
[19] American Medical Association, What Doctors Wish Patients Knew About Prior Authorization, Sep 2023
[20] ProPublica, How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them, Mar 2023

The Latest in Prior Authorization: CMS Prior Authorization and Interoperability Rule

In January 2024, CMS released its final Prior Authorization and Interoperability rule. The rule "emphasizes the need to improve health information exchange to achieve appropriate and necessary access to health records for patients, healthcare providers, and payers. This final rule also focuses on efforts to improve prior authorization processes through policies and technology to help ensure that patients remain at the center of their own care."[21]

The rule attempts to resolve some of the major issues within the prior authorization system. The new rule:

- Requires payers to share denial information with patients starting in 2026
- Shortens the time frame for authorization decisions down to 72 hours for urgent/expedited requests and 7 calendar days for standard requests starting in 2026
- Requires plans to support an electronic prior authorization process that's built into EHRs for improved automation and efficiency starting in 2027

It's important to note that while these changes apply only to government-related health plans, it is likely (and doctors are hopeful) that commercial payers will follow suit.[22]

While the exact details of electronic prior authorization processes have yet to be released, arming your practice with digital solutions to access and manage patient data and practice metrics is a good first step in preparing for these changes.

[21] Centers for Medicare & Medicaid Services, CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)

[22] American Medical Association, CMS Prior Authorization Final Rule Explained with AMA President Jesse M. Ehrenfeld, MD, MPH, Jan 2024

How to Make Prior Authorizations Easier

Altogether, abolishing prior authorization is unlikely. However, doctors and their staff have been through years of training to prepare them to determine the right course of treatment. Through this credentialing process and ongoing medical education training, they should be trusted to make these decisions. While these prior authorization systems won't be eliminated, significant reform has the potential to devolve them back into the edge case verification processes they were initially created for.

In the Future: Gold-Carded Providers

The ultimate solution to prior authorizations involves payers and providers working together to create a system that allows approvals based on provider metrics.

Physicians who show a track record of expertise through practice data metrics, such as diagnosis tracking and outcomes, should be able to establish streamlined processes with payers to receive approvals instantly. Openly sharing this data can show payers what providers are doing and how they're doing it to create a level of trust that gives them gold card status—if not for all procedures, then at least most of the standard procedures their specialty bills for. This would take us back to the original process for prior authorizations and save the administrative workload and resources while protecting patients.

The good news is that, while the legislation is still in its infancy, 5 states have passed laws for some form of gold carding program – with 13 more in the works.[23]

The bad news is that it still leaves most states without these programs and a long journey ahead to get the required buy-in from critical stakeholders.

However, there are things your practice can do to take steps in the right direction.

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[23] KFF Health News, States Target Health Insurers' 'Prior Authorization' Red Tape, Feb 2024

In the Meantime: Optimize Practice Operations

Upgrade Practice Processes

Creating the gold-card standard of prior authorizations will not be easy. Establishing this level of trust between providers and payers requires accessing and understanding data from disparate systems, which many independent practices find challenging when they are outside a bigger healthcare organization.

So, that's the first step: building the structure for internal data gathering beyond a practice's EMR. It is imperative to have access to and understand data from RCM and billing data systems. Next is creating systems that support bidirectional data flow with payers. The time to start building out this infrastructure is now. Practices that have this data available first will be able to reap the benefits of optimized prior authorizations.

It's time to start building your internal data infrastructure to create a stronger relationship with payers, streamline prior authorizations, and reduce administrative headaches.

Value-Based Care and Bundled Payments

The next step is to build upon those upgraded practice processes to support value-based care and bundled payment programs. These care models are designed to create provider accountability for the cost and quality of patient care and reduce the incentives for overutilization and low-value care—both key goals of prior authorization.

Unfortunately, setting up value-based programs is not easy. It requires building out tracking systems to understand and evaluate value.

In some cases, physicians have suffered or lost money with value-based care and have returned to utilizing fee-for-service contracts.

By implementing value-based programs, practices have an opportunity to not only have a better understanding of their own internal metrics and processes but also reduce the need for prior authorizations. In coordination with payers, practices could identify specific drugs, procedures, or services and agree to eliminate prior authorization based on agreed-upon terms. These terms could include quality measures, performance benchmarks, or demonstrating adherence to evidence-based clinical pathways. Another option is to condense prior authorizations into one approval for an entire episode of care. This would allow for a single prior authorization to be approved for a preset care process.

Ultimately, these types of programs require cooperation between providers and payers as well as coordination between networks of providers willing to partner and create clinical care pathways. Coordinating these physician-developed care plans and protocols helps to streamline care and reduce costs.

To make this happen, practices need a better understanding of how they can market themselves to referral partners and payers. It comes down to practices needing to:

Value-based care programs and bundled payment models are ideal drivers for getting practice metrics in order, coordinating care, and providing data to demonstrate the reduced need for prior authorization.

How Do You Rank?

Payers are increasingly evaluating specialists on costs and outcome measurements. It is very likely that some of the payers in your area have scored your practice and created a report card that shows how they rank you. This report card may include cost/quality metrics like ASC utilization rates, cost per patient, encounters per patient, procedures per encounter, replacement readmits, etc. As discussed in our publication, *Independent and Indispensable: Specialty Private Practice in America*, these report cards will increasingly matter when it comes to the volume of referrals your practice will get in the future. Having a clear understanding how you and your practice currently rank is essential for alleviating some administrative burdens associated with prior authorization.

While it may be frustrating that payers are reducing your work as a physician into a few simplistic numbers, the higher you consistently rank by a payer, the better your chances of being gold carded.

Big Payer Health Plan Provider Report Card

METRIC NAME	POINTS AWARDED:	POINTS POSSIBLE:
ASC Utilization	12.2	25
Cost Per Patient	4.3	10
Encounters Per Patient	0	10
Encounters Per Patient Visco	3	10
Hospital-Based Provider	10	10
Nonefficient Hospital Utilization	13	15
Procedures Per Encounter	3.4	5
Replacement Infections Rate	5	5
Replacement Readmits Rate	4	5
Replacement Revisions Rate	3	5
TOTAL	**57.9**	**100**

Do you rank high enough to be gold carded?

Reviewing these report cards now, making necessary improvements, and positioning your practice as a trusted partner worthy of being granted a gold card status is crucial. This is not just a suggestion but a necessity to stay competitive and maintain a strong position in the healthcare market.

Check out our other eBook:
Independent and Indispensable:
Specialty Private Practice in America

DOWNLOAD NOW

Actions You Can Take Right Now: Find a Partner

If you feel like prior authorizations are weighing down your practice, you can start by working with an expert who can reduce administrative burden. As with every process within your practice, there are pros and cons to outsourcing:

PROS	CONS
Increase speed: When you hire a dedicated team to handle prior authorizations, you know that's all they're going to be doing. Instead of managing all the other admin tasks within your practice, an outsourced team can focus on getting the prior auth tasks done.	**Increase direct costs:** Depending on your specific practice, hiring an employee may cost less in direct costs than paying an outsourced company. The right partner, however, should not handle the prior authorization process in a vacuum. They should look at your overall revenue cycle management (RCM) processes holistically by analyzing data to identify bottlenecks, suggesting operational improvements, or implementing best practices that reduce denials and improve cash flow overall.
Gain expertise: An outsourced team has experience with (and insight into) other practices' prior authorizations, so they are more likely to understand the nuances of what it takes to get an authorization processed.	**Surrender control:** Giving up control is the hardest aspect for independent practice owners to accept. Outsourcing processes such as prior authorizations does mean that your practice hands over the reins. However, the right partner will make the process fully transparent, giving you direct access to the entire process, providing real-time communication, and sharing insights into exactly how the prior authorization process is going.
Reduce errors: Having additional expertise and established processes also helps reduce the errors that can occur when dealing with ever-changing processes and the inconsistencies between different payers. An outsourced team has more resources to stay up to date on changes occurring across every payer.	
Decrease operating costs: Some practices have so much prior authorization churn that they have to hire additional employees to handle the workload. It doesn't necessarily make sense to invest the time, money, and resources on a new employee.	

If you decide to outsource, make sure you find a partner who not only delivers the services you need but also provides the transparency and reporting needed for you to effectively evaluate their performance.

How TRIARQ Can Help Today and Tomorrow

The key to alleviating the prior authorization struggle is harnessing your data and then putting it together to tell the story that you want to effectively market to payers and referral providers. Whether you're ready to take the full leap in preparing for gold carding, are just getting started digging into your metrics, or just want to get it off your plate, TRIARQ can help.

Our solutions are part of a greater practice strategy that helps improve all aspects of practice operations so you can hold onto your practice independence.

First, Construct the Data Infrastructure

Building a robust data infrastructure is the first step in improving prior authorization processes. Our team has an arsenal of tools for building you a custom solution that fits within the exact needs of your practice. Once the data flows are established internally, we can build out the interoperability requirements from CMS and position you to take on any additional requirements from them or other payers.

This data will then be leveraged to uncover the metrics that matter to build a strategy to take on risk, market your practice to referring providers and payers, and ultimately solidify your independence.

You're already being evaluated by the payers. Instead of waiting for them to grade you, build out your own data infrastructure to take control of the narrative and create the compelling marketing story that your practice wants to tell.

Then, Put the Data to Work

The proper data infrastructure makes it easier to examine long-term data trends within your practice and see how you compare to similar practices. We help uncover the details of why your prior authorizations are approved or rejected, dive into the metrics that payers use to grade you, and more. Ultimately, access to this level of data, coupled with our team of experts, makes it possible to fully understand how your practice is performing—even beyond prior authorizations.

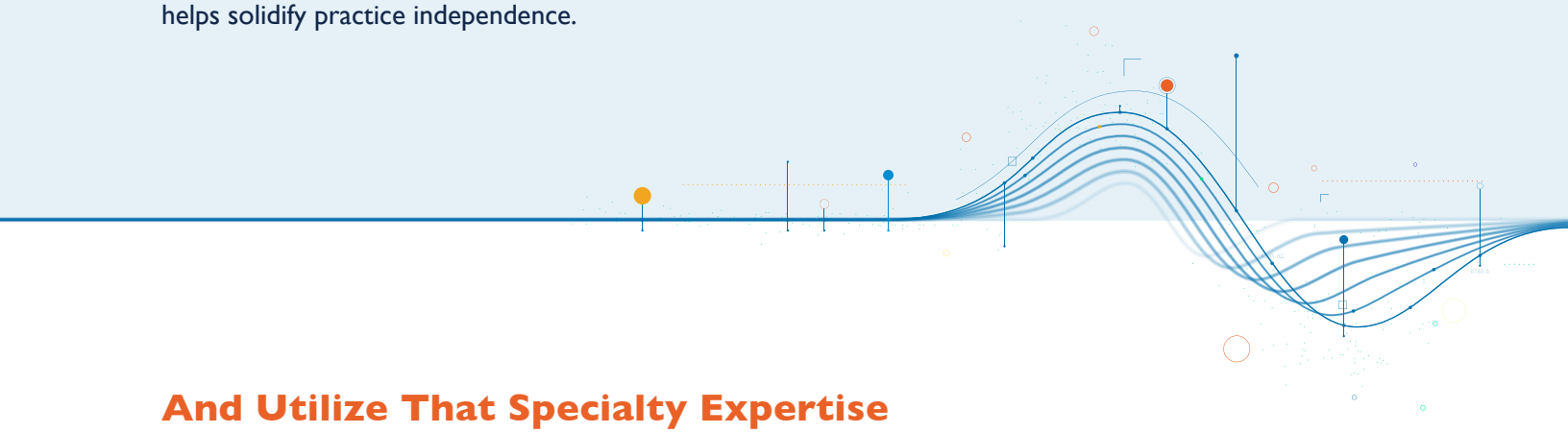
Build Out Your Value-Based Care Programs

Building a capable data infrastructure will help your practice not just in the context of prior authorizations but also with value-based care.

The metrics gathered from these initiatives are exactly what's needed to support value-based care programs. You can leverage these insights to understand where your practice stands in the eyes of payers and then make improvements to better market yourself to payers and referring PCPs while demonstrating you are an attractive partner to both.

As mentioned previously, practices can leverage the framework of value-based care to streamline prior authorizations into preapproved categories and/or episodes of care. We can help you determine the metrics that matter most and use those to build agreements with payers and clinical care pathways with your peers.

Our successful implementation of specialty-specific value-based care programs is the ideal model for future healthcare delivery. It provides the basis for ongoing innovation and practice improvement. Ultimately, it provides a clear pathway that not only helps streamline many of the pitfalls of prior authorizations but also helps solidify practice independence.



And Utilize That Specialty Expertise

Because we work only with independent specialty practices, we have a bird's-eye view of what's happening within other similar practices and the healthcare industry, so we understand the struggles you're facing and know exactly what practices like yours need. We leverage our expertise to help you across all components of practice performance management, not just prior authorizations. We can help optimize workflows and processes, reduce denials, and meet cash flow budgets. In addition to helping improve prior authorizations, we can help you:

- Solidify payer relations
- Maximize profitability
- Close gaps in patient care
- Improve reputation and practice positioning
- Optimize operational and financial performance
- Streamline administrative management

Put the Struggle of Prior Authorizations in the Past

Whether or not the process of authorizing physician decisions began with noble intentions, it has snowballed into an administrative headache for many practices. With the support of organizations like the AMA, the fight to improve prior authorizations is slowly gaining ground—but not quickly enough to address the burden it puts onto practices every day. Though prior authorizations can't be avoided, providers can take action today to leverage practice data and put them in an attractive position to payers looking for value-driving partners. By partnering with the right team of experts, you can uncover the metrics that matter most within your practice to improve day-to-day operations and be proactive in building a practice that is attractive to payers and referring providers.

Ready to dive into your practice metrics to uncover how you can improve your relationships with payers
(and improve prior authorizations in the process)?

GET IN TOUCH

About TRIARQ

TRIARQ Health is a national managed services organization that partners with independent specialty providers to help them adapt to changing market dynamics. We do so by assisting them in becoming a provider of choice to patients, referring clinicians, and payers, thereby strengthening their independence and maximizing profitability. The areas TRIARQ Health focuses on are improving payer relations, maximizing revenue, operational and financial management, and administrative support.