The Tech-Powered Shift from Transactional to Transformational Prior Authorization

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"Maybe it is time for us to rethink health as an investment rather than just a cost and focus on how to truly optimize health care and health systems." - Dipti Itchhaporia, MD, MACC, President of the American College of Cardiology[1]

Prior authorization, along with concurrent review, are major friction points between health plans and providers. According to a study by Health Affairs, 98% of plans using prior authorization do so to promote evidence-based care, and 84% of plans say it helps them address areas prone to misuse.[2] Despite these good intentions, physicians and patients often experience prior authorization as a burdensome process that can delay care. Although the shared frustration around prior authorization and concurrent review is widely recognized,[3] solutions that have been discussed for years have yet to be widely adopted.[4] As a result, health plans must now contend with trending regulatory changes like state-level gold carding legislation, recently announced Centers for Medicare and Medicaid Services (CMS) rules, and the "Improving Seniors' Timely Access to Care Act of 2022," which mandate automation and other significant process changes.

We see the lingering inefficiencies and pending regulations as a strategic opportunity: how can these processes go from being an expensive burden to a lever in delivering better, faster, quality care? The difference now is that innovation and technological advancements provide a pathway to change. By consolidating intake channels, using artificial intelligence (AI) to move beyond "yes" or "no" decisioning, and automating policy-based decisioning, health plans can reduce physician burden and deliver better outcomes. Additionally, by applying AI and machine learning to the data gathered from both prior authorization and claims processing, health plans can transform utilization review processes into a strategic asset that promotes better health and aligns with value-based care models. This white paper explores how health plans can use intelligent prior authorization to shift the limiting focus of utilization review from transactional to transformational to enhance interoperability and deliver better outcomes.

ALIGNING PRIOR AUTHORIZATION STAKEHOLDERS ACROSS MULTIPLE CHANNELS

Physician abrasion stifles the opportunity for collaboration in the quest for optimal care. Adopting better technologies at the point of intake—including fax digitization, EMR integration, and portals—makes it easier to leverage data to collaborate because there is a shared language instead of disjointed, disconnected parts. Introducing intelligent prior authorization tools at the point of intake enhances the physician experience and opens the door to improved collaboration between health plans and practices.

"Fax machines" and "popular" do not seem to belong in the same sentence at this point in history. Yet at least 70% of healthcare providers continue to exchange medical information by fax.[5] By relying on fax machines, which offer poor security and tracking, prior authorization lags behind most other modern industry processes.[6] Intelligent prior authorization digitizes faxes via optical character recognition (OCR) technology, which speeds the process, then consolidates the data to assist in future requests and reviews. As shown in Figure 1, the resulting workflow presents lower cost per fax, increased data quality, and improved turnaround time to assist in meeting compliance requirements.

1 Dipti Itchhaporia, "The Evolution of the Quintuple Aim," Journal of the American College of Cardiology 78, no. 22 (November 2021): pp. 2262-2264

2 A. Mark Fendrick, "Reframe the Role of Prior Authorization to Reduce Low-Value Care," Health Affairs Forefront (Project HOPE, July 11, 2022)

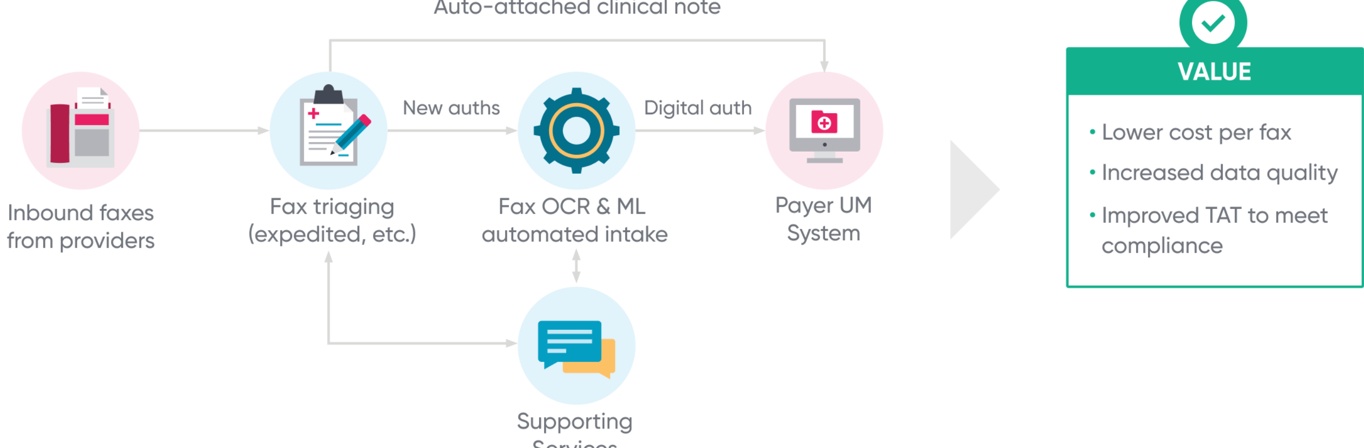
3 Mitchell A. Psotka et al., "Streamlining and Reimagining Prior Authorization under Value-Based Contracts: A Call to Action from the Value in Healthcare Initiative's Prior Authorization Learning Collaborative," Circulation: Cardiovascular Quality and Outcomes 13, no. 7 (July 20, 2020)

4 Thomas H. Lee, Michael E. Porter, and Robert S. Kaplan, "The Strategy That Will Fix Health Care," Harvard Business Review (Harvard Business Publishing, September 14, 2015)

5 Christopher Brown, "Health Care Clings to Faxes as U.S. Pushes Electronic Records," Bloomberg Law (Bloomberg Law, November 4, 2021)

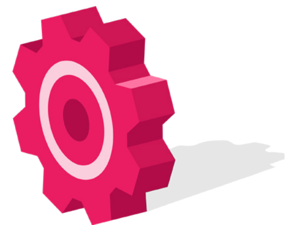
6 Lacey Colligan, et al., "Sources of Physician Satisfaction and Dissatisfaction and Review of Administrative Tasks in Ambulatory Practice: A Qualitative Analysis of Physician and Staff Interviews," American Medical Association. (American Medical Association, October 2016)

Figure 1: The value of intelligent prior authorization: Digitizing faxes



Instead of starting an authorization request via fax, many health plans are unlocking care-focused collaboration by using portals to automate requests. High-performing portals report 96% adoption rates by providers. As a result, provider abrasion decreases, and provider satisfaction rates soar as high as 92%. Capturing intake data using portal technology streamlines the collection of the necessary information in a consolidated, digital format and enables automated decisioning.

EMR integration is another technological advancement that has the potential to revolutionize prior authorization and concurrent review intake. By integrating directly with a health system's EMR, health plans can help reduce provider burden and make prior authorization submission invisible. A touchless experience for physicians, relevant clinical information is gathered directly from a patient's health record to help bolster requests. Automating intake within EMR workflows eliminates non-clinical support staff's manual efforts, resulting in more complete and accurate submissions to health plans.[7] The facilitation of these complete service requests to health plans brings us to the next exciting feature of intelligent prior authorization made possible by digital intake: automated decisioning.



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MOVING BEYOND THE YES/NO BY LEVERAGING AI TO INTERPRET DATA

Automated decisioning is a key capability of intelligent prior authorization. One of the main focuses of the federal "Improving Seniors' Timely Access to Care Act of 2022" is a requirement that Medicare Advantage plans establish real-time decision-making processes for "routinely approved" services to help address physician burden and improve access to care.[8] This legislative approach to fixing prior authorization is part of a larger trend by a variety of governing bodies, including two proposed rules by CMS in December 2022. The rules mandate electronic prior authorization, improved transparency and interoperability, plus a shortened turnaround time. Intelligent prior authorization solutions help health plans improve the accuracy and transparency of decisions, reduce the need for peer-to-peer reviews, and accelerate manual clinical review (when still necessary), thereby reducing physician burden and enabling regulatory compliance.

However, automated decisioning can be more than just a policy-based, "yes" or "no" decision. Plans can anticipate the entire care episode or journey and proactively suggest care choices that drive better and faster outcomes by applying advanced technology

[7] RTI International, "Evaluation of the Fast Prior Authorization Technology Highway Demonstration," AHIP, (AHIP, February 25, 2021).

[8] Alina Czekai, "Prior authorization & 'Improving seniors' timely access to care act'", Cohere Health (Cohere Health, September 19, 2022)

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Figure 2: The unhappy path of an authorization

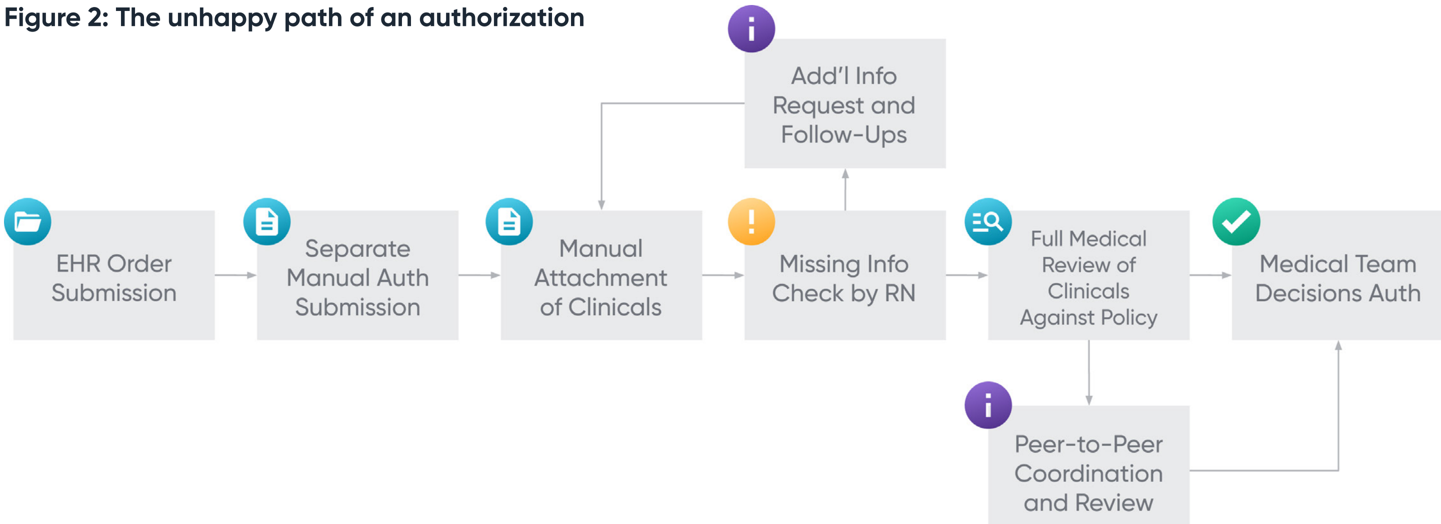
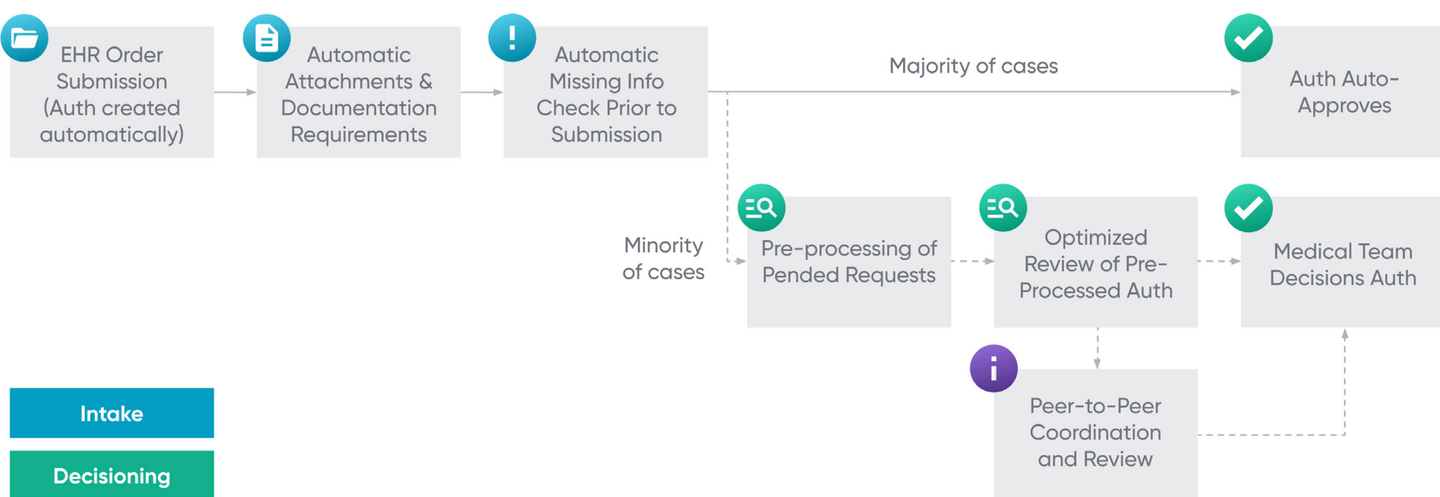


Figure 3: The happy path of an authorization



and incorporating analysis of claims and other health plan data. Building off of digitalized intake and EMR integration, intelligent prior authorization solutions can use AI to leverage insights from within the medical record previously locked away in unstructured text to improve decisioning accuracy without extra effort from the requesting physician.

It is common for prior authorization requests to be submitted with incorrect or missing attachments. Instead of burdening physicians with the time-consuming process of a peer-to-peer review, intelligent prior authorization uses AI to ensure that only complete requests are submitted. Consider Figure 2 and Figure 3 below, which highlight two authorization paths: one manual and one using intelligent prior authorization.

In addition to the completeness scan mentioned above, the diagram also references the pre-processing of pended requests. Pre-processing capabilities prepare pended cases for review, highlighting relevant pieces of information within clinical documentation and pre-populating clinical reviewer checklists with indications that have been identified by the decisioning engine. This application of AI and machine learning to pull and suggest the most relevant information, so reviewers don't

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have to search through pages of disorganized clinical information, improves the turnaround time of manually reviewed cases. Pre-processing enables clinical reviewers to operate at the top of their licenses and reduces the volume of cases requiring peer-to-peer reviews.

The greatest benefit of intelligent prior authorization decisioning is its ability to incorporate analysis of various kinds of data to which health plans have access to improve the accuracy of automated and manual decisioning of prior authorization and concurrent review. By analyzing and applying machine learning to identify the patterns and outliers in approval and denial metrics and claims data, health plans can benefit from greater levels of automated decisioning, while improving decisioning accuracy.

For example, by analyzing provider data for certain services or for certain patient cohorts, health plans can utilize machine learning to help address outliers. A few state governments have tried reducing physician burden through gold carding regulations, which consider providers' authorization history for certain services and, if it meets a certain percentage approval threshold, exempt them from authorization requirements for those services going forward.[9]

Gold carding legislation efforts are well-intentioned, but they leave health plans and patients exposed to increased healthcare costs and patient risk.[10] In a recent survey conducted by AHIP, 73% of health plans with gold carding programs reported some negative outcomes, such as administratively difficult implementation, higher costs, and reduced quality of care for patients.[11] The survey, which included health plans with discontinued gold carding programs, also stated that 75% of plans cited "administratively difficult implementation" as the most common reason for discontinuation of the programs.[12] Health plans require advanced solutions to provide them with the technological scaffolding to comply with legislation and transform utilization management.

Pioneers in the intelligent prior authorization space have developed a more comprehensive alternative to gold carding, called green lighting. Green lighting refines the technique behind gold carding efforts to ease and enhance the quality of implementation. Instead of relying on historical, thereby stagnant, data, green lighting uses real-time analytics to identify providers, or even whole practices, and simplify their authorization process. Green lighting incorporates patient data in these evaluations, so physician results are diagnosis-specific. In this way, health plans can comply with new regulations for gold carding, isolating green lighting to specific in-scope services for the physicians who get routine approval for them, without compromising the decisioning and delivery of evidence-based, quality care. Green lighting also makes it possible for health plans to identify and work with underperforming practices and physicians to

Figure 4: Green lighting example: Spinal fusion care path

Provider Green lighting: Physician-Specific Auto-Decisioning

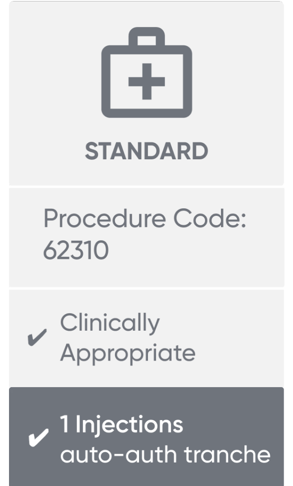
EXAMPLE ON THE SPINAL FUSION CARE PATH:

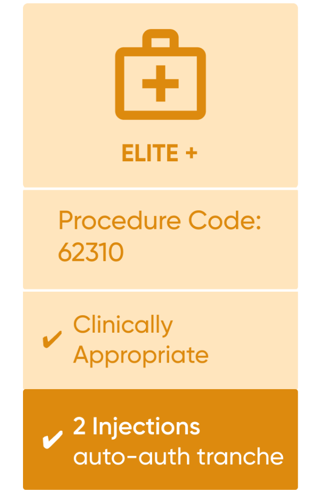
Pain management provider tiering to positively reinforce high-value care

Analyze providers continuously, dynamically adjusting provider tiers

Integrate provider tiering into auth decisions to incentivize high-value providers

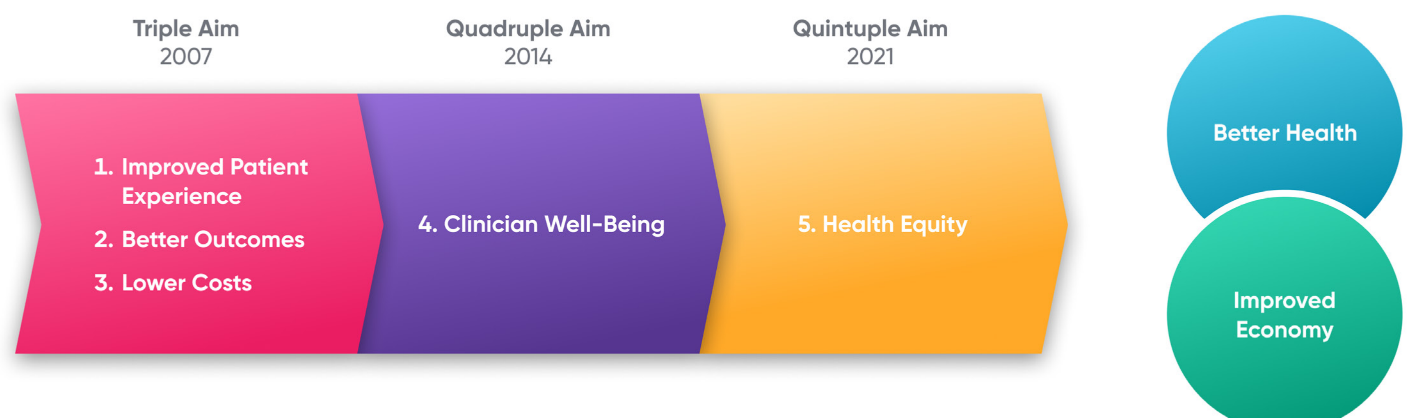
Communicate tiers with scorecards to drive behavior change





[9] [10] [11] [12] AHIP, "New Survey: Effective Gold Carding Programs Are Based on Evidence and Value for Patients," AHIP (AHIP, July 19, 2022)

Figure 5: The Quintuple Aim



increase transparency around decisioning and enhance care. Figure 4 illustrates an example of how green lighting works within a spinal fusion care path. See how green lighting streamlines the process of complying with regulations while maintaining medical expense impact.

The most impactful opportunity for health plans considering automation would be the implementation of an intelligent prior authorization solution that goes beyond simple automation of decisioning along policy guidelines, and instead uses advanced technology to incorporate different forms of data to enhance decisioning capabilities beyond the policy. Health plans have a huge opportunity to improve utilization review if they consider compliance with changing regulations as a catalyst for transformation.

PROACTIVELY TRANSFORMING PRIOR AUTHORIZATION TOWARDS ENABLING VALUE-BASED CARE

When the "triple aim" was released in 2007, the focus was three-fold: improved patient experience, better outcomes, and lower costs. The 2014 update made it a "quadruple aim" with the addition of clinican well-being. Most recently, when health equity was added in 2021 as a response to the health disparities during the COVID-19 pandemic, it grew into the current "quintuple aim."

Compliance with federal and state legislation is essential, but when health plans look at prior authorization through the lens of the quintuple aim, the process demands more. "Access to poor care is not the objective, nor is reducing cost at the expense of quality."[13] There is no shortage of healthcare legislation being introduced on an ongoing basis, working toward a better future state of healthcare. However, plans will need to consider individual service and procedure requests from a broader context if they want to achieve administrative cost savings, timeliness, and medical expense savings while promoting quality care.

Consider value-based care models, which shift the focus away from the individual costs of the tests and procedures that make up a patient's care journey and instead, reframe the services within the context of the patient's diagnosis and desired outcome. Payment then arises from the value of this outcome instead of the cost of each individual service request.[14] "Because the providers' reimbursement amounts would depend in part on meeting quality and patient experience measures, the entire team of providers would be focused on improving quality," writes one study on the philosophy behind transitioning payment from transaction-based to value-based.[15] While value-based care systems like these exist currently, they are focused on the payment side of utilization management, which limits their ability to influence care coordination, a requirement for alignment with the quintuple aim. However, with the technological advances made possible by intelligent prior authorization, it is possible to also align utilization review to achieve end-to-end, value-based care. Some examples of this innovative approach are the alignment of services within evidence-based care paths, the use of proactive moments of influence, and bundling related authorization requests.

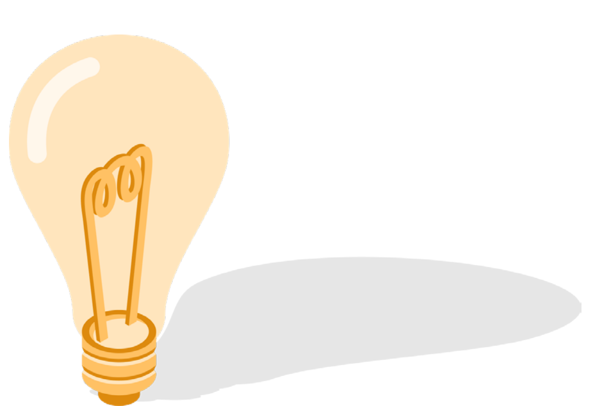
[13] [14] Lee, Porter, and Kaplan, "Strategy That Will Fix" Harvard Business Review (Harvard Business Publishing, September 14, 2015)

[15] Julia Cusick et al., "Alternatives to Fee-for-Service Payments in Health Care," Center for American Progress (Center for American Progress, October 6, 2022)

Drawing from the data gathered from the authorization requests themselves and analyzing the claims data for patient cohorts with similar diagnoses and circumstances, intelligent prior authorization solutions align a service request within an evidence-based care pathway. Following more than just the policy decisioning guidelines, these data-driven care paths allow for a more longitudinal context when considering a service request, transforming utilization review from transactional to longitudinal.

Another example of how the longitudinal patient record can improve patient care is by leveraging health plan data to inform clinical nudges toward high-value, evidence-based care where appropriate. Clinical nudges can be deployed to suggest an alternative service (or decreased number of services) to enable auto-determining or take advantage of moments of influence to suggest lower-cost, evidence-based, yet underutilized, services that the provider might not have on their radar. Consider this cardiology example. Despite evidence that anti-anginal medications can be introduced and titrated to effective levels that avoid percutaneous coronary intervention (PCI),[16] many PCI requests are submitted without optimal guideline-directed, anti-anginal therapy. By adding a nudge indicating that documented medication utilization or the inability to take medication is required for approval, intelligent prior authorization solutions can proactively direct physicians toward less invasive therapy pre-submission without sacrificing quality. This example shows how transparency can reduce delays in care and lower the cost and risks associated with inappropriate cardiac care. This aligns with physicians' desire for health plans to suggest alternative treatment options for a denied service.[17] Clinical nudges can be used to suggest high-performing care alternatives specific to a health plan's preferred policy. While lowering costs by utilizing these services, patient outcomes are optimized.

Intelligent prior authorization harnesses AI and machine learning to suggest related services and aggregate them into a single "episodic authorization" request, shortening the timeline for access to care and helping to place a service within the context of patient care pathways. Authorizations oriented around an entire care journey instead of a single service introduce a more comprehensive approach to utilization management and show the beginnings of true transformation.



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[16] Michael Foley et al., "Achieving Optimal Medical Therapy: Insights from the ORBITA Trial," Journal of the American Heart Association 10, no. 3 (February 2, 2021)

[17] Lacey Colligan, et al., "Sources of Physician Satisfaction and Dissatisfaction and Review of Administrative Tasks in Ambulatory Practice: A Qualitative Analysis of Physician and Staff Interviews," American Medical Association. (American Medical Association, October 2016)

THE FUTURE OF UTILIZATION REVIEW LIES BEYOND REGULATORY COMPLIANCE

Health plans should use intelligent prior authorization as a way to not only comply with the changing regulatory landscape, but to use its advanced capabilities to leverage patient, provider, and regional population data to orient prior authorization to the patient care journey, aligning with value-based models.

Intelligent prior authorization connects the dots between electronic prior authorization and the doors opened by the data that exists from its digitization. While legacy approaches to prior authorization fix some of the issues, like increased physician burden and access to care, intelligent prior authorization takes it to the next level.

This transformative approach reimagines the utilization review process to align health plans and physicians toward driving better value for patients.

Learn more about intelligent prior authorization at www.coherehealth.com/unify

or watch this two-minute video to learn more.

ABOUT THE AUTHOR

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Currently, Kaleb serves as the Vice President of Product Strategy. Prior to joining Cohere, Kaleb worked for Deloitte Consulting in Washington, D.C. Previously, he held positions within the product and software department at Ob Hospitalist Group, the largest dedicated OB/GYN hospitalist employer in the nation.

Kaleb holds a bachelor's degree in biomedical engineering from Clemson University.

ABOUT COHERE

Cohere Health solutions transform UM programs from an inefficient burden into a strategic asset, by aligning physicians and health plans on evidence-based care paths for the patient's entire care journey. By integrating these care paths into the prior authorization submission process, Cohere's digital UM platform reduces denial rates and medical expenses while improving patient outcomes. The company is a winner of the TripleTree iAward and has been named to both Fierce Healthcare's "Fierce 15" and CB Insights' Digital Health 150 lists. Cohere's investors include Flare Capital Partners, Define Ventures, Deerfield, Polaris Partners, and Longitude Capital.