"Evaluation of the Fast Prior Authorization Technology Highway"

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Title “Evaluation of the Fast Prior Authorization Technology Highway”

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Conflict of disclosure:

Dr. Clayton and Ms. Bravo-Taylor were employees of RTI and Dr. Smith and Dr. Pasko were employees of Surescripts at the time the study was conducted

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Title: "Evaluation of the Fast Prior Authorization Technology Highway"

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Abstract

Background: Prior authorization (PA) is a utilization management tool employed by health plans and pharmacy benefit managers (PBMs) where the payer requires additional documentation from health care providers prior to authorization of payment for a medication or procedure. PA processes are hypothesized to be more efficient if electronic transmission is utilized instead of manual submission.

Objective: To evaluate the impact of electronic prior authorization (ePA) on approval rate and time to decision ad to assess health care provider perception of using ePA.

Methods: AHIP selected two technology companies, Availity and Surescripts, and used an independent research organization (RTI) to conduct a provider survey and analyze over 40,000 prior authorization transactions from participating health plans. RTI examined processing time, provider experience, and other

measures for PAs both before and after provider implementation of electronic PA.

Results: Providers used these tools for roughly 62% of PAs in the 6 months after implementation. The median time from PA request to decision fell from 18.7 hours to 5.7 hours. Providers using ePA reported observing some benefits relative to the number of phone calls and faxes required after ePA implementation.

Background

Prior authorization (PA) is a utilization management tool employed by health plans and pharmacy benefit managers (PBMs) where the payer requires additional documentation from health care providers prior to authorization of payment for a medication or procedure. The intent of PA is to support safe, appropriate, and cost-effective care. PA is designed to direct medication and procedure use so that patients who meet a pre-specified criteria for appropriateness and safety will receive a particular treatment while patients who do not meet criteria will be directed to an alternative medication, procedures, or treatment plans.[1]

PA programs may create burdens for health care providers, pharmacies, and patients. Data suggests that approximately $80,000 per physician per year is spent interacting with health plans with a majority of that time spent on PAs.[2] According to a recent American Medical Association survey, 40% of physicians have staff who work exclusively on PAs to complete approximately 41 PAs per physician per week.[3] Administrative burden may lead to a delay in filling a prescription or denial of a potentially beneficial medication for a patient despite meeting criteria, and PAs do not consistently reduce health care costs.[4-6]

Electronic prior authorization (ePA) was introduced to improve efficiency by enabling PAs to be completed electronically with either online portals or technology integrated in an electronic health record (EHR).[7] ePA leverages national standards for two-electronic information exchange to facilitate several aspects of the PA process, including enabling providers to access information from health plans or PBMs on whether a PA is required, submit PA requests and supporting documentation, and receive determinations. ePA is designed to reduce the volume of phone calls and faxes send among prescribers, payers, and pharmacies to decrease the time between a PA is first submitted and when a health plan or PBM makes a decision.[8] Decreasing the time it takes for a coverage decision to be made may allow patients to access medications more quickly. Prescribers have demonstrated willingness to adopt ePA but have cited a lack of vendor and payer support as barriers to implementation. For example, some payers will require documentation submitted via fax despite ePA being available, and some prescribers may choose telephone or fax if ePA technology is malfunctioning. Only 12% of PAs are completed electronically from start to finish.[9,10]

In 2020, America's Health Insurance Plans (AHIP), a national association whose members provide health care coverage and services, launched the Fast Prior Authorization Technology Highway (Fast PATH) initiative with the goal of improving the PA

process for medications and medical and surgical procedures by employing ePA.[11] AHIP selected two technology companies, Availity and Surescripts, because they met criteria of having ePA capabilities offering standards-based, scalable technologies integrated into the provider workflow and are classified as neutral gateways or intermediaries that connect health plans and providers to enable two-way electronic communications. Availity offers a web-based portal for procedure PAs that can be used to access to payer-specific guidelines. The portal guides users through the process of submitting a PA and supporting documentation, monitoring its status, and receiving determination from the payer.[12] Surescripts Real-time Prescription Benefit and Electronic Prior Authorization solutions are embedded in the provider's EHR. Users can access patient-specific benefit information at the point of prescribing, including PA required notifications and clinically relevant alternatives that do not require a PA. If a medication that requires a PA is ordered, the PA can be completed in the e-prescribing workflow.[13]

The ability of ePA to impact administrative burden, including the time between when a PA is submitted to when a coverage decision is made, has not been rigorously evaluated. Current studies are limited to evaluations of individual health systems[8,14] or have focused on adherence as an outcome.[15]

Similarly, studies examining the provider perspective of PA have included a small volume of practices or geographical areas[7,16,17] or were conducted prior to broader adoption of ePA.[18]

Objective

The objective of this study was to evaluate the impact of the FAST Path Initiative on approval rate and time to decision, defined as the time from which the PA was submitted to the health plan or PBM to the time when the provider received the final decision. Time to decision has been used as an outcome in other studies.[8, 16] Secondarily, health care provider perception of using ePA was also assessed.

Methods

RTI International, an independent non-profit research institute, collected data directly from participating health plans and providers.

PA Transactions

Six participating health plans with national coverage provided RTI with data on both manual and electronic PAs before and after implementation of one of the ePA solutions. To ensure the analysis presented a complete view of PA transactions before and after implementation of an electronic prior authorization solution, RTI included only providers with 6 months of data

before and after implementation of ePA. To ensure the data reflected changes in prior authorization patterns for providers who are ongoing, regular users of the tool, the analytic data set only included National Provider Identifiers (NPIs) that had at least three ePAs: one to establish the ePA implementation date, one in months 2 through 5 after implementation, and one in month 6 or later after implementation. Decision time and approval rate was calculated for PA submitted before and after ePA implementation.

Survey methodology

RTI used an email survey campaign to contact providers who provide care to members of participating health plans and who are current users of the vendors' electronic prior authorization solutions. The respondents were not necessarily the same providers included in the prior authorization transaction data analysis, but they had implemented electronic prior authorization recently and were willing to share their experience via the RTI-administered survey. RTI surveyed approximately 300 providers that were identified by the health plans as either early adopters or current users of ePA about their user experience, provider burden, (5 questions) and impact on patient care (3 questions) between the manual and electronic processes.

The survey sample of providers was a convenience sample using all available provider contact information from participating health plans (pharmacists were not included). There were several limitations to the survey. Because no provider characteristic data were available, we do not know how survey respondents compare to non-respondents. Invitations were initially sent in September 2020 with two follow-up reminders over the following four weeks. In some cases, we received contact information for an office manager or other point of contact who was not the intended survey target. For these individuals, we invited the email recipient to send the survey to the relevant clinical staff. Because of this dissemination approach, we do not know how many people were ultimately invited to take the survey and thus do not know the response rate.

Results

After implementing NPI criteria, 41,712 transactions from six months before and after implementation of ePA were analyzed.

Time to Decision

Prior to ePA implementation, the median time to decision was 18.73 hours (IQR 44.37) compared to 5.71 hours (IQR 26.65) after implementation. Prior to ePA implementation, 84% of PAs required

over two hours to be decided, including 24% that required more than 48 hours. After ePA implementation, 33% of ePAs were decided within two hours, and only 15% required more than 48 hours (Figure 1).

Approval Rates

The approval rate of PAs was largely unchanged after implementation of Fast PATH ePA solutions. Prior to implementation, 59.9% of PAs were fully approved; after implementation, 60.3% of PAs were fully approved. In the post period, the approval rate for manual PAs was similar to that of ePAs (60.8% and 60.0%, respectively). In the six months after implementation of Fast PATH ePA solutions, 62% of all PAs were submitted electronically.

Provider Perception of ePA

RTI received responses to at least one survey question from 309 survey respondents. Seventy-four percent of respondents who provided information about their role in practice were clinicians (providers or nurses). Of respondents who answered the question about frequency of electronic prior authorization use, 31% used the solution for most patients at their practice.

Among all users, 22.8% reported that it was easier to understand PA information after implementation of the electronic solution, and 34.4% reported that it was easier to understand whether a PA was required.

Approximately one-quarter of respondents reported that a decision about the PA was easier to view after ePA implementation. Implementation of an ePA solution had some impact on work burden as 25.4% of respondents reported fewer phone calls since ePA implementation, and 28.5% reported fewer faxes. ePA may have improve patient access to medications with 30.1% of respondents reporting patient's speed to fill being faster since ePA implementation(Table 1). Having access to cost information through ePA tools impacted behavior as 51.9% of respondents reported changing prescriptions to a lower cost alternative when presented with options (Table 2).

Discussion/Conclusion

In this evaluation of the FAST Path Initiative, time to decision was improved after ePA technology was implemented. Median time to decision was improved by approximately 13 hours, decreasing from 18.7 hours to 5.7 hours. In the 6-month period post-implementation, one-third of all prior authorizations were decided within 2 hours of submission. The magnitude of this improvement is large relative to both the pre-period data, where only 17% of prior authorizations were decided within 2 hours, and large relative to results from the 2019 American Medical Association survey[20] which reported that 5% of prior

authorizations were decided in under 1 hour and 11% were decided within "a few hours." The approval rate was largely unchanged after ePA solutions were implemented. This finding suggests that although ePA processes may lead to faster times to decision, the decisions did not change because the rules pertaining to PA are the same for manual and electronic authorizations.

When new electronic processes are implemented, utilization and retention rates are often a concern during the post-implementation period. In the six months after ePA implementation, approximately 62% of PAs were submitted electronically which demonstrates opportunity for better engagement in the electronic process. One of the barriers to ePA implementation is that health care providers report having to use manual interventions, such as phone calls and faxes, to facilitate PA approval even when ePA technology is available.[9,14,15] The requirement of these manual interventions may explain why only 62% of PAs were submitted electronically after ePA technology was implemented.

Given the positive findings from this study, there may be additional benefits of ePA by increasing provider adoption. providers could decrease their administrative burden and streamline prescription processes for patients, potentially allowing for quicker time to therapy. To increase provider

adoption, it may be necessary for electronic health record and health information technology vendors to further innovate and find better solutions of integrated workflows for the providers. Providers would then benefit from training and how to utilize the technology for optimal benefit for themselves, the health plans, and patients.

Another option to drive adoption is to increase the proportion of patients for whom ePA is available by increasing participation among health plans and PBMs in ePA solutions. If adoption among both providers and payers could be addressed, the median time to decision and overall provider burden for PA could be further reduced.

There are several study limitations. The quality of the PA's final decision was not assessed for clinical appropriateness or cost impact. Although PA criteria are typically based on evidence-based clinical guideines,[19] relevant patient-specific characteristics should be considered in treatment plans. It is possible that patients in this study received treatment that may have been clinically inappropriate or had a negative impact on cost. The study used a before and after design without a control group, which may lead to inappropriately attributing observed changes to the intervention. In this study, changes in PA transactions measures may be inappropriately attributed to the

implementation of ePA. A before and after design without controls was chosen because comparable controls could not be practically identified within the participating health plans. Lastly, results are not analyzed separately for drugs and procedures or stratified according to a provider's level of experience submitting PAs.

Despite decreasing time to decision, the implementation of ePA technology solutions faced challenges relative to provider engagement. Future studies may investigate how ePA technology and workflows might lead to broader adoption and a more positive perception of benefit.

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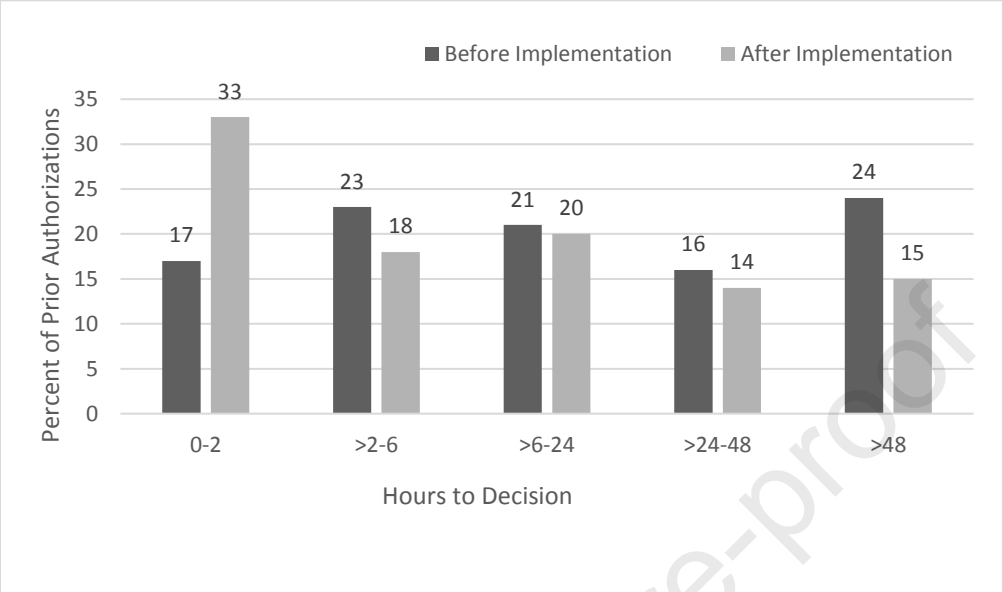
Figure 1. Time to Decision of Prior Authorizations Before and After Implementation of Fast PATH Electronic Prior Authorization Solutions



Evaluation of the Fast Prior Authorization Technology Highway

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Table 1. Electronic Prior Authorization Survey Responses

	Fewer than before I had a prior authorization solution in my EHR/EMR n(%)	Same as before n(%)	More than before having prior authorization in my EHR/EMR n(%)	Don't know n(%)
The number of prior authorization-related phone calls I handle today is (n=201)	51 (25.4)	98 (48.8)	18 (9.0)	34 (16.9)
The number of prior authorization-related faxes I handle today is (n=200)	57 (28.5)	95 (47.5)	14 (7.0)	34 (17.0)
The time I spend on prior authorization-related phone calls today is (n=200)	66 (33.0)	83 (41.5)	17 (8.5)	34 (17.0)
The time I spend on prior authorization-related faxes today is (n=198)	63 (31.8)	87 (43.9)	13 (6.6)	35 (17.7)
	Easier to understand than before having prior authorization in my EHR/EMR n(%)	Same as before n(%)	More difficult to understand than before having prior authorization in my EHR/EMR n(%)	Don't know n(%)
The information I can get about whether a prior authorization is required is (n=221)	76 (34.4)	73 (33.0)	17 (7.7)	55 (24.9)
The prior authorization requirements are (n=219)	50 (22.8)	89 (40.6)	24 (11.0)	56 (25.6)
	More easily because I have a solution in my EHR/EMR n(%)	Same as before n(%)	With more difficulty than before having a solution in my EHR/EMR n(%)	Don't know n(%)
I am able to view a decision about my prior authorization (n=219)	57 (26.0)	85 (38.8)	22 (10.0)	55 (25.1)
	Faster as compared to before I had a prior authorization solution in my EHR/EMR n(%)	Same as before n(%)	Slower than before having prior authorization in my EHR/EMR n(%)	Don't know n(%)
My patient's speed to fill is (n=196)	59 (30.1)	76 (38.8)	8 (4.1)	53 (27.0)

	3 or fewer (less than one/week) n(%)	4-10 (about two/week)	11 or more (about 3 or more/week)	Don't know
The number of prior authorizations I initiated in a month is (n=189)	36 (19.1)	61 (32.3)	63 (33.3)	29 (15.3)

EHR=electronic health record

EMR=electronic medical record

Table 2. Electronic Prior Authorization Medication Cost-related Survey Responses

	Always or often n(%)	Sometimes n(%)	Rarely n(%)	Never n(%)	Don't know n(%)
In the past week, how often did you view the price or benefit information when prescribing a medication? (n=282)	27 (9.6)	66 (23.4)	34 (12.1	138 (48.9)	17 (6.0)
In the past week, how often did you communicate to your patient information on prescription costs using information from the ePA tool? (n=125)	19 (15.2)	55 (44.0)	34 (27.2)	16 (12.8)	1 (0.8)
In the past week, how often did you change to a lower cost alternative when viewing pricing information in the ePA tool? (n=127)	14 (11.0)	52 (40.9)	35 (27.6)	23 (18.1)	3 (2.4)

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