



# Evaluation of the Fast Prior Authorization Technology Highway Demonstration

*Final Report*

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February 25, 2021

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## EXECUTIVE SUMMARY

### *Background*

Prior authorization can help ensure that patients have access to safe, effective, affordable, high-quality care by helping to guard against potential overtreatment or inappropriate treatments that contribute to unnecessary costs and/or potential harm to patients. However, there is agreement that prior authorization can be burdensome to providers, consumers, and health plans alike. In 2018, stakeholders representing providers and payers worked together to develop a Consensus Statement outlining opportunities to improve the prior authorization process with the following aims:

- Promote timely, affordable access to evidence-based care for patients.
- Enhance efficiency in care delivery.
- Reduce administrative costs.

In this Consensus Statement, increasing the adoption of electronic prior authorization<sup>a</sup> was one of the five major opportunities identified for improving the prior authorization process. In January 2020, building on the multi-stakeholder Consensus Statement, America's Health Insurance Plans (AHIP), along with several member insurance providers, launched the Fast Prior Authorization Technology Highway (Fast PATH) initiative with the goal of understanding the impact of electronic prior authorization on improving the prior authorization process. This novel initiative and evaluation lay the foundation for more research on strategies for further improving electronic prior authorization.

### *The Fast PATH Initiative*

AHIP selected two technology companies, Availity and Surescripts, with electronic prior authorization capabilities that offer standards-based, scalable technologies that are integrated into the provider workflow. Both companies selected for the study partnered with a subset of their health plan customers to ensure implementation across a range of providers and provide relevant data. The goal of the demonstration was to understand how the implementation of electronic prior authorization affected the volume of prior authorizations, approval rate, time to decision, and perceived provider experience and associated patient experience.

### *Fast PATH Evaluation*

RTI analyzed over 40,000 prior authorization transactions from participating health plans within the study period to assess measures of prior authorization volume, approval rates, and processing time for prior authorization requests—both before and after provider implementation of electronic prior authorization.

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<sup>a</sup> In this report, electronic prior authorization refers to electronic prior authorizations for both prescriptions and procedures.

RTI also administered a survey to providers and their staff who use the electronic prior authorization solutions to better understand the experiences of providers and the impact on their patients. The survey reached a convenience sample of respondents who, though not necessarily the same group of providers included in the health plan transaction data analysis due to availability of contact information and inclusion criteria in the data analysis, had implemented electronic prior authorization recently and were willing to share their experiences via the RTI-administered survey.

### Key Findings and Conclusions

- After implementation of Fast PATH electronic prior authorization solutions, providers used these tools for roughly 62% of prior authorizations in the 6 months after they implemented the tools in their practices.
- Analysis of prior authorization transaction data and the survey revealed that reduced time from prior authorization request to decision is a significant benefit of electronic prior authorization.
  - In the 6-month period after Fast PATH electronic prior authorization solutions were implemented by providers, the median time between submitting a prior authorization request and receiving a decision from the health plan was more than **three times faster** compared to before implementation. The median time from prior authorization request to decision fell from 18.7 hours to 5.7 hours, a reduction of 69%.
  - For survey respondents using electronic prior authorization for most of their patients (which are referred to as the “experienced” users), 71% said that time to care was faster than before.
- Survey responses also indicated that among providers using these solutions for most of their patients, a majority experienced a reduced burden in terms of fewer phone calls and faxes and less time spent on phone calls and faxes.
  - In addition, most of these more experienced providers indicated that it was easier to understand if a prior authorization was required, easier to understand the requirements for submitting a prior authorization, and easier to view the decision.
  - The survey findings show that provider burden was not significantly impacted when results included providers who used these solutions for only a few of their patients.
- Approval rates were not impacted by electronic prior authorization compared with manual processes. This finding indicates that although electronic prior authorization processes may lead to faster times to decision, the decisions did not change because the rules pertaining to prior authorization are the same for manual and electronic authorizations.
- Given that the benefits of electronic prior authorization solutions are greatest when providers use these solutions for most of their patients, further gains could be realized by increasing provider adoption. Two complementary pathways to improve adoption may include the following:
  - Increase utilization of the tools in situations where they are already available for the given provider and patient (e.g., identify and address the issues that cause prior authorizations to be manual even when the electronic tool is in place for a specific provider and patient, which may include greater emphasis on provider training and workflow integration).
  - Increase the number of providers and patients for whom the tool is available by getting more health plans and pharmacy benefit managers (PBMs) to offer these electronic tools to providers.

## POLICY CONTEXT OF PRIOR AUTHORIZATION

**What is prior authorization?** Prior authorization, sometimes referred to as preauthorization, precertification, prior approval, or prospective review, is a process whereby health care providers obtain advance approval from a patient's health plan before a specific procedure, service, device, supply, or medication is delivered to the patient to qualify for coverage.

**Why is prior authorization used?** Public and private payers, including traditional Medicare and Medicare Advantage, State Medicaid programs and their managed care partners, and health plans in the commercial market (who may be responding to employer requests), use prior authorization for prescription medications, procedures, diagnostic testing, and equipment as a tool for reducing low-value care, improving quality and safety, and promoting affordability. Prior authorization can help ensure that patients have access to safe, effective, affordable, high-quality care by helping to guard against potential overtreatment or inappropriate treatments that contribute to unnecessary costs and/or potential harm to patients. Several government reports and peer-reviewed studies have described the prevalence of unnecessary variation in health care use. For example, a 2013 Institute of Medicine report concluded that wide variation in levels of health care use is evident across providers and organizations within the same geographic areas and could not be explained by geographic variation in costs.<sup>1</sup> This variation presents a potential opportunity to increase the value of care nationwide by eliminating care that does not improve patient health. In a 2014 survey of practicing physicians in the United States, when asked about the care delivered by peers in their specialty, most reported that at least some care, including prescription drugs and tests, was unnecessary for improving patient health.<sup>2</sup>

Other more recent studies have confirmed that significant levels of unnecessary care and waste persist. A 2019 study in *JAMA* found that “the estimated cost of waste in the U.S. health care system ranged from \$760 billion to \$935 billion, accounting for approximately 25% of total health care spending.”<sup>3</sup> This study specifically identifies the cost of low-value medication use between \$14.4 billion and \$29.1 billion and the cost of low-value screening, testing, or procedures between \$17.2 billion and \$27.9 billion. A 2018 report to Congress reviewed evidence from Medicare, Medicaid, and commercial payers, and concluded that a significant percentage of patients received low-value care, resulting in between \$2.4 billion and \$6.5 billion in Medicare spending in 2014 alone. In that report, the Medicare Payment Advisory Commission noted that prior authorization is one policy approach for reducing the amount of low-value care delivered to Medicare beneficiaries.<sup>4</sup>

A recent survey of health plans by AHIP confirmed that health plans use prior authorization programs selectively to increase the value of care delivered and protect patient safety. Health plans report using peer-reviewed, evidence-based studies and provider-developed guidelines to design their prior authorization policies.<sup>5</sup> Some examples of areas where prior authorization is used effectively to promote patient safety include protecting patients from the overprescribing of opioids, which can result in addiction, and the overuse of diagnostic imaging services, which can expose patients to unnecessary and potentially harmful radiation. The traditional Medicare program recently expanded its use of prior

authorization to additional services “for controlling unnecessary increases in the volume of covered [outpatient department] services.”<sup>6</sup>

**How can prior authorization be improved?** Prior authorization can be burdensome to providers, consumers, and health plans alike. According to a 2019 American Medical Association (AMA) survey of primary care and specialty physicians,<sup>7</sup> more than 80% of physicians described the burden of prior authorization as being high or extremely high.

In January 2018, six nationwide organizations representing physicians, pharmacists, medical groups, hospitals, and health plans developed a Consensus Statement outlining opportunities to improve the prior authorization process<sup>8</sup> with the following aims:

- Promote timely, affordable access to evidence-based care for patients.
- Enhance efficiency in care delivery.
- Reduce administrative costs.

In this Consensus Statement, increasing the adoption of electronic prior authorization<sup>b</sup> was one of the five major opportunities identified for improving the prior authorization process. This is consistent with recent AHIP survey findings that identified increased automation of prior authorization as one of the biggest opportunities for improving the prior authorization process.<sup>5</sup> This same survey found that the vast majority of health plans are already taking steps to streamline the prior authorization process through technology solutions like electronic prior authorization and value-based provider contracts to incentivize reduction of unnecessary medical tests, treatments, and procedures.<sup>5</sup>

**What is electronic prior authorization, and how does it improve manual prior authorization processes?** Electronic prior authorization leverages national standards for two-way electronic information exchange to facilitate several aspects of the prior authorization process, including enabling providers to access information from health insurers on whether a prior authorization is required, submit prior authorization requests and any needed supporting documentation to health insurers, and receive prior authorization determinations.

According to the Council for Affordable Quality Healthcare (CAQH) Index,<sup>9</sup> a report of electronic transaction use produced by a non-profit alliance, providers can complete electronic prior authorization requests for medical items and services more quickly.<sup>c</sup> Moreover, by incorporating the ability to retrieve critical information at the point of care via electronic health records (EHRs) or other interfaces, electronic prior authorization solutions can facilitate transparency of information and decision making, resolving another key reported burden of the prior authorization process. Thus, electronic prior

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<sup>b</sup> In this report, electronic prior authorization refers to electronic prior authorizations for both prescriptions and medical items, services, and procedures.

<sup>c</sup> Although the CAQH Index does not include pharmacy transactions, a separate CAQH Pharmacy Services Index (<https://www.caqh.org/sites/default/files/explorations/index/index-pharmacy-brief.pdf>) found that adoption of electronic prior authorization for prescription drugs is higher than adoption of electronic prior authorization for medical items and services for a number of reasons, including the relatively widespread adoption of an electronic standard that can accommodate pharmacy-related clinical attachments to support prior authorization requests.

authorization has the potential to increase timeliness, efficiency, and value, all goals set forth in the Consensus Statement to improve the prior authorization process.

Federal and state efforts to streamline the prior authorization process have also looked to leverage electronic prior authorization technology. For example, on December 31, 2020, CMS published a final rule to adopt a new e-prescribing transaction standard for Part D–covered drugs prescribed to Part D–eligible individuals, as required by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.<sup>10</sup> Under this final rule, by January 1, 2022 Part D plan sponsors will be required to “support version 2017071 of the National Council for Prescription Drug Programs (NCPDP) SCRIPT standard for four electronic prior authorization transactions, and prescribers will be required to use that standard when performing electronic prior authorization transactions for Part D-covered drugs they wish to prescribe to Part D-eligible individuals.”

In addition, on January 15, 2021, CMS published the Interoperability and Prior Authorization final rule to “place new requirements on state Medicaid and CHIP fee-for-service programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plans (QHP) issuers on the Federally-facilitated Exchanges (FFEs) to improve the electronic exchange of health care data and streamline processes” related to prior authorization through use of application programming interfaces (APIs).<sup>11</sup> However, unlike the Part D final rule, the Interoperability and Prior Authorization final rule did not place parallel requirements or incentives for providers to use the new APIs. At the time of this writing, both rules were being reviewed pursuant to a January 20, 2021 Regulatory Freeze Pending Review memorandum.<sup>d</sup>

## FAST PATH: LEARNING MORE ABOUT ELECTRONIC PRIOR AUTHORIZATION

Building on the multi-stakeholder Consensus Statement, AHIP, along with several member insurance providers, launched the Fast PATH initiative in January 2020 with the goal of understanding the impact of electronic prior authorization on improving the process for medical procedures and prescriptions.

AHIP conducted a request for proposal (RFP) process that culminated in the selection of two technology companies offering electronic prior authorization capabilities that met key criteria. Specifically, these vendors offer standards-based,<sup>e</sup> scalable technologies that are integrated into provider workflow. Both technology companies are “neutral gateways or intermediaries” that connect health plans and providers to enable two-way electronic communications. Both vendors are connected to multiple health plans and providers, a subset of which participated in this study.

**Availity** offers an Electronic Prior Authorization solution for a range of procedures, including medical, surgical, radiological, and more. The company, which launched in 2001, offers a variety of services across many health plans, providers, vendors, and patients.

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<sup>d</sup> The Interoperability and Prior Authorization final rule is not listed on the federal register as of February 5, 2021; in its place RTI has provided the proposed rule as a reference.

<sup>e</sup> Availity uses 278 x12 standards for transmission of data but can map to proprietary formats. Surescripts uses NCPDP SCRIPT Standard Version 2013101 for electronic prior authorization.



### **Availity and Electronic Prior Authorization**

Availity's multi-payer, web-based portal helps streamline the prior authorization process for a range of procedures. First, a provider can use *Is Auth Required* functionality to see if a prior authorization is necessary for a given procedure based on payer-specific guidelines. If so, the provider goes to the authorizations dashboard, which serves as the hub for managing all aspects of the process. The dashboard features a tool that guides a provider through the process of creating a request, including uploading supporting documentation. After the request is submitted, the provider can monitor the status of all pending requests, which are updated in real time, eliminating the need to call the payer for an update.

**Surescripts** offers Real-Time Prescription Benefit and Electronic Prior Authorization solutions for prescription medications. Surescripts was founded in 2001 in response to the need to replace paper prescriptions with e-Prescribing.

### **Surescripts Real-Time Prescription Benefit and Electronic Prior Authorization**

Surescripts' Real-Time Prescription Benefit and Electronic Prior Authorization solutions are embedded in the providers' EHR. Surescripts Real-Time Prescription Benefit provides the prescriber or their staff with patient-specific benefit information directly from the patient's benefit plan, including prior authorization required notifications and clinically relevant alternatives that do not require a prior authorization or are lower-cost alternatives. If the prescriber chooses a medication that requires a prior authorization, they can initiate and complete a prior authorization electronically in the e-Prescribing workflow using Surescripts Electronic Prior Authorization.

Each vendor selected for the study partnered with a subset of their health plan customers to ensure implementation across a range of providers and offer data relevant for this study. Health plans were identified to participate in this project based on their existing relationships with the participating technology partners, their experience leveraging those tools to engage providers, and their ability to identify providers with sufficient experience with electronic prior authorization to participate in the provider survey. For this study, Availity worked with Cambia Health Solutions and Florida Blue; and Surescripts worked with Blue Shield of California, Cigna, WellCare (Centene), and Humana. Together, these vendor/health plan partnerships engaged with providers in all 50 states, the District of Columbia, and Puerto Rico on electronic prior authorization.

Following an RFP process, AHIP selected RTI International as the independent evaluator for the Fast PATH demonstration and Point of Care Partners as an advisor to contribute subject matter expertise to the project.

## **EVALUATION METHODS**

### **Research Questions**

The research questions for this evaluation are focused on two domains of interest: provider burden and experience and patient experience. As outlined in Exhibits 1 and 2, each question maps directly to a

specific measure that we constructed from our data sources. A detailed description of each data source is provided in the following section.

**Exhibit 1. Provider Burden and Experience: Research Questions, Measures, and Data Sources**

| Research Question                                                                                                                                                | Measure                                                                                                                                      | Data Source                         |                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|
|                                                                                                                                                                  |                                                                                                                                              | Health Plan                         | Provider Survey                     |
| 1.1. What is the impact of automating aspects of prior authorization on the proportion of prior authorizations that are approved?                                | Volume of transactions approved (numerator); volume of transactions requesting prior authorization (denominator)                             | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 1.2. What is the impact of automating aspects of prior authorization on the volume of prior authorization transactions?                                          | Volume of transactions                                                                                                                       | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 1.3. What is the impact of automating aspects of prior authorization on the volume of prior authorization-related phone calls and faxes?                         | Reported change in volume of prior authorization-related phone calls; reported change in prior authorization-related volume of faxes         | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 1.4. What is the impact of automating aspects of prior authorization on the time spent on prior authorization-related phone calls and faxes?                     | Reported change in time spent on prior authorization-related phone calls; reported change in time spent on prior authorization-related faxes | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 1.5. What is the impact of automating aspects of prior authorization on the availability of prior authorization-related requirements and supporting information? | Reported change in availability of prior authorization-related requirements and supporting information                                       | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |

**Exhibit 2. Patient Experience: Research Questions, Measures, and Data Sources**

| Research Question                                                                                                                                                    | Measure                                                                                                                                                           | Data Source                         |                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|
|                                                                                                                                                                      |                                                                                                                                                                   | Health Plan                         | Provider Survey                     |
| 2.1. What is the impact of automating aspects of prior authorization on the time it takes between submitting a prior authorization request and receiving a decision? | Time (days/hours/minutes) between submission and decision                                                                                                         | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 2.2. What is the impact of automating aspects of prior authorization on the perceived timeliness of recommended care?                                                | Reported change in perceived timeliness of recommended care (Availability: undergoing recommended procedure; Surescripts: starting prescribed medication regimen) | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 2.3. How often do providers change the prescription to one that is less expensive for the patient?                                                                   | Reported frequency of how often providers change the prescription to one that is less expensive for the patient                                                   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |

To examine each question, RTI computed means, distributions, or proportions of each measure over the study period before and after implementation of Fast PATH electronic prior authorization solutions. The

study period is from 180 days (roughly 6 months) prior to electronic prior authorization implementation to 180 days after electronic prior authorization implementation, where the implementation date is specific to each provider within a plan and based on the date of the first electronic prior authorization.

### *Impact of COVID-19 on the Evaluation*

The evaluation of the Fast PATH demonstration had intended to focus on providers who implemented one of the electronic prior authorization solutions during late 2019 or early 2020. Because of the COVID-19 pandemic, RTI modified the approach to analyze data for providers who implemented one of the electronic prior authorization solutions earlier in order to obtain 6 months of post-period data unaffected by the pandemic. RTI received some prior authorization transaction data for providers who implemented recently enough that their post-period prior authorization use might have been affected by COVID-19. To account for the potential impact of the pandemic on the measures of interest, RTI also analyzed the data excluding prior authorization transactions that occurred on or after March 13, 2020, after which many elective procedures were deferred, and prior authorization policies were waived.

## DATA SOURCES

RTI used prior authorization transaction data from participating health plans to assess measures of prior authorization volume, approval rates, and processing time for prior authorization requests. In addition, RTI administered a survey to providers and their staff who use the electronic prior authorization solutions to better understand provider and patient experience.

### *Health Plan Data*

Six participating health plans provided RTI with data on both manual prior authorizations and electronic prior authorizations before and after implementation of one of the electronic prior authorization solutions. For each prior authorization request, RTI received the provider's National Provider Identifier (NPI), the date and time the prior authorization was submitted, the date and time the prior authorization was adjudicated, and whether the prior authorization was approved or denied.<sup>f</sup> Since different providers implemented these solutions at different times, RTI determined the implementation date specific to each NPI within a plan (based on the date of the first electronic prior authorization) and aligned the data to the pre- and post-period based on this date. To ensure that RTI presented a complete view of prior authorization transactions before and after implementation of an electronic prior authorization solution, RTI included only providers for whom RTI had 6 months of data before and after implementation of electronic prior authorization. To ensure the data reflected changes in prior

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<sup>f</sup> Prior authorization data for one health plan were unavailable at the transaction level and unavailable for before electronic prior authorization solution implementation and for any manual prior authorization transactions due to the widespread adoption of the electronic prior authorization solution prior to the study period. RTI worked with the relevant vendor to aggregate the data to the prior authorization level for the analysis, but due to data limitations, RTI was unable to perfectly determine the volume of prior authorizations, time to decision, or approval rates.

authorization patterns for providers who are ongoing, regular users of the tool, the analytic data set included data only for NPIs that had at least three electronic prior authorizations: one to establish the implementation date, one in Months 2 through 5 after implementation, and one in Month 6 or later after implementation.

After RTI received data from each health plan, RTI worked with the health plans and their associated vendor to understand and validate the data as needed. RTI examined the frequency of implausible, duplicate, or missing information. The validation process resulted in a final data set with agreed upon definitions for records to be included in the analysis. After cleaning the data and applying the agreed upon inclusion criteria, there were over 40,000 prior authorization transactions included in the main analysis across all participating plans that provided pre- and post-period data.

### Survey of Provider Organizations

RTI used an email survey campaign to contact providers who work with the participating health plans and who are current users of the vendors’ electronic prior authorization solutions. Some individuals who received the survey were identified as organizational points of contact and asked to forward the survey link to providers or staff involved with the electronic prior authorization process. Thus, this survey reached a convenience sample of respondents. Although the respondents are not necessarily the same providers included in the prior authorization transaction data analysis, they had implemented electronic prior authorization recently and were willing to share their experience via the RTI-administered survey.

The purpose of the survey was to understand respondents’ perceived experience with electronic prior authorization, specifically the transparency of prior authorization requirements and supporting information, the volume of prior authorization–related phone calls and faxes, and time spent on prior authorization-related phone calls and faxes. The survey also asked about perceived patient experience, specifically the impact on timeliness to care and frequency of changing to a less expensive prescription (thereby reducing out-of-pocket costs to the patient). The survey, administered in September and October 2020, asked providers to compare the outcomes of interest (e.g., volume of prior authorization–related phone calls) before and after implementing the electronic prior authorization solution. Appendix A contains the full surveys and response options for both Availity and Surescripts.

RTI received responses to at least 1 survey question from 309 survey respondents. As shown in Exhibit 3, 74% of respondents who provided information about their role in the practice were clinicians (providers or nurses). Of respondents who answered the question about frequency of electronic prior authorization use, 31% used the

**Exhibit 3. Characteristics of Survey Respondents**

| Respondent Characteristic                                                              | Frequency |
|----------------------------------------------------------------------------------------|-----------|
| <b>Role in practice</b>                                                                |           |
| Clinician (Provider or nurse)                                                          | 74%       |
| Other (Medical assistant, authorization specialist, front office staff, or other role) | 26%       |
| <b>Experience with Electronic Prior Authorization</b>                                  |           |
| Uses solution for most patients at the practice                                        | 31%       |
| Uses solution for some or a few patients at the practice                               | 40%       |
| Don't know                                                                             | 29%       |

solution for most patients at their practice. Most survey respondents have used their electronic prior authorization solution for less than a year.

## EVALUATION FINDINGS

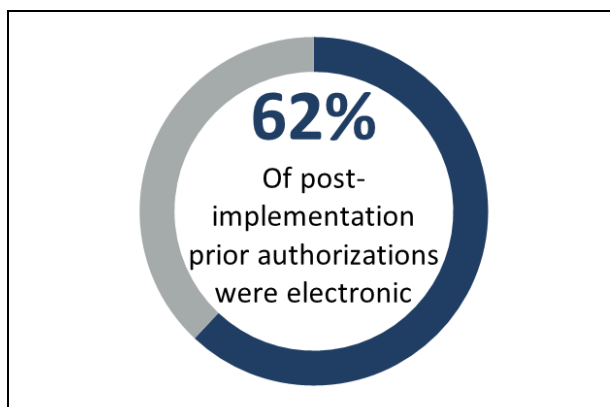
The first part of this section presents results of the prior authorization transaction data analysis addressing research questions on prior authorization volume (question 1.2), approval rates (question 1.1), and time to decision (question 2.1). The second part of this section presents results of the survey of provider organizations where we address research questions about the burden of phone calls and faxes on providers (questions 1.3 and 1.4), whether providers get better information about prior authorization (question 1.5), the impact of provider perception of timeliness of care (question 2.2) and how often providers change to a less expensive prescription (question 2.3).

### *Prior Authorization Transaction Analysis: Volume, Approval Rate, and Time to Decision*

#### *How does volume of prior authorizations change after Fast PATH electronic prior authorization solutions are implemented?*

In the 6 months after implementation of Fast PATH electronic prior authorization solutions, 62% of all prior authorizations were submitted electronically. Providers included in the sample had 48% fewer manual prior authorizations compared to the 6 months prior to implementation but 34% more prior authorizations overall.<sup>8</sup>

**Exhibit 4. Share of Electronic Prior Authorizations After Implementation of Fast PATH Electronic Prior Authorization Solutions**



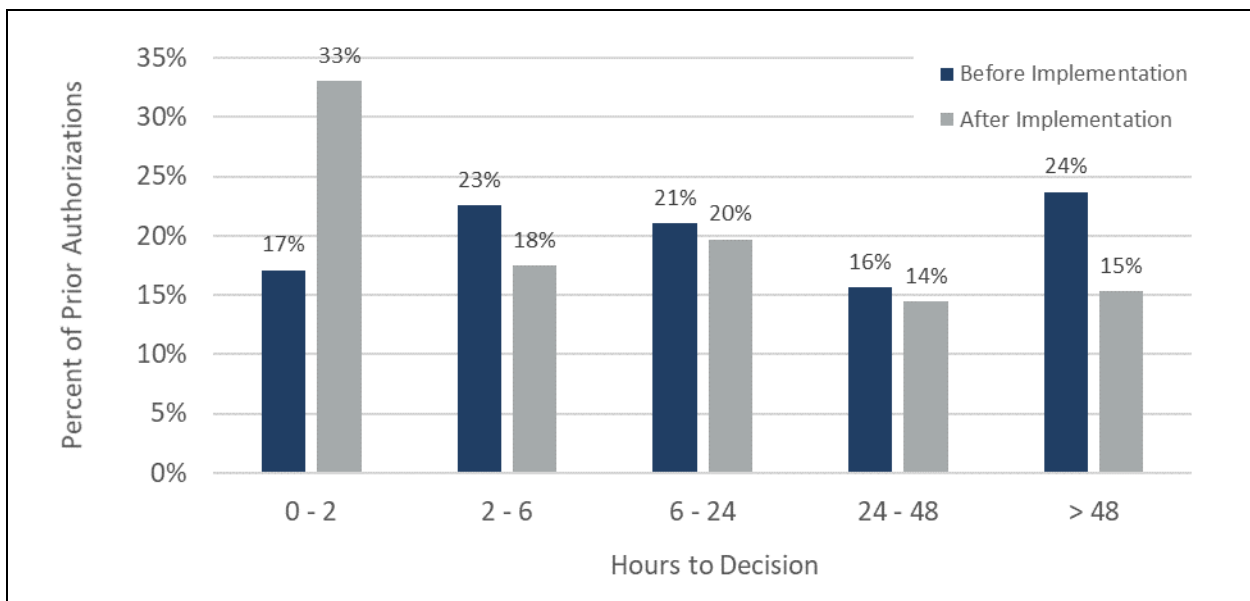
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<sup>8</sup> The overall increase in volume of prior authorizations largely results from assigning the electronic prior authorization implementation date based on when the first electronic prior authorization occurs. The reason this approach would result in an increase in transactions in the post period is because many providers in the sample only have a one prior authorization every several months. Consider a hypothetical example where a provider has one prior authorization every four months. When the provider has their first electronic prior authorization, that date will indicate the start of the post period. If there is a prior authorization every four months, then we will observe two prior authorizations in the 6-month post period, but only one in the 6-month pre-period, which appears as a 50% increase in the number of prior authorizations. Since many providers have infrequent prior authorizations, this can result in higher volume in the post period. In future work, knowing the actual implementation date for each provider would help alleviate this issue. To quantify how much this issue could be affecting volume, we also examined prior authorizations for providers who have at least one prior authorization every month. For this subset of providers, the increase in volume in the post period is only 9% (compared to 34% for the full sample). RTI does not expect bias in approval rates or time to decision related to assigning implementation dates based on the first observed electronic prior authorization.

*How does the time to decision change after Fast PATH electronic prior authorization solutions are implemented?*

RTI analyzed the time to decision for prior authorizations, defined as the time from which the prior authorization was submitted to the PBM or health plan to the time when the provider received the final decision. The median time to decision was more than three times faster after implementation of Fast PATH electronic prior authorization solutions, falling from 18.7 hours in the pre period to 5.7 hours in the post period.<sup>h</sup> As shown in Exhibit 5, 33% of prior authorizations in the post period were decided within 2 hours of submission, which is almost double the share of prior authorizations decided within 2 hours in the pre period (17%). This improvement is partly driven by automatic authorizations or instant approvals, which account for 7% of transactions in the post period. In addition to the dramatic increase in the percentage of prior authorizations that are decided within 2 hours, there is a large decrease in the percentage of prior authorizations that are decided in 48 hours or more.

**Exhibit 5. Time to Decision of Prior Authorizations Before and After Implementation of Fast PATH Electronic Prior Authorization Solutions**



\*Note: Percentages add up to 100% within each category (e.g., Before Implementation or After Implementation), but may deviate slightly due to rounding.

<sup>h</sup> We also analyzed the prior authorization transaction data removing all transactions that occurred on or after March 13, 2020, which is the date on which many elective procedures started to be deferred and when many policies, including prior authorization, were relaxed in recognition of the COVID-19 public health emergency. This analysis is available in the appendix and indicates that the median time to decision in the post period for this smaller sample was 7.1 hours, a 62% improvement relative to the pre period.

### **Additional Insights: Surescripts Analysis**

In addition to the RTI analysis on time to decision, Surescripts conducted a separate analysis on their electronic prior authorization data from calendar year 2020 to provide additional insight related to the time it takes to complete electronic prior authorizations. Surescripts examined inquiries for whether prior authorization was required and found that for instances where prior authorization is not needed, the time from when the prescriber sends the first message to the PBM or payer to when the prescriber or provider staff receives notice from the PBM or payer indicating a prior authorization is not needed is 6 to 7 seconds. This turnaround time for inquiries where prior authorization is not required allows the prescriber to avoid completing a prior authorization form and send the medication to the pharmacy for the member to pick up without delay.

### *How does the approval rate change after Fast PATH electronic prior authorization solutions are implemented?*

The approval rate of prior authorizations is largely unchanged after implementation of Fast PATH electronic prior authorization solutions. Prior to implementation, 59.9% of prior authorizations were fully approved; after implementation, 60.3% of prior authorizations were fully approved. In the post period, the approval rate for manual prior authorizations was similar to that of electronic prior authorizations (60.8% and 60.0%, respectively). The approval rate in this study is specific to the participating providers and payers, more research with a longer time period and sample of providers may lead to additional insights on approval rates.

### **Additional Insights: Data from a Long-Term Availity User**

RTI collected data on electronic prior authorizations from one plan that has used the Availity solution for over 10 years. For this plan, we do not have any pre period data or data on manual prior authorizations. Thus, we present current measures on time to decision and approval rates for electronic prior authorizations. The electronic prior authorization data we received are for prior authorizations in the outpatient setting from 10 providers selected by the plan with the highest prior authorization volume. Although there were limitations and challenges with the data,\* we found that 95% of electronic prior authorizations were adjudicated within 2 hours and the overall approval rate was over 99%. Findings from transactions that occurred before COVID-19 (prior to March 13, 2020) were similar, with 92% of electronic prior authorizations adjudicated within 2 hours and an overall approval rate over 99%. These findings suggest there may be additional benefits of electronic prior authorization solutions over longer time horizons as providers gain experience with the tool and the requirements for prior authorization. Further research is needed to identify drivers of approval rate and time to decision.

\*Note: Although these findings are consistent with the plan's findings on time to decision and approval rates for this setting, sample of providers, and timeframe, the results could be impacted by data issues. RTI observed 978 electronic prior authorizations with complete submission and decision data. However, RTI did not observe a submission for an additional 985 prior authorizations (which could be resulting from the many-to-many relationship between health plan provider identifiers and NPI), and there are 165 prior authorizations for which there was no decision (which could happen when the provider calls the health plan to obtain the decision).



## Survey Results of Provider and Patient Experience

As indicated in the *Data Sources* section, RTI used an email survey campaign to contact providers who work with the participating health plans and who are current users of the vendors' electronic prior authorization solutions. In addition to questions about how electronic prior authorization affected transparency of information, provider burden, and timeliness of care for patients, the survey also asked respondents whether they used electronic prior authorization for most, some, or a few of the patients in their practice. In reviewing the survey data, RTI identified that survey respondents who used electronic prior authorization for most of their patients (approximately one-third of respondents) had more positive experiences with electronic prior authorization than survey respondents who used electronic prior authorization for only some or a few of their patients. These positive experiences included rating electronic prior authorization as reducing the burden of prior authorizations, making it easier to understand the prior authorization process, and reducing time to treatment for patients. Because of the consistently different response patterns for those who used electronic prior authorization for most of their patients (which are referred to as the "experienced" users), the following analysis reports their responses separately from the overall responses. In all analyses, respondents who answered "don't know" or "unknown" from the denominator were excluded, as if they chose to skip the question.

### *Do providers get better information about prior authorization after electronic prior authorization adoption?*

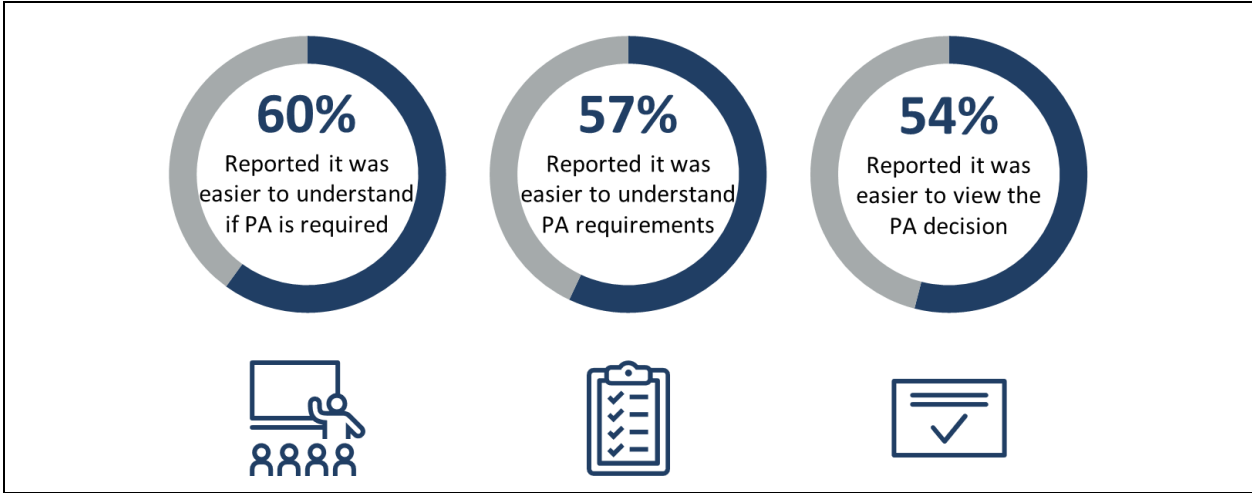
As shown in Exhibit 6, a majority of respondents who used electronic prior authorization for most of their patients said that electronic prior authorization made it easier to understand if prior authorization was required (60%), easier to understand the requirements for prior authorization (57%), and easier to view the prior authorization decision (54%).

"It is helpful to know [if prior authorization is required], therefore I can sometimes change the medication to one that does not need a [prior authorization], if comparable to the original medication, and I can notify the patient upfront that a [prior authorization] is needed for this medication so they are aware sooner."

—Provider using electronic prior authorization for most patients



**Exhibit 6. Information About Prior Authorization for Experienced Users After Implementation of Fast PATH Electronic Prior Authorization Solutions**



\*PA = prior authorization

Among all respondents, the most common response was that it was easier to understand if a prior authorization was required compared to before having electronic prior authorization (47% said easier, 43% said the same). If a prior authorization was required, 33% said it was easier to understand what the requirements for prior authorization were (53% said the same), and 38% said it was easier to view a prior authorization decision (48% said it was the same).

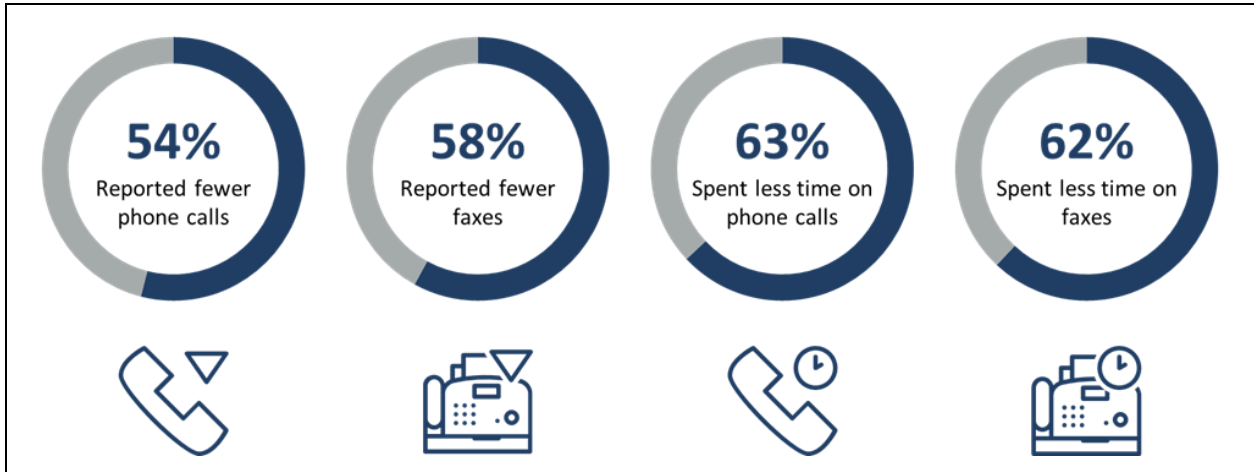
*Do providers face a lower burden of phone calls and faxes after electronic prior authorization adoption?*

A majority of respondents who used electronic prior authorization for most of their patients reported spending less time on phone calls and faxes after adopting electronic prior authorization, as shown in Exhibit 7. This largely correlated with reporting handling a lower volume of phone calls and faxes.

“I prefer automated prior authorizations far more than faxes or phone calls.”  
—Nurse using electronic prior authorization for most patients

“Definitely is now more efficient.”  
—Provider using electronic prior authorization for most patients

**Exhibit 7. Usage of Phone Calls and Faxes for Experienced Users After Implementation of Fast PATH Electronic Prior Authorization Solutions**



Of all survey respondents, 34% reported fewer phone calls, 38% reported fewer faxes, 42% reported less time spent on phone calls, and 41% reported less time spent on faxes. Across these same metrics, 47% to 54% of all survey respondents noted there was no change in the volume of phone calls or faxes or in time spent on phone calls or faxes after implementing the electronic prior authorization solution.

*What impact does electronic prior authorization have on patients’ experience of care?*

As shown in Exhibit 8, for respondents using electronic prior authorization for most of their patients, 71% said that care was faster than before, and 27% said it was the same.

“We get answers back quickly and typically we have answer before they leave the office. Before it was lengthy phone calls to the insurance or waiting for a fax form with slow turn-around times.”  
—Medical assistant using electronic prior authorization for most patients

“It’s a big improvement and allows for improved patient care.”  
—Provider using electronic prior authorization for most patients

“Information is quickly received and handled, so patients wait time is reduced.”  
—Administrative assistant using electronic prior authorization for a few patients

**Exhibit 8. Impact on Timeliness to Care for Experienced Users After Implementation of Fast PATH Electronic Prior Authorization Solutions**



Of all respondents, 43% said that the timeliness to care was faster than before electronic prior authorization, and 49% said it was the same.

**Additional Insights: Surescripts Real-Time Prescription Benefit Solution**

The Surescripts Real-Time Prescription Benefit solution complements its Electronic Prior Authorization solution by making available patient-specific benefit information at the point of prescribing. This solution has the potential to impact patient care by helping patients understand the cost of chosen medications prior to arriving at a pharmacy and giving providers the opportunity to discuss costs and alternatives with patients before prescribing medications.

Of all survey respondents with access to the Surescripts Real-Time Prescription Benefit solution, 35% reported always, often, or sometimes viewing the real-time pricing data. Of those who reported viewing the data, 60% always, often, or sometimes communicated pricing information to patients, and 53% always, often, or sometimes changed the prescription to a lower-cost alternative.

## DISCUSSION AND CONCLUSION

**The analysis of prior authorization transaction data reveals that reduced time to decision is one significant benefit of electronic prior authorization.** As shown in Exhibit 9, in the 6-month period after Fast PATH electronic prior authorization solutions were implemented, the median time was three times faster compared to the 6-month period prior to implementation. In that 6-month post period, 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 AMA survey, which reported that 5% of prior authorizations were decided in under 1 hour and 11% were decided within “a few hours.” Further, the finding from the prior authorization transaction data analysis is consistent with the finding from the survey that 71% of providers using these solutions for most of their patients reported faster time to care.

**Survey responses indicate that the majority of providers using these solutions for most of their patients experience a reduced burden from the prior authorization process.** The majority of providers using electronic solutions for most of their patients indicated that it was easier to understand if a prior authorization was required, easier to understand the requirements for submitting a prior authorization, and easier to view the decision. Most experienced providers also reported fewer phone calls and faxes and less time spent on phone calls and faxes related to prior authorization.

**After implementation of Fast PATH electronic prior authorization solutions, providers used these tools for roughly 62% of prior authorizations in the 6 months after implementation.** The large magnitude of this uptake suggests that for regular users of prior authorization who are in the prior authorization transaction data analysis sample, adoption was largely successful. However, some challenges may remain since providers are still using manual prior authorizations 38% of the time for patients who are insured by plans for which electronic options are available. This finding from the prior authorization transaction data analysis is validated by survey findings. Some comments collected from survey respondents suggested that there are providers who do not see much benefit from the electronic prior authorization solutions. These respondents report having to call or fax the health plan even with these tools in place due to issues with getting the prior authorization completed through the electronic solution.

**Approval rates were not impacted by electronic prior authorization.** Approval rates were not impacted by electronic prior authorization compared with manual processes. This finding indicates that although electronic processes may lead to shorter times to a decision, the decisions did not change with electronic prior authorization in place because the rules pertaining to prior authorization did not change.

**Given that the benefits of electronic prior authorization solutions are greatest when providers use these solutions for most of their patients, further gains could be realized by increasing provider adoption.** The survey findings across all respondents showed that there was a smaller reduction in provider burden for those who used electronic prior authorization for some or a few of their patients compared to those who used it for most of their patients. There are at least two complementary paths for increasing provider adoption and thus achieving greater benefits of electronic prior authorization. One path is to increase use of the tools by providers in situations where the tools are already available for the patient (e.g., identify and address the issues that cause providers to use manual processes even when the electronic tool is in place for a patient). Reviewing how well the tools are integrated into the clinical workflow and identifying hurdles to utilization could help determine if more provider training is needed, if practices need better workflow integration, or if there are issues with the electronic prior authorization tools themselves that could be addressed. The second path is to increase the proportion of patients for whom electronic prior authorization is available by increasing participation among health plans and PBMs in electronic prior authorization solutions. If adoption among both providers and payers could be increased, the median time to decision and overall provider burden for prior authorization could be further reduced. The policy implication for those working to improve the process is to consider

both pathways to improve provider adoption of these tools and thus get necessary treatments to patients in a timely manner.

**Exhibit 9. Summary of Research Questions and Principal Findings**

|                     | Research Question                                                                                                                                                    | Principal Finding                                                                                                                                                                                                                                                                                            |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Provider Experience | 1.1. What is the impact of automating aspects of prior authorization on the proportion of prior authorizations that are approved?                                    | The same proportion of prior authorizations were approved before and after implementation of electronic prior authorization solutions, and approval rates of electronic and manual prior authorizations in the post period were similar (all rates near 60%).                                                |
|                     | 1.2. What is the impact of automating aspects of prior authorization on the volume of prior authorization transactions?                                              | After implementation of electronic prior authorization solutions, 62% of transactions were electronic.                                                                                                                                                                                                       |
|                     | 1.3. What is the impact of automating aspects of prior authorization on the volume of prior authorization-related phone calls and faxes?                             | For more experienced users, most reported fewer phone calls (54%) and faxes (58%) after implementation of electronic prior authorization solutions. Across all users, most reported that the number of phone calls and faxes did not change.                                                                 |
|                     | 1.4. What is the impact of automating aspects of prior authorization on the time spent on prior authorization-related phone calls and faxes?                         | For more experienced users, most reported less time spent on phone calls (62%) and faxes (63%) after implementation of electronic prior authorization solutions. Across all users, most reported that time spent on phone calls and faxes did not change.                                                    |
|                     | 1.5. What is the impact of automating aspects of prior authorization on the availability of prior authorization-related requirements and supporting information?     | For more experienced users, most said that electronic prior authorization made it easier to understand if prior authorization was required (60%), easier to understand the requirements for prior authorization (57%), and easier to view the prior authorization decision (54%).                            |
| Patient Experience  | 2.1. What is the impact of automating aspects of prior authorization on the time it takes between submitting a prior authorization request and receiving a decision? | The median time to decision was three times faster after implementation of electronic prior authorization solutions, falling from 18.7 hours in the pre period to 5.7 hours in the post period.                                                                                                              |
|                     | 2.2. What is the impact of automating aspects of prior authorization on the perceived timeliness of recommended care?                                                | For more experienced users, 71% said that timeliness of care was faster than before, 27% said it was the same. Across all users, 43% said timeliness of care was faster and 49% said it was the same.                                                                                                        |
|                     | 2.3. How often do providers change the prescription to one that is less expensive for the patient?                                                                   | Of all survey respondents with access to the Surescripts Real-Time Prescription Benefit solution, 35% reported always, often, or sometimes viewing the real-time pricing data. Of those who reported viewing the data, 53% always, often, or sometimes changed the prescription to a lower-cost alternative. |

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## APPENDIX

### *Results Using only Prior Authorization Transaction Data Prior to COVID-19*

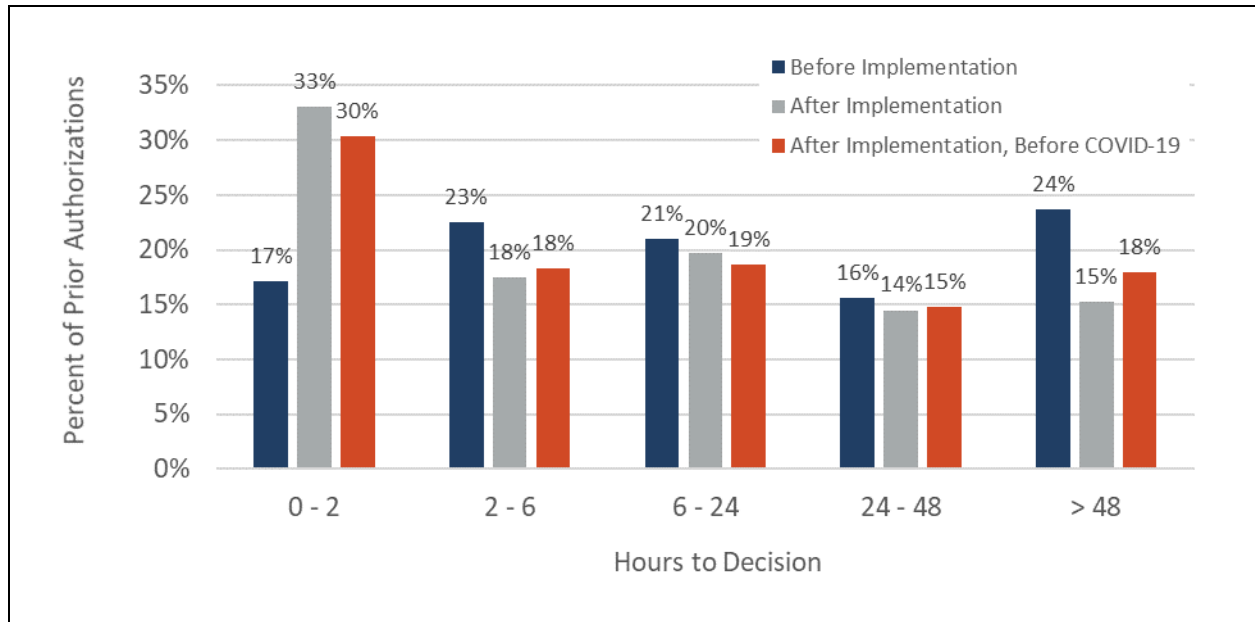
RTI received prior authorization transaction data from health plans for providers who implemented the Fast PATH solutions between September 2017 and March 2020. Because some providers implemented these solutions late enough such that their 6-month post period extended into the time when COVID-19 severely impacted health care utilization, we have also examined our data and results excluding any prior authorizations that were either submitted or decided on or after March 13, 2020, which is the date on which many elective procedures started to be deferred and when many policies, including prior authorization, were relaxed in recognition of the COVID-19 public health emergency.

Of the 23,849 prior authorizations in the post period, 4,880 occurred on or after March 13, 2020, leaving 18,969 prior authorizations in the post period that occurred before major COVID-19 impacts. Of these 18,969 prior authorizations, 58% were electronic, similar to the 62% of the full sample that were electronic. Using only this smaller sample of post-period prior authorizations, the overall approval rate is 59.3%, which is consistent with the 60.3% approval rate for the full post-period sample.

The median time to decision in the post period for the 18,969 transaction that occurred prior to COVID-19 was 7.2 hours. This result is 1.5 hours higher than the 5.7-hour median for the full sample but is still a 62% improvement relative to the 18.7-hour median from the pre period. The frequency of time to decision in Exhibit A-1 shows that there is still a dramatic shift toward prior authorizations that are decided within 2 hours of being submitted (30% of prior authorizations, compared to 17% in the pre period) and a reduction in the percentage of prior authorizations that are decided in more than 48 hours (18% of prior authorizations, compared to 24% in the pre period).



**Exhibit A-1. Time to Decision of Pre-COVID-19 Prior Authorizations Before and After Implementation of Fast PATH Electronic Prior Authorization Solutions**



\*Note: Percentages add up to 100% within each category (e.g., Before Implementation, After Implementation, or After Implementation, Before COVID-19), but may deviate slightly due to rounding.

### Surescripts Survey

The survey administered to provider organizations using the Surescripts solution is given below. The number of respondents, including those who responded “Don’t know,” is given in parenthesis after each question and before the answer choices.

**On this page, please tell us about how you have used a price transparency solution within your EHR/EMR in the past week.**

**For this section of the survey, please focus your responses on the solutions within your EHR/EMR that provide the following price transparency capabilities:**

- **Visibility into the patient’s benefit plan and allows you to see what the patient will pay at the pharmacy counter for their medication**
- **Therapeutic alternatives for the medications being prescribed**
- **Prior authorization and coverage requirements.**

1a. In the past week, how often did you view the price or benefit information using the solution described above, when prescribing a medication? (N=282)

- Always or often
- Sometimes
- Rarely
- Never

- Don't know

1b. In the past week, how often did you communicate to your patient information on prescription costs, using information you received as a part of the price transparency solution? (N=125)

- Always or often
- Sometimes
- Rarely
- Never
- Don't know

1c. In the past week, how often did you change to a lower cost alternative when viewing pricing information? (N=127)

- Always or often
- Sometimes
- Rarely
- Never
- Don't know

**For this section of the survey, please focus your responses on the solution within your EHR/EMR that enables you to initiate and/or complete prescription prior authorizations in real-time within your EHR/EMR workflow. Please choose the response that best describes your experience now, as compared to your experience before you had a prior authorization solution in your EHR/EMR.**

2a. I am notified that a prior authorization is required for a specific patient's prescription in my EHR/EMR during the e-Prescribing process. (N=216)

- Most of the time
- Some of the time
- Rarely
- Don't know

2b. Think back to before you received prior authorization required notifications in your EHR/EMR. How were you typically notified that a prior authorization was required? (N=220)

- Receiving call or fax from other health care provider
- Receiving call or fax from patient
- Calling or faxing the health plan or PBM myself
- Other/don't know

2c. Now, the information I can get about whether a prior authorization for a procedure is required is: (N=221)

- Easier to understand than before having prior authorization in my EHR/EMR
- The same as before
- More difficult to understand than before having prior authorization in my EHR/EMR
- Don't know

2d. Now, once I know a prior authorization is required, the prior authorization requirements are: (N=219)

- Easier to understand than before having prior authorization in my EHR/EMR
- The same as before
- More difficult to understand than before having prior authorization in my EHR/EMR
- Don't know

2e. Now, I am able to view the decision made about a prior authorization: (N=219)

- More easily because I have a solution in my EHR/EMR
- The same as before
- With more difficulty than before having prior authorization in my EHR/EMR
- Don't know

**On this page, please tell us about your experience with prior authorization-related phone calls and faxes with health plans. Please choose the response that best describes your experience now, as compared to your experience before you could initiate and/or complete prior authorization requests for prescriptions in real-time within your EHR/EMR workflow.**

3a. The number of prior authorization-related phone calls I handle today is: (N=201)

- Fewer than before I had a prior authorization solution in my EHR/EMR
- The same as before
- More than before having prior authorization in my EHR/EMR
- Don't know

3b. The number of prior authorization-related faxes I handle today is: (N=200)

- Fewer than before I had a prior authorization solution in my EHR/EMR
- The same as before
- More than before having prior authorization in my EHR/EMR
- Don't know

3c. The time I spend on prior authorization-related phone calls today is: (N=200)

- Less than before I had a prior authorization solution in my EHR/EMR
- The same as before
- More than before having prior authorization in my EHR/EMR
- Don't know

3d. The time I spend on prior authorization-related faxes today is: (N=198)

- Less than before I had a prior authorization solution in my EHR/EMR
- The same as before
- More than before having prior authorization in my EHR/EMR
- Don't know

**On this page, please tell us about your patients' experience, as compared to their experience before you could initiate and/or complete prior authorization requests for prescriptions in real-time within your EHR/EMR workflow.**

4. Now that a prior authorization solution is embedded in my EHR/EMR, my patient's speed to fill is:  
(N=196)

- Faster as compared to before I had a prior authorization solution in my EHR/EMR
- The same as before automated prior authorization
- Slower than before having prior authorization in my EHR/EMR
- Don't know

5. In a few words, what else would you like to tell us about your experience with the prior authorization solution in your EHR/EMR, as compared to your experience before this solution was available to you?  
(N=114)

**Please tell us more about yourself.**

6a. My role in this practice is: (N=189)

- Provider (prescribing the medication)
- Nurse
- Medical assistant
- Front office staff
- Other (please specify)

6b. I have been using a prior authorization solution in my EHR/EMR for a time period of: (N=189)

- Less than 6 months
- 6 to 12 months
- More than 1 year
- Don't know

6c. Now, I use a prior authorization solution in my EHR/EMR for: (N=189)

- Most patients at the practice
- Some patients at the practice
- A few patients at the practice
- Don't know

6d. The number of prior authorizations I initiated in a **month** is: (N=189)

- 3 or fewer (less than one/week)
- 4 – 10 (about two/week)
- 11 or more (about 3 or more/week)
- Don't know

**Thank you for participating! The results of this research will help inform policy. We appreciate your contributions.**

### *Availity Survey*

The survey administered to provider organizations using the Availity solution is given below. The number of respondents, including those who responded “Don't know,” is given in parenthesis after each question and before the answer choices. The number of respondents is lower for Availity compared to Surescripts which is largely expected due to the more centralized handling of prior authorizations for users of the Availity tool who are submitting requests for medical procedures.

**On this page, please tell us about your experience finding the information you need about a prior authorization request.**

**Please choose the response that best describes your experience now, as compared to your experience before automated prior authorization was available to you.**

1a. Using an automated prior authorization solution, I can find out about whether prior authorization is required for procedures for a specific patient *before* entering clinical information: (N=25)

- Most of the time
- Some of the time
- Rarely
- Don't know

1b. Think back to before you used an automated prior authorization solution. How were you typically notified that a prior authorization was required for a procedure? (N=25)

- Receiving call or fax from other health care provider
- Receiving call or fax from patient
- Calling or faxing the health plan myself
- Other/don't know

1c. Now, the information I can get about whether a prior authorization for a procedure is required is: (N=25)

- Easier to understand than before automated prior authorization
- The same as before automated prior authorization
- Harder to understand than before automated prior authorization
- Don't know

1d. Now, once I know a prior authorization is required, the prior authorization requirements are: (N=25)

- Easier to understand than before automated prior authorization
- The same as before
- More difficult to understand than before automated prior authorization
- Don't know

1e. Now, I am able to view the decision made about a prior authorization: (N = 25)

- More easily than before automated prior authorization
- The same as before
- With more difficulty than before automated prior authorization
- Don't know / not applicable

**On this page, please tell us about your experience with prior authorization-related phone calls and faxes with health plans. Please choose the response that best describes your experience now, as compared to your experience before an automated prior authorization solution for procedures was available to you.**

2a. The number of prior authorization-related phone calls I handle today is: (N=24)

- Fewer than before automated prior authorization
- The same as before automated prior authorization
- More than before automated prior authorization
- Don't know

2b. The number of prior authorization-related faxes I handle today is: (N=24)

- Fewer than before automated prior authorization
- The same as before automated prior authorization
- More than before automated prior authorization
- Don't know

2c. The time I spend on prior authorization-related phone calls today is: (N=24)

- Less than before automated prior authorization
- The same as before automated prior authorization
- More than before automated prior authorization
- Don't know

2d. The time I spend on prior authorization-related faxes today is: (N=24)

- Less than before automated prior authorization
- The same as before automated prior authorization
- More than before automated prior authorization
- Don't know

**On this page, please tell us about your patients' experience, as compared to their experience before automated prior authorization was available to you.**

3. With automated prior authorization, timeliness to care for ordered procedure is: (N=24)

- Improved as compared to before automated prior authorization
- The same as before automated prior authorization
- More delayed as compared to before automated prior authorization
- Don't know

4. In a few words, what else would you like to tell us about your experience with the automated prior authorization solution, as compared to your experience before the automated prior authorization solution was available to you? (N=15)

**Please tell us more about yourself.**

5a. My role in this practice is: (N=23)

- Provider
- Nurse
- Medical assistant
- Front office staff
- Other (please specify)

5b. I have been using an automated prior authorization solution for procedures for a time period of: (N=23)

- Less than 6 months
- 6 to 12 months
- More than 1 year
- Don't know

5c. Now, I use an automated prior authorization solution for procedures for: (N=23)

- Most patients at the practice
- Some patients at the practice
- A few patients at the practice
- Don't know

5d. The number of prior authorizations I initiate in a **month** is: (N=23)

- 3 or fewer (less than one/week)
- 4 – 10 (about two/week)
- 11 or more (about 3 or more/week)
- Don't know

**Thank you for participating! The results of this research will help inform policy. We appreciate your contributions.**