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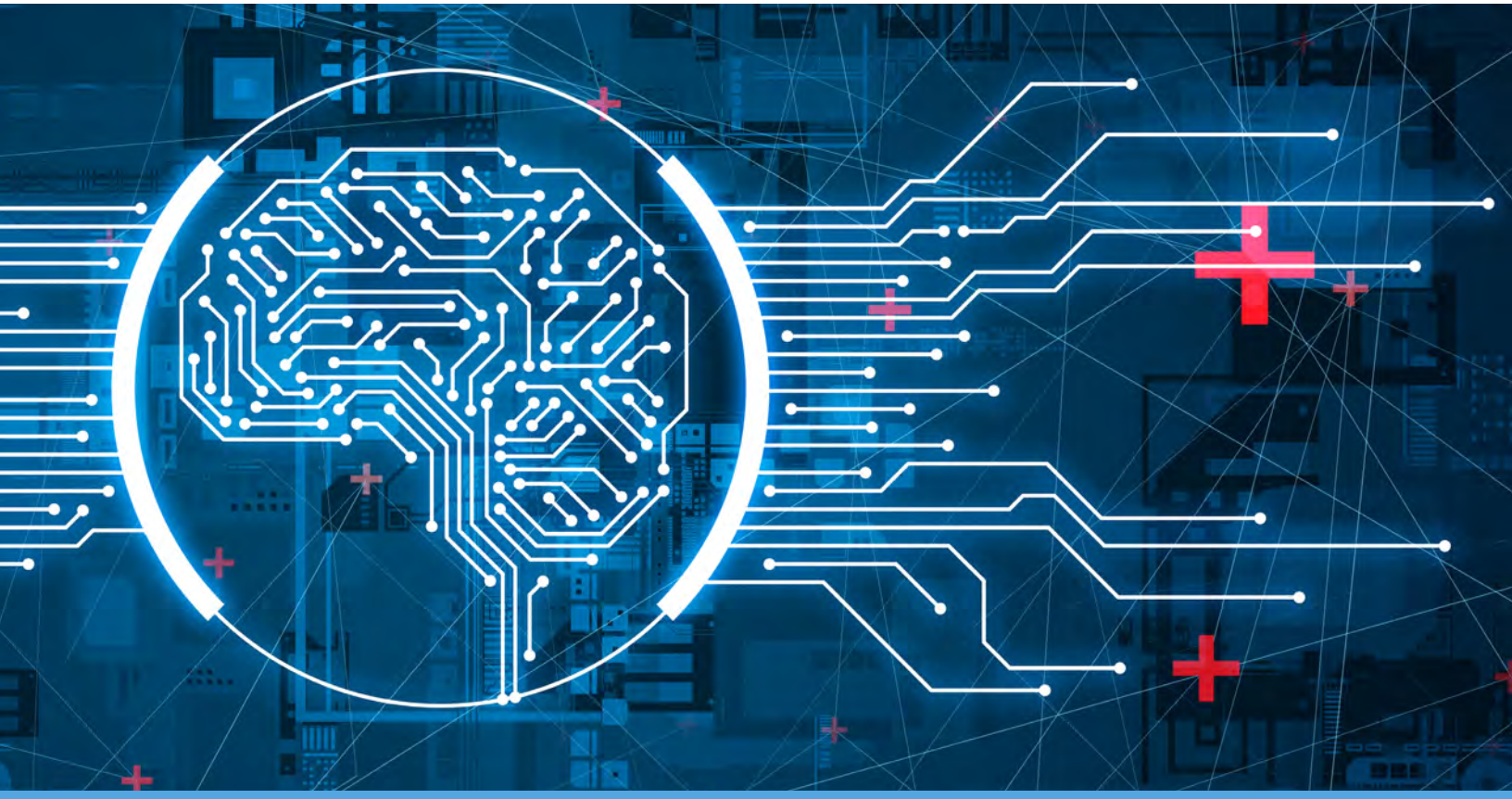


WHITE PAPER

Solving the Prior Authorization Problem With AI

This white paper is designed to provide payers with information and guidance on how automating the prior authorization process can lower administrative burden and operational costs while enabling the delivery of faster, more efficient care.

www.apixio.com

Contents

The Prior Authorization Problem

Knowing where to start.

Prior authorization is a necessity in modern healthcare. It's a complex process by which payers determine the appropriateness of procedures, prescriptions, and referrals. The goal is to not only control costs by preventing unnecessary or duplicate service but also to ensure treatments are safe, effective, and appropriate.

However, the current process is a significant drain on an already strained healthcare system. It's time-consuming and cumbersome and can delay treatments—or worse, be an obstacle to care. In fact, physicians have cited prior authorization as being responsible for poor clinical outcomes as a result of delayed, deferred, or abandoned care; that is, patients get tired of waiting and give up. The entire ecosystem—patients, providers, and payers—pay the price, literally, in higher costs and delayed care.

Prior authorization offers a significant opportunity for process improvement to reduce costs and inefficiencies. Of the many proposals and potential solutions, most focus on the entry point and submission of the requests, including movement from paper-based to digital submissions.

However, improving the submission process doesn't change the complexity of rendering a decision and the many unknowns that often delay decisions. To improve the response time and reduce the need for manual clinical review, Artificial Intelligence (AI) and machine learning have the greatest potential to optimize prior authorization decision making and improve the experience for physicians and patients.

Understanding the Big Picture

The prior authorization process needs an update.

In a nation that spends far more on healthcare than any other developed country, administrative costs account for one-fourth to one-third of total spending. A 2019 McKinsey report found that $950 billion of total healthcare spending was purely administrative, representing 25% of total healthcare spend. (McKinsey & Company *Administrative simplification: How to save a quarter-trillion dollars in US healthcare*)

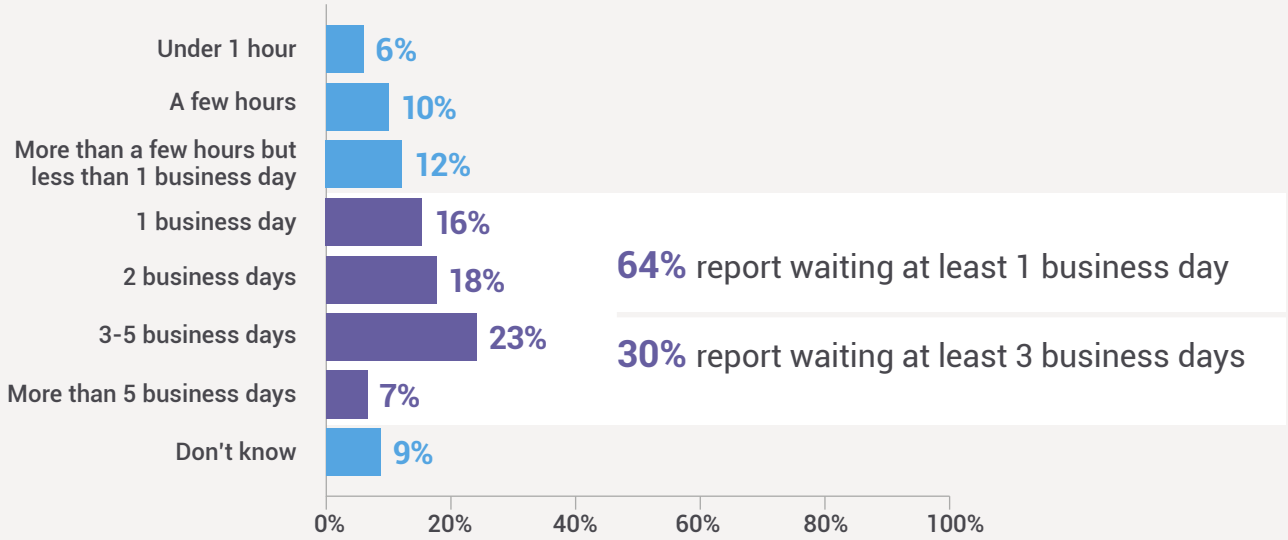
According to the latest CAQH Index, prior authorization is one of the highest costs for the healthcare industry—totaling $437 million a year. Many of the costs for prior authorization requests are unnecessary, driven by inefficiencies and a sub-optimal decision process. Payers pass these costs onto businesses and consumers in the form of higher premiums, inflating the cost of coverage for many Americans.

For providers and care delivery organizations, prior authorization represents a necessary but burdensome challenge that can take days to weeks for final decisions, with multiple cycles of requests for additional information. The cumbersome prior authorization process can also delay necessary and life-saving treatments by creating an obstacle to needed care. According to one AMA survey, 92% of physicians said prior authorization has a negative impact on patient outcomes, and 92% said it delays the delivery of necessary care. Three out of four physicians also admitted that it can sometimes lead to treatment abandonment.

The need to re-engineer the prior authorization process has never been more urgent as the global pandemic has highlighted the need for a more streamlined process to reduce the strain on an already exhausted workforce.

AVERAGE WAIT TIME FOR PA RESPONSES

Q: In the last week, how long on average did you and your staff **need to wait** for a prior authporization (PA) decision from health plans?



Total does not equal 100% due to rounding.

Digging Deeper into the Problem

Longstanding barriers for an improved prior authorization process.

While payers and providers are eager to improve the prior authorization process, there have historically been three significant barriers:

1 The lack of standardized criteria for submitting prior authorization requests across payers.

Every payer has different requirements that sometimes vary, even within the payer's system, based on geography, provider group, or other factors. That means for each submission; providers have to figure out the process each time—essentially reinventing the wheel. Without a standard protocol, prior authorization will remain a manual, labor-intensive process.

Coverage guidelines are often inconsistent and vary by payer, making it impossible to leverage one payer's criteria with another's prior authorization process—in some instances, there isn't even consistency within a single-payer organization as its call center, website, and portal provide different guidance. (TripleTree)

2 The lack of consistent data needs.

Providers submit prior authorization requests for a variety of services ranging from prescriptions to surgeries. Because these requirements differ based on the request and (sometimes within) the health plan, it can be difficult to identify which submissions require which information. This lack of uniformity has resulted in medical practices reporting that they spend an average of 14.6 hours per week completing prior authorization requests manually, sometimes waiting weeks for a decision.[1]

3 There is no integration between clinical and administrative systems.

In order to complete the prior authorization request, medical practices must currently access data from electronic health record systems (EHRs) and manually enter this data into the systems supporting prior authorization submissions, which, if not accurately captured, creates abrasion for the health plan.

These obstacles, along with a general resistance to change, have kept the industry from improving the end-to-end flow of prior auth submissions as well as optimizing decision support. But new alternatives are emerging that will help address the current prior authorization challenges and enable more complete automation of decisions at scale.

1 Link

How Apixio Aims to Solve the Problem

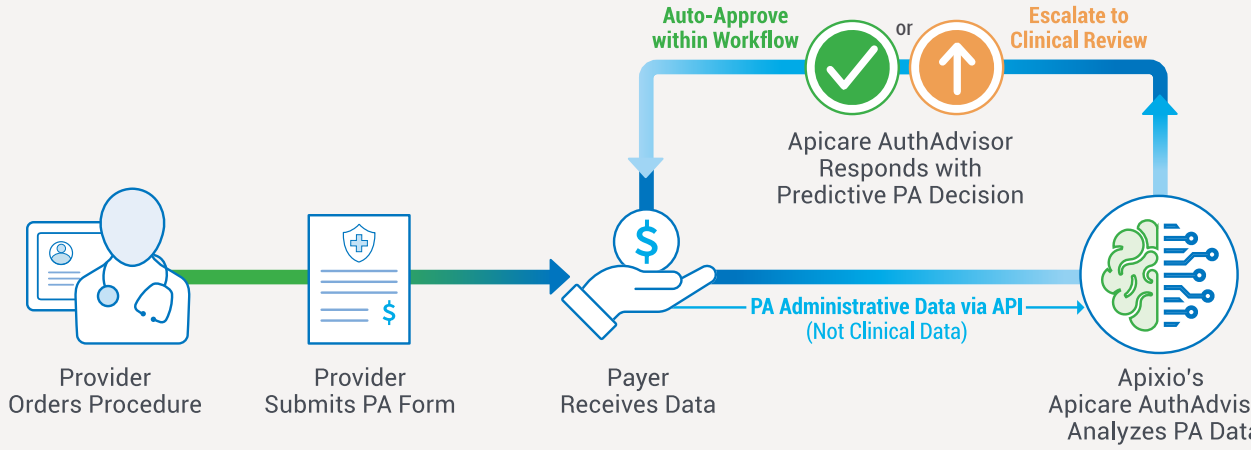
Introducing Apicare AuthAdvisor.

As the innovation leader in AI-driven healthcare analytics, Apixio is tackling the prior authorization problem head-on, developing a solution that optimizes prior authorization decisions, which reduces the cost and inefficiency present in the current prior authorization process. In doing so, Apixio's Apicare AuthAdvisor is able to:

1. Leverage historical data and decisions for predictive prior authorization decisions
2. Enable user-enabled controls to fine-tune data science models on a procedure-by-procedure basis
3. Use machine learning to automate decision requests within the desired workflow using APIs
4. Reduce the amount of data that utilization management teams currently need when submitting their prior authorization requests
5. Optimize the decision process, enabling utilization management teams to spend less time on reviewing the requests and reducing administrative burdens associated with current request process

Finally, by integrating the prior authorization solution at the point of care within the payer workflow, Apixio's solution aims to provide real-time submission with approvals in as little as a few seconds. The result will be better, more efficient, and more affordable care.

HOW IT WORKS:



AI is the Future of Prior Authorization

A new process for improved results.

AI HAS THE PROVEN POTENTIAL to transform the prior authorization process, dramatically reduce the administrative burden and cost, and improve patient outcomes.

By integrating prior authorization submissions into the point of care workflow, we can reduce providers' administrative workload and accelerate patient treatment time, potentially eliminating delays and abandonment. The result is better, more efficient care delivery, a better experience for patients, providers, and payers, all at a much lower cost.

Apixio's Best In KLAS Solutions

Apixio's Best in KLAS risk adjustment and quality solutions are built on patented AI technology that extracts targeted information from patient charts, claims, labs, EMRs, and supports Value-Based Care initiatives.

RISK ADJUSTMENT SOLUTIONS

Unmatched efficiency and accuracy in developing a complete picture of each patient's risk profile to improve clinical, operational, and financial outcomes.

- HCC IDENTIFIER
- HCC AUDITOR
- HCC COMPLETE

INTEROPERABILITY SOLUTIONS

Harnessing data at scale provides risk and clinical insights to support personalized care decisions.

- INFOSTREAM™

CLINICAL GUIDANCE SOLUTIONS

Driving meaningful patient-provider interactions with actionable insights at the point-of-care.

- APICARE PRE-VISIT
- APICARE INSIGHTS

UTILIZATION MANAGEMENT SOLUTIONS

Reduce administrative overhead and improve clinical decision-making.

- APICARE AUTHADVISOR

QUALITY SOLUTIONS

Generating insights focused on closing gaps in care and supporting individuals in the journey to better health.

- QUALITY IDENTIFIER

Apixio's AI-powered solution can deliver reliable predictive decisions, enabling the patient care continuum to be more efficient and effective.

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