HIPAA Administrative Simplification Opportunities (and Challenges) for Physician Practices

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Medical Group Management Association

Advancing Leaders. Advancing Practices.™

About MGMA

- MGMA is the premier association for professional administrators and leaders of medical group practices
- Since 1926, the association has delivered networking, professional education and resources, political advocacy and certification for medical practice professionals
- MGMA represents more than 33,000 medical practice administrators and executives in practices of all sizes, types, structures and specialties, which represent more than 275,000 physicians and more than 46 percent of the healthcare delivered in the nation.

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Todays Agenda

- Prior Authorization: challenges and opportunities
  - Current environment/ CAQH Index/ AMA Survey
  - Electronic Standards
  - Industry efforts to improve
- What's on the horizon
  - Patient relationship codes
  - SSNRI
  - UDI
  - Admin simp standards
- Q/A

Dec. 25, 2016 Edition of *Medical Economics*

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Prior Auth: Current Environment

- Physician often not aware that prescribed drug/service requires PA
- HP criteria not residing within EHR or visible to physician
- Every HP has its own format, criteria and forms
- Little automation for the PA process
- The X12 278 standard is difficult and frustrating for all stakeholders to use, often confusing for providers to interpret
- Paper forms and portals require manual reentry of data that may already reside electronically within an EHR
- HPs often respond to a 278 with “call us”
- When supporting clinical documentation required, no standard

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PA and Patients

- PA process in general slows treatment, adds frustration for patients and providers
- Prescription abandonment and nonadherence
  - 40% of prescriptions with initial claims denied due to PA requirements are never filled[1]
  - PA associated with increased medication discontinuation and subsequent reduction in outpatient mental health visits in patients with bipolar disorder[2]
- Delayed care
  - 86% of physicians report that PA interrupts patient care[3]

1. Hanson KA et al. *J Manag Care Pharm*. 2009;15:573-574. 2. Lu CY et al. *Psychiatr Serv*. 2001;62:186-193.
3. MedChi. Prior Authorization Protocols: Impact on Patient Care in Maryland. July 20, 2011.

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Recent AMA Survey

- Conducted in Dec. 2016:1000 physician respondents
- The average of 37 weekly prior authorizations per physician takes the equivalent of **approximately two business days** of physician/staff time to process (16 hours)
- **75%** of surveyed physicians described prior authorization burdens as high or extremely high
- **Over 1/3** of surveyed physicians reported having staff who work exclusively on prior authorization

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Impact on Patients

- **Nearly 60%** of surveyed physicians reported that their practices wait, on average, at least 1 business day for prior authorization decisions—and **over 25%** of physicians said they wait 3 business days or longer
- **90%** of surveyed physicians reported that prior authorization sometimes, often, or always delays access to care

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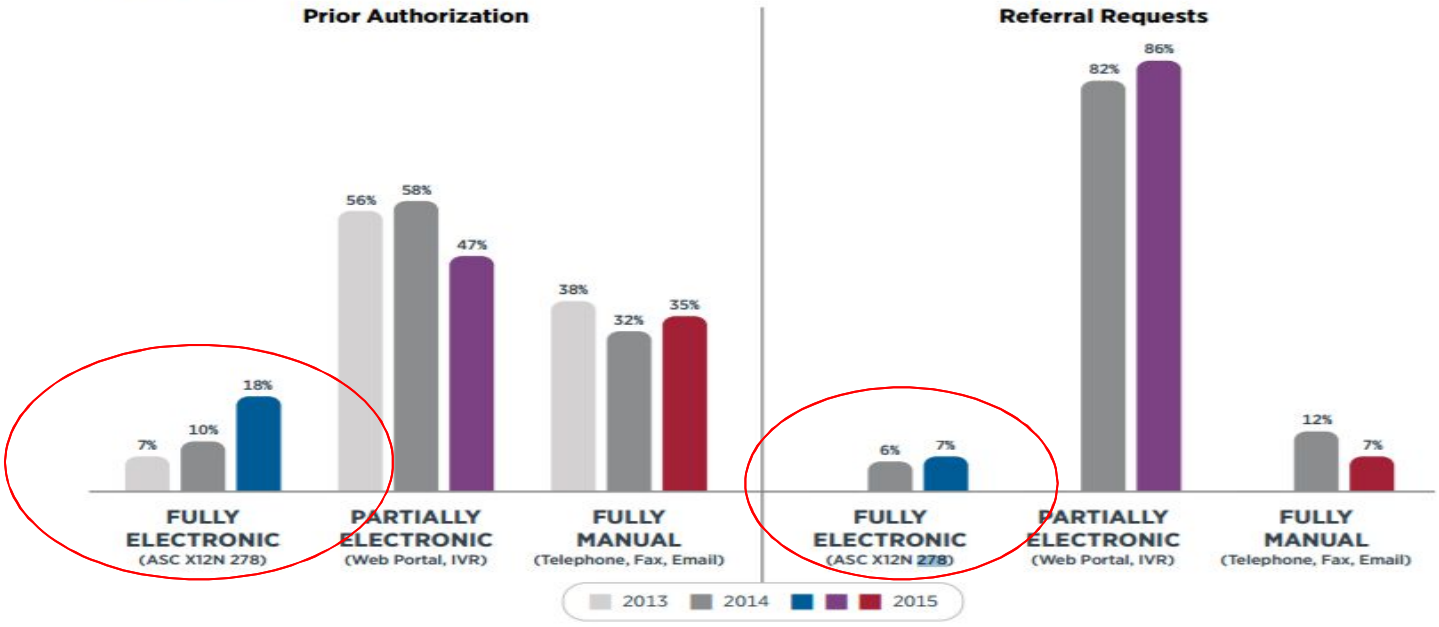
2016 CAQH Index™

Prior Authorization & Referrals

Health plan web portals remain the predominant method for submission and approval of prior authorizations (46 percent) and referrals (86 percent), though a significant increase in fully electronic prior authorizations occurred during 2015.

FIGURE 9:
Adoption of Electronic Prior Authorization and Referral Requests for Commercial Medical Health Plans and Providers



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Electronic PA: Potential Savings of 278 eTransaction

- According to the *2016 CAQH Index™ Electronic Administrative Transaction Adoption and Savings Calendar Year 2015:*
  - Cost per manual PA: $3.68 for payers / $7.50 for providers
  - Cost per electronic 278: $.04 for payers / $1.89 for providers
  - Overall industry cost: Manual ($11.18) vs. Electronic ($1.93)

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Barriers to ASC X12 278 Adoption

- Lack of end-to-end PA automation drives providers to manual processes (phone calls, fax, or portal)
- Internal HP workflows require manual processes and limit real-time PA capabilities
- Limited vendor support for ASC X12 278, especially for implementations that integrate with provider EHRs
- Lack of a standard for electronic clinical attachments; most PAs require supporting documentation for approval

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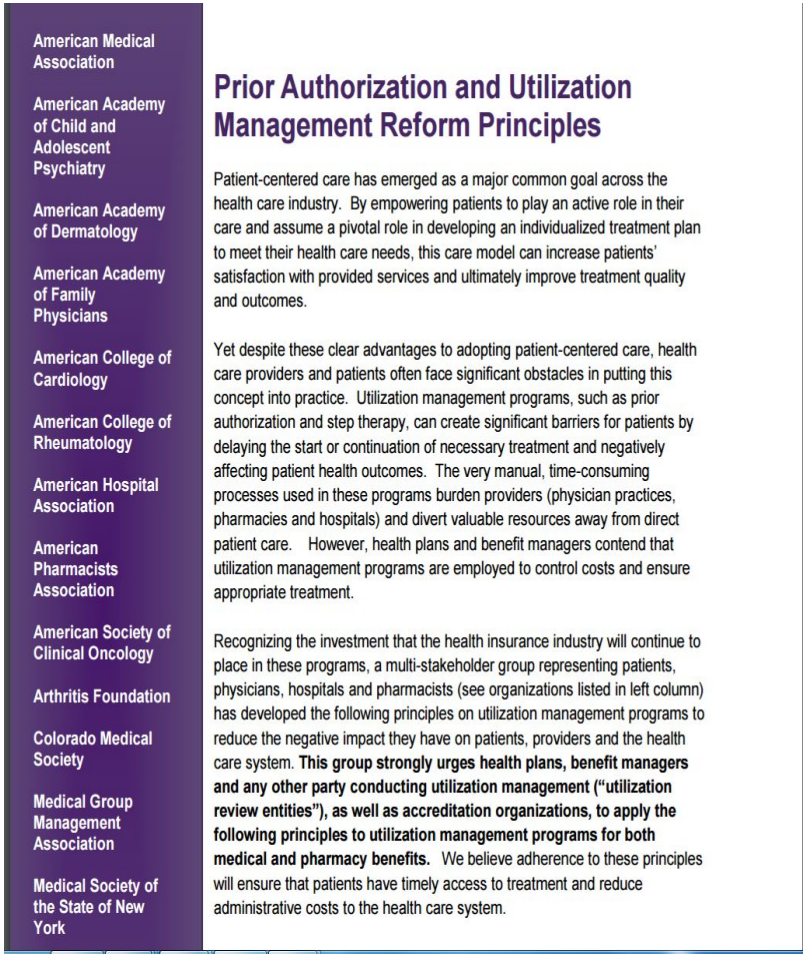
Provider-Developed Principles



American Medical Association

American Academy of Child and Adolescent Psychiatry

American Academy of Dermatology

American Academy of Family Physicians

American College of Cardiology

American College of Rheumatology

American Hospital Association

American Pharmacists Association

American Society of Clinical Oncology

Arthritis Foundation

Colorado Medical Society

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Medical Society of the State of New York

Prior Authorization and Utilization Management Reform Principles

Patient-centered care has emerged as a major common goal across the health care industry. By empowering patients to play an active role in their care and assume a pivotal role in developing an individualized treatment plan to meet their health care needs, this care model can increase patients' satisfaction with provided services and ultimately improve treatment quality and outcomes.

Yet despite these clear advantages to adopting patient-centered care, health care providers and patients often face significant obstacles in putting this concept into practice. Utilization management programs, such as prior authorization and step therapy, can create significant barriers for patients by delaying the start or continuation of necessary treatment and negatively affecting patient health outcomes. The very manual, time-consuming processes used in these programs burden providers (physician practices, pharmacies and hospitals) and divert valuable resources away from direct patient care. However, health plans and benefit managers contend that utilization management programs are employed to control costs and ensure appropriate treatment.

Recognizing the investment that the health insurance industry will continue to place in these programs, a multi-stakeholder group representing patients, physicians, hospitals and pharmacists (see organizations listed in left column) has developed the following principles on utilization management programs to reduce the negative impact they have on patients, providers and the health care system. **This group strongly urges health plans, benefit managers and any other party conducting utilization management ("utilization review entities"), as well as accreditation organizations, to apply the following principles to utilization management programs for both medical and pharmacy benefits.** We believe adherence to these principles will ensure that patients have timely access to treatment and reduce administrative costs to the health care system.

- 21 principles in 5 areas:
  - Clinical Validity
  - Continuity of Care
  - Transparency and Fairness
  - Timely Access and Administrative Efficiency
  - Alternatives and Exemptions

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Clinical Validity

- Programs should be based on up-to-date clinical criteria —never cost alone
- Prior authorization programs must offer flexibility to account for patients' unique clinical circumstances
- Appeal system must be available and provide access to same-specialty physician

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Continuity of Care

- No new or changed coverage restrictions during benefit year
- Alignment between authorization length and duration of treatment
- No requirements to repeat step therapy protocols or retry previously failed therapies
- Grace period in utilization management requirements for patients switching plans and already stabilized on therapy

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Transparency and Fairness

- Full disclosure of all coverage restrictions to both providers and patients (including prospective patients) in a searchable electronic format
- Public reporting of utilization management program results
- Complete information regarding reasons for denials

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Timely Access and Administrative Efficiency

- Required support of standard electronic transactions for prior authorization
- Maximum response times for routine and urgent requests
- No prior authorization for emergency services

Alternatives and Exemptions

- Restrict utilization management programs to "outlier" providers
- Offer physician-driven, clinically based alternatives
  - Gold card programs
  - Preferred provider programs
  - Appropriate use criteria
  - Clinical decision support systems
- Exemptions from utilization management requirements for physicians contracted in financial risk-sharing payment plans

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New Industry Action

- Numerous industry stakeholders are moving forward with proprietary PA efforts (CAQH CORE, X12, HIMSS, NCPDP, Provider Coalition, etc)
- In an attempt to share knowledge, harness expertize and avoid duplication…
- WEDI is initiating a Prior Authorization "coordinating council"
  - Goal is to identify areas of consensus and attempt to have the council speak as one voice to policy makers (including NCVHS) on critical PA issues

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On the Horizon…

Patient Relationship Codes

- Problem, current patient “attribution” approach inherently flawed
- MACRA requires CMS to develop new approach
- MGMA provided comments on
- CMS: new codes (HCPCs modifiers) will be required to be included on Medicare claims as of Jan. 2018
- Concerns:
  - Delayed release of final codes
  - Untested
  - Ability of PM systems/coders to insert appropriate codes
  - Required or claim rejected?
  - Will there be codes for “team-based” care?

SSNRI

- MACRA requires removal of SSNs from Medicare ID cards, consideration of a new #
- CMS has announced they will be issuing all beneficiaries, alive or dead (160 million) a new MBI (to replace HICN on the cards
- Numbers to be issued starting Jan. 2018
- Transition period Apr 2018-Dec 2019 where both numbers can be used on Medicare claims
- Concerns:
  - No proposed rule
  - No “look up” feature for seniors that do not have ID cards
  - Claims with HICNs rejected starting Jan 2020
  - Intersection with National Patient ID (HIPAA)

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UDI

- Unique Device Identifier mandated on the manufacturers
- CMS, HPs now pushing for UDI to be captured on the claim (by providers) and tracked (byplans)
  - Theory:
    - Used for post-surgery surveillance and tracking of recalled devices
  - Reality:
    - HPs cannot effectively track patients who are no longer customers
    - HPs want this data for utilization purposes
- Expected to be included in the next version of the HIPAA transactions
- Better approaches available (i.e., UDI included in 2015 CEHRT)

Forthcoming Standards?

- Electronic attachments
- Electronic acknowledgements
- New version of the HIPAA standards (moving from “5010” to “7030”
- New operating rules for prior authorization
- Payer certification requirements (leading to enforcement actions?)

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Thank you!

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