HIPAA Administrative Simplification Opportunities (and Challenges) for Physician Practices

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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.
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
Challenge 2: Prior authorizations

Prior authorization requirements have increased steadily in recent years, and the growth trend shows no signs of abating in 2017.

The good news is the growing array of products and services available to help practices that are designed to speed up the prior authorization process. There is also the possibility that value-based payment models could reduce the number of drugs and procedures that need approval before payers will cover them.

In the meantime, prior authorizations remain an unpleasant—and increasingly common—fact of life in healthcare. For example, a 2015 Kaiser Family Foundation analysis of Medicare data found that 22% of drugs in private drug plans covered by Medicare Part D required prior authorizations, up from 8% in 2007. During that same period, the percentage of drugs carrying some type of utilization management restriction more than doubled, from 10% to 39%.

The proliferation of prior authorizations is largely a function of cost, says Jack Hoadley, Ph.D., a health policy analyst at Georgetown University’s McCourt School of Public Policy and the lead author of the Kaiser study.

“Although some drugs are more expensive, especially drugs where the use is complicated or has questions about appropriateness, then we see plans and PBM’s [pharmacy benefit managers] increase their use of prior authorizations,” he says.

The nation’s changing demographic profile is also playing a role, notes Randy Vogenberg, Ph.D., principal of the Institute for Integrated Medicine, a research organization.

39% of drugs carrying some type of utilization management restriction in 2016.
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
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\(^3\)

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
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.
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
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)
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
Provider-Developed Principles

• 21 principles in 5 areas:
  – Clinical Validity
  – Continuity of Care
  – Transparency and Fairness
  – Timely Access and Administrative Efficiency
  – Alternatives and Exemptions
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
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
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
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
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 expertise, 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
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)
UDI

- Unique Device Identifier mandated on the manufacturers
- CMS, HPs now pushing for UDI to be captured on the claim (by providers) and tracked (by plans)
  - **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?)
Thank you!

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