Critical Electronic Standards and Operating Rules: The Physician Perspective

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HIPAA Summit
March 29, 2018

Agenda

- **Background:** Prior authorization (PA) burdens
- **PA reform initiatives:**
  - Prior Authorization and Utilization Management Reform Principles
  - Consensus Statement on Improving the Prior Authorization Process
- **X12 278 adoption**
- **Need for electronic attachment standards**
- **Other standard/operating rule issues**

Setting the Stage: Prior Authorization Burdens

Current Issues

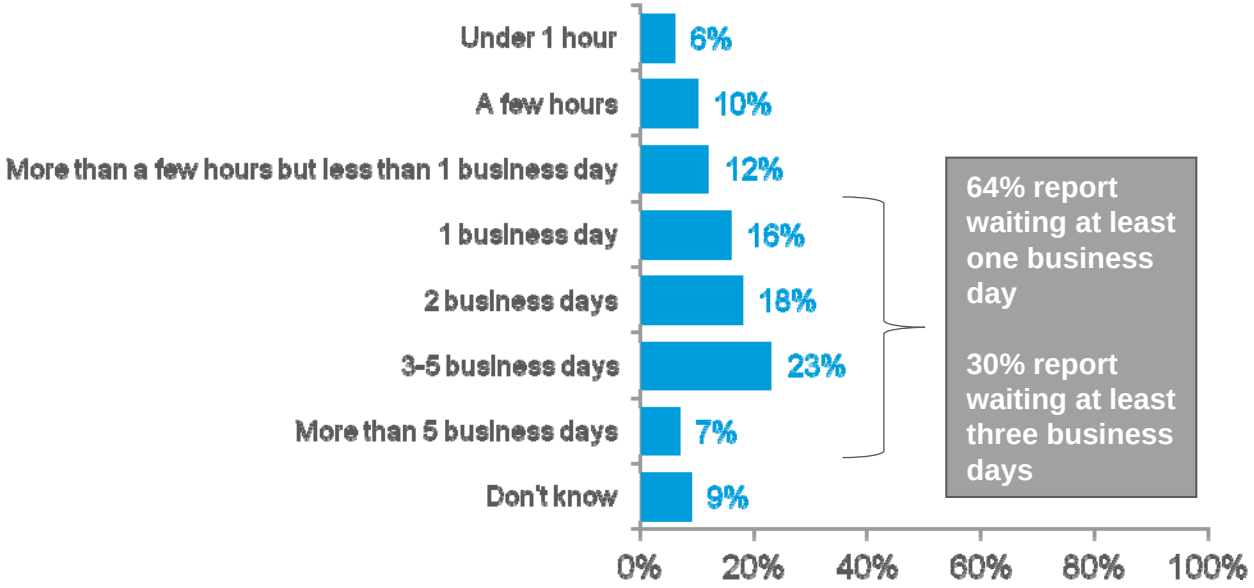
- **Utilization Management Programs:** Cost-containment protocols requiring physicians to receive advanced approval before a health insurer will cover a particular drug or medical procedure
  - Prior authorization
  - Step therapy
- **Concerns:**
  - Delayed patient treatment
  - Questioning practitioner's medical judgment
  - Manual, time-consuming process requires resources that could be spent on clinical care

2017 AMA Survey Overview

- 1000 practicing physician respondents
- 40% PCPs/60% specialists
- Web-based survey
- 27 questions
- Fielded in December 2017

Average PA Response Wait Time

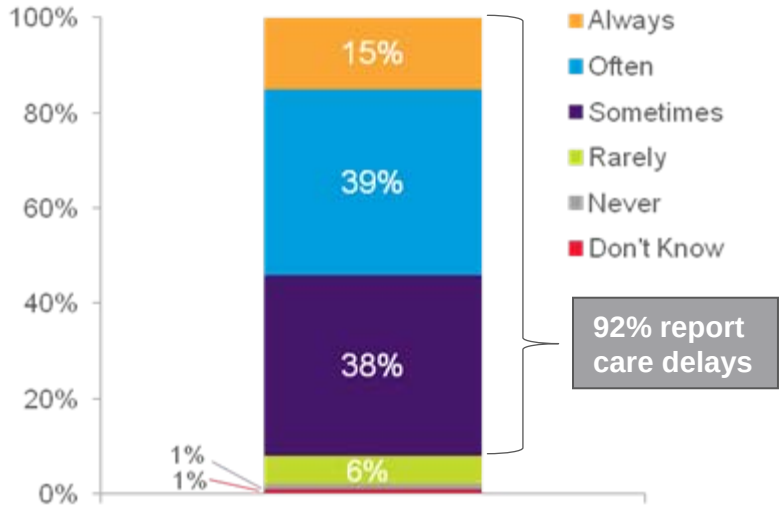
Question: In the last week, how long on average did you and your staff need to wait for a prior authorization (PA) decision from health plans?



Total does not equal 100% due to rounding.

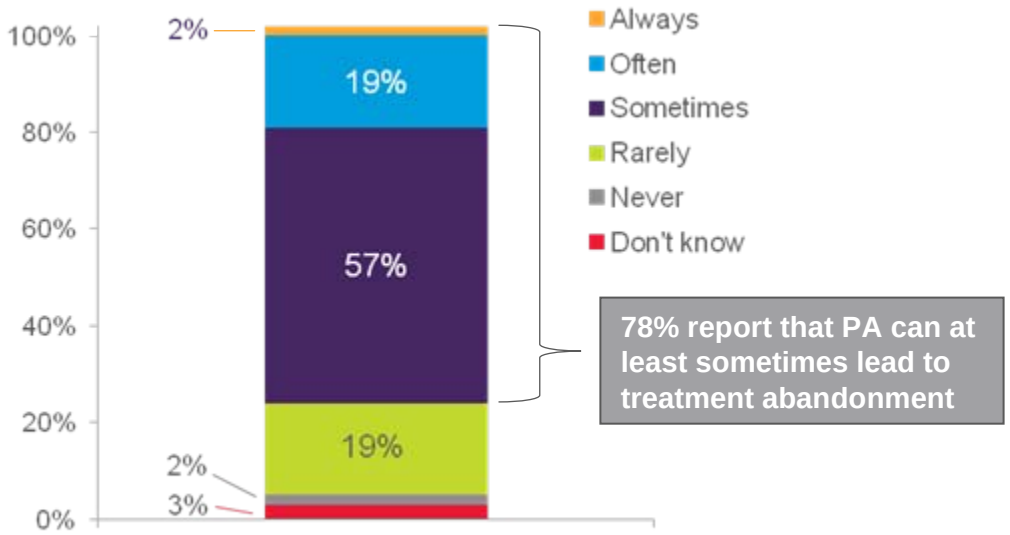
Care Delays Associated With PA

Question: For those patients whose treatment requires PA, how often does this process delay access to necessary care?



Treatment Abandonment Associated With PA

Question: For those patients whose treatment requires PA, how often do issues related to this process lead to patients abandoning their recommended course of treatment?



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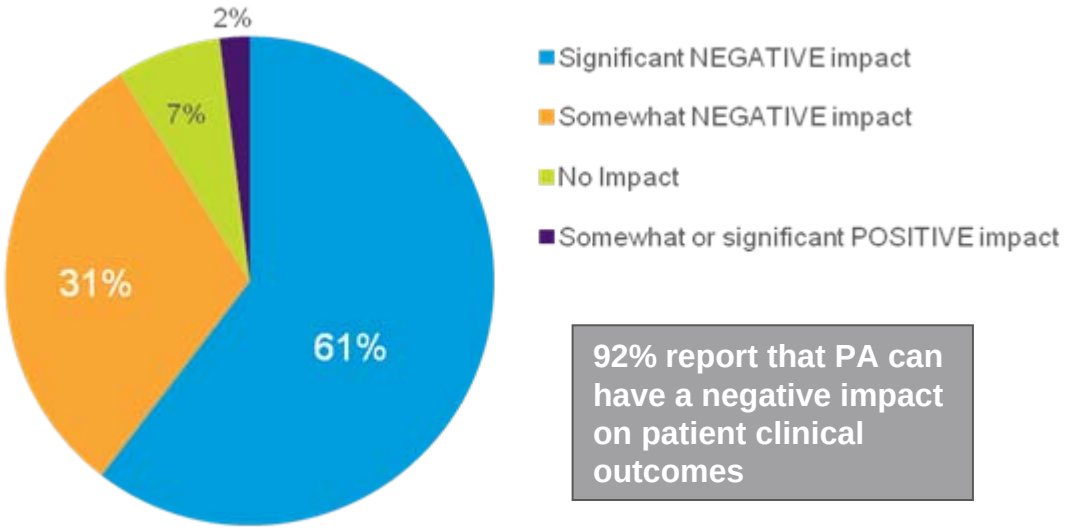
Impact of PA on Clinical Outcomes

Question: For those patients whose treatment requires PA, what is your perception of the overall impact of this process on patient clinical outcomes?

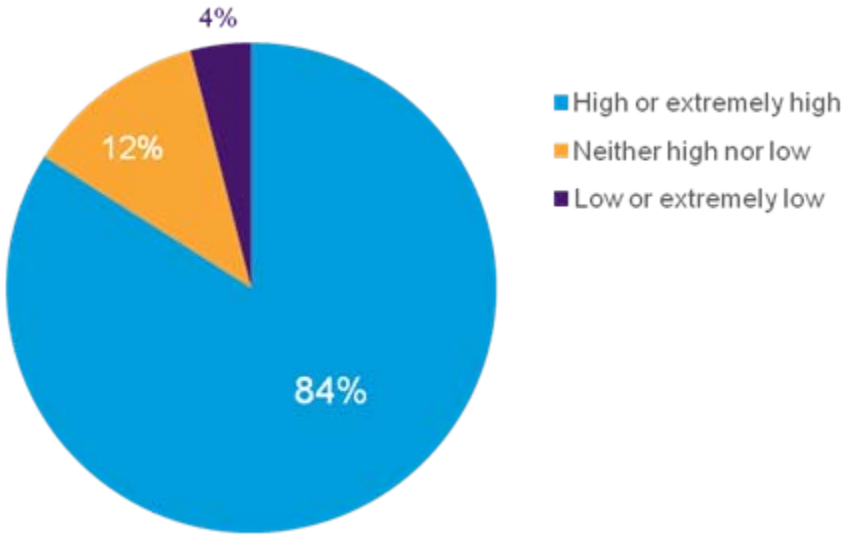


92% report that PA can have a negative impact on patient clinical outcomes

Total does not equal 100% due to rounding.

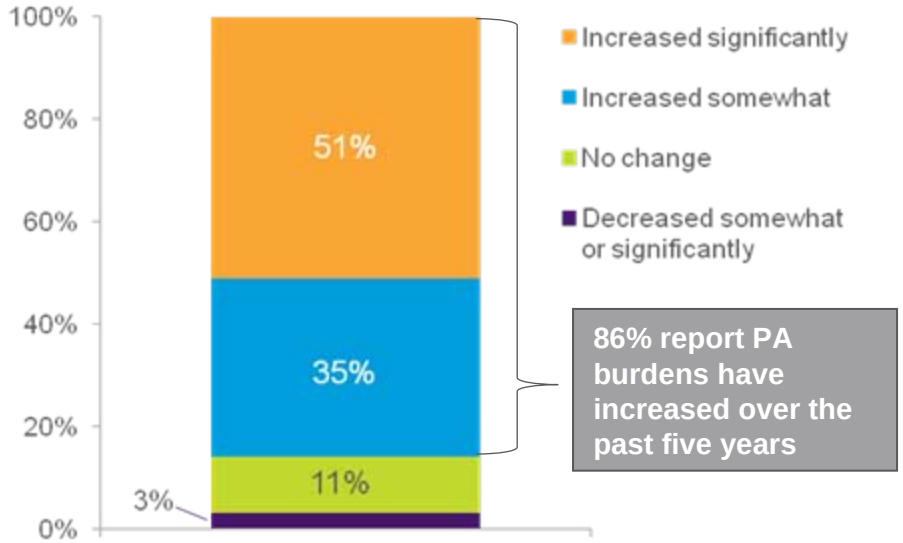
Physician Perspective on PA Burdens

Question: How would you describe the burden associated with PA for the physicians and staff in your practice?



Change in PA Burden Over the Last 5 Years

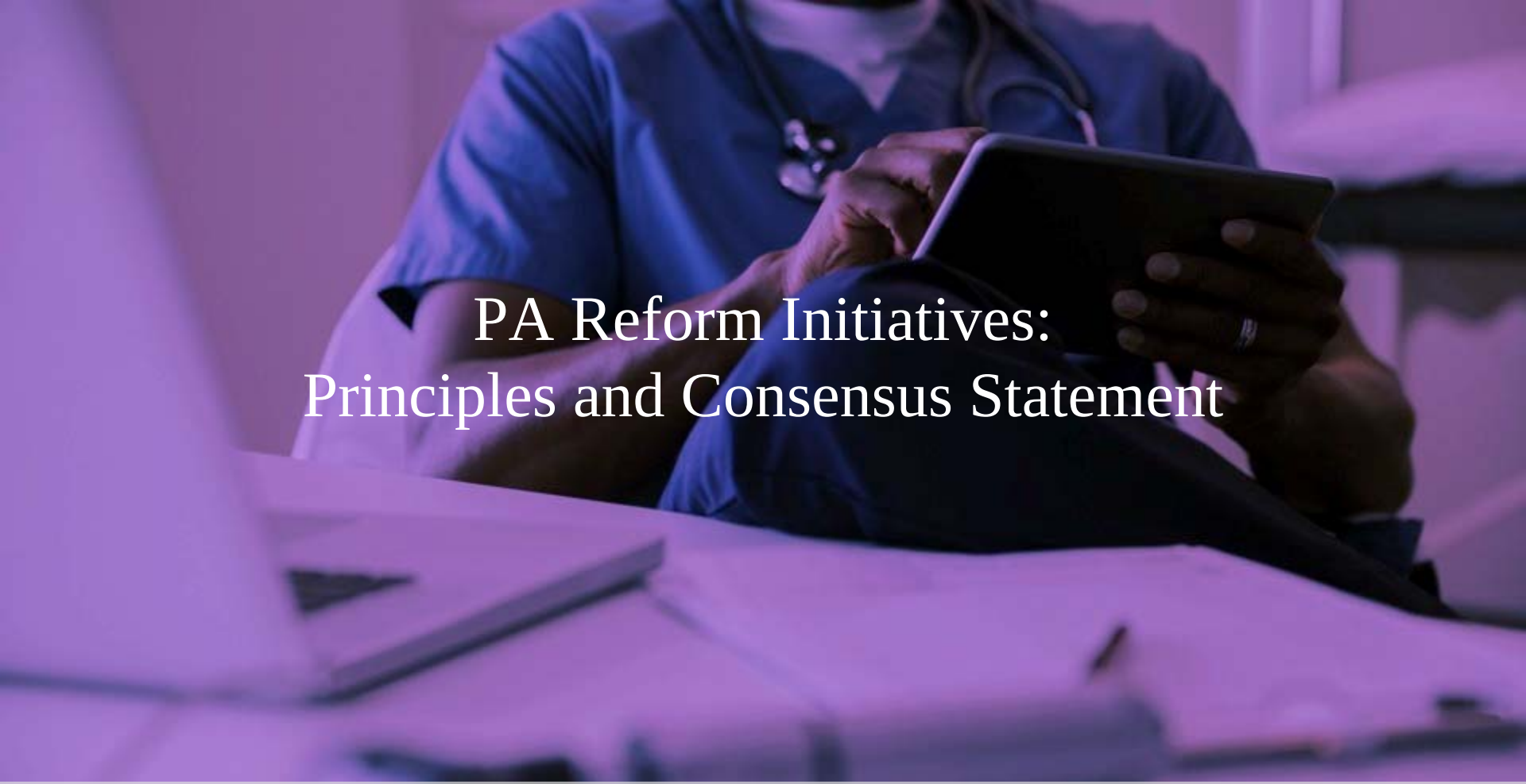
Question: How has the burden associated with PA changed over the last five years for the physicians and staff in your practice?



Additional PA Practice Burden Findings

- **Volume**
  - **29.1 average total PAs** per physician per week*
    - 13.9 average prescription PAs per week
    - 15.1 average medical services PAs per week
- **Time**
  - Average of **14.6 hours** (approximately two business days) spent each week by the physician/staff to complete this PA workload
- **Practice resources**
  - **34%** of physicians have staff who work exclusively on PA

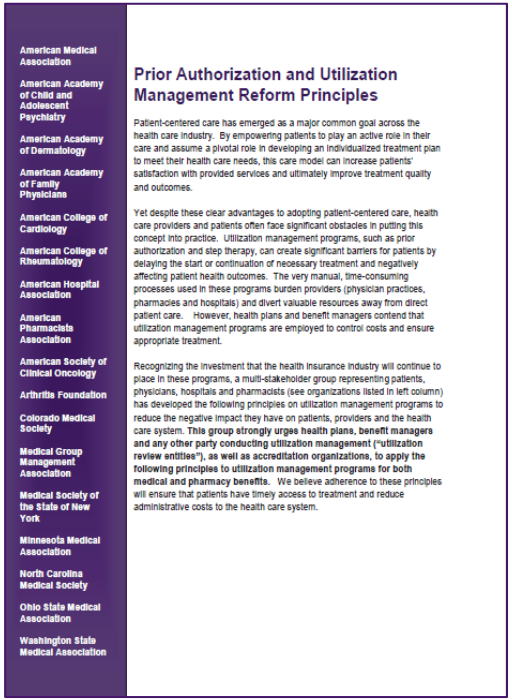
*Total PAs per week rounded after combining prescription and medical services PAs.



PA Reform Initiatives: Principles and Consensus Statement

Prior Authorization and Utilization Management Reform Principles

- Underlying assumption: utilization management will continue to be used for the foreseeable future
- Sound, common-sense concepts
- 21 principles grouped in 5 broad categories:
  - Clinical validity
  - Continuity of care
  - Transparency and fairness
  - Timely access and administrative efficiency
  - Alternatives and exemptions



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
Medical Group Management Association
Medical Society of the State of New York
Minnesota Medical Association
North Carolina Medical Society
Ohio State Medical Association
Washington State Medical Association

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.

Prior Authorization Reform Workgroup

- 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
- Medical Group Management Association
- Medical Society of the State of New York
- Minnesota Medical Association
- North Carolina Medical Society
- Ohio State Medical Association
- Washington State Medical Association

Over 100 additional organizations have signed on as supporters of the Workgroup efforts following the January 2017 release of the Principles

Consensus Statement on Improving the Prior Authorization Process

- Released in January 2018 by the AMA, AHA, AHIP, APhA, BCBSA, and MGMA
- Five “buckets” addressed:
  - Selective requirements to reduce volume of providers subject to PA
  - Regular review of services/ drugs requiring authorization
  - Improved transparency and communication
  - Protections for continuity of care
  - Automation to improve efficiency and transparency

Consensus Statement on Improving the Prior Authorization Process

Our organizations represent health care providers (physicians, pharmacists, medical groups, and hospitals) and health plans. We have partnered to identify opportunities to improve the prior authorization process, with the goals of promoting safe, timely, and affordable access to evidence-based care for patients; enhancing efficiency; and reducing administrative burdens. The prior authorization process can be burdensome for all involved—health care providers, health plans, and patients. Yet, there is wide variation in medical practice and adherence to evidence-based treatment. Communication and collaboration can improve stakeholder understanding of the functions and challenges associated with prior authorization and lead to opportunities to improve the process, promote quality and affordable health care, and reduce unnecessary burdens.

The following five areas offer opportunities for improvement in prior authorization programs and processes that, once implemented, can achieve meaningful reform.

1. **Selective Application of Prior Authorization.** Differentiating the application of prior authorization based on provider performance on quality measures and adherence to evidence-based medicine or other contractual agreements (i.e., risk-sharing arrangements) can be helpful in targeting prior authorization requirements where they are needed most and reducing the administrative burden on health care providers. Criteria for selective application of prior authorization requirements may include, for example, ordering/prescribing patterns that align with evidence-based guidelines and historically high prior authorization approval rates.

   We agree to:

   - *Encourage the use of programs that selectively implement prior authorization requirements based on stratification of health care providers' performance and adherence to evidence-based medicine*
   - *Encourage (1) the development of criteria to select and maintain health care providers in these selective prior authorization programs with the input of contracted health care providers and/or provider organizations; and (2) making these criteria transparent and easily accessible to contracted providers*

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Consensus Statement: Automation to Improve Efficiency and Transparency

Organizations agree to:

•Encourage health care providers, health systems, health plans, and pharmacy benefit managers to accelerate use of existing national standard transactions for electronic prior authorization

•Advocate for adoption of national standards for the electronic exchange of clinical documents (i.e., electronic attachment standards) to reduce administrative burdens associated with prior authorization

•Advocate that health care provider and health plan trading partners, such as intermediaries, clearinghouses, and EHR and practice management system vendors, develop and deploy software and processes that facilitate prior authorization automation using standard electronic transactions

•Encourage the communication of up-to-date prior authorization and step therapy requirements, coverage criteria and restrictions, drug tiers, relative costs, and covered alternatives (1) to EHR, pharmacy system, and other vendors to promote the accessibility of this information to health care providers at the point-of-care via integration into ordering and dispensing technology interfaces; and (2) via websites easily accessible to contracted health care providers

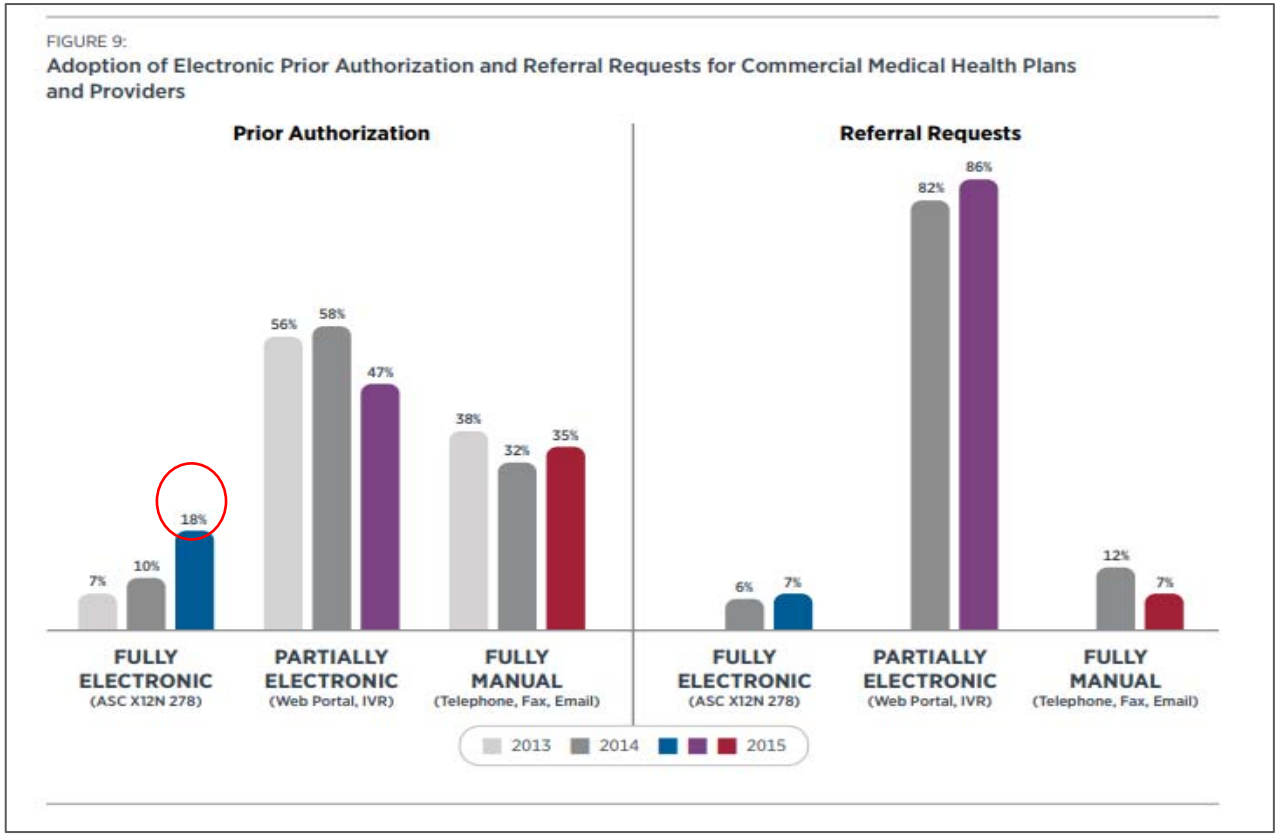
X12 278 Adoption

Prior Authorization –X12 278 Transaction

- **HIPAA standard:** Congress recognized the need for PA standardization, establishing the X12 278 transaction as the industry standard for electronic medical services prior authorizations
    - All health plans are required to accept and process the X12 278 transaction to complete prior authorization
- **Challenges for 278 implementation**
    - Allows responses to be pended with manual follow-up
    - “Conversational” nature of PA business process not supported by current industry implementations
    - Does not specify a standard mechanism for clinical data transmission to support request

X12 278 Transaction Adoption – Glum and Glummer?

- 2016 CAQH Index shows **18%** adoption (despite overall upward trend in adoption of other electronic transactions)
- How do we interpret 2017 Index results???



Reference: 2016 CAQH Index.

X12 278: Industry Efforts and Glimmers of Hope

- WEDI Prior Authorization Subworkgroup
- CAQH CORE Prior Authorization Subgroup
- Attachment standards . . .

Attachments Standards

Current Landscape: Multiple Methods of Sending Clinical Data

- Health plans often require supporting clinical information to process prior authorizations
- Though named in the initial HIPAA legislation, a standard attachment transaction for sending clinical data has not been established
- The lack of a standard format for this information prevents realization of the full benefits and ROI of implementing existing HIPAA standard transactions (i.e., X12 278)
- Without a standard, the industry utilizes various (and often manual) methods to send supporting clinical information:
  - Fax
  - USPS mail
  - Health plan portals

Attachment Standardization

- In order to promote efficiency, the industry needs a standard, defined way of transmitting clinical information between physicians and health plans
    - Current “wild-west” system creates significant provider hardship
- Congress enacted HIPAA standard transactions in order to enable providers “to submit the same transaction to any health plan in the United States” when conducting it electronically[1]
    - Standard = One uniform way of doing something to promote efficiency

1) https://aspe.hhs.gov/report/frequently-asked-questions-about-electronic-transaction-standards-adopted-under-hipaa

Importance of Attachment Standard for Prior Authorization Reform

- Lack of a HIPAA-mandated electronic attachment standard is a **rate-limiting factor** to widespread automation of medical services prior authorization (e.g., 278 adoption)
- June 2014 NCVHS vendor testimony on attachments indicated that the **“uncertainty in the area has had a paralyzing effect”** and serves as a disincentive for vendors to allocate resources to attachment development
- Vendors, providers, and health plans all need clear direction now so that the industry can begin development and implementation plans
- In the case of prior authorization attachments, **timely patient care** is at stake

Urgent Need for Attachment Standards

- Over 20 years have passed since the original HIPAA legislation included attachments as a transaction in need of standardization
    - In order to provide direction to vendors and continuity for providers and health plans, attachment standards are long overdue
- CMS has included attachments on its 2018 Regulatory Agenda
    - August 2018 NPRM scheduled for release

Other Issues for Physicians

Other Physician Concerns With Standards/Operating Rules

- Electronic payments
  - Virtual credit cards
  - Fees for “value-added” EFT standard
- New Medicare Card implementation
- Compliance with and enforcement of administrative standards and operating rules

Please check out our resources!

ama-assn.org/prior-auth

Questions?

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