



# **The Prior Authorization Use Case: The Physician's Perspective on Using and Improving the HIPAA Transactions**

**HIPAA Summit  
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Heather McComas, PharmD  
Director, Administrative Simplification Initiatives  
American Medical Association

# Agenda

- **Setting the Stage: Why use prior authorization (PA) as an example?**
  - AMA PA physician survey data
- **PA Reform Initiatives: Rays of Hope?**
  - Prior Authorization and Utilization Management Reform Principles
  - Consensus Statement on Improving the Prior Authorization Process
- **Utilizing Technology to Improve PA Automation and Transparency**
- **Let's Move: Leveraging Social Media for PA Policy Reform**
  - AMA grassroots efforts
- **Questions**



# Setting the Stage: PA Physician Survey Data

# The Problem

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



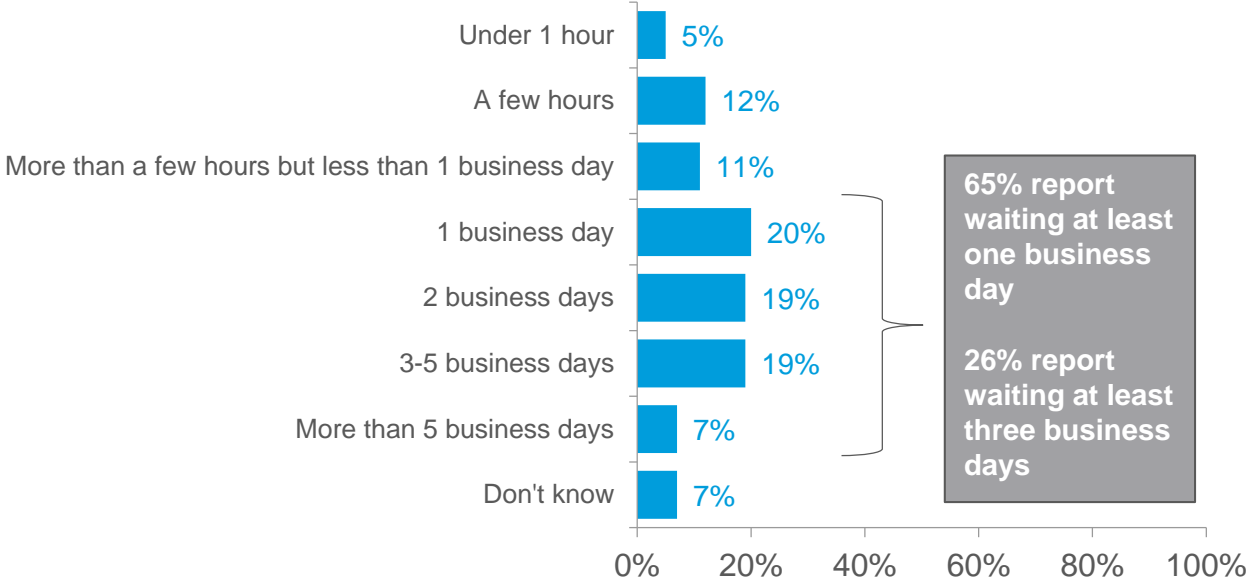
# 2018 AMA PA Survey Overview

- 1000 practicing physician respondents
- 40% PCPs/60% specialists
- Web-based survey
- 29 questions
- Fielded in December 2018



# Average PA Response Wait Time

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

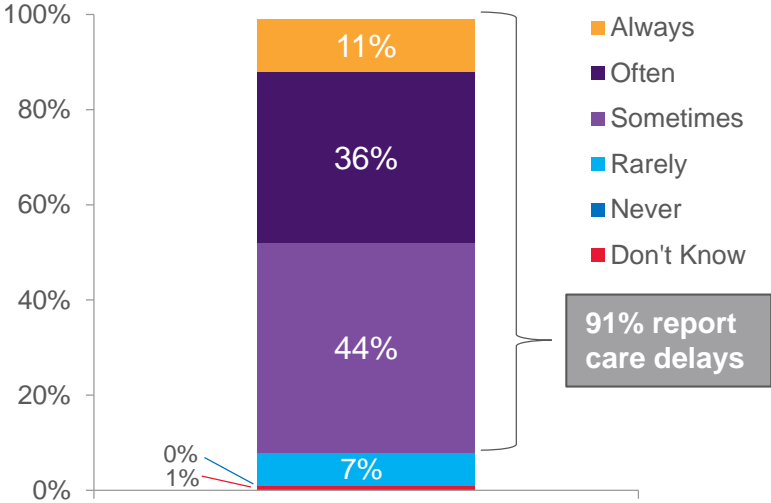


Source: 2018 AMA Prior Authorization Physician Survey



# Care Delays Associated With PA

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



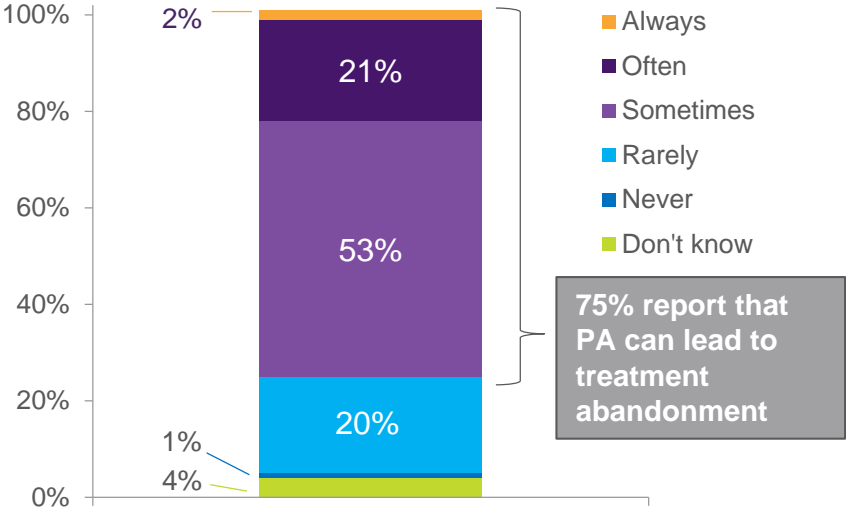
Source: 2018 AMA Prior Authorization Physician Survey

Total does not equal 100% due to rounding.



# Treatment Abandonment Associated With PA

Question: How often do issues related to the PA process lead to patients abandoning their recommended course of treatment?



Source: 2018 AMA Prior Authorization Physician Survey

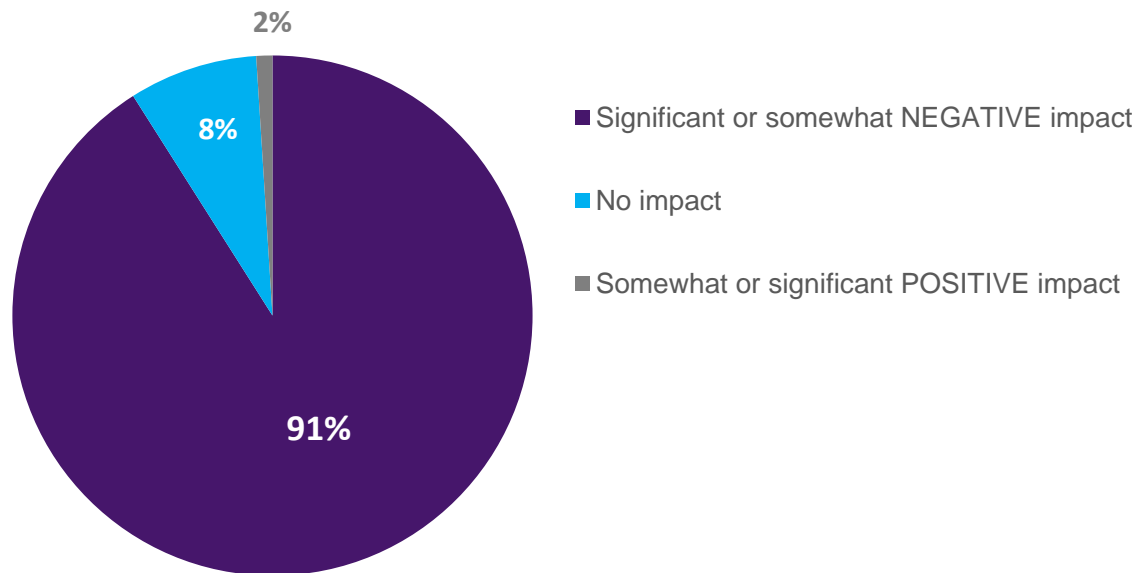
Total does not equal 100% due to rounding.  
Subtotal sums to 75% due to rounding.





# 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?



Source: 2018 AMA Prior Authorization Physician Survey

Total does not equal 100% due to rounding.

## Serious Adverse Events Attributed to PA

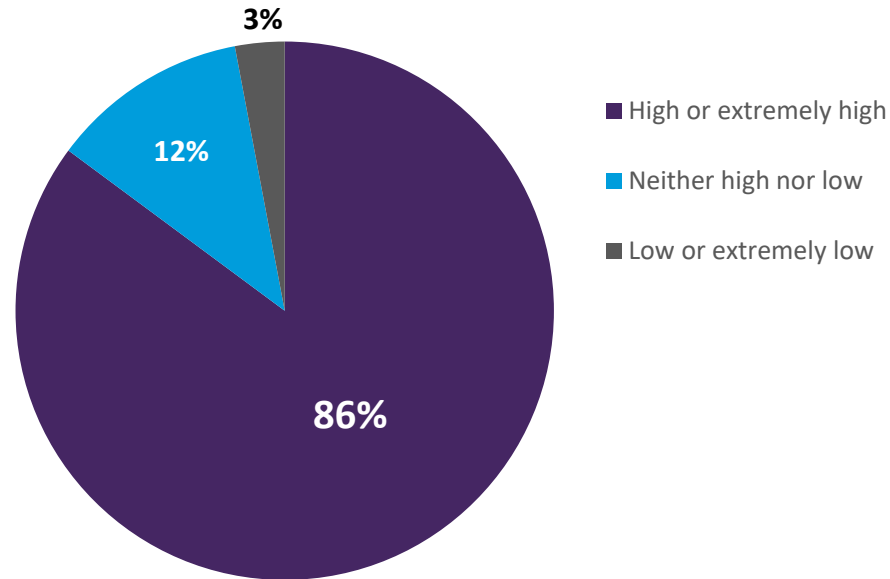
Question: In your experience, has the PA process ever affected care delivery and led to a serious adverse event (e.g., death, hospitalization, disability/permanent bodily damage, or other life-threatening event) for a patient in your care?



**28% of physicians report that PA has led to a serious adverse event for a patient in their care**

# Physician Perspective on PA Burdens

Question: How would you describe the burden associated with PA in your practice?

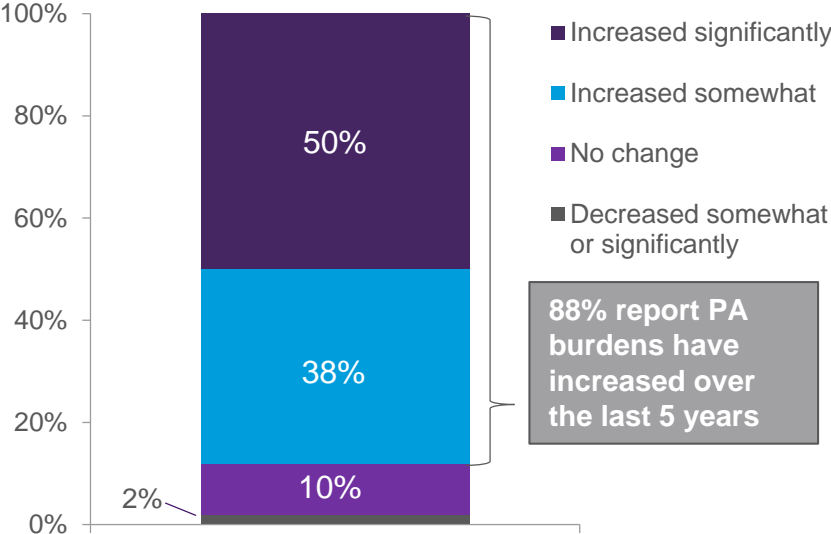


Source: 2018 AMA Prior Authorization Physician Survey

Total does not equal 100% due to rounding.

# Change in PA Burden Over the Last 5 Years

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



Source: 2018 AMA Prior Authorization Physician Survey



# Additional PA Practice Burden Findings

- **Volume**

- **31 average total PAs** per physician per week



- **Time**

- Average of **14.9 hours (approximately two business days)** spent each week by the physician/staff to complete this PA workload



- **Practice resources**

- **36%** of physicians have staff who work exclusively on PA

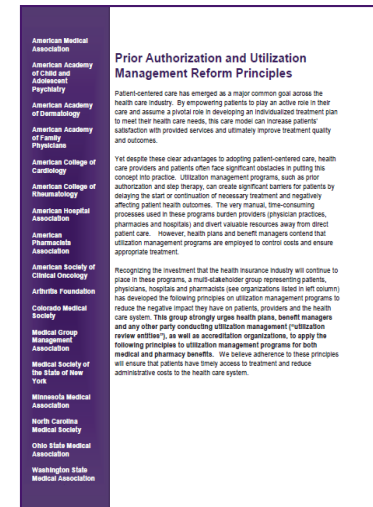




# PA Reform Initiatives: Principles and Consensus Statement

# Prior Authorization and Utilization Management Reform Principles

- Released in **January 2017** by coalition of AMA and 16 other organizations
- 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



Link to Principles: <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-with-signatory-page-for-slscc.pdf>

## 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

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*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, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association
- Five “buckets” addressed:
  - Selective application of PA
  - PA program review and volume adjustment
  - Transparency and communication regarding PA
  - Continuity of patient care
  - Automation to improve transparency and efficiency
- GOAL:** Promote safe, timely, and affordable access to evidence-based care for patients; enhance efficiency; and reduce administrative burdens



Link to Consensus Statement: <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf>

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Link to Consensus Statement: <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf>

A healthcare professional, likely a physician or nurse, is shown from the chest down, wearing blue scrubs and a stethoscope. They are holding a tablet computer with both hands, looking at the screen. The background is a clinical setting with a desk and papers. The entire image has a purple color overlay.

# Using Technology to Improve PA Automation and Transparency

# Automation to Improve Transparency and Efficiency

- Consensus:
  - Encourage health care providers, health systems, health plans, and pharmacy benefit managers to **accelerate use of existing national standard transactions for electronic prior authorization** (i.e., National Council for Prescription Drug Programs [NCPDP] ePA transactions and X12 278)
  - 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

# Standard Electronic Prior Authorization

## What it is:

- Automated exchange of patient clinical data between a provider and a payer to facilitate utilization management determination
- Integrated within provider's workflow in practice management systems (PMS)/electronic health records (EHR) (vs. requiring use of separate payer website portal)
- Uniform process across all payers

## Why it's needed:

- PA process today is manual (phone, fax) and time-consuming for both providers and payers
- Current process leads to treatment delays and abandonment
- Automation saves all stakeholders time and resources, improves communication, and most importantly, improves patient care

# The Problem With Portals

- Improvement on manual processes, but NOT a universal solution
- Limitations/issues:
  - Providers must exit usual EHR workflow to access portals
  - Providers responsible for managing multiple log-ins and passwords
  - Each portal is unique, and the lack of consistency burdens providers
    - Must learn individual nuances and adapt to each one
  - Requires significant amount of data reentry from EHRs
- Any PA technological solution must have universal applicability in order to satisfy provider needs and improve efficiency

# Medical Services Electronic PA

- X12 278 Health Care Services Review - Request for Review and Response is HIPAA-mandated transaction for electronic PA
- CAQH CORE Phase IV Operating Rules address X12 278 connectivity issues (compliance is voluntary)
  - CAQH CORE is developing additional Phase V Operating Rules for X12 278 data content and web portals

# Medical Services PA: X12 278 Adoption Status and Challenges

- **X12 278 implementation status**
  - X12 278 adoption reported at 12% (down from 18% in 2016 CAQH Index)\*
- **Barriers to adoption**
  - Lack of support across stakeholder groups
  - Investment in proprietary portals
  - Multiple iterations of X12 278 to deliver final decision not supported
  - And . . .

Source: [2018 CAQH Index Report](#)



# Lack of an Attachment Standard!



Attachments,  
attachments,  
attachments . . .



# 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<sup>1</sup>
  - 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

## Missing: Have You Seen This Rule?

- 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 included attachments on its 2018 Regulatory Agenda



# Overcoming X12 278 Adoption Challenges

- Significant industry attention focused on finding solutions
  - CAQH CORE Prior Authorization Subgroup/Rules Work Group/Certification-Testing Subgroup/Technical Work Group
  - WEDI Prior Authorization Subworkgroup
  - WEDI PA Council
- Compliance enforcement for X12 278
- Supporting multiple iterations/conversational nature of PA transactions
- Rulemaking for electronic attachment standard

# Transparency and Communication Regarding PA

- Consensus:
  - **Improve communication channels** between health plans, health care providers, and patients
  - **Encourage transparency and easy accessibility** of prior authorization requirements, criteria, rationale, and program changes to contracted health care providers and patients/enrollees
  - **Encourage improvement in communication channels** to support (1) timely submission by health care providers of the complete information necessary to make a prior authorization determination as early in the process as possible; and (2) timely notification of PA determinations by health plans to impacted health care providers (both ordering/rendering physician and dispensing pharmacists) and patients/enrollees

# The First PA Problem: Do I Need PA?

- Traditional ways that physicians determine PA requirements:
  - Phone calls
  - Health plan portals or websites
  - Network bulletins
  - Provider manuals
  - Crossing your fingers . . . (bad idea!)
- Discussed but no widespread industry agreement:
  - Procedure-specific eligibility request/response (X12 270/271) – Can health plans support?
  - X12 278 request (Implications of large volume of PA requests?)
- Newer technologies relay patient-specific, real-time coverage information at the point of care
  - HL7 Da Vinci Project





# HL7 Da Vinci Project

- **Background:** A private-sector initiative that is leveraging HL7 Fast Healthcare Interoperability Resources (FHIR) to improve data sharing in value-based care arrangements
  - Solution is built around specific use cases
- Coverage Requirement Discovery Use Case:
  - Providers need to easily discover which payer-covered services or devices have:
    - Requirement for PA or other approvals
    - Specific documentation requirements
    - Rules for determining need for specific treatments/services
  - With a FHIR-based API, providers can discover in real-time specific payer requirements that may affect payer coverage of certain services or devices

## What Is the Path From Old to New?

- X12 278 is **mandated under HIPAA**
- How does FHIR fit in? Or attachment standard?
- How do we change technologies in a responsible, efficient way that doesn't leave small physician practices behind?
- Flexibility sounds great . . . but two ways of doing something means we have no standard
- “Trading partner agreements” do not necessarily protect physician interests due to imbalance in negotiating power with health plans
- What are potential dangers of abandoning regulatory mandates?



A photograph of three healthcare professionals, two women and one man, all wearing white lab coats and stethoscopes. They are gathered around a tablet computer, looking at the screen with focused expressions. The image has a purple and blue color cast. The text "Let's Move: Leveraging Social Media for PA Policy Reform" is overlaid in white serif font in the center of the image.

# Let's Move: Leveraging Social Media for PA Policy Reform

# New grassroots website: FixPriorAuth.org

Prior authorization hurts patients and physicians. It's time to **#FixPriorAuth.**

Click below to discover how prior authorization affects you.



I am a patient

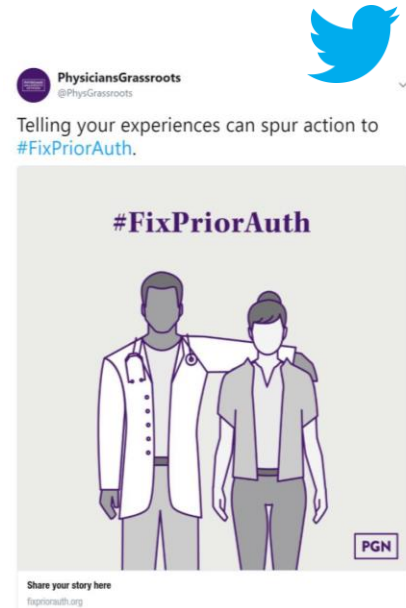
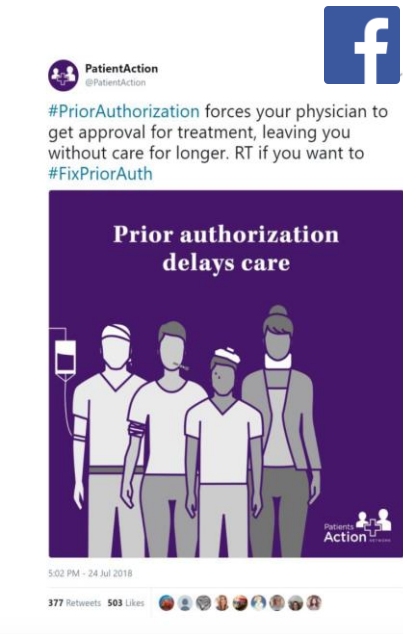


I am a physician

- Physician and patient tracks
- Social media campaign drives site traffic and conversation
- Call to action: Share your story
- Most impactful stories collected in site gallery

# FixPriorAuth.org: Grassroots Results Since July 2018 Launch

- Impressions: **+8.0 million**
- New users: **+74,000**
- Engagements: **+340,000**
- Patient/physician stories: **+500**
- Petitions signed: **+89,000** (since mid-October)



"My daughter had ALS. Her doctor ordered a PET scan of her brain. The appointment was set, medical transportation was set, co-pay paid. The day before the test the hospital called to say the prior authorization had not been received. My daughter passed away the day before we were supposed to go for the rescheduled test." - Kathy M.

"Really, my doctor wanted me to do hormone shots with my chemo but [the insurer] refused, so we had to go on a hormone pill instead. Took 3 weeks to get my chemo pill approved... the shots probably would have been more potent." - Dawn C.

"I need prior auth for my continuous glucose monitor every time I get sensors for it - this device alone has saved my life more times than I can count, yet the insurer thinks it isn't a necessity!" - @KronikerD

# YOUR PRIOR AUTHORIZATION STORIES MATTER

"I work with a surgeon, treating breast cancer patients as the majority of our patients. I recently spent over 10 hours trying to get a patient's surgery authorized." - Kathy D.

"I have a patient with a crush injury to his foot who waited 2 months for appropriate imaging studies and then SIX months for approval to operate. Tell me our system is the best. Please. I have many examples. Everyday." - Dr. Vito R.

[FixPriorAuth.org](http://FixPriorAuth.org)

"I am an ED RN. I frequently see patients who have seen their family doctor and have a CT ordered. The insurance company hasn't authorized them yet so they come to the ED to get a CT...so they can get the test in a timely manner." - Beverly Kay W.

"I have had to make multiple calls and wait as long as 2 weeks trying to obtain authorization for an MRI when there were abnormal mammogram or pelvic sonogram findings. The patients become increasingly anxious about their condition and sometimes angry at me because they think I'm either withholding care or not concerned about their needs." - Dr. Nina S.

"The insurance company would not cover the prescription until I tried three other medications...48 weeks of trying medications we already knew would not work, before I could hope to get the medication we already knew did work...Without an effective treatment, I am at increased risk of several problems, including esophageal cancer." - Lyle S.

# Contact Us

- Heather McComas, PharmD, Director, AMA Administrative Simplification Initiatives, [heather.mccomas@ama-assn.org](mailto:heather.mccomas@ama-assn.org)
- Access our resources at:  
[www.ama-assn.org/prior-auth](http://www.ama-assn.org/prior-auth)  
<https://fixpriorauth.org/>

