Prior Authorization: Burdens, Barriers, and (Maybe) Breakthroughs

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

Terrence Cunningham, JD
Sr. Policy Analyst, Administrative Simplification Initiatives
American Medical Association

Agenda

- Setting the Stage: Why Prior Authorization (PA) is a Problem
  - AMA PA physician survey data

- Putting a Face on the Need for PA Policy Reform
  - AMA grassroots efforts

- 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

- Reality Check: Assessing Industry Progress

- 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

- Survey in the last week, how long on average did you and your staff need to wait for a PA decision from your health plan?

<table>
<thead>
<tr>
<th>Wait Time</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 hour</td>
<td>0%</td>
</tr>
<tr>
<td>1-2 hours</td>
<td>7%</td>
</tr>
<tr>
<td>2-3 business days</td>
<td>13%</td>
</tr>
<tr>
<td>3-5 business days</td>
<td>15%</td>
</tr>
<tr>
<td>More than 5 business days</td>
<td>19%</td>
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</tbody>
</table>

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?

- Always: 11%
- Often: 36%
- Sometimes: 44%
- Rarely: 7%
- Never: 0%

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?

- Always: 4%
- Often: 1%
- Sometimes: 20%
- Rarely: 53%
- Never: 21%
- Don’t know: 2%

Source: 2018 AMA Prior Authorization Physician Survey
Total does not equal 100% due to rounding.
75% report that PA can lead to treatment abandonment.

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?

- Significant or somewhat NEGATIVE impact: 8%
- No impact: 0%
- Somewhat or significant POSITIVE impact: 92%

Source: 2018 AMA Prior Authorization Physician Survey
Total does not equal 100% due to rounding.
Question: In your experience, has the PA process ever affected care to the point of leading 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.

Source: 2018 AMA Prior Authorization Physician Survey

Total does not equal 100% due to rounding.

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

- High or extremely high: 3%
- Neither high nor low: [VALUE%
- Low or extremely low: [VALUE

Source: 2018 AMA Prior Authorization Physician Survey

88% report PA burdens have increased over the last 5 years in their practice.
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

 Putting a Face on the Need for PA Policy Reform

New Grassroots Website: FixPriorAuth.org

• 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
• Powerful videos capture patient and physician PA stories
FixPriorAuth.org: Grassroots Results Since July 2018 Launch

- Impressions: +10 million
- New users: +61,000
- Engagements: +1,000,000
- Patient/physician stories: +500
- Petitions signed: +90,000

(since mid-October)

"I have often thought, in retrospect after my son passed away, if the scans had been done on time, maybe it would have been caught sooner, and possibly it could have saved his life."

- Linda Haller, Maryland
“About three years ago, my husband changed jobs and insurance. I was already on [a] medicine and had to wait for my refill, but I couldn’t get them without the prior authorization process. I missed doses. It felt like everything broke down.” - Candace Myers, Georgia

“If I had to wait until the insurance company actually gave their approval, I may have been in a position where any oncologist would have said ‘No, there’s nothing we can do for you now.” - Kathryn Johanessen, Connecticut
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

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, 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


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Using Technology to Improve PA Automation and Transparency

- 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

Automation to Improve Transparency and Efficiency

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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
  - Lack of an attachment standard for submitting clinical data

*Source: 2018 CAQH Index Report

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 electronically¹
    - Standard – One uniform way of doing something to promote efficiency

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

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

Significant industry attention focused on finding solutions

- 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
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?)

HL7 Da Vinci Project

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 Requirements Discovery:
- Document Templates and Payer Rules
- What specific clinical info is needed?
- Prior Authorization Support
- How can I successfully submit PA electronically?
Only 8% of physicians report contracting with health plans that offer programs that exempt providers from PA.

A strong majority (88% and 86%,* respectively) of physicians report that the number of PAs required for prescription medications and medical services has increased over the last five years.

Almost seven in 10 (69%) physicians report that it is difficult to determine whether a prescription or medical service requires PA.
An overwhelming majority (85%) of physicians report that PA interferes with continuity of care.

Q: How often does the prior authorization process interfere with the continuity of ongoing care (e.g. missed doses, interruptions in chronic treatment)?

Source: 2018 AMA Prior Authorization Physician Survey

Physicians report phone and fax as the most commonly used methods for completing PAs. Moreover, only 21% of physicians report that their EHR system offers electronic PA for prescription medications.

Q: Please indicate how often you and/or your staff use each of the following methods to complete PAs for prescription medications.

<table>
<thead>
<tr>
<th>Method</th>
<th>Prescription PAs (% use always or often)</th>
<th>Medical service PAs (% use always or often)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td>60%</td>
<td>61%</td>
</tr>
<tr>
<td>Fax</td>
<td>46%</td>
<td>47%</td>
</tr>
<tr>
<td>EHR/PMS*</td>
<td>40%</td>
<td>23%</td>
</tr>
<tr>
<td>Plan portal</td>
<td>31%</td>
<td>27%</td>
</tr>
<tr>
<td>Email or U.S. mail</td>
<td>15%</td>
<td>17%</td>
</tr>
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*EHR = electronic health record; PMS = practice management system.

Source: 2018 AMA Prior Authorization Physician Survey
Contact Us

- Heather McComas, PharmD, Director, AMA Administrative Simplification Initiatives, heather.mccomas@ama-assn.org
- Terrence Cunningham, JD, Senior Policy Analyst III, AMA Administrative Simplification Initiatives, terrence.cunningham@ama-assn.org
- Access our resources at:
  www.ama-assn.org/prior-auth
  https://fixpriorauth.org/