State of Prior Authorizations

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Disclaimer

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AMA Update on Prior Authorization Reform

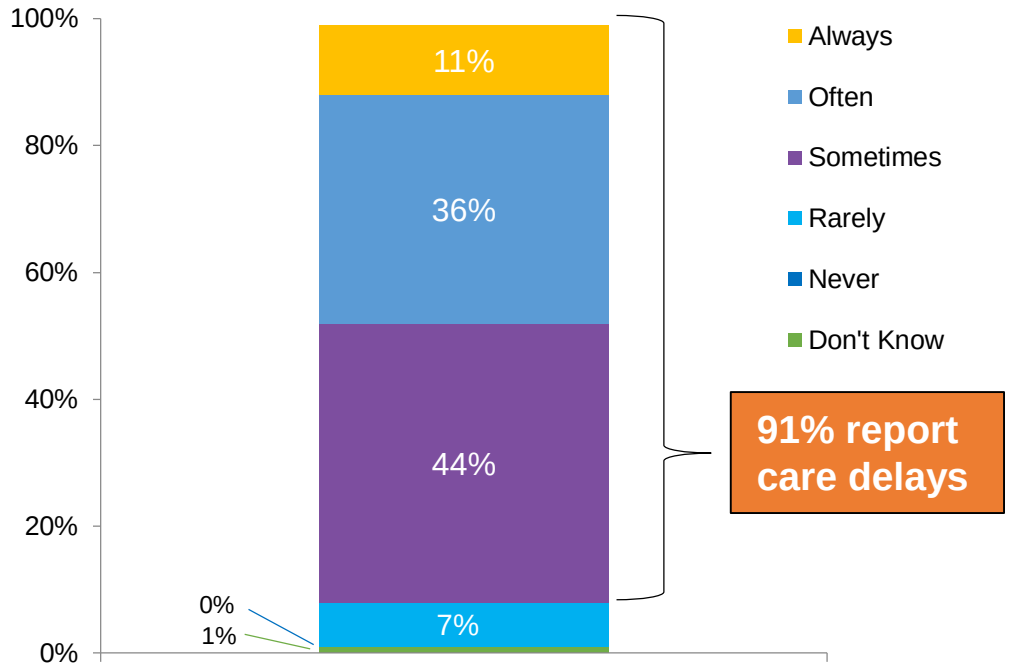
Heather McComas, PharmD
Director, Administrative Simplification Initiatives
American Medical Association

2018 AMA PA Survey Overview

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

Care Delays Associated With PA

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

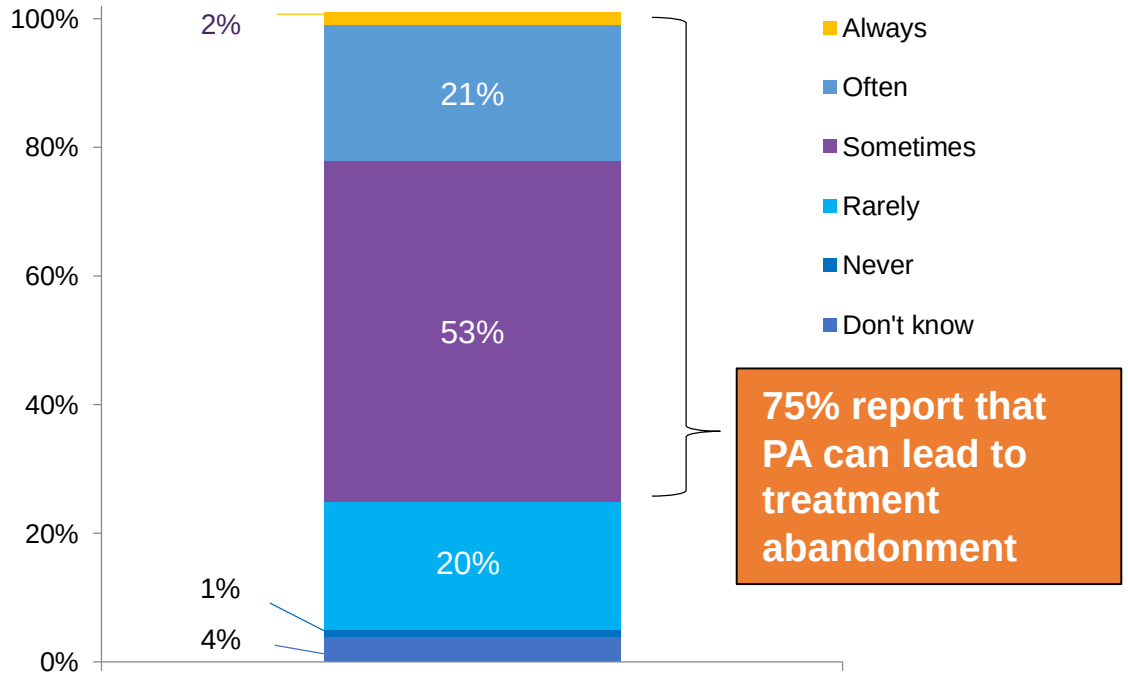


Source: 2018 AMA Prior Authorization Physician Survey

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?

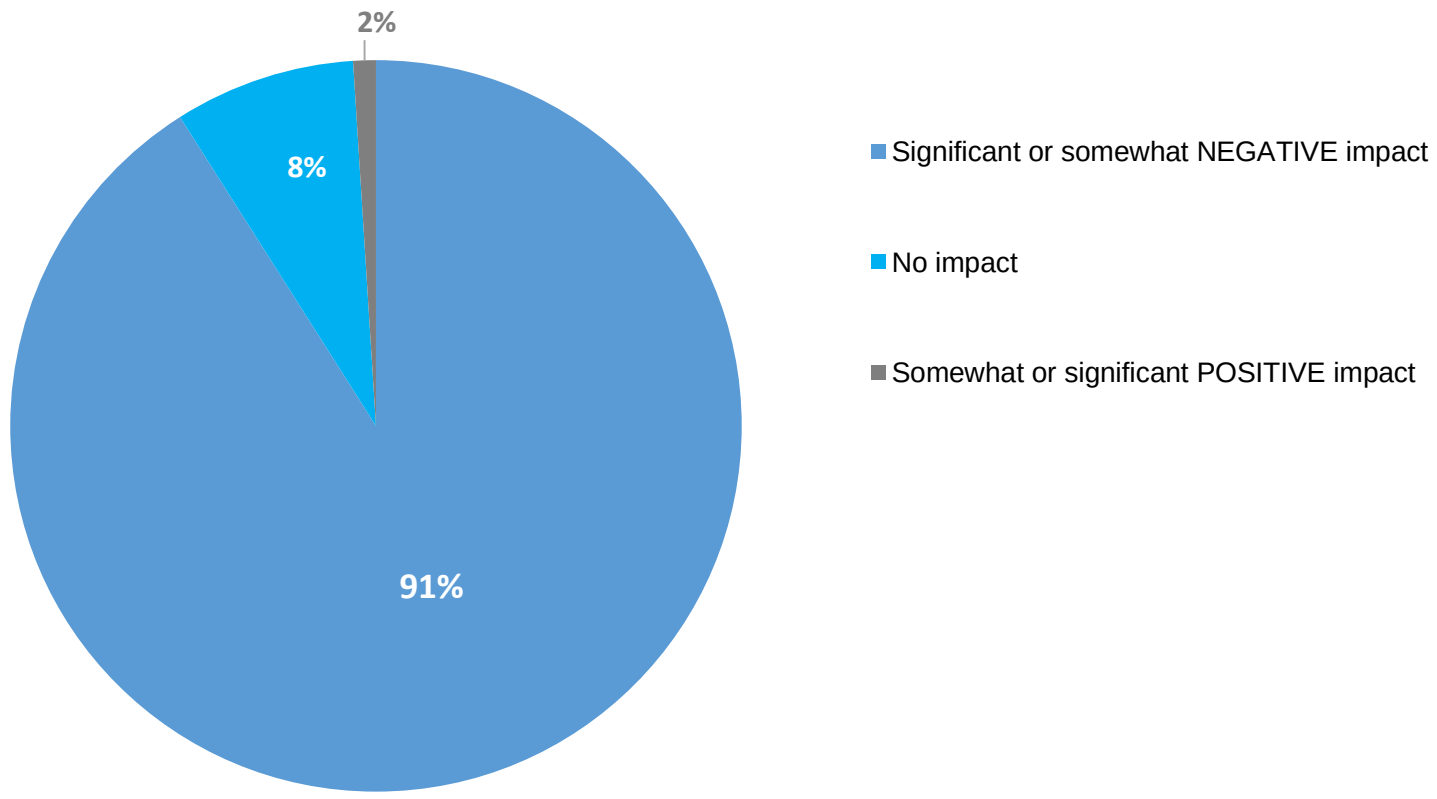


Source: 2018 AMA Prior Authorization Physician Survey

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.

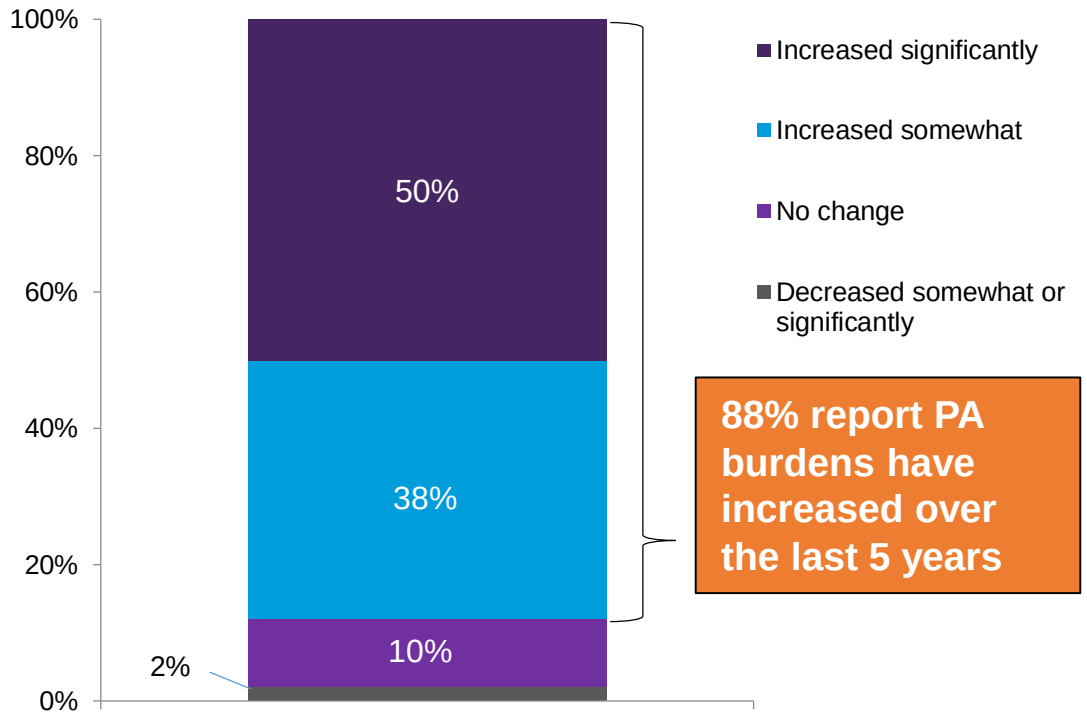
Serious Adverse Events Attributed to PA

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

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

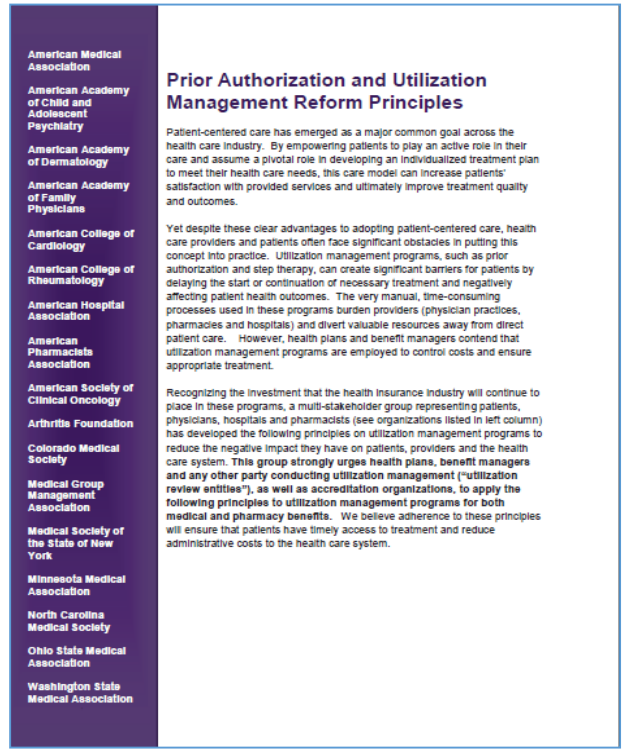
- **Time**
  - Average of **14.9 hours (approximately two business days)** spent each week by the physician/staff to complete this PA workload

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

Source: 2018 AMA Prior Authorization Physician Survey

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



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.

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

American Hospital Association · AHIP America's Health Insurance Plans · AMA American Medical Association · APhA · BlueCross BlueShield Association · MGMA

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*

1

Following the consensus statement, little progress is being made:

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.

Only 8% of physicians report contracting with health plans that offer programs that exempt providers from PA.

69% physicians report that it is difficult to determine whether a prescription or medical service requires PA.

85% of physicians report that PA interferes with continuity of care.

Only 21% of physicians report that their EHR system offers electronic PA for prescription medications.

Reality Check: Automation to Improve Transparency and Efficiency

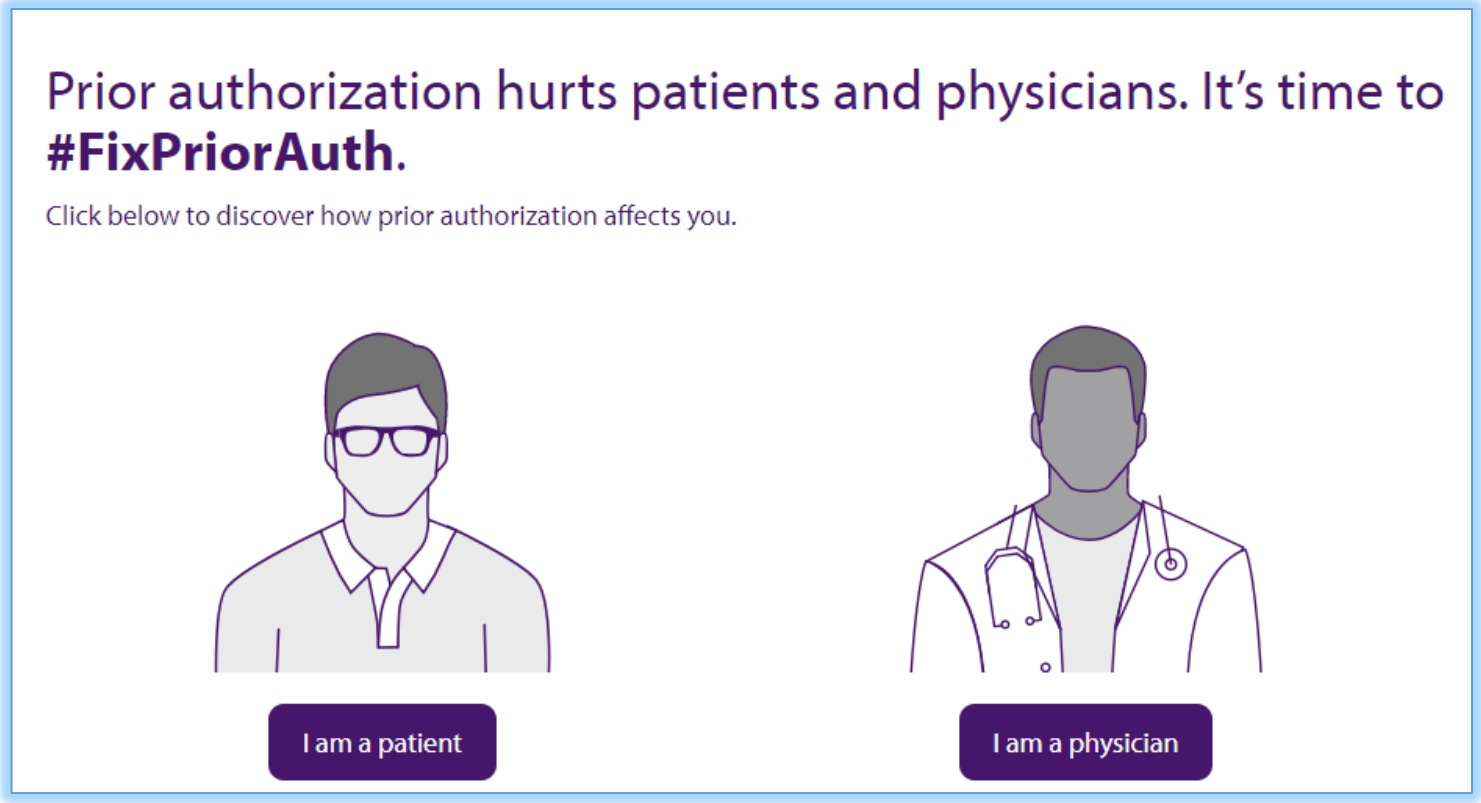
- Physicians report **phone and fax** as the most commonly used methods for completing PAs. Moreover, only **21%** of physicians report that their EHR* system offers electronic PA for prescription medications.

Method	Prescription PAs (% use always or often)	Medical service PAs (% use always or often)
Phone	60%	61%
Fax	46%	47%
EHR/PMS*	40%	23%
Plan portal	31%	27%
Email or U.S. mail	15%	17%

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

*EHR = electronic health record; PMS = practice management system.
Source: 2018 AMA Prior Authorization Physician Survey

AMA 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
- Patient and physician videos amplify power of these stories
- Petition to Congress urges PA reform

YOUR PRIOR AUTHORIZATION STORIES MATTER

FixPriorAuth.org

"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

"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.

"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.

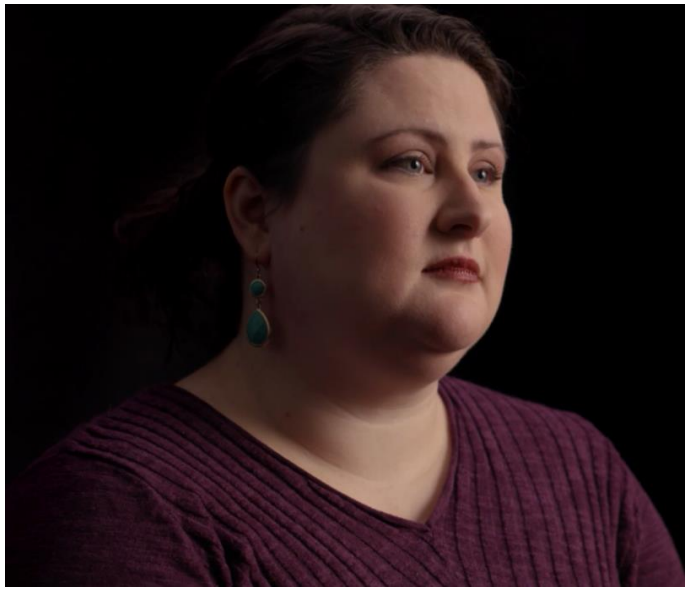
"I have had to make multiple calls and wait as long as 2 weeks trying to obtain authorization for an MRI when there were abnormal mammogram or pelvic sonogram findings. The patients become increasingly anxious about their condition and sometimes angry at me because they think I'm either withholding care 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.

Prior Authorization Hurts Patients

"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. Possibly, it could have saved his life."

- Linda Haller, Maryland



"About three years ago, my husband changed jobs and insurances…I was already on medicine and had to wait for my refill. But I couldn't get them without the prior authorization process…I missed doses…I 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

Watch the video at FixPriorAuth.org

NCPDP and ePA

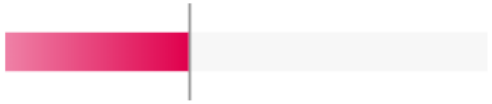
John Klimek R.Ph.

Senior Vice President Standards and Industry IT
NCPDP – National Council for Prescription Drug Programs

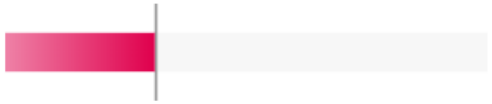
PA CHALLENGES*

66% - Time consuming

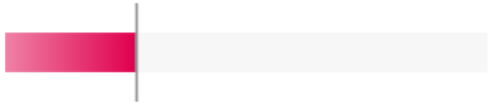
48% - Takes away from patient care



38% - Lack of answers to form questions



31% - Lack of insurance information



27% – Cannot find the correct PA form

ePA BENEFITS*

70% – Faster determinations

69% - Time savings

65% - Ease of use

54% - Organization of PA requests

* Percentages reflect those who selected these individual options.

Electronic Prior Authorization (ePA)

Transactions within the NCPDP SCRIPT Standard

- First published in July 2013
- Supports prospective and retrospective models
- Allows for cancel and appeal functions
- Supports pharmacist-initiated requests; trading partner agreements may determine applicability
- H.R. 6 Section 6062. (Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act)

  This provision requires the Secretary of HHS to establish a standard, secure electronic prior authorization system no later than January 1, 2021. Fax, proprietary payer portals that do not meet standards defined by the Secretary, and electronic forms will not be treated as an electronic submission for the purpose of electronic prior authorization.

Specialty Drugs on the rise!

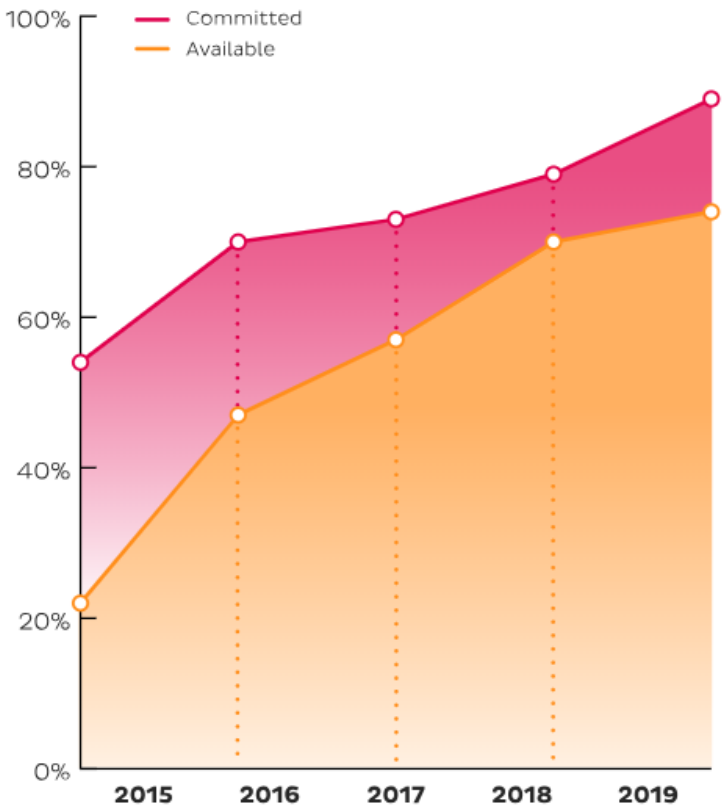
By 2020, a projected 9 out of 10 top-selling drugs by revenue will be specialty and the volume of specialty PA requests is rising.

40% of providers cite PA as the main pain point when prescribing specialty drugs vs. communication, financial assistance and time.

EHR Availability

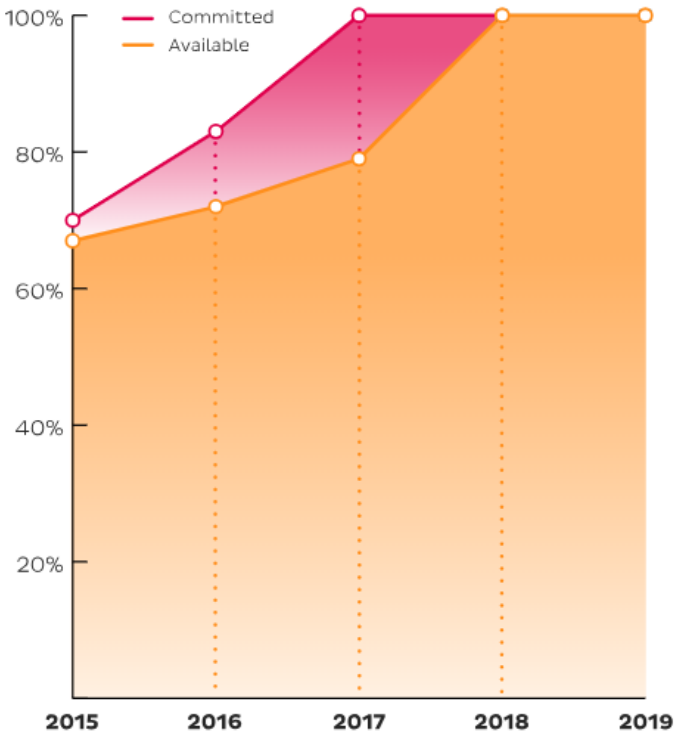
Percentage of the EHR market, representing the majority of market share by prescription volume, committed to an ePA solution.[30]

* The remaining 11 percent of the EHR market is comprised of many smaller EHR system vendors.



Pharmacy Availability

Percentage of the pharmacy market, representing the majority of market share by prescription volume, committed to an ePA solution.[46]



Information from CoverMyMeds 2019 ScoreCard
https://www.covermymeds.com/main/insights/scorecard/

REAL-TIME BENEFIT CHECK (RTBC)

GOAL

To provide patient-specific information on benefit coverage at the point of prescribing

NCPDP STANDARDS

- Develop two standard formats and one implementation guide to be utilized by Providers and Processors/PBMs/Adjudicators
- Request and Response Model
- The data exchange can
  - Establish patient eligibility, product coverage, and benefit financials for a chosen product and pharmacy, and
  - Identify coverage restrictions, alternative products, and benefit alternatives when they exist

STAKEHOLDER BENEFITS FOR RTBC

- Allow the Patient and Provider to have a more meaningful discussion about the patient's therapy
- Identify PA Medications at time of prescribing
- Reduce medication abandonment
- Improve medication adherence and outcomes
- Expand transparency to patient's formulary and prior authorization requirements
- Improve speed to therapy for patients

Goal for both ePA and RTPBC

- Decrease provider burden
- Increase patient likelihood of getting their meds on time!

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CAQH CORE Prior Authorization Update

Rachel Goldstein, MPP

Senior Manager, CAQH CORE

CAQH CORE Mission/Vision & Industry Role

Industry-led, CAQH CORE Participants include healthcare providers, health plans, vendors, government entities, associations and standard-setting organizations. Health plans participating in CAQH CORE represent **75 percent of the insured US population.**

MISSION Drive the creation and adoption of healthcare operating rules that **support standards**, **accelerate interoperability and align administrative and clinical activities** among providers, payers and consumers.

VISION An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.

DESIGNATION CAQH CORE is the **national operating rule author to improve the efficiency, accuracy and effectiveness of industry-driven business transactions.** The Department of Health and Human Services (HHS) designated CAQH CORE as the author of national operating rules for the HIPAA-covered administrative transactions.

INDUSTRY ROLE **Develop business rules to help industry** effectively and efficiently use electronic standards while remaining technology- and standard-agnostic.

CAQH CORE BOARD **Multi-stakeholder.** Members include health plans, providers (some of which are appointed by associations such as the AHA, AMA, MGMA), vendors, and government entities. Advisors to the Board include SDOs (X12, HL7, NACHA, NCPDP) and WEDI.

What are Operating Rules?

Operating Rules are the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted.

Operating Rules	Phase I	Phase II	Phase III	Phase IV	Phase V	Phase VI
Transactions	Eligibility	Eligibility Claims Status	Electronic Funds Transfer Electronic Remittance Advice	Health Claims Referral, Certification and Authorization Enrollment Premium Payments	Prior Authorization	Attachments
	Active					***In Progress***

CAQH CORE is also evaluating opportunities to build on existing rules to support Value-Based Payment.

Industry Use Case	Standard	Operating Rule
Healthcare	Providers and health plans must use the ASC X12 v5010 270/271 Eligibility Request and Response transaction to exchange patient eligibility information.	When using the eligibility transaction, health plans must return patient financial information including copay and deductible in real-time.
Finance	Financial organizations must use ASC X9 standards in all ATM transactions with their clientele, standardizing layout, data content and messaging.	Financial organizations must use NACHA, the Electronic Payments Association, and the Federal Reserve operating rules for every automated clearinghouse (ACH) Transaction which allows consumers to use any debit card in any ATM around the world regardless of bank affiliation.

CAQH CORE Prior Authorization Operating Rules

CAQH CORE Vision for Prior Authorization

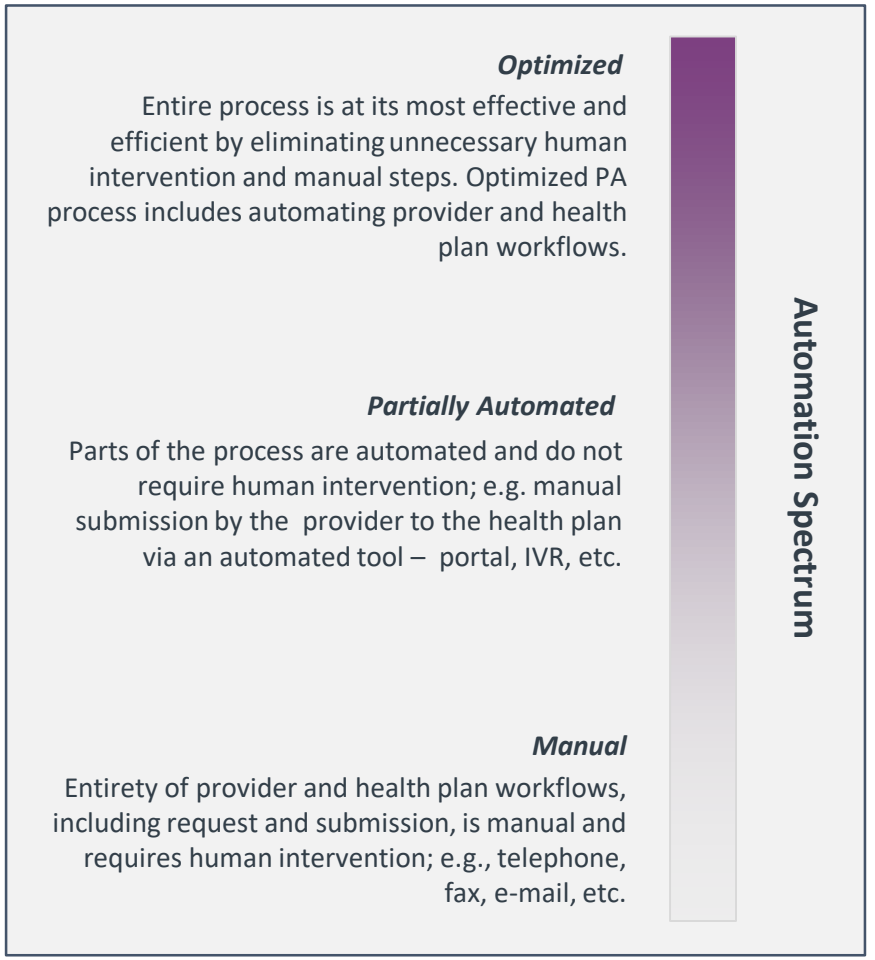
Introduce targeted change to propel the industry forward to a prior authorization process **optimized by automation**, thereby reducing administrative burden on providers and health plans and enhancing timely delivery of patient care.

CAQH CORE Prior Authorization Operating Rules

- The CAQH CORE Phase IV Connectivity Rule and Phase IV Infrastructure Rule Operating Rules establish foundational requirements such as **consistent connectivity methods, safe harbor, allowable timeframes for initial response, system availability**, etc. and overall consistency with other mandated operating rules required for all HIPAA transactions.
- The CAQH CORE Phase V Operating Rules address needed data content **– consistent member identification, error codes,** and **attachments**, (e.g., medical records, imaging, etc.) in the prior authorization standard electronic transaction – to **reduce manual follow-up by clarifying next steps** and to enable **greater consistency** across PA workflow.

Current Efforts

- Update the Phase IV Rule with a **timeframe for final determination.**
- **Pilot test operating rule requirements and associated standards** to assess impact of requirements on entities' efficiency metrics, identify new requirements and inform industry direction.



CAQH CORE Operating Rules Address Pain Points in the Prior Authorization Process*

- ★ **Consistent patient identification** to reduce common errors and associated denials.
- ★ **Application of standard X12 data field labels to web portals** to reduce variation in data elements to ease submission burden and encourage solutions that minimize the need for providers to submit information to multiple portals.
- ☆ **Standard Companion Guide format** to ensure trading partners are informed of the nuances required for successful transaction processing.

- ☆☆ **System availability** requirements for a health plan to receive a PA request.
- ★ **Consistent review of diagnosis, procedure and revenue codes** to allow for full adjudication.
- ★ **Consistent use of codes** to indicate errors/next steps for the provider, including need for additional documentation.
- ★ **Detection and display of code descriptions** to reduce burden of interpretation.
- ☆☆ **Confirmation of receipt of PA submission** to reduce manual follow-up for providers.
- ☆ **Consistent connectivity and security methods** between trading partners to improve timely flow of transactions and data.
- ☆ **Time requirement for initial response.**

- ☆ **Consistent connectivity and security methods** between trading partners to improve timely flow of transactions and data.
- ★ **Detection and display of code descriptions** to reduce burden of interpretation.
- ★ ***Time requirement for final determination.***

Legend

- ☆ CAQH CORE Phase IV Operating Rule Requirement
- ★ CAQH CORE Phase V Operating Rule Requirement
- ★ *Under development as an enhancement to Phase IV Rule*

***** Depicts a truncated version of a common path for the PA process to follow.

These rules can be piloted to document impact and encourage widespread industry adoption. Implementing the operating rules on top of standards yields maximum benefits to industry organizations. Pilots may also reveal additional opportunities for operating rules for national implementation.

CAQH CORE Prior Authorization Pilot Project

Pilot Vision

Reduce administrative burden for providers and health plans by **applying existing and potential new data content and infrastructure operating rules to close automation gaps in the PA workflow** (relating to discovery of services requiring PA, exchange of PA requests and responses, information needs, etc.).

Pilot Goals

- **Work in concert with industry standards** (existing and emerging: X12, HL7, FHIR, etc.).
- **Rapidly apply existing and develop potential new CAQH CORE Prior Authorization (PA) operating rules** that support greater automation of the end-to-end PA workflow.
- **Ensure that operating rules support industry organizations** in varying stages of maturity along the standards and technology adoption curve.
- **Identify opportunities to refine existing rules and develop additional operating rule requirements** to meet automation needs.
- **Measure the impact of operating rules** and corresponding standards on entities' efficiency metrics.
- **Recommend operating rule requirements to the Secretary of the Department of Health and Human Services (HHS)** for national implementation, given CAQH CORE's designation as the author for federally mandated operating rules.

Pilots to Measure Value of Prior Authorization Operating Rules & Existing and Emerging Standards

Pilots apply existing and potential new Prior Authorization Operating Rule Requirements to the Components that participants choose to test.
Pilot participants select underlying standards and technologies based on capabilities and interest.

Provider System*

Payer System

Component A: Infrastructure

Connectivity, Security, and Data Transfer
(e.g. CORE PIV Connectivity / REST Web Services / DIRECT; Acknowledgments; Response Time, etc.)

Component B: Is a PA required?

Provider Query 1: *Is a PA Required?*

***Options for Exchange*: X12 278 / X12 271 / HL7 FHIR**

Plan Answer 1: *Rejected (missing / inaccurate info)*
Plan Answer 2: *No, PA Not Required*
Plan Answer 3: *Yes, PA Required*
Plan Answer 4 *[278 / FHIR only]: Yes, Required; no Additional Information needed*
Plan Answer 5 *[278 / FHIR only]: Yes, Required; Additional Information needed*

Component C: Is this PA authorized?

Provider Query 2: *Is this PA authorized?**

Options for Exchange*: X12 278 / HL7 FHIR

Plan Answer 1: *Rejected (missing / inaccurate info)*
Plan Answer 6: *PA Approved*
Plan Answer 7: *PA Denied*
Plan Answer 8: *PA Pended (if applicable, Additional Information needs are communicated)*

**Provider may submit Additional Clinical Information concurrently*

* Could be an Electronic Health Record (EHR), Practice Management System (PMS), or an Institutional Clinical System.

Thank you!

@CAQH

Website: www.CAQH.org/CORE

Email: CORE@CAQH.org

CAQH CORE Mission

Drive the creation and adoption of healthcare operating rules that support standards, accelerate interoperability and align administrative and clinical activities among providers, payers and consumers.

Appendix slides for discussion

WEDI Prior Authorization Subworkgroup – Join the Team!

SWG calls

- SWG calls the 1st and 3rd Tuesday of every month
- Contact Samantha Holvey (**sholvey@wedi.org**) to receive call invitations and sign up for SWG iMeet page
- Drafting guiding principles whitepaper to address barriers and proposed solutions to adoption of X12 278

WEDI Prior Authorization Survey

- Tracks for providers, vendors/clearinghouses, and payers
- **Response due August 6**

Current SWG iMeet Discussion

- Input on use of X12 278 when multiple service lines involved on a single request – soliciting feedback and suggested best practices
- Comments due **August 2**

Forecast for Prescription Drug PA Automation

- Partly sunny with a chance of showers?
- Prescription ePA is a maturing technology, and increasingly availability of real-time prescription benefit (RTPB) tools that flag PA requirements will boost ePA adoption
- Yet challenges remain:
  - Inconsistent availability of ePA technology in EHR/eRx systems
  - Costs of ePA implementation (although most ePA solution vendors offer to EHRs for free)
  - Lack of physician awareness (AMA offers 3-part educational ePA video series)
  - Full potential of automation not being leveraged (auto-extraction of data from EHRs to populate ePA question sets)
  - Proprietary tools for RTPB do not offer prescription benefit data across all payers/patients

Forecast for Medical Services PA Automation

- Foggy with limited visibility!
- **X12 278:** Can this transaction be saved, despite 12% adoption shown in 2018 CAQH Index?
- Attachments needed to drive X12 278 adoption . . . Have you seen this rule?

View Rule

View EO 12866 Meetings | Printer-Friendly Version | Download RIN Data

HHS/CMS **RIN:** 0938-AT38 **Publication ID:** Fall 2017

Title: •Administrative Simplification; Health Care Claims Attachments (CMS-0053-P)

Abstract:

This proposed rule would adopt standards and operating rules for attachments based on statutory requirements introduced in the Health Insurance Portability and Accountability Act (HIPAA) and reinforced in the Affordable Care Act. In general, it would apply to circumstances in which a provider attaches clinical information to a transaction that it is being transmitted to a health plan. We are required to adopt standards to facilitate the electronic exchange of clinical information.

Agency: Department of Health and Human Services(HHS)
RIN Status: First time published in the Unified Agenda
Major: Yes
EO 13771 Designation: Deregulatory
CFR Citation: 45 CFR 162
Legal Authority: 42 U.S.C. 1320d-1 to 1320d-4
Legal Deadline: None

Priority: Economically Significant
Agenda Stage of Rulemaking: Proposed Rule Stage
Unfunded Mandates: Undetermined

Timetable:

Action	Date	FR Cite
NPRM	08/00/2018	

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- These emerging technologies are very promising in terms of improving the **transparency** of PA requirements and **automating** clinical data exchange
- Challenges and considerations:
  - Patient care may still be **delayed** by PA if manual/human review of medical documentation is required
  - **How soon** will this technology be available for widespread use across providers of all shapes and sizes – not just big facilities? And what are the costs?
  - What protections do we need to ensure that **only the minimum necessary** clinical data are sent to payers? Will EHRs segment data to prevent exposure of sensitive records (mental health, substance abuse treatment, etc.)?
  - How can we ensure that **providers and patients** are aware of **exactly what data are being sent** to the payer and **what the data will be used for?**
  - Physicians and other providers should have a **choice** regarding automation services that require allowing access to their EHRs and not be required to open up their entire clinical record system to payers as part of network contracting