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Prior Authorization: Physicians' Recipe for Reform

ONC HITAC ICAD
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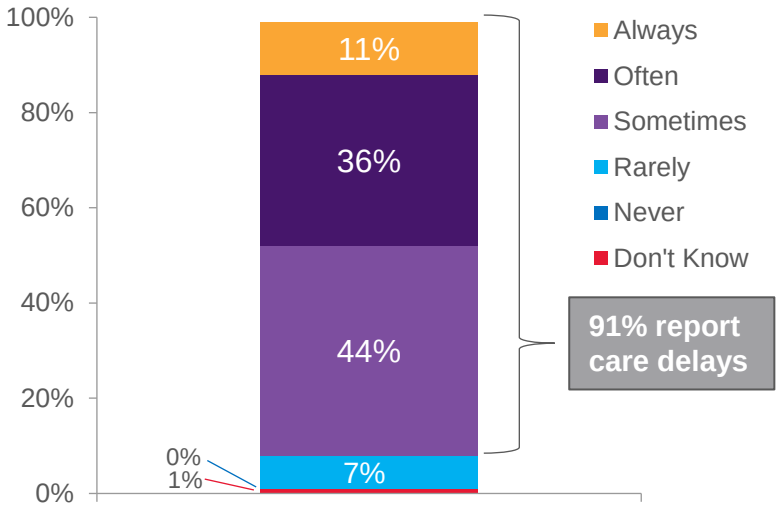
Heather McComas, PharmD
Director, Administrative Simplification Initiatives
American Medical Association

Agenda

- **Current state of prior authorization (PA): not too delightful**
  - 2018 AMA PA physician survey data
  - The human face of PA
- **Where are we on PA reform?**
  - Consensus Statement on Improving the Prior Authorization Process
  - Status of PA reform efforts
- **Observations: we've been listening**
- **Suggestions for path forward**
- **Questions**

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

Percentage does not equal 100% due to rounding.

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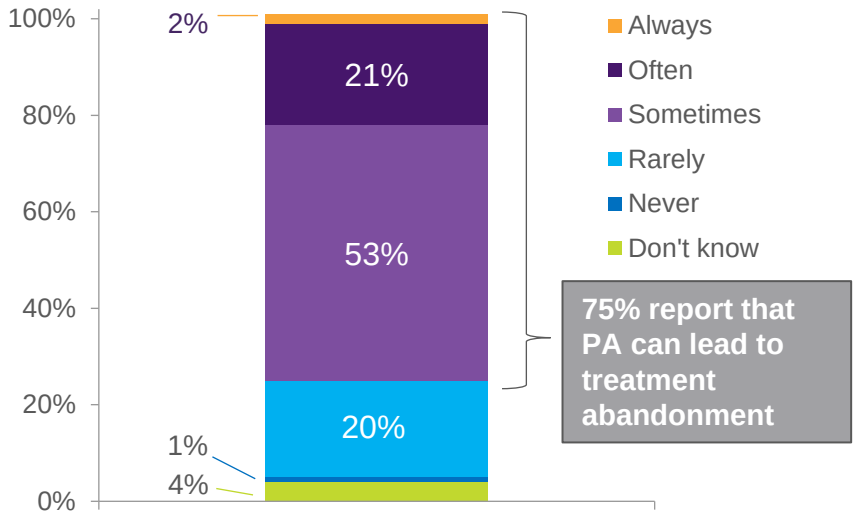
Treatment Abandonment Associated With PA

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

Percentage does not equal 100% due to rounding.
Subgroup percentage sums to 75% due to rounding.

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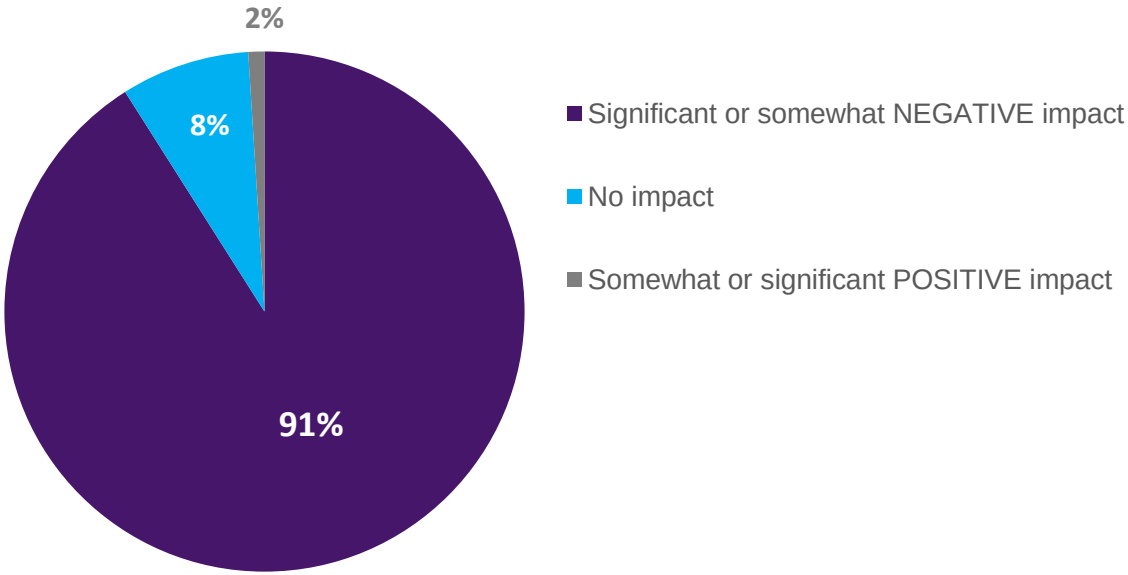
Impact of PA on Clinical Outcomes

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



Source: 2018 AMA Prior Authorization Physician Survey

Percentage does not equal 100% due to rounding.

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Patient Harm: Serious Adverse Events

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

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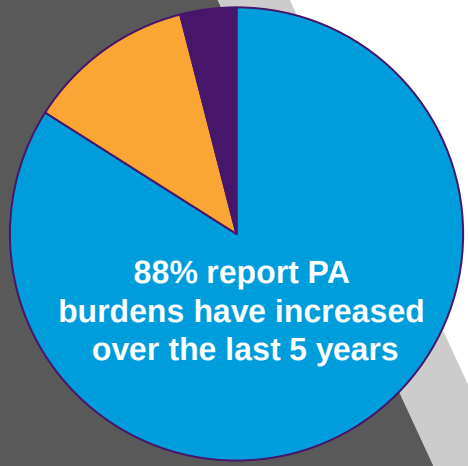
The Burden on Physician Practices



- **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

"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

Watch the video at FixPriorAuth.org

Colin Haller

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 reform categories 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

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*

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

Following the Consensus Statement, Progress Has Been Sluggish

- 86% of physicians report that the number of medical service PAs required 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% of 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; phone and fax are still the most common methods

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ONC HITAC ICAD Task Force: What We've Heard

- Task Force is taking a broad, "sky's the limit" approach
- Consideration for allowing multiple standards to automate the same process (floor/ceiling)
- Prescription drug PA:
  - Established standard exists (NCPDP SCRIPT ePA)
  - Implementation variable across EHRs and payers
  - Even with automation, ePA vendors recommend practices have a "centralized PA team"
  - Exploration of real-time pharmacy benefit (RTPB) technology; current solutions are proprietary
- Medical services PA:
  - HIPAA-mandated X12 278 adoption is weak
  - No mandated standard for exchange of supporting clinical data (attachments)
  - Strong interest in advancing technology, but projects are in prototype/"sandbox" environment

How Do We Win the Great PA Bake Off?

vs.

Ingredients for Success

- **Bottom layer:** Standard technology integrated into EHR ordering workflow that providers use to determine PA requirements across all health plans at the point of care
- **Top layer:** Standard electronic transaction integrated into EHR workflow that supports a payer-agnostic automated PA workflow and minimizes provider burden
- **Icing:** Support for the top and bottom layers to hold the whole cake together; tools to improve adoption of standards
- **Recipe:** Data needed to inform choices in standard selection before we start mixing the batter; metrics to establish baseline and measure progress
- **Scalability:** Multiplication of recipe to serve many guests; baking time for a huge PA cake
- *Toppings:* Extra goodies (e.g., patient communications, cost information, COB) to add after we are sure the cake is stable

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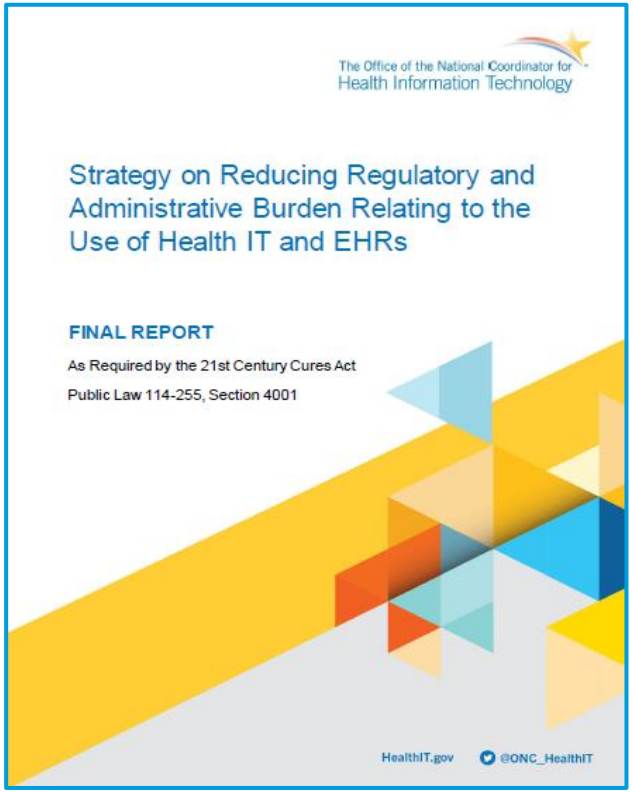
What Could Come Out of the Oven in September?

Ingredient	Prescription drug PA	Medical services PA
Bottom layer	• Finalize NCPDP RTPB standard	• X12 270/271, X12 278, Da Vinci CRD?
Top layer	• Support adoption of NCPDP SCRIPT ePA under Medicare Part D • Mapping of ePA questions to coded references (SNOMED, LOINC, CDA) • Standardized, USCDI-based ePA questions?	• X12 278? • C-CDA mapped to payer criteria? • Da Vinci DTR + PA Support? • Common data set request for each type of PA based on USCDI?
Icing	• Recommend that ONC coordinate pilot efforts to identify best practices for technology integration and establish path to EHR certification requirements	• Recommend that ONC coordinate pilot efforts to identify best practices for technology integration and establish path to EHR certification requirements
Recipe	• Gather baseline data (ePA volume, processing time, etc.) for major PBMs • Track progress	• Establish what data needed to support PA criteria across payers • Cross-payer pilot for a few services; results would inform future recommendations • Gather baseline data and track progress
Scalability	• Consider ROI of using common data set to map ePA questions to coded references • Evaluate path from proprietary RTPB tools to cross-PBM standardized solution	• Evaluate cost/time to practices/vendors/payers to support unique PA criteria across services/payers • Assess standard's ability to support PA volume • Consider common data set for PA requests

We’re Not Half-Baked: See ONC Burden Report

[Clin Doc] Strategy 3: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes

- Integrating **payer coverage rules into EHR workflow** to reduce provider burden
- Adopting **standardized templates, data elements, and real-time standards-based electronic transactions** for PA and clinical attachments
- **Incentivizing use and implementation** of technology that streamlines PA processes and reduces provider burden
- **Supporting/coordinating pilots** of new standard approaches to PA automation
- Leveraging existing data to reduce the total **volume of PA requests** that clinicians must submit



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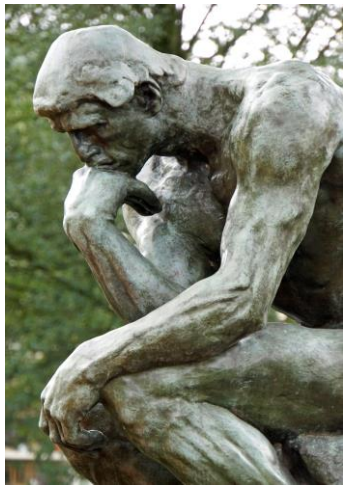
Final Thoughts/Considerations



- Need for PA reform is **urgent** to prevent patient harm and reduce provider burdens
- What **concrete, immediately actionable** recommendations can Task Force make?
- If there **is** an existing, viable standard:
  - Recommend adoption and actions to ensure vendor/payer support
  - Recommend enhanced implementation to further reduce practice burdens
- If there is **not** a viable standard:
  - **Research** PA data needs to ensure any solution will work across payers (e.g., models requiring attestation vs. actual clinical data)
  - Initiate cross-payer **pilot** to test a single PA workflow for a small range of services
  - **Evaluate** the time/costs to implement solution across current volume of services requiring PA
- Establish baseline **metrics** to track progress (e.g., PA volume, approval/denial rates, processing time)
- Consider how **USCDI can be leveraged/expanded** to improve PA and **other types of data exchange**
- Set **timelines** for all actions
- Beware the seductive **siren call of flexibility**
  - Multiple technology options across payers is **not a standard**
  - Without uniform process across payers, there are no efficiency gains for providers
- Keep needs of **small physician practices** in mind – especially in these challenging times

Contact Us

- Heather McComas, PharmD, Director, AMA Administrative Simplification Initiatives heather.mccomas@ama-assn.org
- Access our resources:

  www.ama-assn.org/prior-auth

  https://fixpriorauth.org/

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