Testimony of

The Healthcare Billing and Management Association

Before

The National Committee on Vital and Health Statistics (NCVHS)

Subcommittee on Standards

Prior Authorization Standards

Presented By

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February 16, 2016

Mr. Chairman and members of the Standards Subcommittee. My name is Dave Nicholson and I am here representing my colleagues in the Healthcare Billing and Management Association.

The Healthcare Billing & Management Association (HBMA.org) is a key stakeholder in the $38 billion physician Revenue Cycle Management industry. We have nearly 500 member companies that employ more than 47,000 individuals at billing and revenue cycle practice management firms.

We estimate that annually, HBMA member companies submit more than 350 million initial claims on behalf of physicians and other healthcare providers.

In addition, HBMA members frequently perform all of the physician's practice management functions, accounts receivable management, medical billing consulting, as well as assistance in the preparation and completion of provider enrollment forms and other administrative and practice management services. This includes interactions and communications with Health Plans to verify eligibility, check claims status, seek and obtain, where necessary, prior authorization and the myriad of other administrative task required of a physician's office. Our member companies work with virtually every medical specialty and subspecialty and are knowledgeable, high-volume users of nearly every commercial billing product on the market. In addition, many HBMA members provide coding services in addition to billing – our member companies employ thousands of professional coders, many of who are expert in their respective clinical specialties.

HBMA has been providing education to assist our members and their clients understand and work with the various HIPAA transaction standards and operating rules.

We appreciate this opportunity to offer our views to you this afternoon.

Mr. Chairman and members of the Standards Subcommittee. In a few short months, we will be celebrating the 20th anniversary of the enactment of Public Law 104-191, better known as the Health Insurance Portability and Accountability Act of 1996 or HIPAA.

A lot has happened in healthcare since 1996.

Since 1996, the SGR formula has been proposed, adopted, implemented, suspended, reviled and repealed. We've seen prescription drugs added as a Medicare covered benefit and we've seen a complete rewrite of how health insurance is designed and sold in this country.

Prior Authorization has been around for more than 20 years but for virtually the entirety of its existence, it has been cumbersome, disruptive and costly to both physicians and patients.

In discussing Prior Authorization standards, it is important that we understand that Prior Authorization is a tool designed by insurance companies to be used in a fee-for-service payment system – a payment system that many have criticized because they believe it rewards volume over value.

And it is that criticism – rewarding volume – that prior authorization was intended to address. We recognize that some insurers may argue that Prior Authorization is about more than just volume, it is also about avoiding unnecessary treatment and improving patient care.

Prior to the advent of prior authorization, an insurance company would be obligated to pay for a service or a treatment simply because the physician deemed

it “medically necessary”. Over time, however, insurers began to question the clinical decision making of physicians. Increasingly, under post payment review, insurers were denying claims arguing that the service was NOT medically necessary or a treatment was not needed. In these instances, either the patient would be financially responsible for paying for the ordered service out-of-pocket or the physician to whom the patient had been referred or who had performed an ordered service would have to “eat” the cost.

Neither was an acceptable situation. Thus, the advent of “prior authorization”.

Unfortunately, the pace and complexity of the insurance company’s prior authorization process led many physicians and patients to complain that the process was slow, administratively complex and costly. For physicians and other health care providers, there was a growing concern that insurance companies were using the prior authorization process to improperly discourage the performance of needed diagnostic tests or medically necessary procedures. Insurance companies, argued that they were trying to ensure that the tests and services being ordered had value.

By the mid-90s, the administrative complexities were becoming untenable and the provider community sought federal intervention. HIPAA was the answer – or so we thought.

As part of the Administrative simplification provisions of HIPAA, Congress mandated the establishment of standards that would speed up the prior authorization process and make it simpler for physician’s to comply with the insurers prior authorization requirements.

But HIPAA still did not address the volume issue and by the early 1990s, it was not only commercial insurers who were concerned about volume, the Medicare program was seeing explosive growth in Medicare payments.

Like prior authorization, the previously mentioned SGR payment methodology was another volume control tool.

That was 20 years ago.

Today, even though the healthcare landscape has changed dramatically we continue to struggle with prior authorization requirements.

With that in mind, we make the following observations and recommendations:

1. **Prior authorization MUST be automated and streamlined**

The CAQH/CORE 278 request for response operating rules are sufficient to meet the physician and patient needs – if they are offered and adhered to by the health plans. As you know, adoption and use of the 278 standard is low according to CAQH.

We have been disappointed to see that many practice management vendors do not support the 278 transaction within their practice management and medical billing systems. As such, physician practices – and billing companies that work with physician practices – are required to use the 278 Request and Response submission tools that each HIPAA covered health plan offers, often a web tool to submit the Request.

But it must be mentioned, Mr. Chairman that even when a physician's practice uses the Health Plans own prior authorization process and receives notification

from the Plan that a service is approved, the Plan can still – and does – later refuse payment saying that the prior authorization was issued in error.

Mr. Chairman, if we are going to have a prior authorization process that is meaningful, then the physicians and other health professionals who submit requests MUST have the assurance that they can rely on the answer they receive from the Health Plan. Yes cannot mean maybe.

Health Plans have no difficulty sticking with a No means No policy. They should similarly be required to adhere to a yes mean Yes policy.

It is not clear why practice management software developers have been slow to It develop products for the submission and receipt of the 278 Request and Response transactions but we can't help but think that this may partially explain why use of the 278 option is lagging behind other HIPAA transactions.

2. **Health Care Services Review –Request and Response Real Time Processing Mode Response Time Requirements**

Request must be 20 seconds when processing in Real Time Processing Mode.

We support the real-time processing response time requirement of 20 seconds.

3. **Batch Processing Mode Response Time Requirements**

Must be available to the submitter within one hour of receipt of the Batch To the requester in the case of a Batch of 278 Requests

We support the batch request time of one hour from receipt.

4. **Use of Multiple modalities to comply with the PA standard**

Mr. Chairman, We recommend that the operating rules be enhanced to ensure that each piece of the Prior authorization process is being accomplished electronically, rather than driving practices to the telephone, health plan portal, or fax machine to complete the process.

Finally, we would also like to reiterate an observation we have made on numerous occasions in the past:

5. **Lack Enforcement of the Operating Rules avoids any penalty on the part of the Health plans for failure to fully comply with the operating rules OR work with the Practice Management vendors to develop the tools necessary to make the 278 transactions viable.**

Unless and until there is credible enforcement, setting the operating rules standards will be meaningless. Health Plans must be held accountable for failure to offer a true electronic transaction as envisioned by HIPAA's sponsors when it was adopted 20 years ago.

Offering the appearance of a compliant 278 transaction through the use of the health plans web portal is not acceptable. The 278 transaction for an individual real time request should take no longer than a credit card or debit card transaction with any business with whom we interact.

We recognize that the 278 transaction involves more than the movement of money from one account to another. But the fact is that it is possible – if the true interest

was in streamlining this transaction – to develop algorithms that allow the ordering provider to put certain patient information into the 278 request have that information reviewed by a computer and provider an answer in seconds, not days.

I would note that the process of applying for and receiving credit approval from a bank – a process which used to take days – can now be accomplished in a matter of minutes if not seconds. The banks have developed algorithms that allow the lending institution to do a computerized assessment of the credit worthiness of a potential customer and provide that individual with a response to a loan request amounting to thousands of dollars in mere minutes.

The Future of Prior Authorization

As you know, Mr. Chairman, the "value versus volume" debate I mentioned earlier escalated over the years and in 2015, we not only saw the repeal of SGR, but we saw the adoption of new payment models that will become the norm in just a few years.

Instead of SGR, the physician payment world will be defined by MIPS and APMs.

Why is any of this important and what does this have to do with prior authorization?

We must now ask ourselves whether prior authorization is still relevant? If fee-for-service – as we know it – is no longer going to exist in a few years, are the rules and procedures developed for that payment system going to be necessary?

Is prior authorization the slide rule, the type writer and the rotary dial telephone of this century?

Each of those tools were absolutely critical at one time in our lives but none are in use today. Why? Because technology and the products these tools were designed to address, have changed.

Today, we use calculators to instantaneously perform the tasks once reserved to slide rules. We use computers to perform the tasks of typewriters and digital phones have replaced the rotary phone.

As we discuss prior authorization standards, we must ask - Has the healthcare delivery and payment system changed sufficiently over the past 20 years such that prior authorization is going the way of the slide rule?

Under the new payment models (ACOs, APMs, MIPS population health) physicians and other healthcare providers will be required to assume financial risk for their clinical decision making. If the ordering physician is going to be financially liable for his or her clinical decision making, is prior authorization necessary?

If a physician orders unnecessary tests or unnecessary procedures, he or she will be financially harmed under the new payment models. That being the case, will we see a bending of the volume related cost curve?

We've also seen other tools added to the payment arsenal that may make prior authorization – as we know it – obsolete or at least less prevalent.

In 2014, Congress enacted the Protecting Access to Medicare Act and included in that legislation was a provision mandating that in 2017, physicians ordering advanced diagnostic imaging services consult appropriate use criteria for advanced diagnostic imaging services under the Medicare program.

Ordering professionals will not initially be required to follow the AUC/CDS findings (i.e. whether an image is appropriate) they must only attest that they consulted with an approved AUC/CDS. We believe that eventually, ordering professionals will be required to either follow the AUC/CDS findings on appropriateness or be able to clearly demonstrate why they overrode the AUC/CDS findings.

An important component of obtaining approval as an AUC/CDS is that the tool was developed by a physician-led entity. We believe that having the AUC tools developed by physician-led organizations is critical to their acceptance by the physician community.

It is easy to see how this approach to "prior authorization" could be a vast improvement in the PA process and if appropriately implemented, eliminate the need for insurance companies to undertake their own review process.

Mr. Chairman and members of the Subcommittee, in an ideal world, Prior Authorization could go away for many specialties and many services.

We recognize that it will like be a long time before that day may come. Medicaid programs – which are constantly strapped for money – will likely take much longer to adopt new technology and new methodologies that will make the elimination PA much more unlikely.

Mr. Chairman, HBMA supports the CAHQ Phase IV operating rules for prior authorization but getting us where we want to be in terms of this and other transactions will require more than a set of rules.

We must see credible enforcement of these standards otherwise, the standards will not be worth the electronic screens they appear on.