Prior Authorization: AMA Update

NCVHS Full Committee Meeting
Expert Panel on Prior Authorization
November 13, 2019

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American Medical Association

Overview

Review of the Prior Authorization (PA) Landscape

- 2018 AMA PA Physician Survey
- The human face of PA: AMA grassroots campaign and PA in the news

PA Reform Initiatives

- Prior Authorization and Utilization Management Reform Principles
- Consensus Statement on Improving the Prior Authorization Process

Progress on PA Reform

- Reform status
- Why are we stuck?
    - Confusion and paralysis around electronic standards
    - Automation challenges

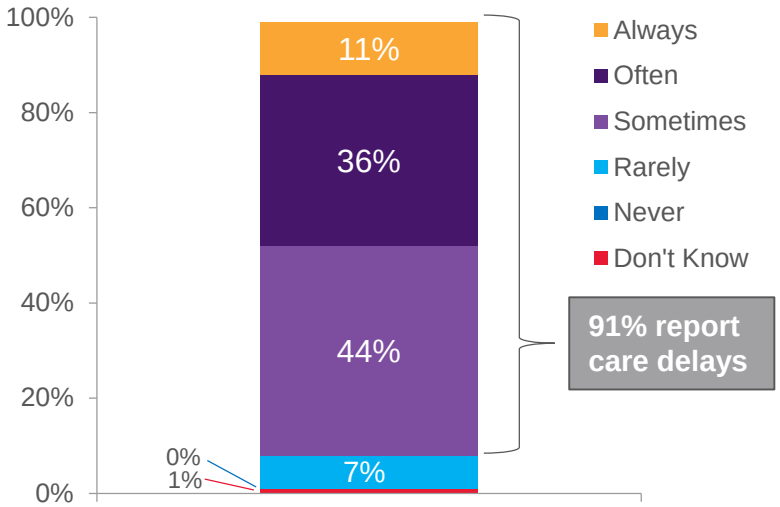
Review of the PA Landscape

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?

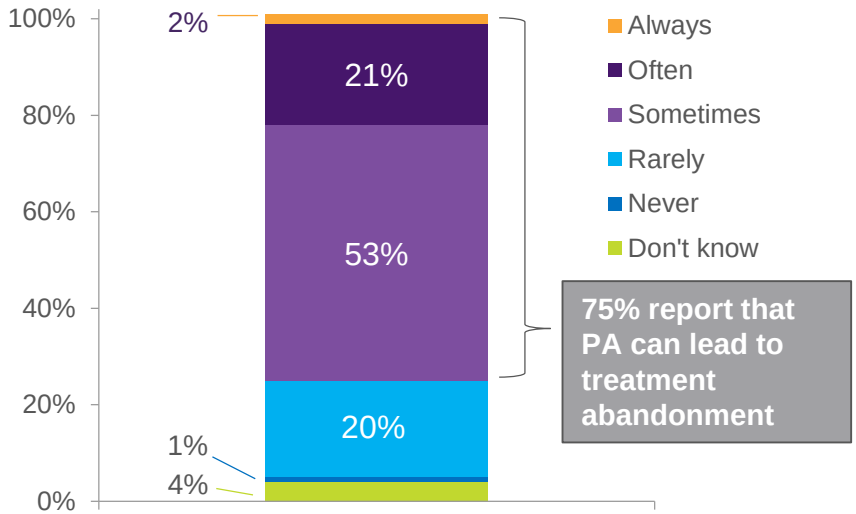


Source: 2018 AMA Prior Authorization Physician Survey

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?

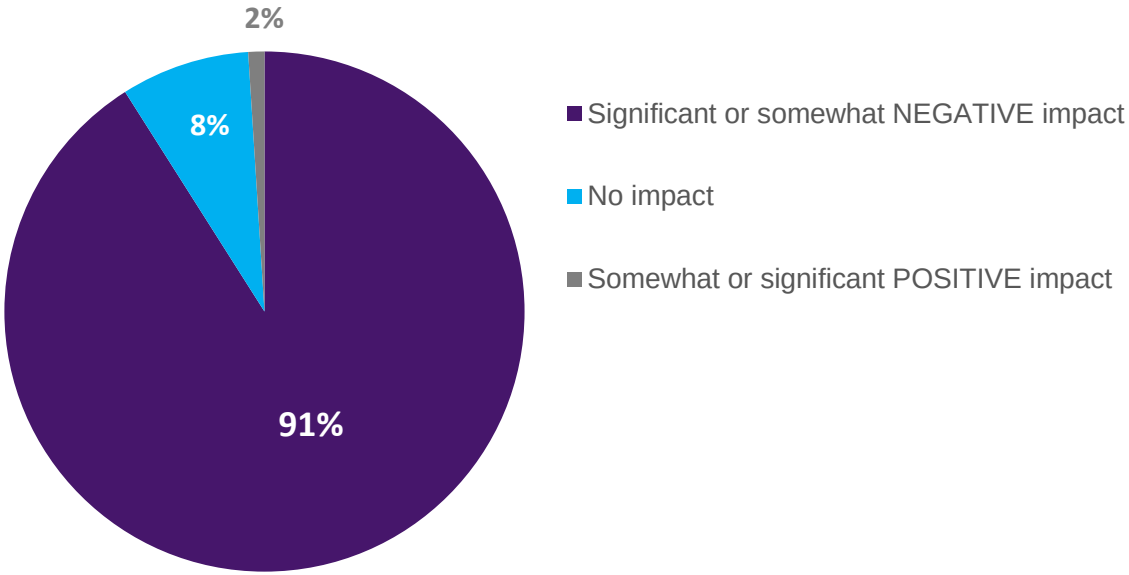


Source: 2018 AMA Prior Authorization Physician Survey

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.

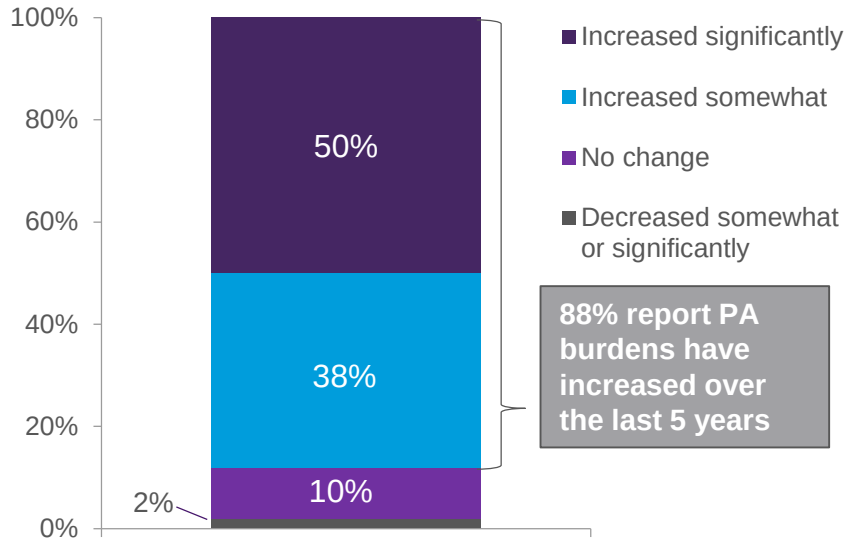
Serious Adverse Events Attributed to PA

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

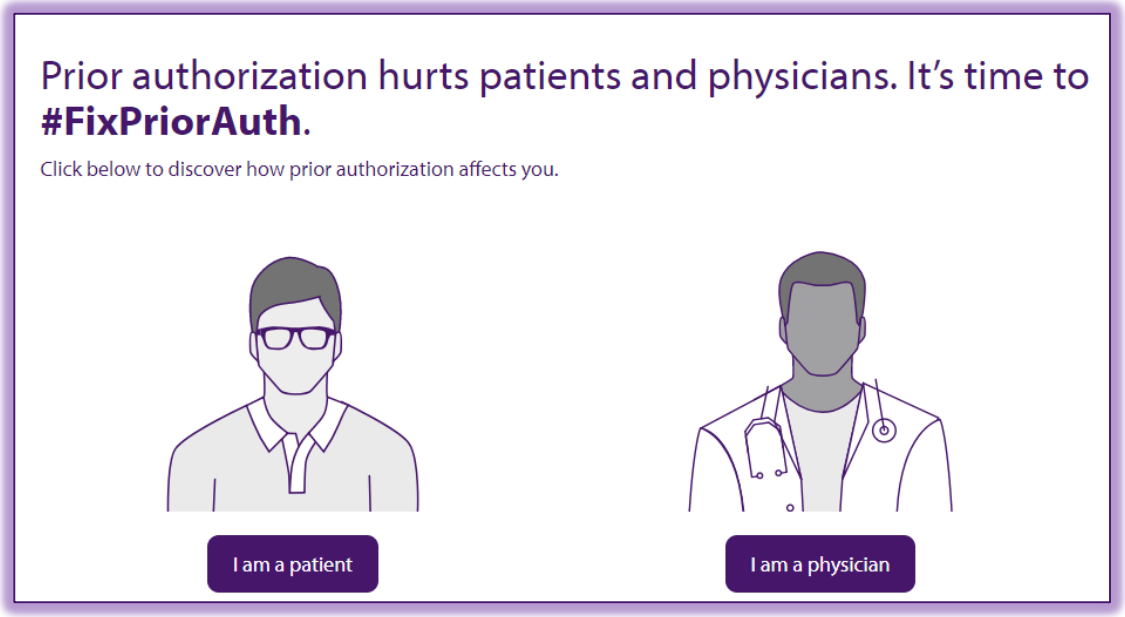
- **Time**
  - Average of **14.9 hours (approximately two business days)** spent each week by the physician/staff to complete this PA workload

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

Source: 2018 AMA Prior Authorization Physician Survey

The Human Face of PA: AMA Grassroots Campaign and Stories

AMA grassroots website: FixPriorAuth.org

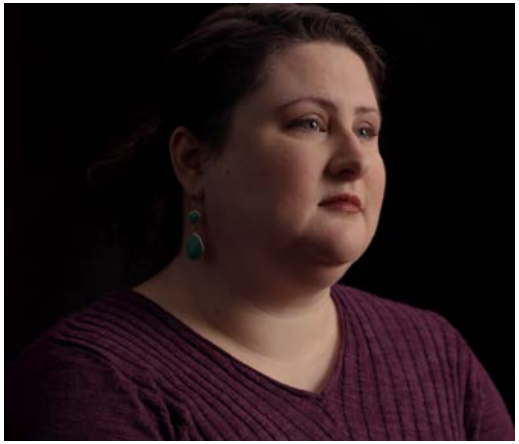


- Physician and patient tracks
- Social media campaign drives site traffic and conversation
- Call to action: Share your story
- Stories collected in site gallery
- Patient/physician PA stories also captured on camera
- Petition to Congress urging PA reform

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

PA in the News

"Dr. Mendel spent 40 minutes on the phone with [my insurer's] designated radiology benefit manager to plead my case to no avail. I would have to delay the procedure and appeal.

Three days later, as I was returning home from a family outing, I experienced two attacks in one night. My wife took me to the emergency room…**I had been walking around with a ticking time bomb in my chest.** The three stents they put in opened the blockages and likely saved my life…

Insurance companies say prior authorization prevents physicians from ordering unnecessary tests and controls health spending. But in my case, [the insurer's] denial led to a four-day hospital stay and the cost of my care soared."*

*https://www.inquirer.com/opinion/commentary/insurance-prior-authorization-pennsylvania-adverse-events-20191028.html

The Philadelphia Inquirer

OPINION

I almost died because of insurance prior authorization rules. Pennsylvania has legislation to fix them. | Opinion

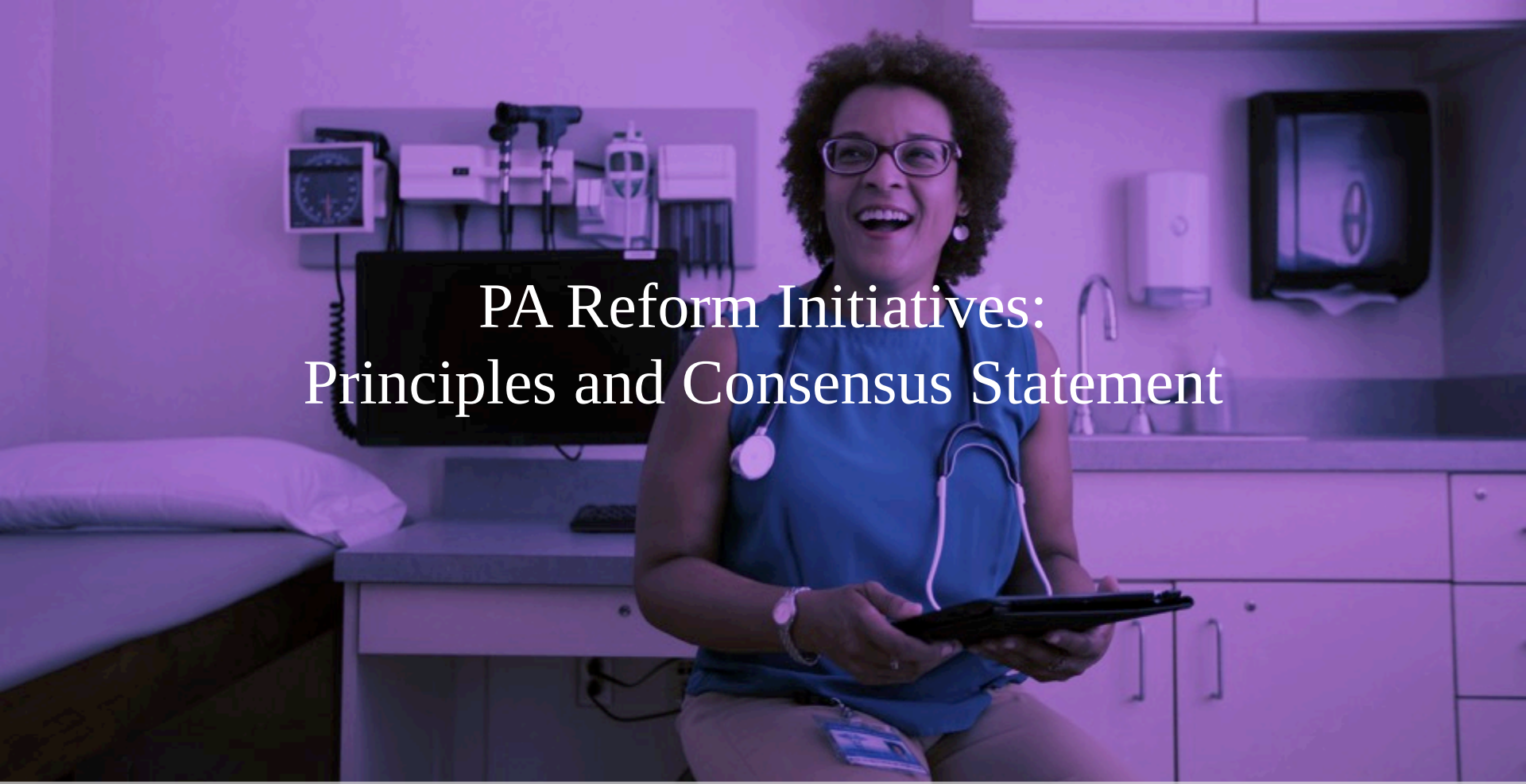
Updated: October 28, 2019 - 1:44 PM

Ross Waetzman, for the Inquirer

VALERIYA POTAPOVA / GETTY IMAGES / GETTY IMAGES/ISTOCKPHOTO

As an active 48-year-old athlete, I don't fit the mold of your typical cardiac patient. I exercise 6-7 days per week and have normal weight and blood pressure. But when I started having chest pains in November, I knew something was wrong.

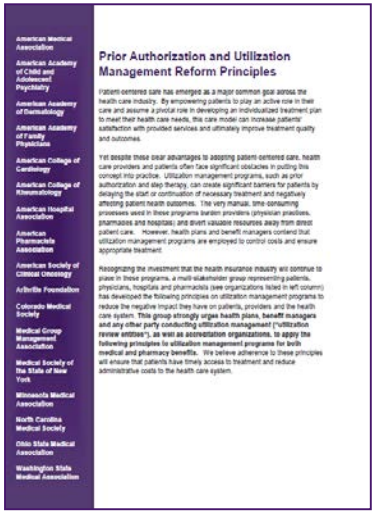
My cardiologist, Dr. Kenneth Mendel, ran a number of tests. My EKG came back fine. My stress test replicated my symptoms but did not show the changes usually seen when blood



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


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 assisting 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.

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

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 areas 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*

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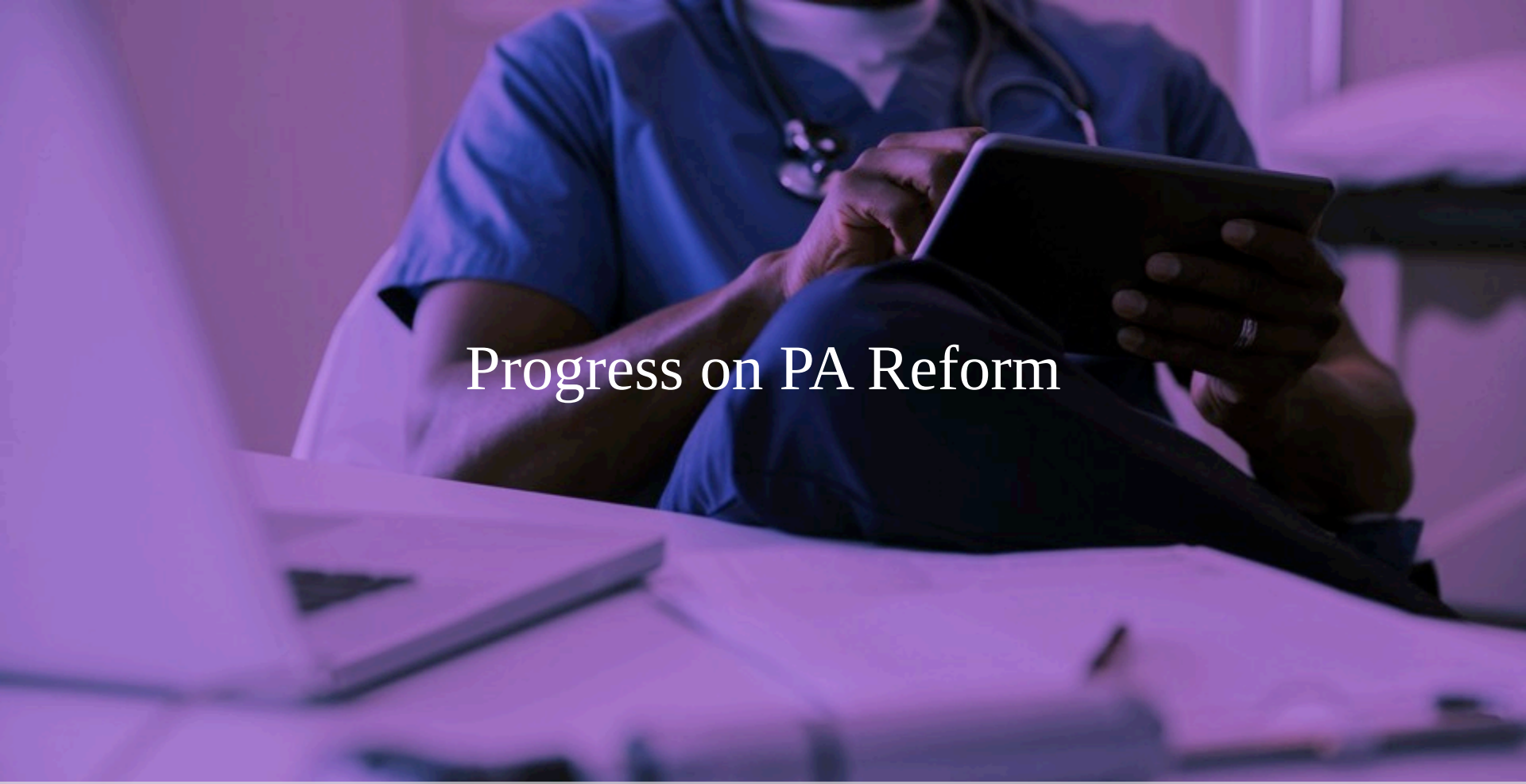
Link to Consensus Statement: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf



Progress on PA Reform

PA Reform Mascot

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.

X12 278: Just the Facts (or Should We Say . . . Fax?)

- X12 278 Health Care Services Review - Request for Review and Response is HIPAA-mandated transaction for electronic PA
- X12 278 adoption reported at 12%, per 2018 CAQH Index*
- For comparison: X12 837 electronic claim adoption is 96%*
- X12 278 can carry only the most basic clinical data
- Most medical service PAs require additional supporting documentation

*Source: 2018 CAQH Index Report

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
- Lack of a HIPAA-mandated electronic attachment standard is a **rate-limiting factor** to automation of medical services PA
- 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
- CMS included attachments on its 2018 Regulatory Agenda
- Vendors, providers, and health plans all need clear direction now so that the industry can begin development and implementation plans

Confusion and Paralysis: How Do We Move Ahead?

- Significant activity on PA-related work with FHIR and Da Vinci has raised questions about the status of electronic standards:
  - Is X12 278 still the best choice for PA?
  - How would/should X12 278 work with FHIR?
  - What are practice costs of implementing both X12 278 and FHIR?
  - What are implications of FHIR on attachment standard?
  - Do we need a new mandate?
- If we aren't ready to make a decision, we need a plan:
  - Request HIPAA exception?
  - Pilot and full report of results (e.g., 2006 AHRQ e-prescribing pilots)
  - Decision on path forward
- Let's **not** have this same conversation five years from now . . .

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Challenges for Automation . . . and Some Recommendations

- Rising **volume** of PAs means a heavy programming lift
  - Selective PA application; review/adjust PA lists to remove low-value PAs
- PA processes are still shockingly **manual**
  - Recognition of value in long-term investment
- Lack of **standardization** in PA criteria and data elements
  - Agreement on standard PA data sets by service type would ease implementation burdens and allay privacy/security concerns surrounding bulk data extraction from EHRs
- Lack of **transparency** in data requirements
  - Improved transparency of clinical documentation requirements at point of care will ease provider burdens and may also promote standardization across health plans when commonalities recognized

Remember: Automation Is Not a Panacea

"Dr. Mendel spent 40 minutes on the phone with [my insurer's] designated radiology benefit manager to plead my case to no avail. I would have to delay the procedure and appeal.

Three days later, as I was returning home from a family outing, I experienced two attacks in one night. My wife took me to the emergency room…**I had been walking around with a ticking time bomb in my chest.** The three stents they put in opened the blockages and likely saved my life…

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Contact Us

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- Access our resources:

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  https://fixpriorauth.org/


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