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NCVHS Subcommittee on Standards Hearing on Proposed CAQH CORE Prior Authorization Operating Rules

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American Medical Association

American Medical Association (AMA): Who We Are

- The AMA is the physician's powerful ally in patient care.
- As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care.
- The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care.
- **Our mission: "To promote the art and science of medicine and the betterment of public health."**

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Prior Authorization (PA) and Patients

- **91%** of physicians report that PA delays necessary care
- **74%** state that PA can lead to treatment abandonment
- **90%** report that PA has a negative impact on patient clinical outcomes
- Nearly one-quarter **(24%)** say that PA has led to a serious adverse event for a patient in their care
- **16%** of surveyed physicians state that PA has led to a patient's hospitalization

Source: 2019 AMA Prior Authorization Physician Survey.

PA and Physician Practice Burdens

- **Volume**
  - **33 average total PAs** per physician per week
- **Time**
  - Average of **14.4 hours** (approximately two business days) spent each week by the physician/staff to complete this PA workload
- **Burdens**
  - **86%** report PA burdens have increased over the last 5 years
- **Practice resources**
  - **30%** of physicians have staff who work exclusively on PA

Source: 2019 AMA Prior Authorization Physician Survey.

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
- PA operating rules can improve transparency and automation – **but volume reduction is still needed**

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

AMA and PA Operating Rule Development

- The AMA participated in all discussions and straw polls involved in the development of the CAQH CORE PA operating rules under consideration, as PA reform is an **advocacy priority** for our physician members
- The AMA urged CAQH CORE to refine the original Prior Authorization Infrastructure Rule to address the response time for final determinations
- **The AMA supports federal adoption of the CAQH CORE PA Infrastructure and Data Content Rules**
    - The Infrastructure Rule represents an important and necessary initial step in reducing patient care delays related to PA
    - The Data Content Rule improves PA-related transparency and communication

Anticipated Value of Proposed PA Infrastructure Rule

- Health plans must provide a final PA determination within **2 business days** of receiving all necessary information
  - Major improvement over existing industry accreditation requirements (14–15 days)
- Health plans must respond to real-time X12 278 PA requests within **20 seconds** and indicate any additional information needed when documentation requirements are referenced in published policy
  - Increased transparency will minimize the time physicians and their staff spend searching for documentation requirements, which widely vary across plans
- Health plans must send a **second, unsolicited X12 278** response with the final determination when an initial PA request is pended
  - Advancement toward end-to-end PA automation; most pended PAs currently drop to manual workflows (phone, fax, or web portal)

Concerns About Proposed PA Infrastructure Rule

- The rule's 2-business-day processing time requirement does not fully address patient care needs
  - Health care is a 24/7 business; **every day is a "business day"**
  - The Prior Authorization and Utilization Management Reform Principles (supported by the AMA, 16 original partner organizations, and over 100 other groups) state that health plans should provide a final determination for nonurgent PAs within 48 hours of obtaining all necessary supporting documentation
  - **48 hours ≠ 2 business days**, especially during a long holiday weekend
- The rule does not dictate a processing time requirement for **urgent PAs**
  - Lack of specifications for urgent PAs is particularly problematic, given that nonurgent PA processing time is defined in business days
  - The AMA urges NCVHS to recommend that any federal rulemaking addressing X12 278 infrastructure requirements includes a provision for **urgent PAs**

Anticipated Value of Proposed PA Data Content Rule

- Health plans must include either a PWK01 Code and/or a Logical Observation Identifiers Names and Codes in an X12 278 pended response to indicate the necessary supporting clinical documentation for certain medical services
  - Improvement in the transparency of PA documentation requirements will save physicians and staff the time involved in searching through insurer manuals, websites, or bulletins
- Health plans must include one or more Health Care Service Decision Reason Code in the X12 278 response, and the code should offer “the most comprehensive information back to the provider”
  - Enhancement in clarity and specificity of PA responses
- Rule provides for consistent and uniform use of AAA error and action codes
  - Reduced confusion due to less variability in messaging between payers

Concerns About Proposed PA Data Content Rule

- The **lack of standards for electronic clinical attachments** will limit this rule's ability to increase adoption of the X12 278
- Over 20 years have passed since the original HIPAA legislation indicated the need for attachments standardization
- Lack of HIPAA-mandated electronic attachment standards 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
- Hope springs eternal: Spring 2020 Unified Agenda suggests a September 2020 release of attachments NPRM

Recommendations to NCVHS on PA Operating Rule

- Because of the anticipated reduction in harmful patient care delays and practice administrative burdens, **NCVHS should recommend federal adoption of the PA Infrastructure and Data Content Rules**
- To protect timely care delivery, NCVHS should recommend that the Infrastructure Rule's **2-business-day requirement be viewed as the "floor"** for the industry and urge shortened processing times in future operating rules
- NCVHS should recommend that federal rulemaking addressing X12 278 infrastructure requirements includes a provision requiring **24-hour processing for urgent PAs**
- NCVHS should reiterate its previous recommendations on the **need for adoption of standards for electronic clinical data exchange (i.e., attachments)**
- NCVHS should consider the operating rules in the **larger context of other concurrent discussions** regarding PA automation (e.g., ONC HITAC ICAD Task Force)*

*See AMA comments to ONC HITAC ICAD Task Force, 5/12/20 – especially regarding need for **research and piloting**.

Contact Us

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- Access our resources:

  www.ama-assn.org/prior-auth

  https://fixpriorauth.org/