3-Part Video Series Trailer

https://www.youtube.com/watch?v=59mFhX02ffk&feature=youtu.be

Leveraging Technology to Improve Prior Authorization

Session #156 - February 13, 2019

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Conflicts of Interest

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

Tyler Scheid, J.D. – Senior Policy Analyst, Administrative Simplification Initiatives, American Medical Association

We have no real or apparent conflicts of interest to report.

Agenda

- **Setting the Stage**
  - Prior authorization (PA) physician survey data
- **PA Reform Initiatives**
  - Prior Authorization and Utilization Management Reform Principles
  - Consensus Statement on Improving the Prior Authorization Process
- **Utilizing Technology to Improve PA**
- **Leveraging Social Media for PA Policy Reform**
  - AMA grassroots efforts
- **Questions**

Learning Objectives

1. Recognize how PA negatively impacts patients and health care professionals using available survey findings
2. Analyze the current status of electronic prior authorization (ePA) adoption for prescription medications, identify current impediments to adoption, and propose solutions to overcome these barriers
3. Describe the challenges that must be addressed to achieve widespread adoption of standardized, automated PA for medical services
4. Explore use of technology to facilitate PA policy reforms
5. Outline how effective utilization of social media and grassroots web technologies can drive important PA policy changes that will benefit health care professionals, patients, and payers

Setting the Stage

PA physician survey data

The Problem

- **Utilization Management Programs:** Cost-containment protocols requiring physicians to receive advanced approval before a health insurer will cover a particular drug or medical procedure
  - PA
  - Step therapy
- **Concerns:**
  - Delayed patient treatment
  - Questioning practitioner's medical judgment
  - Manual, time-consuming process for both providers and payers that requires resources that could otherwise be spent on clinical care

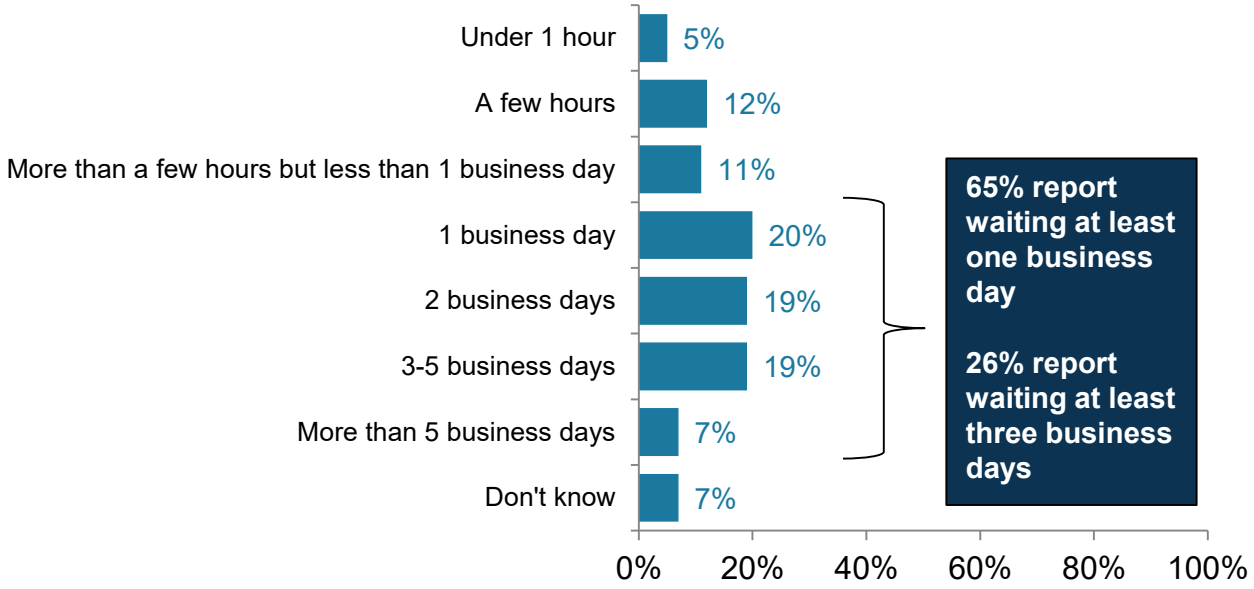
2018 AMA PA Survey Overview

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

HIMSS19

Average PA Response Wait Time

Question: In the last week, how long on average did you and your staff need to wait for a PA decision from health plans?

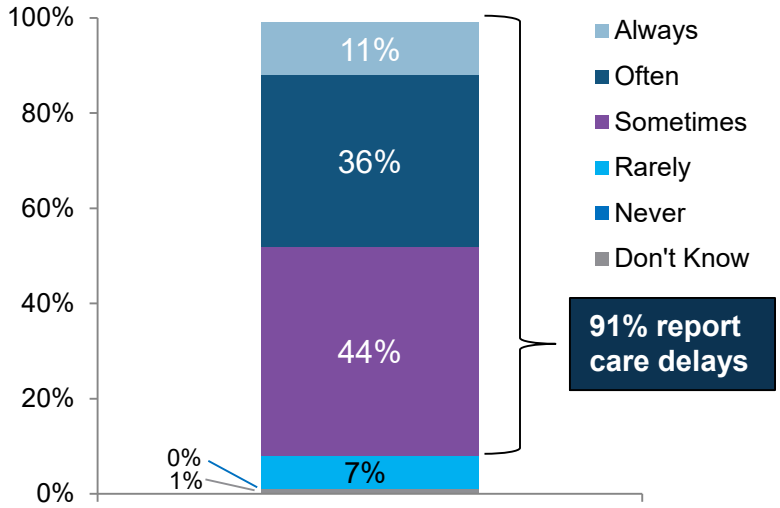


Source: 2018 AMA Prior Authorization Physician Survey

HIMSS19

Care Delays Associated With PA

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



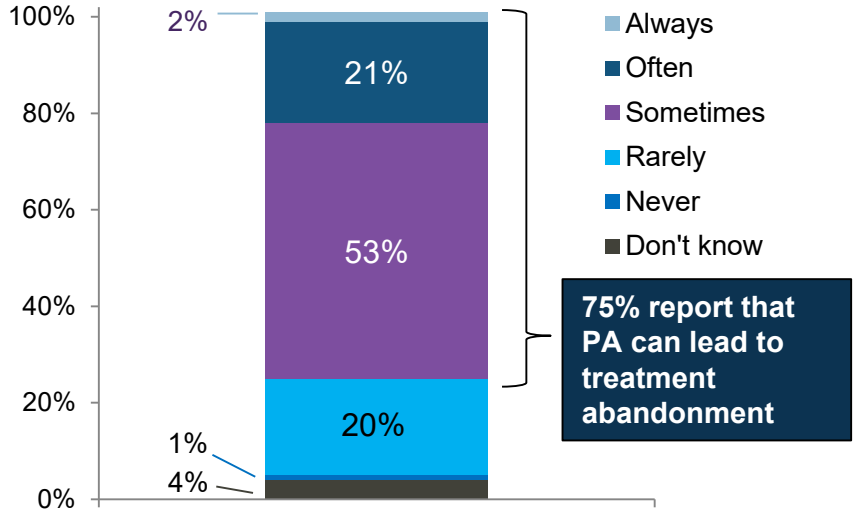
Source: 2018 AMA Prior Authorization Physician Survey

Total does not equal 100% due to rounding.

HIMSS19

Treatment Abandonment Associated With PA

Question: How often do issues related to the PA process lead to patients abandoning their recommended course of treatment?



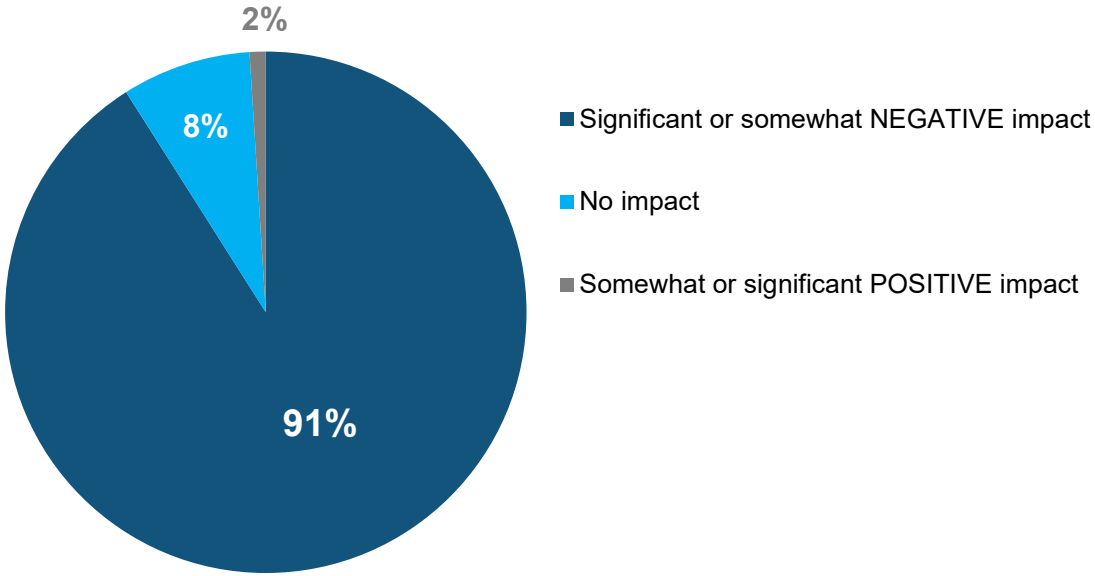
Source: 2018 AMA Prior Authorization Physician Survey

Total does not equal 100% due to rounding.
Subtotal sums to 75% due to rounding.

HIMSS19

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?

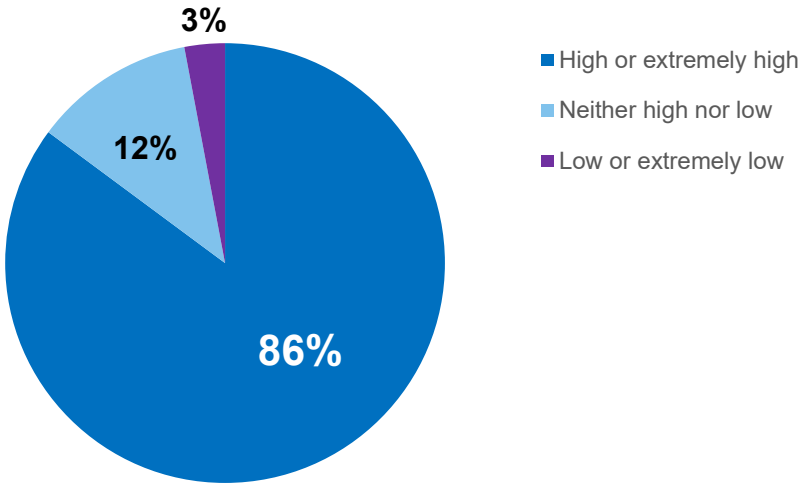


Source: 2018 AMA Prior Authorization Physician Survey

Total does not equal 100% due to rounding.

Physician Perspective on PA Burdens

Question: How would you describe the burden associated with PA in your practice?



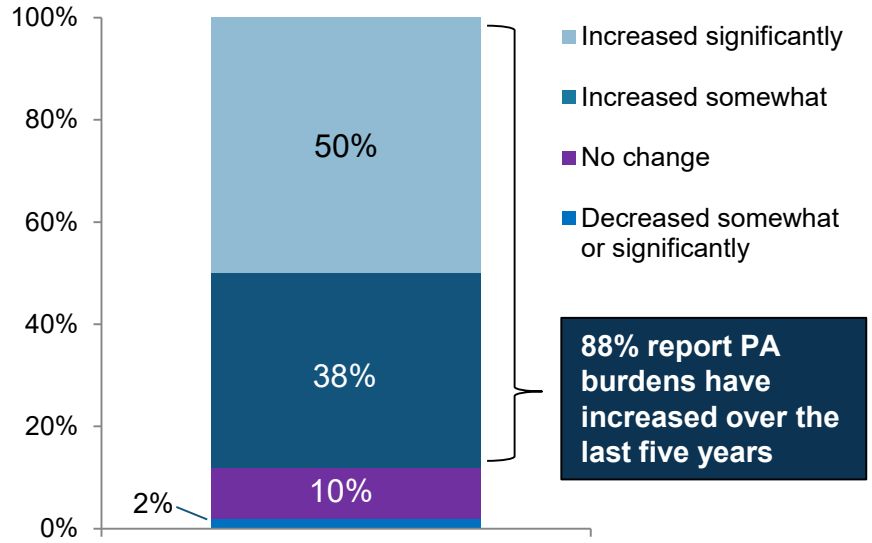
Source: 2018 AMA Prior Authorization Physician Survey

Total does not equal 100% due to rounding.

HIMSS19

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

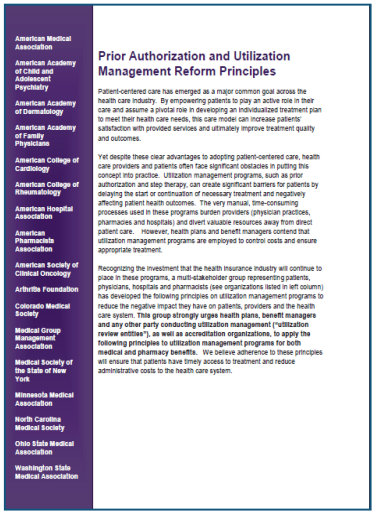
Source: 2018 AMA Prior Authorization Physician Survey

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 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.

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

Prior Authorization Reform Workgroup

- 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

Over 100 additional organizations have signed on as supporters of the Workgroup efforts following the January 2017 release of the Principles.

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

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

Utilizing Technology to Improve PA

Using Technology to Address Areas of the Consensus Statement

- **Areas where solutions <u>developed or well underway</u>:**
  - Automation to improve transparency and efficiency
  - Transparency and communication regarding PA

- **Areas where <u>less work has been done</u> on solutions:**
  - Selective application of PA
  - PA program review and volume adjustment
  - Continuity of patient care

Automation to Improve Transparency and Efficiency

- Consensus:
  - Encourage health care providers, health systems, health plans, and pharmacy benefit managers to **accelerate use of existing national standard transactions for electronic prior authorization** (i.e., National Council for Prescription Drug Programs [NCPDP] ePA transactions and X12 278)
  - Advocate for **adoption of national standards for the electronic exchange of clinical documents** (i.e., electronic attachment standards) to reduce administrative burdens associated with prior authorization
  - Advocate that health care provider and health plan trading partners, such as intermediaries, clearinghouses, and EHR and practice management system vendors, **develop and deploy software and processes that facilitate prior authorization automation using standard electronic transactions**
  - Encourage the **communication of up-to-date prior authorization and step therapy requirements, coverage criteria and restrictions, drug tiers, relative costs, and covered alternatives** (1) to EHR, pharmacy system, and other vendors to promote the accessibility of this information to health care providers at the point-of-care via integration into ordering and dispensing technology interfaces; and (2) via websites easily accessible to contracted health care providers

Standard Electronic Prior Authorization

What it is:

- Automated exchange of patient clinical data between a provider and a payer to facilitate utilization management determination
- Integrated within provider's workflow in practice management systems (PMS)/electronic health records (EHR) (vs. requiring use of separate payer website portal)
- Uniform process across all payers

Why it's needed:

- PA process today is manual (phone, fax) and time-consuming for both providers and payers
- Current process leads to treatment delays and abandonment
- Automation saves all stakeholders time and resources, improves communication, and most importantly, improves patient care

The Problem with Portals

- Improvement on manual processes, but NOT a universal solution
- Limitations/issues:
  - Providers must exit usual EHR workflow to access portals
  - Providers responsible for managing multiple log ins and passwords
  - Each portal is unique, and the lack of consistency burdens providers
    - Must learn individual nuances and adapt to each one
  - Requires significant amount of data reentry from EHRs
- Any PA technological solution must have universal applicability in order to satisfy provider needs and improve efficiency

Electronic PA Standards

Solution to improve prescription PA process:

- NCPDP ePA

Solution to improve medical PA process:

- X12 278 for medical services PA

Prescription PA Process - ePA

Standard History:

- ePA process involves four transactions established in the NCPDP SCRIPT standard
- First published in NCPDP SCRIPT standard V2013071 (2013)

Legislative Mandates:

- **H.R. 6 SUPPORT for Patients and Communities Act (Section 6062) - 10/24/18**
  - Standard, secure ePA system to be established no later than January 1, 2021
  - Facsimile, a proprietary payer portal that does not meet standards specified by the Secretary, or an electronic form shall not be treated as an electronic transmission
- States (including Minnesota, Delaware, and Ohio among others) have passed legislation that requires payers to accept ePA requests for prescription drugs

Status of Pharmacy ePA Adoption

- **Payers:**
  - **96%** of payers are committed to an ePA solution*
- **Vendors:**
  - **79%** of EHRs are committed to implementing ePA*
- **Physicians:**
  - Provider adoption of technology is sluggish
  - **Only 51%** of surveyed physicians were aware of ePA technology#

* 2018 CoverMyMeds ePA Scorecard

Source: 2017 AMA Prior Authorization Physician Survey

Pharmacy ePA Adoption Challenges

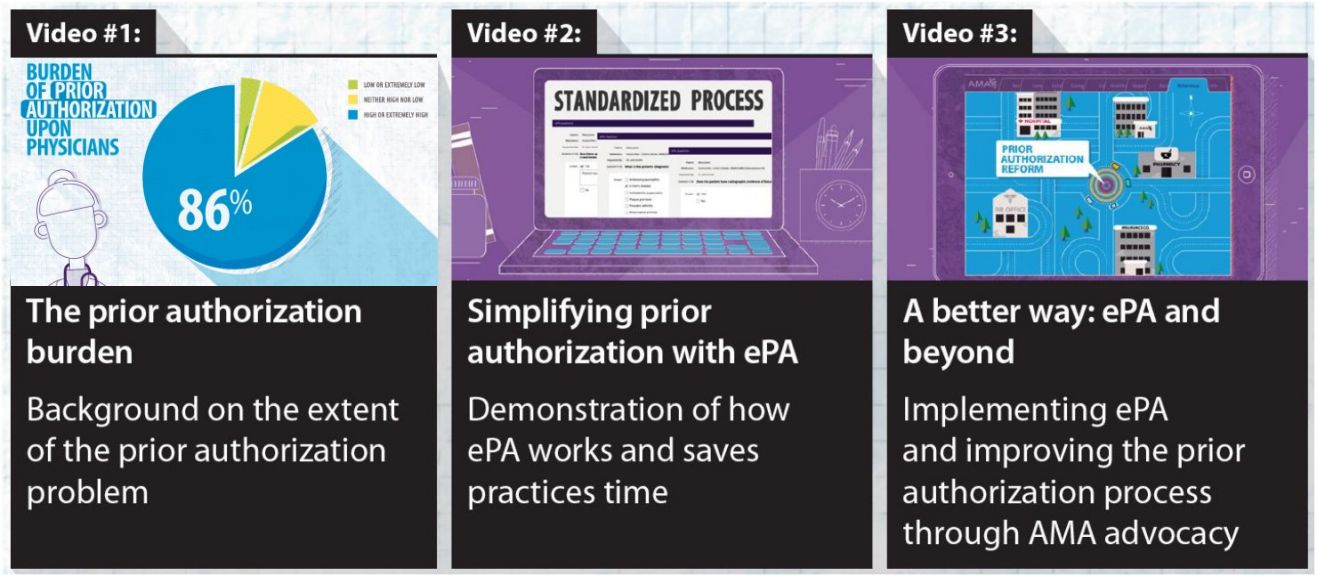
- Vendors not offering no-cost ePA solutions
- Lack of payer support of ePA technology
- Low physician awareness of ePA technology
- Data not being auto-extracted from EHRs
- Confusion/detraction of proprietary portals
- Lack of transparency of PA requirements in EHRs at point of prescribing

Overcoming ePA Adoption Challenges

- Urge vendors to build/offer ePA solutions at no cost to physicians
- Encourage all payers to support ePA technology
- Increase physician education
- Maximize technology to pull data from EHRs (vs reentry of data in question sets)
- Improve accuracy of formulary data/improve real-time pharmacy benefit transactions

AMA ePA Education Efforts

- Committed to educating providers about the advantages of ePA
- 3-part video series – Electronic Prior Authorization: A Better Way



Medical Services Electronic PA

- X12 278 Health Care Services Review - Request for Review and Response is HIPAA-mandated transaction for electronic PA

- CAQH CORE Phase IV Operating Rules address X12 278 connectivity issues (compliance is voluntary)
  - CAQH CORE is developing additional Phase V Operating Rules for X12 278 data content and web portals

Medical Services PA: X12 278 Adoption Status and Challenges

- **X12 278 implementation status**
  - X12 278 adoption reported at 12% (down from 18% in 2016 CAQH Index)*
- **Barriers to adoption**
  - Lack of support across stakeholder groups
  - Lack of an attachment standard to support clinical documentation submission
  - Investment in proprietary portals
  - Multiple iterations of X12 278 to deliver final decision not supported

*Source: 2018 CAQH Index Report

Overcoming X12 278 Adoption Challenges

- Significant industry attention focused on finding solutions
  - CAQH CORE Prior Authorization Subgroup/Rules Work Group
  - WEDI Prior Authorization Subworkgroup
- Rule-making for electronic attachment standard
- Compliance enforcement for X12 278
- Supporting multiple iterations/conversational nature of PA transactions

Transparency and Communication Regarding PA

- Consensus:
  - **Improve communication channels** between health plans, health care providers, and patients
  - **Encourage transparency and easy accessibility** of prior authorization requirements, criteria, rationale, and program changes to contracted health care providers and patients/enrollees
  - **Encourage improvement in communication channels** to support (1) timely submission by health care providers of the complete information necessary to make a prior authorization determination as early in the process as possible; and (2) timely notification of PA determinations by health plans to impacted health care providers (both ordering/rendering physician and dispensing pharmacists) and patients/enrollees

EHR Coverage Information: Static Data

- Updated at predetermined times with data sets that are the same for large groups of plan members
  - Example: NCPDP batch Formulary & Benefit files
- Irregular/inconsistent updates result in outdated and inaccurate information being presented to the prescriber
  - **Only 43%** of surveyed physicians indicated that information about PA requirements in their EHRs is often or always accurate*
  - In informal study using convenience sample of EHR formulary data for 100,000 patients, **only 33%** of formularies contained a least one drug with a PA flag (would expect close to 100%)#
- Inaccurate EHR formulary data can lead to prescription abandonment and medication adherence issues

*Source: 2017 AMA Prior Authorization Physician Survey

Data on file, AMA

EHR Coverage Information: Transactional Data

- Dependent on details such as patient utilization that do not apply equally to a large group of plan members
  - Examples:
    - Real-Time Prescription Benefit (RTPB)
    - HL7 Da Vinci Project
- Newer technologies relay patient-specific, real-time coverage information at the point of care

Real-Time Prescription Benefit

What is RTPB?

- System that delivers patient-specific drug benefit and cost information within the **e-prescribing workflow**
- Provides wide range of cost information including:
  - Out-of-pocket costs, co-pays, and financial assistance programs, among others
  - Utilization management requirements (PA, step therapy)
  - Preferred pharmacy information
- Provides visibility into patient-specific benefits at point of prescribing
- Supports provider-patient conversations about drug selection during office visits, thereby increasing chances of medication adherence

Status of RTPB Adoption

RTPB Pilots

- Number of RTPB pilots from various vendors and PBMs have been introduced and are gaining traction
- While promising, pilots have limitations including:
  - No current solution provides coverage information for all payers
  - Solutions use different syntaxes, hindering interoperability and interconnectivity

RTPB Standard

- NCPDP RTPB Task Group is developing an RTPB standard that will have **two standard formats** (Telecom and SCRIPT) and **one implementation guide** for the real-time exchange of data between providers and payers. RTPB transaction will:
  - Establish patient eligibility, product coverage, and benefit financials for a chosen product and pharmacy
  - Identify coverage restrictions, alternative products, and benefit alternatives when they exist

RTPB and CMS Proposed Part D Rule

Changes to Lower Drug Prices in Medicare Advantage and Part D

- 2018 proposed rule takes steps to increase transparency and accelerate the use of RTPB solutions in Part D
  - Proposes that each Part D plan adopt a RTPB tool of its choosing by January 1, 2020
  - Aggressive timeline may pose challenges for the industry
    - No RTPB standard currently in place

HL7 Da Vinci Project

Background:

- A private-sector initiative that is leveraging HL7 Fast Healthcare Interoperability Resources (FHIR) to improve data sharing in value-based care arrangements
  - Solution is built around specific use cases

Goal:

- Develop a resource that functionally serves as the RTPB for medical benefits

<u>Coverage Requirement Discovery Use Case:</u>

- Providers need to easily discover which payer-covered services or devices have:
  - Requirement for PA or other approvals
  - Specific documentation requirements
  - Rules for determining need for specific treatments/services
- With a FHIR-based API, providers can discover in real-time specific payer requirements that may affect payer coverage of certain services or devices

Selective Application of PA

- Consensus:
  - 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
  - **Encourage appropriate adjustments to prior authorization requirements** when health care providers participate in risk-based payment contracts

Selective Application of PA

- Potential technological solutions:
  - Payers can use data analytics to monitor provider performance to see which providers have high PA approval rates to exempt them from PA programs
    - **"Gold-carding" programs**
      - Payers will continue to use data analytics and monitoring to make sure that gold-carded providers do not change their prescribing/ordering habits
  - **Challenge**: Gold-carding program information must be integrated within EHRs so payer-specific exemptions are relayed to the provider at the point of care/prescribing

PA Program Review and Volume Adjustment

- Consensus:
  - Encourage **review of medical services and prescription drugs requiring prior authorization on at least an annual basis**, with the input of contracted health care providers and/or provider organizations
  - **Encourage revision of prior authorization requirements**, including the list of services subject to prior authorization, based on data analytics and up-to-date clinical criteria
  - **Encourage the sharing of changes to the lists of medical services and prescription drugs requiring prior authorization** via (1) provider-accessible websites; and (2) at least annual communications to contracted health care providers

PA Program Review and Volume Adjustment

- Potential technology solution:
  - Payers can use data analytics to identify what drugs and services have high approval rates and remove these from the PA list
    - Removing high-approval drugs and services from the PA list eliminates unnecessary work for both payers and providers, saving time and money
  - **Challenge**: Payers must continually update coverage data so that current, accurate PA requirements are available in EHRs at the point of care

Continuity of Patient Care

- Consensus:
  - Encourage **sufficient protections for continuity of care during a transition period** for patients undergoing an active course of treatment when there is a formulary or treatment coverage change or change of health plan that may disrupt their current course of treatment
  - **Support continuity of care for medical services and prescription medications for patients on appropriate, chronic, stable therapy** through minimizing repetitive prior authorization requirements
  - **Improve communication between health care providers, health plans, and patients to facilitate continuity of care** and minimize disruptions in needed treatment

Continuity of Patient Care

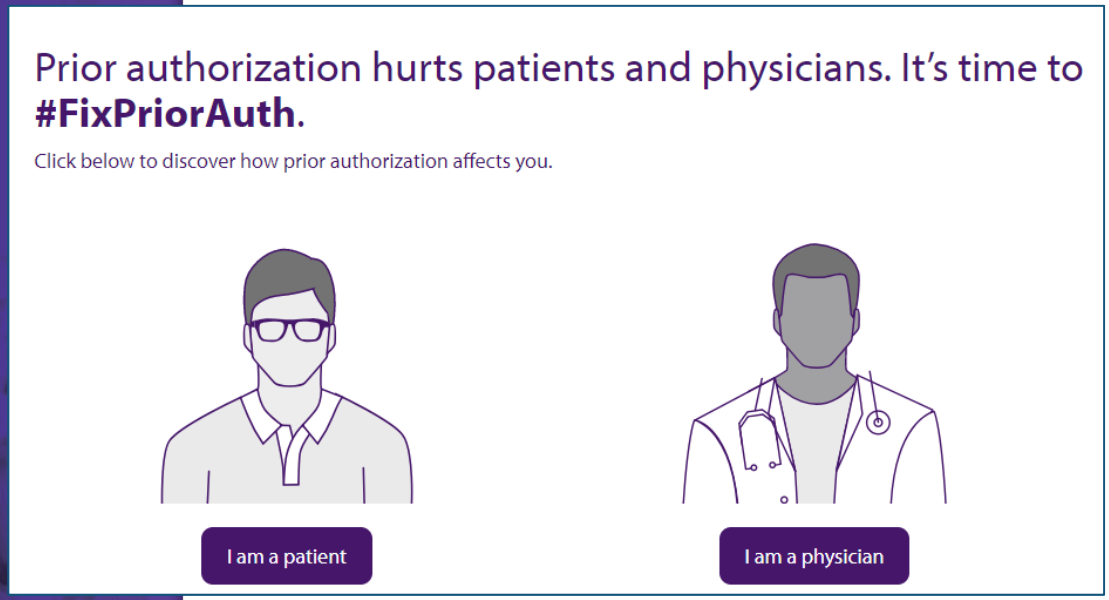
- This area does not have fully developed solutions
  - Improvements in payer system communication and interoperability could facilitate information exchange between payers

Potential technological solution:

- **Blockchain/shared ledger technology**
  - After a patient switches plans, technology could allow payer to see what treatments a patient previously utilized and could avoid unnecessary repetition of utilization management processes
    - Potentially very useful for step therapy requirements
  - **Challenge:** Security measures for sharing protected health information through blockchain technology have not been developed

Leveraging Social Media for PA Policy Reform

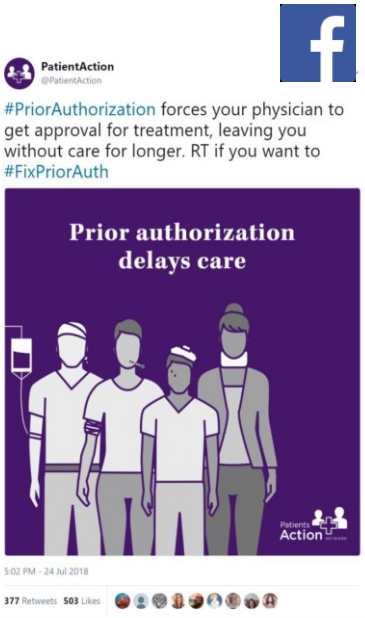
New grassroots website: FixPriorAuth.org

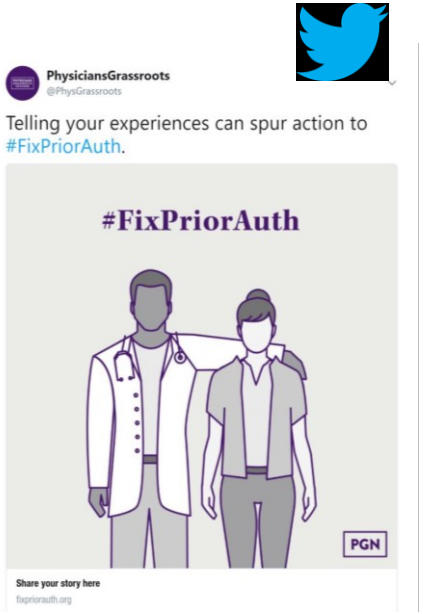


- Physician and patient tracks
- Social media campaign drives site traffic and conversation
- Call to action: Share your story
- Most impactful stories collected in site gallery

FixPriorAuth.org: Grassroots Results Since July 2018 Launch

- Impressions: **+8.0 million**
- New users: **+74,000**
- Engagements: **+340,000**
- Patient/physician stories: **+500**
- Petitions signed: **+89,000** (since mid-October)





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.

AMA Resources

Please share our videos and resources!

ama-assn.org/prior-auth

fixpriorauth.org

Questions?

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Reminder: Please complete online session evaluation

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