American College of Physicians
Leading Internal Medicine, Improving Lives

August 20, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8013

Re: Patients Over Paperwork – Reducing Prior Authorization Burden

Dear Administrator Verma,

On behalf of the American College of Physicians (ACP), thank you for meeting with ACP physician representatives earlier this summer and your concerted efforts to address unnecessary administrative burdens throughout the health care system. We greatly appreciate your ongoing outreach and collaboration with the College and the broader health care community, and believe that the Centers for Medicare and Medicaid Services (CMS) has listened and developed important policies as a result. We understand the Agency is seeking more details on areas of meaningful change regarding prior authorization (PA) burdens, and ACP has a number of recommendations to significantly improve the process. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 159,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Through our Administrative Tasks and Best Practices Data Collection Tool hosted on ACP's Patients Before Paperwork webpage, we continue to collect descriptions of burdensome administrative tasks as well as cost and time estimates for each particular task. As CMS is well aware, prior authorization (PA) tasks continue to be one of the top burdensome issues reported by our membership, coming in second behind clinical documentation burdens. According to the examples reported within ACP's database, our members estimate spending, on average, 30 minutes of either their time or staff time on each PA request. The cost to the practice varies depending on whether the physician is taking their own time to complete the PA or whether other clinical staff are completing the request. If the physician is completing the request, the estimates of cost range from $100-$400 per request. Members also report having to hire additional administrative and clinical staff within their practice to handle these burdensome tasks. Some of the most common examples include hiring one full-time nurse for the practice focused on overhead and paperwork, while other examples calculate their clinical staff's hourly rate by 1-3 hours dedicated to the PA workload per day.

As ACP noted in our recent feedback on the Agency's Patients Over Paperwork Request for Information, recent surveys of physicians found that 91 percent reported PA resulted in care delays for their patients and had a negative impact on clinical outcomes, with 28 percent indicating PA led to a serious adverse event for their patients. Sixty four percent of physicians wait at least one business day for PA decisions from a health plan, while 7 percent wait over a week. This delay can have major negative implications for patient health. Over three quarters of patients abandon their course of treatment at least some of the time as a result of PA.[1] In addition to causing potentially dangerous delays in patients getting the medications, devices, or treatments they need, the hassles that come along with submitting a PA request sometimes require unnecessary in-person appointments, adding burden on the patient and cost to the system. Further, 86 percent reported high burden associated with prior authorization.[2] On a weekly basis, practices field 29 PA requests per physician on average, which absorbs 15 hours to complete. One third of physicians had dedicated staff who work exclusively on fielding PA requests. The prevalence of PA is only increasing. Half of physicians reported that burden in the last five years had increased significantly, while only 14 percent reported no change or a decrease.[3]

A report from the Council for Affordable Quality Healthcare (CAQH) found that 88 percent of PA transactions are completed either partially or completely manually, which is extremely inefficient and burdensome.[4] Moving to an electronic process for PA transactions would help streamline the disparate and burdensome manual processes in the current environment. From a technical perspective, ACP supports CMS' recent efforts to promote the use of a specific technical standard (National Council for Prescription Drug Program's SCRIPT standard) for electronic PA, which we agree is the appropriate standard to use for further implementation of and improvement to the electronic PA process. Furthermore, standardizing PA reporting requirements, data and structure definitions across payers would reduce the burden of PA requests dramatically. Health information technology (health IT) can and should be an integral tool in facilitating this. **ACP urges CMS to collaborate with private payers, the Office of the National Coordinator for Health IT (ONC), health IT vendors, physician organizations, and other necessary stakeholders to establish a standardized set of clinical definitions for data elements and report formats for PA requests so that health IT can be programmed to generate and send this data automatically.** This agreement and process should be done in a transparent manner and include input from all necessary stakeholders. This harmonization would reduce practice costs for data interfaces; reduce the time physicians and their staff spend completing additional forms; and reduce the time payers spend reviewing requests – freeing up time and resources to promote high-value patient care such as care management services. The adoption and consistent implementation of standards will reduce variability across electronic health records (EHRs) and health IT systems – and ensure the functionality meets necessary requirements and does not end up decreasing EHR usability and increasing physician burden.

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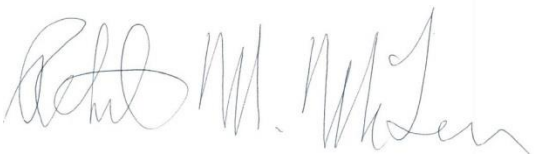
[1] ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc/prior-auth-2017.pdf
[2] https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf
[3] https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf
[4] https://www.caqh.org/sites/default/files/core/phase-v_CORE_RuleSet.pdf

Moreover, CMS should establish transparent practices across payers for posting which medications and devices are subject to PA and the associated documentation requirements to lower the number of denials. The College strongly supports efforts for payers to disclose publicly, in a searchable electronic format, a payer's requirements (including PA requirements and patient cost-sharing information) for coverage of medical services. This publicly available information will be useful and necessary for health IT vendors to begin to automate the process. Additionally, the various portals of data transmission across payers are a significant burden and there is not only a need for standardization in processes and requirements, but also standardization of methods of data transfer across payers.

As CMS engages in industry initiatives that facilitate payer access to clinical data stored within the physician's EHR, ACP strongly contends that payer access to these data should never be used to disadvantage beneficiaries in any way and should never be a determining factor for coverage of services. The College voiced our concerns with payer's increased access to clinical information in our recent comments on CMS' Interoperability and Patient Access Proposed Rule. While historically physicians have controlled the patient's clinical data in determining what to submit to obtain reimbursement for care provided, payers would now have access to information outside of the scope of the specific service being billed. It is possible that payers could impose barriers or restrictions on coverage for medically necessary care that a patient may have received previously. We have heard reports from members that private payers with access to only certain types of clinical data (e.g., for epidemiological research and reporting purposes), through contractual agreements, have inadvertently gained access to patients' entire clinical record throughout the health system – which led to an increase in queries from the payer regarding inpatient payments. Any effort to reduce PA burden through payer access to clinical data should be done in a completely transparent manner and, as mentioned previously, never be used to disadvantage beneficiaries or determine coverage of services.

Thank you for considering our recommendations for reducing PA burdens and for your ongoing outreach and efforts through the Patients Over Paperwork initiative. The College has a number of members who would be more than willing to host CMS at their practices to experience firsthand how these PA issues affect the ability to provide high-value patient-centered care. Please contact Brooke Rockwern, MPH, Health IT Policy Associate at brockwern@acponline.org if you have any questions or need additional information.

Sincerely,



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