**AMA Messaging on CMS Patients Over Paperwork Prior Authorization Initiative**

Prior authorization (PA) ranks among the top concerns of AMA members, both in terms of the impact on timely care delivery and practice administrative burdens. The results of the 2018 AMA Prior Authorization Physician Survey clearly illustrate the negative effect that PA can have on patient clinical outcomes and physicians' workload. **We believe the Centers for Medicare & Medicaid Services (CMS) must be a leader and serve as model for commercial insurers on PA reform.**

**Summary of Reform Efforts**

In early 2017, the AMA and a coalition of physician, medical group, hospital, pharmacist, and patient organizations, released a set of *Prior Authorization and Utilization Management Reform Principles*. The principles aimed to improve and "right-size"—not eliminate—PA programs by addressing clinical validity, continuity of care, transparency, timely access, and administrative efficiency, as well as alternatives and exemptions for PA. Over 100 organizations signed on as official supporters.

The Principles led to the release of the *Consensus Statement on Improving the Prior Authorization Process*.

- Authoring organizations for the Consensus Statement were the AMA, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association.
- It reflects an important agreement between care providers and insurers on critical PA reforms to reduce overall PA volume (through both selective application and regular review/adjustment of PA lists), improve transparency, ensure continuity of care, and automate PA processes.

**Reform Status**

Unfortunately, progress on operationalizing the concepts in the Consensus Statement has been slow, as shown in the AMA's Industry Checkup (subset of 2018 PA survey results). **We urge CMS to encourage uptake of the Consensus Statement's themes among industry stakeholders.**

**Background on CMS Approach to PA Improvement**

- As with many other payers, CMS seems focused on improving and automating the PA **process**, not engaging in a conversation about whether PA should exist.
- CMS, along with major national commercial payers, has invested heavily in the Da Vinci Project, which leverages HL7 Fast Healthcare Interoperability Resources (FHIR) technology to facilitate electronic exchange of clinical data and involves extraction of information from physicians' electronic health records (EHRs).

**Caveat: Automation Is NOT a Full Solution to the PA Problem**

The AMA supports automation of the PA process using standard electronic transactions. We believe that the Da Vinci Project has the potential to improve PA process transparency and efficiency. However, Da Vinci only addresses (at best) 2 of the 5 reform areas identified in the Consensus Statement (improving transparency and automation). **Any conversation about PA with CMS should reiterate that Da Vinci and other automation technologies do not represent a complete PA solution.**

- Overreliance on automation sets the stage for increased volume of PA because it will be "easier."
- Lack of EHR vendor support is a significant rate-limiting barrier to physician use of PA automation. For example, our 2018 survey results found that only 21% of physicians report that their EHR system offers electronic PA for prescription medications. **The practice costs of adopting this technology are unclear and could be significant.**

**Specific Concerns With Da Vinci and FHIR Technology**

- Da Vinci/FHIR processes will allow payers to access a practice's EHR. We have already seen instances of health plans either requiring, or offering as a "burden reduction" service, unfettered access to a practice's EHR. **There are no indications to date of how plans will ensure that they only access the minimum amount of information necessary for PA/payment purposes.** Payers running data analytics on every patient's medical record may end up increasing the number and type of PAs.
- There are multiple potential consequences of plans having such access (e.g., Will a plan be able to access information on patients beyond those enrolled in that plan? **Will a plan start using the information to make coverage decisions that impact or override a physician's medical judgement?**).
- Plans may try to use contracts (and terms hidden in provider manuals) to strong-arm physicians into using automation tools like Da Vinci. **It should always be voluntary for physicians to use such tools.**
- **A fully automated/electronic PA process will not eliminate/prevent dangerous care delays.** Manual review of medical information may be required after documentation has been electronically exchanged, as suggested by the allowed processing times for Medicare PA programs (10 days for Medicare fee-for-service PA demonstration projects, 14 calendar days for Medicare Advantage coverage determinations for services/items, and 72 hours for regular Part D requests).
- It will be difficult for Da Vinci to succeed if plans won't disclose their PA criteria and expose their coverage requirements in EHRs. The lack of standardization of the criteria hinders automation efforts.
- There is a disconnect between technologic capabilities and reality: FHIR is still an emerging technology that is not yet widely implemented across EHRs and practice management systems. The provider groups currently involved in Da Vinci (and those that will be most likely to initially have access to FHIR) will be large physician groups and facilities. Even among health plans that have invested significant resources in Da Vinci, it will be years before this technology is widely used. CMS has indicated that the esMD (Electronic Submission of Medical Documentation) system is not FHIR-enabled and this transition will take some time to accomplish. **Da Vinci offers no PA relief for small physician practices in the near future.**

**Transparency is Critical**

- Plans have claimed that PA helps them to protect patients from inappropriate care. This does not make sense given how many different PA clinical criteria plans use. If they are really using valid, evidence-based criteria created by specialty societies, there should be far less variation in PA criteria.
- Both the AMA and CMS have heard that plans can't reveal criteria and/or discuss standardization because of antitrust concerns. We do not agree with this reasoning: First, physicians and patients – i.e., those who would be impacted by the "collusion" – would embrace standardization and transparency. Second, any valid clinical guidelines are publicly available (e.g., on specialty society websites) and are not proprietary.

**AMA Asks of CMS on PA Reform**

We have urged CMS to take a leadership role on this issue and develop a **comprehensive strategy** to address PA concerns that includes all areas of the Consensus Statement:

- Selective application of PA (CMS should continue the successful Targeted Probe and Educate program; the AMA supports identification of outliers and education as needed);
- Review/adjustment of services/drugs that require PA to eliminate low-value PA – applying PA to services with high approval rates is costly for plans and providers;
- Improved communication of PA requirements to patients and health care professionals (including CMS encouraging plans to disclose the clinical basis for their PA requirements);
- Protections of patient continuity of care, particularly when patients enroll in new plans or plans change PA requirements; and
- Automation to improve PA transparency and process efficiency while maintaining physician oversight of payer access to EHR data.