



May 2, 2018

The Honorable David Schweikert
U.S. House of Representatives
Washington, DC 20515

Dear Representative Schweikert,

On behalf of the American College of Physicians (ACP), I thank you for the opportunity to provide feedback on the Standardizing Electronic Prior Authorization for Safe Prescribing Act of 2018 (H.R. 4841). We applaud your efforts to reduce the burden associated with the prior authorization process and ACP supports this legislation as a good first step in streamlining administrative processes. However, we believe that there are elements of the bill that could be strengthened and we offer some recommendations below on how to achieve that. We also suggest the need for greater harmonization of standards and automation of prior authorization across the health care industry, as a goal for broader legislation in the future, and as a way to reduce administrative burdens on physicians and patients.

The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 152,000 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.

Understanding the Burdens Associated with Prior Authorization

The major source of administrative burden associated with the prior authorization process is the varying forms, data elements, and submission mechanisms required by payers in order to complete the prior authorization. HR 4841 establishes a uniform and electronic method for transmitting prior authorization requests and responses within the Medicare Part D program and is a good first step in streamlining the process for clinicians.

Electronic Transmittal of a Prior Authorization Request

ACP supports Section 2 of H.R. 4841, which provides for the secure electronic transmittal of a prior authorization request from the prescribing health care professional for coverage of a Medicare Part D drug to the PDP sponsor or Medicare Advantage organization offering such plan. It also requires a response from said sponsor or Medicare Advantage organization back to the professional.

ACP recommends strengthening this section by specifically including the need for “timely responses from payers,” such as PDP sponsors or Medicare Advantage organizations, to clinicians ordering a prescription that requires prior authorization via the secure electronic transmission. Receiving a response to a prior authorization request after the patient has left the office, even if it is transmitted electronically, causes additional, unnecessary administrative work outside of the patient visit and can delay appropriate treatment for the patient. A timely response (at the point of care) is integral to streamlining this process. Additionally, the legislation should require the payer’s response to include precisely what documentation is needed in order for the clinician to reverse a negative coverage decision. In order for the electronic transmittal to actually be useful to the clinician, decrease burden, and improve patient care, the response from the payer must contain actionable information so the clinician can either easily provide any missing information or provide a clinically appropriate alternative to their initial prescription.

Specifically, the language should read:

“(II) a **timely** response, in accordance with this subparagraph, from such PDP sponsor or Medicare Advantage organization, respectively, to such professional, **clearly describing why, if necessary, the request was rejected and exactly what information is needed for approval, or provide clinically appropriate alternatives.**”

Harmonizing Standards and Automation of Prior Authorization

It is often the case that when a clinician is required to obtain prior authorization for any type of health care service, including prescription drugs, the major source of administrative burden is the varying requirements and procedures for collecting the necessary data among both private and public payers. A clinician must often go through additional steps beyond what is necessary for them to appropriately prescribe a medication in order to provide information for the prior authorization request, which could vary based on the patient’s health plan (even within the Part D program). This means the clinician constantly has to deal with differing data elements and report formats, often creating unnecessary or duplicative tasks on the part of the clinician in completing the prior authorization request and ultimately taking time away from providing high-value patient care.

Section 2 of H.R. 4841 includes a *Sense of Congress* that greater priority should be placed on increasing the adoption of such electronic prior authorizations among prescribers of such drugs, pharmacies, PDP sponsors, and Medicare Advantage organizations. While ACP supports that intent of Congress in the context of this legislation, we believe more substantial and expansive policy reforms are needed to standardize data elements and report formats so that health information technology (health IT) could be programmed in the first place to generate and send the necessary prior authorization criteria automatically. In order to achieve this, it would be necessary to convene stakeholders, including the Centers for Medicare and Medicaid Services (CMS), private payers, clinicians and electronic health record (EHR) vendors to accept the same


clinical definitions for data elements and report formats, and work together in a transparent fashion.

Ideally, there should be little to no need for the clinician to enter unnecessary data or perform a duplicative task outside of the clinical workflow. The technology exists to perform this very process but the underlying data standards and elements vary across payers and vendors. If prior authorization reporting requirements are standardized, and stakeholders agreed to use the same data and structure definitions, the burden of prior authorization would be reduced dramatically and EHRs could become one of the key solutions to reducing administrative burden.

If this harmonization of standards and automation of prior authorization across the industry was achieved, it would dramatically reduce practice costs for data interfaces; reduce the time clinicians and their staffs 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.

As the healthcare system continues to evolve from one based on volume to one based on value of services provided, it is important to address the issue of excessive administrative tasks and the serious adverse consequences it has on patients and physicians. H.R. 4841 represents a good step forward in streamlining administrative processes, with respect to prior authorization under Medicare's Part D Program. We look forward to working with you on future initiatives.

Sincerely,

A handwritten signature in blue ink that reads "Ana Maria Lopez". The signature is written in a cursive, flowing style.

Ana Maria Lopez, MD, MPH, FACP
President