NCVHS Testimony on Operating Rules for Prior Authorizations

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On behalf of the American College of Physicians and our 141,000 members, who are dedicated to the provision of high value care, thank you for this opportunity to offer testimony today. My comments will focus primarily on operating rules for prior authorization for referrals and healthcare services, as these are most pertinent to our membership and their patients.

Reducing administrative burden is critically important. In 2009, clinician groups spent approximately $214 billion on conducting administrative tasks, with half of these tasks considered by the IOM to be excessive.[i] This approximately $107 billion reflects time diverted from patient care; clinicians spend approximately 43 minutes per day on these largely unnecessary administrative tasks, with staff spending significantly more time than that.[ii] Further, adoption and optimization of electronic health records, an endeavor the ACP supports, is in jeopardy because to date, the promise of EHRs leading to more efficient care by reducing practice burden has not been kept.

The College would like to offer unqualified support for this proposed operating rule, as, it could potentially reduce costs, improve EHR usefulness, and free up time that would allow clinicians to focus on improving quality and outcomes. However, while we appreciate CAQH's efforts, we do not believe that this work would lead to anything more than marginal improvements in efficiency for clinicians, as it neither addresses the most burdensome components of prior authorization; nor resolves the need for prior authorization – which is the lack of transparent and accurate information about cost and coverage. While we specifically note our concerns about clinician efficiency and cost, it is ultimately patients that pay the price of the unresolved administrative inefficiency. Each hour of staff time spent on unnecessary administrative tasks is an hour not spent on patient care.

This rule only addresses the process of requests and responses for prior authorizations, but it does not address the other requirements that are typically part of prior authorization, including content – which is often uniquely specified for each plan, and clinical attachments. Therefore, the College believes that this approach would result in a significant number of referrals or healthcare services requiring additional manual processes prior to approval. And while we appreciate that this first step of addressing requests and responses can be followed with operating rules for content and attachments, a more significant problem remains. Payers are completely unfettered in their ability to require unique content and content formats that are not readily evident to the clinician and that, typically result in the need for additional information gathering and duplicative documentation. Without greater transparency and

standardization, this issue would not be resolved even with establishing new operating rules. Further, while most of what is required by payers to request referrals or other services exist in a clinical document, and thus could be readily extracted, payers have generally not accepted this approach, and in fact are increasingly requiring manual entry of any number of clinical data points, all of which exist in the EHR, into paper forms or proprietary systems.

The College believes that technology could reduce administrative burden through iterative operating rules for administrative simplification; but only where the standards and policy within those rules ensure transparent, logical, and predictable approaches across all payers. These rules should also leverage existing applicable standards and technology wherever possible – rather than to create duplicative parallel processes – leading to a compelling and efficient solution. One such solution, use the just proposed infrastructure rules for prior authorization and add a trajectory to re-use structured information contained in a certified EHR and delivered via the existing or modified Summary of Care Document. This approach would obviate the need to create standards and rules for content and attachments, as well as creating real value for clinicians for EHR use and interoperability. Note that such an approach would not require new regulations, incentives or penalties.

That said, the College strongly believes that the optimal solution is not just to make prior authorizations easier to resolve, but to avoid them wherever possible. This approach, which utilizes technology to bring transparent, accurate, and actionable cost and insurance coverage information to patient and clinician before and at the point-of-care not only reduces administrative burden; it facilitates informed value-based shared decisions about treatments and testing.

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[i] Institute of Medicine Roundtable on Evidence-Based Medicine, "The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary"; McKinsey Global Institute, "Accounting for the cost of US health care: A new look at why Americans spend more" (2008): 1–122.

[ii] Lawrence Casalino and others, "What Does It Cost Physician Practices to Interact with Health Insurance Plans?" Health Affairs 28 (4) (2009): w533–543.