**National Committee on Vital and Health Statistics (NCVHS)**

**Subcommittee on Standards**

**Hearing on Prior Authorization Operating Rules**

February 16, 2016

**Public Comment from Anthony J Schueth, MS on Electronic Prior Authorization**

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Ladies and Gentleman of the Subcommittee:

My name is Tony Schueth, and I am CEO and Managing Partner of Point-of-Care Partners (POCP), a health IT Strategy and Management consulting firm that focuses on subject matters such as ePrescribing and ePrior Authorization, and then works with stakeholders in those transactions. I am also the leader of the NCPDP Prior Authorization to Workflow Transactions Task Group.

I am pleased to submit these comments during the Public Comment today to highlight the need for electronic prior authorization (ePA), a topic about which I am passionate. I am doing so on my own dime and of my own accord, not on behalf of any client. I am motivated to share my concerns because I — like many testifiers here today — believe ePA would make health care better for everyone. My comments today are not on ePA for medications but ePA for devices, procedures and diagnostic tests.

Prior authorization in this realm has long been problematic because of its antiquated, time-consuming paper, fax and phone work flows. It is frustrating for payers, providers and patients, and delays critical care for those in need. I believe that PA is a necessary quality and necessity check and cost-savings measure, and that frustrations will ease with the ubiquitous use of ePA.

A Successful Model

I am familiar with NCVHS because of its hearings on ePrescribing. When NCVHS first started hearing testimony on ePrescribing in 2005, its level of adoption was comparable to what ePA is today —minimal. A decade later, 80% of physicians are prescribing electronically. Lessons learned can be applied to ePA.

Like ePrescribing, ePA is a many-to-many transaction with one or more intermediaries. Those intermediaries are critical to ePrescribing's success, as were transaction standards, and a solid infrastructure. I believe we have that today with the X12N 278.

ePrescribing also was successful because recommendations to spur its adoptions were developed by NCVHS and adopted by the Centers for Medicare and Medicaid Services (CMS). Then usage incentives were introduced under the 2010 Medicare Improvements for Patients and Providers Act (MIPAA).

ePA needs those kind of drivers to incent the two most important stakeholders in this transaction – providers and, in my opinion, most importantly payers – to make the technology and workflow changes necessary to implement such a system and to do so in relative parallel. (The reason I highlight payers as being the most important is because, in our analysis, payers have not yet built the back-end integration

to support ePA. *Without ePA being at least as fast if not faster than a paper-, fax- and phone-process, providers are not apt to adopt.*)

I believe the path forward involves several incentive-based approaches, focusing on these two key stakeholders.

Recommendations

**First, I believe there needs to be incentives for payers to build an automated back-end to process standardized ePA requests. That can be done through Medicare Advantage's STARS Performance Measures, specifically by measuring patient satisfaction with health plan performance and access to care.** As it currently stands, the non-electronic PA process is a nightmare for patients, often resulting in significant delays for therapies. Linking PA with patient satisfaction (and ultimately payment) would create a reason for health plans to improve the PA process through electronic means.

**Further, successful demonstration of a working solution and transaction standards create a platform, which can be used to advocate that the government mandate the development and use of fully automated ePA as an operating requirement for Medicare Advantage plans.**

The other critically important stakeholder is the provider, who can be influenced by Medicare payments. **I recommend ePA as an incentive in one or both of the new Medicare value-based quality programs — Merit-Based Incentive Payment System (MIPS) and the Alternative Payment Models (APMs) — that were created under recent Medicare payment reform legislation. It may also possible to require ePA under Meaningful Use stage 3; if it is too late for that, use of ePA certainly can be required in future programs, regardless if they are created by statute.**

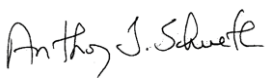
While some physicians may be open to ePA as part of new reimbursement models that focus on quality and pay-for-performance – as one of your testifiers said -- that is well in the future and will not be true for all providers. I believe that providers need to be incentivized to use ePA right now so that both sides of the ePA transaction are appropriately motivated and in a similar timeframe. Furthermore, physicians need the cooperation of their EHRs. *Building ePA functionality will not be a high priority for EHR vendors if physicians are not asking for (demanding) it or it is not required by regulation.*

In Conclusion

Like ePrescribing before it, ePA will become successful only if policy and payment levers are brought to bear. The time to start is now. All consumers of healthcare will be better for it.

I wish to thank the Subcommittee again for the opportunity to make a public comment on this important issue. I would be pleased to answer any questions that you may have or provide additional information. I can be reached at 954-346-1999 or tonys@pocp.com.

Respectfully Submitted,



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