Volume 4, Issue 8 August 2017

Population Health NEWS

The Time Is Ripe for Prior Authorization Reform

by Charles W. Stellar

Ask any physician about the biggest time waster in their practice, and they likely would say prior authorization (PA). Three-quarters of 1,000 practicing physicians surveyed by the American Medical Association (AMA) late last year said the prior authorization burden is "high or extremely high." Each individual physician fielded nearly 37 PA requests in the week before taking the survey, and answering those requests consumed nearly 17 hours of physician and staff time.[1]

Any way one slices it, that's too much time deferred from direct patient care. Payers are simply doing their jobs to satisfy requirements that insurance is being used properly. The same challenges of PA vary little from those in the 1970s, when the process was first introduced.

One would think by now that insurers would have settled on the information required to approve a certain drug, test, device or procedure; however, time and again physicians express exasperation at being thrown curveball questions that require more research or additional information. Despite the rise of utilization management vendors, software and more standardized forms, the issue hasn't abated. If anything, it appears to be growing worse if physicians surveyed are to be believed.

Fortunately, several efforts are under way to standardize PA forms to bring more sanity to the process. The role of the Workgroup for Electronic Data Interchange (WEDI) is to help other organizations find common ground, identify gaps and bring payer, provider and vendor representatives together to tackle this issue head-on.

(continued on page 6)

In This Issue

1 The Time Is Ripe for Prior Authorization Reform

1 Predicting Readmission Risk in a Cardiac Population

2 Population Health Engagement: Population Health Survey Shows Decrease

7 The Case For Patient-Centered Assessment of Value

10 Thought Leaders' Corner: How Is Evidence-based Medicine Being Used to Improve Health Outcomes?

11 Industry News

12 Catching Up With… David Veroff

Predicting Readmission Risk in a Cardiac Population

by Deirdre Baggot, Ph.D., R.N.

With good reason, the Centers for Medicare & Medicaid Services (CMS) has signaled a move toward holding providers accountable for 90-day readmission rates as opposed to 30 days that have been the focus since the Hospital Readmission Reduction Program (HRRP) was first announced in 2010. While there have been steady declines over the last five years in 30-day readmission rates in the Medicare population overall, 90-day readmission rates in a number of populations remain high.

In 2015, for example, nearly 40% of patients were readmitted within 90 days of discharge in the Medicare acute myocardial infarction (AMI) population. Similarly, in 2015 nearly 20% of Medicare beneficiaries having coronary artery bypass grafting were readmitted within 90 days of being discharged from a hospital.

Generally speaking, a hospital readmission occurs when a patient is admitted to a hospital within a specified time period after being discharged from a previous hospitalization.

The Affordable Care Act (ACA) established HRRP in which Medicare reduces payments to hospitals that have relatively high readmission rates for patients in traditional Medicare. Beginning in 2013 (Table 1), under the HRRP, hospitals with readmission rates that exceed the national average receive a reduction in payments across all of their Medicare admissions—not just those which resulted in readmissions.

Prior to comparing a hospital's readmission rate to the national average, CMS adjusts for certain demographic factors, such as age and illness severity. CMS then calculates a rate of "excess" readmissions, which determines a hospital's readmission penalty.

(continued on page 4)