



Physicians Caring for Texans

March 25, 2022

Micky Tripathi, PhD, MPP  
National Coordinator for Health Information Technology  
Office of the National Coordinator for Health Information Technology  
Mary E. Switzer Building, Mail Stop 7033A  
330 C. Street SW  
Washington, DC 20201

RE: Request for Information: Electronic Prior Authorization Standards, Implementation Specifications, and Certification Criteria | [Federal Register Notice](#)

Dear Dr. Tripathi,

On behalf of the Texas Medical Association (TMA), which has a membership of more than 56,000 physician and medical student members, we thank you for the opportunity to provide input on your request for information (RFI) on electronic prior authorization standards, implementation specifications, and certification criteria.

TMA appreciates that the Office of the National Coordinator (ONC) wants to make health care more efficient through innovation and automation, which also has the potential to reduce physician burden. ONC's RFI on this topic is important, as prior authorization was meant to be a check on the medical necessity of expensive and less common services and treatments, yet both public and private payers are increasingly applying prior authorization requirements to basic and routine patient care. The overutilization of prior authorizations negatively impacts patient care and injects wasteful inefficiencies into the health care system.

A 2020 TMA survey revealed that Texas physicians saw a drastic increase in prior authorizations over the past five years. In fact, 87% say this burden increased, and nearly half (48%) of physicians had to hire staff solely to process prior authorization requests.

In a [2021 survey by the American Medical Association](#), 82% of the physicians surveyed reported that prior authorization can at least sometimes lead to treatment abandonment by the patient. In the same survey, 34% of physicians reported that prior authorization led to a serious adverse event for a patient in their care.

A [Medical Group Management Association \(MGMA\) Stat poll](#) conducted in May of 2021 showed that 81% of medical groups indicated that payer prior authorization requirements increased since 2020. In another [MGMA Stat poll](#) conducted on March 1, 2022, 79% of respondents indicated that prior authorization requirements increased in the past 12 months.

The surveys indicate the payer community continues to push the prior authorization envelope despite concerns expressed by health care stakeholders and patients who have been, and continue to be, negatively impacted by their extensive use.

Prior authorizations contribute to physician burnout, as their requirements frequently take physician time away from direct patient care. The burden of prior authorizations is exacerbated by a tight labor market as physicians must deal with the pandemic-era phenomenon known as the Great Resignation, which has left practices short of office staff needed to meet ever-increasing prior authorization demands.

Simply put, this is unsustainable. The growing prior authorization burdens add significant administrative expense and waste to the overall health care system.

**For this reason, TMA emphasizes that though we appreciate any efforts made to decrease the inefficiencies of prior authorizations, an efficiency applied to unnecessary work only allows users to do unnecessary work faster.** TMA, therefore, reiterates stressing the importance of eliminating unnecessary prior authorizations.

That being said, TMA specifically addresses questions that ONC poses in the RFI asking about “Impact on Providers,” below. (We recognize that even though there are medication examples in our response, this RFI is limited to electronic prior authorization for items and services other than medications that patients seek.)

*To what degree is availability of electronic prior authorization capabilities within certified health IT likely to reduce burden for health care providers who currently engage in prior authorization activities?*

TMA is concerned that although there may be some initial efficiencies to electronic prior authorization, it may turn into the same data bloat that physicians experience with electronic health records (EHRs). Physicians now receive daily reams of prior authorizations on medications, from expensive chemotherapy medication for cancer treatment to a low-cost oral diabetes medicine. The process entails payers faxing a sheet of paper requiring the physician to manually transcribe the authorization numbers into the payer’s site. The physician then waits while the payer’s application programming interface (API) asks the physician basic demographic questions on the patient, essentially causing the physician to do the work for the payer or collect information the payer already should have on the patient. The value of the time spent by the physician on this activity often costs more than the medication. Physicians are not optimistic that payers will invest in the technology tools needed to make electronic prior authorizations as efficient as ONC envisions.

*To what degree are health care providers likely to use these new capabilities across their patient panels? Will additional incentives or requirements be needed to ensure health care providers effectively use these capabilities? What accompanying documentation or support would be needed to ensure that technology capabilities are implemented in ways that effectively improve clinical workflows?*

It is likely that physicians will only use electronic prior authorizations when – once fully implemented – it will be a payer-required method, leaving physicians without a choice.

Physicians should be paid for the time spent on prior authorizations. TMA policy states:

Authorizations Initiated by Third-Party Payers, Benefit Managers, and Utilization Review Entities: The Texas Medical Association supports policy and legislation that (1) third-party payers, benefit managers, and utilization review entities may not implement prior authorization mechanisms unless these payers compensate physician practices for work required independent of any payment for patient care; specifically, medical practices must be compensated for the burden of added staff and resources required to navigate payer-initiated prior authorizations for medications, studies, or procedures; (2) third-party payers, benefit managers, and utilization review entities should disclose all prior authorization requirements and restrictions on their websites in both the subscriber section and the physician section with neither location requiring a log-in or password; (3) third-party payers, benefit managers and utilization review entities should confirm patient eligibility, payment

determinations, medical policies and subscriber specific exclusions as part of the prior authorization process; and (4) third-party payers, benefit managers, and utilization review entities should make detailed statistics regarding prior authorization approval and denial rates available on their website.

Physician payment is determined using the [resource-based relative value scale](#), which aligns payments based on the cost and resources used to provide services using three factors: On average, (1) physician work is 51% of the value; (2) practice expense is 45% of the value; and (3) medical liability is 4% of the value. A recent [RAND study](#) details the five practice expense categories for care delivery.

**Figure 3.1. Practice Expense Categories**

Staffing	Clinical services supplies and equipment	Office space	Office Supplies and services	Professional Services
<ul style="list-style-type: none"> <li>• Nonphysician clinical staff</li> <li>• Nonclinical support staff</li> <li>• Other labor</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical and clinical support services</li> <li>• Disposable supplies and drugs</li> <li>• Acquisition, operating, and depreciation costs of equipment</li> </ul>	<ul style="list-style-type: none"> <li>• Rent/lease</li> <li>• Building services and maintenance</li> <li>• Utilities</li> <li>• Repairs</li> </ul>	<ul style="list-style-type: none"> <li>• IT-related supplies, equipment, and services</li> <li>• EHR costs</li> <li>• Appliances and furniture</li> <li>• Non-IT office supplies</li> </ul>	<ul style="list-style-type: none"> <li>• Billing services from third party</li> <li>• Accounting, management, and consultant fees</li> <li>• Professional memberships</li> <li>• Certifications</li> </ul>

In the professional services section in the chart above, there is a component for billing services from a third party. This does not include the excessive amount of time spent on prior authorizations.

Also, all payers should adopt a set of standard and transparent protocols with a clinically accurate foundation that automates the prior authorization process while setting clear expectations for patients and physicians. The documentation required should be the minimum necessary for a determination. Once the standard is adopted, the technology should follow with a standardized workflow pattern used by all certified health IT products that leads the physician (or preferably their staff) through the necessary prompts to provide the minimum necessary information for the payer to make a determination for the service requested. If the service is denied, the reason should be provided and supported by clinical decision-making tied to a physician of the same specialty following nationally approved care standards. If more information is needed beyond the standard information agreed upon by all payers, the payer should clearly state the reason for the additional information and list all information needed to finalize its determination. The technology should enable prior authorizations to be determined within 24 hours, although, using artificial intelligence, the approval should be immediate in many instances.

**Additionally, certified health IT developers should not pass on to physicians the cost of adding the technical capabilities for electronic prior authorizations to its products. It is the payer community that demands the volume of prior authorizations and therefore the payer community should bear the cost.**

It is worth exploring whether EHR vendors could play a smaller role if payers, via their payer portals, standardize the electronic prior authorization process. Since practice staff already look up patients’ benefit information in the payer’s portal, ideally a payer would use the portal to send the prior authorization request pre-populated with the patient information and a list of required documentation. This method would eliminate dual data entry and, once working well, links to the portals could be embedded in the EHR so that the physician or practice staff – within

the practice workflow – have immediate access to the specific page within the portal with the pre-loaded patient information.

*What estimates can providers share about the cost and time (in hours) associated with adopting and implementing electronic prior authorization functionality as part of care delivery processes?*

At this time, it is impossible to determine the time and cost associated with adopting and implementing electronic prior authorization functionality. This greatly depends on how the technology developers implement the process and whether payers adapt and upgrade their systems to ensure a seamless process within the physician’s workflow. Payers should be held accountable for the volume and types of services requiring prior authorizations. Each time a physician is interrupted due to prior authorization requests, it takes away from patient care as the physician must adjust his or her focus to what many times amounts to an unnecessary task. In the low-cost oral diabetes medicine example above, the time spent on a prior authorization far exceeds the cost of the medication. Just because a process is automated does not mean the volume should increase, and physicians are very concerned that this is exactly what will happen.

In conclusion, TMA believes ONC’s leadership in the area of electronic prior authorizations has the potential to reduce the volume of prior authorizations while increasing efficiency and reducing physician burden. **ONC should consider advancing the “gold card” approach adopted by the Texas Legislature in 2021. Under [House Bill 3459](#), for certain health plans, physicians can earn a continuous exemption from prior authorization by earning approvals on at least 90% of prior authorization requests for the particular medication or service.** This allows patients to get the treatment needed quickly while reducing administrative burden for physicians.

TMA appreciates the opportunity to provide this important feedback and implores ONC to adopt the recommendations made. Any questions may be directed to Shannon Vogel, TMA associate vice president for health information technology, by emailing [shannon.vogel@texmed.org](mailto:shannon.vogel@texmed.org) or calling (512) 370-1411.

Sincerely,



E. Linda Villarreal, MD  
President  
Texas Medical Association