21 principles to reform prior-authorization requirements

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The utilization-management (UM) requirements that gobble up physician and staff time while interrupting or delaying appropriate care need to be dramatically reshaped to ensure they are clinically valid and implemented in a way that is transparent, timely, efficient, flexible and standardized. That is the resounding message set forth in a comprehensive set of 21 principles released Wednesday by the AMA and a coalition of 16 other organizations representing physicians, medical groups, hospitals, pharmacists and patients.

“Strict or bureaucratic oversight programs for drug or medical treatments have delayed access to necessary care, wasted limited health care resources and antagonized patients and physicians alike,” AMA President Andrew W. Gurman, MD, said in a statement. “The AMA joins the other coalition organizations in urging health insurers and others to apply the reform principles and streamline requirements, lengthy assessments and inconsistent rules in current prior-authorization programs.”

A weekly per-physician average of 37 prior-authorization requirements consume an average of 16 hours of practice time, according to a December 2016 survey of 1,000 practicing physicians. To slash this administrative burden and protect patients while encouraging proper use of medical interventions, the coalition has offered up these 21 principles to guide overdue reform of UM programs, including prior-authorization and step-therapy requirements.

The coalition “strongly urges” health plans, benefit managers and utilization-review entities, along with accreditation organizations, to apply the principles to UM programs for medical and pharmacy benefits.

The 21 principles are divided into five broad categories.

Clinical validity. This includes concepts such as UM criteria being based on up-to-date clinicalcriteria and never cost alone. This category also highlights the need for flexibility to meet patient-specific needs. Principle No. 2, for example, says: “[UM] programs should allow for flexibility,including the timely overriding of step therapy requirements and appeal of prior authorization denials.”

Continuity of care. This set of principles is designed to ensure that patients’ care isn’t disrupted by prior-authorization requirements. For example, principle No. 4 says: “Utilization-review entities should offer a minimum of a 60-day grace period for any step-therapy or prior-authorization protocols for patients who are already stabilized on a particular treatment upon enrollment in the plan. During this period, any medical treatment or drug regimen should not be interrupted while the utilization management requirements (e.g., prior authorization, step therapy overrides, formulary exceptions, etc.) are addressed.”

Transparency and fairness. The principles in this category address the need for detailed explanations for denials and full public disclosure of all coverage restrictions in a searchable, electronic format. As another example, principle No. 9 states, “Utilization-review entities should provide, and vendors should display, accurate, patient-specific, and up-to-date formularies that include prior authorization and step therapy requirements in electronic health record (EHR) systems for purposes that include e-prescribing.”

Timely access and administrative efficiency. This includes principles that establish maximum-response times for UM decisions and seek health plans’ acceptance of electronic prior authorizations. Another example in this category is principle No. 13, which says, “Eligibility and all other medical policy coverage determinations should be performed as part of the prior-authorization process. Patients and physicians should be able to rely on an authorization as a commitment to coverage and payment of the corresponding claim.”

Alternatives and exemptions. This category includes a call for health plans to offer at least one alternative to prior authorization, such as a “gold card” program. Another option is laid out in principle No. 21: “A provider that contracts with a health plan to participate in a financial risk-sharing payment plan should be exempt from prior authorization and step-therapy requirements for services covered under the plan’s benefits.”

The AMA offers a variety of resources to help physicians address prior-authorization issues.

In 2016, the AMA House of Delegates adopted in-depth policy on standardization and simplification of prior authorization. Several states have already passed legislation to protect patients from overly burdensome utilization-management requirements, with Delaware and Ohio among the most recent.

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