Physicians, payers collaborate on prior-authorization relief

JAN 17, 2018

Andis Robeznieks
Senior News Writer

In the past, Jack Resneck Jr., MD, expected to fill out an occasional prior-authorization (PA) request if he ordered a new or unusually expensive medication or diagnostic test for his patients. But lately, he said, “the burden has grown exponentially.” His practice has been inundated with requirements to submit PA forms—even for long-available generic drugs and for patients on an established medication regimen to manage a chronic condition.

“Sometimes, health plans deny reasonable prior-authorization requests for evidence-based treatments and instead send back ‘suggested alternatives’ that are completely inappropriate for the disease being treated,” Dr. Resneck, chair-elect of the AMA Board of Trustees, told *AMA Wire*®. “We also now have to submit prior-auth requests for many patients who are already stable on a therapy when their health plan suddenly changes the rules.”

To reverse this alarming trend, the AMA has undertaken numerous advocacy initiatives to reform prior authorization and reduce the burden on physicians and patients. Among these is the recent release of a consensus statement between the AMA, the insurance industry trade group America’s Health Insurance Plans (AHIP), and other stakeholder organizations announcing their commitment to improving the prior-authorization process.

“I hope that this consensus statement, in combination with other actions we are taking, will help move us in the right direction to reduce the growing burden of prior authorizations,” said Dr. Resneck, a health policy expert and professor of dermatology at the University of California, San Francisco. “The growing time spent on prior authorization for appropriate drugs and procedures is consuming hours that we would rather spend with our patients.”

Statement builds on principles

A December 2016 AMA survey measured the burden created by PA requests and the impact on timely patient care. Supported by these data, the AMA and 16 other health care and patient associations released a set of 21 principles in January 2017 to guide reform of PA and utilization-management requirements.

“That effort jump-started our discussion with the health insurance industry and led to the development of the consensus statement, which we believe is a good initial step toward meeting the intent of our previously developed principles,” Dr. Resneck said. “While individual health plans will be determining the specific implementation strategies for improving their prior authorization programs and processes, the consensus statement recommends the involvement of clinicians who are contracted with the health plan, as well as professional organizations representing physicians, pharmacists, medical groups and hospitals.”

Along with the AMA and AHIP, the consensus statement was also signed by the American Hospital Association, the American Pharmacists Association, the Blue Cross Blue Shield Association and the Medical Group Management Association.

“We have partnered to identify opportunities to improve the prior-authorization process, with the goals of promoting safe, timely, and affordable access to evidence-based care for patients; enhancing efficiency; and reducing administrative burdens,” the organizations said in the statement. The associations also stress the importance of communication and collaboration between stakeholders in improving the prior authorization process.

The statement identifies five opportunities for improving the PA process and details agreements to take specific actions on each of these in order to achieve meaningful reform.

Selective application of prior authorization, which would include differentiating application of PA based on provider performance, adherence to evidence-based medicine or contractual agreements, such as participation in risk-based payment contracts.

PA program review and volume adjustment, which would include regular review of services, drugs and therapies that no longer warrant PA due to low variation of utilization or low PA denial rates.

Improved transparency and communication regarding PA to ensure timely resolution of PA requests to minimize delays in treatment and clearly articulate requirements, criteria, rationale and program changes.

Protections for continuity of patient care for individuals undergoing an active course of treatment when there is a formulary, treatment coverage or health plan change.

Automation to improve transparency and efficiency of PA requirements and processes, which includes moving toward industrywide adoption of electronic prior authorization transactions based on national standards and provision of formulary information and coverage restrictions at the point-of-care in electronic health records.

The December 2016 AMA survey of 1,000 practicing physicians found that physicians typically completed an average of 37 PA requests a week that took 16.4 hours to process.

If health plans reduce the number and scope of PA requirements, it's hoped that patients will experience fewer delays or interruptions in receiving recommended treatment, according to Dr. Resneck.

"While the potential time savings will vary by practice and the health plans with which they contract, we are hopeful that the combined impact of fewer physicians being subjected to prior authorization, a reduction in the services and medications requiring prior authorization, and an increase in the use of electronic prior authorization will lead to time savings for physician practices," Dr. Resneck said.

It's about time—with patients

In addition to being optimistic about the gains that could be realized by reforming PA policies, he said it's about time that technology solutions—such as the pharmacy electronic prior authorization workflow demonstrated in the AMA's new three-part educational video series—be developed to streamline the PA process. (Other AMA PA resources include instruction on reducing administrative burden through electronic PA, model legislation and a PA toolkit.)

"One of my biggest frustrations is that health plans, pharmaceutical manufacturers, pharmacy benefit managers, and electronic health record [EHR] vendors haven't yet worked together to give physicians real-time information in our EHRs at the point-of-care about which drugs are on-formulary, how much they actually cost, and whether they require prior authorization or step therapy," Dr. Resneck said.

"The consensus statement shows that there is growing agreement across the entire health system that prior authorization programs and processes need to be 'right-sized,'" Dr. Resneck said. "And it reflects a willingness among physicians, pharmacists, medical groups, hospitals and health plans to try to work together to achieve changes that both ensure that patients have access to timely and necessary care and medications, while reducing administrative burdens to physician practices and other health care professionals."