A huge win for prior authorization reform in Michigan with Bobby Mukkamala, MD

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Featured topic and speakers

In today’s AMA Update, Bobby Mukkamala, MD, an otolaryngologist from Flint, joins to discuss a prior authorization victory for physicians in Michigan. Dr. Mukkamala is also the immediate past chair of the AMA Board of Trustees. AMA Chief Experience Officer Todd Unger hosts.

Learn how the AMA is #FightingForDocs and access resources from the AMA Recovery Plan for America’s Physicians.

Find out more information on the AMA's efforts to fix prior authorization.

Speaker

- Bobby Mukkamala, MD, otolaryngologist; immediate past chair, AMA Board of Trustees

Transcript

Unger: Hello and welcome to the AMA Update video and podcast. Today we're talking about prior authorization and specifically a victory in Michigan I'm joined by Dr. Bobby Mukkamala, an otolaryngologist from Flint, Michigan, and immediate past chair of the AMA Board of Trustees. I'm
Todd Unger, AMA’s chief experience officer in Chicago. Dr. Mukkamala, welcome back

**Dr. Mukkamala:** Thank you, Todd. It’s good to be here.

**Unger:** Well, new legislation passed in Michigan last spring, which marks a giant step forward in fixing prior authorization. Let’s start, before we talk about the legislation, about why prior authorization has been such a challenge for physicians and what you’ve seen at how it’s playing out in your particular practice.

**Dr. Mukkamala:** Yeah, it’s almost like where do you start? Let me just start by saying that like so many things that we deal with as physicians, it seems to be something that we’ve, unfortunately, just gotten used to. We’ve built in solutions to this problem in our practice.

When I started my practice 22 years ago with my wife Nita, we were exposed to this issue. And it sort of became something that we almost gave up on and then just created office staff to solve the problem. So we were insulated from it. Of course, that’s not a solution. And that’s what’s led to the fact that now, for every physician in this country, we have something like 1.4 people working on just prior authorization. And it happens in a room isolated from where we are and it just gets done.

Well, that doesn't make it right. And it’s just the fact that it takes so much resource to do the right thing. We have a local managed Medicaid program that delays surgery by more than a month just for the prior authorization process, that now, when patients come in and we see that card, everyone sort of groans inside and says, you know what, this is going to be a while before we get permission. And we prepare the patient by saying, it’s going to be at least a month before we can get this done because the prior authorization process for this insurance company takes a month to get through. And it's just sad that we've gotten used to it.

But now, here we are bringing the fight with conversations like this, successes like we’ve had in Michigan. It just feels good to now sort of be on the offensive about it. So we don't have to share stories anymore, hopefully, about people with stage one cancer advancing to stage two cancer while waiting that month or two for their PET scan, or the juvenile diabetic that that's supposed to get prior authorization for their insulin every 90 days but now has to wait to get an appointment with their regular endocrinologist, not their pediatric endocrinologist, and in that time is having to ration their insulin.

These are just things that shouldn't be happening. Insulin is a condition that these kids are going to have for the rest of their life, not just 90 days where you have to double check if they're still diabetic. That's a no brainer. So it's just these are the things that we're seeing in our practices that create those statistics, that one out of every three physicians has seen patients have a severe adverse consequence to prior authorization. And it's a hard enough time to find medical staff anyway in this post-COVID era, hard to find any workers, let alone bringing somebody into a job that's fraught with
frustration.

My medical staff doesn’t like the fact that they’re begging administrators for permission to do the right thing and when they’re not getting it, have to pick up the phone a minute later and call the patient saying, you know what, we’re going to have to push back this test or push back this procedure because of it. That’s not something that lends itself to a happy work staff when it’s already hard to find them. So so many consequences of bad prior authorization policy that has a ripple effect health-wise and administratively across the country.

**Unger:** Gosh, just listening to your stories right there, just a huge amount of burden on physician offices and their patients with delays that could be life-threatening. We’ve had a chance to talk to our head of advocacy, Todd Askew, about the work that’s going on at the federal level and how you build stakeholders for this. Can you talk a little bit about how do you build that kind of group at the state level to make traction here?

**Dr. Mukkamala:** Yeah. The nice part about this issue is that it’s not hard to find people that have experienced it. It’s just one of these things. When we went to our state House and our state Senate to say that we need to solve this problem, and we share stories about rationing insulin while waiting to get in to get a test done or waiting for a PET scan to stage cancer, you could just see heads nodding across the committee on the other side of this room from us because everybody has this experience.

And so the nice part about it is that we didn’t have to start from zero. We have national data on this issue. The AMA brings to the state capitals the resources and the data so we’re not inventing that wheel. And that is so critical because we’re starting on a firm foundation, and then building state legislation, state-specific solutions not from inventing that but from model legislation, from other states that have done it. And that helps immensely.

**Unger:** So those are some really specific ways that the AMA collaborates with the states to make sure that we’re learning from state to state about how to really take models that work. How else does the AMA work in that situation in terms of the collaboration?

**Dr. Mukkamala:** Yeah. So model legislation is one thing, but data is another. So it's one thing to have a theoretical benefit to a legislative solution that we have. But when we can show data that shows that the number of physicians that report adverse effects to their patients, that 95% of us have witnessed the burden of prior authorization in our practice—the delays in practice, the FDEs required to do this, the data that then comes to the state capitals in the form of our testimony and testimony from coast to coast—is incredibly important.

And when you back up that data with patient stories, when we can sort of give the national landscape for prior authorization, and at the same time have somebody sitting next to us that’s sort of been a victim of prior authorization, so to speak, that's not really much of an exaggeration. When your cancer
goes from stage one to stage two because of this flawed policy, you're a victim of that policy. So having that national data and then these personal stories is enormously powerful when we're talking to those nodding heads on the other side.

**Unger:** Yeah, that is a powerful combination. Well, let's talk a little bit more about the specific legislation, Senate Bill 247, which was passed in April. Let's walk through some of the highlights of the reform because it really is a significant step forward in fixing prior auth. Tell us a little bit about the major wins in the new law.

**Dr. Mukkamala:** Yeah. Yep. So one of the main things that the new law will ensure that the criteria being used to determine whether or not a prior authorization is approved, it has to be clinically valid and has to sort of meet current standards of care. And it seems like a no brainer. But that's how things used to be before this law, is that it was this black box where these decisions got made.

And now everything has to be scrutinized through the lens of science. And go figure, right? It seems like it should be a no brainer. This is health care. This is medicine. It should be driven by science, not in a black box. And to accomplish this, these prior authorization requirements are based on peer reviewed clinical criteria. And the entity has to work directly with clinicians to make these decisions. And it can be within the plan or outside the plan.

And another no brainer, there shouldn't be a financial incentive in the outcome of these decisions. And that's something that this law now enshrines in this language that says that the entity that's deciding this shouldn't have a financial interest in the outcome of these decisions. Again, it should be a no brainer, and now it's codified in law.

And then other important aspects is that this needs to consider atypical populations. Not every patient's going to be the same. It needs to ensure quality of care and access, and it needs to be evidence-based. And it needs to be flexible, that there's patients that have unique either scientific medical situations or social situations that would require a different treatment approach.

We see that. That's the art of medicine. And now it applies that art of medicine to policy that says that not every patient's going to be standard. And when they aren't standard, there needs to be some flexibility in this policy. And it's incredibly important because in addition to the harm that comes from prior authorization requirements in the first place, we can't have decisions that are made by made up criteria that ultimately sort of denies patients medically necessary care. And this puts that into language and holds them to that standard.

**Unger:** Now I remember Dr. Resnick talking at the House of Delegates meeting about his frustrations with these kind of peer reviews. I think, from what I understand, it's pretty hard to get a person on the phone, and a person who can really speak at the level that a physician is. How does this legislation address this particular issue?
Dr. Mukkamala: One thing that's great about this is that it makes sure that the person on the other side of the phone, or the computer—most likely a phone—has the same level of training. It's so frustrating to see these decisions being made by people that don't have the clinical expertise. So many times when we're on that phone, I find myself teaching the other person on the other side of the phone the basics of this ENT-related care in my case that I shouldn't have to do. The person that's giving permission, their level of knowledge about this condition is being raised by the person that's asking for that permission. I'm teaching them.

That's not what I want. If I'm asking permission for something, I want to know that I'm asking somebody that has that same background knowledge, that understands these patients, that has seen these patients before. I would be ecstatic to learn something from that phone call instead of teaching from that phone call. How awesome would that be? Like "Oh, actually, you know what, thanks. I didn't realize that. I don't actually need this. I'll do something else."

That never happens. It's almost 100% of the time it's the opposite. The other person is like, oh, I didn't realize that. OK, now I get it. Approved, after how many hours and how many weeks of delay. That's just not right.

Unger: And so how does that change in this new scenario? They have to guarantee that they're at the level of the physician?

Dr. Mukkamala: Yep. So in Michigan, if it gets denied, that peer review process has to be a peer now. So the person that is now looking at that appeal, when we say you know what, that denial ain't gonna fly. This is something that needs to happen. This PET scan is needed. This medication is needed, and here's why. When I'm making that case, now I'm making that case to somebody that has my education and knowledge about otolaryngology.

When Nita, my wife, makes it, who's an OB/GYN, she's asking permission for this test or this procedure from somebody that is an obstetrician gynecologist. And so how awesome is that, that it's true peer to peer. I'm no longer asking somebody that hasn't looked at the middle ear since medical school or even if they went to medical school, now they're doing exactly what I'm doing for their day job, and they understand why my patient needs what I'm asking for.

Unger: That's great news and it must be a huge relief. You mentioned kind of this black box where there's just not a lot of transparency in these conversations. And sometimes physicians and patients are the last to know when an insurer changes requirements or even when something's been denied. How does this legislation make all of this a bit more clear?

Dr. Mukkamala: Yeah. So what's fantastic about this is now, whatever those criteria that are going to be applied can't exist in a vacuum, can't exist in a black box. And better than that, if that's something that the insurance company is thinking about doing, we don't find out about it after it's done in some
newsletter where then my office staff is shocked saying, boy, I didn't realize that I need authorization for that. I never needed it before. And now we're learning that after it takes effect.

Now this has to be put out there beforehand so we have a head start on it, so we know that this is coming. We can talk to them about this and why it's a good idea, why it's a bad idea. My office staff can be prepared. So we're not surprising a patient that this is Christmastime. This is when a lot of people, their deductibles are met. They're getting their procedure scheduled. The last thing I want to do is have them call three days before their scheduled procedure when they've been planning on doing this all year this month and telling them it now has to be pushed up because there's some new prior authorization requirement.

Not anymore. So now we know about that way beforehand, which is fantastic.

**Unger:** That's huge. Along the same lines, one of the other big problems, obviously, has been just the sheer volume of prior authorizations. Again, when we talked about this with Dr. Resnick, he said it used to be select things, and now it's just expanded greatly, even like using generic prescriptions.

The new law asks that plans work to implement individual exception programs. What are those and how do they work?

**Dr. Mukkamala:** Yeah. Yep. So for example, I see patients with sinusitis all day every day. Almost all of them, at some point, if they're coming to me, it's because they've been treated half a dozen times this past year for sinusitis. They need a CAT scan of their sinuses. That's something that I routinely get because if they're coming to me, it's because plan A didn't work and maybe they need plan B, and to determine that a CAT scan is necessary. That gets approved 100% of the time.

And yet it requires me to have somebody with a 1.4 FTE, I'm just like any other physician in this country, asking for permission for something that gets granted 100% of the time. And on the other side of the coin, Blue Cross Blue Shield of Michigan says that I am a top performer. They give me a 10% uplift in my payment, because I meet all the standards of care that they set out. So I am a great physician relative to my peers in otolaryngology, as evidenced by that 10%.

So how is it that on one hand, you can tell me that I'm in the top 10% and I'm doing everything great, and you're going to pay me 10% more but on the other side say, well, but you need permission to get these scans. And yeah, we're approving them 100% of the time but you've got to keep asking. That just doesn't make any sense.

And so this sort of gold carting is something that's also built into this, that if, indeed, you're going to identify me as a good physician in your network and doing things by your standards, and you're acknowledging that by giving me more as far as payment, then don't also burden me by having that payment go in one door and out the other door to my 1.4 FDEs.
My office staff would love to spend that time doing something else, not just on the other end of this phone. They’d love to be calling patients back and saying, hey, how are you doing, or dealing with the patients in their office instead of the administrator on the phone. So this gold carding program is a nice way to acknowledge high quality by not giving us the burden of doing more prior auth.

**Unger:** That makes a lot of sense. I know some parts of the reform have still yet to take effect. But in the meantime, have you noticed a difference in your practice and what are the biggest benefits so far?

**Dr. Mukkamala:** Well, unfortunately right now, it's just a lot of hope and anticipation because the first part of this is set to take place in summer of 2023. And it's so funny because we know it's coming. And yet we're dealing with that frustration of the old way still. And so all of us are sort of anxiously anticipating summer of 2023. It's like coming soon to a clinic near you, prior authorization reform. We're just excited for this blockbuster. I mean, hopefully it'll be everything that we've worked for.

But so when we're talking to patients, that light at the end of the tunnel is coming this coming summer. When? Now. And something as simple as just the return time. There's literally patients, like I said earlier, there’s a particular plan that we push surgery out a month because we know prior auth isn't going to happen that quickly.

Well, now there's a time requirement. For urgent requests it has to happen within 72 hours. For non-urgent requests, it has to happen within a week or so. And so that's going to be wonderful that we can plan on that when we're scheduling things instead of pushing things out indefinitely because we don't know when the authorization is going to come in.

**Unger:** Well, you mentioned earlier in this episode that this is a thing that a lot of people have experience with, including legislators. And that's what's made it, in particular, a bipartisan issue. No matter what your politics are, it feels like everybody can get behind eliminating this kind of burden that it puts on physicians and staff. What's your advice for physician leaders who'd like to see something like this happen in their own states? And where do they begin specifically? And how do they get buy in from stakeholders in both medicine and government and leverage the AM at the same time?

**Dr. Mukkamala:** Yeah. I think that starting with that last statement, having that national data, being able to show the people that you're talking to in committee in your own state capitals about this with that AMA data to show what that 10,000 foot landscape is. But in the very next breath, after sharing that, also having patients at your side. It's not hard to find patients that have been harmed by prior authorization.

And these are constituents, and that always helps to make the case. So the economic case of it, the personal case of it is critical. And then what's interesting about Michigan is that we went to the Chamber of Commerce, which is usually in line with insurance companies on this issue. And they want whatever it's going to take to keep their business premiums down because that's what they're paying...
And for the first time ever, they were neutral on this. They weren’t opposed to what we were asking because yes, I mean, they have this theoretical risk of insurance premiums going up because of prior authorization. They go up anyway. I mean, when was the last time we saw an insurance premium go down?

But what they are dealing with is the fact that that patient that comes in to see me, that we know what we need to do but we can’t do it yet because we have to go through this, this and that, which means an extra visit or two to my office. That means an extra day or two out of the workplace.

And so they see the toll of prior authorization on the economics of the workplace and the health of their patients. And it’s not just limited to their perspective on the cost of the insurance premium. They’re looking at that other cost of the prior authorization, people missing work. And so for the first time, they were neutral on the issue. And so what I would say to states that are looking at this is that take that data with you to the chambers of commerce. Take patients with you to the lawmakers and give the comprehensive reason why prior authorization needs to be reformed.

Unger: It is that powerful combination of the data and the stories. And the AMA has made this a huge priority as part of our Recovery Plan for America’s Physicians. You can find out more about that and our efforts on prior auth at ama-assn.org/recovery.

Dr. Mukkama, thank you so much for being here with us today and for all your efforts and leadership on this particular issue. We’ll be back soon with another AMA Update. You can find all our videos and podcasts at ama-assn.org/podcasts. Thanks for joining us today. Please take care.

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