The life and death reality for cancer patients facing insurance denials with Debra Patt, MD, PhD

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Featured topic and speakers

In today's AMA Update, Debra Patt, MD, PhD, MBA, a breast oncologist in Austin, joins to discuss how prior authorizations can lead to delays in care that significantly impact physicians and patients. AMA Chief Experience Officer Todd Unger hosts.

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Speaker

- Debra Patt, MD, PhD, MBA, breast oncologist; vice president, policy and strategic initiatives, Texas Oncology

Transcript

Unger: Hello and welcome to the AMA Update video and podcast. Today we're discussing how prior authorizations can lead to delays in care that significantly impact physicians and patients. I'm joined by Dr. Debra Patt, a breast oncologist in Austin, Texas, who recently took part in a panel discussion on fixing prior authorization at the 2023 AMA State Advocacy Summit. Fixing prior authorization is one pillar of the AMA's Recovery Plan for America's Physicians and I encourage you to learn more about the AMA's recovery plan at ama-assn.org/recovery. I'm Todd Unger, AMA's chief experience officer in

Chicago. Dr. Patt, thanks so much for joining us today.

Dr. Patt: Thanks for having me.

Unger: I know you've been a huge advocate of prior authorization reform and you have also experienced the challenge personally in your own practice, I know you told a particular story at the state advocacy conference, I'd love if you could share that same story with our audience out there today.

Dr. Patt: Sure. So as you know, Todd, prior authorization has become a real challenge for patients to get the care they need. As a cancer specialist, as a breast cancer specialist, we encounter prior authorization when we write for imaging studies to evaluate the extent of cancer involvement in a person. We encounter prior authorization when we write for new therapies.

So I have a patient who is a 40-year-old with metastatic breast cancer. And I wrote for a therapy to treat her metastatic breast cancer. And that therapy has good evidence that's been published in the peer reviewed literature. It was denied and then appealed and denied. In the process of peer-to-peer review, they stated would take six weeks—or up to six weeks and they wouldn't inform me when it would occur. I just gave them my cell phone number and they informed me some time—usually around 8:00 in the morning—between now and six weeks from now, you will get a call to do a peer-to-peer review.

So when I saw the patient in follow up the following week to discuss how to manage this, I could see that her breast cancer was growing. She had palpable skin nodules and they were worse. And so I just told her I said, even though I think this is the best therapy for you to have and even though the evidence would suggest that it's twice as good as giving you a different kind of chemotherapy, I'm not able to give you this therapy because it's—I don't have an authorization and I don't feel like we can safely wait. And so what we did is we chose to give her a different therapy instead.

Unger: I mean, it's just a horrifying story, metastatic breast cancer. You can see that progressing, why on earth are you prevented from giving that treatment? What was blocking that prior auth?

Dr. Patt: It's really challenging. I think that the peer-to-peer review process would have approved the treatment, but the problem was we couldn't get that in a timely fashion. And, as you know, even if you can get it in a timely fashion, frequently it's not someone with the expertise to really make that decision because they're—I'm an oncologist, maybe they're not an oncologist, so I think those are real challenges for the patients we serve and frequently delay and deter care.

What surprises me more is that this happens more and more, despite the fact that we've been going through this pandemic. And I think one driver for that is the vertical integration that we see in the payer environment today.

So as an oncologist, I write for a lot of oral therapies and this was an oral therapy called Verzenio or abemaciclib. It's an oral targeted therapy. And the pharmacy benefit managers are integrated with the payers, which are integrated with specialty pharmacies. And so there's only three of them that control 80% of the market. And if you take the additional next three, it's 96% of the market of drugs that are administered to patients from pharmacies, so the interaction between formulary restrictions, prior authorization, pharmacy benefit manager steerage, opaque rebates that aren't translated to patients are all interrelated because of this vertical integration that we see in the market.

Unger: Dr. Patt, I'm almost afraid to ask the question, but what did this ultimately mean to your patient?

Dr. Patt: Well, as I mentioned, in late October, early November, when I initially wrote for the therapy, I had the anticipation that she would do well with that, but I had to write for something else, which she got in late November, early December and she passed away two weeks ago.

Unger: I'm so sorry. What a dramatic implication of that delay.

Dr. Patt: It's terrible. And I'll say, as you think about this, utilization management I would say more broadly is for the purpose of managing cost and I understand that. But when insured patients that pay for their insurance can't get the care that they need and it leads to an adverse outcome, it's really challenging. I would just go for a very long time, lead a lot of studies in breast cancer to be able to do what I do really well. And when I know—and sometimes we lose patients because cancer is terrible and maybe we don't have other things to offer—but when we do have the best treatments to offer and cannot get it to the patients we serve who pay for their insurance, it's really frustrating and demoralizing as a physician.

Unger: Now, you mentioned this concept of a, quote, "peer-to-peer" consult. And in the end the treatment that you originally wanted to prescribed was approved, but, obviously, it came way too late. In addition—

Dr. Patt: And I think it was about five weeks after that I originally—that I spoke to someone who was an oncologist and was very familiar with the study I spoke about and said that's absolutely reasonable. And I said, well, four weeks ago, I had to start her on this other therapy because I didn't know when I was going to be able to talk to you. And he said, oh, I can't believe they told you it could be up to six weeks. And I said, well, here we are five weeks out. He said, well, this treatment sounds really reasonable. But because you started this other therapy, they won't approve that for her now because you've started this other thing and you'd have to start the whole process over again. Well, she didn't have time to do that.

And I'll say cancer care I think is the extreme. It's tragic to hear about a 40-year-old woman that was working full-time and functional in her daily life, and interactive with the people that she knows and

loves and in two months time had to stop working, initiate a therapy that was toxic and then died as a result of her disease. I mean, that is truly tragic, but it happens every day, both in cancer care and in the simple things.

I chaired the council on legislation last legislative session for the Texas Medical Association and there was a pediatrician who was telling me about an antibiotic that she wrote for a child with a urinary tract infection that was a generic antibiotic, but because it was not one of the formulary preferences, she had to go through prior authorization and peer-to-peer review to give a generic antibiotic. And the natural consequence of her having to do that is that the child was delayed in getting appropriate therapy for their urinary tract infection.

So the natural consequence of delays and deters in care is that patients have adverse outcomes. Children have urinary tract infections that could turn into sepsis, that could turn into death. Patients have cancers that are undertreated or delays in treatment that could convey increased morbidity and mortality related to their disease. So I think these are challenges that we face every day and it needs to be right-sized.

Unger: And we heard similar story from our president Dr. Jack Resneck in his own dermatology practice with generic prescriptions as well. These kind of peer-to-peer consults, in addition to the delays which you've talked about specifically, how else would you like to see them change?

Dr. Patt: Well, I think that there needs to be some boundary around appropriate use. For example, I treat a lot of patients with metastatic breast cancer. They require imaging frequently. I shouldn't have to peer-to-peer review every single time they need imaging. This is the standard of care. This should not require prior authorization.

And so one of the things that we've championed in Texas is the gold carding legislation, led by then Senator, now Land Commissioner, Dr. Dawn Buckingham, which is to say that if a doctor has been routinely a prescriber that has written for diagnostic studies or therapeutic interventions that have been approved, we should be more lenient with the prior authorization process to allow them to not have delays in care with the patients they serve.

Now, Todd, as you may know, Texas was the first to pass this kind of legislation and other states have had a lot of interest. But—so our state department of insurance that was in charge of rulemaking and really to follow and track implementation was really the first to try to manage this. And I will say that the intent of the legislation has not manifested yet into real changes and care delivery, but I think that the Texas Medical Association this year is working on some additional legislation to clean that up, to make it a little better in alignment with the desires of the proposed legislation.

Unger: And really beginning with that inspiration, there are now over a dozen gold carding proposals in the states this year. It's a concept, obviously, that has physicians excited. And as its popularity

shows, perhaps we really do need to reduce the volume of prior authorizations. What do you think other states could learn from Texas' experience or even as we look to enact legislation at the federal level.

Dr. Patt: I think it's a great callout. And I would just say that Kelly Walla, who's our general counsel, and Clayton Stewart, who's the VP of policy for the Texas Medical Association, are crafting this legislation now that will be introduced this session in Texas. And I would say to reach out as your state seeks to make good policy to Texas, as we've tried to do this first and have learned from some of the limitations we've had and, I think, we'll seek to do it better. So I think sharing proposed legislative language is a really important way to improve upon the steps that have been taken.

Unger: And on that topic, as I mentioned up front, the AMA is very active in this space as well—a key part of our Recovery Plan for America's Physicians. And we do offer resources like model prior authorization legislation and reform principles to help physicians. Dr. Patt, take us through your wish list. What do you want to see in reform bills that we haven't talked about already?

Dr. Patt: I want to see some type of gold carding for people that are good actors, doing exactly evidence-based practices to be permitted to do that without having to take additional time away from much needed other things. Because every time I get pulled out of clinic to do a prior auth, it—I'm usually pulled out of an important discussion with a patient because they have a new cancer and I'm discussing that with them. So that's not trivial to be pulled out of clinic. So I think the gold carding is the right way to go.

I also think that we need timely peer-to-peer review. We need that to happen within 48 hours. Patients can't wait for the things that they need. I mean, maybe some things can wait. Maybe if you had something that was minor, maybe it wouldn't be harmful to wait. But for so many things—like urinary tract infections and cancer, and lack of control of a chronic disease—those things require immediate attention. And so I think to have meaningful review within 48 hours with someone of a similar specialty or the same specialty is really important.

Unger: Dr. Patt, thank you so much for being here today and sharing these stories. As we know from the state advocacy summit, those kinds of stories, which folks in Congress can relate to because they've been through it on the other side as patients—they make such a difference in moving this work forward. If you want to find out more about the AMA's work to fix prior authorization, you can visit ama-assn.org/recovery.

That's it for today's update. We'll be back soon with another episode. Find all our videos and podcasts at ama-assn.org/podcasts. Thanks for joining us. Please take care.
