

AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution 1
(June 2021)

Introduced by: Elizabeth T. Curtis, MD

Subject: Prior Authorization Reform for Specialty Medications

Referred to: OMSS Reference Committee

1 Whereas, Since the inception of prior authorization (PA) requirements it has been a strategic
2 priority of the American Medical Association (AMA) to improve efficiency in the process to
3 prevent delays in treatment; and
4

5 Whereas, In spite of attempts to specialize PA forms, approval is often delayed for the following
6 reasons: 1) insurers often require information that was not part of the original PA form, and 2)
7 information submitted to the pharmacy PA manager isn't made available to other offices
8 involved in the PA system; and
9

10 Whereas, It is painfully clear that market forces often drive the PA process; i.e. during the
11 Covid-19 pandemic the price of Planquenil (hydroxychloroquine) increased and a restriction was
12 placed on the number of pills dispensed monthly at a substandard level. The insurer not the
13 physician is now writing the orders. Although we now have studies that demonstrate a limited
14 value of Planquenil in critically ill ICU Covid patients, this restriction in dispensing continues at
15 the present time; and
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17 Whereas, A delay in receiving medications on a timely basis and in adequate doses has
18 resulted in many patients experiencing flare-ups in their diseases; and
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20 Whereas, The PA process has greatly increased the burden on medical practices often
21 requiring ten to fifteen hours weekly to obtain approval for the physician's order; and
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23 Whereas, Even a medical staff person well-trained in obtaining PAs often requires the help of
24 the physician to complete; and
25

26 Whereas, The peer-to-peer review component of the PA process is problematic because the
27 physician reviewer often does not have access to the original information submitted, thus
28 requiring the resending of the information and creating further delay of the process; therefore be
29 it
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31 RESOLVED, That our American Medical Association issue an executive and legislative directive
32 to allow all medications to be dispensed for one year before the prior authorization process
33 begins (New HOD Policy); and be it also
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35 RESOLVED, That our AMA petition pharmaceutical companies to expand eligibility for their
36 assistance programs to include people in the \$50,000 to \$150,000 income bracket (Directive to
37 Take Action).

Fiscal Note: Not yet determined

Received: 4/26/21

RELEVANT AMA POLICY

Prior Authorization and Utilization Management Reform H-320.939

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.

Citation: CMS Rep. 08, A-17; Reaffirmed: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19, Reaffirmed: Res. 811, I-19

Prior Authorization Reform D-320.982

Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

Citation: Res. 704, A-19

Approaches to Increase Payer Accountability H-320.968

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)

(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

Citation: BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMD Rep. 4, A-95; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMD Rep. 13, I-98; Reaffirmed: I-98; Reaffirmed: A-99; Reaffirmed: I-99; Reaffirmed: A-00; Reaffirmed in lieu of Res. 839, I-08, Reaffirmed: A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmed: A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed in lieu of Res. 242, A-17; Reaffirmed in lieu of Res. 106, A-17; Reaffirmed: A-17; Reaffirmed: I-17; Reaffirmed: A-18; Reaffirmed: A-19; Reaffirmed: Res. 206, I-20

Promoting Accountability in Prior Authorization D-320.983

Our AMA will study the frequency by which health plans and utilization review entities are using peer-to-peer review prior authorization processes, and the extent to which these processes reflect AMA policies, including H-285.987 (“Guidelines for Qualifications of Managed Care Medical Directors”), H-285-939 (“Managed Care Medical Director Liability”), H-320.968 (“Approaches to Increase Payer Accountability”), and the AMA Code of Medical Ethics Policy 10.1.1 (“Ethical Obligations of Medical Directors”), with a report back to the House of Delegates at the 2020 Annual Meeting.

Citation: Res. 709, A-19

Opposition to Prescription Prior Approval D-125.992

Our AMA will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians.

Citation: Sub. Res. 529, A-05; Reaffirmed: A-06; Reaffirmed: A-08; Reaffirmed in lieu of Res. 822, I-11

Administrative Simplification in the Physician Practice D-190.974

1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will continue its efforts to ensure that physicians are aware of the value of automating their claims cycle.

Citation: CMS Rep. 8, I-11; Appended: Res. 811, I-12; Reaffirmed: A-14; Reaffirmed: A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 805, I-16; Reaffirmed: I-17; Reaffirmed: A-19; Modified: CMS Rep. 09, A-19