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PRIOR AUTHORIZATION

A physician's biggest headache

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WHAT IS
prior authorization?

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WHAT IS prior authorization?

Prior authorization is a mechanism for health plans to control costs by requiring providers to obtain approval before performing a service to qualify for payment.

Health insurers require prior authorization for:

- Pharmaceuticals
- Durable medical equipment
- Medical services

Process

1. After a physician orders a service for a patient, the patient's insurer is contacted to determine if prior authorization is required.
2. The process to obtain prior authorization varies from insurer to insurer, but involves the completion of a form. Upon review, the medical service may be approved, rejected, or additional information may be requested.
3. If a service is rejected, the physician may file an appeal based on the provider's medical review process. In some cases, an insurer may take up to 30 days to approve a request.

Perceived Advantages

Employers have tried many ways to control the ever-rising costs of medical coverage for employees. Once such step is through prior authorization. Employers believe prior authorization:

1. Reduces health care costs;
2. Offers management of over-prescribing medications; and,
3. Allows management of unnecessary medical procedures.

Disadvantages

Physicians and their practices say payers use prior authorizations as a way to hold down costs with a short-term focus on the bottom line often results in far higher costs later on, in the form of patients requiring hospitalization and/or emergency department treatment.

1. Delays patient care
2. Increases administrative burden
3. Increases costs to physician practices

HOW DOES MSMS VIEW prior authorization?

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HOW DOES MSMS VIEW prior authorization?

The Michigan State Medical Society (MSMS) believes that prior authorization is **overused** and that existing processes are too **difficult**. Due to its widespread usage and the significant administrative and clinical **concerns** it can present, the MSMS believes that prior authorization is a **hassle** that needs to be **addressed through a multifaceted approach to expedite patient care** and **reduce burdens on physicians**.

Prior Authorization 2017 Physician Survey

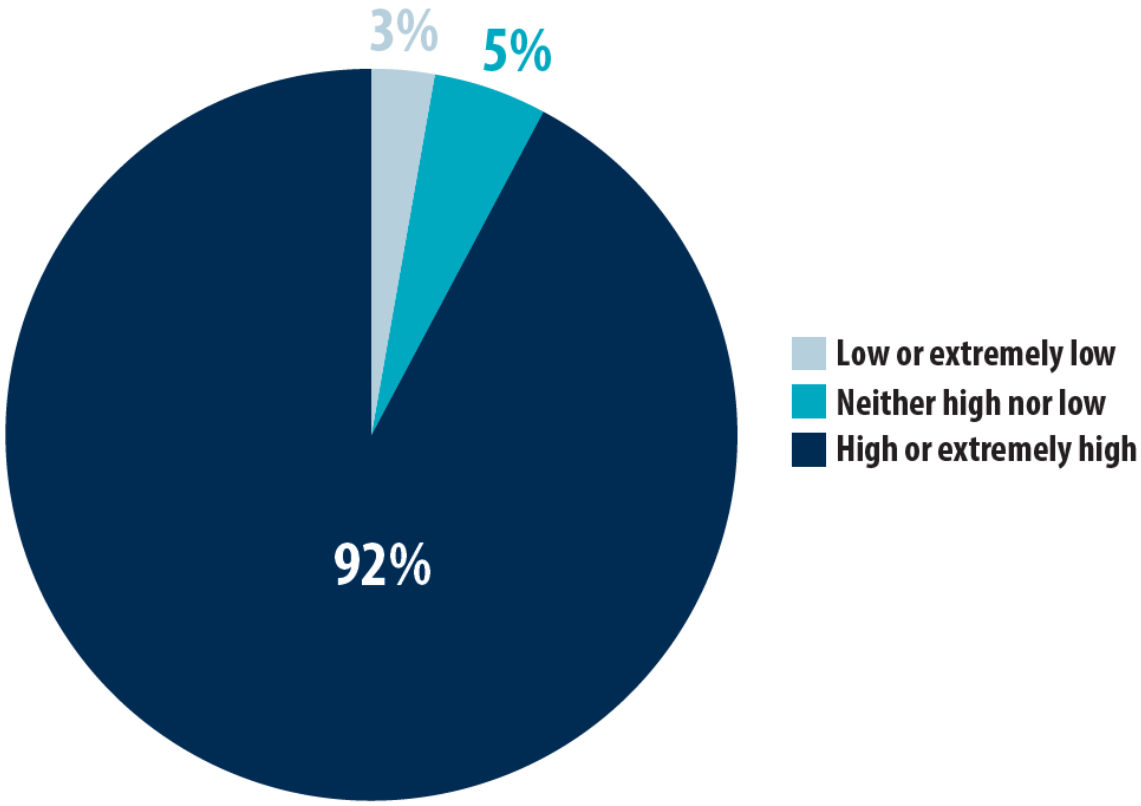
A 12-question, web-based survey was administered by MSMS in July 2017. A sample of more than 600 Michigan physicians responded and refined to ensure that all participating physicians are currently in active practice in Michigan. Of the physicians who responded, 29% are in primary care and 70% are specialists.

The following slides are the results from those respondents.

HOW DOES MSMS VIEW prior authorization?

Physician perspective on PAs

Question: How would you describe the burden associated with prior authorization for the physicians and staff in your practice?



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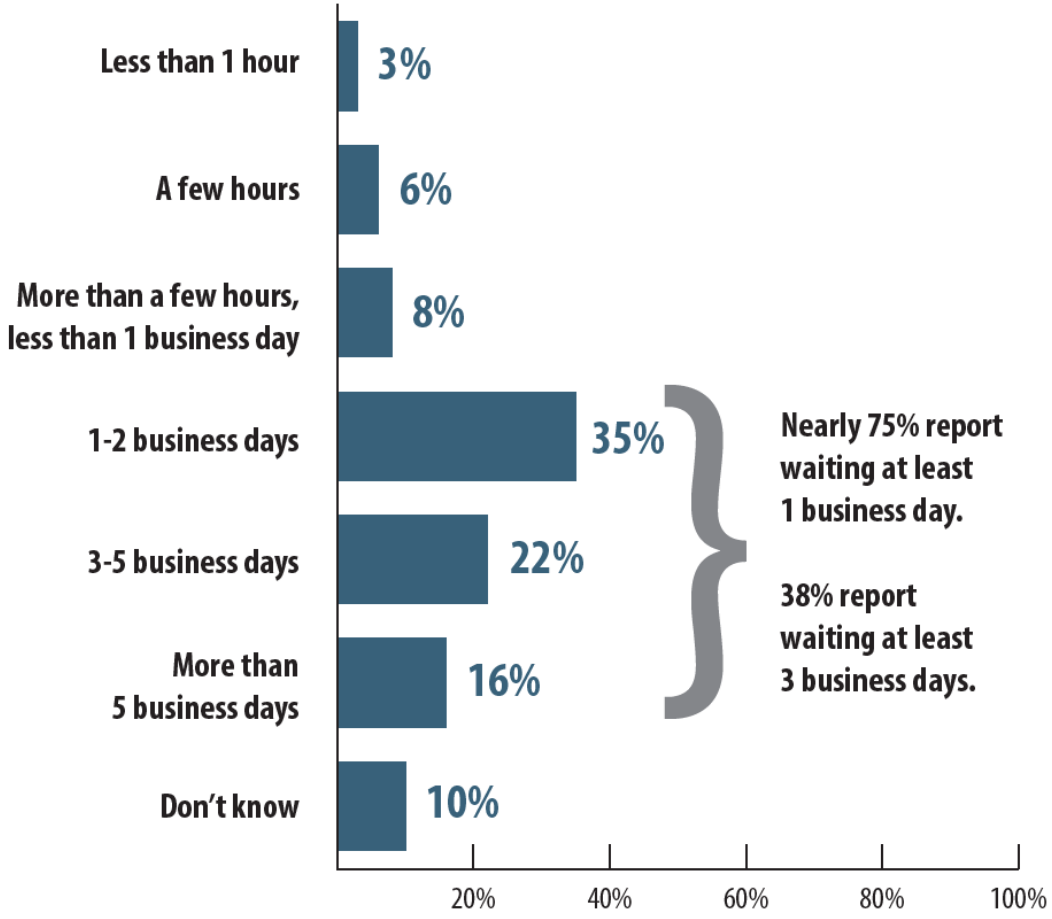
Average wait times for PA responses

Question: In the last week, how long on average did your practice need to wait for a PA decision from health plans?



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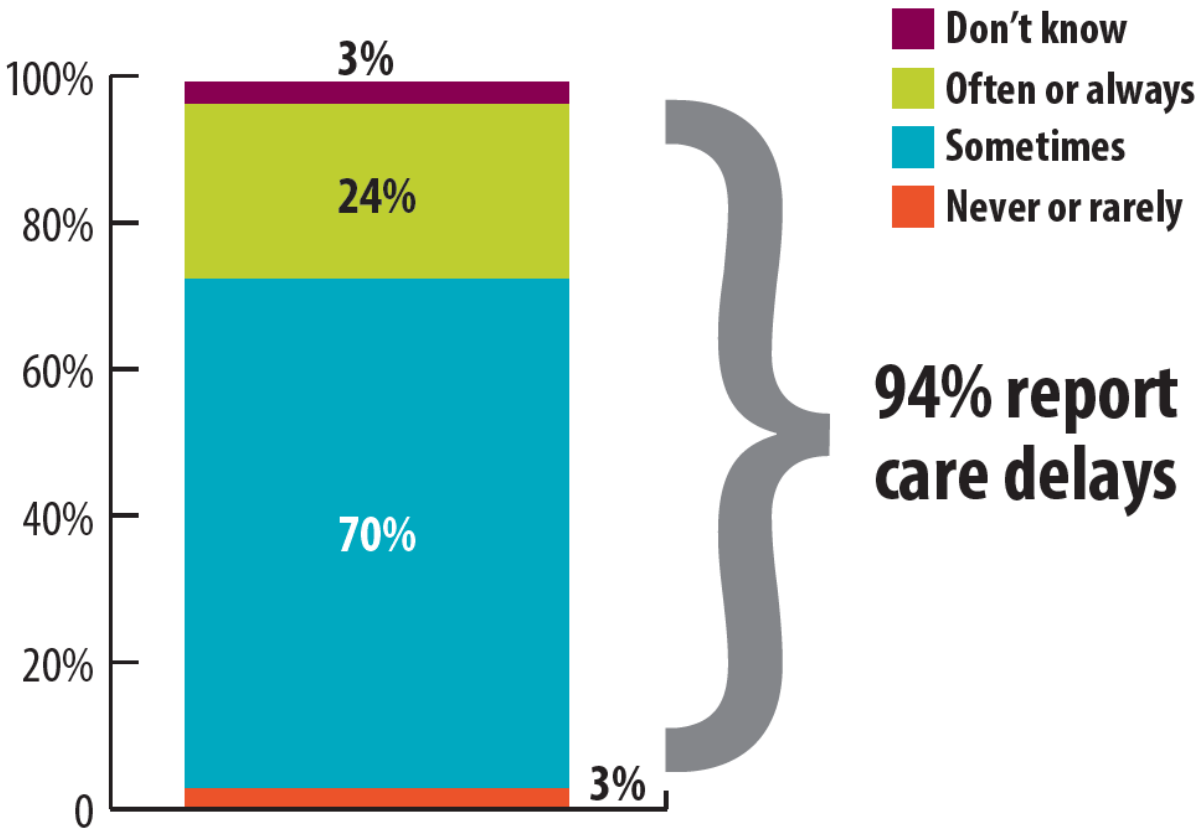
Care Delays Associated with PA

Question: For those patients whose treatment requires PA, how often does this process delay access to necessary care?



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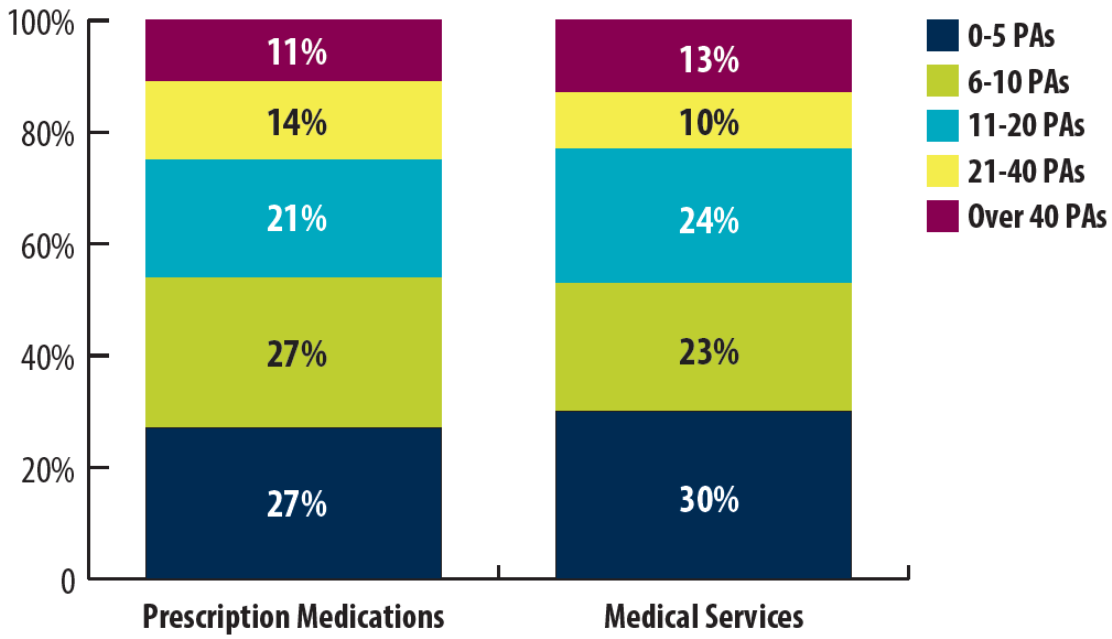
Number of PAs per week

Question: Please provide your best estimate of the number of prescription and medical services prior authorizations completed by you yourself and/or your staff for your patients in the last week. Do not include prior authorizations that practice staff completed for the patients of other physicians in your practice.



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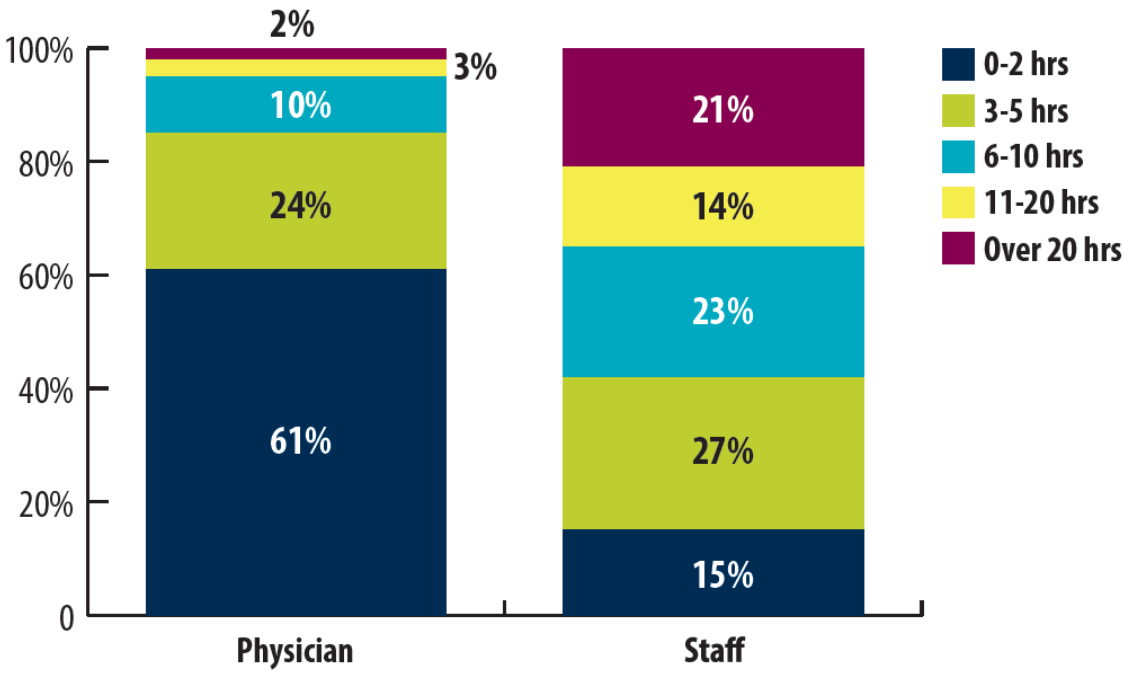
Hours spent on PAs per week

Question: Please provide your best estimate of the number of prescription and medical services prior authorizations completed by you yourself and/or your staff for your patients in the last week. Do not include prior authorizations that practice staff completed for the patients of other physicians in your practice.



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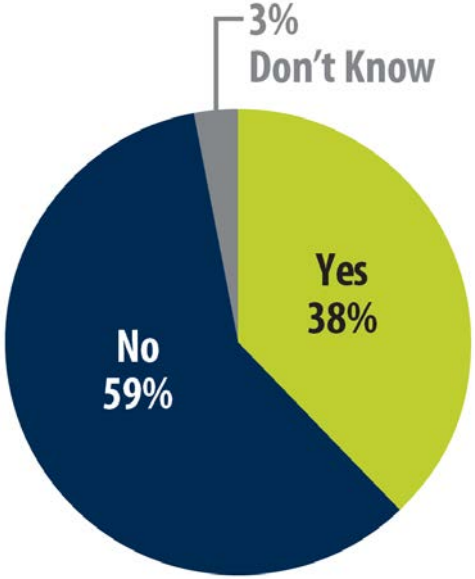
PA staffing burdens

Question: Do you have staff members who work exclusively on PAs?



Initial PA approvals

54%

of physicians surveyed say at least 70 percent of PA requests are approved on initial request.

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REFORM OF
prior authorization?

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REFORM OF prior authorization?

Through its research and partnership with the American Medical Association, MSMS identified the most common provider and patient complaints associated with utilization management programs. These principles seek to improve prior authorization and utilization management programs by addressing the following broad categories of concern:

1. Clinical validity
2. Continuity of care
3. Transparency and fairness
4. Timely access and administrative efficiency
5. Alternatives and exemptions

Clinical Validity

- Utilization management programs must have a clinically accurate foundation for provider adherence to be feasible. Cost-containment provisions that do not have proper medical justification can put patient outcomes in jeopardy.
- While a particular drug or therapy might generally be considered appropriate for a condition, the presence of comorbidities or patient intolerances may necessitate an alternative treatment. Failure to account for this can obstruct proper patient care.
- It is imperative that these clinical decisions are made by providers who are at least as qualified as the prescribing/ordering provider.

Continuity of Care

- Patients forced to interrupt ongoing treatment due to health plan utilization management coverage restrictions could experience a negative impact on their care and health.
- Unanticipated changes to a formulary throughout the plan year can negatively impact patients' access to needed medical care.
- Recurring prior authorizations requirements can lead to gaps in care delivery and threaten a patient's health.
- Forcing patients to abandon effective treatment and repeat therapy that has already been proven ineffective under other plans' step therapy protocols delays care and may result in negative health outcomes.

Transparency and Fairness

- Utilization review entities need to be transparent about all coverage and formulary restrictions and the supporting clinical documentation needed to meet utilization management requirements
- Incorporation of accurate formulary data and prior authorization and step therapy requirements into electronic health records (EHRs).
- Utilization review entities need to provide industry stakeholders with relevant data, which should be used to improve efficiency and timely access to clinically appropriate care.
- Utilization review entities provide specific justification for prior authorization and step therapy override denials, indicate any covered alternative treatment and detail any available appeal options.

Timely Access and Administrative Efficiency

- In order to ensure that prior authorization is conducted efficiently for all stakeholders, utilization review entities need to complete all steps of utilization management processes through NCPDP SCRIPT ePA transactions for pharmacy benefits and the ASC X12N 278 Health Care Service Review Request for Review and Response transactions for medical services benefits.
- Unexpected payment denials create hardship for patients and additional administrative burdens for providers.

REFORM OF prior authorization?

- Prior authorization must remain valid and coverage must be guaranteed for a sufficient period of time to allow patients to access the prescribed care.
- In order to ensure that patients have prompt access to care, utilization review entities need to make coverage determinations in a timely manner.
- The utilization review entity has a responsibility to ensure that the appeals process is fair and timely.
- In emergency situations, a delay in care to complete administrative tasks related to prior authorization could have drastic medical consequences for patients.
- Any clinically based utilization management criteria should be similar—if not identical—across utilization review entities.

Alternatives and Exemptions

- Broadly applied prior authorization programs impose significant administrative burdens, and for those providers with a clear history of appropriate resource utilization and high prior authorization approval rates, these burdens become especially unjustified.
- Health plans should offer alternative, less costly options to confirm clinically appropriate care and managing utilization.
- By sharing in the financial risk of resource allocation, providers engaged in new payment models are already incented to contain unnecessary costs, thus rendering prior authorization unnecessary.

NEXT STEPS

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NEXT STEPS

MSMS believes there are various legislative opportunities available, each taking a considerable amount of investment. The opponents to our position have a significant amount of financial backing. In order for MSMS to determine the proper level, staff will be:

- Developing strong partnerships throughout the Michigan health care community, including specialty associations and other interested groups;
- Begin drafting legislation based upon the aforementioned five broad categories; and,
- Begin its grassroots advocacy and outreach.

MSMS RESOURCES

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MSMS RESOURCES

Resources

Take advantage of MSMS's resources covering legal and regulatory, human resource management, on-demand webinars, and much more. MSMS also offers in-house experts who will intervene to help you resolve payment problems, and answer your questions about licensure, billing and coding.

MSMS RESOURCES

- AIDS/HIV
- Autopsies
- Certificate of Need
- Compliance
- Discrimination
- Drug Prescribing/Dispensing
- End-of-Life Issues
- Laboratories
- Managed Care
- Medical Board: Discipline & Licensing
- Medical Practice: Workforce Issues
- Medical Records
- Medicare/Medicaid
- Minors
- National Practitioner Data Bank
- Organ Donation
- Patient Communication
- Peer Review
- Professional Corporations
- Professional Liability
- Reimbursement: From Patients
- Reimbursement: Other Issues
- Reporting Requirements
- Scope of Practice

Health Law Library

Current, comprehensive, and uniquely tailored to the physician perspective, the Michigan State Medical Society's Health Law Library, sponsored by Kerr Russell, is Michigan's premier health law resource.

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Thank you!

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