GMCB PCAG Questions for BCBSVT re Prior Auths

1. **Referring to the BCBSVT slide deck: Prior Authorizations/ Senate Committee on Health and Welfare April 14, 2017:**

    a. **How was the 15 minutes per prior authorization derived? Most take much longer.**

    "A 2010 American Medical Association survey found that physicians spend an average of 20 hours per week (a number that some doctors say is too low) on prior authorization activities."[7]

    "Doctors devoted, on average, 8.7 hours each week to administrative work, accounting for 16.6 percent of their total work week. These figures exclude all patient-related record keeping and patient-related office work."[2]

    "The mean time per prior authorization request ranged from 9.4 minutes to 47 minutes." [8]

    b. **What percentage of the 29,125 prior authorizations from 2016 were ultimately approved?**

    c. **Is BCBSVT able to identify specific practices and/ or physicians, NPs, and PAs who have a high prior authorization denial rate?**

    d. **How was the cost savings calculated?**

2. Members of the GMCB-PCAG have reported patients not filling prescriptions or taking prescribed medications and having subsequent ER visit or hospitalizations due to confusion with the prior authorization process. This seems to occur in our most vulnerable patient populations.

    a. **Where in your analysis are the indirect costs (ER visits, hospitalizations, etc.) associated with patients not receiving care due to the prior authorization process?**

    "In the evaluation of a PA program seeking to control costs associated with the use of branded type 2 diabetes medications, this study found that members who were prescribed a medication requiring PA, but who never filled the prescription, had higher plan-paid healthcare costs (overall and medical alone), compared with those who qualified for the medication and subsequently filled the prescription within 45 days. A notable number of individuals who were assumed to have met the criteria based on a claims based equivalent, but who never received the medication, made no change to their current therapy despite receiving a prescription for this medication. Failure of a member to take medication deemed necessary by his or her physician could translate to inadequate control of the diabetic condition and result in an excess of resource utilization and costs for treating the disease and associated comorbidities." [3]

    b. **In your experience, has the prior authorization process ever increased costs?**

    "Mandatory referral to a physiatrist before surgical evaluation did not result in persistent reduction in lumbar fusions. Instead, these programs were associated with the unintended consequence of increased costs from more nonoperative care for only a transitory change in the lumbar fusion rate, likely from delays due to the introduction of both PA programs." [4]

    "Implementation of a prior authorization process by insurance carriers does not seem to significantly impact appropriate selection for SPECT-MPI. Socioeconomic status does not seem to significantly influence physicians' adherence to [appropriate use criteria] for SPECT-MPI." [6]

3. **After watching the entire 20 minute video of a doctor doing a prior authorization for a Head CT for a patient with an enlarging skull mass @: http://blogs.aafp.org/cfr/freshperspectives/entry/prior_authorization_call_shows_inefficiency or https://youtu.be/z20wfv4A604** (You Tube link).

    a. **Should a patient with an enlarging skull mass require a prior authorization if the ordering physician deems it necessary?**

    b. **Is this example an efficient use of physician/ NP/PA time?**

4. Most, if not all, MD/DO/NP/PAs consider prior authorizations to be inefficient and delay care while often approved after wasting time going through an extremely frustrating process.

    a. **What is your response to quotations below taken from the recent American College of Physicians Position Paper on *Putting Patients First by Reducing Administrative Tasks in Health Care?***

        i. *"Tasks that are determined to have a negative effect on quality and patient care, unnecessarily question physician and other clinician judgment, or increase costs should be challenged, revised, or removed entirely."* [1]

        ii. *"Excessive administrative tasks have serious adverse consequences for physicians and their patients. Stakeholders must work together to address the administrative burdens that prevent physicians from putting their patients first."* [1]

5. Prior authorizations increase overall administrative work, which has been shown to increase career dissatisfaction. Time spent on administrative tasks means less time in direct patient care.

    a. **How can that be good for Vermont patients and the medical system overall?**
    b. **How important is MD/DO/NP/PA career satisfaction versus cost-savings when considering the value of prior authorizations?**

    "Doctors devoted, on average, 8.7 hours each week to administrative work, accounting for 16.6 percent of their total work week. These figures exclude all patient-related record keeping and patient-related office work."[2]

    "Interestingly, physicians who reported that their practice made extensive use of information technology actually spent more time on administration." [2]

    "Physicians who spent more time on administration were markedly less satisfied with their careers."[2]

    "After controlling for several other factors reported to affect physicians' career satisfaction (4), the proportion of time spent on administration remained a significant (p = 0.01) predictor of dissatisfaction" [2]

    "Our data suggest that prior authorization measures used were not effective in limiting inappropriate testing, thus questioning the value of this frustrating and time-consuming process." [6]

6. **What are your thoughts regarding the American Medical Association's Prior Authorization and Utilization Management Reform Principal #19:**

    a. *Broadly applied prior authorization programs impose significant administrative burdens on all health care providers, and for those providers with a clear history of appropriate resource utilization and high prior authorization approval rates, these burdens become especially unjustified.* [5]

    b. *Health plans should restrict utilization management programs to "outlier" providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors.*[5]

7. **What is your opinion regarding the GMCB-PCAG recommendation that:**

    a. **All prior authorizations are stopped in Vermont.**
    b. **Third party payors concerned about cost can use existing prior authorization staff and infrastructure to educate MD/DO/NP/PAs and the general public about appropriate use, starting with medical practices and patient groups that would benefit the most from the education (i.e. leave the people doing it correctly alone).**

8. **How can BCBSVT assist in reducing the burdens on primary care practitioners and their staff that are caused by prior authorization needs?**

9. **If BCBSVT insists on primary care practitioners doing a prior authorization process, how do they propose that PCPs are to be paid for the work effort that it requires?**

10. **What would happen if all Vermont physicians, NPs, and PAs refused to participate in the prior authorization process?**

References:

1. Erickson et al, Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians, *Ann Intern Med*. 2017; 166:659-661.
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3. Bergeson et al, Retrospective Data Base Analysis of the Impact of Prior Authorization for Type 2 Diabetes Medications on Health Care Costs in a Medicare Advantage Prescription Drug Plan Population, *J Manag Care Pharm*. 2013;19(5):374-84.
4. Goodman RM et al, The Impact of Commercial Health Plan Prior Authorization Programs on the Utilization of Services for Low Back Pain, *Spine*, 2016; 41 (9): 810–815.
5. American Medical Association's *Prior Authorization and Utilization Management Reform Principles*, https://www.ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf, accessed February 7, 2017.
6. Doukky R, et al, Impact of Insurance Carrier, Prior Authorization, and Social Economic Status on Appropriate Use of the SPECT Myocardial Perfusion Imaging in Private Community-Based Office Practice, *Clin. Cardiol.*, 2015; 38, 5:267–273.
7. Bendix J, The Prior Authorization Predicament, *Med Econ,* 2014; 91 (13), 29-35.
8. Morley et al, The Impact of Prior Authorization Requirements on Primary Care Physician's Offices: Report of 2 Parallel Network Studies; *JABFM* 2013; 26: 93–95