Prior authorization reform

NCOIL

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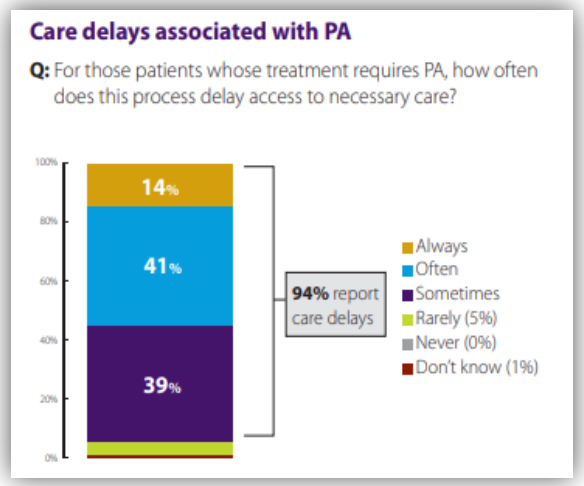
Prior authorization harms patients

Nearly 1 in 4 physicians (24%) report that PA has led to a **serious adverse event** for a patient in their care.

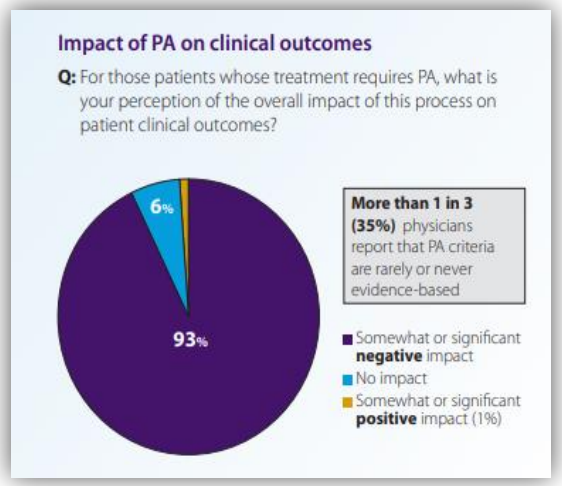
19% of physicians report that PA has led to a patient's hospitalization

13% of physicians report that PA has led to a life-threatening event or required intervention to prevent permanent impairment or damage

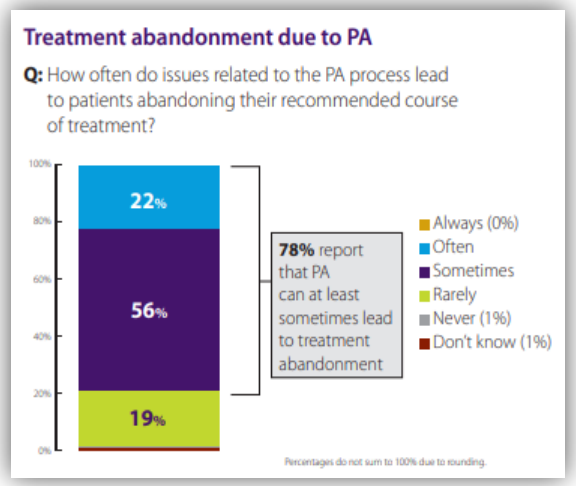
7% of physicians report that PA has led to a patient's disability/ permanent bodily damage, congenital anomaly/birth defect or death



Increases care delays



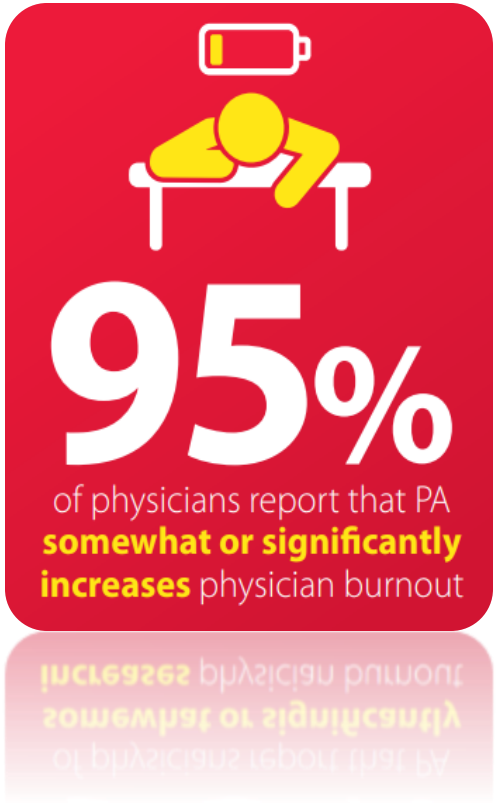
Negatively impacts clinical outcomes

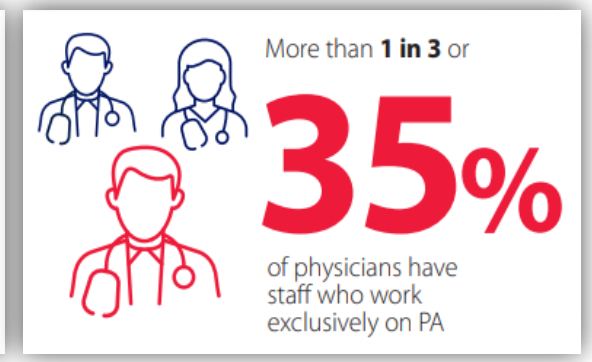


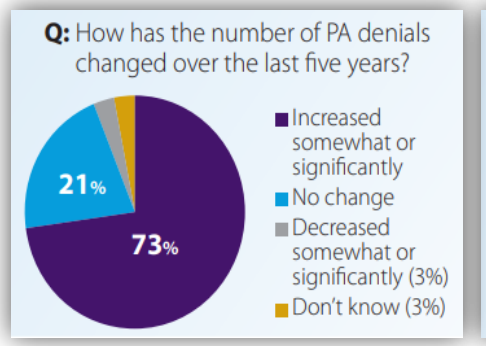
Increases treatment abandonment

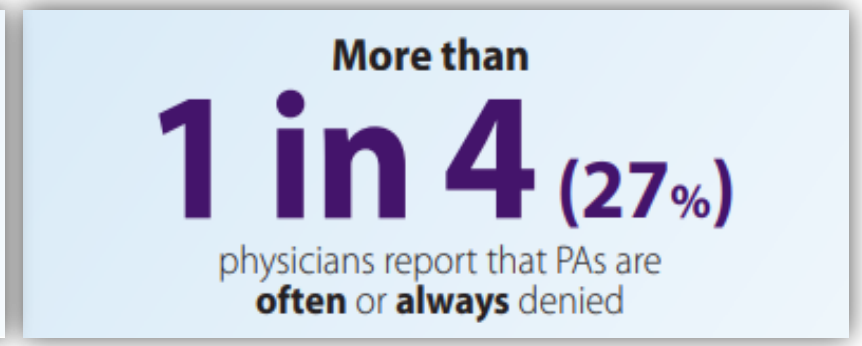
Source: 2023 AMA Prior Authorization Physician Survey. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

Prior authorization creates provider burdens







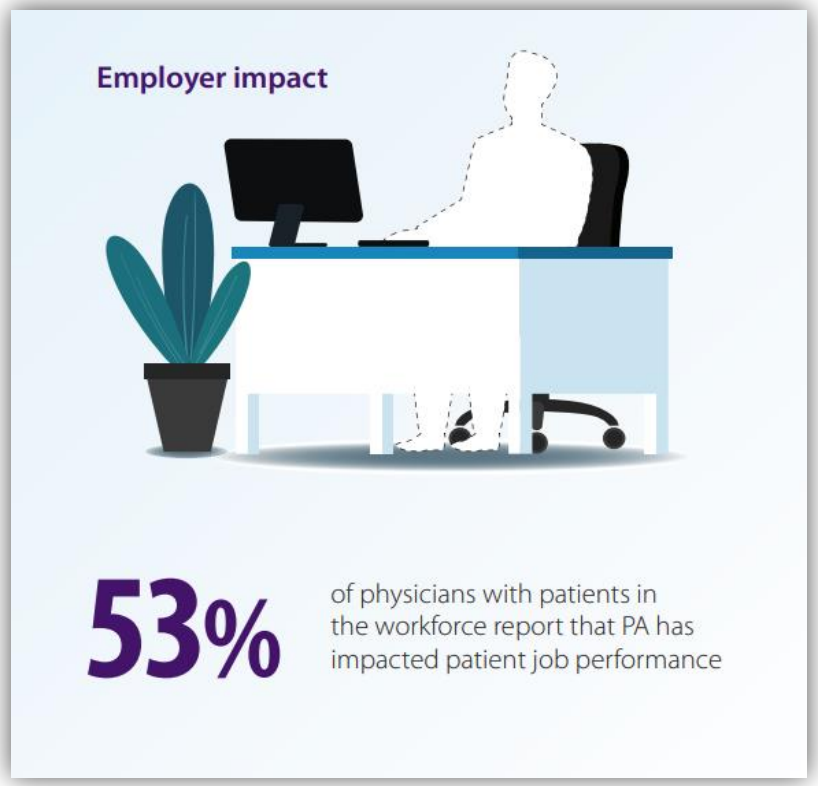


Source: 2023 AMA Prior Authorization Physician Survey.
https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

Prior authorization impacts employers and employees

Increases absenteeism & presenteeism

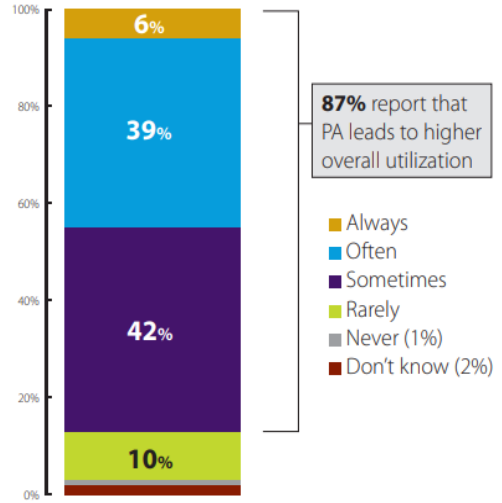
The “cheap” option may cost employers more—and at the expense of employee health.



Source: 2023 AMA Prior Authorization Physician Survey.
https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

Prior authorization increases costs for the healthcare system

Q: Please consider how your patients' utilization of health care resources is impacted by the PA process. In your experience, how often does the PA process lead to higher overall utilization of health care resources?



Q: In which of the following ways has the PA process led to higher overall utilization of health care resources for patients in your care?

69% report ineffective initial treatment (e.g., due to step therapy requirements)

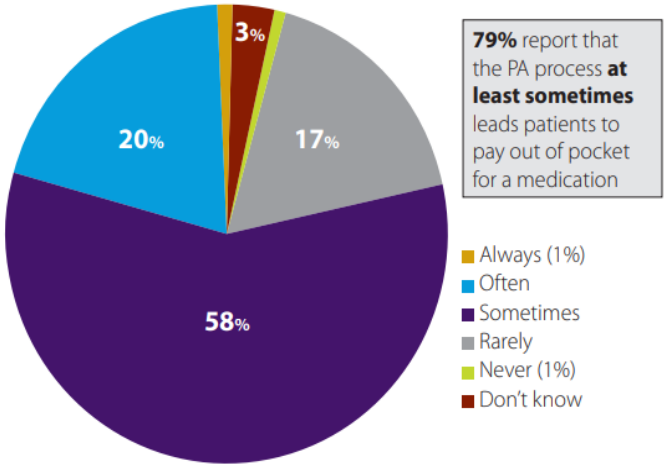
68% report additional office visits

42% report immediate care/ER visits

29% report hospitalizations

Patient out-of-pocket costs and PA

Q: How often does a PA delay or denial lead to a patient paying out of pocket for a medication that you prescribe (i.e., the health plan does not cover the prescription and the patient pays the full cost)?



Increases health care utilization

Increases patient OOP

Source: 2023 AMA Prior Authorization Physician Survey. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

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Solutions

Faster response times

24 hours for urgent care and 48 for nonurgent.

Use of APIs and ePA w/ standards transactions (must be paired with other solutions since, by itself, ePA could increase rather than reduce unnecessary use of prior auth).

Reducing prior authorizations

A prior authorization should be good for the course of treatment.

Eliminate prior auth for care with high approval rates.

Ensuring clinical integrity

Denials made by physician of same specialty, licensed in the state, experience treating condition.

Clinical criteria based on nationally recognized standards of care developed by medical specialty societies.

Data collection and reporting

Rates of approval, denials, appeals, response times, more.

Available to patients, providers, and policymakers.

Summary reports by regulators.

Continuity of care

90+ day grace period when patient is switching plans.

Prevent repeat prior authorizations.

Transparency and more

Decisions are binding (no retroactive denials).

Public clinical criteria and prior authorization requirements.

Reason for adverse determination

Appeal processes

Consensus statement

Released in **January 2018** by the AMA, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association

Five reform categories addressed:

- Selective application of PA
- PA program review and volume adjustment
- Transparency and communication regarding PA
- Continuity of patient care
- Automation to improve transparency and efficiency

Consensus Statement on Improving the Prior Authorization Process

Our organizations represent health care providers (physicians, pharmacists, medical groups, and hospitals) and health plans. We have partnered to identify opportunities to improve the prior authorization process, with the goals of promoting safe, timely, and affordable access to evidence-based care for patients; enhancing efficiency; and reducing administrative burdens. The prior authorization process can be burdensome for all involved—health care providers, health plans, and patients. Yet, there is wide variation in medical practice and adherence to evidence-based treatment. Communication and collaboration can improve stakeholder understanding of the functions and challenges associated with prior authorization and lead to opportunities to improve the process, promote quality and affordable health care, and reduce unnecessary burdens.

The following five areas offer opportunities for improvement in prior authorization programs and processes that, once implemented, can achieve meaningful reform.

1. **Selective Application of Prior Authorization.** Differentiating the application of prior authorization based on provider performance on quality measures and adherence to evidence-based medicine or other contractual agreements (i.e., risk-sharing arrangements) can be helpful in targeting prior authorization requirements where they are needed most and reducing the administrative burden on health care providers. Criteria for selective application of prior authorization requirements may include, for example, ordering/prescribing patterns that align with evidence-based guidelines and historically high prior authorization approval rates.

   We agree to:

   - ***Encourage the use of programs that selectively implement prior authorization requirements based on stratification of health care providers' performance and adherence to evidence-based medicine***
   - ***Encourage (1) the development of criteria to select and maintain health care providers in these selective prior authorization programs with the input of contracted health care providers and/or provider organizations; and (2) making these criteria transparent and easily accessible to contracted providers***

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Little progress following the consensus statement

80% of physicians report that the number of medical service PAs required has increased over the last five years.

Only 11% of physicians report contracting with health plans that offer programs that exempt providers from PA.

64% of physicians report that it is difficult to determine whether a prescription medication requires PA.

89% of physicians report that PA interferes with continuity of patient care.

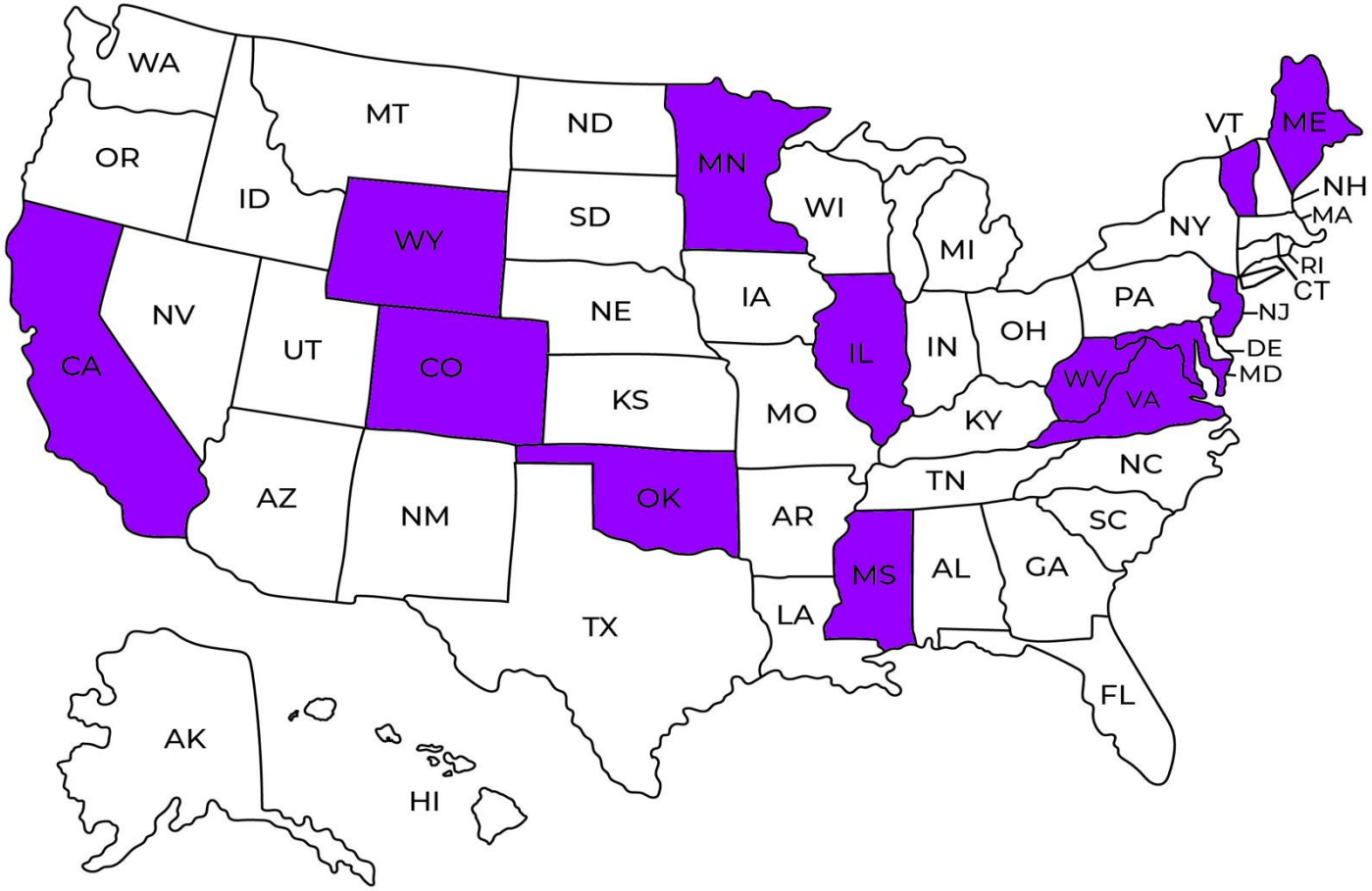
Only 29% of physicians report that their EHR system offers electronic PA for prescription medications; phone is still the most common method of completing PAs.

Source: 2022 Update: Measuring progress in improving prior authorization.

Available at:

https://www.ama-assn.org/system/files/prior-authorization-reform-progress-update.pdf

2024 State activity



Federal activity:
Final CY2024 Medicare Advantage (MA) Rule

Clinical Validity

- MA plans may only use PA to confirm diagnoses/medical criteria
- MA beneficiaries must have access to the same items and services as they would under traditional Medicare vs. plans using internal proprietary clinical criteria
- MA plans must establish a Utilization Management Committee
- MA plans cannot deny care based on provider type or setting

Continuity of Care

- MA plans' PA approvals must remain valid for the duration of the course of treatment
- MA plans must provide beneficiaries with a 90-day transition period where a PA would remain valid for an ongoing course of treatment when beneficiaries change plans
- After PA approval, MA plans cannot retroactively deny coverage

Federal activity: CMS Interoperability and PA Final Rule

MA, Medicaid/Medicaid MC, CHIP/CHIP MC, QHPs in FFEs

Processing timelines: 72 hours for urgent prior authorizations

- AMA advocates for **24 hours** for urgent and **48 hours** for regular PAs

Electronic PA process via application programming interfaces (APIs) that integrate with EHRs

- AMA supports electronic PA process as component of reform
- Concerns with AI programs/lack of human review of denials
- Accessibility for small practices and those in rural or underserved community

Transparency requirements:

- Plans required to post metrics (approval/denial rates; overturns on appeal; average processing time)
- Plans required to provide specific reason for denial, regardless of processing method

Note: drugs are out of scope – whether administered under the medical benefit or Part D/prescription benefit.

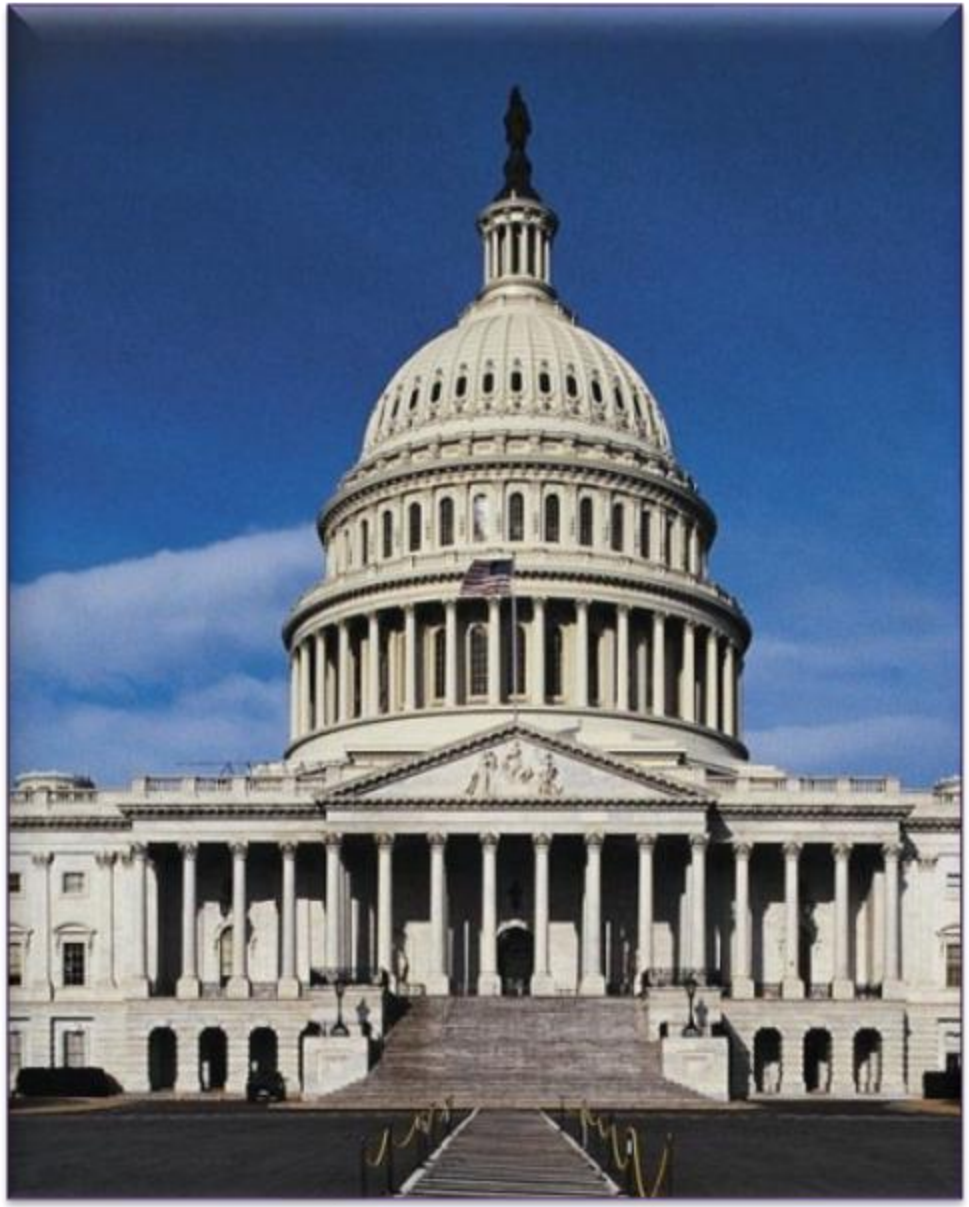
Federal legislation

Improving Seniors' Timely Access to Care Act in the House and Senate (H.R. 8702; S. 4532)

- Proposed streamlining and standardization of PA in MA program
- Codify and even improve some of the provisions in the MA rule
- Passed House of Representatives in September 2022 by unanimous voice vote
- Broad bipartisan support

H.R. 4968 "Getting Over Lengthy Delays in Care as Required by Doctors" (GOLD CARD) Act

- Exempts physicians from MA plan PA requirements if 90% of the physicians' requests were approved in the preceding 12 months
- Based on a similar law enacted in Texas that took effect in 2021
- Establishes protections against inappropriate revocation of gold card status and right to appeal attempt to rescind PA waiver



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