The Prior Authorization Pilot 2013-2016

Allan Ramsay, MD
Allan.m.ramsay@gmail.com
@AllanRamsayMD

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Methods

- - Three payers (Medicaid, BCBSVT, MVP) and GMCB
- - Two drug classes (statins, PPIs)
  - -New prescriptions, changes in prescribing, total costs
- - One MRI (non-contrast MRI lumbar spine at 2 hosp)
  - - Volume changes
- - Independent clinicians vs employed (hospital, FQHC)
- - Pre-post pilot surveys
- - One year pilot period

Results

- Increase in PPI cost for Medicaid (drug rebate program)
- No increase costs for any payer for statins
- RRMC: ACR criteria met 940/946 exams, PMC: 58/58 exams
- Administrative burden at two hospital radiology programs
- Initial survey information:
  - 81% difficult to determine what needs a PA
  - 88% spent more than 5 hours per week
  - 47% several days to receive a PA
  - 94% PA have a negative impact on patient care

Conclusions

- Medicaid increased PPI costs related to the drug rebate program (no formulary rule).
- Radiology groups can develop a process for approving advanced images. The difficulty is when one image is treated differently from others.
- Vermont Radiology Society is committed to improving the appropriateness of adv imaging orders and real time decision support for clinicians.
- Payers were not able to agree on a common drug formulary
- Payers were not willing to scale up the pilot or continue it in any form

Personal Observations

- Payer participants
  - Strong belief PA reduces costs (dec premium increases) w/o acknowledgement of their costs
  - Strong belief they have made efforts to reduce PA burden
  - Changes in PBM or drug rebate program complicates PA
  - If the GMCB has no regulatory authority (CIGNA) payer will not participate

Personal Observations

- Clinicians
  - Overall impact on a practice was small
  - VT clinicians maintain a high generic prescribing ratio so finding a true difference with only 2 classes was unlikely
  - VT clinicians do not overuse MRI of the spine in LBP
  - The initial provider survey was most revealing about how clinicians feel about PA

Finally…

- The economic argument for continuing PA for high volume/value-lost cost drugs in Vermont is flawed

- Prior authorization goes against every principle of shared decision making between patient and clinician (http://blogs.aafp.org/cfr/inthetrenches/entry/reducing_administrative_burden_ter …)

- *Something must be done, this burden has the greatest impact on primary care*

What can be done for primary care?

- GMCB
  - Further pilot study
  - ACO rule making process
  - Independent PA cost analysis
- Legislature
  - Eliminate PA for high value low cost therapies
- Payers
  - Common formulary for high value low cost drugs
  - Value based benefit design
- Others?