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- Practicing in Vermont since 2000
- Board Certified in both Family Medicine and Sports Medicine for over 20 years.
- I do not bill patients or insurers and have **no financial incentives** around patient volume, procedures, or reimbursement. My income is salary based.
- I served two years on the Green Mountain Care Board – Primary Care Advisory Group culminating with a 2018 recommendation to **eliminate prior authorizations in favor of patient and provider education** (see below).
- 99.9999% of prior authorizations for my patients are ultimately approved, yet they consistently delay care, contribute to bad medical outcomes, increase costs, and waste countless hours of administrative time.
- I will now only do peer-to-peer review for prior authorizations if the relevant medical expert calls me
    - Calling them takes hours (on-hold, hang ups, phone trees, etc.).
    - Initial reviews are done and rejected by staff, typically not physicians, not in the relevant field of medicine. Once I can speak to a physician in the field, they get approved.
- Some examples:
    - Patient **used narcotics** to manage pain waiting for a Celebrex prior auth (electronic auth system failed).
    - Patient **used the ER** to get a timely MRI rather than wait for a prior auth.
    - Patient decompensated and **was hospitalized** after not getting medication refill because the formulary changed and their medication now required a prior auth.

Prior authorizations reduce patient access and increase risk of medical errors.

- Time spent justifying a prior authorization that will ultimately be approved reduces time spent addressing that patients other issues and/ or is time spent not seeing other patients**.**

Prior authorizations contribute to significant hidden costs omitted from most analyses

Proponents of prior auths claim ending them will increase costs. Their analyses regularly fail to account for hidden or hard to quantify but very real costs associated with poor patient access, physician burnout and shortages, inappropriate use of emergency rooms, hospitalizations due to care delays.

- It now takes at **least 6-9 months to establish routine care** with a primary care provider in Vermont, and longer if it is an MD or DO.
- Hospitals are struggling to recruit and retain physicians.
- Delays in screening and/ or direct care lead to more significant disease and over all worse outcomes
    - What if high blood pressure or abdominal pain could be addressed in days rather than months?
    - How are these costs of delayed patient care accounted for by the proponents of prior authorizations?
- Physicians suffer moral injury, not burnout, from routinely not being able to provide adequate and timely care to their patients. [12]
- The number of physician suicides is more than twice that of the general population. [13]
- Nearly 1 in 5 US physicians intend to reduce clinical work hours in the next year, and roughly 1 in 50 intend to leave medicine altogether in the next 2 years to pursue a different career. [11]
- Replacing physicians can cost as much as $250,000 each. For Stanford Medicine this costs as much as $7.75 Million per year. [10]
- 2017 Green Mountain Care Board VT Clinician Landscape Study: administrative burden was the greatest threat among both employed and independent physicians.[14]

Imagine if we could:

1. Increase patient access by replacing administrative tasks to justify care that will ultimately be approved with **more patient care appointments**.
2. Make Vermont the best place to practice medicine, reduce moral injury, and help recruitment and retention efforts by allowing physicians to do what they were trained to do.

3. Redirect the insurance industry infrastructure away from putting up costly roadblocks and move toward a model that educates patients and providers around best and safest utilization practices (tell us how and why we should manage care a certain way, but let the physician decide what is best for a particular patient).

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Primary Care Advisory Group
Recommendation to Eliminate Prior Authorizations in Vermont
January 10, 2018

Preamble

Section 10 of Act 113 establishes the Primary Care Advisory Group (PCAG) to address and provide recommendations regarding administrative burdens facing primary care professionals, including: *creating opportunities to reduce requirements for primary care professionals to provide prior authorization **(PA)** for their patients to receive radiology, medication, and specialty services.*

Since the first PCAG meeting in September, 2016, the issue of PAs has been reviewed and discussed extensively, including regular discussions with third-party payers (BCBSVT, MVP). At the December 20, 2017 PCAG meeting, PCAG members expressed sincere gratitude for the contributions and willingness of BCBSVT and MVP to address the issue of PAs.

The PCAG recommendations regarding PAs that follow are based on the following points:

While the PCAG recognizes that there may be some outliers, the majority of PCPs (primary care physicians, nurse practitioners, and physician assistants) want to provide excellent evidence-based medical care, understand their individual patient's unique medical needs and are in the best position to order the appropriate test, medication or specialist referral for that patient. The PA process interferes with appropriate care, poses a significant administrative burden, and has a major negative impact on PCP career satisfaction and burnout.

"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]

"The growing number of administrative tasks imposed on physicians, their practices, and their patients adds unnecessary costs to the U.S. health care system, individual physician practices, and the patients themselves. Excessive administrative tasks also divert time and focus from more clinically important activities of physicians and their staffs, such as providing actual care to patients and improving quality, and may prevent patients from receiving timely and appropriate care or treatment. In addition, administrative tasks are keeping physicians from entering or remaining in primary care and may cause them to decline participation in certain insurance plans because of the excessive requirements. The increase in these tasks also has been linked to greater stress and burnout among physicians." [1]

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

"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]

Major medical organizations (i.e. American Academy of Family Physicians, American Medical Association and the American College of Physicians, etc) recognize the significant burden of PAs and have published

statements and/ or position papers calling for reform of prior authorizations and reducing administrative burden.[1,5,9]

"Prior authorizations create significant barriers for family physicians to deliver timely and evidenced-based care to patients by delaying the start or continuation of necessary treatment. The very manual, time-consuming processes used in prior authorization programs burden family physicians, divert valuable resources away from direct patient care, and can inadvertently lead to negative patient outcomes. The AAFP believes family physicians using appropriate clinical knowledge, training, and experience should be able to prescribe and/or order without being subjected to prior authorizations"[9]

"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] *"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]

Most PA's are approved and for most PCPs, over 90% of all required PAs are ultimately deemed appropriate and approved. The system is tremendously inefficient.

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]

Data has been presented by BCBSVT noting that in a 1-year period, 71% of PAs by PCPs were ultimately approved, and that the other 29% that were denied saved the plan $1.2 M. There is no information regarding why the 29% were ultimately denied and if the denial was medically appropriate. The PCAG appreciates BCBSVT sharing this information, but also recognizes that there is a lot of information that is not available that would be helpful in creating a complete picture.

"My PA denial rate is close to zero. They always get approved. It is so frustrating that I have to do them and that my patient's care gets delayed" (PCAG member).

"Insurers should redeploy their PA infrastructure to patient and provider education regarding inappropriate testing and medication usage. Insurers are in the unique position of knowing where these educational resources would be best deployed, including the minority of PCPs who cause the majority of inappropriate claims. If they truly cared, they would do that instead of this shotgun PA approach." (PCAG member).

PA's have been shown to increase cost or not change PCP practices around testing or prescribing

"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]

The 2015 GMCB study on PAs showed no significant increase for certain imaging tests and mixed results with respect to pharmacy costs. Where the preferred drug option was available at the point of care, the drug arm of the study showed no increase in cost.

Insurers claim that PAs provide a significant return on investment and reduce overall medical costs; however:

Analyses provided to PCAG do not account for a multitude of indirect costs, including:

- ER visits and hospitalizations for patients who did not fill prescriptions or undergo testing due to the PA process
- Time spent on the PA process by pharmacies/ radiology departments/ referral centers waiting for the PA
- Insurer's PA department – which gets passed on to the consumer.
- Employee benefits for PCP staff that work solely on PAs
- Replacing PCPs who leave due to burnout
- Hiring more PCPs to manage patient volume as administrative burden increases
- Patient and resources spent (fuel, time out of work, etc) going to the pharmacy multiple times for a single prescription involving a PA.

Cost information is not provided to PCPs or patients at the point of care:

Clinicians, practices, and other health care provider organizations generally have focused on providing the highest-quality care and often do not have access to the information they need to fully account for the cost of products and services. Also, concern is growing that an increased focus on cost reduction, particularly as it is monitored and enforced by payers and oversight entities, will result in patients not getting the care they need (that is, underutilization). However, clinicians generally recognize that they have to consider the cost of services, particularly as it affects their patients who, for example, may not be able to access certain pharmaceuticals they need because of high prices, as well as how it affects the health care system as a whole.[1]

Time estimates for PA completion used in calculations is highly debatable. Available published reports and anecdotal experience is equally highly variable.

"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]

AAFP 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
"If the insurer's had to pay us and our staffs for time spent doing PAs, they would probably get rid of them" (PCAG member)

PA completion is done by different personnel at each practice (PCPs vs nursing or administrative staff) which has varying associated impacts on availability for direct patient care and the practice costs.

PAs can actually increase the overall cost of care for patients who either over-utilize emergency rooms to access care (where PAs are not required but add an associated ER charge), or do not participate in the PA process for medication changes or testing and have subsequent higher medical costs due to decompensation. GMCB-PCAG members have repeatedly expressed concern and provided case examples that this increased

cost impacts our most vulnerable patients who may not possess the financial or intellectual resources required to navigate this increasingly complex system.

> *"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]
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> *"When I am really concerned about a patient who needs a CT or MRI, I will send them to the ER to get the study so they do not have to wait for the PA. It might not be a true emergency, and they end up with an ER bill, but sometimes waiting for several days for a PA to clear is not in the best interest of the patient" (PCAG member)*
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> *We all have patients who end up in the ER or hospitalized because they did not fill the new prescription because it required a PA. (PCAG member)*
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> **PAs represent an unreimbursed cost-shift from insurers to medical practices**.
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> **PAs might have a greater impact on rural and underserved areas, where PCP access is limited and PAs reduce time for direct patient care.**
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> **Efforts to use electronic PAs are ineffective as they often require a separate login and screen for each plan, follow up phone calls, faxing or uploading documentation, or involve web sites that malfunction. Up to date point-of-care information regarding preferred medications would be helpful, but integration with the myriad of EMRs in the state and effective regular updates does not seem probable in the near future.**

PCAG recommendations to the GMCB regarding PAs:

1. Eliminate PAs for Vermont PCPs. a. Insurers concerned about cost-containment could redeploy PA staff to educate certain PCPs and/ or patient groups about appropriate use.

2. PAs for medications prescribed by Vermont PCPs could be reconsidered and implemented only after the insurance and EMR industry creates a reliable system for updating all formulary changes in real-time for point-of-care access for EMRs used in Vermont.
3. Insurers should provide education to both patients and PCPs regarding appropriate use criteria for imaging, medications, step-therapy, and specialty referrals.
4. Insurers should communicate with "outlier" PCPs whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors.

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