THE PRIOR AUTHORIZATION BURDEN

The process is frustrating, time-consuming and costly.

BY HOWARD BELL
Moose Lake family physician Randy Rice, M.D., recalls the frustration he experienced when he tried to get a routine refill for a patient’s rescue inhaler. He initially prescribed Ventolin, which the patient had been using for years, and was told that even though it had been a drug of choice on the health plan’s formulary, it now required prior authorization (PA). “But they wouldn’t tell me what the preferred drug was,” he says.

Thus began the guessing game. Rice wrote a second prescription for Proventil, which was denied, then a third for ProAir, which was also denied. He then submitted a PA request for ProAir. Late on a Friday, he found out the request had been denied. He was told to choose a different drug, but the insurer still didn’t tell him which one would be covered. “The patient, who has severe asthma, went home that weekend without his rescue inhaler and could have ended up in the ER or hospital,” Rice says. On Monday, he learned that he needed to prescribe Xopenex, a newer, more expensive medicine that wasn’t even on most formularies. “We shouldn’t have to play this guessing game,” he says.

Prior authorization is that extra step health plans require before they decide if they will pay for certain prescriptions. To physicians, PA is a time-consuming, costly task that takes them away from patients.

Nationwide, primary care physicians spend an average of 2.8 hours per week on PA and other formulary interactions, according to a survey of two-thirds of all practicing physicians in the United States. The investigators, who published their findings in Health Affairs in 2009, found nursing staff spent 16.9 hours per week...
and clerical staff 5.6 hours per week on such tasks. Converting time into dollars, they calculated the average primary care practice spent $64,859 annually per physician on PA, nearly one-third the amount they paid for salary and benefits for the average primary care physician.

Rice says he personally spends about three hours a week on PA and that his nurses and other clinic staff spend about 10 to 15 hours on it. “My time spent on PA has gone up exponentially in the past few years. It’s become vastly overused. No matter how well I follow best-practice lowest-cost guidelines, I still need to do PA, and I even have to do annual repeat PAs for drugs they’ve already approved.” In what he calls the “ultimate absurdity,” Rice says he once even had to fill out a PA form in order to get permission to fill out another PA form.

**GOOD INTENTION IN NEED OF A FIX**

Prior authorization has been part of medical practice in Minnesota since the advent of managed care formularies in the 1980s. But physicians say it is now required more often and for more drugs than it used to be. There are a number of reasons for that: More health care dollars get spent on drugs now because there are more drugs for more conditions. Biologics such as Enbrel and Humira and personalized drugs made possible by advances in pharmacogenomics can cost tens of thousands of dollars per month. In addition, the advent of Medicare Part D drug coverage in 2003 increased prescribing.

Health plans say they use PA to protect patient safety and reduce drug costs, encourage use of less-expensive generics, limit off-label uses of drugs, quell demand for newer and more-expensive drugs that are advertised directly to patients, and limit access to specialty drugs that only certain physicians have the expertise to prescribe. All of these are laudable reasons for PA. But for physicians, the recurring paperwork, phone calls, faxes and bureaucratic battles that it brings feel like an unnecessary burden.

Frustration over PA led the Minnesota Medical Association last year to search for ways to reduce the inconvenience. Staff have been interviewing health plan medical directors to learn more about their PA processes and talking with pharmacists, representatives from the state’s Medicaid order to get permission to fill out another PA form.

**ELECTRONIC PRIOR AUTHORIZATION**

The National Council for Prescription Drug Programs is in the process of implementing nationwide standards for electronic prior authorization (PA) transmittal. This will allow providers to transmit information requested for PA to a pharmacy benefits manager using e-prescribing networks such as SureScripts.

“Electronic PA will reduce missing or illegible information often found in paper-based faxes,” says Kevin Burns, spokesperson for the Academy of Managed Care Pharmacy. “Turnaround time for PA responses would be reduced because of the built-in logic of the question sets.” For example, one of the first questions might ask for a diagnosis code, which might eliminate the need for further questions.

Electronic PA will first be used for prescriptions paid for by Medicare Part D. Eventually it’s expected to be adopted by all private and public health plans. Minnesota is already poised to accelerate adoption. Under current state law, all drug PA must be submitted electronically by January 2016. —H.B.
program and clinic office staff about its effect on cost and practice. And they’ve encouraged physicians to share their PA stories through an online tool on the MMA’s website. The hope is that they’ll have a plan for reducing the burden associated with prescription drug PA by January.

“We’re not trying to eliminate drug prior authorization,” says MMA Policy Director Janet Silversmith. “We just want to add some sanity to the process. As it’s practiced now, we believe drug prior authorization is an onerous, inefficient process that sometimes harms patients.”

HOW PA WORKS—AND DOESN’T
Prior authorization generally takes three forms in Minnesota, says MMA staffer Barbara Daiker, R.N, Ph.D. Health plans may require physicians to show that a patient has a clinical need for a particular medication before that medication will be authorized for coverage. They may require clinicians to show that one or more other drugs were tried first—and failed to work—before giving approval for the desired drug. They also may cap the amount of a drug that can be prescribed in a given time, so a physician who wants to prescribe beyond that must get permission to do so.

The health plans pay pharmacy benefit managers (PBMs) such as Express Scripts, CVS Caremark, Medical Impact and Prime Therapeutics to handle approvals, denials and most appeals for them. State law stipulates that initial decisions must be communicated to the physician and patient within 10 business days.

Many requests get approved almost instantly and automatically. And most eventually get approved, says George Schoephoerster, M.D., a geriatrician who has met with several Minnesota health plan medical directors to learn more about the PA process on behalf of the MMA. During those discussions, Schoephoerster learned that one plan denied 20 percent of requests in 2012. Such reviews delay care, he points out.

Not knowing which drugs are on each health plan’s formulary and which ones require PA is one of the biggest frustrations for physicians. Rice’s experience with inhalers is a case in point. Lists change often, and each health plan’s may be different; in fact, each product offered by an insurer may have its own unique list.

“Every health plan has its own forms, questions and procedures for the same drugs, and very different lists of which drugs require PA,” says Monica McKinnon, R.N., nurse manager for the Center for Reproductive Medicine in Minneapolis. She estimates her clinic staff spend 10 to 15 hours per week on drug PA. Another source of irritation is when the health plan says one thing and the PBM says another. For example, McKinnon has been told by a PBM to submit a PA request for certain drugs and after doing so received a letter from the health plan saying PA wasn’t needed.

“We spend a lot of time on the phone on hold, taking away time that should be spent with our patients,” she says. “And when we finally get through, they give us yet another number to call.” Sometimes,
before McKinnon is allowed to talk to a real person, she has to navigate an automated phone tree. “When you finish that and finally get to talk to a real person, they ask you the same questions you just spent a lot of time answering.”

Usually, McKinnon says, the person on the other end of the line has little or no medical knowledge about fertility medications and codes. That’s true even when you appeal a PA denial, according to Randy Saliares, M.D., a gastroenterologist with CentraCare in St. Cloud, who along with Rice has been part of the MMA workgroup looking into the problems with PA. “For the appeal stage, I’ve learned to ask right away to speak with a specialist in my field. I’ve had cases where I ask again and again and never do get to talk to that specialist.”

When Saliares suspects a drug may require PA, he sometimes sends a request to the pharmacy along with the prescription, before McKinnon is allowed to talk to a real person, she has to navigate an automated phone tree. “When you finish that and finally get to talk to a real person, they ask you the same questions you just spent a lot of time answering.”

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When Saliares suspects a drug may require PA, he sometimes sends a request to the pharmacy along with the prescription, in hopes his patient gets the medication quicker. But that doesn’t always happen. “I’ve been told I can’t submit the prior authorization request because it [the prescription] hasn’t been denied yet—even though it’s going to be denied and everybody knows it. If one drug gets denied and I call the plan or the PBM to find out which drug is O.K. to prescribe without prior authorization, they say they can’t tell me until I try to get the drug I want.”

A LOOK INSIDE A PUBLIC PAYER’S PROCESS

Because Medical Assistance (MA) is a public health plan, its prior authorization (PA) process is relatively transparent. Last year, fee-for-service MA approved 26,000 PA requests and paid for more than 3.4 million prescriptions, according to Sara Drake, R.Ph., pharmacy program manager for the Minnesota Department of Human Services, which administers MA. “More than 99 percent of prescriptions paid for by MA did not require a provider or pharmacy to submit a PA request,” Drake says. “Often, prescribers can avoid PA on the front end by choosing to prescribe the preferred drug on our formulary,” she says. That information is on the department’s website or may be accessed through SureScripts. A drug may be on the PA list if it is more expensive than a similar one or if it has significant safety issues or abuse potential.

About 50 percent of PA requests to MA are denied. “That might sound high,” Drake says. “But many of these denials are for drugs that never should have been submitted to us in the first place because federal law doesn’t allow us to cover them for any purpose, Viagra being a good example.”

Federal law requires the Department of Human Services to make a determination on the PA request within 24 hours of receiving it. They are required to notify the pharmacy through secure email or fax, and generate a letter to the patient within 24 hours after making the determination. The department isn’t required to notify physicians but does so as a courtesy.

Prescribers can submit a PA request to MA by using MA’s PA form or Minnesota’s Uniform PA Form or by submitting the request electronically through the CoverMyMeds.com website.

Like private health plans, the state negotiates with drug makers to get lower prices for people on MA. But it also gets guaranteed minimum rebates that drug manufacturers must pay as a condition of being covered by the federal-state Medicaid program. When rebates and discounts are added up, it’s not unusual for MA to pay 80 percent less than the manufacturer’s list price for drugs that have been around for several years. —H.B.
Checking with the pharmacy isn’t necessarily a solution, as the pharmacies don’t always know which drugs may or may not get approved. “That’s not their fault,” Saliarea says. “Some plans don’t have a look-up feature for pharmacists to access on their computers.”

Daiker says even when physicians have access to a plan’s formulary, it can be difficult to find a particular drug on the list because health plans classify drugs differently. For example, Ambien might be listed on one formulary as an antipsychotic and on another as a sleeping aid. “It’s unnecessarily complicated,” she says.

Classification isn’t the only concern. For example, the definition of “failure” in the case of step therapy may not be spelled out or may be different depending on the plan or the insurance products offered by a plan, according to Daiker, who has studied the language used by the health plans. “How many courses of a medicine do you need to try? Over what period of time—six weeks? A year? Is an allergic reaction considered failure? Sometimes it just doesn’t say,” she says.

Sifting through patient records to document why previously tried drugs failed is time-consuming, so it’s especially annoying when the process must be repeated. Rice recalls a patient he put on the more expensive Benicar for hypertension because he couldn’t tolerate lisinopril or other angiotensin receptor blockers. After
The patient had been on the drug for a year, the PBM requested a new form be filled out detailing all prior failures before they would re-approve the medication they’d already approved. “PBMs should have that information in their records,” Rice says. “Making physicians look up all that failure documentation again and resubmit it delays medications and costs my staff and me a lot of time and money without improving the patient’s care.”

**CARE-DRIVEN OR COST-DRIVEN?**

Health plans say quality of care is the reason for PA. Many physicians, Rice included, think it has less to do with quality and more to do with money. “A PBM’s profit equals what the health plans pay them minus the cost of the drugs the PBMs pay for through submitted claims,” he says. “So they have a vested interest in denying or at least delaying drug prescriptions. If they can delay by even three days approval of a one-month prescription, that’s 10 percent of the drug cost they’ve saved for that month.”

Daiker, who has compared the formularies of six Minnesota health plans, also is skeptical that quality is the primary motive for health plans. “There is extreme inconsistency across plans about which drugs are on their PA lists,” she says. Of the 1,036 different medications she found that required PA, only six were on the PA lists of all the health plans. When she looked at which drugs were on five of six PA lists, it was only 26 more. Which prompts the question: If quality of care is the main reason for PA, why don’t they have similar lists? “There’s no evidence to refute that it’s a financial model,” Daiker says.

The heart of the PA issue, according to Rice, is that drug costs are divorced from other health care costs because they’re carved out and managed by the PBMs. “If a patient doesn’t get their meds in a timely fashion and ends up in the hospital, it’ll cost the health plan, but it won’t cost the PBM, which is looking at its own bottom line,” he says. “I believe most PA decisions are purely about what saves the health plan or the PBM money in the short term, rather than what provides the best care for patients or what saves on the overall cost of care in the long run.”

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-- RANDY RICE, M.D.

The MMA’s Silversmith says drug companies dislike PA as much as physicians do. “They work to stay off prior authorization lists by offering discounts to PBMs,” she says. For that reason, one health plan might pay a very different price for a drug than another plan, according to Sara Drake, R.Ph., pharmacy program manager for Minnesota’s Medical Assistance program. “When there are multiple similarly safe and effective drugs in a class, drug makers offer discounts to compete for placement on the PBM’s formulary,” she says.

First-line drugs of choice not requiring PA give the best discounts. That explains why there might be six hypertension drugs on a formulary, Rice says, “all generic and all costing within a few dollars of each other, yet every year the first-choice drug changes. It also explains why formulary lists often don’t jive with what unbiased sources such as the Medical Letter recommend as most cost-effective.”

**SEARCHING FOR SOLUTIONS**

In meetings with health plans, MMA staff have expressed physicians’ frustrations and worked to gather information about the inner workings of the PA process in order to come up with recommendations for how to make it easier and quicker.

“They were willing to talk about their PA process,” Schoephoerster says, “but it took a lot of asking and effort to get the most basic information about approval and denial rates.”

Silversmith says she’s been somewhat frustrated with their response. “Some say we don’t see that there’s a problem. Others say, we know there’s a problem and prior authorization costs us money, too, but what are we supposed to do about it?”

The MMA’s workgroup is tossing around ideas for how to make PA less burdensome. There’s been some discussion about a standardized statewide formulary to reduce the extreme variability in how plans treat the same drug when it comes to PA. “As it is now,” Rice says, “which medicine to pick to avoid PA is a moving target.” But Drake doesn’t see that happening because health plans and PBMs would no longer be able to use their national leverage to negotiate prices. “For better or worse, these discounts and rebates keep costs down for the whole health care system,” she says.

Some think it would be a good idea if health plans at least deleted drugs from their formularies only once per year. Currently, they can make changes as often as they want. “This would minimize frequent switches often caused by price changes negotiated with drug makers,” Saliares points out.
The workgroup has not ruled out proposing legislation requiring health plans to comply with a standardized approach to PA, as 15 other states have done. Among states that have passed PA legislation, most have focused on requiring use of short, standardized PA request forms. Some stipulate how quickly a plan or PBM must respond to a PA request. For step therapy, some say failure need occur only once.

Legislation could require health plans to spell out which drugs must be tried first, for how long and what it means for a drug to fail. “It’s simply telling the physician up front what they need to know so they’re not prescribing blind,” Daiker says.

Minnesota already has its Uniform Form for Prescription Drug Prior Authorization Requests. All plans accept this form, but Silversmith says clinics aren’t using it. That’s partly because it’s not mandated and because clinics are waiting for the federal government to come out with its electronic transaction standard (see “Electronic Prior Authorization,” p. 20).

Silversmith says that before the MMA workgroup makes its recommendations, it’s trying to shed light on the “upstream end of the PA process.” Why does a drug get put on a plan’s PA list in the first place? Why do the drugs on these lists change so often? Why are the PA rules so unclear? Why are the PA lists and processes so different for each health plan? Why isn’t the whole process easier?

Rice sums it up, saying, “If we had evidence-based formularies that were similar across health plans, and not changing with every new price deal, I suspect most physicians would have little trouble with prior authorization.” Until then, PA will remain a costly, time-consuming burden.

Others would like to see staff at PBMs and health plans who handle PA requests have medical knowledge. “Some are minimally trained and follow a prompt sheet, or only look for the magic key words you may or may not have included in your request,” Saliares says. “Appeals, in particular, should always and from the beginning be reviewed by an appropriate medical specialist. And if you ask to speak to a specialist in your field regarding an appeal, they should honor that request.”

Minnesota law requires that appeals be reviewed by physicians licensed in the state. But, according to anecdotal information submitted to the MMA workgroup, many believe that although an appeal must be signed off on by the medical director of a Minnesota health plan, the actual appeal reviews are done by people in other states under contract with the health plans or PBMs. “These outside reviewers have a financial incentive to deny or delay appeals,” Saliares says.

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