RESOLUTION 38-19

Title: Require Payers to Share Prior Authorization Cost Burden

Introduced by: Anup Lal, MD, for the St. Clair County Delegation

Original Author: Anup Lal, MD

Referred to: Reaffirmation Calendar

House Action: **REAFFIRMED**

Whereas, "pre-authorization" takes up a significant portion of time, and

Whereas, prior authorization remains a primarily manual, time-consuming process that often delays patient access to indicated therapy or even alters the course of therapy and places excessive burden on providers, including nurses and pharmacists, health care practices, and hospitals, and

Whereas, prior authorization disrupts workflow and diverts valuable resources away from direct patient care, and

Whereas, despite estimates varying by type and size of health care practice, one survey found that, on average, in United States medical practices, physicians spent three hours per week interacting with payers, nurses spent 19.1 hours, clerical staff spent 35.9 hours, and lawyers/accountants spent 7.2 hours,[1] and

Whereas, this translates into substantial increase in uncompensated overhead health care costs, and

Whereas, a critical consequence is nonpayment if prior authorization is not obtained in advance of providing the therapy or service, and

Whereas, there are substantial costs with processing prior authorizations for nonformulary drugs on the physician office side of managed care as well as on the insurance side of the process[2], and

Whereas, there is some evidence that prior authorization requirements reduce non drug-related costs but little evidence that they have a positive impact on clinical or humanistic outcomes[3], and

Whereas, it has been found that preauthorization is a measurable burden on physician and staff time with the mean annual projected cost per full-time equivalent physician for prior authorization activities ranged from $2,161 in one study to $3,430 in another;[4] therefore be it

RESOLVED: That MSMS actively support insurers paying physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to actively support insurers paying physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000 or more for costs related to the reaffirmation of MSMS or AMA policy.

Relevant MSMS Policy:

Compensation for Prior Authorization Efforts
Resolution 59-14
RESOLVED: That MSMS work with Michigan insurance companies to study the effectiveness, efficiency, and outcomes of prior authorization processes with the goal of minimizing the burden of prior authorization activities and eliminating non-value added processes including, but not limited to, such issues as value, efficiency, and compensation; and be it further
RESOLVED: That the AMA prioritize and aggressively pursue the simplification of prior authorization processes.

Prior Authorization for Delivery
MSMS opposes the current practice/rule requiring prior authorization for elective delivery of any patient. (Res74-99A)

Prior Authorization for Surgical Procedures
MSMS supports requiring Michigan health plans to finalize their decisions on "prior authorization" at least one calendar week before the scheduled procedure. (Res28-13)

Prior Authorization Reform
MSMS supports the American Medical Association's 21 guiding principles to reform prior authorization requirements and will utilize the principles as a guide for prior authorization reform. (Res89-17)

Relevant AMA Policy:

Prior Authorization and Utilization Management Reform H-320.939
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.

Payer Accountability H-320.982
Our AMA: (1) Urges that state medical associations and national medical specialty societies to utilize the joint Guidelines for Conduct of Prior Authorization Programs and Guidelines for Claims Submission, Review and Appeals Procedures in their discussions with payers at both the national and local levels to resolve physician/payer problems on a voluntary basis.
(2) Reaffirms the following principles for evaluation of preadmission review programs, as adopted by the House of Delegates at the 1986 Annual Meeting: (a) Blanket preadmission review of all or the majority of hospital admissions does not improve the quality of care and should not be mandated by government, other payers, or hospitals. (b) Policies for review should be established by state or local physician review committees, and the actual review should be performed by physicians or under the close supervision of physicians. (c) Adverse decisions concerning hospital admissions should be finalized only by physician reviewers and only after the reviewing physician has discussed the case with the attending physician. (d) All preadmission review programs should provide for immediate hospitalization, without prior authorization, of any patient whose treating physician determines the admission to be of an emergency nature. (e) No preadmission review program should make a payment denial based solely on the failure to obtain preadmission review or solely on the fact that hospitalization occurred in the face of a denial for such admission.
(3) Affirms as policy and advocates to all public and private payers the right of claimants to review by a physician of the same general specialty as the attending physician of any claim or request for prior authorization denied on the basis of medical necessity.

Remuneration for Physician Services H-385.951
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.

2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Web-Based Prior Authorization Process H-285.912
Our AMA supports legislation requiring all health insurers to include web-based prior authorization services among options for granting prior authorization.

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[1] The Journal of Cardiovascular Nursing: May/June 2017 - Volume 32 - Issue 3 - p 209-211
[2] Allergy & Asthma Proceedings . Mar/Apr2006, Vol. 27 Issue 2, p119-122
[3] J Manag Care Spec Pharm, 2001 Jul;7(4):297-303 4. 4. J Am Board Fam Med January 2013, 26 (1) 93-95
[4] J Am Board Fam Med January 2013, 26 (1) 93-95