AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

PRIOR AUTHORIZATION

Recommendation

The American Academy of Family Physicians (AAFP) calls on prior authorization to be standardized and universally electronic throughout the public and private healthcare industry to promote efficiency and reduce administrative burdens. The manual, time-consuming processes currently used in prior authorization programs burden family physicians, divert valuable resources from direct patient care, and can inadvertently lead to negative patient outcomes by delaying the start or continuation of necessary treatment.

Family physicians using appropriate clinical knowledge, training, and experience should be able to prescribe medications and order medical equipment without being subjected to prior authorizations. In the rare circumstances when a prior authorization is clinically relevant, the AAFP believes the prior authorization must be evidence-based, transparent, and administratively efficient to ensure timely access to promote ideal patient outcomes. Additionally, family physicians that contract with health plans to participate in a financial risk-sharing agreement should be exempt from prior authorizations.

Generic medications should not require prior authorization. The AAFP further believes step therapy protocols used in prior authorization programs delay access to treatment and hinder adherence. Therefore, the AAFP maintains that step therapy should not be mandatory for patients already on a course of treatment. Ongoing care should continue while prior authorization approvals or step therapy overrides are obtained. Patients should not be required to repeat or retry step therapy protocols failed under previous benefit plans.

Background

Prior authorization is the process by which physicians must obtain advanced approval from a health plan before the delivery of a procedure, device, supply, or medication in order for insurance to offset the cost for that service. Health plans use prior authorization as a cost-containment strategy by limiting and restricting access to expensive services and ensuring that services are appropriate, necessary, and safe for the patient. Automation of prior authorization has occurred for medications and is referred to as electronic prior authorization.

Impact of Prior Authorization on Physicians and Patients

Prior authorization creates an administrative burden for physicians and other health care providers. Seventy-five percent of physicians report that the burden associated with prior authorization is “high” or “extremely high.” The average physician completes 37 prior authorization requirements each week. Studies estimate that prior authorization costs 1, 13.1, and 6.3 physician, nursing, and clerical hours per week, respectively and $2,161 to $3,430 annually per full-time equivalent physician. Further, prior authorization interactions with insurers cost practices $82,975 per physician annually.

The burden of prior authorization also has an effect on patients. Ninety percent of physicians report that prior authorization sometimes, often, or always delayed patient access to care. Nearly 60% of physicians report waiting at least one business day for a prior authorization decision from a health plan while 26% report waiting at least three business days. These delays increase wait times for medical services and prescription medications for patients while diminishing access to timely care.

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Federal Prior Authorization Regulations
The Centers for Medicare & Medicaid Services (CMS) has developed various prior authorization programs and regulations that affect Medicare patients and their treating physicians. Thus far, federal regulations have targeted medical devices and equipment, rather than prescription medications. CMS began the Prior Authorization of Power Mobility Devices (PMDs) Demonstration on September 1, 2012. The demonstration is active in 19 states (AZ, CA, FL, GA, IL, IN, KY, LA, MD, MI, MO, NJ, NY, NC, OH, PA, TN, TX, and WA) and will end on August 31, 2018. This prior authorization program is designed to improve methods of investigation and prosecution of fraud alert billing for PMDs and targets states with high populations of fraud- and error-prone providers. On December 30, 2015, CMS established a prior authorization program for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) covered under Medicare. The program applies to DMEPOS items that are frequently subject to unnecessary utilization and went into effect on February 29, 2016. Additionally, prior authorization for two additional items of durable medical equipment (both power wheelchairs) began in four states (IL, MO, NY, and WV) on March 19, 2017. The rule expanded the authorization requirement to the remaining 46 states effective July 17, 2017.

State Prior Authorization Activity
State legislation has focused on prescription drug prior authorization. Some states have implemented legislation to limit the burden that prior authorization has on physicians and other health care providers. Twenty-nine states (AR, CA, CO, DE, FL, GA, IN, IA, KY, LA, MD, MA, MI, MN, MS, NV, NH, NJ, NM, NY, ND, OH, OK, OR, TX, VT, VA, WA, and WV) have legislation regarding prior authorization standards. Legislation focuses on requiring a standard, universal form for prior authorization and states are increasingly moving to electronic prior authorization. Sixteen states (CA, DE, GA, IN, IA, KY, MD, MN, NH, NM, NY, OH, TX, VT, VA, and WV) with prior authorization legislation require the use of standard transactions for electronic prior authorization that were developed by the National Council for Prescription Drug Programs. The remaining twenty-one states and the District of Columbia do not have state regulated prior authorization standards.

Prior Authorization and Utilization Management Reform Principles
The AAFP joined the American Medical Association's multi-stakeholder group representing patients, physicians, hospitals and pharmacists to develop the Prior Authorization and Utilization Management Reform Principles to reduce the negative impact these programs have on patients, providers and the health care system. Together this group advocates with health plans, benefit managers and any other party conducting utilization management, as well as accreditation organizations, to apply its principles to utilization management programs for both medical and pharmacy benefits. The coalition produced 21 principles that could improve prior authorization programs by applying the principles' concepts grouped in five broad categories – clinical validity, continuity of care, transparency and fairness, timely access and administrative efficiency, and alternatives and exemptions.

AAFP Resources
- AAFP Prior Authorization Policy
- AAFP Letter to CMS Regarding the 2018 Proposed Medicare Physician Fee Schedule - August 30, 2017
- AAFP Letter to President Trump on Regulatory Burdens for Family Medicine - January 31, 2017
- AAFP Medicare Red Tape Relief Project
- AAFP Letter to CMS on Proposed Prior Authorization Process for DMEPOS Items - July 24, 2014
- AAFP Response to HHS on Burdensome Regulations - October 10, 2013