Prior Authorization Literature Review

Healthcare Utilization and Cost Effects of Prior Authorization for Pregabalin in Commercial Health Plans

- **Objective:** compare medication usage and over-time expenditure changes for patients with painful diabetic peripheral neuropathy (pDPN) or postherpetic neuralgia (PHN) using health insurance plans requiring prior authorization (PA) for pregabalin versus those that did not
- **Methods:** 12 insurance companies selected (6 companies required pregabalin PA and 6 did not); examined 2005-2007 claims data for pDHN or PHN patients with at least 1 claim for pain medication related to these conditions. Pharmacologic therapy, healthcare utilization, and costs were compared from baseline to 1-year follow-up.
- **Results:** Prior authorization insurance plans (2,084 patients' data) and non-prior authorization plans (1,320 patients' data)
- Prior authorization insurance plan participants had 5% lower pregabalin use increase each year ($P < 0.001$). PA-plan patients used other anticonvulsants 3.7% more ($P = 0.03$) and non-opioid pain medications 5.2% less ($P = 0.01$). No significant differences were found for "opioid, antidepressant, or other pDPN or PHN medication use or pDPN- or PHN-related total healthcare costs."
- **Conclusion:** PA was equated to lower pregabalin use, but there was no significant difference in medication costs for pDPN or PHN patients, since they simply used different medications when they could not access pregabalin.

Margolis JM, Cao Z, Onukwugha E, Sanchez RJ, Alvir J, Joshi AV, Mullins CD. Healthcare Utilization and Cost Effects of Prior Authorization for Pregabalin in Commercial Health Plans. *Am J Manag Care*. June 2010;16(6).

Non-Pharmacologic Low Back Pain Insurance Coverage

- **Rationale:** The opioid epidemic provides urgent need to examine insurance coverage for non-pharmacologic pain management options.
- **Objective:** To study "how [insurance] payers' coverage policies may facilitate or impede access to [five non-pharmacologic pain management options]"
- **Design/Methods:** Cross-sectional; 15 commercial, 15 Medicaid, and 15 Medicare Advantage healthcare coverage policies examined for 5 non-pharmacologic pain management options for acute or chronic low back pain during 2017. Study took place in 16 states and participant data represented more than half of the U.S. population. Interviews were also conducted with "43 senior medical and pharmacy health plan executives" from "6 Medicaid managed care organizations, 2 Medicare Advantage or Part D plans, 9 commercial plans, and 3 trade organizations (eg, Blue Cross Blue Shield Association)" as part of their data collection.
- **Outcome Measures:** Medical necessity, coverage status, and use of utilization management tools, as well as cost-sharing magnitude and structure.

- **Results:** The most common non-pharmacologic options covered: physical therapy (98% [44 of 45 plans]), occupational therapy (96% [43 of 45 plans]), and chiropractic (89% [40 of 45 plans]). For Medicaid plans only, transcutaneous electrical nerve stimulation (67% [10 of 15 plans]) and steroid injections (60% [9 of 15 plans]) were the most common non-pharmacologic options covered. ***Acupuncture*** **was not covered or information about coverage was lacking by 67% of all plans [30 of 45],** and 80% of Medicaid plans [12 of 15] lacked information about psychological intervention coverage. Many insurance plans used utilization management tools such as prior authorization, but "criteria varied greatly with respect to which conditions and what quantity and duration of services were covered."
- **Conclusions:** The interview data showed "a low level of integration between the coverage decision-making processes for pharmacologic and nonpharmacologic therapies for chronic pain." Lack of best practice guidelines, administrative work involved in developing new or revising existing policies, and cost-related pressures may be the reasons for coverage variation. Best practice standards are needed to reduce coverage variation and improve consistent coverage of non-pharmacologic interventions for low back pain among major insurance plans. Doing so is "an important opportunity to improve the accessibility of services, reduce opioid use, and ultimately improve the quality of care for individuals with chronic, noncancer pain while alleviating the burden of opioid addiction and overdose."

Heyward J, Jones CM, Compton WM, Lin DH, Losby JL, Murimi IB, Baldwin GT, Ballreich JM, Thomas DA, Bicket MC, Porter L, Tierce JC, Alexander GC. Coverage of Nonpharmacologic Treatments for Low Back Pain Among US Public and Private Insurers. *JAMA Network Open.* 2018;1(6):e183044. DOI:10.1001/jamanetworkopen.2018.3044.

Physician satisfaction and dissatisfaction of administrative tasks

- **Rationale:** EHR has contributed to pressures upon medical staff within the healthcare system
  Objective: To describe physicians' satisfaction and dissatisfaction of administrative tasks and gain a better understanding how these tasks affect workload
- **Method:** Semi-structured interviews conducted with "38 physicians in family medicine, internal medicine, cardiology and orthopedic surgery" and administrative staff "at ambulatory care practices in four states" during July and August 2015; transcribed interviews analyzed using inductive grounded theory to produce qualitative summary
- **Results:**
  - Physicians satisfied: "providing good medical care and taking care of patients"
  - Physician dissatisfied: "EHR/desk work, complexities of the payer systems and practice administration" takes valuable time that "negatively affects patient care." These tasks were perceived as "disrespectful to physicians both personally and professionally."

Colligan L, Sinsky C, Goeders L, Schmidt-Bowman M, Tutty M. Sources of physician satisfaction and dissatisfaction and review of administrative tasks in ambulatory practice: A qualitative analysis of physician and staff interviews. Published October 2016. Accessed Dec 18, 2021. ama-assn.org/go/psps.

Prior authorization costs for primary care practices

- **Rationale:** Prior authorization (PA) requirements of insurance companies increase "administrative and financial burdens" upon medical offices, adding to "workload and inefficiency"

- **Objective:** To examine how primary care practice characteristics affect the amount of time spent for each PA request
  Methods: Secondary analysis of existing data collected from 9 primary care practices in Central New York; "participants were instructed to complete an "event form" (EF) to document each prior authorization event during a 4–6 week period; Stepwise Ordinary Least Squares (OLS) Regression was used to analyze the time spent in minutes on each PA event
  Results:
- PA events (N = 435) took approximately 20 minutes each (beta = 20.017, $p < .001$)
- "Medicaid requests took less time" (beta = −6.085, $p < .001$)
- Use of EHR systems "reduced prior authorization time by about 5 minutes" (beta = −5.086, $p = .002$)

Epling JW, Mader EM, Morley CP. Practice characteristics and prior authorization costs: secondary analysis of data collected by SALT-Net in 9 central New York primary care practices. *BMC Health Serv Res.* 2014. doi:10.1186/1472-6963-14-109

Pregabalin Step Therapy Policies for Medicare Recipients

- **Background:** Insurance companies use utilization management techniques such as prior authorization and step therapy to control costs and "guide appropriate medication use"
- **Objective:** To examine "clinical and economic outcomes" of a "pregabalin step therapy (ST) policy among Medicare Advantage Prescription Drug (MAPD) members"
- **Methods:** Pharmacy and medical claims records (restricted cohort = Humana, step policy began 1/1/2009) and unrestricted cohort = Thomson Reuters MarketScan) analyzed for MAPD participants ages 65 - 89 years of age "receiving treatment for painful diabetic peripheral neuropathy (pDPN), postherpetic neuralgia (PHN) or fibromyalgia (FM)." Difference-in-differences (DID) and regression analysis were used to analyze the data.
- **Results:** 13,911 restricted cohort members' data were matched to member data from unrestricted plans. Most patients had FM (51.0%) and pDPN (41.8%). *"The restricted cohort demonstrated greater year-over-year decrease in pregabalin utilization and increase in year-over-year gabapentin utilization compared with the unrestricted cohort."* Step restriction cost pharmacies more but decreased medical costs for the restricted cohort. Both cohorts had similar total healthcare costs with no significant differences.

Suehs BT, Louder A, Udall M, Cappelleri JC, Joshi AV, Patel NC. Impact of a Pregabalin Step Therapy Policy Among Medicare Advantage Beneficiaries. Competitive Health Analytics Inc, Pfizer, Inc., and Humana, Inc. 2013.

Insurance Coverage for Behavioral Health

- **Rationale:** To improve access to and quality of behavioral healthcare programs, it's important to track trends in healthcare program management
- **Objective:** To examine "behavioral health care arrangements and changes over time"
- **Methods:**

    - A nationally representative survey of commercial health insurance plans' **alcohol, drug abuse, and mental health services** in 1999 and 2003 (linked to the longitudinal Community Tracking study funded by the Robert Wood Johnson Foundation)
    - 434 plans in 60 market areas were surveyed in 1999 via telephone; 368 plans in the same market areas were surveyed in 2003, also via telephone
    - Data was collected on product type (HMO, PPO, or POS), contracting arrangement (speciality, comprehensive, internal-only), covered services for mental health/substance abuse (MH/SA), **prior authorization requirements for each service,** treatment entry (how clients access services), pharmacy arrangements (PBM or three-tiered system), and cost-sharing (co-pay or co-insurance benefits for MH/SA services. "Questions regarding newer (as of 2003) drugs and four brand-name antidepressants, five antipsychotics, and three medications for attention deficit hyperactivity disorder (ADHD) were also included."
    - Paired t-tests, t-tests, and chi-square tests were used to analyze the weighted data.
- **Results:** Insurance plans' behavioral health services coverage showed an "increase in contracting with managed behavioral health care organizations," … "loosening administrative controls such as prior authorization," and "higher levels of cost sharing"
- **Conclusions:** Although prior authorization limits have been reduced, suggesting greater access, cost sharing imbalances "suggests financial barriers have grown."

Horgan CM, Garnick DW, Merrick EL, Hodgkin D. Changes in How Health Plans Provide Behavioral Health Services. *J Behav Health Serv Res.* 2009;36(1):11-24. doi: 10.1007/s11414-007-9084-0

Promoting Accountability in Prior Authorization

- 2019 *Council on Medical Service* and the *American Medical Association* position on prior authorization, step therapy, and other utilization management strategies:
    - Used **"to control access to certain treatments and reduce health care expenses"**
    - Medical literature demonstrates **"time and cost burdens** associated with UM requirements on physician practices"
        - UM can result in "manual, time-consuming processes that can divert valuable and scarce physician resources away from direct patient care"
        - "interfere with patients receiving timely and optimal treatment"
        - "Delay access to needed care"
        - "May lead to patients receiving less effective therapy, no treatment at all, or even potentially harmful therapies"
        - Physicians view P2P requirement as a "time-consuming and potentially detrimental use of UM"
        - Physicians believe that many insurance peer physicians are not qualified to properly assess their patients' need(s) for medical services (i.e., they have limited information about these patients, have not seen/spoken with/evaluated them)
- Relevant AMA Advocacy
    - PA and UM practices considered high priority
        - <u>State Legislative Activity</u>
            - AMA's Advocacy Resource Center produced **model bill "Ensuring Transparency in Prior Authorization Act"**
            - **2019** "**nearly 40 bills related to PA and step therapy in the state legislatures**" including
                - **"broad reform efforts based on the AMA model bill"**

        - several "directed at **reducing UM requirements for individuals with HIV/AIDS, cancer, substance use disorder and other chronic diseases and conditions"**
    - State lawmakers **encouraged to "reduce certain UM requirements"** in response to **COVID-19 safety concerns** "to ensure safe access to care during state stay-at-home orders and other restrictions"

- Prior Authorization and Utilization Management Reform Principles
    - AMA "**workgroup to develop PA and UM best practices**
        - developed the Prior Authorization and Utilization Management Reform Principles
        - Reforms principles highlighted
            - **APPEALS to PROVIDERS OF SAME TRAINING /TIMELINESS** all appeal decisions made by providers of the same qualifications as the appealing physician; communication from UM org within 24 hours for expedited review; all appeal decisions within 10 calendar days; *appeals reviewer should not have been involved in original denial*
- The Consensus Statement on Improving the Prior Authorization Process
    - **21 reform principles** "led to the **development of the Consensus Statement on Improving the Prior Authorization Process"**
        - created by the AMA, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, BlueCross BlueShield Association, Medical Group Management Association
- Prior Authorization Research
    - **AMA gathering research re: "impact of PA on patients and physician practices, including an annual physician survey [on UM]"**
    - Online 27-question survey of 1,000 practicing physicians (40% PCP, 60% speciality) who "routinely complete PAs", Dec 2019:
        - Most physicians responded that they are sometimes (45%) involved in a peer-to-peer review during the prior authorization process, that the **frequency of peer-to-peer reviews during the prior authorization process have increased significantly or increased somewhat over the last five years (60%), and** "When completing a peer-to-peer review during the prior authorization process, they sometimes (41%) feel that the health plan's 'peer' has the appropriate qualifications to assess and make a determination regarding the prior authorization request.

- Council recommendations for AMA
    - "Encourage **sufficient clinical justification** for any **retrospective payment denial**" and forbid "retrospective payment denial when treatment was previously authorized"
    - UM criteria:"based upon **sound clinical evidence**"
    - Establish "**clinical basis** for health plans' coverage decisions and policies"
    - ***"Overturned denials demonstrate that insurers' processes for determining medical necessity often do not reflect current clinical standards of care."***
    - "**Utilization review decisions to deny payment for medically necessary care constitute the practice of medicine** and that medical directors of insurance entities ***be***

held accountable and liable for medical decisions regarding contractually covered medical services"

- COVID-19
    - Temporarily suspend or otherwise adjust PA requirements"
    - "AMA is tracking individual health plan COVID-19 related PA program updates to help physicians stay informed of these rapidly changing policies" https://www.ama-assn.org/system/files/2020-04/prior-auth-policy-covid-19.pdf
    - **"Council recommends** that the AMA urge **temporary suspension of all prior authorizations** and calls for the extension of existing approvals during a declared public health emergency."

Council on Medical Service, presented by Young LM. REPORT OF THE COUNCIL ON MEDICAL SERVICE: Promoting Accountability in Prior Authorization. June 4, 2021. Accessed January 23, 2022. https://www.ama-assn.org/councils/council-medical-service/health-insurance-council-medical-service-reports.

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