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LEADERSHIP PAGE




Prior Authorization Reform for Better Patient Care

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Being patient-centered is a core value of the American College of Cardiology (ACC)—the safety and needs of cardiovascular patients are central to everything we do. When policies and procedures hinder the ability of patients to get the right cardiovascular care in a timely fashion, it is the College's duty to advocate for workable solutions.

For more than a decade, mandated, payer-directed prior authorization of diagnostic imaging and medications has been one of the biggest barriers to patient access. Tests, procedures, and drugs are often denied based on payer benefit managers' coverage policies without review of patient medical records. Patients are forced to await "peer-to-peer" reviews involving their cardiovascular professional and a paid agent of the health plans. This past February 2018, a former Aetna medical director made headlines when he allegedly said he rarely, if ever, reviewed actual patient medical records when deciding to approve or deny prior authorizations. Rather, he relied heavily on written coverage policies and nurse administrators (1).

There are countless stories of patients being denied coverage of nuclear imaging procedures, cardiac stress tests, echocardiography, cardiac catheterization procedures, and other imaging procedures who are ultimately admitted to the hospital for an emergent intervention. In a highly publicized 2010 case in Delaware, prior authorization was repeatedly denied for cardiac stress testing. The patient involved ended up in the emergency room 35 days later, prompting investigations by the U.S. Senate Commerce Committee and the Delaware Insurance Commissioner (2).

The challenges posed by prior authorization are among the biggest pain points for health care professionals, including cardiologists, across the country. Prior authorization takes time away from direct patient care, adds cost to delivery of care, and requires additional staff to process and follow requests. A 2016 survey by the ACC found that 70% of cardiologists say their practices have been negatively affected by prior authorization processes, citing delays in care, increased overhead costs, and less time with patients. Additionally, 87% of survey respondents said they must address prior authorization issues at least once a week, with 74% noting they can spend up to 60 min addressing each request (3).

Similarly, an American Medical Association (AMA) survey found that 64% of physicians said their practices wait an average of at least 1 business day for insurers to provide pre-approval for a test, procedure, or drug. Of these, 30% said they wait at least 3 business days. Additionally, 78% of respondents reported that prior authorization sometimes leads to treatment abandonment by patients. Nearly 80% of physicians also noted the need to repeat prior authorizations for prescription medication, even after a patient was stabilized on a treatment regimen for a chronic condition (4).

Over the years, the ACC has led efforts to find a solution to prior authorization that balances the needs of all involved. The College launched its first set of appropriate use criteria (AUC) in 2005. These criteria define "when to do" and "how often to do" a given procedure in the context of scientific evidence,

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health care environment, patient's history, and physician's judgment. Their intended goal: to help health care providers, policymakers, payers, and other medical societies ensure patients are receiving the most appropriate care, limit variations in care, and reduce unnecessary health care costs. Unfortunately, pharmacy and imaging benefit managers often use proprietary criteria, rather than AUC, to determine coverage.

The College has also joined with other cardiovascular societies, including the Society for Cardiovascular Angiography and Interventions, American Society of Echocardiography, American Society of Nuclear Cardiology, Heart Rhythm Society, Society of Cardiovascular Computed Tomography, and Society for Cardiovascular Magnetic Resonance, to urge payers and prior authorization contractors to modify their requirements and criteria to be more transparent, based on AUC, and less burdensome on providers. Individual state ACC chapters have lobbied local state legislators and Insurance Commissioners on behalf of patients to improve transparency, efficiency, and validity of the prior authorization process.

The Prior Authorization Reporting Tool (PARTool) is the College's answer to protect patients by collecting real-world denial data from its members and their practices regarding prior authorization and imaging studies. Launched in 2017, the PARTool has already collected more than 500 reports of prior authorization experiences from 36 states and the District of Columbia. Catalogued by insurer and benefit manager, these data shed light on the heretofore clandestine process of peer-to-peer review. Early data demonstrate:

- About two-thirds of denials are based on payer guidelines, with the far minority citing AUC;
- A total of 45% of encounters required more than 30 min and 74% required more than 10 min of the reporting cardiovascular professional's time to complete the process; and
- A total of 60% of encounters resulted in a procedural delay due to the prior authorization process (5).

The entire "House of Medicine" has also united to demand changes to prior authorization requirements. A coalition led by the AMA that includes the ACC as well as a broad range of health care industry stakeholders, including physicians, hospitals, medical groups, patients, and pharmacists, has developed a set of principles that would allow easier access to certain drugs and treatments recommended by their health care providers. The principles are centered around ensuring any requirements to be clinically valid and evidence-based; maintaining continuity of care; being transparent and fair; allowing patients timely and efficient access to drugs and treatments; and clearly articulating alternatives and exemptions (6). The need for standardization is an important element to help ease the burdens on physicians and practices, who must navigate varying processes that differ from payer to payer.

State legislatures are also getting into the mix. Several states have already passed laws to protect patients from overly burdensome requirements. In Ohio, insurers must now disclose all prior authorization rules to providers. Enrollees of the health plan must receive basic information about which drugs and services require prior authorization. The law also requires timely prior authorization decisions for urgent/nonurgent situations and prohibits retroactive denials regarding coverage or medical necessity, provided the procedure was performed within 60 days of receiving an authorization. Laws like this provide a blueprint for other states looking to make prior authorization more transparent and patient-centered.

Although few in the medical community were surprised by the news alleging abuses of the prior authorization process by the Aetna medical director, we should take this opportunity to highlight the problems with prior authorization and to leverage data from the PARTool to empower all stakeholders to find solutions that meet the needs of providers, patients, and payers. The ACC recommends further refining the goals developed by the AMA-led coalition in the following ways:

1. Define "selective application of prior authorization" to mean review and authorization for coverage of a test or treatment where appropriate for requests not covered by AUC or clinical practice guidelines. Prohibit procedure and medication substituting by payers consistent with AUC and guidelines.
2. Allow for "prior authorization program review and volume adjustment"—also known as "gold-carding"—which would let payers or their contracted benefit managers authorize requests for tests and treatments from providers or practices that demonstrate compliance with established AUC and clinical guideline recommendations.
3. Ensure transparency and communication by requiring payers to publish and make available to consumers the rates of allowed and denied procedures.
4. Guarantee continuity of patient care by allowing patients granted coverage for a given treatment/medication under one payer to transfer that

coverage to another payer. This would avoid interruption in care and/or patients having to start the process over again with step therapy.

5. Establish online standardized prior authorization tools and criteria for providers and their practice staff to ensure improved transparency and efficiency.

Much work to find a solution that meets the needs of patients, providers, and insurers is still needed. The prior authorization process as a cost-containment strategy continues to place patients at jeopardy. Prior authorization reform offers the potential to remove unnecessary costs and burdens to the patient through fewer delays in care, while giving providers more time at the bedside. Not to mention, prior authorization reforms can save taxpayer dollars through reduced administrative costs. ACC members can support and drive this initiative by:

- Meeting with local payer prior authorization staff and state insurance commissioners to voice concerns as a patient advocate;
- Engaging in state and local advocacy efforts with local ACC chapters; and
- Systematically submitting data to the PARTool, thereby joining their many ACC colleagues who are making a difference.

Prior authorization reform is consistent with the mission and vision of the ACC and supports the "Quadruple Aim," by removing barriers to care, promoting evidence-based best practices, and improving patient satisfaction, while enhancing care team engagement. Anecdotes are plentiful, but data are what will sway public and policymaker opinions. Together we can bring about change and ensure best care for patients, cost-efficient practice, as well as patient and provider satisfaction.

This Leadership Page was written in collaboration with Robert Hendel, MD, FACC, Akshay Khandelwal, MD, FACC, Mary Norine Walsh, MD, MACC, and Edward Fry, MD, FACC.

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REFERENCES

1. Drash W. California launches investigation following stunning admission by Aetna medical director. CNN. February 11, 2018. Available at: https://www.cnn.com/2018/02/11/health/aetna-california-investigation/index.html. Accessed March 15, 2018.

2. Myers, L, Gardelia, R, Relph, A. Insurer Denied Needed Medical Tests, Senate Finds. *NBC Nightly News*. April 18, 2011. http://www.nbcnews.com/id/42613298/ns/nbc_nightly_news_with_brian_williams/t/insurer-denied-needed-medical-tests-senate-finds. Accessed March 15, 2018.

3. American College of Cardiology. Barriers to new medications for cardiovascular disease: insights from CardioSurve. Cardiology. February 23, 2017. Available at: http://www.acc.org/latest-in-cardiology/articles/2017/02/21/12/42/barriers-to-new-medications-for-cardiovascular-disease-insights-from-cardiosurve. Accessed March 15, 2018.

4. American Medical Association. 2017 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/sites/default/files/media-browser/public/arc/prior-auth-2017.pdf. Accessed March 15, 2018.

5. ACC PARTool Data from February 2017-March 2018. Available at: http://www.acc.org/PARTool. Accessed March 25, 2018.

6. American Medical Association. Prior authorization and utilization management reform principles. Available at: https://www.ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf.pdf. Accessed March 15, 2018.