

Statement of the American Academy of Family Physicians

By

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To

U.S. House Small Business Committee

**Hearing – “Utilization Management: Barriers to Care
and Burdens on Small Medical Practices”**

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Chairwoman Velázquez, Ranking Member Chabot and members of the Committee; I am Dr. John Cullen, the President of the American Academy of Family Physicians (AAFP), and I am honored to be here today representing the 134,600 physician and student members of the AAFP.

I am a practicing family physician in Valdez, Alaska, a community of about 4,000 people. Along with five family physician colleagues, we are the sole providers for a geographically isolated community 300 miles from the nearest tertiary care hospital. Our census area is about the size of Ohio.

Family physicians conduct approximately one in five of the total medical office visits in the United States per year – more than any other specialty. They deliver care in more than 90 percent of U.S. counties – in frontier, rural, suburban and urban areas. Our members practice in a variety of professional arrangements, including privately owned solo practices as well as large multi-specialty integrated systems and public health agencies.

Family physicians provide comprehensive, evidence-based, and cost-effective primary care dedicated to improving the health of patients, families, and communities. Family medicine's cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient's integrated care team. More Americans depend on family physicians than on any other medical specialty.

Most family physicians in private practice have contractual relationships with seven or more health insurance plans, including Medicare and Medicaid, yet there is no standardization of administrative functions required among public or private payers. Unfortunately, the administrative framework each payer imposes makes practicing family medicine daunting and often demoralizing. As a result, physicians are forced to learn and navigate the rules and forms of each independent payer and plan. Needless to say, this is extremely frustrating and unnecessarily burdensome.

One of the best examples of this burden is the issue of prior authorization. The definition of 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. However, I believe there is truth in the description of prior authorizations used in a February 2019, *Medical Economics* [article](#) describing them as “nothing more than insurance companies inserting themselves into the care decision-making process, creating problems for both doctors and patients.”ⁱ

While there may be a limited number of justifiable cases where prior authorization is appropriate, it is clear that health plans more often require prior authorization as a cost-containment strategy by limiting and restricting access to specific services. In submitting prior authorizations, family physicians and their staff spend countless hours reviewing documents, processing paperwork, checking boxes, and waiting on hold to talk to health plans to meet their often arbitrary and not evidence-based requirements so that our patients can get the care they need.

Physicians strive to deliver high-quality medical care in an efficient manner. The frequent phone calls, faxes, and forms physicians and their staff must manage to obtain prior authorizations from prescription drug plans, durable medical equipment suppliers, and others impedes this goal. Even aggressive workflow optimization cannot eliminate the burden of unreasonable and redundant prior authorization requirements.

Impact of Prior Authorization on Patients

The hours physicians squander on prior authorization should be better spent caring for patients, but that is not the only impact on patients. Securing prior authorization for tests, devices, medications, treatments, or procedures often delays the patient’s access to necessary care. Appealing a denied request for prior authorization can significantly add to those delays. In a 2018 American Medical Association survey, nearly two-thirds of physicians reported waiting at least one business day to receive prior authorization, while 26 percent waited at least three business days. Further, 28 percent of those surveyed reported the prior authorization process lead to a serious adverse event.ⁱⁱ

This is especially true regarding the health of patients with chronic disease receiving ongoing treatment. Their health should not be threatened by the patient changing health plans. Patients should not be required to repeat or retry step therapy protocols failed under previous benefit plans. Payers should be prohibited from requiring repeated prior authorizations of effective medication management for such patients.

A patient of mine had a combination of Crohn's disease and severe Psoriasis. We were able to control both disorders with Remicade, after trying many other regimens in consultation with specialists over the course of years. Suddenly, we had to pre-authorize this medication which resulted in a delay in care of several months, during which her condition worsened. Remicade must be given every couple of months without a break. When we finally were able to get the medication authorized, she had a serum sickness reaction to it resulting in anaphylactic shock. We nearly lost her. She can now never have a medication that was working extremely well.

Another egregious example of prior authorization is Hydrochlorothiazide, a common and inexpensive first line medication used to treat hypertension. We ended up going back and forth with the insurance companies about what first line agents we had tried. Other thiazide diuretics like Chlorthalidone were unavailable, because he was already on an ACE inhibitor one of the other first line antihypertensives. We spent days on this.

My patients rarely blame their insurance company for this administrivia. They blame me for not getting them the medications they need, yell at my staff, or just stop taking the medications they need to prevent hospitalization. This is the hidden cost of prior authorization. My staff burn out and quit because of the frustration inherent in this crazy system compounded by being yelled at by patients for not having their medications.

Impact of Prior Authorization on Physicians

A [study](#) published by Health Affairs on prior authorization and other health insurance plan requirements estimated that primary care physicians spent “significantly more time (mean = 3.5 hours weekly) than medical specialists (2.6 hours) or surgical specialists (2.1 hours)” interacting with health plans.ⁱⁱⁱ This study estimated that the administrative

costs to physician practices spent on interactions with health plans is between \$23 billion to \$31 billion annually.^{iv} Given the growth of prior authorization requirements since this study, the current cost is likely far higher.

I employ both a registered nurse and a medical assistant whose main task is to tackle prior authorizations. Their salaries account for at least 10 percent of my total employee business expense. This is not factoring in the opportunity costs for my or my partner's time spent in useless uncompensated administrative work.

Part of the problem is that it is impossible to know which medications are preferred for each health plan, given that the preferred medications change on a regular basis. My nurse had to spend 45 minutes on the phone with a wildly inappropriate male employee just to find out which medications were preferred. This is repeated on a regular basis.

We don't know what is on the formularies. We have 35 insurance plans we deal with, each with its own system of prior authorization. We often can't write for albuterol because some formularies don't like generic names. It must be Pro Air, unless this is not covered in which case, we substitute Ventolin. These are both Albuterol inhalers. There is no difference. For someone with asthma, they are lifesaving. Our staff has become adept at switching back and forth, but we do not know in advance which will be covered.

This often means that I when I write a prescription, the patients must take it to the pharmacy to find out if it is covered. If it is not, I need to find an alternative, often by writing a new prescription and the process is repeated. I have even had reviewers be confused about the difference between generic and trade name, refusing to cover a medication unless I wrote for the generic, then using the trade name.

A 2016 study published in the *Annals of Internal Medicine* found that primary care physicians spent 27 percent of their time on clinical activities and 49 percent on administrative activities. The authors concluded that primary care physicians spend nearly 50 percent of their time on cumbersome administrative tasks such as prior

authorization, performance measurement and reporting, electronic health record documentation, and care management documentation.^v This inefficiency and time away from patient care is clearly not acceptable.

According to a 2019 AAFP member survey, the highest priority for the AAFP is to reduce physicians' administrative and regulatory burden. Fully 74 percent of respondents said the time spent on administrative tasks has increased since 2018. They cite the greatest administrative burdens as those associated with electronic health record documentation, prior authorization, and quality measure reporting. Prior authorization for prescription drugs was reported to be a task contributing to administrative burden by 88 percent of respondents in our survey. 76 percent indicated prior authorizations for durable medical equipment (DME) contributed to the administrative burden in their practice in the past 12 months. Prior authorization for procedures, including imaging, was reported to be a burden by 79 percent in our member survey. Most troubling is that 84 percent reported that the amount of time they personally spent on administrative functions and tasks associated with patients' care has increased in the past three years. This is a serious problem that is getting worse.

The Quadruple Aim

The Quadruple Aim calls for enhancing patient experience, improving population health, reducing costs, and improving the work life of health care providers.^{vi} The regulatory framework for physician practices drives operating costs up and causes a reduction in meaningful face to face time with patients. The administrative and regulatory burden is one of the top reasons independent physician practices close and is a leading cause of physician burnout. Despite the good intent of underlying health care policies, the burden has expanded to an untenable level and is a significant barrier to achieving the Quadruple Aim.

There are real economic costs to practices of prior authorization. AAFP members have had to hire full-time staff dedicated to handling prior authorizations. But the frustration with prior authorization processes also stems from the fact that the required interactions with payers are not peer to peer conversations. We often hear from members that “for

the person on the other end of the line, their job is to make money for their employer. They do not understand what is in the patient's interest.”

Despite all this needless hassle, I have never had a preauthorization turned down, though it has taken a great deal of time out of my day. I spend 15 minutes on hold, providing patient information before being granted a peer to peer conversation. This conversation is usually short unless the reviewer wants to talk about Alaska. My requests for testing for my patients are invariably approved. I do not order unnecessary tests.

The AAFP is committed to work toward tangible solutions to the administrative burden of prior authorization. We are grateful to the House Committee on Small Business for convening this hearing on prior authorization which hinders patients' access to treatment and is an unreasonable burden on physicians. In addition, we appreciate that both the Administration and Congress have recognized the need for administrative simplification in the “Patients Over Paperwork” and the “Medicare Red Tape Relief Project.”

Shared Principles for Reducing Administrative Burden

The AAFP and the five other physicians' organizations who collectively make up America's Frontline Physicians have developed [joint principles](#)^{vii} on reducing administrative burden in healthcare. We urge all stakeholders, including Congress, the Administration, payers, and vendors, to adopt policies which adhere to these shared principles which will ensure that patients have timely access to treatment while reducing administrative burden on physicians.

AAFP Policy on Prior Authorization

The AAFP strongly urges the adoption of our prior authorization and step therapy [recommendations](#).^{viii} We call for prior authorization to be standardized and universally electronic 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.

Generic Medications

Prior authorization should not be required for a patient to obtain generic medications. The AAFP further believes step therapy protocols used in prior authorization programs, in which insurers encourage less expensive prescription drugs to be prescribed prior to more costly alternatives, 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.

Durable Medical Equipment

Family physicians also experience prior authorization hassles requesting durable medical equipment or DME. These requests typically require the physician to fill out a paper form or submit specific data for approval, and each DME company has different data requirements for submission. Specifically, the AAFP calls on all payers to simplify the rules surrounding prescription of diabetic supplies. Family physicians simply want to be able to prescribe efficiently and effectively what their patients need to help manage their condition in a way that maintains their health.

This is especially true for patients with diabetes. Unfortunately, many prior authorization rules surrounding the prescribing of diabetic supplies impede this goal and add no discernible value to the care of such patients. If the patient regularly uses quantities of supplies that exceed the utilization guidelines, new documentation to support these supply quantities must be obtained every six months. We understand that glucose testing and other diabetic supplies are an identified area of claims processing errors within the Medicare program and that physicians have a role to play

in fraud prevention. However, the related Medicare requirements have become overly burdensome with little to no value added to the actual care of the diabetic patient. Ideally, it should be acceptable for a physician to write for "diabetic supplies," which would encompass syringes, needles, test strips, lancets, glucose testing machine, etc., with only a need to provide a diagnosis and an indication such a prescription is good for the patient's lifetime.

Furthermore, we request additional improvements for payers to ease the prescribing of DME. Specifically, the AAFP calls for public and private payers to clarify clinician roles and the documentation required in the provision of therapeutic shoes for persons with diabetes. Our members report increasing confusion and frustration resulting from the process by which Medicare's diabetic beneficiaries qualify for and obtain medically necessary therapeutic shoes. In particular with Medicare, the AAFP takes issue with the current requirements imposed that the certifying physician must "obtain, initial, date (prior to signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other MD or DO, physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/inserts" The co-signing requirement detailed above impedes this goal and serves no purpose in furthering patient safety or improving care for patients. The AAFP urges the Congress to direct CMS to eliminate the co-signing requirements for therapeutic shoes for persons with diabetes. We believe this change will result in balanced improvements that clarify provider roles and remove confusion and regulatory inconsistencies in the provision of this medically necessary benefit.

Physicians in Alternative Payment Models

Alternative payment models offer physicians and others the ability to move away from archaic fee-for-service and toward value-based payment arrangements. Physicians who participate in alternative payment models should be exempt from all prior authorization requirements as their financial incentives are already aligned with the payers, so nothing is gained by these burdensome requirements.

Conclusion

The AAFP appreciates the Committee's interest in reducing both barriers to care for patients and administrative burdens on family physicians. We strongly support policy initiatives to eliminate or reduce and streamline prior authorization procedures and these should be aligned and harmonized across all payers – public and private. By taking steps to standardize and automate prior authorization processes and requirements across the health care system, this will help minimize restrictions that prohibit timely access to medically necessary care.

ⁱ *Medical Economics*. February 27, 2019 vol. 96 issue 5. <https://www.medicaleconomics.com/business/impact-prior-authorizations>

ⁱⁱ <https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf>

ⁱⁱⁱ *Health Affairs (Millwood)*. 2009 Jul-Aug;28(4):w533-43. doi: 10.1377/hlthaff.28.4.w533. Epub 2009 May 14. <https://www.healthaffairs.org/doi/10.1377/hlthaff.28.4.w533>

^{iv} *Ibid.*

^v *Ann Intern Med*. 2016;165(11):753-760. doi: 10.7326/M16-0961 <https://annals.org/aim/article-abstract/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties>

^{vi} *Ann Fam Med* November/December 2014 vol. 12 no. 6 573-576 <http://www.annfammed.org/content/12/6/573.full>.

^{vii} <https://www.aafp.org/dam/AAFP/documents/advocacy/legal/administrative/ST-Group6-AdministrativeBurden-061118.pdf>

^{viii} <https://www.aafp.org/dam/AAFP/documents/advocacy/legal/administrative/BKG-PriorAuthorization.pdf>