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Statement

of the

American Academy of Dermatology Association

U.S. House of Representatives

Committee on Small Business

"'Utilization Management' Barriers to Care and Burdens on Small Medical Practice"

Presented by

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September 11, 2019

Introduction

Thank you Chairwoman Velázquez, Ranking Member Chabot, and members of the Small Business Committee for the opportunity to appear before the Committee at this hearing titled "'Utilization Management' Barriers to Care and Burdens on Small Medical Practice," and to speak with you about the impact of utilization management on small medical practices. My name is Howard Rogers, and I am testifying on behalf of the American Academy of Dermatology Association, which represents 13,800 dermatologists nationwide. I am a board-certified dermatologist who owns a small private practice, Advanced Dermatology, with two locations in Connecticut. I currently serve on the Academy's Patient Access and Payer Relations Committee and the Council on Government Affairs and Health Policy. I have been in private practice for over 19 years in Connecticut.

Dermatologists diagnose and treat more than 3,000 diseases, including skin cancer, psoriasis, immunologic diseases, and many genetic disorders.[1] One in four Americans suffers or will suffer from a skin disease. As dermatologists are at the forefront of the fight against skin cancer and treating numerous skin diseases, the Academy appreciates the Committee's efforts to prioritize reducing further administrative burden such as utilization management processes. My testimony will focus on how increasing administrative burdens are impacting small medical practices such as my own business. Most importantly, though, I will highlight how prior authorization and step therapy delays necessary care for patients.

Administrative Burdens and the Rise of Practice Costs

Increasing access to high quality care while reducing costs is a goal you hear often throughout the Halls of Congress, by the Administration, and throughout the healthcare system. It is our belief that containing healthcare costs should not come primarily from spending on direct patient care, but rather from curbing administrative costs of care. In a 2017 Medical Group Management Association survey, almost half of the group practices cited administrative burdens costing their practices more than $40,000 per full-time physician per year to fulfill the requirements of federal regulations. The Medicare Quality Payment Program reported prior authorization requirements as one of the most burdensome to practices.[2] Physician practices are on the frontline – and complying with management utilization has driven up the cost of running a medical practice. On average, dermatologists dedicate eight hours per week solely to administrative activity; precious time they could be otherwise dedicating to patient care. Prior authorization is one of the most unbalanced

[1] The Academy's *Burden of Skin Disease* briefs are a set of informational resources that capture the scope and importance of various skin conditions, and can be accessed at https://www.aad.org/about/burden-of-skin-disease/burden-of-skin-disease-briefs.
[2] Medical Group Management Association, Regulatory Burden Survey, October 2018, available at https://www.mgma.com/getattachment/0dcef899-fe2c-4225-ac94-5820df6475cf/MGMA-Regulatory-Relief-Survey-2018.pdf.aspx?lang=en-US&ext=.pdf

approaches to utilization management in terms of increasing practice costs while providing no increase in quality of care and regularly delaying patient treatment.

The Burden of Prior Authorizations on Physician Practice

Prior authorization is a significant barrier to care that has harmed the patient-physician relationship. The Academy has long advocated for solutions that remove prior authorization policies that adversely affect patient care. For many skin diseases and conditions, medications are specialized and highly nuanced, and their efficacy is dependent on several patient factors. Prior authorization policies that place a third party in a decision-making position, with no knowledge of the complexity or full history of a patient's condition, are not only inappropriate; they also impede a patient's access to the most effective treatment, and a delay can cause irreparable harm. The clinically indicated choice of therapy should be respected and should rest on the patient-physician relationship where all critical factors—including efficacy and safety of all the treatment options, co-morbidities, and support system—are considered, fully discussed, vetted, and prescribed. Preserving the treatment value between physicians and their patients should remain paramount; therefore, prior authorization and associated appeals policies should not encroach on or unduly burden physicians or patients in accessing optimal, medically necessary drug therapies.

In 2016, the Academy conducted a survey of its members regarding the burden of prior authorizations. Over 90 percent of dermatologists reported experiencing an increase in the number of drugs requiring prior authorizations. Over 90 percent also cited prior authorizations as preventing or delaying treatment of the patient. More than two-thirds of dermatologists reported prior authorizations negatively affecting at least one patient per day. On average, dermatologists claim that they completed six prior authorizations a day, taking up to three hours each day. This is a significant cost to dermatology practices, which are small business in your communities. Small and solo practices are forced to hire staff just to administer the prior authorizations for drugs and medical procedures. It is not just dermatologists who are impacted by the burden of prior authorizations. A study by Health Affairs revealed that when the time is converted to dollars, practices spent an average of $68,274 per physician per year interacting with health plans. This equates to $23 billion to $31 billion annually.[3] The majority of dermatologists report prior authorizations ultimately get approved after frequent provider appeals. Many describe the mechanism as a tool not to ensure medically necessary treatment, but rather a practice to exhaust providers in the hopes of them

[3] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.28.4.w533
Health Affairs, *What Does It Cost Physician Practices To Interact With Health Insurance Plans?* VOL. 28, NO. SUPPLEMENT 1: WEB EXCLUSIVES, 2009

abandoning the treatment for the patient. Prior authorization ultimately ends up costing the health care system more than it saves, and furthermore, harms patient care.

To combat the 70 hours a week my office staff was dedicating to prior authorizations, my practice has hired two full time staff at a cost of $120,000 per year to handle the volume of prior authorizations. Even with extra support staff, providers in my practice are regularly disrupted from patient care to deal with prior authorizations. One quarter of my office's communications, be it phone calls, faxes, emails, or notifications from EHRs or payer portals, are associated with prior authorizations. My practice partner of 15 years with more than 30 years of dermatology experience is in good health and loves seeing patients, but is retiring because of the frustration and difficulty in seeing patients due to the administrative burden of prior authorizations and step therapy. My colleagues and I became physicians to help patients, and prior authorizations are impeding our ability to do that. Imagine diagnosing a patient in severe pain and discomfort, finding a treatment option for them, walking them through how to use the medication and how it will make them feel better, and then not being able to get that medication or waiting weeks for them to get approval, all the while seeing them suffer.

To address the toll prior authorization is taking on patients, physicians, and medical practices, the Academy created a web-based tool that allows members to access a letter for dermatologists to use when submitting prior authorizations for over 30 different drugs. This is one small but important step to help dermatologists manage and expedite the submission of required documentation to an insurance company or pharmacy benefit manager (PBM). To quantify the impact prior authorizations have had on dermatology, I would like to highlight that since this tool launched in March of 2017, more than 45,000 letters have been downloaded, and over 2,900 members have accessed this content. These template letters serve as a starting point for providing some relief to our members and their patients from a burdensome process. They are the most accessed tool on the Academy's Practice Management resource page, and this speaks to the need for a solution to this costly burden on small and solo dermatology practices.

The Increasing Burden of Prior Authorizations and Step Therapy Processes for Drugs

Prior Authorizations for Drugs

We applaud the Administration and Congress's continued focus on increasing competition in the drug market and lowering out of pocket costs for patients. With that being said, the Academy is concerned about a recent statement by a Centers for Medicare and Medicare Services (CMS) official that prior authorizations are needed, particularly in some parts of Medicare. There is absolutely no constructive way to balance prior authorizations while preserving access to care.

The Academy has long advocated for solutions that remove this hindrance to patient care, especially as dermatology is disproportionately impacted by increasing prior authorizations for both generic and brand drugs. We appreciate Congress working to address prior authorizations in the "SUPPORT for Patients & Communities Act" (Public Law No: 115-271), which was enacted into law in October 2018. Congress included language, that the Academy advocated for, to create a standardized electronic prior authorization form for Medicare prescription drugs intended to streamline and reduce prior authorization delays. We applaud CMS for recently proposing prior authorization electronic standards for Part D. Under the standards, dermatologists can use an electronic prescribing system or electronic health record (EHR) with electronic prescribing capabilities to determine in real time whether a plan requires prior authorization for a medication.

This is an important step forward in protecting the value of point-of-care access to medications. We applaud Congress and CMS for building on their previous efforts to require MA and Part D prescription drug plans to provide doctors with real-time access to drug pricing data via EHR or prescribing software, so physicians are informed of beneficiary-specific drug coverage and cost information.

While the proposal moves toward increasing transparency and improving access to necessary medications for patients, we would like to recommend that Congress ensure CMS require plans to offer electronic prior authorization (ePA) transactions that are integrated into prescribers' EHRs. Physicians should not be required to login to a separate portal to access the software. A separate portal often requires the physician to re-enter the medical information or transfer the data, often taking time away that could be spent with patients.

Also, we would like to recommend that while Part D plans must support the National Council for Prescription Drug Plans (NCPDP) transactions, it should not be the only supported method of submitting a prior authorization. This new standard should be an available option for those physicians with access to ePA software. Physicians in rural areas rarely have access to this type of technology and will still need the ability to submit appeals to ensure their patients get access to necessary medications.

The Academy recommends that Congress urge CMS to alleviate the prior authorization burden by requiring MA and Medicare Part D participating plans to shorten the turnaround time for prior authorizations and to extend the length of the prior authorization appeal period. Additionally, patients who are stable on a therapy and switching to a plan where a prior authorization is necessary for that treatment should continue to have access to that same therapy for at least 60 days. The Academy also recommends that CMS encourage plans to provide detailed explanations for prior authorization denials, including the clinical rationale, covered alternative treatment, and details on the provider's

appeal rights. Furthermore, CMS should standardize the prior authorization form across all MA and Medicare Part D plans in order to streamline the process.

Lastly, the Academy urges Congress to call on CMS to continually review the list of drugs requiring prior authorizations. A reduction in the number of drugs subject to prior authorizations, especially those that are commonly approved, should be considered on an annual basis. CMS should also require plans to restrict prior authorizations to outlier clinicians and exempt those who have demonstrated very low denial rates due to their consistent use of evidence-based standards.

Step Therapy

Step therapy protocols, a cost containment tool used by health insurance plans, require patients to try one or more prescription drugs before coverage is provided for a drug selected by the patient’s health care provider. We understand the need to contain health care costs, but we are concerned that step therapy strategies for medication and other treatment selection have the potential to impact patient outcomes and quality of life.

Requiring patients to try and fail treatments jeopardizes the health of patients, potentially resulting in dangerous consequences. In some instances, health plans force patients to return to the same treatments that have proven to be ineffective when tried previously under a different health plan. The decision to change plans may occur through no fault of the patient, but rather an employer’s decision to change plans.

Further, step therapy interferes with the patient-physician relationship by preventing dermatologists from prescribing drugs they know will provide the best treatment results in the most effective manner. Physicians know their patients’ medical histories, which enables them to identify potential contraindications and life-threatening adverse reactions. Retaining physicians’ medical judgement in patient treatment plans is a cost-effective way to prevent health care dollars from being used on medications that are not effective. It also protects patients from a prolonged treatment that includes scheduling multiple visits to their physician and spending money on prescription medications that are not effective, not to mention disease progression while the patient waits to receive the effective treatment originally prescribed by the physician.

To avoid these adverse effects of switching therapies and to ensure adherence to a prescribed treatment plan, in the event that a patient switches insurance plans, he or she should not be forced to repeat a step therapy process already completed under the last insurance plan.

With regard to a scenario where a patient is forced to repeat a step therapy protocol, Secretary Azar has even stated, "This is not just injurious to health, it is also penny wise and pound foolish.”

Due to this dangerous and burdensome practice, we urge members of the Committee to support bipartisan bill H.R. 2279, the "Safe Step Act." It is intended to ensure physicians remain the clinical authority over a patient's care, and to lessen the burden on patients required to go through step therapy protocols instituted by insurance companies. Modeled after state legislation, which the Academy is on record supporting through the State Access to Innovative Medicines (SAIM) Coalition, the bill provides a process for patients to easily access a request for an exception to step therapy protocol. The bill applies to insurance plans regulated by the federal Employee Retirement Income Security Act (ERISA). The bill would also require insurance companies to approve an exception request within three days, or 24 hours in the event of an emergency when the patient's life or health is in danger. A Senate companion bill is expected to be introduced by Senators Lisa Murkowski (R-AK) and Doug Jones (D-AL) in the near future. To date, 27 states have enacted step therapy reform laws.

Prior Authorizations for Medical Procedures Continue to Delay Care

In addition to impeding access to pharmaceutical treatments, prior authorizations are also delaying patient access to necessary dermatologic procedures. Dermatology procedures, such as Mohs Surgery[4], are complex and often require unpredictable additional procedures while the patient is on the operating table. Dermatologists often do not know the extent of the repair procedure that will be needed prior to receiving the prior authorization for Mohs Surgery. Requiring prior authorization that may take days to receive approval while a patient is in the midst of surgery and being forced to send them home with an open surgical wound increases risk of infection and adds additional cost by requiring patients to return for a second surgical procedure. By prohibiting plans from requiring additional prior authorizations for medically-necessary services, such as closing a surgical wound during Mohs Surgery that already received or did not initially require prior authorization, patients are ensured the best chance of positive outcomes.

To address this burden, we ask that the members of the Committee support the "Improving Seniors' Timely Access to Care Act" (H.R. 3107). This legislation aims to relieve prior authorization burdens for procedures under MA plans, as well as provide transparency to patients and providers.

We appreciate that H.R. 3107 prioritizes the creation and utilization of ePA forms while also requiring MA plans to report to CMS the extent of their use of prior authorization and the rate of approvals or denials. To help ensure timely delivery of care and best outcomes for patients, the Academy has also consistently supported policies that encourage real time prior authorization approvals.

Conclusion

[4] e, Z., MBA, Eliason, M., MD, FAAD, Callis Duffi, K., MD, FAAD, & Secrest, A., MD, FAAD. (2017). The burden of prior authorizations in a large academic dermatology practice. *Journal of the American Academy of Dermatology,76*(6).

Streamlining prior authorizations and step therapy protocols will help reduce the burden of the process, but it does not take away from the fact that health plans’ use of prior authorizations and step therapy often delay much-needed treatment and care to patients. The Academy supports Congress in its efforts to further reduce the volume of unnecessary utilization management processes and its impact on small medical practices.

On behalf of the Academy and its member dermatologists, I thank you for holding this hearing, and for your commitment to maintaining timely access to affordable and effective medications for patients. The Academy looks forward to working with you and asks that you consider including physician stakeholders’ opinions in your ongoing hearings. We welcome the opportunity to serve as a future reference to the Small Business Committee on this issue and others to ensure that the physician’s perspective on helping patients access needed and affordable treatments and services is considered as the Committee considers the challenges facing small medical practices and the patients they serve.