2024 Vermont Clinician & Administrator Prior Authorization Baseline Impact Survey Results

January 15, 2025

This survey was requested by the Vermont legislature in Section 7(a) of Act 111 of 2024 to measure the impact of prior authorizations before and after the implementation of Act 111's changes. The survey is considered the baseline data before Act 111 goes into effect and conducted using the SurveyMonkey tool. It was distributed and circulated by the Vermont Medical Society, HealthFirst, Bistate Primary Care and the Vermont Association of Hospitals and Health Systems. The questions were designed to mirror questions asked in the American Medical Association's national prior authorization survey. The survey was open from November 5, 2024 through December 11, 2024. The survey was completed by **241 health care clinicians**. A parallel survey was distributed and completed by **65 health care administrators**.

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Survey Highlights

"I've lost 3 nurses in 2 years that said the main reason they were quitting was because of prior authorizations and the burden and frustration and moral injury they are causing to staff and ultimately patient care."

PAs are time consuming:

- Clinicians report they complete **21.4 authorizations per week** and spend **15.13 hours** on these authorizations
- Administrators report **52.66 hours of ordering provider time** and **27.21 FTEs of additional staff time** spent on PAs each week in their practice

PAs are increasing:

- 77% of clinicians/94% of administrators say the number of PAs for medications have increased in the last year; 64% of clinicians/77% of administrators report PAs for medical services have increased

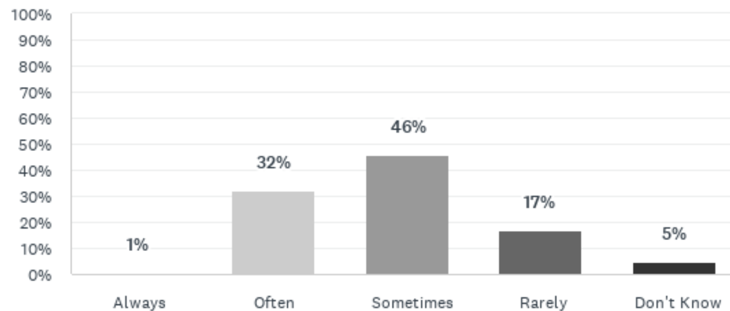
PAs harm patients and clinicians

- 95% of clinicians report that PAs lead to **higher utilization of health care resources** such as additional office visits or ED visits and 81% that it **delays access to necessary care**; 32% report that it has led to a **serious adverse event** such as hospitalization or death
- **99% of clinicians and 100% of administrators report that PAs increase burnout**

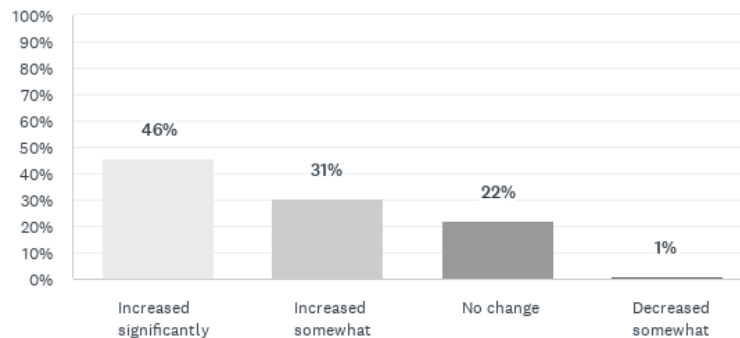
Q7: Please provide your best estimate of the number of prescription prior authorizations completed by you yourself and/or your staff for your patients in the last week.
12.80 authorizations

Q8: Please provide your best estimate of the number of hours spent on processing these prior authorizations by you and/or your staff in the last week.
8.57 hours

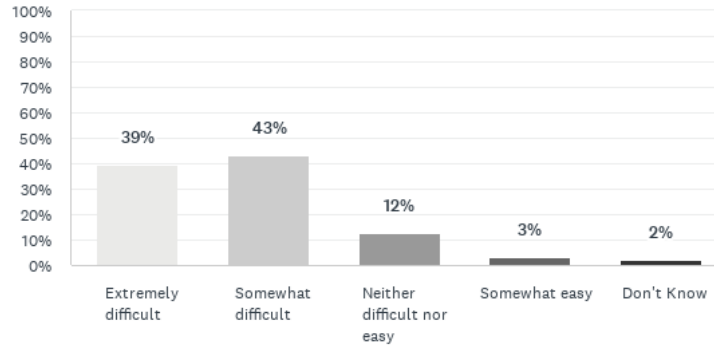
Q10 How often is prior authorization required for a generic prescription medication?



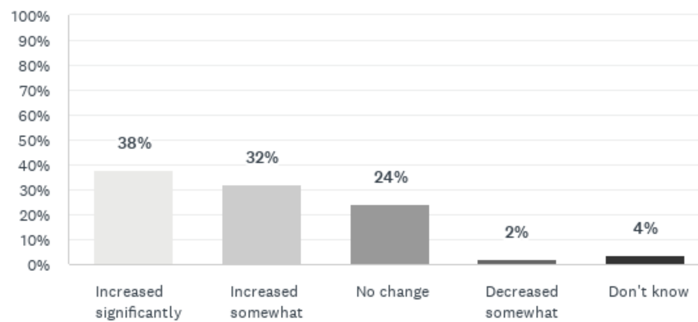
Q9 How has the number of prior authorizations required for prescription medications used in your patients' treatment changed over the last one year?



Q11 How difficult is it for you and/or your staff to determine whether a prescription medication requires prior authorization?



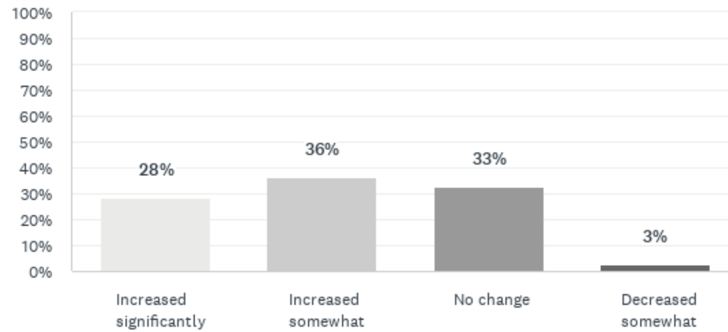
Q12 How has the number of prior authorization denials for prescription medications changed over the last one year?



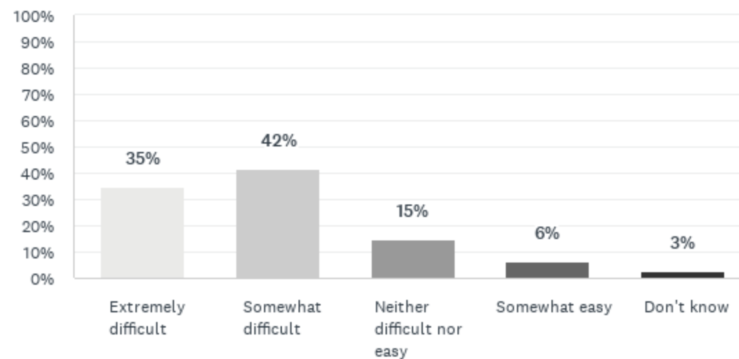
Q14: Please provide your best estimate of the average number of <u>medical services</u> (e.g., procedures, labs, durable medical equipment, imaging) prior authorizations completed by you yourself and/or your staff for your patients in the last week.
8.58 authorizations

Q15: Please provide your best estimate of the number of hours spent on processing these prior authorizations in the past week.
6.56 hours

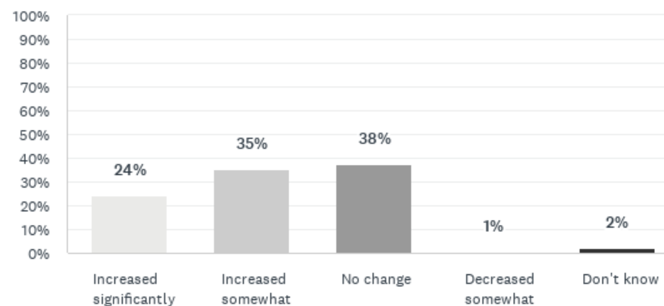
Q16 How has the number of prior authorizations required for medical services used in your patients' treatment changed over the last one year?



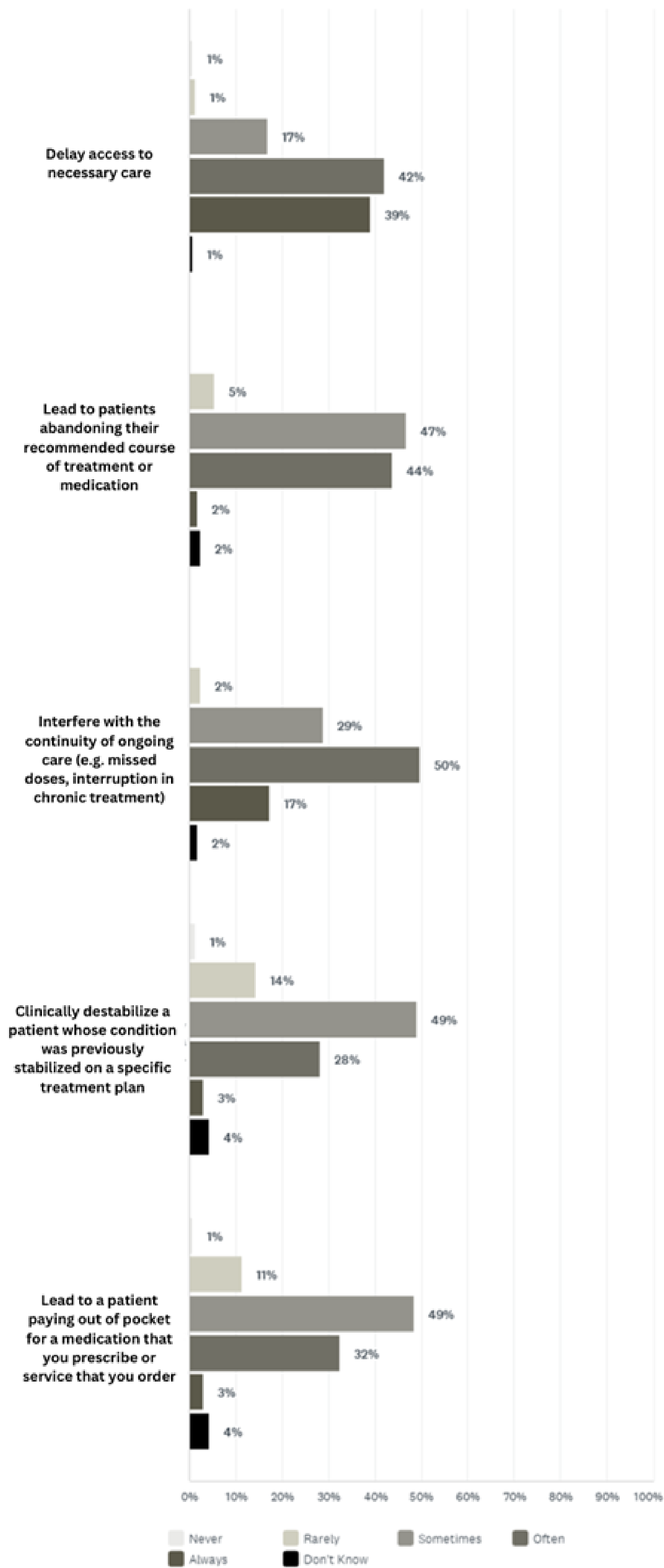
Q17 How difficult is it for you and/or your staff to determine whether a medical service requires prior authorization?



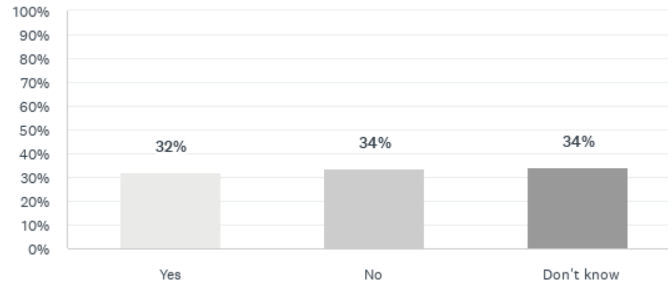
Q18 How has the number of prior authorization denials for medical services changed over the last one year?



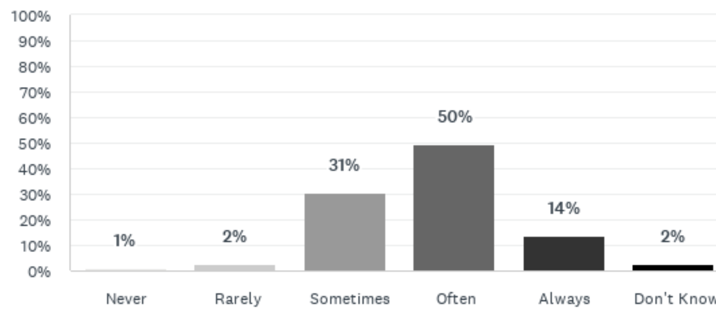
Q19 For those patients whose treatment or medications requires prior authorization, how often does this process:



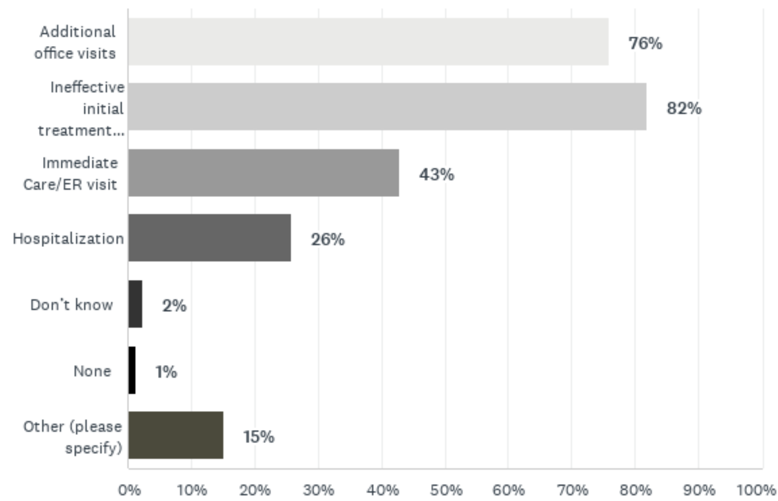
Q20 In your experience, has the prior authorization process ever affected care delivery and led to a serious adverse event (e.g., death, hospitalization, disability/permanent bodily damage, or other life-threatening event) for a patient in your care?



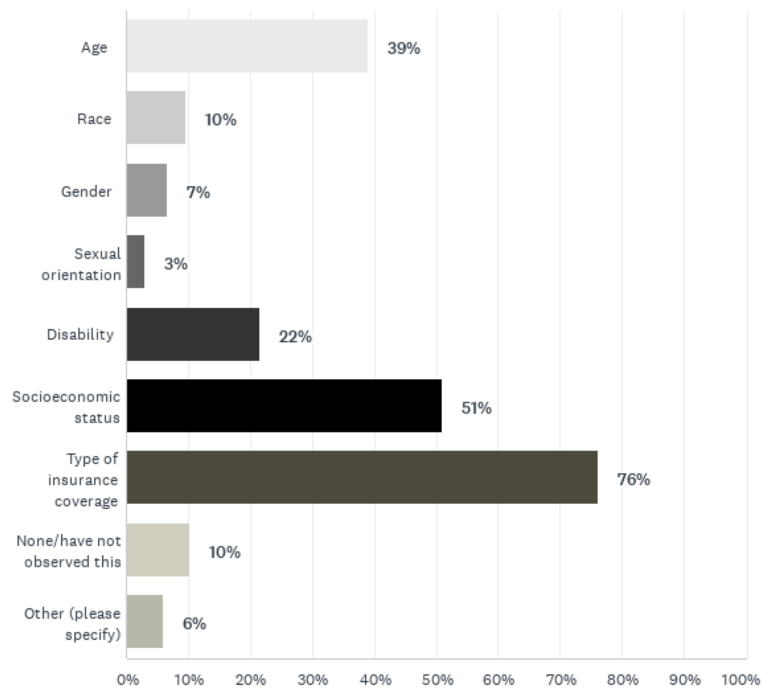
Q21 In your experience, how often does the prior authorization process lead to higher overall utilization of health care resources (e.g., additional office visits, initial use of less effective therapy due to step therapy requirements, emergency room visits, hospitalization)?



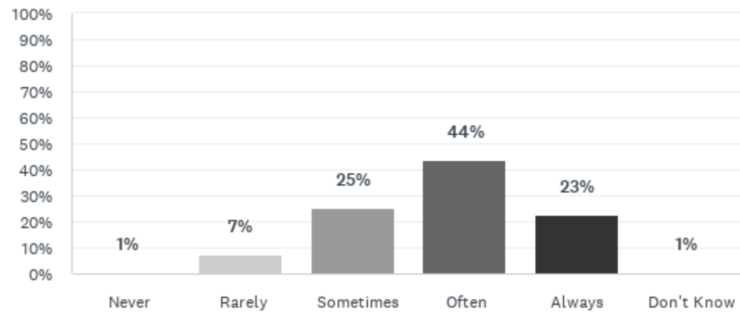
Q22 In which of the following ways has the prior authorization process led to higher overall utilization of health care resources for patients in your care? Select all that apply.



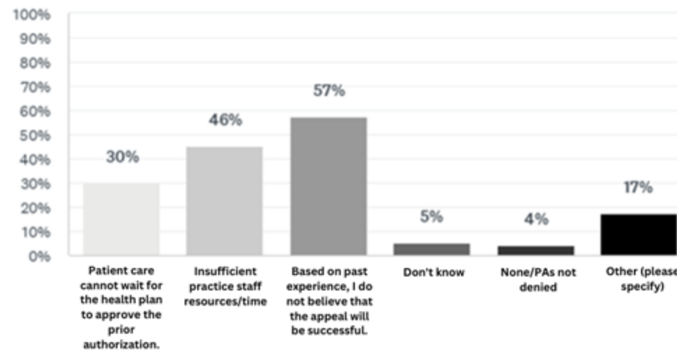
Q23 In your opinion have any adverse health effects or economic impacts of prior authorization fallen disproportionately on certain populations or individuals in terms of:



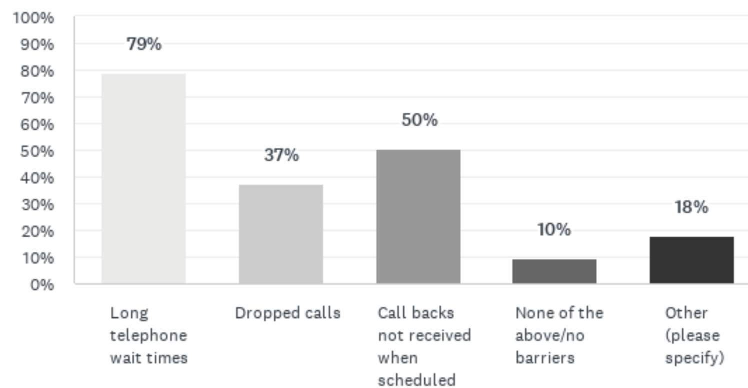
Q24 In the event a prior authorization is denied, how often do you appeal the denial?



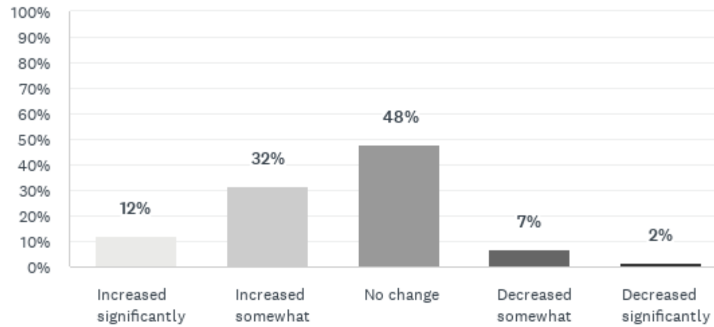
Q25 In the event that a prior authorization request is denied, which of the following is a common reason you do not appeal the denial? Select all that apply.



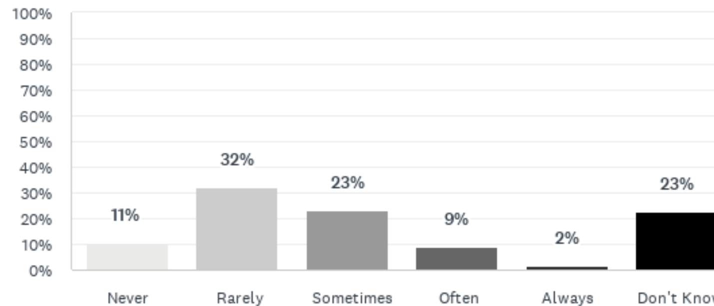
Q27 When requesting a peer-to-peer review, have you experienced any of the following:



Q28 How has the frequency of peer-to-peer reviews during the prior authorization process changed over the last year?



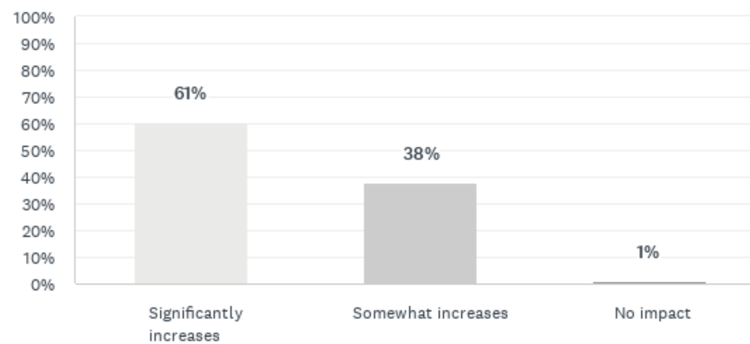
Q29 When completing a peer-to-peer review during the prior authorization process, how often does the health plan's "peer" have the appropriate qualifications to assess and make a determination regarding the prior authorization request (i.e., Is the "peer" licensed in your state and of the same specialty as a clinician who typically manages the medical condition or disease or provides the health care service involved in the request)?



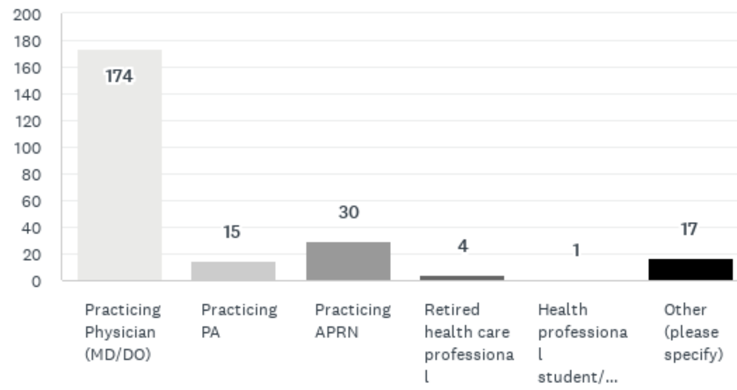
Q30: How would you describe the burden associated with prior authorization in your practice for the following health plans?

	EXTREMELY LOW	LOW	NEITHER HIGH NOR LOW	HIGH	EXTREMELY HIGH	DON'T KNOW	I DON'T WORK WITH THIS HEALTH PLAN	TOTAL
UnitedHealthcare	0% 0	1% 1	5% 8	31% 49	25% 40	31% 49	8% 13	160
Aetna	0% 0	1% 1	12% 19	27% 43	8% 13	44% 70	9% 14	160
Cigna	0% 0	1% 2	8% 12	36% 58	23% 36	28% 45	4% 7	160
BlueCross BlueShield of VT	2% 3	6% 10	18% 29	38% 61	11% 17	23% 37	2% 3	160
Humana	0% 0	1% 2	9% 14	12% 19	8% 13	49% 78	21% 34	160
Centene/Fidelis	0% 0	1% 2	4% 7	8% 13	9% 15	48% 76	29% 47	160
Anthem/Elevance	0% 0	2% 3	8% 12	12% 19	9% 14	49% 79	21% 33	160
MVP	1% 1	3% 4	15% 24	29% 46	13% 20	34% 55	6% 10	160
Traditional Medicare	8% 12	8% 13	13% 20	22% 35	9% 15	28% 45	13% 20	160
Vermont Medicaid	5% 8	14% 23	19% 30	24% 38	13% 20	21% 34	4% 7	160

Q31 Based on your experience, what is your perception of the overall impact of prior authorization on clinician burnout?



Clinician Survey Respondent Demographics



Q3: How many hours of direct patient care do you provide during a typical week of practice?

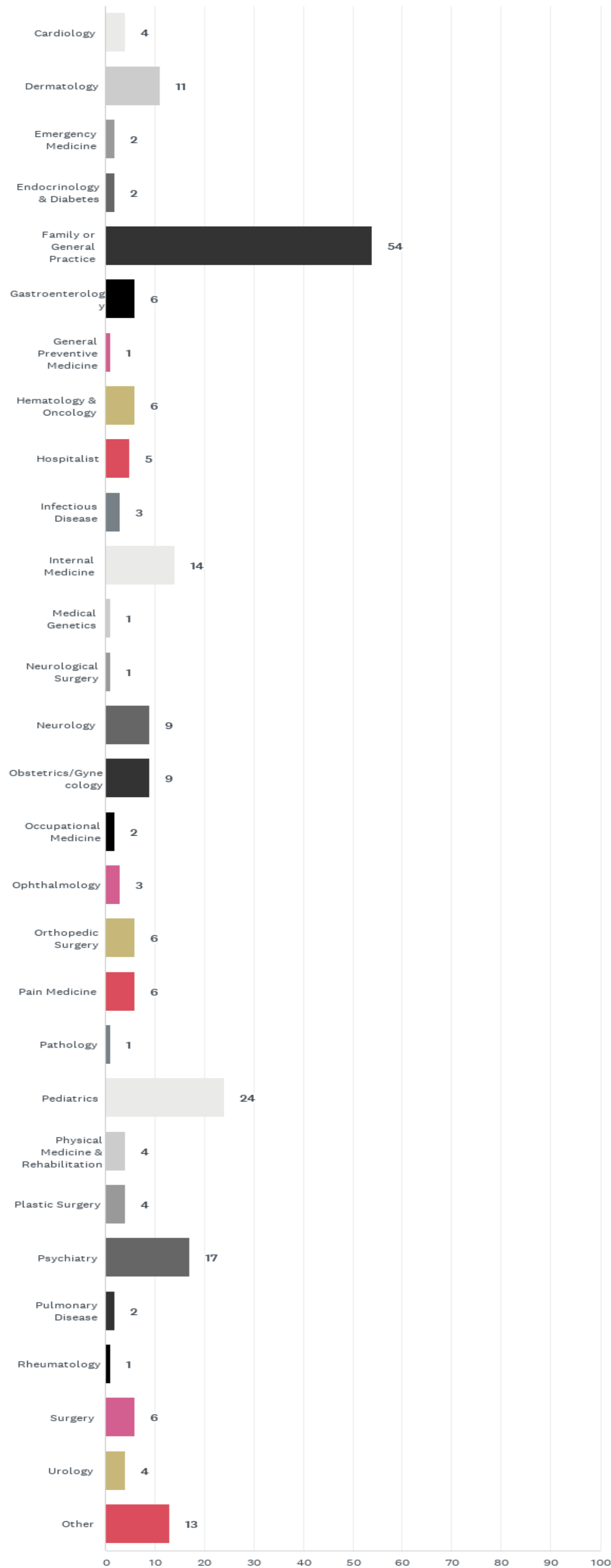
29.73 hours on average

Q4. What is the primary state in which you practice?
Omitted, screening question for only those practicing in VT

Q6. Do you complete PAs for prescription medications?
Answers omitted, screening question only for those who complete PAs

Q7. Do you complete PAs for medical services (e.g., procedures, labs, durable medical equipment, imaging)?
Answers omitted, screening question only for those who complete PAs

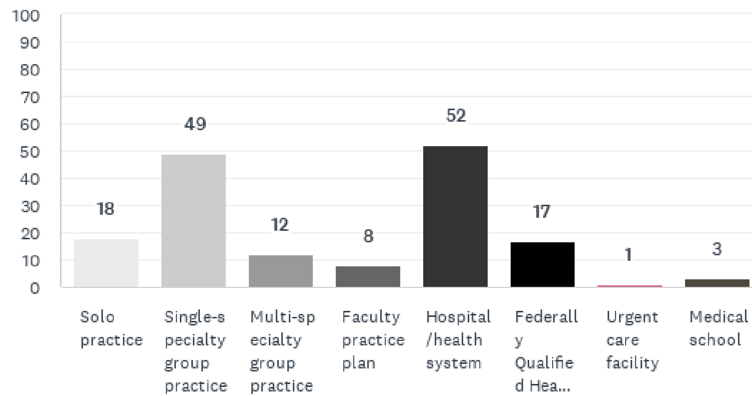
Q5 Please select your primary medical specialty from the following list.



Q33: Including yourself, how many physicians and other health care professionals (MD, DO, APRN, PA, ND) are in your practice? Please include all of your practice locations/sites in your answer. Please enter a number below.

11.55 average

Q34 Which of the following best describes your main practice?



Q35 Is your practice owned by a hospital or health system?

Clinician Respondent Free Answers

Q22 - In which of the following ways has the prior authorization process led to higher overall utilization of health care resources for patients in your care? Select all that apply.

- wasted office time - PAs are almost never denied, just more work
- Use of opioids and invasive surgeries instead of minimally invasive treatments I recommended
- unnecessary surgery
- surgeries that wouldn't otherwise be needed, flares of disease that could have been avoided
- stress for parents and caregivers
- specialty referrals to obtain testing that was denied to the PCP
- repeat visits to pharmacy
- Referral to specialist when not needed
- Reduction in services (x days of treatment approved -> perceived financial pressure for patient)
- prolonged work disability
- prolonged hospital stays and significant discharge delays on the order of days
- Other (please specify)
- NA
- Multiple phone calls, delays in transitioning off of opioids to buprenorphine,
- much more phone calling
- More time for provider to look up alternative meds/etc.
- Increased time spent on MyChart messages and phone calls
- Increased prescriptions filled (ie- having to fill a step one treatment and then having to fill a second prescription for the next step, etc)
- Increased phone calls/time for staff re: pt questions/concerns
- increased communications via portal and or phone
- Extra effort/time for me and staff to complete paperwork
- extensive time by provider doing appeals, peer to peer, letter writing
- Email and phone calls
- decreased patient trust in the healthcare system
- Asthma care delayed and difficult to establish control
- ADDITIONAL PHONE CALLS

Q27 - When requesting a peer-to-peer review, have you experienced any of the following:

- Usually not speaking to a true peer. Often a pharmacist or primary care doctor who has very little understanding of the complex conditions we are treating.
- unable to get through - closed for lunch or prior to or after patient clinic time - no one available to take call

- Trouble scheduling these calls
- these are SO frustrating. They leave no direct number so MDs are waiting (and wasting costly time) to talk to a person. Often trying to do this between patients and have to drop the call after waiting for 20-30 minutes.
- The "peer' is not actually a peer anymore. A decade ago it was a physician and I was never once rejected because I had a good rationale. Now it is a nurse with an algorithm and no power to actually change the decision.
- so disruptive to my day and very stressful
- scheduling time eats away at efficiency of day
- Scheduling at times that are not available because I am scheduled to be taking care of patients; Being REQUIRED to be on the phone even when a "PEER" is not available; RARELY speak to a "PEER"
- Rarely a barker, once we get to peer to peer, common sense and good medical care usually prevail. The whole thing is quite tedious on both ends.
- Person not qualified to make the decision.
- Peer to peer discussions usually involve the insurance company agreeing with my clinical decision, but they just say “too bad, the policy doesn’t cover this treatment”
- Not speaking to a "peer"
- Not offered often enough to say
- no return call from insurance company in order to schedule peer-to-peer
- needing to repeat the same demographic info about a patient multiple times while on the phone
- need for multiple calls
- N/a (not a MD/medical provider)
- Multiple phone calls to complete the process
- Long delays and difficulties identifying how and whom to schedule the peer to peer with. Incredibly frustrating and timing wasting
- language barrier
- just noted in last question I have never been offered or participated in peer to peer review
- it is usually not a peer. it is often a medical provider from a totally different field with no knowledge about pediatric cancer
- issues with coordinating convenient time
- Inability to get on the phone to do the peer to peer because I am busy seeing patients when they are available.
- I don’t have 45-75 min per appeal
- Having to adapt my busy schedule to meet the appointment availability of the insurance company
- have not had any peer to peers
- Delay in scheduling peer-to-peer meetings
- Always I'm told to call a certain number for the peer-to-peer only to be connected to an entry level person who starts the process over asking me all the basic information AGAIN and making me wait or call back another time for the actual "peer-to-peer" which is often

not with a medical person but rather a non-medical person who reads me their rules and denies the care again.

- "peer" is not a peer, ie is not same specialty or anything close

Question 32 - Please use the space below to provide any additional information regarding you or your staff's experience with prior authorization and/or suggestions for how health plans' prior authorization programs could be improved.

- If there is a reasonable alternative drug I usually pick that one to avoid the prior auth process. If I think a patient really needs a specific med I will go all out to get it approved. I will often refer a patient to a specialist if I think they need an imaging study requiring a prior authorization and let them deal with it. If they need a stat study and I know the ED can get it I will send them there, again avoiding the prior auth process. Both of these strategies needlessly increases the cost of care, but from a work flow standpoint I don't get tied up and frustrated! The insurance companies reap what they have sown. (Galatians 6:7)
- Increases burden for staff as well. 2. Prior authorization doesn't ensure payment for treatment/test. This is frustrating as treatments in our specialty are increasingly expensive due to Orphan Drug Pricing 3. Eliminating some prior auth for FDA approved medications/treatments would be helpful. 4. Authorization for testing is less clear, especially when trying to get standard of care genetic testing. Vermont insurers/Care Board do not seem to understand the clinical landscape in 2024 where genetic testing is needed to establish patient diagnoses.
- 1. Less prior auths in general. 2. Eliminate referrals needed from primary care to start a prior auth for a procedure. (Humana specifically) 3. Medicare specifically for mbb/RFA - multiple denials with explanation that does not make sense. 4. denials for a reason that was already clearly listed in the notes . 5. Scheduling peer to peers - the insurance companies where you need to call to schedule a peer to peer (waste of 30 min)
- Timely review of critical imaging (stress test for angina, PET/CT for lung cancer) 2. No PA for generic medications, less step therapy requirements
- a lot of time used to get approved the correct care for patients so insurance companies save money
- As a hospitalist who takes care of many patients with cancer, I encounter often the issue of prior authorization to prescribe adequate opiates. For example, right now I am trying to discharge a patient with a higher dose of Xtampza. He has VT Medicaid. It is a Sunday. They will not approve even a 3 day supply. I can't discharge the patient in pain. Healthcare is a 7 day a week system and I'm not sure why no one can do prior auths on the weekend nor do I understand why patients dying of cancer can't get opiates approved.
- As a hospitalist, I often need to perform "peer to peer" reviews for approval to rehab which takes time and resources as well as delays discharge from the hospital
- BCBS Vermont does a good job in limited. United Health is bad
- commonly (with any plan) call centers do not provide the same information which creates more calls needed for an official decision of coverage
- Create a system where low utilizers, ie of advanced imaging do not require PA. Appreciate the impact on practices of changing preferred meds and needing PA for established meds

or changing patient to different med. Especially with stimulants in children that has significant negative impact! Same for changing preferred inhalers. My staff and I spent hours each week on those! Time wasted that should be used for direct patient care instead. Staff needs to get paid to obtain PAs which then again increases cost of care! Makes no sense. Educate and analyze high utilizers instead (by specialty and practice type), or penalize them if needed.

- Denials used to be rare and the "peer-to-peer" an inconvenience that granted requests if you were persistent. Now denials are common even after the "peer-to-peer" process.
- Either cover service or not with patient to be involved with decision making process.
- For all the peer to peers I've done, there has only been one instance where the "peer" was someone in obgyn.
- For biosimiliars they often do not say which biosimiliar they cover, and so it is a game to see which one they approve.
- Forced to be on hold for long periods of time, often leading to missed obligations (scheduled meetings, deferral of administrative tasks while on hold, etc.) Many have automated systems which result in being "kicked" and starting the manual entry process all over again, resulting in further time loss
- Generics should be available w/o PA in all circumstances. When a drug is NOT covered, all covered drugs in the same class should be offered up front to the provider and not require a call to the insurer to provide a list.
- Having a streamlined document with medications that will be approved or require a PA for medications like GLP-1, inhalers, antidepressants. Inhaler PAs are very burdensome and vary between insurances
- HUGE barrier to care- and worsens medical care/condition of the patient as they wait for PA.
- I am a pediatric subspecialist. Many of the medications, treatments, imaging and lab work up that standard of care for pediatrics are different than adults. Many of the national guidelines do not pertain to children but are used as evidence of why a service or treatment should be denied. For certain conditions for example cancer many of the chemotherapy medications that are standard of care of not always FDA approved for pediatric use which despite being used for decades and being the standard of care some insurance companies will give push back. For the most part I am able to get my patients the care they need however this requires a lot of my staff and my time to make sure the patient is getting the needed care. many times the hospital will take on the cost burden because it is in the best interest of the patient aka they do the right thing when the insurance company is not. the amount of time with the back and fourth between my team and our internal PA team in addition to the time setting up peer to peers is draining.
- I believe PAs should only be permitted when there are metrics to show how often individual docs/practices requests are denied and, if/when denial rates are below X% those docs/practices should no longer be required to hew to PA demands... perhaps for Y years' time. (If it is determined that a doc/practice are practicing appropriately and not being wasteful, etc, they should be relieved of the PA administrative burden.)

- I do not request PA for medications, since I mostly prescribe generic antibiotics and pain meds. It is ludicrous to require a PA for 5 tabs of a generic pain med that will cost less if pts pay out of pocket!
- I feel that much of the time the PA goes through so it's frustrating that I have to go through the process at all and that I just can't order what i feel is appropriate for the patient. It's more expensive if my imaging request is denied and so the pt goes to the ED to have it done, or gets a specialty visit and then the test is approved.
- I feel they need to be removed altogether. Appeals are usually granted. PA's don't save money and waste our resources and contribute to burnout for providers and staff.
- I hav found that if I get to a Peer-to Peer, they always see my rationale and give approval.
- I have a very small office with 2 employees; my senior employee spends much of her time working on prior authorizations, including trying to track down the appropriate forms for both the insurance company and the specialty pharmacy. I suppose having an easy to access form that is clearly the correct one, and having clearly laid out criteria for when they will cover the medicine and what the copays/deductibles will be, would be helpful. Having a designated contact person would be helpful as well
- I have started having my patient families speak with their insurance carrier to see if a particular procedure (e.g. MRI) will require a prior authorization. I have had experiences of trying the provider line listed on their insurance cards and only getting a "click" at the other end, ending up in a never-ending cycle of a telephone tree, and once, I spent over an hour getting transferred through 3 different BCBS providers in different states until I was finally transferred to the one that my patient belonged to. The burden for prior authorizations is high, inefficient, uncoordinated, and takes up available and precious time that we could spend interacting and listening to patients.
- I have switched to a limited, cash based private practice because I was unable to serve my patients with the interference from non-clinicians. I continue to also work part time employed by a health system.
- I primarily work with children on Vermont Medicaid. An advantage of Vermont Medicaid is that the formulary, clinical criteria, and prior authorization steps are publicly available and transparent. Nonetheless, I still have had some difficulty with prior authorizations with Vermont Medicaid. More often, however, I have difficulty with commercial insurance prior authorizations because their formulary is not readily available, it is not clear which mediations are preferred or non-preferred, and it is not clear what steps or information are required for a prior authorization if it is required. Improving these barriers would be an important step, but not the only step, as even if these steps were completely transparent a prior authorization would still delay care if not promptly and properly addressed.
- I think if an insurance is going to require a prior auth, the criteria for coverage should be easily accessible to avoid wasting everybody's time. For example, I can easily look up the Vermont Medicaid formulary to determine coverage criteria, but for every other insurance plan including Medicare it is impossible to find this information until after the script is denied.
- I was disappointed in the VT legislation decision because the MAIN BURDEN of prior authorizations is for prescription medications. Sometimes for imaging, but MUCH MORE for

prescriptions. The perception I have is that lobbyists were able to get this out of the bill. I don't think the changes made last year will significantly improve our workflow in primary care as the main issue is prescription medications.

- I waste SO MUCH time with peer to peers with just getting the right person on the phone. In 20 years I have NEVER had a request denied by the peer. Such a waste of time and effort.
- I will do almost anything to avoid medications which require a PA. I'm sure this limits my patients' access to potentially useful treatment, but I do not have the time or support to do otherwise.
- I work at Comp Pain Program We are not a primary care office. My Rx's are mostly limited to meds for pain so we don't reflect a typical primary care office. We did spend about 5 hours recently on one PA. Group of 6 providers discussed for 1/2 hr, plus 2 providers for 1 hr=total 5 hours of clinician time. Plus a phone call at home on my person cell.
- I'm not sure
- I've considered leaving medicine due to prior authorization burden
- I've stopped trying to appeal even if it would likely get approved due to lack of time and not caring anymore due to burn out. I tell patients to complain to their state and federal representatives if they want the drug.
- In my experience, prior authorizations only delay the patient receiving the appropriate care.
- In pediatrics the biggest number of PA's are being done to prescribe a "controller inhaler" for an asthmatic, and the only ones "approved on an insurance list are not appropriate for a child under 6 for example. We have to do a PA to state that the child is too young for the inhalers on the plan to get an appropriate one. I also frequently cannot get authorization for an MRI for a knee or other extremity injury if I have not gotten an X-ray first, which in many cases is needless for what we are looking for, more expense, more radiation and more time. If there is going to be a need for a PA process it needs to look more carefully at what the drugs on formulary are and who they work for, etc.
- It is a big issue for our staff. Over utilization of out patient service does not seem to be a bit factor in driving up health care expense in this state. Maybe more utilization of out patient services could lower cost.
- it is a huge problem for staffing, patient care, provider and patient satisfaction.
- It is disheartening to submit multiple prescription requests only to be denied for basic medications without being told what the preferred agent is. Example: I recently prescribed a basic LABA/ICS inhaler for asthma not controlled on inhaled steroids alone - an appropriate step up to therapy. The first prescription was denied and I was given a list of preferred agents. I sent in one from the list only for that to be denied as well, and I was given the same list. It took four different prescriptions over two weeks to get the patient her inhaler. Meanwhile she had an acute exacerbation requiring another office visit and ultimately had to pay out of pocket for an inhaler (hundreds of dollars) while awaiting final approval
- It is most bothersome that treatment decisions are so often dictated by what insurance will cover, rather than what the medical professional recommends based on evidence and experience.

- It is often more burdensome than it needs to be. It should focus on the pt & provider, not a 3rd party
- It is often unclear why things are being denied, and takes our nurses a lot of time to figure out. A lot of the time, the solution is actually pretty easy or quick, but the time and effort spent getting to that point is too much.
- It sometimes takes many many hours and attempts at PA to determine why a PA is not going through or why a previous PA is not being applied (e.g. Rx written for 90 days instead of 30 days, nobody able to see this is the issue with the PA)
- It would help a lot if reasons for denial were clear and if physicians could talk to other physicians sooner in the process. As a specialist, we prescribe some rare medications with specific indications and often the insurance doesn't seem up to date with current recommendations and sometimes I have to share guidelines with the peer physician as well.
- let's go back to basics and trust the provider has the skills and knowledge base to correctly order what the patient needs in a timely fashion
- Managed Medicare Plans have become increasingly problematic
- Many insurance companies refer prior authorization to contracted companies including Evicor and Availity who are managing the prior authorization requests. This adds delay and confusion to the prior authorization process. Since my practice does not take insurance, and so do not have staff available for managing prior authorizations, this time and burden falls on myself or my office manager and fundamentally disrupts patient care.
- Most often will prescribe a preferred medication but usually requires 2-3 phone calls to determine what their preferred medication is.
- Needing prior authorization for any component of health care is a burden, but it has worsened in the last few years. We experience significant barriers to discharge from our inpatient rehab unit when insurers deny PA for equipment/DME in particular. This leads to longer stays in the hospital at unnecessary expense (on the order of $4000/day). Each insurer has their own list of items that need PA and it is not transparent from the beginning so we cannot plan in advance. Case management spends almost half their time just getting PA, appealing denials, procuring the equipment, etc.
- No idea, but it is a daily frustration to have insurance companies determine what medications I use to treat patients.
- NY Medicaid is TERRIBLE.
- Often I have to jump thru unnecessary hoops and increase the cost of getting the person the correct test etc. i am so sick of pa's i just send them to a specialist - this is very poor primary care
- One of the most frustrating parts of the PA process is to have a patient on a medication and doing well, then change insurance plans OR have the insurance company change their policy . Then a PA is required and denied because of the policy change, and not based on patient well being. It seems that these cases should be exceptions to the PA process.

- On-line PA's don't work well for us. We don't have one person who is able to work on them every day. We used to fax them which worked most of the time but not having to do them at all and insurance companies trusting the providers decisions would be best.
- online portals for PAs have made it much easier but it still takes a lot of time. We have one medical assistant who's job it is to do PAs all day long for the three providers in our office.
- Our staff has streamlined this process - 4 years ago it was a much higher toll on resources. We are a specialty clinic and can focus on the evidence of our diseases, which helps speed up the process.
- PA for commonly prescribed medications should not exist, especially within primary care. Primary care physicians rarely prescribe "designer drugs" such as Humira. However, especially in more rural locations where specialty referral is scarce, there should not be limits on a primary care physician's ability to prescribed. D
- PAs should be confined to mid level or general practice. Complete waist of a specialists time.
- PAs are the biggest impediment to patient care that we experience as an office.
- PAs delay discharges, cause additional admissions, increase work load of nurses and providers and pull them away from direct care
- PAs take up clinical staff time and often involve requests for follow up information that is the same information that has already been submitted. This adds to the burden of clinical staff to do repetitive tasks as well as delaying pt from getting their medication.
- Peer to peers are a waste of time and demoralizing
- Please stop the prior auth madness.
- Prior auth is generally unnecessary extra work that has to occur outside of the patient encounter. There is never a qualified individual to whom you can discuss your care plan and specific patient factors that require the treatment you are prescribing. It is wasted time that could be spent providing care to another. What is the point of board certification and years and years of specialty training when a medical decision and recommendation is denied by someone who does not share the same skills.
- Prior Authorization are a disaster for patient care, especially medication
- Prior authorization for surgeries in the OR do not happen until the week or two prior to surgery. If there are any issues with the prior authorization, this often does not leave enough time to remedy the situation, appeal, or provide additional information. This leads to stress for the patients, schedulers, and the entire team. We have had to cancel surgeries a couple days prior to the scheduled date because the prior authorization denial came in so late, this is not good patient care.
- Prior authorization significantly delays care for pediatric patients with severe & chronic medical issues. Having to call for "peer 2 peers" and speak with someone who is a) not pediatric trained and b) not a hematologist or oncologist is insulting.
- Prior authorizations are absolutely out of control. Over 2/3 of the medications I prescribe now require a PA, even older generics in some cases. I make choices informed by effectiveness and tolerability of medications. I am not choosing expensive medications for the wrong reasons. It is unconscionable that my many years of medical experience and

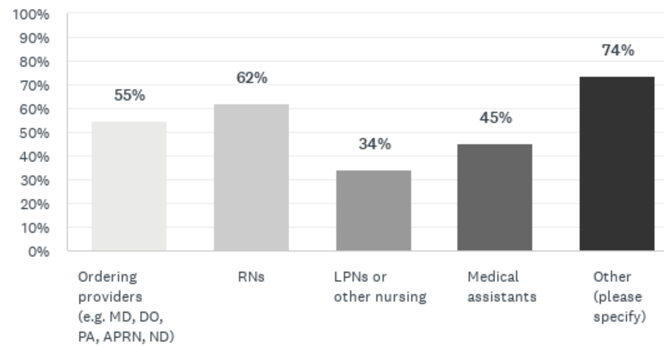
expertise are constantly undermined by people with no knowledge of the specialized work I do (I am a subspecialist in a tertiary care clinic for my specialty).

- Provide clear and easily accessible info re: preferred options, especially when denying coverage for the initial Rx.
- Reauthorization for ongoing coverage is not medically indicated and delays access to care. It is hard to delegate these tasks given the need of specific medical knowledge and I am not staffed in a solo practice to have nursing staff support. I don't know how to make it such that unnecessary brand formulary medications are not used if you remove the PA stipulation but I would think that clinicians could be judicious and intentional with prescribing a brand name medication vs. widely available generic. Sometimes newer is better and there are no alternatives at the level of medication type. An example is sleep medication: Zolpidem (ambien), lunesta, has some disastrous side effects that can lead to clinical worsening. I am in position of prescribing that just so I can get to the newer "DORA" class of medication that has less side effect and dependency burden. There are alternatives, but often times patients have tried these without success (example: Trazodone) but had intolerable side effects such as next day sedation. Many health plans would have me prescribe the zolpidem despite knowing that this is a bad idea for patient (given substance abuse history for example) and just wanting to go for the belsomra / suvorexant which is effective with less side effect burden. Anytime I wish to reach for these agents for the "best choice" , I have to wade through the PA issue and do this on my own time. If anything - we should be able to bill for the time spent doing Prior Auths and perhaps disincentive creating barriers.
- Such that it exists, Prior Authorization should be relegated to an "advisory" discussion, ie "Medication X is the preferred initial treatment by this insurance plan" with the prescriber then either agreeing or providing a brief explanation ("tried and failed" or "alternative considered but not acceptable per clinical reasoning") and proceeding with the original prescription.
- The expertise of care managers should not be spent of prior authorizations-they are supposed to be communicating with families and clinicians. We should not have to pay for a whole other person to do PA's--this is a barrier to care put forth by insurance companies that makes no sense in pediatrics.
- The insurers have strong profiles on my utilization and they know well that I do not overutilize. in the last year I have won 100% of appeals. They know that, in my practice, this process is just a money-saving effort on their part. they should waive any prior appeal for physicians with reasonable records.
- The need to do PA's for with loss medications (GLP's) has taken PA burden to a whole new level. This has placed a disproportionate burden on the staff and providers in primary care offices.
- the people denying PAs are not physicians or clinicians who understand pharmacotherapy. it is unconscionable that such individuals unfamiliar with direct service to patients as well as off label uses for medications are dictating patient care and risking horrible outcomes, including death and higher levels of care

- the pre-authorization step takes time, is unpredictable and creates much more work In the peer- to peer. it is rarely denied bringing up question of why it is used
- the staff have learned to do the PA process according to the current rules. however the rules seem to change
- The technology systems are antiquated and do not allow for meaningful data entry
- The wait times on the phone for myself and my staff is quite burdensome especially since we run a small office and do not have anyone dedicated to doing prior auths, detracts from our patient care.
- This could be improved by having the patients assist with the prior authorization process, by calling their insurance company to assist with PA approval, since staff in the office cannot keep up with other patient needs. Vermont Medicaid does not fax determinations on PA outcome. Navitus (PBM for Blue cross) is very difficult to deal with due to significant logistics.
- this process results in unpaid time, frustration in meeting patients' needs and delays care.
- time consuming burdensome insulting to providers intelligence when perfectly good medications or supplies are available but not approved
- We frequently get PAs for medications that were actually approved, spend the time completing the forms to find it was already picked up. I personally have dealt with insurance asking for alt meds to be prescribed, that alt med sent in, another PA request for that med to be covered or a different alternative med, another alt med sent, and another PA sent to our office with the original med suggested as an alternative. Since no med is covered, even to be trialed, it becomes near impossible to treat the patient. This is especially common with diabetic patients with their insulins or people on specific inhalers. Another common experience is being asked to call the insurance, waiting on hold for 15-45 min (minimum) to answer one or two questions that were already covered during the initial PA. The decision for the medication is delayed for another week. I frequently speak with people from the insurance who have no clinical experience and do not understand the lab information, disease process, or have knowledge about treatment options. This makes it difficult to share important medical information as they frequently do not understand the questions they are asking and the answers they are getting. I see some PAs sent to our office after hours on Friday, demanding a 24-48h turn around. By the time we return on Monday, the PA has timed out and been denied as a result. In a similar vein, there have PAs asking for us to not call until a specific date to start the new PA. We call at that date and are told we already missed the PA window as the actual date we needed to submit info for has come and gone. This has happened both with paper PAs and when calling insurance companies. The most recent even was a medication PA that we delated 2 months and made at least 4 phone calls regarding to only be told we should have sent information 6 weeks prior.
- we get things approved 99+ percent of the time-- a total waste of our time
- We have had prior authorizations denied, based on what is clearly outdated information accessed by some kind of AI, before they were actually assessed by a human being.
- We now utilize staff in a separate location to work the PA and send back. It is frequently laborious despite this process to take work off of our office staff so they can do other duties.

- When calling the phone number listed, we often can't get an answer or get different answers.
- When patients have multiple insurance (ie, BCBS primary, Medicaid secondary), the formulary rules conflict. One of them requires brand, one of them requires generic, they both reject the PA. This is a complete waste of EVERYONE'S time - mine, the patient, the pharmacist, and their own.

Q6 What types of staff complete or assist with the prior authorization process? Check all that apply.



Other for Q6

- admin staff
- Admin staff
- Administrative Assistant
- Administrative staff
- authorization team
- Centralized Prior Authorization team
- Clerical Employees
- Clerical Staff and Technologists
- Dedicated prior authorization staff and office staff
- Financial Navigator/ Billing team
- Front desk patient service specialists
- In PC we hired an individual specific to doing Medication PAS
- Medical secretaries
- Ophthalmic Technicians/Billing Specialist
- Patient Access
- Patient Approval Specialist
- Patient coordinators
- Patient Service Specialists
- patient service specialists
- Patient Service Specialists, Office Support Specialist
- Practice Manager
- Pre-cert department (separate from our practice)
- Precert Staff

- Pre-cert team and front office representatives
- Precertification Associates
- Prior Auth representatives
- Prior Authorization (non-clinical) Staff
- Prior Authorization Associates
- Procedure schedulers
- Procedure schedulers and Healthcare support specialists
- receptionists
- Referral coordinator (diagnostic imaging only)
- Referral Specialist/ Prior Authorization Specialist
- referral specialists
- schedulers and clinical navigators
- Secretarial role
- Secretaries
- Surgical Schedulers
- Trained auth specialists

Q7 - Thinking of all the prior authorizations completed by <u>ordering providers</u> (e.g. MD, DO, PA, APRN, ND) in your practice in the past week, please provide your best estimate of total clinician hours spent on processing <u>medical service</u> prior authorizations.

24.66

Q8 - Thinking of all the prior authorizations completed by <u>ordering providers</u> (e.g. MD, DO, PA, APRN, ND) in your practice in the past week, please provide your best estimate of total clinician hours spent on processing <u>prescription medication</u> authorizations.

28.00

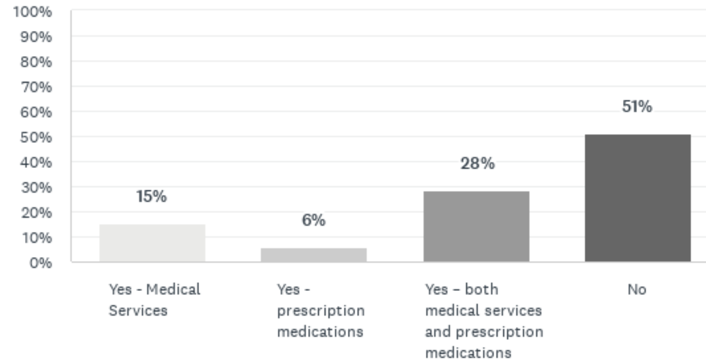
Q9 - Thinking of all the prior authorizations completed by <u>staff</u> other than ordering providers in your practice in the past week, please provide your best estimate of total staff <u>FTEs dedicated to processing medical service</u> prior authorizations.

10.78

Q10 - Thinking of all the prior authorizations completed by <u>staff</u> other than ordering providers in your practice in the past week, please provide your best estimate of total staff FTEs dedicated to <u>processing prescription medication</u> prior authorizations.

16.43

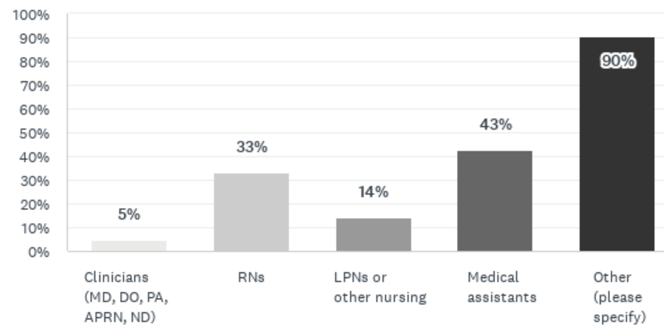
Q11 Do you have staff members in your practice who work exclusively on prior authorization?



Q12: How many staff members in your practice work exclusively on prior authorization? Enter a number between 0 - 100.

8.30

Q13 What types of staff work exclusively on the prior authorization process?

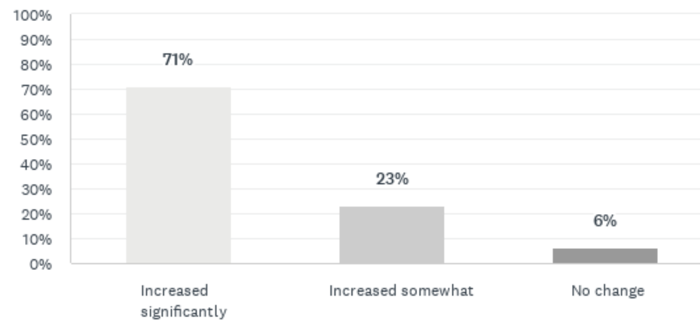


Q13 – Responses for Other

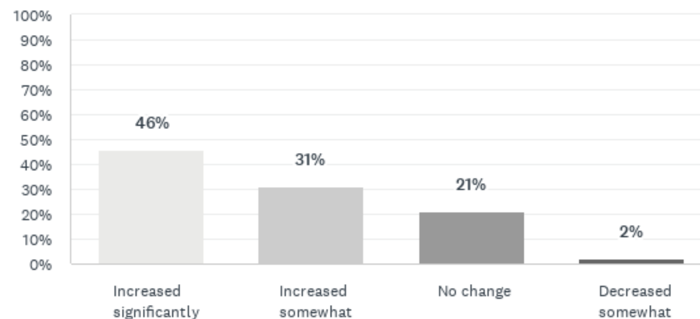
- 2 PA specialists
- admin
- admin
- administrative staff
- Administrative staff
- Clerical Staff
- Clerical Staff & Technologists
- Dedicated prior auth staff

- Patient Approval Specialist
- Patient coordinators
- patient service specialists
- Patient Service Support staff
- Prior Auth Representatives
- Prior Authorization (non-clinical) Staff
- Prior Authorization Associates
- procedure schedulers
- Procedure schedulers, healthcare support specialists
- referral coordinator
- Trained authorization specialists

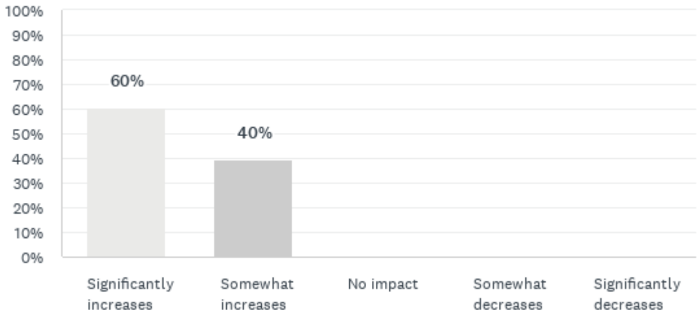
Q14 How has the number of prior authorizations required for prescription medications processed by your practice changed over the last one year?



Q15 How has the number of prior authorizations required for medical services processed by your practice changed over the last one year?



Q16 Based on your experience, what is your perception of the overall impact of prior authorization on clinician and staff burnout?

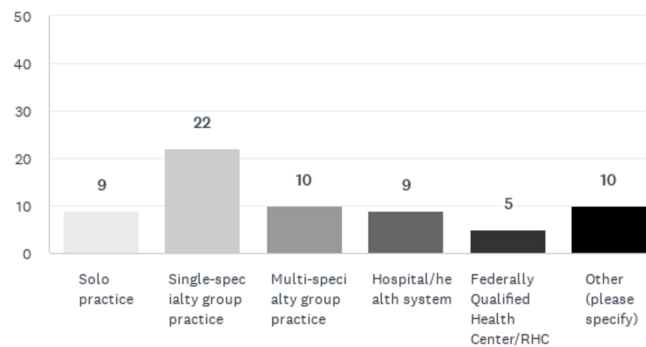


Administrator Survey Respondent Demographics

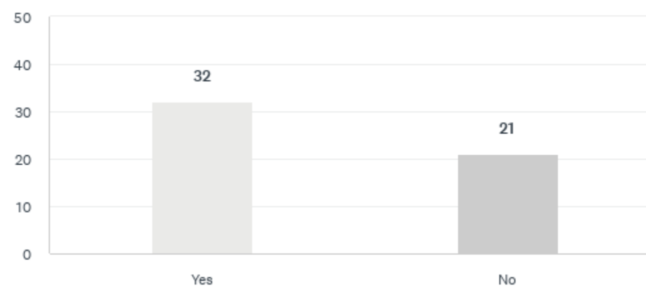
How many physicians and other health care professionals (MD, DO, APRN, PA, ND) are in your practice? Please include all of your practice locations/sites in your answer. Please enter a whole number below in the range of 1 - 3,000.

75.83 average

Q3 Which of the following best describes the practice type?



Q5 Is your practice owned by a hospital or health system?



Administrator Respondent Free Answers

Please use the space below to provide any additional information regarding you or your staff's experience with prior authorization and/or suggestions for how health plans' prior authorization programs could be improved.

- 1. Providers are at the mercy of the payer timelines for processing authorizations. 2. Payers utilize different third-party vendors for different services, have to navigate multiple different systems for the same payer depending on service. 3. The same payer has different authorization guidelines depending on plan type. 4. There should be one universal list for all plan types for one payer. 5. Dissatisfaction is disproportionate to the personal burden. Providers and staff have moral outrage & frustration related to bureaucracy & insurances inhibiting & restricting care. 6. Each insurance has different requirements. It can be very time-consuming to locate/research these, locate forms, decide to complete online or on paper, and turn-around times can be up to 14 days. This delays patient care when someone is in pain, uncomfortable, or just needs medication - 14 days can feel like a lifetime. 7. Immense amount of rework to investigate why services were denied, provide additional information, and hope for an override so it doesn't go to a peer to peer with provider
- a big improvement would be if secondary insurances to medicare would say upfront whether or not they follow the guidelines of medicare, otherwise we have to go through the entire process of obtaining a PA only to find out that the insurance DOES follow the guidelines of medicare. Additionally, if PA requests for medication said upfront what medication IS covered as an alternative.
- Any reduction in need for prior authorizations should be extended to specialty offices as well. Limiting this to primary care creates extra work and will contribute to burnout for primary care providers. PCP's utilize specialists when a workup and diagnosis are beyond their knowledge and experience. Also, this will have an impact on primary care access for patients if the additional work of ordering more tests occur.
- As a Sleep Medicine clinic, we navigate a small volume of complex medication prior authorizations. The largest volume of PA needs surround the provision of DME and getting the approval for diagnostic study. This process bridges third party vendors in the community and is one of the most challenging and arduous tasks in our clinic. It is a drain on clinical and clerical resources and often has little bearing on the clinical direction. We unfortunately commit multiple FTEs to ensure documentation and paperwork are in line with current guidelines.
- Eliminate Prior Authorizations all together. Patient's need medications and supplies for a reason.
- I think the rate of medications or services not being covered and requiring a PA has increased significantly. Clinical notes and records are no longer efficient for approval and often PA are denied now more than ever. It creates double the work trying to fight with insurances when the clinical history meets the standards of these drugs we want covered.
- I wish there were less insurances that require a PA for gastro procedures.
- I'm a nurse in pediatric nephrology. The PA process causes delays in patient care and significant stress for families and clinic staff. Insurance companies need to trust our specialized pediatric doctors who know what is best for their patients. Fighting insurance consumes RN and MD time increasing burnout. For patients with lifetime diagnosis, we must restart the fight for approval every year (or more). Parents may have to pay out of

pocket when waiting for a PA, which is often not feasible so a child may go without. The PA process is incredibly frustrating.

- If you do a peer to peer review it is almost always approved, so all the work leading up to it is a waste of time.
- INS's being more lenient, and read providers notes more thoroughly.
- It is very time consuming and the impact on patient care is huge as they don't receive the medication or medical test they need in a timely fashion.
- It should be as easy as looking at the back of an insurance card to see what patients pharmacy benefit manages are. Specified plans if applicable, so that preferred medications are easily located. 1/4 of the time the provider would choose an alternative if that information was easily accessible. The appeal process takes a significant amount of time, even when marked as urgent. Insurances will state it can take up to 7 business days. That's too long for some of these medications.
- I've lost 3 nurses in 2 years that said the main reason they were quitting was because of prior authorizations and the burden and frustration and moral injury they are causing to staff and ultimately patient care.
- Lots of time spent processing, submitting, resubmitting and speaking to customer service representatives weekly regarding prior authorizations. Lots of time spent being sent from one company to another and back because insurance companies do not process PA's themselves most of the time it is sourced out. I have been transferred many times from one department to another to only be told that I have to call another number. STREAMLINE THE PROCESS! Cover my meds is great but it does not always work with every insurance company. It would also be great to have a program similar to cover my meds for procedures such as MRI's.
- More availability to do prior authorizations online rather than the phone, Prior authorizations are hard to determine if they are needed and pharmacies are saying Prior authorizations are needed when in fact they are not. Insurance companies to utilize updated technology to communicate with the goal to increase notifications and efficiencies.
- Much time spent on hold on the phone with insurance companies, transferred multiple times throughout the company at times provided with conflicting information. At times they will auto disconnect your phone call as " no one is available to take this call please call back goodbye" On line portals difficult to access, passwords expire and accounts locked difficult to access and then you have to rely on the phone again. Many PA's take 7-10 days to process and our device surgical cases are very time sensitive and stressful to obtain PA in time. Staff has learned the process by trial and error, really no education or guidance from anywhere. Not sure which companies require PA is it primary or secondary insurance. It can be a very challenging part of the job. Have patients urgently ready for case and cannot get the PA in time and have to reschedule cases.
- My personal experience with the medical prior authorizations typically takes approximately half of each work day, if not longer. Increases in difficulty to obtain authorizations, find where to obtain authorizations through, and time spent waiting on hold for insurances (sometimes 4+ hours) that are only available by phone is a significant time constraint on my position. I have additional tasks to complete outside of prior authorizations, and at times can spend hours per day on one authorization due to the above mentioned hindrances. These ultimately lead to delay in patient care.
- Number 9 would not let me put in a number over two digits. I was trying to enter 110 hours, but it would only let me go as high as 99
- Obtaining prior authorizations for procedures, labs and medications delays patient care which in turn increases patient anxiety and unhappiness with the medical establishment.

An unreasonable burden is placed on nursing and support staff who must take time away from patient care to work on PA's. Providers are increasingly being dictated to by insurance companies on how medical care is provided. Vermont is a rural state. Many of our patients can drive 1 or more hours to receive care in our clinic. If a service that a provide recommends for a patient requires a PA, then the patient must return another day, necessitating a return trip to the clinic. If a PA is denied, provider is required to schedule a peer to peer with insurance company to get an over-ride, necessitating provider blocking time in their schedule that could otherwise be spent on patient care. Bottom line: obtaining PA's impacts the time that providers have to provide patient care. It is a frustrating process.

- on hold wait times provide increased challenges
- Our authorization team, which consists of two people, obtains all of our Cardiac Testing prior authorizations. We have seen a significant increase in these tests being denied by insurance companies and peer to peer reviews with the ordering Provider required in order to obtain an authorization for the test. This in turn adds more to the Providers, but also patient care being delayed.
- Our office needs to PA every surgical procedure and MRI testing. We have had an increase in surgeries and scans over the past 2 years leading to more time working with payers for PA's. We also on occasion need a PA just for the patient to be seen and need the PCP help to get this done quickly so their care is not held up.
- Our team of 5 pediatric pulmonary physicians have a team of nurses helping with medication authorizations, and the docs can also enter therapy plans for some patients. Our nurses say 20% of their 40 hour a week job is devoted to this task and following up. We also have a centralized PA team who actually works the referrals but they are not included in my FTES.
- Over the last 5 years the number of forms, preferred meds, clinical backup, alternate medical service and general hoops that have had to be through to allow a patient to obtain a service or maintain a medication that they have been on for more than a year have been outrageous. Patients are suffering both in their continuity of care and financially because insurance companies are trying to save a dollar. I have had patients forgo tests or medication due to cost because they did not feel comfortable changing therapy or have already done everything that their current insurance required previously. It's sad to think that these people pay significantly for their health insurance and still can't get the help they need to be healthy.
- PA's mostly slow down patients getting the medications they need. It is especially hard for patients in pain and on palliative care to have to wait days for their medications. They don't understand insurance rules so they keep calling the office which is more work and stress for the staff. Fewer PA rules around medications for pain and cancer would be huge! Having to rewrite medications because of PA's is annoying, wastes time and is unpredictable for providers. question #10 should be .125 but it wouldn't let me put in less than 1.
- Prior authorizations continue to get more payers to them, making them very cumbersome. Additionally, many denials result from insurers saying no auth is required when it's not a covered benefit or we are out of network, so the service is provided on the information that no auth is needed only to find afterward that 'no auth required' meant that no auth was possible and the claims are denied.
- Staff are spending too much time on the phone trying to get information needed and it impacts the entire team as it takes them away from their other duties. The best plan would be simplifying the process in general and dedicate a specific team to solely take care of PA.

- Staff, providers, and patients are constantly frustrated by the burden of medication PAs. Whether a med needs a PA or not is often unclear. Patients will call their insurance and get a different answer than we do when we send the Rx in and get the response- the same across with acceptable alternatives. If our 1.0 FTE did not have to focus on med PAs as much as they do, we could utilize her help in so many other ways. Peer to peer reviews with providers always seem unnecessary and like an absolute waste of provider time. VT has agreed to medical service PAs for a certain population, but this is not the burden we are dealing with and don't think it will have much impact on providers, staff, or even patients.
- Standardization across payers in terms of the resource, preferably via website rather than phone/fax, would be ideal. There is opportunity by specific payer to improve response time, as well as the response itself. It is not unusual to receive contradictory responses between a website or phone call for the same payer. Some payers provide a disclaimer stating they have up to 14 business days to respond to a prior authorization request and often a response is not received until day 14. All of this greatly impacts timely processing of prior authorization requests and, ultimately, delays patient care.
- the overall PA requirements have increased dramatically prior to and all through covid when we were terribly short staffed. We are still short staffed. Private practices do not have the funds available to hire numerous extra staff to do this work, so we have to try to fit it in, in between so many other tasks. This affects patient response time, patient care and overall staff burnout. I often hear my nurses stating they were on a call related to a PA that was over 30 minutes. My referral staff are completely burnt out and overwhelmed. We used to only have one referral person and now we have 2 plus another part time to help close the loop. This is essentially because of the excessive wait time to get in to be seen by specialists, and the ongoing issues associated with excessive PA requirements.
- The process of obtaining PA's is long, extensive and stressful for our staff. Between completing the necessary patient/clinical information, providing the clinical documentation and chasing down the status of the PA for the actual approval/denial it can be exhausting at times. There is often little to no information provided from insurance companies once the PA has been submitted therefore you wait and hope for the best. Lengthy wait/call times and being bounced from call rep to call rep to check on the status is not efficient and often not effective. The entire process from start to finish is often NOT done in the timely fashion needed for providing care to our patients who are under very specific time constraints given their reproductive age as many services are not considered eligible for 'urgent review'. From an overall practice management & patient experience level, it's hard to understand why PA's are necessary. If coverage is provided on the plan, why require a PA at all? The provider knows the patient and their history the best, therefore why do we leave it up to an uninvolved 'clinical reviewer' hired by an insurance plan to review whether a medicine or service is sufficient for the patients WE are caring for? Removing the PA requirement all together would save everyone time, headaches and most importantly avoid delays for the patient. Perhaps look at only requiring a PA for out-of-network services as this alone would cut down on a large percentage of service PA requests. These are exhausting for staff to complete and, as mentioned, most times required when the patient has appropriate coverage outlined on their plan. Completing PA's is costly on our clinic between trying to hire/maintain staff that want to complete PA's and the staff hours and resources spent completing them… the list goes on! Any improvement to this process is greatly appreciated by our entire team and the patients we serve!
- The processes are cumbersome and wait times on hold can consume hours. Having to pull providers out of clinic for peer-to-peer impacts access to care and a positive patient

experience. Peer to peer are done on the vendors timeline and are often last minute. Patients are left with added anxiety and stuck in the middle.

- The question about # FTE it takes for prescription and service PA would not allow a partial FTE. Our nurses probably spend 5-10 hours a week working on PA for medications and probably around 1 hour a week working on PA for procedures. PA for procedures, like MRI and CT have reduced greatly. PA for medications especially inhalers have increased greatly.
- time consuming, complicated, frustrating for staff and patients
- When service ends up approved why take the time to go through the process. How can this be automated by procedure and diagnosis. If all payers were required to have the same edits in claims processing, then the rules would be the same. It's the level of payer differences and third party administrators that make the process very complicated. One patient, you could have to go to 3 different portals to obtain authorization: one portal for radiology, one for infusion and one for the inpatient stay because the payer has hired 3rd party administrator by service level.