

# ***Identifying How Prior Authorization Impacts Treatment of Underserved and Minority Patients***



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Prior Authorization Work Group

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## Executive Summary

Underserved and minority patients face unique challenges to cardiovascular care and treatment that impact their health outcomes. The ability to access new treatments is often hampered by utilization management processes that are put in place by insurers in an effort to make sure that these treatments are only approved for appropriate patients. In particular, the need for prior authorization (PA) – the approval from an insurer that may be required before patients receive a device, intervention, or medical treatment to be covered by that insurer – for specific drugs focused on cardiovascular care has been a barrier to treatment and a burdensome process for physicians and other providers. Representatives from ABC, in conjunction with a multisector group of experts<sup>1</sup>, hypothesized that lower resource levels at cardiology practices with a majority of patients from underserved and minority populations may pose a unique barrier to responding to PA needs for these patients, further fostering existing treatment disparities.

The objective of this white paper is to present survey data that sheds more light on this hypothesis. The results suggest that the heavy PA burden on physician practices impacts the access to newer medications, and enhances the unintended consequences of PA on underserved and minority patients.

## Introduction

Cardiovascular disease (CVD) is the leading cause of death among both black and white adults in the US and this continues despite the declining rate of CVD mortality over the last 50 years.<sup>2</sup> This decline has been consistent across all racial and ethnic groups and improvement in the quality of cardiovascular care has led to a tightening in the gap between white and black patients on some CVD clinical outcomes, particularly the rates of death attributable to CVD.

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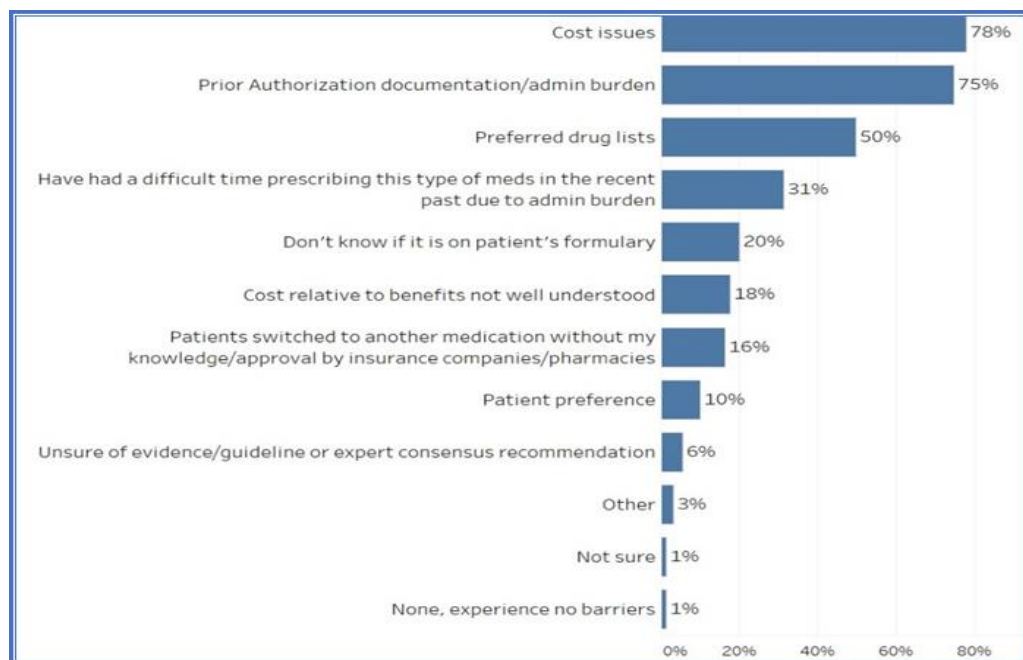
<sup>1</sup>Association of Black Cardiologists Roundtable: Improving Health Care Access for Minority and High-Risk Populations. Meeting held November 11, 2016.

<sup>2</sup>Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2015 on CDC WONDER Online Database, released December 2016.

Although there has been progress, significant disparities continue to exist when comparing the health status of black individuals to whites. A continued divergence in life expectancy between black and white patients can be largely attributed to cardiovascular-related mortality.<sup>3,4</sup> When recognizing the changing demographics in the US, this is an important consideration. The Census Bureau reports that close to 38 percent of the current population belongs to minority groups, and census data project that minority populations will continue to grow and predominate by 2045.<sup>5</sup> It is increasingly critical to focus delivery of care to these populations with CVD.

Within the current cardiovascular environment, an issue that has far-reaching implications for health care providers and their patients is access to care. Research has suggested that access can be impacted by a variety of factors, including insurance status, cost of treatments, patient fees, drug costs, therapy selection, and social determinants of health. Innovative treatments have the potential to address the persistency of CVD as the leading contributor to mortality. Data indicate that barriers to new medications continue to be prevalent for all patients.

A survey conducted by the Association of Black Cardiologists (ABC) and the American College of Cardiology (ACC) in February 2018 asked physicians about barriers encountered in



prescribing the newest evidence-based therapy for cardiovascular care.<sup>6</sup>

<sup>3</sup>Go AS Mozaffarian D Roger VL Benjamin EJ Berry JD Blaha MJ et al., Heart disease and stroke statistics—2014 update: a report from the American Heart Association. *Circulation*, 2014. 129(3): p. e28-e292.

<sup>4</sup>Macinko J Elo IT, Black-white differences in avoidable mortality in the USA, 1980–2005. *J Epidemiol Community Health*, 2009. 63(9): p. 715-21.

<sup>5</sup>Mozaffarian D Benjamin EJ Go AS Arnett DK Blaha MJ Cushman M et al., M Heart disease and stroke statistics—2015 update: a report from the American Heart Association. *Circulation*, 2015. 131(e29).

<sup>6</sup>American College of Cardiology. Eliminating Barriers and Reducing Disparities. January - February 2018 Survey.

Data from that survey show that almost all physicians (98%) experience a barrier when prescribing new evidence-based therapy, with the most prevalent being cost issues (78%) and prior authorization documentation/administrative burden (75%). These data are consistent with a previous survey conducted by ACC in 2016.<sup>7</sup>

When considering health care disparities within this context however, an outstanding question is whether certain groups of patients – underserved and minority patients – have a more difficult time accessing new or novel medications. From a health equity perspective, comparable health care and health outcomes will not be achieved as long as barriers to access exist for these groups of patients. These barriers may further limit treatment for groups that are already undertreated.

Using the recently approved medications for hyperlipidemia and heart failure as examples – proprotein convertase subtilisin/kexin type 9 (PCSK9 inhibitors) and angiotensin receptor-neprilysin inhibitor (ARNI) – the ABC Work Group has not found evidence in any published data that explored or confirmed a differential rate at which particular groups within the population have been rejected from receiving these medications.

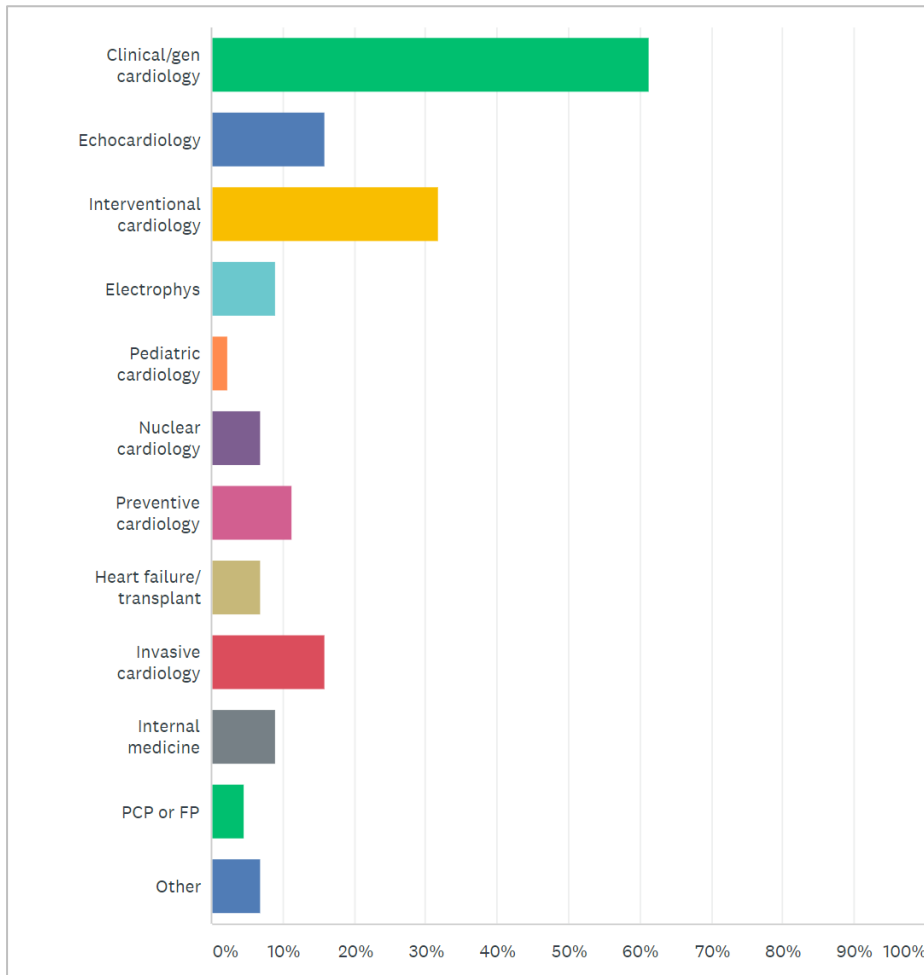
In response to this gap in data, the ABC Work Group hypothesized that lower resource levels at cardiology practices with large underserved and minority patient populations may result in unique barriers to responding to PA needs, thereby exacerbating treatment disparities for these populations. In order to close the gap in understanding the unintended consequences of PA, a survey was conducted in the second half of 2018 among physicians (cardiologists and others) who treat underserved and minority patients. The data presented below summarizes the responses of 44 physicians to a short online questionnaire administered online.

The responding physicians are members of the ABC or the ACC; the ACC physicians invited to participate practice in areas with a high proportion of underserved patients. A small number of qualitative interviews were also conducted to add further insight into the perspectives shared.

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<sup>7</sup>American College of Cardiology. Cardiologist Perceptions of Access to New Therapies. October 2016. CardioSurve.

## Sample Overview



The large majority of participating physicians are cardiologists; only a small proportion, about ten percent, are internal medicine, primary care or family physicians. Slightly over 60 percent of the participants classify themselves as Black/African American, about a quarter as White and seven percent Asian. In terms of practice ownership, half of the physicians work in physician-owned practices, about 30 percent

work in practices owned by medical schools/universities, and 20 percent work in hospital owned practices.

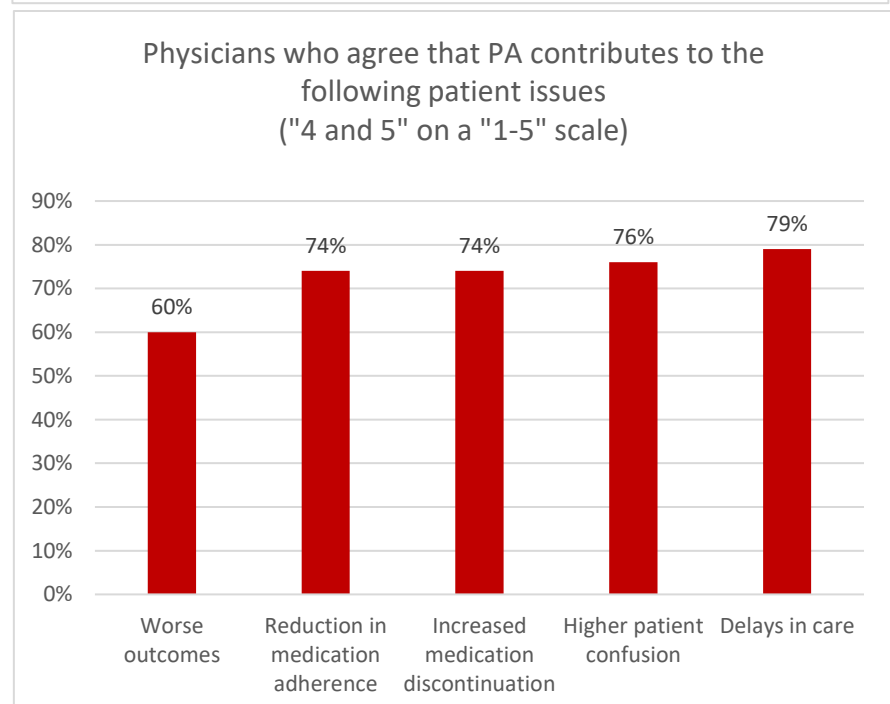
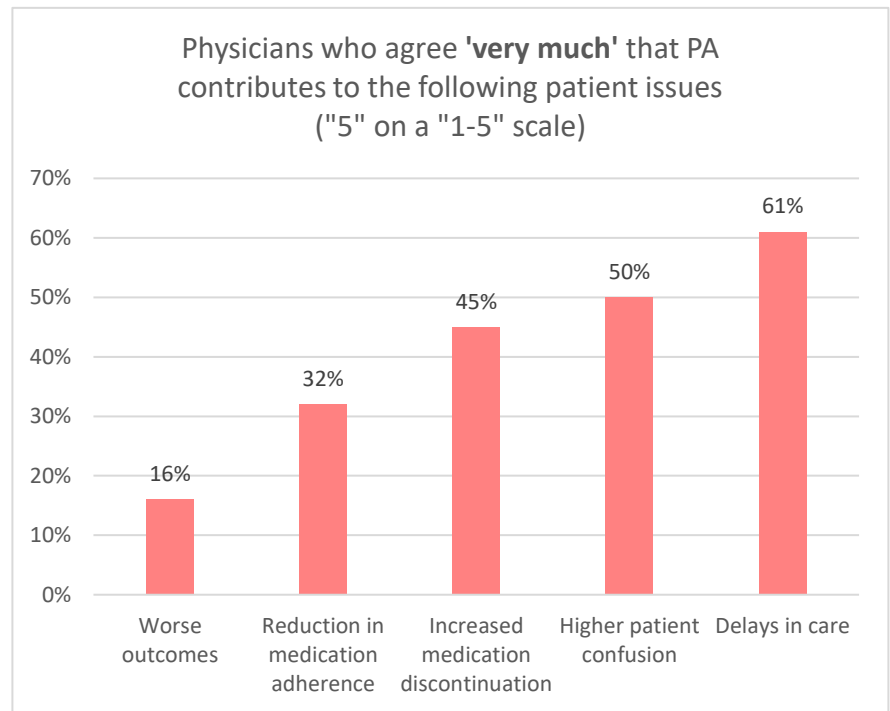
Since physicians in a range of practice settings are represented, the number of patients seen varies, with a median monthly patient load of about 300. The practices represented are not heavily resourced, likely related to the fact that over half of the practices are physician-owned, rather than part of a hospital or university. A little over half (57%) report that five or fewer registered nurses (RNs) or nurse practitioners (NPs) work on their staff. Similarly, about one-third (33%) of physicians say that five or fewer other staff members (for example, front desk staff or clerical staff) support their practices.

## Effect on Patients

Physicians were asked about the impact of the PA process on their minority patients; overall, a substantial impact was noted in a number of areas.

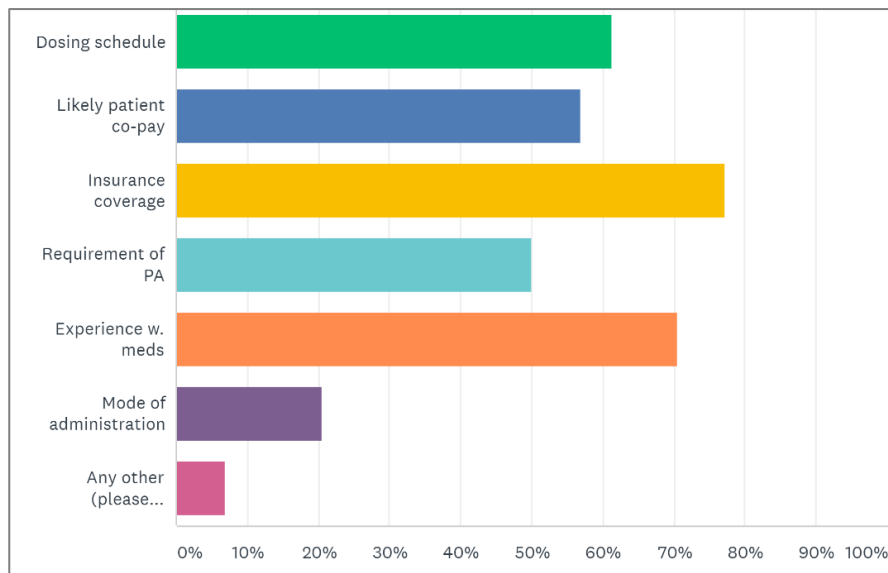
Using a "1-5" scale, where "1" means does not agree and "5" means very much agree, half or more of the physicians very much agree that PA contributes to delays in care and higher patient confusion. A substantial proportion very much agree that PA leads to increased medication discontinuation and a reduction in medication adherence.

Evaluating those physicians who agree that PA contributes to various patient issues (provide a "4" or "5" on the five point scale), these proportions increase substantially for all areas.



## Cardiovascular Care and the PA Process

Insurance coverage and experience/comfort with the medication are cited most frequently by the participating physicians as the non-clinical factors they consider when prescribing a



new cardiovascular medication to their minority patients (77% and 70%, respectively). Approximately half or more of the physicians think about dosing schedule (61%), likely patient co-pay (57%) and PA requirement (50%). To a much lesser extent, mode of administration is considered (20%).

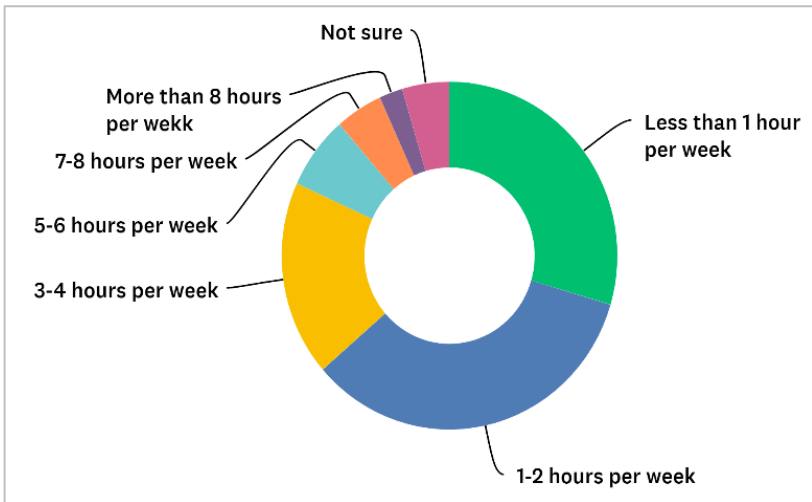
When asked how likely they are to prescribe new cardiovascular-related pharmacologic therapies (for example, an ARNI or PCSK9i) for patients who meet the evidence/guideline based indication for the condition, over three-quarters (77%) say they are likely to do so. However, 40 percent of the participating physicians feel that obtaining these newer drugs is difficult; in contrast, less than a quarter (23%) say these drugs are easy to obtain.

The perspective that these medications are difficult to get may be linked to the number of hours physicians estimate is spent on the PA process, either by themselves or others in their practice. Although physicians' time appears to be fairly limited (64% typically devote two hours or less per week), the majority (52%) describe this burden as high or extremely high.

The number of hours spent on PA by other individuals in the practice, whether nursing or administrative staff, is far higher.



**Time physicians typically spend on PA process**

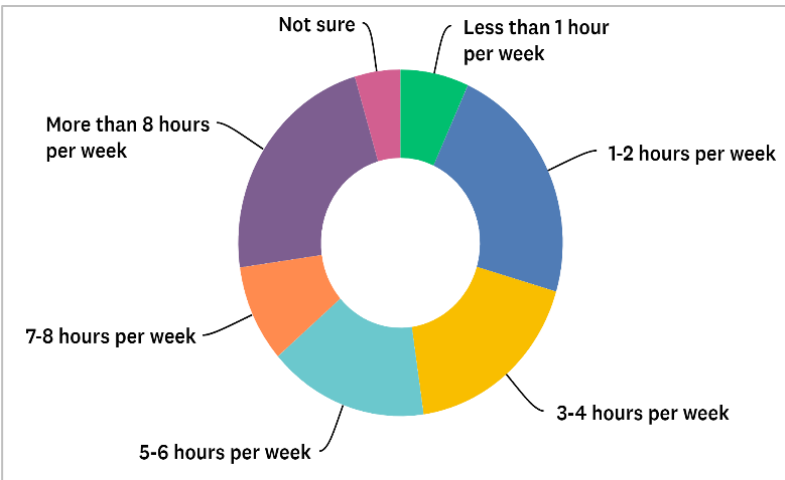


Typically, registered nurses and/or office staff provide support for PAs (52% and 55% respectively), and physicians are equally divided between those who have a staff member or members who work exclusively on PAs.

In terms of time devoted to PA, about half of physicians (47%) note the staff spends five hours or more per week, and a third (32%) say their staff spends seven or more hours a week. This time also includes appeals, since about sixty percent of physicians (61%) submit an appeal if a PA is rejected.

The burden on practice staff is considered high or extremely high by a majority of physicians (57%).

**Time others typically spend on PA process**



To support the ability to respond to required PAs, a little over 50 percent of physicians are currently utilizing tools or resources in order to help reduce the administrative burden of prior authorization; these include universal PA forms, sample appeal letters, and manufacturer-created web-based tools. Most of these physicians indicate that using these resources is not very expensive – they are perceived to have minimal financial impact on the budget of their practice.

Those physicians not using any tools or resources to assist with the administrative burden of PAs indicate they are just not aware that specific tools or resources are available.

Physicians were asked to comment on what other ways the PA process **negatively** impacts their underserved and minority patients. Responses included:

- Requires too much physician and staff time, leaving less time for direct patient care

*“Takes valuable time away from my patients.”*

- Restricts/discourages use of guideline recommended therapies

*“Deprives patient the benefit of modern advances and benefits that could be derived from new discoveries.”*

- Causes patients to lose faith in the system and/or their physician

*“Patients get discouraged when they are not able to receive the medications their doctors initially prescribe for them. They lose faith in the system and feel rejected.”*

*“Causes patient anger towards physician, not insurance company.”*

- Causes patients to lose faith in recommended therapies

*“They [patients] are likely to be less compliant with the secondary medications they receive because of the perception that it is not the first medication the doctor chose for them.”*

*“The process can erode faith and trust in indicated therapies making adherence much more difficult even when medication is approved.”*

- Burdens and stigma directly related to minorities are mentioned by a few

*“It creates a fear in the patient that they cannot afford or they do not deserve the medical care dictated by physicians.”*

*“It doesn’t consider the many burdens faced by the underserved and contributes to maintenance of discrimination.”*

*“Reinforces stigma for access to care issues for minorities.”*

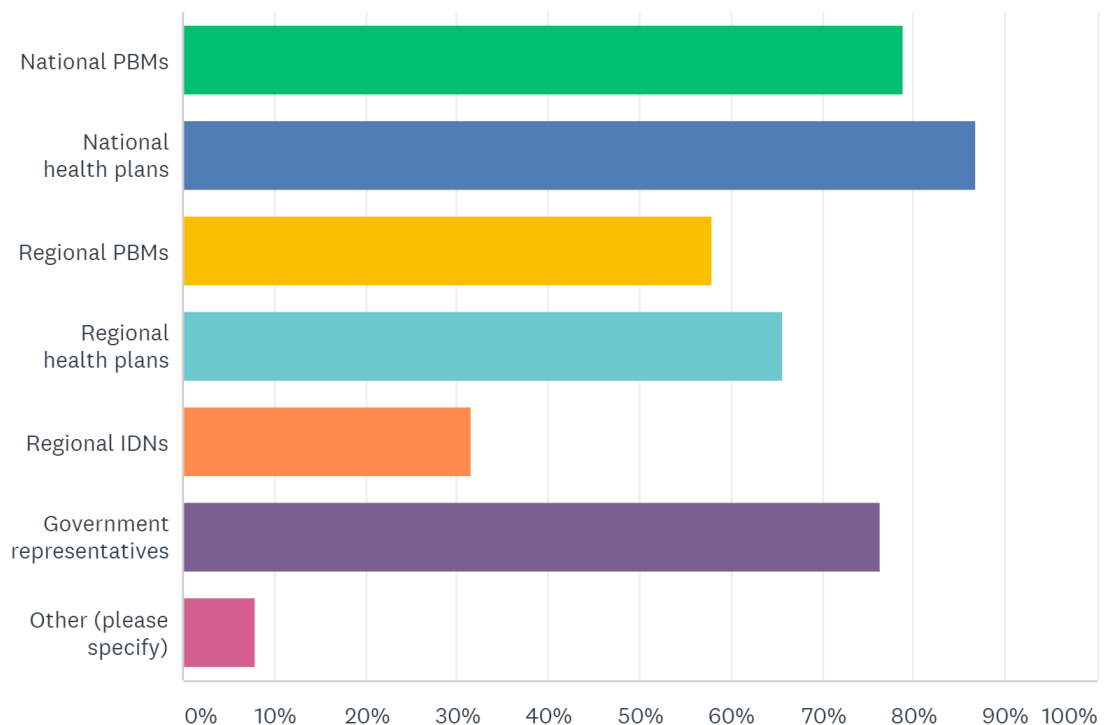
When asked in what ways the PA process **positively** impacts their underserved and minority patients, a handful of physicians noted that it ensures appropriate use of medication. Most physicians were unable to provide a response.

## Provider-Payer Collaborative Meeting

A recent article from the Journal of Managed Care & Specialty Pharmacy (JMCP) concluded that, “formulary coverage decisions may have unintended consequences on patient and payer outcomes despite lower drug utilization and pharmacy cost savings.”<sup>8</sup> Thinking specifically about their underserved and minority patients, close to three-quarters (74%) of participating physicians agreed with this statement.

With this as a backdrop, the concept of a provider-payer collaborative meeting was introduced to the respondents. When asked how compelling they felt the concept was of bringing together providers and payers in order to engage in conversations about shared challenges facing underserved and minority patients, close to two-thirds (63%) indicated they found this idea compelling.

A wide range of payer groups were recommended as representatives at the meeting, most notably, national PBMs, health plans, and government representatives.



<sup>8</sup>Park Y Raza S, The effect of formulary restrictions on patient and payer outcomes: a systematic literature review. J Manag Care Spec Pharm, 2017. 23(8):p. 893-901.

Topics or solutions related to access to treatment that would affect underserved and minority patients thought to be valuable to discuss at this meeting included:

Focus on costs:

- Ways to reduce costs for new/valuable medications
- Pharmacoeconomics of treatment and non-treatment of chronic illness in minority communities
- Reducing co-pays, improving patient assistance programs and patient education programs

Focus on PA process:

- Ways to streamline the PA process to avoid negative impact on patient medication use or adherence
- Easing speed of approvals for appropriate patients for new therapies
- Eliminating PAs for guideline-directed therapies

*“The amount of time and human resources involved in the PA process disproportionately affects practices that operate on tight financial margins. Losing the opportunity to provide appropriate guideline directed therapy to patients at highest risk increases the number of unnecessary hospitalizations and procedures.” – Participating Cardiologist*

## Conclusion/Call to Action

The ABC is committed to reducing the cardiovascular disease disparity gap by 20% by 2025. In order to meet this aggressive goal, the ABC highlights factors that contribute to health disparities and develops solutions-oriented programming. Addressing prior authorization and the unintended consequences of this process on underserved and minority patients has been an area of ongoing focus. The ABC recognizes that closing the disparity gap also requires including underserved populations in clinical trials to determine the impact of treatments, and a commitment to making medications accessible on all insurance lines. These are additional areas of focus for the organization.

Physicians who participated in this survey provided a number of comments that underscore the importance of access and progressing a collaborative relationship between providers and payers.

- *“Treatment, in general, is being controlled and restricted by third party payers.”*
- *“The system imposes hardship on individuals who already have their hands full meeting their basic day-to-day needs.”*
- *“There is a need to provide easy and affordable access to guideline directed medical therapy for all patients; this will improve adherence.”*
- *“This [PA] negatively affects my ability to care for my patients which impacts their lives.”*
- *“Strict focus on cost and [over] utilization has been associated with increased mortality for vulnerable patients.”*
- *“Access to treatment directly impacts survival.”*
- *“Any additional barrier leads to a greater occurrence of disparity in an already at-risk population.”*
- *“Maintenance of health and management of disease are holistic and longitudinal processes. Leveraging resources to achieve those goals serves the best interest of payers, providers and patients.”*
- *“Empower the downtrodden to power the process.”*

The ABC Work Group asks that a priority be placed on contributing to the discussion on access to care by reducing the PA burden; specifically, supporting a program that brings together providers and payers to address PA and the disparities that result from limited resources in practices that serve minority patients.

## About the Association of Black Cardiologists

The Association of Black Cardiologists (ABC) is a nonprofit organization with an international membership of over 1,700 health professionals, community health advocates, corporate and institutional members, all dedicated to eliminating the disparities related to cardiovascular disease in all people of color. The association's aggressive goal is to reduce the cardiovascular disease disparity gap by 20% by 2025.

To begin addressing the critical issue of access, ABC convened thought leaders for the *Improving Health Care Access for Minority and High-Risk Populations Roundtable*. This unique Roundtable consisted of experts in various key cardiovascular areas, as well as from an array of health care sectors. Roundtable participants discussed barriers and then identified consensus-driven solutions that can enhance access and positively impact minority and high-risk populations; one such solution was to standardize and centralize the prior authorization process. The Roundtable was conducted in November of 2016.



Work Group comprising members from multiple sectors began meeting to advance the program ideas recommended in support of standardizing and centralizing the prior authorization process in late spring 2017. A number of activities were outlined that include:

- |   |   |
|---|---|
| 1 | White paper to identify the gap in literature and understanding regarding the hypothesis that lower resource levels at cardiology practices with large underserved and minority patient populations may pose a unique barrier to responding to PA needs for these populations, further fostering existing treatment disparities. This has been completed and can be found at <a href="http://www.abccardio.org">www.abccardio.org</a> |
| 2 | Survey to fill the gaps in information related to the above. This white paper summarizes the survey findings.   |
| 3 | Regional meetings to bring together physicians and payers to discuss the challenges and potential solutions. Physician feedback through the survey data indicates regional meetings are a compelling and valuable idea.   |

This white paper is supported by the ABC leadership:

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More information about the ABC Access to Care Initiative, the Prior Authorization Work Group, and the other access solutions in development can be found on the ABC website: <http://abc cardio.org/advocacy/abc-access-initiative/>

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