Perceived burden and impact of prior authorization on urology practices and clinical outcomes

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High health costs in the United States prompted health insurance companies to turn to prior authorization (PA) to reduce costs. While useful from a cost-benefit analysis, these policies create disproportionate barriers to access and timely, patient-centered treatment. This study utilizes the American Urological Association (AUA) Census 2023, in which urologists nationally were questioned regarding the impact of PA on their practice

OBJECTIVES

- Detail the impact of prior authorization in urology
- Highlight steps to reduce delays and barriers to care

METHODS

- Cohort study surveying urologists across the United States
- Data collected using the AUA Census 2023
- Statistical analysis was performed using SPSS Statistics (29.0.2.0)
- Descriptive data were analyzed using 2-sided chi-squared tests
- Multivariate regression analysis was then performed with a significance threshold of $p<0.05$

RESULTS

- 14,716 responses collected
- Frequency of insurer representatives having experiences in their specialty or working in their specialty was statistically significantly less frequent based on ownership in practice ($p<0.002$)
- Receipt of prior authorization taking more than 7 days was statistically shown to correlate to subspecialty ($p<0.008$), employment status ($p<0.044$), and work setting ($p<0.031$)
- Whether clinical outcomes are affected by treatments requiring PA, there was a statistically significant difference regarding age ($p<0.008$) and practice ownership ($p<0.039$), with those <54 years old and those having some form of practice ownership, feeling treatments were extremely affected

How do you believe clinical outcomes are affected by treatments that require prior authorization?

	Odds ratio for "They are extremely affected"	P value
Age		**0.008**
Over 65 years old	Reference	
< 45	1.960	0.007
45 to 54 years old	1.771	0.023
55 to 64 years old	1.035	0.886
Gender		0.734
Male	Reference	
Female	1.080	0.734
RUCA Classification		0.903
Non-Metropolitan	Reference	
Metropolitan	0.967	0.903
Primary Subspecialty Area		0.627
Others	Reference	
General without subspecialty	0.813	0.351
Oncology	0.850	0.563
Employment Status		**0.039**
I am employed by others	Reference	
I am the sole owner of my practice/I am a partner in my practice/A	1.566	0.039
Work Setting		0.961
Other Settings	Reference	
Private Practices	1.177	0.595
Academic Medical Centers/Medical S	1.085	0.793
Public and Private Hospitals	1.094	0.801
AUA Section		0.727
Western	Reference	
Mid-Atlantic	0.937	0.841
New England	1.202	0.686
New York	0.560	0.160
North Central	0.949	0.843
Northeastern	0.684	0.475
South Central	0.952	0.856
Southeastern	1.202	0.471
Encounters in a typical week Grouped		0.611
101 or more	Reference	
≤101	0.890	0.611

When you are required to conduct a peer-to-peer consultation for prior authorization, how often is the insurer's representative in the same/similar specialty or have experience with your particular specialty and the services you perform and/or medications you prescribe?

	Odds ratio for "Rarely/Never"	Pvalue
Age		**<.001**
Over 65 years old	Reference	
< 45	3.791	<.001
45 to 54 years old	2.984	<.001
55 to 64 years old	2.531	0.001
Gender		0.606
Male	Reference	
Female	0.854	0.606
RUCA Classification		0.245
Non-Metropolitan	Reference	
Metropolitan	1.467	0.245
Primary Subspecialty Area		0.392
Others	Reference	
General without subspecialty	0.773	0.329
Oncology	1.239	0.561
Employment Status		0.615
I am employed by others	Reference	
I am the sole owner of my practice/I am a partner in my practice/A Combination	0.878	0.615
Work Setting		0.312
Other Settings	Reference	
Private Practices	1.562	0.226
Academic Medical Centers/Medical Scho	1.217	0.604
Public and Private Hospitals	2.417	0.077
AUA Section		0.430
Western	Reference	
Mid-Atlantic	0.620	0.283
New England	0.541	0.163
New York	0.354	0.024
North Central	0.481	0.034
Northeastern	0.524	0.213
South Central	0.563	0.133
Southeastern	0.656	0.223
Encounters in a typical week Grouped		0.458
101 or more	Reference	
≤101	1.204	0.458

CONCLUSIONS

- PA can cause harm to patients and places overwhelming burden on clinicians
- Study shows clinicians feel PA has significant impact on our ability to provide treatment to patients
- Various groups have proposed changes to the PA process to help minimize the burden placed on clinicians and assist in access to care
- Changes are time-sensitive and must be prioritized

REFERENCES

1. Yang E, Yang S. Prior Authorization. *JACC Case Rep*. 2020;2(10):1466-1469. doi:10.1016/j.jaccas.2020.05.095
2. Warnock N. Prior Authorization: Process Redesign with a Focus on Value-Based Care. *Population Health Management*. 2023;26(S1):S-21. doi:10.1089/pop.2023.0146
3. Miller AP, Shor R, Waites T, Wilson BH. Prior Authorization Reform for Better Patient Care. *Journal of the American College of Cardiology*. 2018;71(17):1937-1939. doi:10.1016/j.jacc.2018.03.465
4. Malay DS. Prior Authorization and the Cost of Health Care. *The Journal of Foot and Ankle Surgery*. 2019;58(2):201-202. doi:10.1053/j.jfas.2019.01.008
5. Sharma SP, Russo A, Deering T, Fisher J, Lakkireddy D. Prior Authorization. *JACC: Clinical Electrophysiology*. 2020;6(6):747-750. doi:10.1016/j.jacep.2020.04.022
6. Smith AJB, Mulugeta-Gordon L, Pena D, et al. Prior authorization in gynecologic oncology: An analysis of clinical impact. *Gynecologic Oncology*. 2022;167(3):519-522. doi:10.1016/j.ygyno.2022.10.002
7. Marble KY, Briggs GR, Gordy XZ. Improvements for the Prior Authorization Process for Elective Surgical Procedures at an Academic Medical Center. *Perspect Health Inf Manag*. 2022;19(1):1l.

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