

March 4, 2020

Demetrios Kouzoukas
Principal Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Blvd Baltimore, MD 21244

RE: 2021 Medicare Advantage and Part D Advance Notice, Part II

Dear Mr. Kouzoukas:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations (including more than 90 of which offer health plans), our clinician partners – including 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on Part II of the Medicare Advantage (MA) and Part D Advance Notice. In particular, the AHA appreciates the Centers for Medicare & Medicaid Services' (CMS) ongoing efforts to solicit stakeholder feedback on how to improve the MA Star Ratings Program, and we encourage the agency to develop and incorporate into that program measures related to prior authorization.

PRIOR AUTHORIZATION

Prior authorization is a health plan utilization management tool that requires providers to solicit approval from a patient's health plan to proceed with scheduling a service. Health plans evaluate whether the service is covered by the patient's plan and is medically necessary. Approval of a prior authorization request does not guarantee payment for the service. Prior authorization has traditionally been used to ensure appropriate use of new or high cost diagnostics and therapies.

When instituted appropriately, prior authorization can help align patient care with health plan benefits and facilitates compliance with clinical best practices. However, prior authorization requirements and processes vary widely, even among different health plan products offered by the same issuer, and can create dangerous delays in care delivery when not applied appropriately. They also can create confusion and burden for both



patients and providers, leading to additional administrative costs for the health care system.

The MA Star Ratings Program provides a useful mechanism to monitor the impact of prior authorization processes on patients, and we encourage CMS to develop a prior authorization measure that accounts for the following elements:

- **Average time for a response:** Uncertainty as to whether the care recommended by your physician can be received, and if so, when it can be, is extremely stressful for patients. For a provider, having to delay treatment until a health plan makes a prior authorization determination can be an administrative hassle, and more importantly, can potentially lead to worsening patient health outcomes. According to a 2018 American Medical Association survey, 91% of physicians report that prior authorization has led to a delay in patient access to care. In order to minimize care delays caused by prior authorization and increase predictability of decision-making, health plans should be required to respond to prior authorizations in a timely manner. **MA Star Ratings should measure the average time from submission of a complete prior authorization request until the health plan decision is transmitted back, with expectations being that the average time is no more than 48 hours for non-urgent care procedures and 24 hours for urgent care.**
- **Approval rates/denial rates:** While the goals of ensuring appropriate care and prudent allocation of resources are valuable objectives for health plans, the prior authorization process is inherently burdensome and can result in care delays. As a result, prior authorization plans should be used judiciously. **Accordingly, CMS should measure the approval rates for prior authorizations by services and set a standard for when a service should be “retired” from prior authorization requirements, such as when requests for such a service are routinely approved more than 90% of the time.** In such instances, health plans should pursue alternative means of identifying and addressing outlier physicians that do not burden the more than 90% of physicians adhering to clinical criteria.
- **Appeal overturn rate:** When health plans improperly deny prior authorizations for medically appropriate drugs or procedures, a patient care plan is disrupted and their health is jeopardized. Unfortunately, hospitals and health care providers frequently experience situations where a clearly medically necessary service is denied. The Department of Health and Human Services Office of Inspector General issued a September 2018 audit report detailing the routine denial of prior authorization for medically necessary care among MA plans. It found that approximately 75% of beneficiary and provider appeals of MA plan denials were successful. **To help protect patients from being inappropriately denied access to necessary medical care, CMS should measure the rate at which appeals for denied care are successful and establish a threshold over which a plan is determined to have an excessive denial rate.**

The AHA appreciates your consideration of these recommendations. We look forward to continued engagement with CMS to ensure that the MA program works for patients and the providers who care for them. Please contact me if you have questions or feel free to have a member of your team contact Terrence Cunningham, director of administrative simplification policy, at tcunningham@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development