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Advancing Health in America

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October 18, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445–G
Washington, DC 20201

Re: Medicare Advantage prior authorization and medical necessity determinations

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations and our clinician partners – including more than 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) writes to offer our recommendations on how the Centers for Medicare & Medicaid Services (CMS) should revise and reissue recent proposed regulations streamlining prior authorization to ensure benefits extend to patients enrolled in Medicare Advantage; consider additional regulations to limit care delays; and conduct oversight and enforcement for plans who have demonstrated problematic prior authorization usage in the past.

Background

Prior authorization is a process whereby a provider, on behalf of a patient, requests approval from the patient's insurer before delivering a treatment or service. Although initially designed to help ensure patients receive optimal care based on well-established evidence of efficacy and safety, many health plans apply prior authorization requirements in ways that create dangerous delays in care, contribute to clinician burnout and drive up costs for the health care system. One of the most frustrating aspects for providers and patients is the variation in prior authorization submission processes. Plans vary widely on accepted methods of prior authorization requests and supporting documentation submission. For each plan, providers and their staff must ensure they are following the right rules and processes, which may change from one request to the next.

Revise and Finalize Proposed Rule
As a result of the administrative and clinical difficulties caused by inefficient prior authorization processes, hospitals and other providers were pleased that CMS took action to streamline prior authorization through the Reducing Provider and Patient Burden by Improving Prior Authorization Processes and the Promoting Patients' Electronic Access to Health Information notice of proposed rulemaking (NPRM) released in December 2020. If finalized, the regulation would create a standardized method to identify whether a procedure was subject to prior authorization, submit prior authorization and supporting documentation, and receive a determination from the health plan. Additionally, the regulation recognized the need to reduce the amount of time that prior authorizations take to process.

The proposed rule would place new requirements on Medicaid and Children's Health Insurance Program (CHIP) managed care plans, state Medicaid and CHIP fee-for-service programs, and Qualified Health Plan (QHP) issuers on the Federally-facilitated Exchanges (FFEs), while also indicating that Medicare fee-for-service will be adhering to the requirements. **The notable exclusion of MAOs is extremely troubling and significantly reduces the potential impact of the regulation.**

The proposal establishes that impacted plan beneficiaries, including those belonging to managed care plans, would experience improved efficiencies in the manner in which they receive care by reduced timelines and procedural improvements. By excluding MAOs, the agency would be withholding these benefits from many Medicare beneficiaries. Currently, approximately one-third of all Medicare beneficiaries (approximately 22 million people) are enrolled in an MAO, with the Congressional Budget Office projecting this percentage to increase to approximately 47% by 2029.[1] **In order to promote procedural improvements and prevent negative health outcomes associated with delays in care for all beneficiaries, we urge CMS to require MAOs to adhere to the requirements set forth in this proposal.** Including them also would reduce administrative burdens and costs as providers would have less variation among health plans.

We also strongly encourage the agency to establish requirements related to when prior authorization processes may be applied. Health plans frequently apply prior authorization to services for which there is a clear clinical pathway and for which the overwhelming number of requests are authorized. In these instances, the potential care delays and administrative costs associated with prior authorization simply cannot be justified. **We urge CMS to modify the proposed regulations to require MAOs to automatically consider a service authorized when the provider for that service has a history of prior authorization approval of 90% or greater.** The MAO would still be permitted to require a provider to request prior authorization in instances where the provider historically has not met that threshold. This approach would go a long way in

[1] https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/#:~:text=In%202019%2C%20one%2Dthird%20(,rate%20as%20the%20prior%20year.

reducing unnecessary care delays and clinician burden while giving the plan the ability to ensure care adheres to the patient's coverage rules.

Reducing Prior Authorization Timelines

Unlike other transactions between a provider and health plan, prior authorization involves clinical information and has a direct impact on prospective patient care. A prior authorization request is often the final barrier between a patient and the implementation of their provider's recommended treatment, making judicious processing of such transactions extremely important. Research has shown that prior authorization procedures cause significant delays in care[2], frequently leading to negative clinical outcomes for patients. Current CMS rules allow MAOs to take up to 14 days to respond to a prior authorization request, during which time a patient/provider is uncertain as to whether their planned treatment can go forth. This delay in patient care is both unnecessary and unacceptable. In many instances, the patient is in the hospital awaiting transfer to the next site of care to continue their treatment, such as inpatient rehabilitation. These patients can sit unnecessarily in hospital beds for days or even weeks as MAOs process the prior authorization request. These delays can not only contribute to a degradation of the patient's condition, but they also waste costly health system resources, prevent hospitals from freeing up inpatient capacity (an issue we return to again below), and increase the patient's exposure to hospital-based pathogens.

Health plans have the capability to determine whether the patient meets the medical necessity threshold in a more timely manner, particularly as the industry implements technology improvements that enable timely information exchange. **We recommend that plans be required to deliver prior authorization responses within 72 hours for standard, non-urgent services and 24 hours for urgent services.**

Increased Plan Oversight and Enforcement

MAOs have an established history of inappropriately utilizing prior authorization to delay access and deny necessary treatment for patients. According to a 2018 report by the Department of Health and Human Services' Office of Inspector General, 75% of MAO prior authorization and claims denials were overturned when appealed by providers between 2014 and 2016.[3] As a result of these findings, the Inspector General recommended increased oversight of MAO prior authorization processes in order to ensure that beneficiaries could access appropriate treatment in a timely manner.

The COVID-19 pandemic has manifested the widespread, inappropriate usage of prior authorization, particularly in regard to patient transfer to post-acute facilities. As the pandemic surged, hospitals have reported extreme delays and difficulties in transferring patients to skilled nursing facilities and other post-acute care sites, despite clear clinical

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[2] https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf

[3] U.S. Department of Health and Human Services Office of Inspector General. "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials," OEI-09-16-00410. September 2018.

justification and appropriate authorization requests. This process has prevented acute care beds from being freed up to care for incoming patients, compounding the issue of overcrowded acute care facilities. All this is taking place as health plans are posting record profits. Indeed, several large commercial insurers were recently cited by CMS for failure to pay an adequate amount of premiums toward medical claims.[4,5]

Additionally, despite clear CMS guidance on the matter, MAOs frequently establish overly stringent medical necessity policies that prevent patients from obtaining necessary care. As CMS established in its recent MAO Health Plan Management System memo, although MAOs "are not required to follow Original Medicare's documentation requirements or policies for establishing medical necessity, the methods implemented by MAOs and/or their contracted providers to determine medical necessity cannot result in coverage standards that are more stringent than standards that apply in Fee-For-Service Medicare". Insurers frequently disregard this guidance and create obstacles to patient access to various services. For example, the medical necessity determination needed to admit a patient to a hospital is often a significantly higher threshold for MAOs as compared to the "two-midnight rule" CMS uses for its fee-for-service patients. Health plans frequently deny hospital requests for patient admission, despite having met the two-midnight criteria and having clear clinical justification for in-patient care. This denial forces hospitals into a precarious situation in which they must admit the patient and hope to win on claims appeal or delay patients from medically necessary care while they navigate the plan's prior authorization appeal process. Meanwhile, the decision can have very real implications for patients, including in how much they owe in cost-sharing. Indeed, two identically situated patients – one in fee-for-service Medicare, the other in an MAO – can have very different coverage and cost-sharing obligations if the MAO determines the stay was observation but FFS Medicare deems it inpatient. The AHA urges CMS to reign in this inappropriate health plan usage of roadblocks that delay access to or jeopardize coverage for essential care.

In order to protect the millions of patients utilizing Medicare Advantage (MA) plans, we urge CMS to establish increased oversight and enforcement of MA plans, with particular focus on eliminating unnecessary care delays and inappropriate denials caused by prior authorization usage. Specifically, we encourage CMS to start by better tracking plans' use of prior authorization, as well as the results of plan prior authorization decisions. This would require plans to report distinct data on prior authorizations versus reporting all types of requests/authorizations together. CMS should require that this data be submitted monthly to enable timely oversight and penalize plans that fail to validate the data, such as through increased risk of audit. Finally, and most importantly, CMS should use this data to identify outliers – those plans with disproportionately high usage of prior authorization and those with high rates of adverse determinations overturned on appeal – for audits. This oversight would help fulfill the OIG report recommendation and help providers deliver timely and effective care that Medicare enrollees deserve.

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[4] https://www.cms.gov/files/document/unitedofthemidwestsanction09022021.pdf
[5] https://www.cms.gov/files/document/mmmhealthcaresanction09022021.pdf

We appreciate your consideration of these issues. We request the opportunity to discuss how CMS could better protect MA plan enrollees from problematic prior authorization policies. Please contact me if you have questions, or feel free to have a member of your team contact Terrence Cunningham, director of policy, at tcunningham@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President
Government Relations and Public Policy