How prior authorization disrupts patient care, Part II
Moving Medicine

How prior authorization disrupts patient care—and how we can fix it, Part II

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In part two of this series, guests continue their conversation on the state of prior authorization and, specifically, developments by CMS related to Medicare Advantage. Guests include AMA President Jack Resneck Jr., MD, Heather McComas, PharmD, director, Administrative Simplification Initiatives, AMA, and Emily Carroll, JD, senior legislative attorney, Advocacy Resource Center, AMA.

Moderator

- Jack Resneck Jr., MD, president, American Medical Association

Speakers

- Heather McComas, PharmD, director, administrative simplification initiatives, AMA
- Emily Carroll, senior attorney, AMA Advocacy Resource Center

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- Todd Unger, chief experience officer, American Medical Association

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Transcript


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Welcome to Moving Medicine—a podcast by the American Medical Association. Today's episode is part two of our discussion on the state of prior authorization in health care and how the AMA is working to fix it. If you missed part one, I encourage you to go back and give it a listen. AMA President Dr. Jack Resneck Jr. and guests Heather McComas, AMA director of Administrative Simplification Initiatives, and Emily Carroll, senior legislative attorney with the AMA Advocacy Resource Center, continue their conversation about developments in prior authorization and, specifically, updates from CMS related to Medicare Advantage. Here's Dr. Resneck.

Dr. Resneck: The Center for Medicare and Medicaid Services, CMS, announced that it is taking important steps towards right sizing the prior auth process imposed by Medicare Advantage plans on medical services and procedures. We have, at the AMA, really applauded CMS administrator Brooks-LaSure for leading the effort to include provisions in this final rule to streamline prior auth requirements, to improve clinical validity of coverage criteria and to increase transparency of health plans prior auth process.

Medicare Advantage enrollees will benefit from these important new protections which is going to help reduce disruptions to their care and allow physicians to get back to what we came into medicine for in the first place: treating patients. Additionally, just last year, the U.S. House of Representatives passed, in an overwhelming bipartisan way, the Improving Seniors Access to Timely Care Act. That would have reformed prior auth nationally in the Medicare Advantage program as well.

Unfortunately, it didn't pass in the Senate yet, but new proposed federal regulations address a lot of the same issues covered by the bill and we're going to talk more about those regulations. It's not just at the federal level, we're seeing change happen in states as well. Heather, I had several meetings with the CMS administrator and her team. It's been a sea-change. They've been very receptive to hearing from us and our patients about how big of a problem this is, and I really sort of feel heard and seen, and our patients being heard and seen in this rule. Can you tell us a little bit more about a couple of the things that are in this proposed rule?

McComas: Yeah, sure. And first of all, I will just echo the sentiment of feeling heard, because all of us have been advocating for such a long time on this issue. And then to finally hear some of the concerns that we've brought forward addressed in rule-making, has been really exciting. So, the rule that was finalized is the 2024 Part C, which is Medicare Advantage, and Part D rule.

And the prior authorization piece of that rule just addresses Medicare Advantage, but some really exciting things in there. And I think the first exciting thing about this rule is in the first couple characters of the long title of the role, it's CY or calendar year, contract year 2024. So, these provisions go into effect at the beginning of 2024.

And throughout the rules, CMS notes that health plans and their comments said, “oh, we need more time, whatever.” But the government stuck with their guns and there you are, making changes going
into effect at the beginning of 2024. So relief, at least for Medicare Advantage, is on the way. So I think that's exciting.

And then particularly on the issue of feeling heard, we see in this final rule CMS addressing prior authorization in a very holistic fashion. In recent years, the only thing that health plans, whether they are commercial or government plans, all they really wanted to talk about in terms of approving prior authorization has been automation and making things electronic.

And again, we are 100% in favor of automating things and getting rid of the fax machine and phone calls, but that is not the silver bullet. I'm sure everyone in the audience realizes that is not going to magically fix everything about this process. One of my very smart colleagues in the D.C. office, Matt Reed, came up with this phrase last year, but I think it is—really, I'd like to use it because it's so perfect.

He said, “If the underlying clinical criteria are not sound, all you're going to accomplish with a lot of prior authorization is get to an inappropriate no faster.” And I totally agree with that. It's like if you have an apple and you shine it, but the core is rotten, it's still a rotten apple, right? So it's really important that the clinical foundation of prior authorization programs is appropriate. And that is exactly what CMS is going after in this final rule.

To your point, they are very much responding to those very upsetting results from the Office of Inspector General HHS report that was released last year that looked at Medicare Advantage prior authorization issues and found that in many cases, Medicare Advantage patients are not getting services that they would have gotten if they were covered by regular fee-for-service Medicare.

And that should not be the case, but that's what's happening right now because Medicare Advantage plans are using their internal proprietary criteria, which are obviously not appropriate because they're not aligning with fee-for-service Medicare. So in this rule, CMS is saying to the MA plans, you need to follow Medicare statute regulation, local coverage determinations and national coverage determinations in your prior authorization programs.

And if there are not sufficient criteria available for Medicare, you can develop your own proprietary internal criteria, but they have to be based on, well-use treatment guidelines on clinical literature and you've got to make that information public. So I think that's really important. It's putting a light on all this. They're going to be showing us what clinical criteria that they are using in their prior authorization programs.

And they're also requiring a level of oversight on making these changes. Each MA plan is now going to have to have a utilization management committee that is going to make sure that these changes are occurring and review every year and make sure that the clinical criteria are aligning with Medicare when there are existing Medicare guidelines.
And it's also important to note that the rule says that the plans cannot use prior authorization to delay or discourage care. It's really only just to be used to confirm a clinical diagnosis, or to ensure that a service is medically necessary. And then one last thing—this was actually in the behavioral health part of the rule. But the rule says that an emergency medical condition can be physical or mental. And as such, behavioral health services furnished as emergency services cannot be subject to prior authorization.

And I'm sure that's obvious to all of us, but I think it's really important to have it in writing. Basically, mental health emergencies are not allowed to have prior authorization. I think that's really important that the rule addressed that. And then also some of the movement in the states in this area, the rule also very much got into the area of continuity care when patients are switching between plans.

And Dr. Resneck, I know you brought it up over and over again what a challenge it is. A patient is stabilized on treatment, and all of a sudden, they change plans and they need another prior authorization. And not only is that a huge hassle for the practice, but it disrupts the patient's treatment and their medical condition might worsen.

So the rule is going to require that MA plans have at least a 90-day transition period when patients transition between plans. And during that transition period, the plan cannot require new prior authorization and an ongoing course of treatment. It also requires that the duration of a prior authorization approval before the length of treatment, which is really important. That gets at the root cause nature of prior authorization that Emily was highlighting.

And then finally—and this gets to the point that you just made about retroactive denials and things—you do get a prior authorization and then suddenly, the claim gets denied at the end of the day. The rule says that if MA organization approves a prior authorization, they can't then deny the claim later for medical necessity reasons.

So that's really important. That's a huge issue. At the end of the day, if the claim is denied, that puts the practice at huge financial risk. So, on the whole, a lot of really great things in this rule that just came out. So we're really excited to see it go into effect at the beginning of 2024.

Dr. Resneck: Yeah, I just love some of this content. I think as physicians, we're used to getting these prior auth procedures that at the bottom say, this is not a guarantee of payment. And I mean, I get it if the patient is no longer on the plan, but this notion that you then go and do the procedure and find out later that they've withdrawn the prior auth is ridiculous.

So I'm glad CMS is addressing that, and I love it that the rule is barring MA plans from just making up their own proprietary criteria for prior auth out of whole cloth. If there's a national coverage determination or a local coverage determination and fee for service Medicare that says something is covered with certain criteria, then MA plans have to follow the same thing. And if there isn't one, that
they actually have to use big national specialty society criteria or other similar things and they can't just make this stuff up. And you mentioned automation.

At AMA, we have been very supportive of “this should be easier to file prior auth.” We shouldn't be handwriting these and faxing them. We shouldn't be facing every single insurer creating their own proprietary portal so that every physician has 40 more passwords. This needs to be built into our daily work, but automation alone is not enough. And sometimes I even hear health plans sort of snickering that, yeah, if we automate this, then it'll be easier to have prior auth on more things.

And so you just start spinning on the hamster wheel faster and faster. So even using AI, and I have seen some early interesting uses of AI to help create “finding in the note” what the health plan needs and feeding it to them. But again, we just have to reduce the number of things that are subject to this as well. Any other things, Heather, besides what's in this rule in terms of regulatory stuff happening or being considered?

**McComas:** Yeah, sure. So just to kind of draw the line. So that rule is final. It's going into effect. Again, the government is taking a holistic approach to prior authorization. So they actually released another proposed rule late last year. The rule I'm talking about now is the CMS prior authorization and interoperability rule. This is just proposed at this point. I want to make that clear, this is not final.

But a lot of provisions in that rule also address prior authorization. It leans a little bit more definitely in a technology bent of the rule. It would require the impacted plans to require an electronic prior authorization process that integrates with physicians' electronic health records, which is a really great thing.

And one interesting thing about this rule that makes it different from the one that we just talked about, the scope is a little bit larger in terms of the impacted plan. So, it does include Medicare Advantage, which is something we actually advocated for. There was a previous iteration of this rule that came out late 2020 that did not include Medicare Advantage, so we were very happy to see that change. But it also includes Medicaid plans, Medicaid Managed Care, CHIP and CHIP Managed Care.

And then qualified health plans under the federally facilitated health care exchanges. So, kind of a bigger scope for this rule. So these plans are beginning January 1, 2026 or at least that's the proposal. We'll have to offer this new application programming interface technology that would, again, connect the health plan to the clinician's EHR. And it would basically be end-to-end automation of the prior authorization process. So really some cool stuff, if this stuff all works the way that we all hope it does.

As the physician starts to order a service in their electronic health records, it will be hitting this API and it will say, “Dr. Resneck, you need prior auth for this service.” And then should you choose to proceed, it will tell you exactly what documentation you need to submit for that service to the plan. That's very helpful — bringing this welcome transparency to this process. It's not like you have to call the plan and


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say, “Does this require prior authorization?” So it's happening right there in your workflow, which is great.

And then the final piece is, the information is pulled from the EHR, exchanged with the health plan, the health plan comes back with a decision. Again, we overall generally think this is very promising. Again, getting the process within EHR workflow versus those proprietary portals is a big step forward. We do think that there needs to be a fair amount of testing done before this all goes live. We think this is a good thing.

The one negative aspect of this technology side of the proposed rule is the proposal regarding a new MIPS program promoting interoperability measure that would make sure—I see Dr. Resneck smiling. It would add a measure regarding physicians' use of this electronic prior auth API technology. And we came out very strongly against this proposal in our comments, I'm sure many of the other medical organizations listening today did too.

We think that it's very counterintuitive. We're trying to reduce burden here for physicians and you're adding a MIPS requirement that requires physician practice to be tracking how much they're using this API or not using the API. I mean, it's a real reporting nightmare.

So we're very much hoping that does not go forward. And we firmly believe that if this technology is really all it's cracked up to be, physicians will really want to use it—it will sell itself. There doesn't need to be this stick of a MIPS measure. So also in this rule, it's kind of interesting, there's a technology side, but there are also some more policy-oriented proposals.

The rule does address the requirements for processing time for both urgent and regular prior authorizations. It's saying that urgent prior authorization should be completed within 72 hours, and regular prior authorization within seven days. We are directionally supportive of the fact that CMS is trying to shorten the timelines. However, we have problems with those particular numbers.

I think any of us who have ever suffered from an urgent health care problem know that 72 hours is way too long to get a prior authorization approved—my goodness. So we are urging CMS to reduce that timeline to 24 hours, which aligns with our policy. And then for regular prior authorizations, we're saying that those should be completed within 48 hours.

And we think that this piggybacks nicely with the new technology requirements being proposed because again, if this is all being automated, there's no reason that a regular prior authorization shouldn't be able to be completed within 48 hours. That's a whole kind of promise of the technology, right? Another interesting thing in this role and we think it's really important and it gets, again, back to something that Emily was mentioning, it's going to require the impacted plans to publicly report statistics about their prior authorization programs.
Things like approval rates, denial rates, overturns on appeal and their average processing times. And we think this is really important. I think that watch behavior makes people want to do things better. And so we're really glad to see CMS proposing this. We are urging CMS to require plans to start implementing this transparency piece of the rule earlier than 2026.

We think it should go into effect immediately so that when the technology piece is in effect, we can hopefully see an improvement and a change. We think that benchmarking is really important. So hopefully, when they finalize the rule, they will make these data available sooner. And then also, the rule would require plans to provide a specific reason for denial, regardless of what method is being used to process the prior authorization.

So again, another important piece of prior authorization regulation, uncertain exactly how it's going to look in its final form or when it's going to get finalized, but it's an important piece of the puzzle here.

**Dr. Resneck:** Wait, you mean doesn't meet criteria is not a good enough reason? Yes, it would be lovely to have some statistics.

**McComas:** That tells you exactly what to do. Come on. There was also a very, I think, important sign on letter with all the national medical specialty societies and state medical associations on that, the Part C rule. And basically, it outlined the parts of the prior authorization proposals that we supported. And CMS pretty much finalized them when they added a little bit of clarification, but they did not scale things back despite some bellyaching on the part of health plans, so we were really excited to see the provisions go through pretty much as they had been initially proposed.

**Dr. Resneck:** The hours should actually include weekend hours, and 48 hours shouldn't be just business days. Patients' lives and their suffering from their diseases do happen on nights and weekends as well. So, an important point. We've had a couple of folks asking us about the degree to which this may eventually impact the commercial non-Medicare Advantage market, especially employer-sponsored plans and ACA plans?

And our consensus document that we put out with the National Health Plans a few years ago, which unfortunately didn't lead to them following through on any of their promises to do some of this work on their own, which is why we've been seeking legislation and regulatory change.

There were some headlines where a couple of plans basically announced that they were going to voluntarily make some changes all of a sudden. I think they're probably responding to some of this momentum in legislatures and I certainly would welcome this. I said from the beginning of that consensus document that I would go out on stage and hold hands with any plan and congratulate them for progress on this.
And I unfortunately haven’t had the opportunity to do that yet because they haven’t done the work to create that opportunity, but I have to admit some skepticism about that announcement a couple of weeks ago. Emily, you probably know more about this than I do. Can you tell us about the developments that led to these news releases?

**Carroll:** Yeah, absolutely. And I don’t know that I do know more than you on this one because I think the details are still a little bit foggy. But UnitedHealthcare announced it was planning to make some changes to its prior authorization program both by significantly cutting the prior authorization requirements and also implementing a national gold carding program.

Certainly, as you said, good news. And I think to quote you, we are cautiously optimistic that these changes will actually be meaningful. But at this point, we’re kind of still awaiting the details, and I think it will be important once we get those details to really dive into those changes and certainly monitor the implementation of those changes.

But I’ll say—on its face, that is really exactly the sort of voluntary action we were hoping to see when that consensus statement between the Insurer Trade Associations, the AMA and GMA, AHA and the pharmacists was done a number of years ago. We certainly hope that UnitedHealthcare is not the only commercial payer that starts moving in this direction and looks to reduce the volume of prior authorization in the future based on those consensus principles that were drafted so long ago. So, like I said, I think cautiously optimistic and hopeful that if it is meaningful changes, that other plans sort of follow suit.

**Dr. Resneck:** We’ll remain cautiously optimistic and hopeful. Either one of you want to jump in and say anything about sort of our grassroots campaign, FixPriorAuth, and any additional resources that we have for either physicians or patients who are in our audience?

**McComas:** Yeah, sure. We have a whole grassroots FixPriorAuth reform campaign, fixpriorauth.org, and it has various tracks to it. Some are oriented more towards patients, others towards physicians. We actually added an employer-facing track fairly recently because again, we think that’s an important target of our advocacy messaging and trying to make the point to employers that prior authorization really might not be saving them money. It might be hurting their employees.

So all the resources that we’ve been talking about today, the survey results, are on this website. There are multiple physician videos and Dr. Resneck’s featured in some of them. So I encourage you to go take a look at that, as well as patient videos.

And then I think a really impactful part of this website is the story gallery. And, again, Dr. Resneck mentioned this before, there are stories from physicians and patients and health care professionals about how they’ve seen prior authorization impact care. And I know that these can be very helpful in advocacy work, and I know Emily, you’ve seen that be very helpful at the state legislature level and
also helping with the work that's done in the states, which is also featured on the website as well.

**Carroll:** Yeah. To echo that, I think the story collection page is critical. You can organize it actually by state. So you can pull stories from your specific state and use them in testimony, which I do regularly and in other resources as you lobby your state legislatures.

Also mentioned there's a couple or a number of our state advocacy resources on that page—are on the website as well, including our model legislation and our state prior authorization law chart so you can see what's happening in the states and what has been enacted, and try and get some similar reforms enacted in your state.

**Dr. Resneck:** I just really want to emphasize how important this website has been. It's been a consistent way to sort of communicate with the public, and actually receive these stories, which we use all the time. And so that's useful.

And I would say, both your state policymakers and your members of Congress and your Senator, making sure that you share your stories with them so that they continue to hear about and prioritize this would be important. We got one question about the CMS rule and whether—saying it sounds like it relates to drugs, does it also apply to surgery?

And actually, just for clarification, it really deeply applies to procedures and tests. And one of the bits of feedback we've given from CMS is we want more of it to apply to drugs, just to make sure that we're covering both of those. But thus far, it's even primarily focused on procedures and tests. I want to turn to—can we require health plans to actually be more transparent about the cost of different alternatives? Especially if they're rejecting one thing, what is the cost?

I would say—and when I think about cost, I both think about what's the patient exposure in terms of copay and what's the cost to the health plan if I'm going to try to be a good steward of resources? But given the incredible opacity of that whole system and the PBMs and the health plans, we almost know nothing. It used to be fairly predictable. The generic would be the cheapest alternative. That's not even predictable anymore. Heather, any thoughts about progress on actually transparency around pricing?

**McComas:** Yeah, sure. So I realize this is getting a little confusing talking about the various federal rules, and what's been done and what hasn't been done yet. But the Part C and Part D rule indicated there was part two to come. Because in the proposed version of that rule they talked about requiring Part D prescription drug plans to support a standard transaction for real-time prescription benefit information.

And this is really important, because, Dr. Resneck, as you indicated, you just have no idea. It's like you're prescribing blind in terms of what is going to be covered and what the patient is going to have to pay. And I know you've talked before about—which is just a horrifying thought—of you when finding a

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moment to talk to a pharmacist who will run through dummy claims to help you try to figure out what's covered. That is a huge waste of time for everybody.

So the idea is that this transaction would enable the physician, while they are e-prescribing, to ping the PBM. And it would come back, and tell you if prior auth was required for this drug. It would tell you what the expected amount the patient is going to pay for that drug at the pharmacy counter, so the patient pay, which is really important as you have a conversation with the patient about whether or not they can afford the medication.

And it also would indicate the plan's preferred alternatives in the same class and clinically equivalent that they prefer, as you indicated, because of their arrangements with the pharmaceutical companies. And that way, you would have a much better insight into the coverage. And so there is going to be further rule-making that will hopefully require this to go into effect. I think the proposal was that Part D plans would have to support this technology beginning January of 2025. Again, that hasn't been finalized yet.

And then the hope is that they would offer it across their books of business, not just for Part D plans. But again, that is really important. Just, it's such a time suck for physicians and for pharmacists and for patients. And we know as you described earlier, it's a huge factor in treatment abandonment. Once a patient gets to the pharmacy counter and they can't pick up their medication because there is a cost issue or there's an unmet prior authorization need, they might never come back and that's just bad for everybody.

**Resneck:** Somebody who in their community, they got together with docs and medical societies and payers and hospitals and the Department of Insurance and agreed on some prior auth reductions, but then the PBMs blocked it. And it's very hard to know in these situations. There's a lot of pass the blame, I think, that goes on with health plans and PBMs as we even find this—personally, I run into it all the time at the individual patient level.

You sort of call the PBM and they say, no, this denial is—you have to appeal to the health plan. And you call the health plan and they say, "No, no, no, it's a PBM issue." Thoughts about just the role of broader regulation that includes PBMs, how to use state insurance commissioners when this goes poorly, sort of things beyond some of the basic model state legislation that we've looked at the state level, Emily?

**Carroll:** Yeah, it's a great question. And I think we can't underestimate the role of PBMs in this problem and other access issues. I think our legislation and a lot of the bills that we're seeing in the states would apply not only to health insurers but to the PBM utilization management practices as well. So I think that's a really critical component of state legislation, is pulling the PBMs into these reforms as well.


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Health insurance commissioners at the state level are a really important resource. I think historically, insurance commissioners have maybe generally preferred outreach from patients on some of these issues. But I think there's a growing interest from those departments to hear from physicians on behalf of patients. At least most of the departments I've talked to in the last couple of years are really open to that kind of complaint and discussion.

So I really encourage patients and physicians, on behalf of their patients, to outreach to the departments. They have a lot of enforcement tools at their discretion that they can use, and they also have a lot of tools that can sort of look at systematic issues in the state and make sure there is compliance with state law as it exists. And that they're looking at issues maybe where there isn't state law yet, but raising the alarms in some of those bad payer and PBM practices.

Resneck: We've got a question about whether we have statistics available about how prior auth adds to health inequity. And I can say—I'm going to ask you guys if you know of any studies, which I don't. But my own experience is that this, like many other things in health care, falls hardest on historically marginalized communities who don't have necessarily the time and resources to fight these long fights to get their medications.

And some of the practices that also take care of those historically marginalized and minoritized communities are also some of the most overwhelmed practices in terms of being able to have the resources to hire staff to work on this. And so that's certainly been my experience. I don't know—we're about out of time, but Heather and Emily, if you've seen anything else on the intersection of this with health equity issues?

McComas: I think that's something we would love to have more concrete data. And I totally agree that certainly, the impact on those communities is exacerbated. And I think certainly, particularly to talk about patients with chronic conditions too or that are disabled, there's certainly a disproportionate impact there.

But I know all the time with my colleagues who share insurance horror stories and we always say to each other, we understand this stuff and we are having such a hard time trying to get those prioritization approved or help a family member. What is it like for someone who doesn't know the intricacies of health insurance design. And so yeah, it's really a huge challenge and it's something, I think, we very much hope to explore in our further research because it's an important thing to highlight in all of this.

Dr. Resneck: I want to start by thanking Emily and Heather for joining us. In my role as AMA president, I get to see behind the curtain just the incredible number of hidden gems on our advocacy team and our staff who do work that affects millions of patients, thousands of doctors every day, but who all those folks who benefit don't get to see.
And so, you have had a chance today to see a couple of those hidden gems in our organization. And I'm glad you have had that opportunity because we're lucky to have them.

Thank you for your engagement on prior auth, your involvement on these issues. It's so important physicians and patients working on this really make the difference. And I'm feeling the momentum on prior auth. Take care.

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