AMA

How Medicare Advantage plans wrongly deny prior auth requests

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What's the news: Momentum to fix prior authorization is building in the wake of a Department of Health and Human Services Office of Inspector General (OIG) report showing that Medicare Advantage plans delayed and denied patients' access to medically necessary treatment. They also denied payments to physicians and other health professionals for services that met both coverage and billing rules.

OIG found that 13% of the prior-authorization requests that were denied by Medicare Advantage plans met the clinical coverage rules of traditional Medicare. And of the claim-payment denials in the study sample, 18% met Medicare coverage rules and Medicare Advantage plan billing rules.

The OIG recommended that the Centers for Medicare & Medicaid Services (CMS):

- Issue new guidance on the appropriate use of Medicare Advantage clinical criteria in medical necessity reviews.
- Update its audit protocols to address the issues identified in this report, such as Medicare Advantage plans' use of clinical criteria.
- Direct Medicare Advantage plans to take steps to identify and address vulnerabilities that can lead to manual review errors and system errors.

According to the OIG report (PDF), "CMS concurred with all three recommendations."

Why it's important: AMA President-elect Jack Resneck Jr., MD, told *The New York Times* that Medicare Advantage plans' denials have become commonplace, and that prior authorization has "spread way beyond its original purpose."

In a statement, AMA President Gerald E. Harmon, MD, added that the OIG report "uncovered information that mirrors physician experiences. He noted that the AMA's prior authorization physician surveys (PDF) "have consistently found that excessive authorization controls required by health

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insurers are persistently responsible for serious harm when necessary medical care is delayed, denied or disrupted."

Read more about why prior authorization is bad for business and bad for patients.

In addition to CMS adoption of the OIG's recommendations, Dr. Harmon said that "more needs to be done to reform prior authorization." He cited the AMA's support for "The Improving Seniors' Timely Access to Care Act" (H.R. 3173; S. 3018), which "would require Medicare Advantage plans to streamline and standardize prior authorization processes and improve the transparency of requirements."

The bill has earned bipartisan support from over 300 members of Congress in the House and Senate. Find out more about how the legislation would reduce prior authorization burdens (PDF) and how physicians can urge their senators and representatives to join in supporting it.

"The time is now," Dr. Harmon said, "for federal lawmakers to act to improve and streamline the prior authorization process so that patients are ensured timely access to the evidence-based, quality health care they need."

On another front, the AMA welcomed the Biden administration's rule issued early this month that strengthens Medicare Advantage network adequacy. Under the rule, CMS will approve an application for a new or expanded Medicare Advantage contract only after applicants demonstrate a sufficient network of contracted physicians to care for enrollees.

The AMA has written (PDF) in support of the proposal, saying that these strengthened Medicare Advantage (MA) plans would enable patients to access needed services.

"Sunlight is said to be the best disinfectant, and that's what this rule is all about. It will bring sunlight into the decision-making process, so patients know the MA plan they enroll in has an adequate network," Dr. Harmon said. "Obviously, this information is needed at the beginning of the process. Discovering that you do not have access to necessary care in a time of illness adds a challenging layer to an already trying time. We very much welcome this patient-friendly move by CMS."

Learn more: Earlier this spring, the AMA submitted comments (PDF) in response to the Office of the National Coordinator for Health Information Technology's (ONC) request for information on electronic prior authorization. ONC and CMS are considering policies to address widespread problems with prior authorization.

The AMA's comments stressed that automating prior authorization through the use of technology is not enough to produce the needed reform. The AMA urged the federal government to examine its role in reducing prior authorization volume, increasing transparency in payers' criteria and minimizing

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repetitive requirements.

And while technology has the potential to improve some aspects of the prior auth process, the standards ONC is considering are not sufficiently mature and lack the necessary testing to support electronic prior authorization goals. The AMA suggested a two-pronged approach, emphasizing the importance of systemwide reform while also emphasizing the need to test electronic prior authorization technology in real-world settings across medical facilities of various sizes and specialties.

The AMA also strongly cautioned CMS and ONC against requiring physicians to use electronic prior authorization before it is shown to reduce patient harm, provide a return on physician investment, and clearly reduce the burden for physician practices.

The AMA is tackling prior authorization through research, collaborations, advocacy and leadership so physicians can focus on patients rather than insurance requirements. Patients and physicians can read about reform efforts and share their personal experiences with prior authorization at FixPriorAuth.org.

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