AMERICAN MEDICAL ASSOCIATION PRIVATE PRACTICE PHYSICIANS SECTION

Resolution: 4
(A-24)

Introduced by: Alex Shteynshlyuger, MD

Subject: Rebuke and Appeal CMS Interoperability and Prior Authorization Final Rule

Referred to: PPPS Reference Committee
(xxxx, MD, Chair)

Whereas, prior authorization is a major concern for physicians; and

Whereas, the American Medical Association has adopted numerous policies addressing prior authorization and, according to the AMA Board of Directors, prior authorization is a high priority for AMA advocacy; and

Whereas, the Centers for Medicare and Medicaid Services (CMS) has delegated power under HIPAA administrative simplification requirements to set national standards and regulate prior authorization for all health plans in the United States, public and private, fully-insured and self-insured, with the only limitation that the regulations must lower the costs and administrative burden such that no regulation may raise the cost of the healthcare service or transaction that it aims to regulate; and

Whereas, CMS issued CMS Interoperability and Prior Authorization Final Rule on February 8, 2024, that fails to comply with the HIPAA administrative simplification requirements, as CMS has:

- Arbitrarily and capriciously failed to respond to concerns about higher than projected costs of implementing the proposed regulations[1],
- Arbitrarily and capriciously failed to incorporate expected costs into cost analysis, which explicitly allowed health plans to impose on healthcare providers[2],
- Arbitrarily and capriciously allowed broad exemptions from proposed requirements to a large proportion of health plans without setting reasonable criteria that would demonstrate an “inordinate” burden and in doing so failed to consider how exempting a large number of health plans that often have the most draconian prior authorization requirements would affect the cost analysis of the proposed regulations,
- Arbitrarily and capriciously allowed health plans to exclude Medicare-participating providers who were not participating in Medicare Advantage plans from provider API requirements,
- Arbitrarily and capriciously adopted regulations without a legitimate enforcement mechanism that would be expected to induce compliance and in doing so failed to account for rampant non-compliance in its cost analysis, which has been the case to date and expected to continue being so,
- Arbitrarily and capriciously failed to extend prior authorization requirements to pharmacy benefits, or for that matter for in-office injectables, thus excluding 80 to 90 percent of prior authorization services and prior authorizations from the proposed regulations; and

Whereas, CMS has failed to properly account for the cost of implementing these regulations and failed to address concerns from many parties (providers, health plans, and services providers) during the comment period that the rules are contradictory, impossible to implement in the

absence of an ability to electronically identify counterparties in the absence of an adopted Health Plan ID[3]; and

Whereas, while CMS estimates that the proposed regulation will save $15 billion, a more realistic estimate is that the proposed regulations will cost physicians billions of dollars each year, will result in no savings, and therefore cannot be legally adopted under HIPAA administrative simplification requirements as they exceed CMS' delegated power; therefore be it

Resolved, that our American Medical conducts an independent cost analysis of the CMS Interoperability and Prior Authorization Final Rule of 2024 and determine whether it is allowable and appropriate for the AMA to file a federal lawsuit for one or more violations of the Administrative Procedure Act for exceeding delegated authority under HIPAA administrative simplification requirements (Directive to Take Action); and be it further

Resolved, that, as a potential claim for relief in the event it initiates a lawsuit as described in the foregoing Resolution or in such other lawsuit as our AMA may initiate to address the concerns expressed in these Resolutions, the AMA shall determine whether it is allowable and appropriate to demand that courts direct the Centers for Medicare and Medicaid Services to rewrite regulations under the CMS Interoperability and Prior Authorization Final Rule of 2024 to comply with applicable laws while advocating the principles enumerated in AMA and Medical Society of the State of New York policies (Directive to Take Action); and be it further

Resolved, that our AMA report back at Interim 2024 on the progress of the implementation of this resolution and subsequently at each Annual Meeting (Directive to Take Action).

Fiscal Note: TBD

Received: 4/29/2024

References:

1. Centers for Medicare and Medicaid Services. CMS Interoperability and prior authorization final rule (CMS-0057-F). Accessed May 1, 2024: https://www.cms.gov/priorities/key-initiatives/burden-reduction/policies-and-regulations/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f
2. *Ibid*
3. *Ibid*

RELEVANT AMA POLICY

Prior Authorization and Utilization Management Reform H-320.939

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.

2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.

3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.

4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

Citation: CMS Rep. 08, A-17; Reaffirmed: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmed: A-22

Prior Authorization Reform D-320.982

Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

Citation: Res. 704, A-19; Reaffirmed: A-22

Fair Reimbursement for Administrative Burdens D-320.978

Our AMA will: (1) continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices; (2) continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes; (3) oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services; and (4) advocate for fair reimbursement of established and future CPT codes for administrative burdens

related to (a) the prior authorization process or (b) appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.

Citation: Res. 701, A-22