

November 4, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Health Plan Prior Authorization

Dear Ms. Verma:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, and our clinical 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, we thank you for your attention to improving health plan prior authorization processes through appropriate standardization. **The AHA recognizes the value of prior authorization; however, the approach some health plans have taken negatively impacts patient care and adds significant additional cost and burden to the health care system.** Hospitals and health systems are committed to working with you to address these issues and believe changes to prior authorization processes can achieve positive results for patients, providers and health plans.

IMPACT OF PRIOR AUTHORIZATION ON PATIENT CARE, HEALTH SYSTEM COST AND BURDEN

Prior authorization is a tool that, when used appropriately, can help align patients' care with their health plan benefit structure and facilitate 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. They also can create confusion and burden for patients, their families and caregivers, and providers, resulting in additional costs as each attempts to navigate this component of the health care system. Standardization in prior authorization requirements and processes would go a long way to reduce risk to patient care and health care system burden.



There are numerous examples of questionable application or implementation of prior authorization requirements that the Centers for Medicare & Medicaid Services (CMS) could address through more standardization. CMS could pursue standardization without compromising health plans' ability to manage benefits or create compelling products for the market. The following are areas of top concern that standardization should help address.

Variation across Plans in Submission Processes. Each plan uses a different process for providers to submit prior authorization requests. Some use electronic means, but many still rely on verbal conversations and fax machines. In addition to adding burden, these latter approaches do not allow for plans and providers to easily track the course of a decision. This can be particularly important when third party vendors hired by plans apply different prior authorization criteria than the health plan staff when reviewing payment claims. For example, it is common for health plan staff to verbally indicate that no prior authorization is required, only to have one of the plan's payment review vendors decline a claim for failure to obtain prior authorization. Reproducing the initial verbal conversation often is not possible.

Plans also vary in what information providers must include in a request. This variation adds burden to the system as providers and their staff must ensure they are following the right rules and processes, which may change from one request to the next. Inevitably, providers cannot always keep these straight and end up with denials that must be reprocessed or appealed.

Inappropriate Application of Prior Authorization. Some health plans require prior authorization even for services where there is no evidence of abuse and for which the standards of care are well established. One member recently reported the inability to provide a newly diagnosed diabetic with a prescription for insulin. With a fasting blood glucose level of 520, the health plan informed the clinician that it would respond within 24 hours to the prior authorization request for this life-saving medication that has been widely used since its introduction nearly 100 years ago. The clinician could not immediately get them access to their prescription but rather had to rely on samples.

Health plans frequently apply criteria for accessing post-acute care services that are inconsistent with clinical guidelines, and, therefore, inappropriately apply prior authorization to those services. For example, despite clear clinical guidelines directing providers to place certain stroke patients in rehabilitation hospitals for follow-up care, health plans often will require prior authorization for those services and attempt to force the providers to direct patients to a lower-acuity setting.

Inappropriate Denials. Hospitals and health systems frequently experience situations where a service was clearly medically necessary, but the plan denies it anyway, resulting in significant burden to resolve the dispute. Many hospitals and health systems have examples of health plans denying emergency care as not medically necessary for individuals who ultimately passed away. One AHA member recently reported that a plan denied prior authorization for the hospitalization of a young adult experiencing their first

psychotic episode because there was no prior history of psychosis for that patient. A challenge is that health plans frequently use different clinical guidelines from providers, as well as from each other, and even modify the guidelines that are broadly available. These modifications often are deemed proprietary and not shared with providers.

Unreasonable Requests for Documentation. Health plans use different requirements for what information a provider must include in a prior authorization request, and health plans often change those requirements unilaterally throughout a contract term. For example, after submission of a prior authorization request for rehabilitation services following a six-week inpatient hospital stay, one plan responded that they needed different information. The plan requested to know whether the patient was taking any medication that would impact the need for rehab services, and whether the patient had experienced shortness of breath during the six-week hospital stay. Neither of these pieces of information were relevant to a determination regarding rehabilitation. However, both the health system and health plan medical directors spent an hour on the phone before the care was ultimately approved.

Inappropriate Delays in Decisions. Health plans frequently delay prior authorization decisions, returning requests multiple times claiming insufficient information or simply not responding outside of traditional office hours. Hospitals and health systems report frequently having to keep patients in the emergency department or in inpatient beds due to delays in decisions. This occurs frequently for patients who come into the emergency department in need of behavioral health services or inpatients who need to transfer to post-acute care. These patients can end up waiting for days in the emergency department or in an inpatient bed, which is not good for their care or wellbeing and creates hospital backlogs, straining capacity.

These delays raise questions not only about generally timeliness for prior authorization responses, but whether inadequate networks are contributing to delays in plans' decision-making. These delays also can mean that health plans are adjudicating requests based on the patient's condition after they have already begun receiving treatment. This most frequently occurs when the patient comes in overnight or on the weekend.

These practices put patient access to care at risk. The Department of Health and Human Services (HHS) Office of Inspector General (OIG) warned in a September 2018 report that high rates of Medicare Advantage (MA) health plan payment denials and prior authorization delays could negatively impact patient access to care. A recent study appears to document just that consequence. The study found that "Medicare Advantage beneficiaries were significantly less likely than traditional Medicare beneficiaries to receive treatment from high-quality home health agencies." The authors noted that "[l]ower HH [home health] quality for MA beneficiaries may be attributable to plans' narrow HHA [home health agency] networks, which may include low-quality HHAs that

are willing to accept lower prices.”¹ For providers, “lower prices” can mean either lower contracted rates for a particular service or lower total reimbursement when taking into account the rate of denied claims.

A recent survey by the American Medical Association of more than 1,000 physicians underscores the negative impact on patient care resulting from prior authorization. The survey found that more than 90% of respondents said prior authorization “had a significant or somewhat negative clinical impact, with 28% reporting that prior authorization had led to a serious adverse event such as a death, hospitalization, disability or permanent bodily damage, or other life-threatening event for a patient in their care.”^{2,3} Negative patient outcomes often result from delays in care because it is unclear whether prior authorization is required at all, the health plan does not have an adequate provider network for patient referrals, the health plan does not have the right staff to make prior authorization decisions, or the staff are unavailable outside of traditional business hours.

Prior authorization processes also add considerable burden to the health care system and contribute to physician and other staff burn-out. Hospitals often have multiple full-time employees whose sole role is to manage health plan prior authorization requests. These staff often are physicians and nurses who have been diverted from patient care. Part of the challenge stems from health plans’ use of peer-to-peer calls to establish prior authorization for a service or treatment without providing access to clinicians with the right type of expertise. One 17-hospital system spends \$11 million annually just complying with health plan prior authorization requirements. Physicians report that their offices spend on average two business days of the week dealing with prior authorization requests, with 89% rating the burden level as high or extremely high.⁴

Finally, many claims denials stem from issues related to prior authorization. For example, while a health plan’s response to a prior authorization request is pending, a provider may determine that a patient can no longer wait before receiving treatment. For the health and safety of the patient, the provider will initiate treatment or proceed with moving a patient to a more appropriate site of care. The health plan often will deny those claims because the prior authorization process was not followed, even though the services provided were medically necessary, covered services.

AHA RECOMMENDATIONS

¹ Schwartz, M. “Quality of Home Health Agencies Serving Traditional Medicare vs Medicare Advantage Beneficiaries,” JAMA: The Journal of the American Medical Association. September 4, 2019.

² American Medical Association, “2018 AMA Prior Authorization (PA) Physician Survey,” Feb. 2019. Accessed at: <https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf>

³ American Medical Association, “1 in 4 doctors say prior authorization has led to a serious adverse event,” Feb. 2019. Accessed at: <https://www.ama-assn.org/practice-management/sustainability/1-4-doctors-say-prior-authorization-has-led-serious-adverse>

⁴ Id. 2.

We thank CMS for its focus on prior authorization and encourage the agency to pursue the development and implementation of prior authorization standards and increase its oversight of the health plans the agency regulates. We recognize that, in some instances, CMS guidance already addresses the issues identified above. In those cases, we urge CMS to ensure that health plans and their contract vendors understand and adhere to existing CMS standards. The following are specific recommendations for additional actions the agency should take.

Standardize Prior Authorization Requirements and Processes. We urge CMS to standardize components of prior authorization processes, and require that health plans regulated by the agency abide by these rules. We encourage CMS to identify standards in the following areas:

- 1. Services requiring prior authorization.** Most services should be considered automatically authorized with no further action required. Prior authorization should apply only to services that are new, high cost, require particular safety protocols, or have a past history of abuse or overutilization. CMS should work with expert stakeholders to identify those services that would be considered automatically authorized and those that could be eligible for prior authorization, and health plans should be required to adhere to these lists. In addition, health plans should follow a common schedule for updating the services that require prior authorization.
- 2. Format for communicating services subject to prior authorization and health plan contacts.** Health plans should use the same approach to informing providers about services requiring prior authorization. While health plans generally provide lists of services via their websites, it can be challenging for providers to locate the right list for the right plan, especially as changes are made. In addition, providers report that obtaining direct contact with health plan staff to confirm what is needed can be challenging as plans often contract out prior authorization functions. Contract for prior authorization services should not obviate the responsibility of the health plan to conduct oversight of the contracted services.
- 3. Format for prior authorization requests and responses.** All health plans should accept requests using a standardized form, as well as return responses in the same way. The format for requests should have standardized fields for the clinical information required. Denials must include a detailed rationale. Providers and health plans also should use the same electronic processes for transmitting requests and responses. Alternate mechanisms, such as fax, only should be used in rare circumstances, such as in areas with limited broadband or other technical limitations. One member estimates that switching from verbal/fax processes to an electronic transmission process would reduce the amount of provider staff time for each request by at least 50% — from a current average of 30 to 45 minutes per request to 15 minutes per request. In addition, they expect

25% fewer inappropriate denials simply as a result of better compliance with prior authorization requirements.

- 4. Criteria used to approve/deny requests.** CMS should identify the clinical standards health plans must use to make prior authorization determinations for covered services. Health plans should not be permitted to deviate from or modify those clinical guidelines. However, health plans can apply different health benefit structure rules when determining whether a service is covered. This would help ensure that the patients with the same clinical profile receive the same care and any deviations could be handled through peer-to-peer review, which would become the exception, not the rule. Common clinical rules and policies among health plans also would greatly reduce the administrative burden for providers and reduce the hassle for providing patient care particularly by making it easier for hospitals to extract the needed data from within their own clinical information systems and then place it onto the electronic prior authorization standard. Variation in plan requirements make it difficult for providers to automate data collection needed for prior authorization.
- 5. Timeline for responses.** All health plans should abide by the same timeframes for responses: 10-14 days for certain scheduled, non-urgent services; 72 hours for most other care; and 24 hours for urgent services. There also should be a period of retroactive consideration of prior authorization requests for urgent services for which the patient's clinical condition warranted immediate intervention. Plans should be required to have staff available 24-hours, 7 days a week to respond to prior authorization requests.
- 6. Appeals processes.** Health plans should follow the same appeals processes, which include an opportunity for external review of denials.

Implementing standards in the above areas would reduce significant administrative burden over time and better ensure that patients are receiving access to the services they need. Health plans would still have ample opportunity to differentiate their products through unique constellations of providers, benefit structures, quality, and enrollee experience, among other aspects of coverage.

We recognize that standardization will require effort on the part of all parties, including by requiring providers to adjust their technology applications and implement new work flows. However, we believe it is critical to take on this additional effort in the short-term to reduce the complexity and burden associated with prior authorization over time.

Develop and Test Standards and Best Practices. We appreciate CMS's attention to this issue and that the agency has convened relevant stakeholders to define objectives of prior authorization, identify the challenges such processes create for patients and providers, and identify opportunities for standardization. CMS should consider using the findings from these discussions to develop a multi-payer demonstration project through

the Center for Medicare and Medicaid Innovation to test prior authorization standards, as well as develop other solutions. For example, some health plans have explored developing “Gold Star” programs where they selectively apply prior authorization requirements to certain providers based on historic practices that have been reviewed and the results indicate appropriate application of services scheduled for the patient. CMS could work with plans and providers to identify which services may be eligible for such a program and performance thresholds that could exempt a provider from prior authorization requirements.

Increase Oversight of Health Plans. CMS is responsible for ensuring that MA and marketplace plans adhere to program rules, including, most importantly, providing enrollees with access to covered services. Existing oversight mechanisms have been insufficient to identify and prevent health plan actions that negatively impact access. We agree with the recommendations put forward by the HHS OIG related to MA, and we urge CMS to increase its oversight and enforcement activity by:

- Establishing thresholds for “appropriate” levels of prior authorization and payment delays and denials in order to target potential bad actors for increased scrutiny;
- Making publicly available statistics on health plan performance on measures related to prior authorization and payment delays and denials, including the rate of denials overturned upon appeal;
- Increasing the frequency of health plan audits for those found to exceed established thresholds for prior authorization and payment delays and denials; and
- Consistently applying penalties to those plans found to be out of compliance with the identified thresholds.

Thank you for the opportunity to convey our recommended solutions for challenges posed by health plan prior authorization requirements and processes. We look forward to continuing to work with the agency on ways to improve patient access to care and reduce burden and cost in the health care system. Please contact me if you have questions or feel free to have a member of your team contact Molly Smith, vice president for policy, at mollysmith@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development