**Medicare Red Tape Relief Project**

Submissions accepted by the Committee on Ways and Means, Subcommittee on Health

Date: August 25, 2017

Name of Submitting Organization: Physicians Advocacy Institute

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Statutory

Regulatory √

**Please describe the submitting organization’s interaction with the Medicare program**: PAI is a not-for-profit advocacy organization focused on securing fair and transparent payment for physicians. PAI’s Board is comprised of CEOs/former CEOs of state medical associations from California, Connecticut, Georgia, Nebraska, New York, North Carolina, South Carolina, Tennessee and Texas and a Kentucky physician. A significant portion of the members of these and other states’ medical societies treat Medicare patients and submit claims to Medicare.

**Short Description**: The lack of clear guidance on prior authorization in the Medicare Advantage (MA) program has allowed MA plans to increasingly utilize these practices. The growing and inconsistent use of prior authorization in MA creates significant administrative and financial challenges for providers and imposes unfair barriers to care for beneficiaries.

**Summary:** Despite the statutory restrictions related to the use of prior authorization practices in the fee-for-service (FFS) Medicare program, CMS regulations do not clearly address if, when and how prior authorization can be applied by MA plans. In light of this uncertainty, MA plans have increasingly used prior authorization practices in recent years and applied these practices to a growing number of services and procedures. This is especially concerning considering that MA plans are statutorily required to cover the same benefits provided in FFS Medicare. Furthermore, MA plans take different approaches to the services subject to prior authorization and the steps required for physicians to obtain prior authorization, creating great uncertainty for physicians and their patients with respect to coverage and payment.

The rising use of prior authorization in the MA program results in significant administrative and financial challenges for physicians. In fact, an American Medical Association (AMA) survey found that 75% of surveyed physicians described prior authorization burdens as “high or extremely high,” and that nearly 90% reported that prior authorization “sometimes, often, or always delays access to care.” Furthermore, PAI members have reported that MA plans have denied coverage even after the physician has received prior authorization, creating additional frustrations for physicians.

Prior authorization practices have also resulted in treatment delays for vulnerable patients. In the same AMA survey, nearly 60 percent of surveyed physicians reported that their practices wait, on average, at least one business day for prior authorization decisions, and more than 25% of physicians report that they wait three business days or longer. With Medicare beneficiaries representing some of the oldest and sickest patients in the nation, these delays can be life-threatening for PAI’s patients.

**Related Statute/Regulation:** 42 CFR 417.414; 42 CFR 422.101; Medicare Managed Care Manual Chapter 13

**Proposed Solution:**

* CMS should issue guidance that clearly establishes when and how prior authorization can be used by MA plans, and establish oversight measures to monitor MA plan compliance with these requirements
* CMS should clarify that, once providers receive prior authorization, MA plans are generally prohibited from subsequently denying coverage
* CMS should create new timeframes for MA determinations on prior authorization requests – such as 24 hours for an expedited request and 48 hours for a standard request – to avoid harmful treatment delays