



## Prior Authorization

**Support legislation to increase transparency and efficiency of prior authorization requirements.**

Surgical patients are encountering barriers to timely access to care due to onerous and unnecessary prior authorization (PA) requests from Medicare Advantage (MA) plans. Utilization review tools such as PA can sometimes play a role in ensuring patients receive clinically appropriate treatment while controlling costs. However, the American College of Surgeons (ACS) is concerned about the growing administrative burdens and the delays in medically necessary care associated with excessive PA requirements.

### **Growing Administrative Burdens**

A 2017 ACS questionnaire of nearly 300 surgeons and practice managers indicated that, on average, a medical practice receives approximately 37 PA requests per provider per week, taking physicians and staff 25 hours – the equivalent of three business days – to complete. The exorbitant amount of time and resources practices must devote to PA is due largely in part to the lack of automated PA processes that integrate with electronic health records (EHR) and other digital practice management systems.

### **Applying Prior Authorization When Appropriate**

Many of MA plans' PA requirements are applied to items or services ordered in accordance with an already-approved plan of care, as part of appropriate, ongoing therapy for chronic conditions, or for items or services with low PA denial rates. The ACS believes that PA requirements should be restricted to complex cases or to clinicians whose ordering patterns differ substantially from other practitioners after adjusting for patient population.

### **Legislative Efforts**

The ACS has joined with the Regulatory Relief Coalition, a coalition of specialty provider organizations, in working with key Members of Congress on bipartisan legislation to improve transparency and efficiency of the prior authorization process in the MA program. In order to improve continuity of care, the Regulatory Relief Coalition is advocating that the following issue areas should be addressed in any proposed legislation:

Guidance to Health Plans: MA plans should follow the PA practices endorsed in a consensus statement by the American Medical Association, America's Health Insurance Plans, Blue Cross/Blue Shield Association, American Hospital Association, Medical Group Management Association, and the American Pharmacists Association. These practices include the following:

- MA plans should apply PA requirements selectively, exempting providers that meet evidence-based guidelines;
- Services involving low variation in utilization or low PA denial rates should be removed from PA lists; and





- Medicare Advantage plans should minimize repetitive prior authorization requirements for chronic conditions.

Standardization of Prior Authorization: The administrative burden of the prior authorization process is in part attributable to the lack of a uniform format for the submission of prior authorization requests. To facilitate uniformity, an electronic attachment standard should be finalized as soon as possible, as should model prior authorization forms for both online and manual submissions.

Data Collection: Medicare Advantage plans should report on the extent of their use of prior authorization and the rate of approvals or denials by service. This should include the submission of the following data as one component of Medicare Advantage plans' annual reports to the Centers for Medicare & Medicaid Services (CMS):

- Data on the specific procedures and prescription medications subject to prior authorization;
- The proportion of each service and prescription medication approved; and
- The time elapsed from submission until the issuance of an organization determination.

Oversight: Without additional oversight of MA plans' prior authorization processes, it is unlikely any meaningful progress in reducing excessive PA requirements will be achieved. Medicare Advantage plans' prior authorization processes should be reviewed based on clear criteria and their performance made public on the CMS website, based on information gathered through Medicare Advantage plans, annual reports, and special focus audits.

## **Congressional Action**

Support legislative efforts to improve the continuity of patient care by increasing transparency of prior authorization requirements for Medicare Advantage plans.<sup>i</sup>

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<sup>i</sup> Current to April 2, 2019. Please contact [ahp@facs.org](mailto:ahp@facs.org) for an updated version.