Alliance of Specialty Medicine

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HHS/CMS Roundtable on Prior Authorization

Meeting Summary

Leadership from the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) convened a stakeholder roundtable on Jan. 17, 2023, on the prior authorization process and recent proposals for reform. In December, the Biden Administration proposed several regulations to improve prior authorization in federally-sponsored health care programs, including Medicare Advantage, Medicaid and federal exchange plans:

- Advancing Interoperability and Improving Prior Authorization Processes (comments are due on 3/13/23)
- Strengthen Beneficiary Protections, Improve Access to Behavioral Health Care, and Promote Equity for Millions of Americans with Medicare Advantage and Medicare Part D (comments are due on 2/13/23)
- Standardize Electronic Health Care Attachments Transactions and Electronic Signature Processes to Improve the Care Experience for Patients and Providers (comments are due on 3/22/23)

Attendees

The Alliance of Specialty Medicine was among a handful of groups invited to attend. Attending on behalf of the Alliance were:

- Eugene Rhee, MD, MBA (urologist from San Diego, Calif.)
- Shivan Mehta, MD, MBA (gastroenterologist from Philadelphia, Pa.)
- Katie Orrico, Esq. (neurosurgery staff)
- Kathleen Teixeira (gastroenterology staff)
- Raymond Wezik, Esq. (urology staff)

Also included were representatives from the following groups:

- American Hospital Association
- American Medical Association
- Medical Group Management Association
- National Association of Community Health Centers
- Neighborhood Health

Attending for HHS/CMS were the following leaders (others were in the room but didn't directly participate in the discussions at the table):

- Chiquita Brooks-LaSure, CMS Administrator
- Vivek H. Murthy, MD, MBA, U.S. Surgeon General
- Mary Greene, MD, Director, CMS Office of Burden Reduction & Health Informatics
- Meena Seshamani, MD, PhD, CMS Deputy Administrator and Director of the Center for Medicare
- Jonathan Blum, CMS Principal Deputy Administrator & Chief Operating Officer

Meeting Discussion

Administrator **Brooks-LaSure** opened the meeting. She stressed that reducing unnecessary burdens is a priority for the administration. Additionally, CMS wants to make sure that individuals are getting appropriate care. Hence, the release of the three proposed rules related to prior authorization.

Dr. **Murthy** highlighted concerns about moral injury due to physician burnout. He reminded attendees about the Surgeon General's report "Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce" and the need to reduce physician burdens — including prior authorization. He praised the work of CMS for taking these important steps with the proposed rules. He reinforced that HHS is committed to ensuring that patients get timely care and that physicians are taken care of to reduce burnout.

Mr. **Blum** then commented about how beneficiaries often change plans. One of the priorities for the agency is to ensure that when patients — particularly those with chronic health care needs — change plans, they do not have to go through the same prior authorization processes.

Dr. **Greene** noted that everyone around the room had been part of the "fix prior auth journey" with CMS. She highlighted some of her office's work to reduce burden and improve interoperability. Dr. Greene provided a brief summary of the highlights of the interoperability and prior authorization and electronic attachment rules. She noted that CMS has been waiting for this conversation for about three years!

Finally, Dr. **Seshamani** thanked the group for all the comments and input they have given to help shape the proposed rules. She discussed elements of the proposed Medicare Advantage (MA) proposed rule, including ensuring that MA plans must adhere to Medicare coverage decisions, prior authorization protocols must follow publicly available clinical practice guidelines and prior authorization should allow for the complete course of treatment. She also acknowledged the burnout and the labor issues in health care, pointing out that CMS needs to use "the levers" it has to address these issues.

Following these preliminary comments, Dr. Murthy started the interactive discussions by asking attendees a broad question about what attendees are hearing about the latest experience with prior authorization, particularly examples.

Jack Resneck, MD, AMA president, kicked off the discussion by thanking CMS and acknowledging the significant work CMS has done on this issue. He relayed some data and shared a personal story about a plan requiring prior authorization for a generic topical steroid. He reinforced that burnout is real. Dr. Resneck also pointed out that the continuity of care protections are essential but should also apply to drugs. Finally, he expressed frustration with the peer-to-peer prior authorization consultation process, noting that he spends more time "teaching" the so-called peers because, typically, these individuals are not from the same specialty and how this is a waste of time that could be better spent on taking care of patients.

Molly Smith, staff for the AHA, also thanked CMS for all these rules. She pointed out the top two reasons they hear from their members: their ability to deliver coordinated care to their patients and the impact on their workforce. She also stressed the wasteful time and money spent on prior authorization. Finally, she pointed out that the AHA, AMA and others tried to work these things out with the plans (referring to the 2018 consensus statement), but unfortunately, despite this agreement, things are getting worse because the plans have not been willing to abide by this agreement.

Dr. **Rhee** jumped in with a few prior authorization stories from urologists, including one who needed surgery. The prior authorization process caused delays in the surgery, and the cancer advanced to a more serious stage in just six weeks. Dr. Rhee informed the group that problems related to prior authorization are the number one issue for urologists. It has become a "boulder" in urologists' shoes rather than a pebble.

Basim Khan, MD, from Neighborhood Health, noted that in primary care, safety net setting, burnout is a problem. He relayed a story about one colleague who left private practice because of prior authorization hassles.

Vacheria Keys, Esq., director of regulatory affairs of the NACHC, underscored the health equity concerns, noting that their patients have some of the most complex and chronic diseases, so prior authorization can be a particular problem — especially if these patients abandon their treatment. She also pointed out that these patients typically have other socioeconomic challenges and may be more concerned about putting food on the table than their health care. Finally, she noted that these barriers could foster distrust in the health care system among vulnerable patients.

J. Scott Just, MD, MBA, an emergency physician representing the AHA, reinforced that the burdens of prior authorization are still there and getting worse. These burdens are also contributing to workforce problems, with significant nursing turnover. He relayed a story about a stroke patient who needed to go to neuro-rehab. Initially, the prior authorization was denied forcing a peer-to-peer consultation, and eventually, the care was approved. These challenges impact the emergency department because they have patients boarding in the ED who need beds but can't get them due to throughput issues, sometimes caused by prior authorization delays. Finally, Mr. Just pointed out that his hospital system is an effective, 2-sided risk shared-savings, accountable care organization, so prior authorization should be largely unnecessary.

Anders Gilberg, staff for MGMA, echoed some of Ms. Smith's comments regarding efforts to find common ground with the health plans. **Jeff Smith**, CEO of Piedmont HealthCare, noted that each facility has at least one dedicated staff person for prior authorization and complained that there is no standardization among the plans. He also pointed out that most services get approved, particularly following the peer-to-peer process, so what is the point? We are spending all this time and money even though the care is approved—as long as the patient and providers keep working for these approvals. Mr. Smith also echoed the comments about value-based care, noting that prior authorization is unnecessary in these arrangements. Finally, he gave an example of his wife, who needed ulnar nerve surgery in both elbows, and the plan would only approve surgery in one. In a peer-to-peer consultation (naturally with a non-peer), she was told she probably had carpel tunnel syndrome, despite her physician's diagnosis and treatment plan.

Ms. **Orrico** addressed several topics in her remarks. She stressed that the peer-to-peer process is entirely overused and plans schedule these consultations at the whim of the plan and not at the convenience of the patient or physician, so CMS should expand the rules to address this problem, including requiring a clinician in the same or similar specialty to conduct these peer-to-peers. Ms. Orrico also pointed out the need for real-time prior authorization decision-making, as is included in the *Improving Seniors' Timely Access to Care Act*. She pointed out that most prior authorizations are ultimately approved, so what is the point? She also raised the common problem where a surgeon or

proceduralist has been preauthorized for a service but discovers a related problem that needs to be addressed once performing the procedure. If the physician proceeds with that additional procedure, the plans will typically pay for this or sometimes will refuse to pay for the entire procedure since the physician didn't strictly follow the treatment approved by the plan. Finally, she pointed out that prior authorization doesn't guarantee payment, and the rules should be adjusted to require plans to pay providers when they deliver care that has been preapproved.

Dr. **Mehta** pointed out that the volume of prior authorizations has gotten worse. He mentioned that health plans are often relying on outdated guidelines. Dr. Mehta also raised the problems related to the so-called "fail first" policies, noting that patients may get worse or incur higher health care costs before getting the best drug treatment. Finally, he agreed about the need to tackle this issue in the context of health equity, noting that the most vulnerable patients cannot manage the complexities of these situations.

Finally, **James B. Chadduck**, MD, a neurosurgeon representing the AHA, noted that things are getting horribly worse. He relayed that prior authorization compromises efficiency, particularly with the expansion of unnecessary peer-to-peers. Dr. Chadduck also walked through his hospital's process for scheduling surgeries, stating that the plans typically won't engage in the prior authorization process until surgery is scheduled — however, the prior authorization review doesn't begin until a day or two (and sometimes hours) before surgery. Frequently, he has to cancel surgery at the last minute because it has not yet been approved. He also shared an example of a plan refusing to pay for a patient who was treated on an in-patient rather than out-patient basis, demonstrating how health plans are hurting patient care. He also complained about the peer-to-peer process, particularly because the plans schedule these at their convenience rather than physician availability. Finally, he pointed out how plans drag out the process in the last few months of the year because they know that patients often change plans.

Dr. **Greene** asked the group if some of these delays are attributed to the sloppiness of the plans. For example, she has heard stories about providers getting multiple answers from the plan. The group uniformly rejected this supposition. Ms. **Orrico** pointed out that the health plans are making money on the premium float, so it is in their financial interest to delay or deny care since that means more money in their coffers. Ms. **Keys** agreed that it is more than just sloppiness; the plans are making business decisions. Dr. **Mehta** also pointed out that plans are putting more effort into helping patients change plans (e.g., Medicare Advantage marketing) than in addressing prior authorization. Dr. **Resneck** firmly stated that the plans are actively pursuing these barriers to care, noting that if even a handful of patients abandon treatment or treatment is delayed or denied, that keeps millions of dollars in the plan's hands (he informed the group that behind closed doors, the health plans admitted this strategy).

Administrator **Brooks-LaSure** then asked if any particular plans (e.g., MA, Medicaid, commercial) are better or worse than the others. Ms. **Smith** noted that MA was the worst, followed by Medicaid-managed care and commercial payers. Others indicated that the plans are all bad. Finally, Ms. **Orrico** used the opportunity in this discussion to urge CMS *not* to expand prior authorization in fee-for-service before we fix what is currently broken.

Request of HHS/CMS

Administrator **Brooks-LaSure** encouraged participants to comment on the proposed rules and "bring to life" the provisions of the rules with experiential examples. She reiterated that CMS finds our comments

extremely helpful and appreciated the information shared at the roundtable. Dr. **Murthy** also expressed his thanks to us and how HHS/CMS values our partnership in helping to make these improvements. He concluded by stating they feel a sense of urgency around this issue.

Post Meeting

Following the meeting, the Alliance issued a press release. This led to at least one article (with more mentions possibly to come) from *Inside Health Policy*:

> **Prior Auth Proponents Eye Next Steps As CMS Unpacks Rule Feedback**
> January 17, 2023
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> Proponents of prior authorization reform are optimistic about the slew of proposed rules that the administration says would reduce provider burden and lower workforce burnout, but now advocates are focused on next steps as the Congressional Budget Office reassesses the cost of a bill that would streamline the prior authorization process and transition it to an electronic system.
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> CMS issued three rules in the final months of 2022 aimed at revamping the prior authorization process. If finalized, the rules would increase transparency about the approvals and denials process, shorten the permissible waiting period for approvals, make the rationale behind denials available to patients and providers, and transition the system to an electronic prior authorization process.
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> Now, CMS is unpacking elements of the proposed rules stakeholders feel are important ahead of the deadlines for comment submissions. An expert told Inside Health Policy the administration and advocates discussed in a stakeholder-only call on Tuesday (Jan. 17) how the proposed rules would impact provider burnout, transparency and patient awareness of the approvals process.
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> The expert told Inside Health Policy some stakeholders are encouraging CMS to beef up some of the components of the proposed rules, including tightening timelines for urgent and non-urgent prior authorizations and improving peer-to-peer approvals conversations to align specialists seeking a prior authorization with a peer from their specialty.
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> Meanwhile, a bill meant to transition prior authorizations to an electronic system accrued huge bipartisan support in both the House and Senate last year, but ultimately fell short. The Congressional Budget Office slapped a $16 billion price tag on the legislation shortly after it passed the House, and lawmakers' year-end deal came together before CBO had time to rescore the bill -- though lobbyists said rescoring it while factoring CMS' proposed rules into the cost could lower the cost by half.
>
> Legislators and stakeholders are waiting for CBO to rescore the prior authorization bill before deciding whether and when to reintroduce the bill. This rescore could either include the set of proposed rules, which could lower projected costs by half, or could incorporate the rules once they're finalized, which an expert says could cut costs to negligible amounts.

Depending on how CBO chooses to rescore, the bill may not be reintroduced for weeks or months, the expert said, especially as legislators scramble to avert a government shutdown as the federal debt ceiling looms.

CMS Administrator Chiquita Brooks-LaSure and Surgeon General Vivek Murthy said during a press call Tuesday that the proposed overhauls would significantly lighten their administrative workload, which could cut back on exhaustion and burnout and allow providers to spend more time caring for patients.

“I think what I took away from this was just how much prior authorization and administrative burden is really weighing down providers, and it is interfering with their own well-being and their ability to deliver care,” Brooks-LaSure said. “So as we think about ways that we can support the workforce, this is very high on their list. It’s also high on their list of in terms of waste and cost, which affect all of us, whether we think about the trust fund, the programs, or think about the impact of patients, people, as well as, of course, as a clinician.”

According to a survey from the Alliance of Specialty Medicine, over 93% of respondents answered that prior authorization has increased for procedures, and 92% reported that PA has had a negative impact on patients.

“Prior authorization is a barrier to care that profoundly harms patients,” said Eugene Rhee, public policy chair of the American Urological Association. “The AUA applauds CMS for the opportunity to participate in today’s dialogue about how we can remove this barrier so that patients can get the care they need when they need it. Ongoing communication is key to ensuring CMS understands and addresses the challenges physicians and their patients face every day.” -- Bridget Early (bearly@iwpnews.com)