

MAY 2023

SPOTLIGHT

— prior authorization —

IN MEDICARE ADVANTAGE



MEDICAL GROUP
MANAGEMENT
ASSOCIATION

INTRODUCTION

Following substantial growth of enrollment in Medicare Advantage (MA) plans during the previous two decades, in April 2022, the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) published a report which detailed how MA beneficiaries' care was often negatively impacted as a result of delayed and denied prior authorization requests, despite the requests meeting Medicare coverage rules.

To further understand the critical impact of prior authorization within the MA program, and to allow us to better educate Congress and the Administration about obstacles to delivering high-quality patient care to beneficiaries, in March of 2023, MGMA surveyed over 600 medical groups. Findings overwhelmingly show that prior authorization in MA is increasingly burdensome for medical group practices and contributes to:

- Increased practice administration costs;
- Disrupted practice workflow; and,
- Delays and denials of necessary medical care.

There is still much to be done at the federal level to provide regulatory relief for medical groups and alleviate barriers to patient care. MGMA will continue to play a key role in prior authorization policy discussions with policymakers to ensure that medical practices have a voice in Washington.

RESPONDENTS

The survey includes responses from executives representing 601 group practices. 65% of respondents represent independent medical practices; 23% represent hospital-owned practices, integrated delivery systems (IDS), or a practice owned by an IDS; 4% represent a medical school faculty practice plan or academic clinical science department; and 8% represent a management service organization, physician practice management company, independent practice association, or other.

ABOUT MGMA

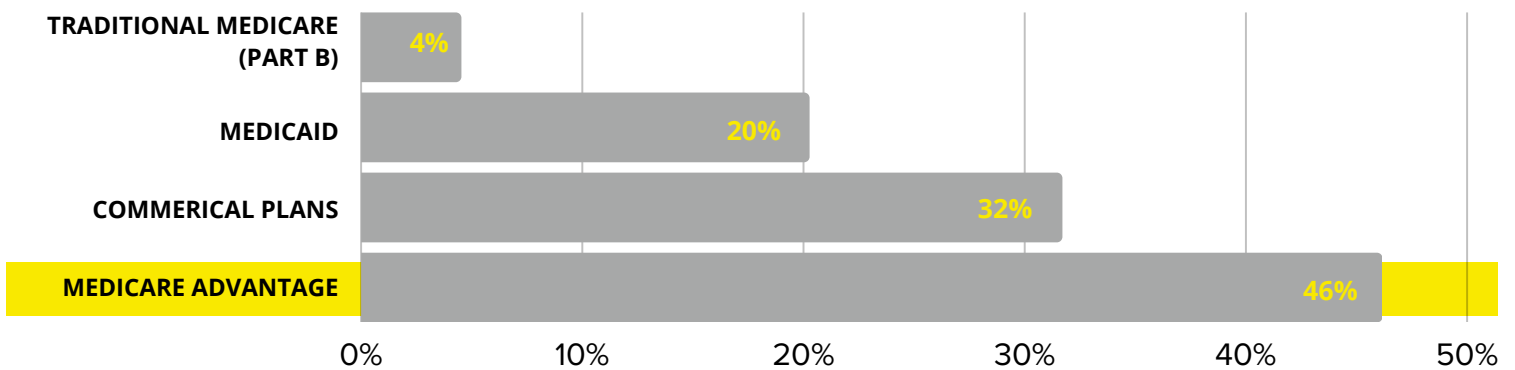
With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups comprising more than 350,000 physicians. These groups range from small independent practices in remote and other underserved areas to large regional and national health systems that cover the full spectrum of physician specialties. For more information on how MGMA is advocating for medical practices in Washington, please visit mgma.com/advocacy or contact us at govaff@mgma.org.

FINDINGS

PRIOR AUTHORIZATION BURDENS ARE INCREASING AS MEDICAL GROUPS SEE MORE MEDICARE ADVANTAGE PATIENTS.

The uptake of MA plans was reflected among practices surveyed; 95% treat patients that are covered by MA, and 75% report they are seeing an increasing number of MA patients. Practices ranked MA as the most burdensome as it pertains to obtaining prior authorization when compared to commercial plans, traditional Medicare, and Medicaid.

MOST BURDENSOME FOR OBTAINING PRIOR AUTHORIZATION:



84%

of practices surveyed report prior authorization requirements for MA have increased in the last 12 months, while **less than 1% report that they had decreased**

58%

of practices saw 15% or more of their patients either switch from traditional Medicare to MA or between MA plans

84%

of practices report having to reauthorize existing Medicare-covered services for those Medicare beneficiaries who've switched plans

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Already existing prior authorization becomes null when patients change plans. Patients are without treatment while waiting for the approval.

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- PENNSYLVANIA, FAMILY PRACTICE

FINDINGS

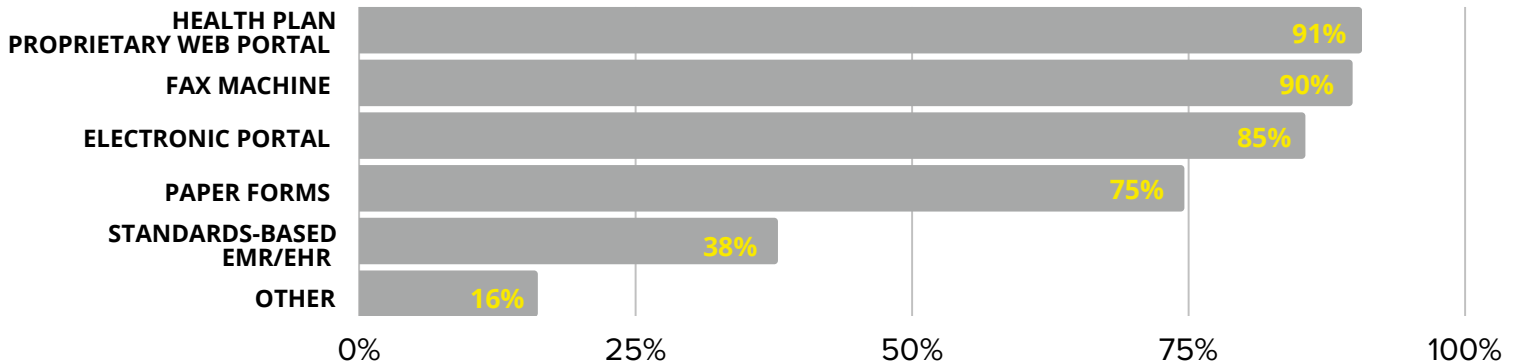
PRIOR AUTHORIZATION IS DISRUPTING PRACTICE WORKFLOW. MGMA has long advocated that policymakers in Washington find solutions to scale back prior authorization requirements for medical practices, arguing that these divert significant time and effort away from delivering patient care.

35%

of medical groups report spending **upwards of 35 minutes on an average single prior authorization request**, with nearly 5% saying they spend 91 minutes or more



WHAT DIFFERENT SUBMISSION METHODS IS YOUR PRACTICE REQUIRED TO UTILIZE BY INSURERS?



30%

of medical groups report **having to interface with 11 or more health plan proprietary web portals**, with 76% of groups interfacing with 5 or more proprietary portals

“

There are so many prior authorization requirements and half-baked portals that it is nearly impossible to keep up with the level of administration required to maintain access for the staff performing them. Every time a new prior authorization is required, it's like starting over from the beginning, or worse.

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- IDAHO, FAMILY PRACTICE

FINDINGS

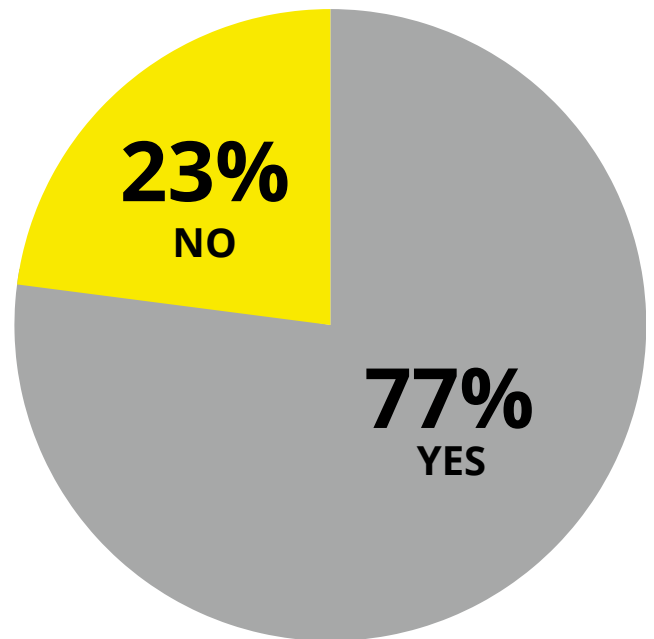
PRIOR AUTHORIZATION IS INCREASING PRACTICE COSTS. After three years of increased financial uncertainty due to the COVID-19 pandemic, medical groups are also facing record inflation, staffing shortages, and across the board cost increases. Reducing prior authorization requirements that do not improve patient care will assist group practices in focusing on patients and allow them to invest resources in initiatives that improve healthcare delivery, further clinical priorities, and reduce costs.

60%

of practices surveyed report that there are **at least three different employees involved in completing a single prior authorization request**



HAS YOUR PRACTICE HIRED OR REDISTRIBUTED STAFF TO WORK ON PRIOR AUTHORIZATIONS DUE TO THE INCREASE IN THESE REQUESTS?



It's a frustrating and expensive process for both patients and medical providers. Often the outcome is approved but only after wasting valuable staff and MD time. Our Referral Specialists often spend their days on hold for 20-30 minutes waiting to get a single PA approved. It's frustrating and demoralizing for all involved.



- INDIANA, FEDERALLY QUALIFIED HEALTH CENTER

FINDINGS

MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUESTS RESULT IN DANGEROUS DELAYS AND DENIALS IN NECESSARY MEDICAL CARE — REFORM IS CRITICALLY NEEDED.

With an increase in utilization of prior authorization across both commercial payers and MA, practices are struggling to ensure patients continue to maintain access to medically necessary care. Prior authorization processes can vary greatly across payers, resulting in a convoluted and overly burdensome process.

97%

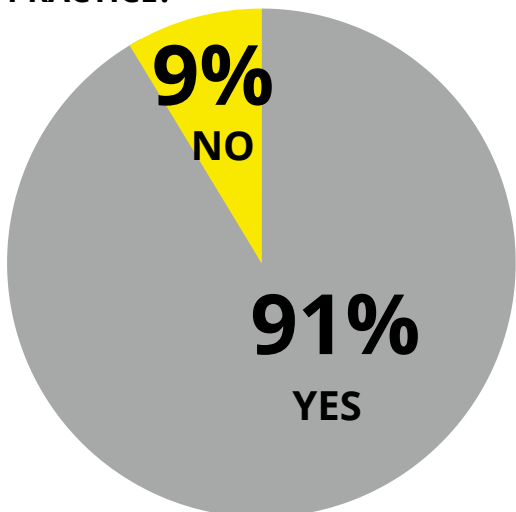
of medical groups report their **patients experienced delays or denials for medically necessary care (e.g., prescription medicine, diagnostic tests, or medical services)** due to prior authorization requirements



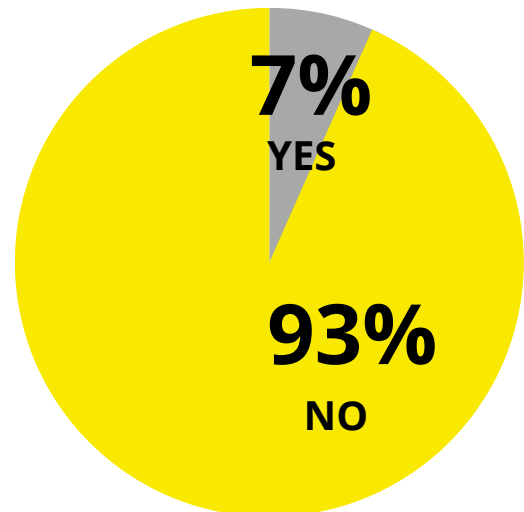
FOR PRIOR AUTHORIZATIONS THAT REQUIRE A PEER-TO-PEER (PRACTICE CLINICIAN TO HEALTH PLAN CLINICIAN) DISCUSSION, IS THE HEALTH PLAN CLINICIAN GENERALLY FROM A RELEVANT SPECIALTY TO THE TREATMENT OR DISEASE IN QUESTION?

72% SAY NO

WOULD A SINGLE STANDARD ELECTRONIC PRIOR AUTHORIZATION SYSTEM ACROSS ALL INSURERS ALLEVIATE BURDEN ON YOUR PRACTICE?






DO ANY OF THE MEDICARE ADVANTAGE PLANS YOU CONTRACT WITH OFFER A GOLD-CARDING PROGRAM?



NEXT STEPS

AS MEDICARE ADVANTAGE ENROLLMENT IS PROJECTED TO CONTINUE TO INCREASE, MGMA REMAINS CONCERNED ABOUT THE GROWING BURDEN PRIOR AUTHORIZATION PLACES ON MEDICAL GROUP PRACTICES. MGMA IS COMMITTED TO ADDRESSING THE CHALLENGES PRACTICES EXPERIENCE BY:

-  Working with the Centers for Medicare & Medicaid Services (CMS) to refine and finalize regulations which would address critical aspects of prior authorization reform in MA. The "Prior Authorization and Interoperability" proposed rule would establish an electronic prior authorization program to help automate requests, require MA plans to publicly report data on prior authorization practices, and shorten the required timeframes for MA plans to return prior authorization decisions. MGMA was encouraged that CMS finalized its "Medicare Advantage and Part D" rule, which implemented recommendations from the OIG regarding incorrect coverage denials by MA plans.
-  Working with Congress to pass and sign into law the *Improving Seniors' Timely Access to Care Act*, which would largely codify many provisions of the "Prior Authorization and Interoperability" proposed rule and put commonsense guardrails around prior authorization practices in MA.
-  Working with stakeholders and policymakers to address and adequately reform other aspects of prior authorization, such as challenges related to peer-to-peer reviews and supporting gold-carding programs.

STAY IN TOUCH

Have questions about any of the contents of this report, or looking to speak with subject matter experts? MGMA's Government Affairs team can be reached by emailing govaff@mgma.org.

If you haven't already, sign up for MGMA's weekly Washington Connection email newsletter to stay apprised of the latest federal policy and regulatory updates impacting medical groups.