LACK OF MEDICARE PRIOR AUTHORIZATION LEADS TO IMPROPER PAYMENT AND WASTE

CMS Administrator Seema Verma recently lamented CMS' lack of adequate legal authority to conduct Medicare prior authorization reviews that are routine in the private sector, coming as American Medical Association (AMA) President Barbara McAneny told reporters that prior authorization can cause major disruptions to care and contributes to providers' administrative burden.

"The Medicare program has extremely low administrative costs, but this isn't exactly something to brag about. The reality is we aren't focusing enough on critical program oversight functions like medical review of claims," Verma said at the America's Health Insurance Plans (AHIP) conference, according to a transcript. "We review less than two tenths of a percent of the over 1 billion claims that Medicare receives a year. Given the scope and size of the Medicare program, that is ridiculously low. We also lack adequate legal authority to do the types of prior authorization reviews that have become routine in the private sector, leading to a high frequency of improper payments, and more fraud and abuse."

CMS earlier this year also indicated interest in using prior authorization more within fee-for-service Medicare to prevent waste, fraud and abuse. In July, CMS program integrity chief Alec Alexander pointed to the president's budget, which included a proposal to expand CMS' authority to require prior authorization for certain Medicare fee-for-service items and include more items, as ways to reduce waste, fraud and abuse.

The Medicare Payment Advisory Commission (MedPAC) in its June 2018 report also said traditional Medicare could more broadly adopt tools, including prior authorization, that are used by Medicare Advantage to address the use of low-value services, and the Government Accountability Office (GAO) released a report noting that CMS has yet to implement prior authorization for chiropractic services as required by the Medicare Access and CHIP Reauthorization Act. That GAO report says CMS intends to issue a notice of proposed rulemaking in December to begin that process.

CMS has received pushback for its take on prior authorization. Earlier this year, beneficiary advocates alleged that CMS' draft Medicare handbook distorted the facts surrounding traditional Medicare and Medicare Advantage, in part by describing MA prior authorization as a "right" that beneficiaries in MA have but those in Medicare fee-for-service do not, rather than a management tool for plans. The agency removed that reference in the final 2019 handbook.

A bipartisan group of 103 House members also recently asked CMS to tell Medicare Advantage plans not to use prior authorization to inhibit beneficiaries' access to services.

Administrator Verma was asked about prior authorization in Medicare Advantage in September, and said it was "on my list" of issues to tackle. "We're sort of finding that, you know, spot between also giving flexibility to the Medicare Advantage plans and other providers to make sure that care is appropriate," she said. "That is something that we've been talking about internally."

McAneny told reporters that prior authorization puts up a barrier to care. There's a huge amount of administrative burden that goes into prior authorization, she said. "The average physician is either spending or paying for 14 hours a week of staff time to spend time talking to the people that the insurance company pays to talk to us about care. One of my health plans said to me, 'You know we never turn you down,' and I said 'Now why are you still torturing us with all this prior authorization process if you're never going to turn us down?' This is one of the areas of documentation that we absolutely have to fix, and the AMA is working hard on that," she said.

AMA, American Hospital Association, AHIP, American Pharmacists Association, BlueCross BlueShield Association and Medical Group Management Association released a consensus statement in January laying out five areas where prior authorization could be improved -- selective application, program review and volume adjustment, transparency and communication, continuity of patient care and automation.

McAneny said prior authorization should be able to be handled quickly and electronically. When asked whether AMA was working with CMS on prior authorization issues, she said that the AMA is working with the agency and as the agency looks at how to reduce documentation burdens on physicians, "we absolutely want to work with them for that."