

Reforming the Use of Prior Authorization

Prior authorization (PA) is a process used by health insurance plans requiring physicians to obtain approval before providing care to patients for covered services. This process is a major burden for psychiatrists and increases the time and labor required to diagnose and treat their patients — delaying or, ultimately denying, access to care and potentially leading to negative health outcomes.

According to the HHS Office of Inspector General, the use of PA by insurers has increased significantly in recent years, particularly in Medicare Advantage (MA), which now covers one half of Medicare beneficiaries. Physicians working in inpatient rehabilitation hospitals and units (IRFs) report that an inordinate number of prior authorization requests for IRF care are initially denied by MA plans, which forces referring acute care hospitals to send patients to less intensive, and potentially inappropriate settings of post-acute care. Of those denials that are appealed, most are overturned on appeal. Excessive and unnecessary use of PA places an untenable burden on physicians and creates significant barriers to patients in accessing timely rehabilitation care. Data from the Medicare Payment Advisory Commission (MedPAC) demonstrate that MA beneficiaries receive one third the access to IRFs that traditional Medicare beneficiaries receive.

AAPM&R supports the bipartisan *Improving Seniors' Timely Access to Care Act* (H.R. 3514/S. 1816). This important legislation would codify recent regulatory actions by the Centers for Medicare and Medicaid Services (CMS) focusing on prior authorization reform and streamline and standardize prior authorizations for many routinely-approved items and services under the Medicare Advantage program.

AAPM&R also supports the bipartisan *Medicare Advantage Improvement Act* (MAIA, H.R. 8375). This bipartisan legislation would implement groundbreaking reforms to the prior authorization process under the MA program, including the addition of IRFs under the MA Network Adequacy standards, implementing anti-clawback provisions for payments, and requiring service-level data collection.

AAPM&R also supports the bipartisan *Reducing Medically Unnecessary Delays in Care Act* (H.R. 2433). This bipartisan legislation would require all prior authorization (PA) decisions and adverse determinations under Medicare, MA and Part D to be made by a licensed physician who is board-certified in the specialty relevant to the request.

As more American citizens, especially seniors and individuals with disabilities and chronic conditions, turn to the Medicare program for their healthcare needs, it is crucial that prior authorization not function as a barrier to accessing medically necessary care. AAPM&R is strongly in favor of taking legislative steps towards reforming the prior authorization process and increasing transparency in all of the programs under CMS.

AAPM&R urges all Members to cosponsor the *Improving Seniors' Timely Access to Care Act* (H.R. 3514/S. 1816), the *Medicare Advantage Improvement Act* (MAIA, H.R. 8375), and the *Reducing Medically Unnecessary Delays in Care Act* (H.R. 2433), and to support additional legislative efforts to reform the prior authorization process in order to protect patient access to care and reduce physician burden.

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