Improving Prior Authorization in Medicare Advantage

Prior authorization is a form of utilization management whereby a clinician must receive insurer approval prior to rendering medical service. Medicare Advantage (MA) insurers, which now cover more than 48% of Medicare beneficiaries, commonly use prior authorization to manage spending and use for their enrollees. An estimated 99% of MA plans require prior authorization for at least some medical services.1 The use of prior authorization is also increasing in traditional Medicare. Historically, traditional Medicare did not use prior authorization requirements, but with rising health care costs, the Centers for Medicare & Medicaid Services (CMS) is reevaluating this policy and has introduced prior authorization for a small number of services (eg, home health) and certain surgical procedures (eg, anterior cervical fusion surgery).

Although using prior authorization to curb unnecessary medical services may reduce waste and slow the growth of health care spending, a serious consequence is that necessary medical services may also be limited. This may lead to an increase in expensive downstream care and disparities in access. As bipartisan legislation is moving forward in both chambers of Congress (HR 3173 and S 3018) to modernize and monitor the use of prior authorization in MA, it is important to consider the benefits and harms of prior authorization policies and their potential effects on various groups (patients, clinicians, MA insurers, and the CMS).

Potential Benefits of Prior Authorization

Prior authorization aims to reduce low-value care by ensuring appropriate use criteria are met and the right care is delivered to the right patient at the right time.2 Thus, it aims to increase guideline-concordant care and reduce unnecessary spending. Prior authorization generates a check on potential overuse of medical services stemming from supplier-induced demand. Whereas rationing care on the basis of price has historically done a poor job targeting the types of care administered,3 in theory, requiring clinicians to seek prior authorization generates a way for clinicians to signal to insurers that a given service is high value.

Additional potential benefits of prior authorization include potential downstream reductions in premiums and out-of-pocket costs for patients due to better care allocation, and reduced medical service claim denials for clinicians and health care centers. When applied to medications, prior authorization can also provide an additional level of safety review to reduce the use of contraindicated treatments or overuse of controlled substances.4

Potential Harms of Prior Authorization

For patients, omissions or errors in the medical record, or inappropriate application of clinical practice guidelines, can trigger inappropriate denials of health care services. According to a 2018 investigation by the Office of Inspector General in the US Department of Health and Human Services, the CMS cited 56% of 140 MA contracts it audited for inappropriately denying prior authorization requests and 45% of MA contracts for sending insufficient denial letters, missing required information such as why the prior authorization request was denied or how the denial can be appealed.5

According to a follow-up 2022 Office of Inspector General report, 13% of 12,273 requests that MA insurers denied met Medicare coverage rules and were inappropriately denied.6 The Office of Inspector General also found that 75% of approximately 863,000 denial appeals were ultimately successful, raising concerns that MA plans were denying services and payments that initially should have been approved.5

Poorly implemented administrative processes, such as mandatory waiting periods or other reasons for prolonged time required to conduct a prior authorization review, can also result in care delays. For many elective procedures, a delay of several days is unlikely to fundamentally alter the course of treatment or clinical outcomes. However, initiation of lifesaving measures, such as chemotherapy or limb amputation for sarcoma, can be affected by the timing of care. Furthermore, an unintended consequence of prior authorization is that denials may increase the use of other health care services and total spending. For instance, patients in need of spine surgery may be directed toward other treatments (such as physical therapy or spinal injections), but may ultimately undergo surgery, resulting in increased total cost of care and prolonged pain and functional limitations.7 In addition, the prior authorization process may potentially undermine the therapeutic alliance between patients and clinicians and ultimately undermine trust.

From the perspective of clinicians and health care centers, prior authorization presents a substantial administrative burden.
physician, consuming 13 staff hours per week; furthermore, 93% of physicians reported care delays and 82% reported care abandonment (either not initiating or not continuing the recommended treatment) due to prior authorization policies. Another source of frustration for clinicians may arise from the fact that the appeals to overturn prior authorization decisions may often involve peer-to-peer discussions that are formulaic, or may be conducted by nonpracticing clinicians or those with inadequate clinical expertise in the specific clinical domain. Thus, administrative burden from prior authorization policies also may potentially contribute to clinician burnout.

Health Policy Implications and Opportunities for Improvement

With the increasing enrollment in MA and increased spending in both MA and traditional Medicare, prior authorization is likely to have an ongoing role in care management in the Medicare program. If used effectively, prior authorization can serve as a powerful lever to improve appropriateness of care, reduce overuse, and contain burgeoning health care costs. However, misapplication can result in harms to patients and unnecessary care delays, which can be expensive in the mid-term and long-term, and further undermine patient and clinician confidence in the process.

There have been widespread calls to reform prior authorization and provide regulatory oversight and transparency. There are currently bills in both chambers of Congress to legislatively establish requirements for MA plans with respect to timeliness and efficiency of prior authorization processes. The American Hospital Association has also petitioned the CMS to propose regulations to require MA plans to automatically consider a service authorized when the clinician who recommends that service has a history of prior authorization approval of 90% or greater, and to require responses for prior authorization requests within 72 hours for nonurgent services and within 24 hours for urgent services.

Consistent with the congressional legislation, the following proposed measures may help improve the use of prior authorization in Medicare:

- Plans should use an electronic-based prior authorization process with time-bound requirements for initial and appeal decisions.
- Plans should be mandated to report guidelines used to make prior authorization decisions and seek input from respective medical societies and stakeholder groups on an annual basis.
- In addition, to expand the congressional legislation, the following proposed measures could be considered:

  - The relative benefits and costs of prior authorization should be reviewed by the CMS at the procedure level. Such review could consider evidence from other care rationing mechanisms, including price. All else equal, unnecessary care is less of a concern in clinical scenarios for which demand is inelastic and there is little price sensitivity (eg, high-cost chemotherapy when there is not a lower-cost alternative). In such cases, restrictions on access due to prior authorization will introduce little change in wasteful or unnecessary care while still generating additional administrative costs.
  - Medicare Advantage insurers should report approval and denial rates annually to the CMS based on beneficiary sociodemographic characteristics and by procedure type so that the CMS can monitor whether prior authorization policies may be increasing disparities in access to care.
  - Drawing upon MA insurer-submitted data on denial rates, the CMS should audit the denials of plans with high-denial rates. Setting thresholds for audit could be based on a comparison with other MA plans, as well as in consultation with patient, caregiver, clinician, and insurer stakeholders.
  - By improving transparency and accountability of the process, prior authorization can better function as a tool to improve high-value care for Medicare beneficiaries.

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REFERENCES


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