RRC
Regulatory Relief Coalition

Protecting patients' timely access to care.

May 9, 2024

The Honorable Sheldon Whitehouse
Chairman
Committee on the Budget
United States Senate
624 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Chuck Grassley
Ranking Member
Committee on the Budget
United States Senate
624 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

On behalf of the Regulatory Relief Coalition (RRC), a coalition of national physician specialty organizations seeking to reduce regulatory burdens that interfere with patient care, we are pleased that the Senate Committee on the Budget held a hearing on May 8, 2024, titled, "Reducing Paperwork, Cutting Costs: Alleviating Administrative Burdens in Health Care." We thank you for your investigation into the serious and persistent issue of administrative burden in health care and your consideration of strategies to curb the overuse and abuse of utilization management tools that delay and deny medically necessary care.

The RRC was established to advocate for regulatory burden reduction to ensure that health insurers' policies are not a barrier to timely and equitable access to care for the patients our members serve. To this end, our coalition is advancing legislative and regulatory changes to ensure that Medicare Advantage (MA) plans serve our nation's seniors. Our recent activities focus on ensuring that utilization review policies are not a barrier to timely and equitable access to care for the patients we serve.

The RRC strongly supports enacting the *Improving Seniors' Timely Access to Care Act*[1] (*"Seniors Act"*), which is widely supported as evidenced by 53 Senate cosponsors and 327 House cosponsors in the 117th Congress. A majority of the Senate Committee on the Budget members supported the reforms in the *Seniors' Act* and the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) electronic PA rule.[2] We applaud you and your Committee members for your strong leadership on this critical issue.

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[1] S. 3018 in the 117th Congress. Most recently, the provisions in the Seniors Act were included in the House Ways and Means Committee-passed Health Care Transparency Act of 2023 (H.R.4822).

[2] The following committee members co-sponsored and/or signed a letter to HHS and CMS urging finalization of the proposed electronic PA rule in June 2023.

Sens. Mike Braun (R-IN), Time Kaine (D-VA), John Kennedy (R-LA), Ben Lujan (D-NM), Roger Marshall (R-KS), Jeff Merkley (D-OR), Alex Padilla (D-CA), Rick Scott (R-FL), Debbie Stabenow (D-MI), Chris Van Hollen (D-MD), Mark Warner (D-VA), Sheldon Whitehouse (D-RI).

Enactment of this legislation would modernize and streamline the prior authorization (PA) process for the nearly 32 million Americans currently enrolled in Medicare Advantage (MA) plans. Along with the RRC, more than 500 organizations representing patients, health care physicians and other clinicians, the medical technology and biopharmaceutical industry, health plans and other organizations have endorsed this legislation. It is time for this bill to become the law of the land.

The RRC commends the Centers for Medicare & Medicaid Services (CMS) for finalizing two rules[3] in 2023 and 2024 that closely mirror provisions of the *Seniors' Act*. CMS estimated in the rule that the improvements to prior authorization in Medicare Advantage will **save** physician practices an estimated $15 billion over 10 years. We believe it important to codify these critical reforms by passing the *Seniors' Act* in the 118th Congress.

The *Seniors' Act* and CMS final rules align on many solutions to the pressing issue of delayed and denied care due to utilization management tools including:

- Requiring MA plans to adopt electronic-PA;
- Ensuring MA plans to respond to PA requests within specific timeframes;
- Requiring public reporting on PA metrics, such as the number of delays, denials and appeals (in the aggregate and individual service level); and
- Allowing waivers or modifications of PA requirements based on physician performance.

The *Seniors' Act* and the rules recognize that PA increases physician and payer administrative burden due to inconsistent payer policies, presents serious physician workflow challenges and contributes to significant physician and other clinician burnout. These findings reflect those from a survey of RRC-member physicians, which found, among other things, that:

- Eighty-two percent of respondents state that PA always (37%) or often (45%) delays access to necessary care;
- Wait times can be lengthy, and for most physicians (74%), it takes between 2 to 14 days to obtain prior authorization, and for 15%, this process can take 15 to more than 31 days;
- PA causes patients to abandon treatment altogether, with 32% reporting that patients often abandon treatment and 50% reporting that patients sometimes abandon treatment;

[3] Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program. See final rule: https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

Advancing Interoperability and Improving Prior Authorization Processes. See final rule: https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

- Overwhelmingly (87%), physicians report that PA has a significant (40%) or somewhat (47%) negative impact on patient clinical outcomes;
- The burden associated with PA for physicians and their staff is high or extremely high (92%); and
- Ultimately, most services are approved (71%), with one-third of physicians getting approved 90% or more of the time

Enacting the *Seniors Act* has the potential to significantly improve health care outcomes while saving costs. Research clearly demonstrates that the delays and denials resulting from onerous PA requirements are hurting medical practices and reducing quality of care for patients. For example, one recent national medical group practice survey[4] found the following:

- 89% of medical practices find prior authorization "very or extremely burdensome."
- 92% of medical practices "hired or redistributed staff to work on prior authorization due to the increase in requests."
- 83% of practices said a top challenge is prior authorization for routinely approved items and services.
- 97% of medical practice reported that patients "experienced delays or denials for medically necessary care due to prior authorization requirements."

Additionally, the most recent (2022) Annual Report issued by the Council for Affordable Quality Health Care (CAQH)[5] indicates that increased use of electronic prior authorization would result in $449 million in cost savings for the medical industry annually, including $139 million/year for health plans and $310 million/ year for providers.

Physician practices are also experiencing challenges getting paid for pre-approved services, as some health plans are refusing to pay claims or are recouping payments after approved health care services have been rendered. For example, a neurosurgical practice recently analyzed its claims to determine the scope of the post-service payment recoupment process, discovering more than $3 million in payment denials and/or recoupments over a 2 ½ year period. The combination of administrative costs and lack of payment is a one-two punch — a significant contributor to physician burnout and a catalyst for increased health care consolidation as physicians can no longer remain in independent practice in the face of these administrative burdens.

Delays in care not only have a negative impact on patient outcomes but they also increase health care costs. Several examples illustrating the adverse impact of PA on patient outcomes and health care costs are attached.

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[4] See https://www.mgma.com/getkaiasset/423e0368-b834-467c-a6c3-53f4d759a490/2023%20MGMA%20Regulatory%20Burden%20Report%20FINAL.pdf

[5] See https://www.caqh.org/sites/default/files/2022-caqh-index-report%20FINAL%20SPREAD%20VERSION.pdf

The RRC looks forward to assisting you with this and other initiatives aimed at getting our patients the care they need when they need it. Please contact Peggy.Tighe@PowersLaw.com. Thank you for considering our views.

Sincerely,

RRC Members

American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Physical Medicine and Rehabilitation
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Osteopathic Association
Association For Clinical Oncology
Congress of Neurological Surgeons
Medical Group Management Association
National Association of Spine Specialists

RRC Allies

American Medical Rehabilitation Providers Association
The National Association for Proton Therapy
Premier Inc
Select Medical

Illustrations of the Adverse Impact of PA on Health Care Outcomes and Costs

- The patient is a 51-year-old male who presented in the fall of 2021 with shortness of breath (SOB) and cough. He was treated with antibiotics and steroids and improved but after the holidays noted increasing SOB especially when lying flat. He was admitted with a large mediastinal mass and after several biopsies was diagnosed with Hodgkin's Lymphoma. Because of the policy that PET scans cannot be done in the hospital, he received steroids, which provided some relief and was seen by his physician the next week. At the time, consent for chemotherapy was obtained and orders written to begin urgently. PA (prior authorization) was required prior to the PET scan and treatment. Ten days after the orders were written, he developed increasing SOB and went to the Emergency Department and was re-admitted to the hospital. His PET had been scheduled the morning of admission, but his treatment was still not yet scheduled awaiting PA. His breathing deteriorated and he was intubated and taken to the MICU. The physician visited him in the ICU the morning after admission and helped orchestrate emergent chemotherapy. His course was complicated by bacterial hospital acquired pneumonia, and he remained in the ICU for 10 days when he was weaned from the vent and transferred to the Hematology/Oncology service. He was discharged to receive his treatment in the outpatient setting. Brentuximab was denied by his insurance until "peer to peer," which took several days to arrange. None of this needed to happen had he received timely therapy.

- The patient is a 32-year-old female who presented to the Emergency Department with SOB, chest pain and a large anterior chest mass growing into the anterior soft tissues. A biopsy was done in interventional radiology (IR) and the physician was called about the patient while she was in radiology. The physician added her to the next clinic, and because of her symptoms, she was admitted to receive her first dose of ABVD (chemotherapy combination used to treat Hodgkin lymphoma). A randomized trial has shown that AVD-Brentuximab is superior, but the Brentuximab requires approval and her situation required urgent treatment. After receiving her C1D1 treatment, she was to receive C1D15 in the clinic. The orders were written but the infusion center refused to schedule her because they had yet to receive PA. After multiple communications including texts, phone calls, and "peer to peer" the patient was scheduled for treatment 5 days late. For her second cycle, her payor finally approved brentuximab after more back and forth with insurance.

- Following cataract surgery, an ophthalmology patient travels to have an exam and needs a YAG laser capsulotomy. This procedure addresses post-cataract surgery vision issues by using a laser to rupture a membrane holding the lens implant in place that can become cloudy and reduce vision. The ophthalmologist cannot do the procedure immediately because of PA requirements by the patient's insurance company. This requires the patient to again travel to the ophthalmologist's office for a common

procedure on a later date. It also requires the practice to make adjustments to their already overbooked schedule to accommodate the patient’s additional visit. This practice is a regional referral center for many rural areas in northwest Georgia and northeast Alabama. In this case, PA results in increased cost an inconvenience for the patient for a procedure that could have been provided during a previously scheduled visit.

- In Florida, a third-party administrator manages Aetna Medicare Advantage beneficiaries’ ophthalmology services. The administrator is now asking for Manifest Refractions to be within 90 days of cataract surgery scheduled for the patient’s second eye. The passage of 90 or more days sometimes occurs with the elderly population, as other health issues arise between the procedures for the first and second eye, which necessitates a delay in the second eye procedure. Since a Manifest Refraction was done for both eyes prior to the first eye surgery that clearly showed the patient’s vision could not be improved, requiring the practice to repeat the patient’s Manifest Refraction results in additional costs to the health care system and further delays medically necessary care. . This ophthalmology practice has also had PA denied for not specifically indicating that "The patient would like to have cataract surgery". This has unnecessarily delayed patients’ timely access to sight-restoring eye care and added additional administrative burden for the practice’s staff