



Issue: Prior Authorization/H.R. 3173 Improving Seniors' Timely Access Care Act of 2021

Currently this proposed legislation has the bipartisan support of 284 members.

Background: Improving Seniors' Timely Access to Care Act of 2021 was introduced in the 117th Congress by Congresswoman Suzan DelBene (D-WA) in May of 2021. Essentially if passed, this law would modify title XVIII of the Social Security Act and primarily focus on correcting issues and streamlining processes as it relates to the practice of obtaining Prior Authorizations. Patient-Centered Care remains a major goal across the health care industry. By providing patients with the tools to play an active role in their care and participate in developing an individualized treatment plan to meet their health care needs, this care model can increase patients' satisfaction and ultimately improve treatment quality and outcomes.

Yet despite these clear advantages to adopting patient-centered care, health care providers and patients often face significant obstacles in putting this concept into practice. Utilization management programs, such as prior authorization create significant barriers for both the patient and provider as it can delay the start of, or the continuation of ongoing treatment and will most likely negatively affect patient health outcomes. It is the cumbersome, manual, and time-consuming processes used in these programs that burden providers and divert valuable resources away from direct patient care. However, Insurance Payers contend that utilization management programs are applied to control costs and ensure appropriate treatment. Recognizing the investment that the healthcare insurance industry will continue to place in these programs, AAHAM has developed the following principles on utilization management programs to reduce the negative impact they have on patients, providers, and the health care system. AAHAM strongly urges health plans, benefit managers and any other party conducting utilization management, as well as accreditation organizations, to apply the following principles to utilization management programs that will benefit all involved parties. We believe adherence to these principles will ensure that patients have timely access to treatment and reduce administrative costs to the health care system.

AAHAM Prior Authorization Principles:

1. **We want a bill that applies to all health plans.** Medicare, Medicare Advantage, Medicaid MCO's, and all commercial health plans. Without consistency amongst health plans, we will continue to add millions of dollars of operational costs to healthcare. By fully standardizing the prior authorization process with all payers, it provides much needed administrative relief.
2. **We want a bill that establishes an electronic standard—including requiring all health plans to accept electronic clinical information.** CORE is a not-for-profit industry alliance designated as the authoring entity for federally mandated operating rules under HIPAA. CORE recently released a study that shows only 13% of reported transactions were completed fully electronically. CORE's study shows that each manual prior authorization being done today costs the industry an average of \$14.24, whereas when



electronic transactions can be utilized, the cost falls to \$1.93 per transaction. Their study shows moving to a standard electronic transaction could save over half a billion dollars annually. If requiring electronic standards are not feasible currently across all health plans, then at the very least, require each health plan to utilize the same template to gather their information that they need to make a prior authorization decision. Currently each health plan has their own template with their own

requirements. Can we agree that a health care procedure should only have one set of criteria that a provider would need to be compliant with an order to perform the test? The current environment adds billions of dollars to the cost of healthcare through hospital operational costs by requiring hospitals and providers to understand the various differing requirements of each health plan template. This also delays patient care.

3. **We want a bill that requires health plans to meet quality and timeliness of prior authorization standards.** CORE's recommendation on this was to require a 2-day response time on all requests. These currently range within health plans from 24 hours to 15 business days, which greatly delays the ability for patients to receive care and adds costs to the healthcare system as it requires hospital providers to contact the health plan multiple times for their decision. We recommend that CMS implement a requirement for payers to respond 24 hours a day and 7 days a week (24/7) to prior authorization requests. Providers see patients on a 24/7 basis, not just during normal business hours. This change will provide relief from typical holiday or weekend backlogs. Real-time authorization responses will also allow for more timely treatments to beneficiaries.
4. **We ask for national standardization as to what makes a specific test medically necessary.** For example, an MRI must meet specific criteria in order to be prior authorized, so the provider can order the test and so the patient can receive it. This should be the same standard no matter who the health plan payer is. Today, we deal with different standards between different payers, which requires providers and hospitals to know and meet different standards for the same procedure. Each payer also requires submission of different information. This may include authorization request forms or various pieces of a patient's medical records that providers must manually key into the authorization submission website. We recommend considering standardizing language to specify the data required for prior authorization. Consistency in the submission process will relieve existing administrative burdens.
5. **We ask for a "family of codes" that is consistent across the country.** For example, if a provider orders and authorizes an MRI with contrast but when performing the procedure decides to do the procedure without contrast, the code should be approved since that code is within the same "family of codes." This example and occurrence result in frequent denials of services from insurance companies. When this occurs, the CPT code billed may be 1 number different from the CPT code that was authorized, because something just a little different was required when the provider was performing the service. Services provided that fall within the same procedure family of codes and within a pre-determined cost threshold should be a covered service for the patient and should be



paid by the insurance company. AAHAM would be willing to collaborate on the

establishment of a standard of a national family of codes utilizing current national coding guidelines. Without an improvement in HIPAA related items, this is the number one item that could improve the prior authorization process and reduce costs to the system. We recommend establishing authorizations for services when a specific CPT code is approved, any codes that fall within that same family of codes is also authorized and approved. An example for imaging services would be an MRI Thoracic spine w/o contrast, CPT 72146, but the radiologist makes a clinical decision during the visit to do an MRI Thoracic spine w/o & w/ contrast, CPT 72157. We recommend that a payer would still approve these services if they authorized the grouping or family of codes for MRI Thoracic Spine. Currently providers expend resources to work through the payer denial and re-authorize a different CPT code within the same grouping. This is an additional administrative burden to both payers and providers.

- 6. We ask for one standard list of tests that would apply to all health plans across the country for what tests require a prior authorization before they can be performed.** Currently each health plan has their own lists of tests that require prior authorization, and those lists vary from health plan to health plan. This also adds hundreds of millions of dollars to the cost of healthcare through hospital operational costs that are required to figure out what tests each health plan needs to have authorized. This also delays patient care.

Recommendation: We encourage Congress to pass legislation that includes the patient centric model that has been outlined by AAHAM above. This legislation is a good starting point, but changes that incorporate AAHAM's core principles above are critical if we are going to achieve real reform that is both patient centric and effective for hospitals. Anything less will cause unmanageable hurdles for hospitals and increased confusion and patient dissatisfaction.