AMERICAN ACADEMY OF FAMILY PHYSICIANS

June 30, 2022

The Honorable Diana DeGette
Chair
Oversight & Investigations Subcommittee
Energy & Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable H. Morgan Griffith
Ranking Member
Oversight & Investigations Subcommittee
Energy & Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Chair DeGette and Ranking Member Griffith:

On behalf of the American Academy of Family Physicians (AAFP), which represents 127,600 family physicians and medical students across the country, I write in response to the hearing: "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans" to share the family physician perspective and the AAFP's recommendations.

Over the last decade, Medicare Advantage, the private plan alternative to traditional (fee for service) Medicare, has taken on a larger role in the Medicare program. In 2022, more than 28 million Medicare beneficiaries enrolled in a Medicare Advantage plan, which represents 45 percent of all Medicare beneficiaries.[i] With the growing role of Medicare Advantage, family physicians are concerned with the increasing number of administrative requirements that detract from time that would be better spent on patient care. Studies have estimated that primary care physicians spend nearly 50 percent of their time on cumbersome administrative tasks, such as prior authorizations.[ii] Family physicians report that prior authorization and other utilization management processes regularly cause patient care delays and can worsen health outcomes.

In fact, a recent Department of Health and Human Services' (HHS) report found that Medicare Advantage plans sometimes delayed or denied beneficiaries' access to services, even when prior authorization requests met Medicare coverage rules. Denying requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers. These denials also run directly counter to federal statute, which requires Medicare Advantage plans to provide enrolled beneficiaries with the same benefits they would receive in traditional Medicare. As such, the AAFP urges the Committee to consider the following recommendations to ensure all Medicare Advantage beneficiaries have timely access to quality, comprehensive care.

Streamline Prior Authorization

Prior authorization is the process by which physicians must obtain advanced approval from a health plan before the delivery of a procedure, device, supply, or medication for insurance to cover the cost for that service. Health plans use prior authorization as a cost-containment strategy by limiting and restricting access to expensive services. The HHS report found that among the prior authorization requests that Medicare Advantage plans denied, 13 percent met Medicare coverage rules - in other words, these services likely would have been covered for these beneficiaries under traditional Medicare.

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We know firsthand from family physicians that prior authorization creates an administrative burden for physicians and other clinicians. The manual, time-consuming processes used in prior authorization programs burden family physicians and their practice staff, divert valuable resources from direct patient care, and can delay the start or continuation of necessary treatment, leading to lower rates of patient adherence to treatment and negative clinical outcomes. In general, the federal government needs to automate and streamline prior authorization, as well as reduce the overall volume of prior authorizations to improve patient care and minimize physician burden.

According to an American Medical Association (AMA) survey, 85 percent of physicians report that the burden associated with prior authorization is "high" or "extremely high" and 30 percent of physicians report that prior authorization has led to a serious adverse event for a patient in their care. The survey reports that physicians and their staff spend almost two business days each week completing an average of 40 prior authorizations per physician, per week.

The AMA survey also highlights the impact of prior authorization on patients: 90 percent of physicians say that prior authorization somewhat or significantly impacts patients' clinical outcomes. Furthermore, 79 percent of physicians report that issues related to prior authorization can at least sometimes lead to patients abandoning their recommended course of treatment while 94 percent of physicians report care delays associated with prior authorization. These delays increase wait times for medical services and prescriptions for patients while diminishing access to timely care.

To mitigate the impacts of prior authorization on patients and improve Medicare beneficiaries' health outcomes, and ease administration burden on physicians, we urge Congress to pass the *Improving Seniors' Timely Access to Care Act* (H.R. 3173) and the *GOLD Card Act* (H.R. 7995). These two bills will streamline the prior authorization process in Medicare Advantage plans by ensuring it is evidence-based, transparent, and administratively efficient to protect patients from unnecessary delays in care, promote improved clinical outcomes, and reduce administrative burden for physicians.

Strengthen Network Adequacy for Medicare Advantage Plans

Network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to enough in-network primary care and specialty physicians, and all health care services included under the terms of the contract. The AAFP has long supported strong federal network adequacy standards and oversight. Robust clinician networks are vital to ensuring Medicare beneficiaries have timely, equitable access to comprehensive primary care and other health services. We are concerned that patients enrolled in plans operating with insufficient networks may experience care delays, which can worsen health outcomes and health disparities. Earlier this year, the AAFP submitted comments in response to a CMS proposed rule stressing that network reviews should be part of the application process for Medicare Advantage plans and that network failures should be considered reason for application denial. The AAFP is pleased that CMS finalized this proposal to strengthen Medicare Advantage network adequacy requirements. **We urge Congress to support additional regulatory proposals to continue strengthening network adequacy standards to ensure seniors in Medicare Advantage plans have timely, equitable access to care**.

The AAFP applauds the work of the Committee to strengthen oversight of Medicare Advantage plans and ensure beneficiaries have access to timely care. For more information, please contact Erica Cischke, Director of Legislative and Regulatory Affairs, at ecischke@aafp.org.

Sincerely,

Ada D. Stewart, MD, FAAFP
Board Chair, American Academy of Family Physicians

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[i] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Contract-and-Enrollment-Summary-Report

ii Arndt, B., Beasley, J., Watkinson, M., Temte, J., Tuan, W.-J., Sinsky, C., & Gilchrist, V. (2017, September 1). Tethered to the EHR: Primary care physician workload assessment using EHR event log data and time-motion observations. Annals of Family Medicine. Retrieved June 27, 2022, from https://www.annfammed.org/content/15/5/419.full