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MGMA Survey Highlights Prior Authorization Challenges

On May 3, the Medical Group Management Association released the results of a survey of over 600 medical group practices that sheds more light on how prior authorizations in the Medicare Advantage program are both increasing in number and disruptive for providers and patients.

The survey found significant time being spent on completing prior authorization requests, with 35% of respondents indicating they spend as much as 35 minutes on an average single prior authorization request, with nearly 5% saying they spend more than 90 minutes. Part of the complexity involves having to deal with different web portals for different Medicare Advantage plans, with 30% of groups responding to the survey indicating they had to interface with 11 or more proprietary portals. These factors contribute to time taken away from delivering patient care and increased costs.

Further, according to the report, 97% of respondents indicated that prior authorization requests have resulted in patients experiencing delays or denials for medically necessary care.

As a result, MGMA is encouraging CMS to refine and finalize proposed regulations that would require Medicare Advantage plans to publicly report prior authorization data, provide for an electronic prior authorization platform, and shorten timeframes for plans to respond to prior authorization requests. WHA submitted a comment letter on this proposed rule in March. That's in addition to the rule that CMS finalized in April that restricts certain prior authorization practices.

MGMA also supports the "Improving Seniors Timely Access to Care Act," which WHA has also supported and recommends working with stakeholders to address other aspects of the prior authorization process.

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