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Statement for the Record

on behalf of the

American Association of Neurological Surgeons
and the
Congress of Neurological Surgeons

before the

Committee on Small Business
U.S. House of Representatives

on the topic of

Utilization Management: Barriers to Care and Burdens on Small Medical Practice

Wednesday, September 11, 2019
11:30 a.m.
2360 Rayburn House Office Building

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Chairwoman Velázquez, Ranking Member Chabot and members of the committee, on behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 practicing neurosurgeons in the United States, we appreciate the opportunity to submit a statement for the record regarding your hearing titled, "Utilization Management: Barriers to Care and Burdens on Small Medical Practice." Like you, we believe that reducing unnecessary administrative burden is critical to lowering costs and removing obstacles that get in the way of physicians delivering high-quality care to their patients. While our health care system, including the Medicare and Medicaid programs, is complex, over time, the accumulated regulatory burdens foisted on physician practices has reached a tipping point.

The single most pressing issue facing neurosurgical practices today is burdensome utilization review programs — including prior authorization and appropriate use criteria (AUC) for advanced diagnostic imaging. This is especially true for smaller neurosurgical practices. We, therefore, appreciate you holding this hearing today to shed light on this topic.

PRIOR AUTHORIZATION

Framing the Issue

Prior authorization is a cumbersome process that requires physicians to obtain pre-approval for medical treatments or tests before rendering care to their patients. The process for obtaining this approval is burdensome and costly to physician practices, requiring physicians and their staff to spend an enormous amount of time each week negotiating with insurance companies. As a result, patients are now experiencing significant barriers to medically necessary care, even for treatments and tests that are eventually routinely approved.

A recent survey[1] of neurosurgeons conducted by the AANS and the CNS found the following:

Prior Authorization Burden in Neurosurgical Practice has Increased

- Ninety-one percent of neurosurgeons report that the **burden** associated with prior authorization has **significantly increased** over the past five years.
- Insurers have **increased** the use of **prior authorization** over the past years for procedures (95%); for diagnostic tools (93%); and for prescription medications (55%).
- In any given week, many neurosurgeons (41%) must contend with between 11 and 40 prior authorizations. More than one-quarter (27%) of respondents face **more than 40 per week**.
- Many neurosurgeons must now engage in the so-called **peer-to-peer** process to obtain prior authorization, and nearly one-third (32%) of respondents experience this requirement for 26% to 75% or more of their services (including prescription drugs, diagnostic tests and medical services).
- More than three-fifths (62%) of neurosurgeons have staff members **working exclusively** on prior authorization, with most staff spending between 10-20 hours per week on prior authorization.
- **Ultimately**, the **majority of services** are **approved** (80%), with nearly forty percent (39%) of neurosurgeons getting approved 90% or more of the time.
- Unbelievably, **despite gaining prior authorization**, insurance companies **deny payment** after services are rendered, an outcome three-fifths of neurosurgeons have experienced more than once in the past year, and 24% have had this happen 20 or more times.

Patient Access to Care is Impacted

- Eighty-two percent of respondents state that prior authorization either always (34%) or often (49%) **delays access** to necessary care.

[1] *See* Attachment 1.

- The **wait time** for prior authorization can be **lengthy**. For most neurosurgeons (67%) it takes between 2 to 14 days to obtain prior authorization, but for 22%, this process can take from 15 to more than 31 days.
- Prior authorization causes patients to **abandon treatment** altogether with 21% reporting that patients often abandon treatment and 60% reporting that patients sometimes abandon treatment.
- Overwhelmingly (88%), neurosurgeons report that prior authorization has a significant (37%) or somewhat (51%) **negative impact** on patient **clinical outcomes**.

Observations from Practicing Neurosurgeons

The comments from our members are particularly illustrative regarding the burden of prior authorization on their practices, with one neurosurgeon summing-up the prior authorization process in a single word — "**exhausting**." Some observations include:

"**Peer to peer** level discussions are frequently unnecessary and unnecessarily delay surgical intervention. The clinicians that we speak to are not specialty-specific, and many times have no idea what the procedure we are proposing even is."

"**Peer to peer** is not a reality. Those phone calls rarely have a physician with my same specialty, and on spine cases, the individual is not neurosurgeon or even an orthopaedic spine surgeon. Some are reading a protocol (script) that they have been given to justify **delaying or canceling patient access** to care."

"I spend an absurd amount of time dealing with prior auths and **peer to peers**, which is time I need to have dedicated to my patient care. The process is obnoxiously inefficient for health care providers. It is unrealistic to think that a health care provider can give an exact date and time to be able to be reached to discuss the reason a patient needs an image that is for surgery. Our day is unpredictable. I shouldn't have to spend 20-50 minutes on the phone explaining the reasons behind diagnostics only to be told that a physician will need to make the final decision and that the appointment needs to be scheduled for a different date only to spend 20-40 minutes explaining myself over again. Something needs to change."

"[ABC health plan] is by far the worst offender. They deny frequently and never read my chart notes, which are very thorough and contain all the information needed to get authorization. I still have to speak to a non-peer physician, who never looks at the notes beforehand. It is a complete waste of time. I would consider this a top cause of **physician burnout** and makes me think about retirement on a daily basis!"

"The increasingly burdensome process of pre-auth has led to a significant increase in the **cost of running a practice** and **staff burnout**. There are increased cancellations of surgery and imaging that causes significant frustration to patients who plan time off from work as well as the loss of revenue for hospitals as valuable OR and MRI time slots are wasted on a weekly basis. This makes the delivery of high-quality pre-operative care very hard. Interestingly, almost all the requested neurosurgery procedures and imaging eventually get authorized, confirming that this process is meant to limit care but slowing down the process, rather than critically looking at the indications for each request."

"It has been a significant **burden on the practice** and has resulted in many **delays in care**. These delays have resulted in patients suffering. Worse, patients have had to choose between urgent surgery that prevents further neurological deterioration but with the risk that it will ultimately

be denied, versus waiting for approval, knowing that they may irreversibly deteriorate while they are waiting. This has significantly and adversely affected patient health and happiness."

"I am in a university practice. I have no say in what insurance plans are accepted. With **100% of our appeals ultimately approved**, it is clear that this process has not helped a single patient under my care and only delays their care with an unnecessary process-delay loop. It has increased **patient dissatisfaction**, as well as **provider dissatisfaction**, frustration, and **burnout**. It is creating big problems in my ability to treat patients."

"We have **1.5 staff** to take care of three surgeons' prior authorizations, and then the surgeons end up spinning their wheels with **peer to peer**, which is never a true peer. Many of our patients just lose hope of getting the care that is recommended. It is a sham and a way for the insurance carriers to deny care. This has made the **practice of medicine almost unbearable**."

"We have decided it's just a game to try to **delay patients** in hopes that they will give up and not have the services recommended. ABC health plan will often not authorize an MRI scan until physical therapy is done, so we are treating the patient without knowing what is going on. Then when we try to get authorization for surgery, they often require the patients to have recent physical therapy and injections even if the imaging and exam clearly demonstrate the need for surgery. Most of the time, **peer review** is not with a neurosurgeon or even a spine doctor of any capacity. We've had podiatrists and pediatricians making decisions for spine and brain surgery."

"The majority of the time prior authorization process **delays access** to surgery and rarely, if ever, actually changes the plan of care. Reform is needed."

"With the exception of fee-for-service Medicare, prior authorization occurs now almost across the board. As a board-certified neurosurgeon, I cannot order an MRI scan of the spine without asking the patient to complete a course of physical therapy, whether or not I think it will be beneficial. If I attempt to order an MRI on a patient who has not had physical therapy, the patient will automatically receive a generic form letter, which ultimately **delays** diagnostic workup, care delivery, and mandates physical therapy. In most instances, if I feel the therapy will be of no benefit, it actually has no long-term effect or positive benefit and actually **increases their healthcare cost**. There is certainly a place for physical therapy, but that should be ordered as a result of my judgment rather than by the insurance company. Not only does this interfere with patient care, but in my opinion, constitutes *de facto* practice of medicine by the insurance company without a license. The entire process results in a higher number of office visits in order to document what the insurance company perceives as justification for the MRI, untold man-hours of the office personnel and staff dealing with the authorization and a significant delay, frustration, and disappointment for the patients."

As you can see, there is a great deal of frustration with a process that adds unnecessary administrative burden and costs to physician practices, delays medically necessary care and saves the health care system very little since most prior authorizations are ultimately approved (indeed, health care costs may actually increase because of delays or other unnecessary care — e.g., physical therapy or office visits before an MRI scan).

Solving the Problem

Turning to solutions, the AANS and the CNS believe that Congress can lead the way in addressing this problem by adopting some reasonable requirements for Medicare Advantage (MA) plans. Joining with

more than 125 medical organizations, we have endorsed the "Prior Authorization and Utilization Management Reform Principles."[2] Additionally, we fully support the "Consensus Statement on Improving the Prior Authorization Process," agreed to by the American Hospital Association, America's Health Insurance Plans, American Medical Association, American Pharmacists Association, Blue Cross Blue Shield Association and the Medical Group Management Association.[3]

Reflecting these principles, and consistent with the Consensus Statement, the ***Improving Seniors' Timely Access to Care Act of 2019*** (H.R. 3107) was recently introduced by Reps. Suzan DelBene (D-WA), Mike Kelly (R-PA), Roger Marshall, MD (R-KS), and Ami Bera, MD (D-CA). This bipartisan legislation, endorsed by approximately 370 national and state-based patient, provider and health care stakeholder organizations,[4] would help protect patients from unnecessary delays in care by streamlining and standardizing prior authorization under the Medicare Advantage program — providing much-needed oversight and transparency of health insurance for America's seniors.

The provisions of H.R. 3107, which are consistent with the Consensus Statement principles, address the following issues:

1. **Standardization and Automation.** Each MA plan may have different forms or formats for their prior authorization requests, proprietary portals. Remarkably, in the 21st Century, plans also still require physicians to use facsimile machines. Under the bill, the use of standard electronic prior authorization (ePA) to facilitate an automated process that is integrated into the physician practice's electronic health record (EHR) system and workflow would be accelerated. Re-entering data into a health plan's proprietary online portal, downloading forms from an insurance company website and faxes would not be treated as electronic transmissions. The benefits of ePA are clear in that it would establish a uniform process, eliminate the need to manage numerous payer portals and accelerate time to treatment. In adopting ePA, however, it is essential that this technology not add more burden and costs on physicians.

   Ultimately, the ePA process and standards must allow for the efficient transfer of clinical information to facilitate automatic, real-time prior authorization decisions — particularly for items and services that are routinely approved. H.R. 3107 would set forth a system for real-time prior authorization.

2. **Reduce Prior Authorizations.** A consistent complaint about the current prior authorization process is that ultimately, a high percentage (90 percent or more) of medical services or tests are approved. The bill would direct MA plans to minimize the use of prior authorization for services that are routinely approved, focusing instead on those gray areas where the evidence is not as clear-cut, or a service is not covered. Moreover, plans would be prohibited from imposing additional prior authorization for medically-necessary services performed during a surgical or invasive procedure that already received, or did not initially require prior authorization.

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[2] Prior Authorization and Utilization Management Reform Principles; https://www.ama-assn.org/system/files/2019-06/principles-with-signatory-page-for-slsc.pdf (accessed September 2019).

[3] Consensus Statement on Improving the Prior Authorization Process; https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf (accessed September 2019).

[4] *See* Attachment 2.

3. **Increase Transparency**. H.R. 3107 would increase transparency by requiring that MA plans annually report to the Centers for Medicare & Medicaid Services (CMS) the following:

    - a list of items and services that are subject to a prior authorization;
    - the percentage of prior authorization requests that are approved;
    - the percentage of requests that were initially denied, appealed and subsequently overturned; and
    - the average and median amount of time (in hours) that elapsed between the submission of the prior authorization request and the MA plan determination.

    This information would be published on public websites so patients and providers can assess these metrics when deciding whether to enroll or participate with a particular MA plan. Additionally, MA plans must make it clear what medical or other documentation is required for the plan to review and complete the prior authorization request.

4. **Accountability**. To hold MA plans accountable to patients, providers and the Medicare program, H.R. 3107 would require CMS to take the following steps:

    - require plans to make timely prior authorization determinations, provide rationales for denials and ensure that any "peer-to-peer" reviews utilize physicians from the same specialty/subspecialty as the ordering or prescribing physician;
    - maintain continuity of care for individuals transitioning to, or between, MA plans to minimize any disruption to ongoing treatment; and
    - conduct annual reviews of items and services for which prior authorization requirements are imposed by MA plans through a process that takes into account input from physicians and is based on current evidence-based medicine guidelines or clinical criteria.

    While not included in H.R. 3107, we also believe it is incumbent upon CMS to prohibit health plans from denying claims for services or procedures that have been approved following prior authorization.

Neurosurgeons take care of very sick patients who suffer from painful and life-threatening neurologic conditions such as brain tumors, debilitating degenerative spine disorders, stroke and Parkinson's Disease. Without timely medical care, our patients often face permanent neurologic damage, and sometimes death. Congress must act to streamline prior authorization, and passage of H.R. 3107 would be a significant step in the right direction. Physician burden will be significantly reduced, but more importantly, requiring MA plans to fix the broken prior authorization process will help ensure that seniors have timely access to the medically-necessary care they need when they need it.

AUC FOR ADVANCED DIAGNOSTIC IMAGING SERVICES

While the AANS and the CNS are committed to consulting with appropriate use criteria before ordering advanced diagnostic imaging tests, we continue to have deep concerns about Medicare's AUC for Advanced Diagnostic Imaging Program. Under the program, ordering clinicians must consult specified applicable AUC using a qualified clinical decision support mechanism (CDSM) before ordering such tests as computed tomography (CT) and magnetic resonance imaging (MRI) scans. Like its prior authorization cousin, if the ordering clinician fails to document AUC consultation, the test will not be performed.

More than five years have passed since the enactment of the Protecting Medicare Access Act (PAMA), which established the AUC Program, and much has changed since 2014. In this regard, the Medicare AUC Program:

- **Is outdated**. The AUC Program is unnecessary in the environment of evolving payment and delivery models in which providers are at financial risk. Physicians are now incentivized through Medicare's Quality Payment Program (QPP) to improve health care quality and reduce resource use. Medicare requires alternative payment model (APM) participants to assume more downside risk. And CMS estimates that one in four primary care providers will participate in Medicare direct contracting models scheduled for 2020 implementation.

- **Diverts provider resources away from quality improvement**. The AUC Program implementation is occurring at the same time providers are struggling to assign adequate resources for health information technology infrastructure and QPP participation. Additionally, the AUC Program has no metrics of quality or patient outcomes.

- **Adds administrative burden.** The number of clinicians affected by the program is vast, crossing almost every medical specialty, including primary care, and CMS estimates that 579,687 ordering professionals will be subject to this program. The AUC Program sets up a complex exchange of information between clinicians that is not yet supported by interoperable EHR systems and relies on claims-based reporting at the same time CMS is migrating away from claims reporting for quality data. The coding methods include G-codes and modifiers to report the required AUC information on Medicare claims, and such a new reporting system introduces significant burden to physicians. Moreover, the AUC Program it is duplicative of the QPP, so physicians are going to be documenting and reporting on multiple programs, with little demonstrated value.

- **Is a costly and disproportionate response to imaging utilization**. According to the Medicare Payment Advisory Commission, imaging volume has dropped .2 percent on average each of the last five years (2012-2016) with advanced imaging accounting for only 4.7 percent of total Medicare allowed charges in 2017.[5] By some estimates, it will costs physicians $75,000 or more to implement the AUC program — again, in addition to investments that physicians are already making to participate in the QPP.

- **Takes away provider flexibility for consulting AUC**. Clinicians are required only to use CDSMs qualified by CMS, which, in many cases, will force clinicians to abandon long-standing methods of AUC consultation, as well as the consultation of specialty-specific AUC. By CMS' admission, information on the benefits of physicians adopting qualified CDSMs or automating billing practices for specifically meeting the AUC requirements do not yet exist, and "information on benefits overall is limited."[6]

Solving the Problem

Since there remain many outstanding technical and practice workflow questions and challenges, the AANS and the CNS appreciate that the July 26, 2019, CMS transmittal to the Medicare Administrative

[5] Medicare Payment Advisory Commission Report to the Congress: Medicare Payment Policy, March 2019; http://www.medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec.pdf?sfvrsn=0 (accessed September 2019).

[6] Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019.

Contractors (MACs) updating information about the AUC Program states that CMS will continue to pay claims that do not include the consultation information or that contain errors related to the AUC information.[7] Nevertheless, the complex implementation challenges of the current program will never be fully resolved, so we strongly recommend that Congress adopt legislation to delay the full implementation of this program and provide CMS with the flexibility the agency needs to harmonize the AUC program with the QPP, rather than perpetuating a stand-alone program that includes no measures of quality or patient outcomes. CMS has made clear that the agency lacks the administrative authority to make any substantial changes to the AUC program, so legislation is necessary to delay full implementation and provide CMS with the flexibility to incorporate AUC more broadly into Medicare's quality programs.

CONCLUSION

The AANS and the CNS appreciate your commitment to removing unnecessary burdens on physicians and their practices, and urge Congress to improve prior authorization in Medicare Advantage by passing H.R. 3107, the *Improving Seniors' Timely Access to Care Act.* We also urge lawmakers to reevaluate the need for the stand-alone AUC Program and to pass legislation that will allow CMS to incorporate the use of appropriate use criteria for advanced diagnostic imaging into Medicare's quality programs. Both actions will vastly improve physician practices and help ensure that Medicare beneficiaries get timely access to medically necessary care.

We thank you for considering our comments and recommendations and stand ready to answer any questions you have or provide you with any additional supporting information.

[7] CMS Manual System, Change Request 11268, Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements; https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R2323OTN.pdf (accessed September 2019)

ATTACHMENT 1: AANS/CNS Prior Authorization Survey Results

American Association of Neurological Surgeons

AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS
CONGRESS OF NEUROLOGICAL SURGEONS

Congress of Neurological Surgeons

PRIOR AUTHORIZATION SURVEY

TOP-LINE RESULTS

Patient Access to Care Has Been Impacted

- Eighty-two percent of respondents state that prior authorization either always (34%) or often (49%) **delays access** to necessary care.
- The **wait time** for prior authorization can be lengthy. For most neurosurgeons (67%) it takes between 2 to 14 days to obtain prior authorization, but for 22%, this process can take from 15 to more than 31 days.
- Prior authorization causes patients to **abandon treatment** altogether with 21% reporting that patients often abandon treatment and 60% reporting that patients sometimes abandon treatment.
- Overwhelmingly (88%), neurosurgeons report that prior authorization has a significant (37%) or somewhat (51%) **negative impact** on patient **clinical outcomes**.

Prior Authorization Burden Has Increased

- Ninety-one percent of neurosurgeons report that the **burden** associated with prior authorization has **significantly increased** over the past five years.
- Insurers have increased the use of prior authorization over the past years for **procedures** (95%); for **diagnostic tools** (93%); and for **prescription medications** (55%).
- The burden associated with prior authorization for neurosurgeons and their staff is **high** or **extremely high** (95%).
- In any given week, most neurosurgeons (41%) must contend with between 11 and 40 prior authorizations. More than one-quarter (27%) of respondents face more than 40 per week.
- Many neurosurgeons must now engage in the so-called **peer-to-peer process** to obtain prior authorization, and nearly one-third (32%) of respondents experience this requirement for 26 to 75% or more of their services (including prescription drugs, diagnostic tests and medical services).
- Ultimately, the **majority of services are approved** (80%), with nearly forty percent (39%) of neurosurgeons getting approved 90% or more of the time.
- Unbelievably, despite gaining prior authorization, insurance companies **deny payment** after services are rendered, an outcome three-fifths of neurosurgeons have experienced more than once in the past year, and 24% have had this happen 20 or more times.
- More than three-fifths (62%) of neurosurgeons have staff members working **exclusively** on prior authorization, with most staff spending between 10-20 hours per week on prior authorization.
- **Most plans** employ prior authorization, although UnitedHealthcare (72%), Blue Cross Blue Shield (72%) and Aetna 68%) are the top utilizers.

Demographics

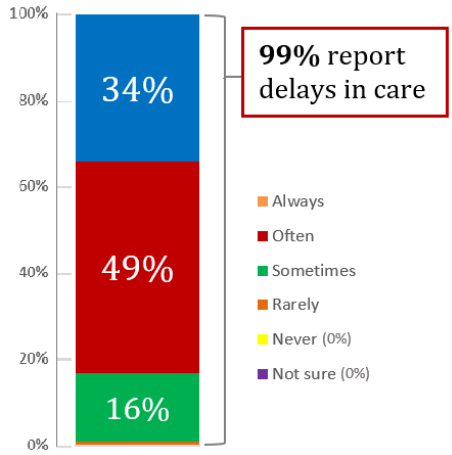
- Forty-two percent of respondents are from the South; 15% from the Northeast; 29% from the Midwest; and 14% from the West and U.S. Territories.
- Forty-one percent of respondents are in private practice; 11% are in private practice with an academic affiliation; 31% are in academic practice; and 16% are employed by a hospital or health system.
- Eleven percent of respondents are in solo practice; 23% are in a small group (2-5 physicians) single specialty practice; 26% are in a medium (6-20 physicians) group single specialty practice; 10% are in a large group (21+) single specialty practice; and the remaining (30%) are in multi-specialty group practices.
- Fifty-nine percent of respondents practice in an urban setting; 35% practicing in a suburban setting; while only 6% are in rural practice.

Prior Authorization is Putting Patients at Risk and Increasing Physician Burden

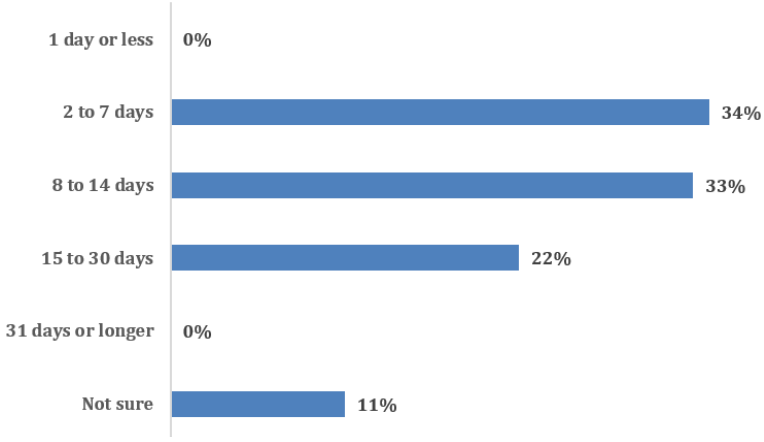
Patient Access to Care Has Been Adversely Impacted

Nearly all respondents state that prior authorization causes **delays in access** to necessary care, and the **wait time** for prior authorization can be lengthy. For most neurosurgeons (67%) it takes between 2 to 14 days to obtain prior authorization, but for 22%, this process can take from 15 to more than 31 days.

Q. *For those patients whose treatment requires prior authorization, how often does this process delay access to necessary care?*

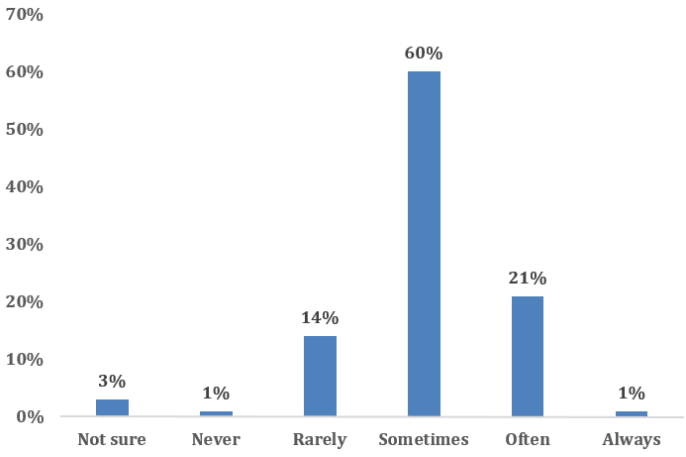


Q. *What is the average length of time to obtain prior authorization after all required documentation has been submitted?*

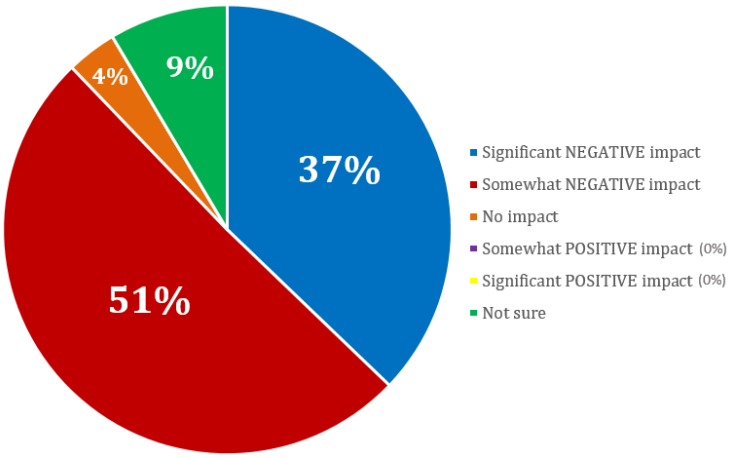


A majority of neurosurgeons reported that prior authorization causes patients to **abandon treatment** altogether, with 21% reporting that patients often abandon treatment and 60% reporting that patients sometimes abandon treatment. Overwhelmingly (88%), physicians report that prior authorization has a **negative impact** on patient **clinical outcomes**.

Q. *For those patients whose treatment requires prior authorization, how often do issues related to this process lead to patients abandoning their recommended course of treatment?*



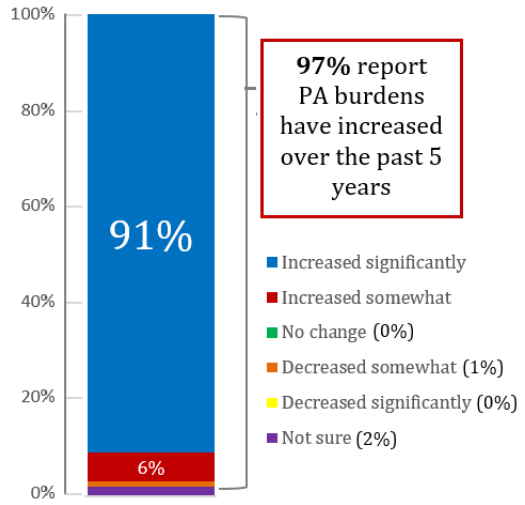
Q. *For those patients whose treatment requires prior authorization, what is the impact of this process on patient clinical outcomes?*



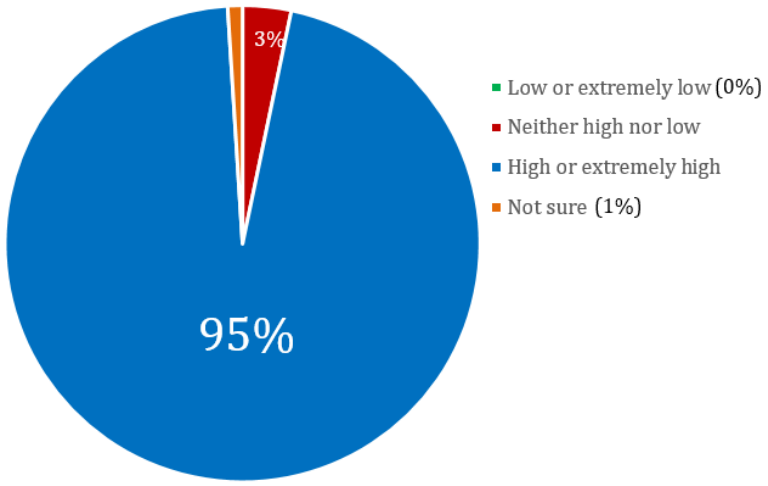
The Burden of Prior Authorization on Physicians Has Increased

Most neurosurgeons (91%) report that the **burden** associated with prior authorization has **significantly increased** over the past five years as insurers have increased the use of prior authorization for procedures (95%); for diagnostic tools (93%); and for prescription medications (55%). The burden associated with prior authorization for neurosurgeons and their staff is now **high** or **extremely high** (95%).

Q. *How has the burden associated with prior authorization changed over the last five years for the physicians and staff in your practice?*

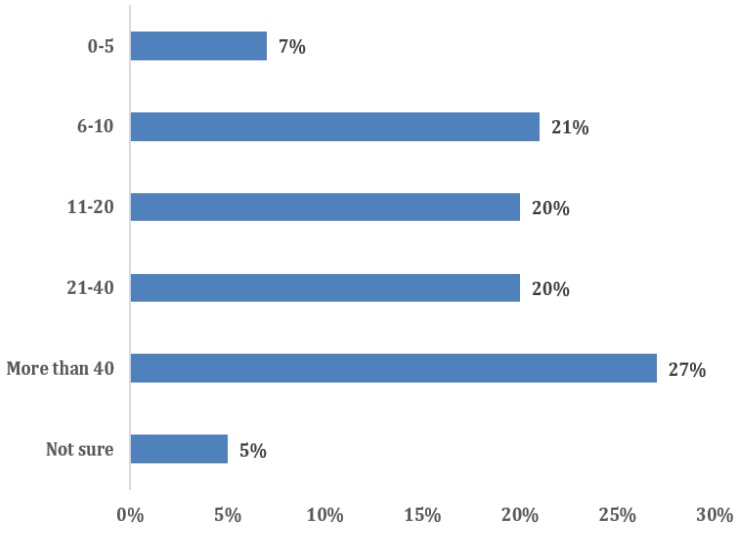


Q. *How would you describe the burden associated with prior authorization for the physicians and staff in your practice?*



In any given week, most neurosurgeons (41%) must contend with between 11 and 40 prior authorizations. More than one-quarter (27%) of respondents face more than 40 per week. Many physicians must now engage in the so-called **peer-to-peer** process — meaning after they go through an extensive paperwork process they must first speak directly to a clinician working for the health plan — to obtain prior authorization, and nearly 32% of respondents experience this requirement for 26-75% or more of their services (including prescription drugs, diagnostic tests and medical services).

Q. *Please provide your best estimate of the number of prior authorizations (total for prescription medicine, diagnostic tests and medical services) completed by yourself and/or your staff for your patients in the last week.*

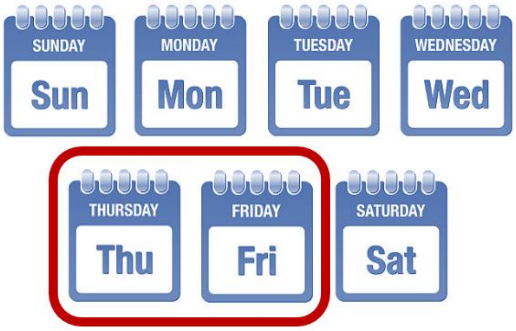


32% of neurosurgeons go to "peer-to-peer" review for **26-75%** or more of their prior authorizations—and frequently the reviewer is not in the same or similar specialty

Ultimately, the **majority of services are approved** (80%), with nearly forty percent (39%) of neurosurgeons getting approved 90% or more of the time. Unbelievably, despite gaining prior authorization, insurance companies **deny payment after services are rendered**, an outcome three-fifths of neurosurgeons have experienced more than once in the past year, and 24% have had this happen 20 or more times.

More than three-fifths of neurosurgeons have staff members **working exclusively** on prior authorization

Physicians and their staff spend the equivalent of at least **two days** on prior authorization each week.



Survey Methodology

A 27-question, web-based survey was administered from November 2018 through January 2019.

Forty-two percent of respondents are from the South; 15% from the Northeast; 29% from the Midwest; and 14% from the West and U.S. Territories. Forty-one percent of respondents are in private practice; 11% are in private practice with an academic affiliation; 31% are in academic practice; and 16% are employed by a hospital or health system. Eleven percent of respondents are in solo practice; 23% are in a small group (2-5 physicians) single specialty practice; 26% are in a medium (6-20 physicians) group single specialty practice; 10% are in a large group (21+) single specialty practice; and the remaining (30%) are in multi-specialty group practices. Fifty-nine percent of respondents practice in an urban setting; 35% practicing in a suburban setting; while only 6% are in rural practice.

About the AANS and CNS

The American Association of Neurological Surgeons (AANS), founded in 1931, and the Congress of Neurological Surgeons (CNS), founded in 1951, are the two largest scientific and educational associations for neurosurgical professionals in the world. These groups represent over 8,000 neurosurgeons worldwide. Neurological surgery is the medical specialty concerned with the prevention, diagnosis, treatment and rehabilitation of disorders that affect the entire nervous system, including the spinal column, spinal cord, brain and peripheral nerves. For more information, please visit www.aans.org or www.cns.org, read our blog www.neurosurgeryblog.org, or follow us on Twitter @neurosurgery.

More Information

For more information about the AANS/CNS prior authorization survey, please contact:

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Congress of Neurological Surgeons
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ATTACHMENT 2: Stakeholder Endorsement Letter of H.R. 3107

September 9, 2019

Dear Members of Congress:

The undersigned patient, physician, health care professional, and other health care stakeholder organizations strongly support the *Improving Seniors' Timely Access to Care Act of 2019* (H.R. 3107) recently introduced by Reps. Suzan DelBene (D-WA), Mike Kelly (R-PA), Roger Marshall, MD (R-KS), and Ami Bera, MD (D-CA). This bipartisan legislation would help protect patients from unnecessary delays in care by streamlining and standardizing prior authorization under the Medicare Advantage program, providing much-needed oversight and transparency of health insurance for America's seniors. We urge you to join your colleagues in supporting this important legislation.

Based on a consensus statement on prior authorization reform adopted by leading national organizations representing physicians, medical groups, hospitals, pharmacists, and health plans, the legislation would facilitate electronic prior authorization, improve transparency for beneficiaries and providers alike, and increase Centers for Medicare & Medicaid Services (CMS) oversight on how Medicare Advantage plans use prior authorization. Specifically, the bill would:

- Create an electronic prior authorization program including the electronic transmission of prior authorization requests and responses and a real-time process for items and services that are routinely approved;
- Improve transparency by requiring plans to report to CMS on the extent of their use of prior authorization and the rate of approvals or denials;
- Require plans to adopt transparent prior authorization programs that are reviewed annually, adhere to evidence-based medical guidelines, and include continuity of care for individuals transitioning between coverage policies to minimize any disruption in care;
- Hold plans accountable for making timely prior authorization determinations and to provide rationales for denials; and
- Prohibit additional prior authorization for medically-necessary services performed during a surgical or invasive procedure that already received, or did not initially require, prior authorization.

The demand and need for such reforms is growing — particularly as more seniors choose Medicare Advantage for their health insurance needs. According to a recently released Kaiser Family Foundation report, *"A Dozen Facts About Medicare Advantage in 2019,"* Medicare Advantage enrollment has nearly doubled in a decade. One-third (34%) of all Medicare beneficiaries — 22 million people — are enrolled in Medicare Advantage plans, and nearly four out of five enrollees (79%) are in plans that require prior authorization for some services. The Congressional Budget Office (CBO) projects that beneficiaries enrolled in Medicare Advantage plans will rise to nearly half of all Medicare beneficiaries (about 47%) by 2029. Recognizing the need to protect a growing number of Medicare beneficiaries, more than 100 members of Congress called for such reforms in a letter last year to the CMS.

For our seniors — and as representatives of organizations seeking to protect patients from delays in care and relieve unnecessary administrative burdens that impede delivery of timely care—we are committed to advancing this legislation in Congress and ask that you join Representatives DelBene, Kelly, Marshall, and Bera in co-sponsoring H.R. 3107 and securing its enactment.

Thank you.

Sincerely,

ACCSES
Aimed Alliance
Alliance for Aging Research
Alliance for Balanced Pain Management
Alliance for Patient Access
Alliance of Specialty Medicine
Alzheimer's Association
Alzheimer's Impact Movement
AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology – Head and Neck Surgery
American Academy of PAs
American Academy of Physical Medicine & Rehabilitation
American Academy of Sleep Medicine
American Alliance of Orthopaedic Executives
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Nurse Practitioners
American Association of Orthopaedic Surgeons
American Association of Pediatric Ophthalmology and Strabismus
American Association on Health and Disability
American Autoimmune Related Diseases Association
American Brain Coalition
American Cancer Society Cancer Action Network
American Clinical Laboratory Association
American Clinical Neurophysiology Society
American College of Allergy, Asthma and Immunology
American College of Cardiology

American College of Emergency Physicians
American College of Gastroenterology
American College of Mohs Surgery
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiation Oncology
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Congress of Rehabilitation Medicine
American Dance Therapy Association
American Gastroenterological Association
American Geriatrics Society
American Glaucoma Society
American Group Psychotherapy Association
American Liver Foundation
American Medical Association
American Medical Rehabilitation Providers Association
American Medical Women's Association
American Music Therapy Association
American Nurses Association
American Occupational Therapy Association
American Osteopathic Association
American Osteopathic Colleges of Ophthalmology and Otolaryngology
American Physical Therapy Association
American Psychiatric Association
American Psychoanalytic Association
American Society for Clinical Pathology
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society for Radiology and Oncology
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract & Refractive Surgery
American Society of Clinical Oncology
American Society of Echocardiography
American Society of Hematology
American Society of Interventional Pain Physicians
American Society of Nephrology
American Society of Neuroimaging
American Society of Neuroradiology
American Society of Nuclear Cardiology
American Society of Ophthalmic Plastic and Reconstructive Surgery
American Society of Plastic Surgeons

American Society of Retina Specialists
American Society of Transplant Surgeons
American Spinal Injury Association
American Urological Association
American Uveitis Society
American Vein & Lymphatic Society
American-European Congress of Ophthalmic Surgery
America's Physician Groups
Arthritis Foundation
Association for Molecular Pathology
Association of Academic Physiatrists
Association of American Medical Colleges
Association of Black Cardiologists
Association of Rehabilitation Nurses
Association of University Professors of Ophthalmology
Beyond Type 1
Brain Injury Association of America
Bridge the Gap - SYNGAP Education and Research Foundation
Cancer Support Community
CancerCare
Caregiver Action Network
Child Neurology Foundation
Children with Diabetes
Christopher & Dana Reeve Foundation
Clinician Task Force
CMSC- Consortium of Multiple Sclerosis Centers
Coalition For Headache And Migraine Patients
College Diabetes Network
College of American Pathologists
Community Oncology Alliance
Congress of Neurological Surgeons
Cornea Society
Crohn's & Colitis Foundation
Delaware Academy of Ophthalmology
Depression and Bipolar Support Alliance
Derma Care Access Network
Diabetes Patient Advocacy Coalition
DiabetesSisters
Digestive Disease National Coalition
Disability Rights Education and Defense Fund
Dystonia Advocacy Network
Dystonia Medical Research Foundation
Epilepsy Foundation
Eye and Contact Lens Association
Eye Bank Association of America

Federation of American Hospitals
Free2Care
GBS|CIDP Foundation International
Global Alliance for Behavioral Health and Social Justice
Global Healthy Living Foundation
Global Liver Institute
Healthcare Information and Management Systems Society
Hematology/Oncology Pharmacy Association
IFAA - International Foundation for Autoimmune & Autoinflammatory Arthritis
International Essential Tremor Foundation
International Foundation for Gastrointestinal Disorders
International Society for the Advancement of Spine Surgery
Interstitial Cystitis Association
Lupus and Allied Diseases Association, Inc.
Medical Group Management Association
METAvivor
Movement Disorders Policy Coalition
Multiple Sclerosis Association of America
National Alopecia Areata Foundation
National Association for the Advancement of Orthotics & Prosthetics
National Association of Rural Health Clinics
National Association of Social Workers
National Association of Spine Specialists
National Association of State Head Injury Administrators
National Association of State Mental Health Program Directors
National Comprehensive Cancer Network
National Diabetes Volunteer Leadership Council
National Health Council
National Infusion Center Association
National Lipid Association
National Medical Association, Ophthalmology Section
National Multiple Sclerosis Society
National Osteoporosis Foundation
National Pancreas Foundation
National Patient Advocate Foundation
NephCure Kidney International
North American Neuro-Ophthalmology Society
Ocular Microbiology and Immunology Group
Outpatient Endovascular and Interventional Society
Partnership to Advance Cardiovascular Health
Partnership to Fight Chronic Disease
Partnership to Improve Patient Care
Prevent Blindness
Pulmonary Hypertension Association
Remote Cardiac Services Provider Group

Renal Physicians Association
Restless Legs Syndrome Foundation
RetireSafe
Sjogren's Syndrome Foundation
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Critical Care Medicine
Society of Gynecologic Oncology
Society of Hospital Medicine
Spine Intervention Society
The Headache and Migraine Policy Forum
The Leukemia & Lymphoma Society
The Marfan Foundation
The Michael J. Fox Foundation for Parkinson's Research
The Retina Society
The Society of Thoracic Surgeons
Tourette Association of America
Treatment Communities of America
Uniform Data System for Medical Rehabilitation
United Spinal Association
US Hereditary Angioedema Association

Alabama Academy of Ophthalmology
Alabama Society for the Rheumatic Diseases
Lakeshore Foundation
Medical Association of the State of Alabama
Neurosurgical Society of Alabama
Alaska Rheumatology Alliance
Alaska Society of Eye Physicians and Surgeons
Denali Oncology Group Alaska Chapter ASCO
Arizona Medical Association
Arizona Neurosurgical Society
Arizona United Rheumatology Alliance
The Arizona Clinical Oncology Society
Arkansas Medical Society
Arkansas Ophthalmological Society
Arkansas Rheumatology Association
Association of Northern California Oncologists
California Academy of Eye Physicians and Surgeons
California Association of Neurological Surgeons
California Medical Association
California Rheumatology Alliance
Medical Oncology Association of Southern California, Inc.
Cedars/Aspens, non-profit society of ophthalmic surgeon educators
Colorado Medical Society

Colorado Neurosurgical Society
Colorado Rheumatology Association
Colorado Society of Eye Physicians and Surgeons
Connecticut Rheumatology Association
Connecticut Society of Eye Physicians
Connecticut State Medical Society
Delaware Society for Clinical Oncology
Delaware State Neurosurgical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association
Florida Neurosurgical Society
Florida Society of Clinical Oncology
Florida Society of Ophthalmology
Florida Society of Rheumatology
Georgia Society of Clinical Oncology
Georgia Society of Rheumatology
Medical Association of Georgia
Hawaii Medical Association
Hawaii Society of Clinical Oncology
Association of Idaho Rheumatologists
Idaho Medical Association
Idaho Society of Ophthalmology
Illinois Medical Oncology Society
Illinois Society of Eye Physicians & Surgeons
Illinois State Medical Society
Illinois State Neurosurgical Society
Indiana Academy of Ophthalmology
Indiana Chapter, American College of Cardiology
Indiana Oncology Society
Iowa Medical Society
Iowa Oncology Society
Midwest Neurosurgical Society
Kansas Chapter, American College of Cardiology
Kansas Hospital Association
Kansas Medical Society
LeadingAge Kansas
Midwest Rheumatology Association
Kentucky Academy of Eye Physicians and Surgeons
Kentucky Association of Medical Oncology
Kentucky Chapter, American College of Cardiology
Kentucky Medical Association
Louisiana Academy of Eye Physicians and Surgeons
Louisiana Chapter, American College of Cardiology
Louisiana Neurosurgical Society

Louisiana State Medical Society
Rheumatology Alliance of Louisiana
Maine Medical Association
Maine Society of Eye Physicians and Surgeons
Maryland Chapter, American College of Cardiology
Maryland DC Society of Clinical Oncology
Maryland Society for the Rheumatic Diseases
Maryland Society of Eye Physicians and Surgeons
MedChi, The Maryland State Medical Society
Massachusetts Society of Clinical Oncologists
Massachusetts Medical Society
Michigan Society of Eye Physicians and Surgeons
Michigan Society of Hematology & Oncology
Michigan State Medical Society
Minnesota Medical Association
Minnesota Neurosurgical Society
Mississippi Arthritis and Rheumatism Society
Mississippi Oncology Society
Mississippi State Medical Association
Missouri Oncology Society
Missouri Society of Eye Physicians & Surgeons
Missouri State Medical Association
Montana Medical Association
Montana Neurosurgical Society
Montana State Oncology Society
Nebraska Chapter, American College of Cardiology
Nebraska Medical Association
Nebraska Rheumatology Society
Nevada State Medical Association
Northern New England Clinical Oncology Society
New Hampshire Medical Society
Medical Oncology Society of New Jersey
Medical Society of New Jersey
New Jersey Academy of Ophthalmology
New Jersey Neurosurgical Society
New Mexico Medical Society
Empire State Hematology & Oncology Society
Medical Society of the State of New York
New York State Neurosurgical Society
New York State Ophthalmological Society
New York State Rheumatology Society
North Carolina Medical Society
North Carolina Rheumatology Association
North Carolina Society of Eye Physicians & Surgeons
North Dakota Medical Association

North Dakota Society of Eye Physicians and Surgeons
Ohio Association of Rheumatology
Ohio Chapter, American College of Cardiology
Ohio Hematology Oncology Society
Ohio Ophthalmological Society
Ohio State Medical Association
Ohio State Neurosurgical Society
Oklahoma Academy of Ophthalmology
Oklahoma Chapter, American College of Cardiology
Oklahoma Neurosurgical Society
Oklahoma State Medical Association
Oregon Academy of Ophthalmology
Oregon Medical Association
Oregon Rheumatology Alliance
Oregon Society of Medical Oncology
Pennsylvania Academy of Ophthalmology
Pennsylvania Medical Society
Pennsylvania Neurosurgical Association
Pennsylvania Rheumatology Society
Philadelphia Rheumatism Society
Pittsburgh Ophthalmology Society
Pennsylvania Society of Oncology & Hematology
The Hospital and Healthsystem Association of Pennsylvania
Puerto Rico's Hematology and Medical Oncology Association
Rhode Island Chapter, American College of Cardiology
Rhode Island Medical Society
Rhode Island Neurosurgical Society
Rhode Island Society of Eye Physicians and Surgeons
South Carolina Medical Association
South Carolina Oncology Society
South Carolina Rheumatism Society
South Carolina Society of Ophthalmology
South Dakota Academy of Ophthalmology
South Dakota State Medical Association
Tennessee Chapter, American College of Cardiology
Tennessee Medical Association
Tennessee Rheumatology Society
State of Texas Association of Rheumatologists
Texas Medical Association
Texas Ophthalmological Association
Society of Utah Medical Oncologists
Utah Medical Association
Utah Ophthalmology Society
Vermont Medical Society
Medical Society of Virginia

Virginia Association of Hematologist & Oncologist
Virginia Chapter, American College of Cardiology
Virginia Society of Eye Physicians and Surgeons
Neurosurgical Society of the Virginias
Washington Academy of Eye Physicians and Surgeons
Washington Rheumatology Alliance
Washington State Medical Association
Washington State Medical Oncology Society
West Virginia Academy of Eye Physicians & Surgeons
West Virginia State Medical Association
West Virginia State Rheumatology Society
Wisconsin Academy of Ophthalmology
Wisconsin Association of Hematology & Oncology
Wisconsin Medical Society
Wisconsin Rheumatology Association
Wisconsin State Neurosurgical Society
Wyoming County Community Health System
Wyoming Medical Society
Wyoming Ophthalmological Society