REPORT OF THE PRIVATE PRACTICE PHYSICIANS SECTION
GOVERNING COUNCIL

PPPS GC Report B
(I-24)

Subject: Rebuke and Appeal CMS Interoperability and Prior Authorization Final Rule (PPPS Resolution 4-A-24)

Presented by: Carolynn Francavilla, MD, Chair

Referred to: PPPS Reference Committee
(, MD, Chair)

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1 INTRODUCTION
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3 At its 2024 Annual Meeting, the PPPS Assembly referred Resolution 4-A-24, Rebuke and Appeal
4 CMS Interoperability and Prior Authorization Final Rule, for report. The resolution asked the
5 AMA to:
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7 1. Conduct an independent cost analysis of the CMS Interoperability and Prior
8 Authorization Final Rule of 2024 and determine whether it is allowable and appropriate for
9 the AMA to file a federal lawsuit for one or more violations of the Administrative
10 Procedure Act for exceeding delegated authority under HIPAA administrative
11 simplification requirements; and
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13 2. Initiate a lawsuit as described in the foregoing Resolution or in such other lawsuit as
14 our AMA may initiate to address the concerns expressed in these Resolutions, the AMA
15 shall determine whether it is allowable and appropriate to demand that courts direct the
16 Centers for Medicare and Medicaid Services to rewrite regulations under the CMS
17 Interoperability and Prior Authorization Final Rule of 2024 to comply with applicable laws
18 while advocating the principles enumerated in AMA and Medical Society of the State of
19 New York policies.
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21 DISCUSSION
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23 Resolution 4-A-24 seeks to provide relief to physicians from the administrative and financial
24 burdens placed on them by engaging in onerous prior authorization processes instituted through
25 various public and private payors. The resolution finds a lack of appropriate action on the part of
26 the United States Centers for Medicare & Medicaid Services (CMS), particularly through the
27 construction of the CMS Interoperability and Prior Authorization Final Rule of 2024. The
28 resolution contends that CMS's actions, or inactions, have left physicians vulnerable to financial
29 and operational hazards.
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31 To examine the resolution's requests and understand them more thoroughly, the Governing Council
32 consulted with both the AMA Office of the General Counsel (OGC) and the AMA's Advocacy
33 Resource Center (ARC). The OGC was able to provide a legal perspective for evaluating the
34 resolution's requests while ARC was instrumental in providing technical details about CMS's

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rulemaking process as well as the extent to which the AMA has itself engaged with CMS specifically on the Interoperability and Prior Authorization rule during its open consideration period prior to finalizing the rule. The Governing Council's findings here are reflective of the contributions of both OGC and ARC.

In examining the CMS Final Rule, some of Resolution 4-A-24's provisions are unfortunately inaccurate. The resolution grounds its justifications in HIPAA administrative simplification provisions enacted through the Patient Protection and Affordable Care Act, among other federal legislative and statutory decisions. The rule, however, does not fall under these simplification provisions, which are directed at electronic standards, not prior authorization policy. Rather, provisions of the rule are incorporated into regulations for government health plans such as Medicare Advantage, CIP, Medicaid, etc. It is important to recall that CMS, as a federal agency, only has authority over public health plans such as Medicare, Medicaid, Tricare, and the like. Private health plans are regulated by the Department of Labor, which is outside the scope of CMS rulemaking.

Likewise, the resolution states that CMS "arbitrarily and capriciously failed to incorporate expected costs into cost analysis, which explicitly allowed health plans to impose on healthcare providers." The Final Rule, however, does include a Regulatory Impact Analysis that analyzes projected costs and savings and found an estimated savings of $15 billion over 10 years to providers. This projection was also reviewed and accepted by the Congressional Budget Office (CBO). It also worth noting that the finding of $15 billion in savings is based in part on findings of AMA physician survey data quantifying the number of hours per week spent on prior authorization.

The resolution's statement that CMS failed to extend prior authorization requirements to pharmacy benefits or in-office injectables is also incorrect. The Final Rule addressed this issue, stating that the regulations for these will require new data capture and transmission regulations, which are currently being considered. Because they were not available at the time of publication, they are not expressly included. (Additionally, the AMA is involved in the crafting of these standards.)

Claims that CMS failed to properly account for the cost of implementing regulations and address the concerns of the public during the comment period potentially misunderstand the regulatory process for this Final Rule. The agency with authority over the technology and technical capability to implement electronic PA (ePA) for physicians and other healthcare providers has yet to propose the necessary regulations needed to inform a cost analysis as of the time of this writing. These regulations will dictate the requirements certified health IT (EHRs) must meet for ePA to function for physicians. Physicians will, at a future date, update their EHRs to support these new technologies. However, as the CMS regulations won't go into effect until 2027, the earliest likely date for sufficient cost/fee analysis data will most likely not be until 2028.

It is difficult to see how an additional review or cost analysis conducted by the AMA would arrive at any other conclusions than the ones outlined by CMS and confirmed by the CBO. Likewise, based on the review already conducted of the CMS Final Rule by AMA staff and the work AMA's Advocacy and Regulatory teams have already done to promote the AMA's position with respect to CMS's conclusions, there does not seem to be strong evidence that CMS has violated federal statutes with respect to the claims made in the original resolution.

CONCLUSION

After consideration, your Governing Council does not find evidence of inappropriate legal or regulatory action on the part of the Centers for Medicare & Medicaid Services as it relates to the

Interoperability and Prior Authorization Final Rule of 2024. Your Governing Council also finds evidence that a robust financial accounting of the Final Rule does exist, and it is not persuaded that the AMA has any special expertise to add to the existing actuarial analysis. The Governing Council thus does not believe that advancing the requests of Resolution 4-A-24 would prove fruitful in the House of Delegates.

RECOMMENDATION

The PPPS Governing Council recommends that the following be adopted in lieu of Resolution 4-A-24, and that the remainder of this report be filed:

1. That the Private Practice Physicians Section does not support a motion that the AMA conduct a cost analysis of the CMS Interoperability and Prior Authorization Final Rule.

2. That the Private Practice Physicians Section does not support initiating legal action regarding the CMS Interoperability and Prior Authorization Final Rule but shall revisit supporting such legal action at ~~without~~ the ~~express~~ recommendation of the AMA Office of the General Counsel or any other duly authorized representative of the AMA.

3. That the Private Practice Physicians Section will host an educational seminar at the Annual 2025 meeting that will utilize experts in Centers for Medicare & Medicaid Services (CMS) rulemaking to examine and explain the CMS Interoperability and Prior Authorization Final Rule with an eye toward helping attendees understand what the rule covers and does not cover as well as any obligations the rule places on independent physician practices.