March 13, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS–0057–P. Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program

Dear Administrator Brooks-LaSure:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the Notice of Proposed Rule Making (proposed rule) outlining proposals to advance interoperability and improve prior authorization (PA). Further, we are encouraged that CMS included Medicare Advantage (MA) plans in the scope of this rule and thank the agency for addressing overdue prior authorization reform in both this proposed rule and the 2024 Part C/D proposed rule.[1]

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups in which more than 350,000 physicians practice. These groups range from small private practices in rural areas to large regional and national health systems, and cover the full spectrum of physician specialties and organizational forms, making MGMA well-positioned to offer the following feedback.

[1] [CMS–4201–P] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

Key Comments and Recommendations

MGMA urges CMS to:

- **Finalize the inclusion of MA plans in the scope of this rule.** When a similar rule was published at the end of the 2020, MGMA urged for the inclusion of MA plans within the scope of the rule. MGMA is encouraged that CMS heeded our call, but we urge the agency to leverage its authority to continue reforming prior authorization. Automating prior authorization is only one part of achieving meaningful reform. Much work remains to be done, including efforts to provide greater transparency, reduce the overall volume of prior authorization requests, and improve peer-to-peer reviews.
- **Finalize the proposal to require plans to provide specific reasons for prior authorization denials.** MGMA supports CMS' intent to provide more clarity around prior authorization denials, but encourages the agency to require plans to provide more actionable information alongside the specific denial reasons.
- **Shorten the proposed timeframes to 48 hours for standard prior authorizations and 24 hours for expedited prior authorizations.** CMS' current proposal of 7 days for standard prior authorizations and 72 hours for expedited prior authorizations will do little to mitigate the current challenges involved with processing prior authorization requests in a timely manner as to not delay care. MGMA urges CMS to clarify in the final rule that these required timeframes refer to final decisions and to develop an enforcement plan that does not entirely rely on medical groups to ensure plan compliance.
- **Finalize the proposal to require plan public reporting of prior authorizations.** MGMA supports CMS' intent to require plans to provide more transparency around prior authorization practices. However, we do not understand the need to wait to implement this provision until 2026 — CMS should make these requirements effective immediately upon finalization of this rule.
- **Encourage the usage of gold-carding programs in the MA program.** MGMA supports gold-carding initiatives, and while gold-carding programs have the potential to reduce burden and delays in care, only 7% of practices report that MA plans have a gold-carding program available.
- **Not link electronic prior authorization requirements to CMS' Quality Payment Program (QPP).** To link prior authorization to the Promoting Interoperability (PI) component of Merit-based Incentive Payment System (MIPS) would only exacerbate unnecessary burden and work against CMS' goal of reducing physician burden, medical staff time, and prior authorization-related costs.

Current prior authorization challenges

Prior authorization requirements are routinely identified by medical groups as the most challenging and burdensome obstacle to running their practices and delivering high-quality care. Increasing prior authorization requirements are detrimental to both practices and the patients they treat. In 2018, MGMA partnered with several provider groups and health plans to publish a *Consensus Statement on Improving the Prior Authorization Process*.[2] These organizations agreed that selective application of prior authorization, volume adjustment, greater transparency and communication, and automation were areas of opportunity to improve upon. However, since the time this consensus statement was released, medical groups report little progress in any of these areas. When asked to rank payers from most burdensome to least burdensome as it pertains to obtaining prior authorizations, medical groups identified Medicare

[2] Consensus Statement on Improving the Prior Authorization Process

Advantage (MA) plans as the most burdensome, followed by commercial plans, Medicaid, and Traditional Medicare.[3] The MA program is overdue for reform and this Administration, through this rule, is well-positioned to address it.

Ninety-five percent of group practices report treating patients that are covered by MA plans. MGMA is increasingly alarmed by reports of rising prior authorization requirements – 84% of medical groups recently reported that prior authorization requirements in MA specifically have increased over the last 12 months. Seventy-seven percent of groups reported that they had to hire or redistribute staff to work on prior authorizations due to the increase in requests.[4] Group practices were already facing significant workforce shortage issues — this situation is simply unsustainable.

Despite feedback from MGMA to the Administration and Congress over the years regarding the unnecessary administrative burden, cost, and delay of treatment associated with prior authorization, little has been done to adequately address these concerns. **We applaud the Administration for taking much-needed steps to modernize prior authorization and address the administrative burden associated with it.** Ninety-one percent of medical groups believe a single standard electronic prior authorization system across all insurers would alleviate burden on their practices. However, automating prior authorization is one piece of the reform puzzle — meaningful reform must involve an overall reduction in prior authorization requests, greater transparency, improving peer-to-peer reviews, as well as other guardrails.

Scope of proposed rule

MGMA strongly supports CMS' inclusion of MA plans in the scope of this proposed rule and appreciates the agency's willingness to heed our concern that the previous iteration of this rule excluded MA plans from the scope. As discussed earlier, the number of MA patients being treated by MGMA members continues to increase. Thus, it is critical that the Administration continue to develop policies that will safeguard against dangerous and arbitrary prior authorization practices that directly impact patient care and waste medical group resources that should be diverted to patient care.

Reason for denial of prior authorization

CMS proposes that in 2026, impacted payers must provide a specific reason for denied prior authorization decisions. The specific reason for denial is required regardless of the method used to send the prior authorization request (i.e. fax machine or online proprietary portal). **MGMA supports this proposal as clearer information surrounding the reason for denial from payers is needed. However, we urge the agency to require payers to go a step further and ensure that the information given is actionable and clearly understood by the medical groups.** For example, proprietary codes that mean little to anyone outside of that specific payer would not fulfil the intent of the proposal and clearer information would be warranted.

Prior Authorization Requirements, Documentation, and Decision (PARDD) API

[3] MGMA Prior Authorization Questionnaire, March 2023
[4] MGMA Prior Authorization Questionnaire, March 2023

CMS proposes to require payers under this rule to implement and maintain a PARDD API to facilitate prior authorization processes beginning in 2026. The PARDD API would streamline and automate certain tasks, including allowing providers to see if a prior authorization is required and the necessary documentation, as well as allowing payers to provide the status of the prior authorization request. **MGMA supports this proposal but encourages CMS to work with stakeholders to ensure practices are able and ready to utilize and leverage this API.**

Currently, practices must complete prior authorizations via multiple platforms, including health plan proprietary web portals, fax machines, electronic portals, standards based EMR/EHRs, paper forms, and phone calls. Seventy-six percent of group practices report interfacing with 5 or more health plan proprietary web portals and 30% report interfacing with 11 or more web portals.[5] Practices report waiting on the phone with plans to only have their calls ended abruptly before reaching the correct representative, being told by plans that their documentation was never received, and tracking down constantly changing plan requirements. An automated and streamlined process is long overdue and is expected to decrease unnecessary burden. **However, automating the prior authorization process should not cause an increase in requests. Comprehensive reform should include a decrease in overall prior authorization requests as well as automation.** MGMA is concerned that the proposed rule does fully recognize the benefits of the PARDD API but restricts access to in-network providers. This approach works against the spirit of the proposed rule to achieve automation and interoperability. Thus, access to this data should be shared with all providers of that patient, regardless of their network status with the plan.

Prior authorization decision timeframes

CMS proposes to require MA organizations and the other plans included in the scope of this proposed rule to send prior authorization decisions no later than 7 calendar days for non-urgent ("standard") requests and no later than 72 hours for urgent ("expedited") requests. **Although MGMA supports efforts to require these payers to send prior authorization decisions in a timelier manner, we believe the proposed timeframes are unacceptably long and will do little to mitigate the challenges associated with the current wait times. We believe that with the new proposed technology that CMS touts in this proposed rule, 24 hours for urgent requests and 48 hours for standard requests would be reasonable timeframes.** In a recent MGMA survey, 98% of practices reported that their patients experienced delays or denials for medically necessary care.[6] Nephrology practices report that the delay in medical approvals for needed therapies and treatments to preserve kidney functions can cause their patients to enter renal failure at a more progressed rate. These delays are unacceptable, especially since many of these prior authorizations are ultimately approved.

Moreover, **we urge CMS to specify that these shorter timeframes apply to final prior authorization decisions.** If plans are allowed to simply pend prior authorization requests in that required timeframe just to request additional information, practices and the patients they treat will not benefit from this policy change. MGMA is further concerned about CMS' proposal to have group practices contact payers to obtain the prior authorization status if the payers fail to meet the timeline. **The burden should not fall on medical groups to enforce these policies. It runs completely counter to the purpose underlying this**

[5] MGMA Prior Authorization Questionnaire, March 2023
[6] MGMA Prior Authorization Questionnaire, March 2023

proposed rule — to automate the prior authorization process and provide for more efficiencies. We encourage CMS to put guardrails in place to ensure plans are complying with the shortened timeframe and to develop an oversight plan.

Public reporting for prior authorization metrics

CMS proposes to require payers to publicly report aggregated metrics about their prior authorization programs annually. **MGMA strongly supports CMS' proposal and urges the agency to take these additional steps that will contribute to more meaningful information:**

- Implement this policy as soon as possible. We understand the need to wait to implement other policies in this rule until 2026, due to IT infrastructure development and other restraints, but urge CMS to implement the public reporting requirements earlier.
- Disclose information at a more granular level — aggregated data does not give a clear depiction of prior authorization performance.
- Require plans include additional information, such as clinical criteria. In MGMA's 2024 Part C and Part D comments, we urged CMS to require MA plans to publicly publish an accessible summary of the evidence, a list of the sources of evidence, and an explanation of the rationale for the internal coverage criteria in a prompt and timely manner. We reiterate that recommendation in these comments.
- CMS should include all publicly reported data on a centralized website, available to the public. An ongoing challenge for medical groups is that many payers have their own proprietary portals which require group practices to interface with many platforms. We urge CMS to prevent further burden by collecting this information and making it easily accessible to stakeholders who are trying to gain actionable insight from these metrics.

Additional prior authorization reform efforts

MGMA applauds CMS for these prior authorization reform proposals and believes this is a critical step to patient care is not delayed. In addition to policies that CMS proposes in this rule, we urge CMS consider the following in future rulemaking to build upon these reforms:

- **Elimination of step therapy.** Step therapy, otherwise known as "fail first," requires patients to try and fail certain treatments before allowing access to more appropriate (albeit usually more expensive) treatments. Step therapy puts the health plans in the driver's seat of a patient's care, undercutting the provider-patient decision-making process. In 2019, the Trump administration rolled back a step therapy prohibition in MA plans for Part B drugs. Since that time, we are concerned that patients who switch MA plans may have their current treatment disrupted — resulting in care delays or having to retry drugs that previously failed. **MGMA urges CMS to reinstate step therapy prohibition in Medicare Advantage (MA) plans for Part B drugs.**
- **Gold-carding programs.** A commonsense approach to exempting certain clinicians or items and services from prior authorization requirements is implementing a "gold-carding" program. Gold-carding programs exempt providers from prior authorization requirements for certain services if they reach a particular approval rating over a period of time, thereby allowing physician practices to divert resources towards patient care. States have embraced this approach — Texas and West Virginia have successfully passed gold-carding laws. However, gold-carding programs are largely underutilized. Ninety-three percent of medical

groups report that the MA plans they contract with do not offer a gold-carding program.[7] Moreover, experiences in Texas with implementing a gold-carding law illustrates that certain considerations are critical to the law's success. We encourage CMS to work with group practices and provider stakeholders to discover and address these critical issues. Last Congress, MGMA supported the GOLD CARD Act, which would exempt physicians from MA plan prior authorizations if they had 90% of requests approved in the preceding 12 months. We support gold-carding initiatives and see these programs as a suitable alternative**. We urge CMS to work with stakeholders to encourage MA plans to develop gold-carding programs.**

- **Waive prior authorization requirements for providers who are participating in value-based models of care.** Groups who are part of value-based care models are already incentivized to control costs and deliver high-quality care. It is unnecessary and a further impediment to delivering care to require these group practices to go through the motions of seeking prior authorization approvals when their costs are already controlled.

Consistency across other reform efforts

- **MGMA anticipates the *Improving Seniors' Timely Access to Care Act* will be reintroduced this year in substantially the same form and will urge Congress to pass it into law.** This bill, which MGMA helped draft, was passed by unanimous voice vote in the 117th Congress and had over 50% of the Senate and 75% of the House co-sponsoring and over 500 endorsing organizations. This legislation is related to a handful of provisions in this purposed rule. To best align this rule with the bill, we urge CMS to modify the timeframe for expedited requests to 24 hours as opposed to 72 hours. We additionally encourage CMS to incorporate the bill's reporting requirements to move away from aggregated data and towards meaningful data on an individual service basis.
- MGMA recently submitted comments in reference to the CY 2024 Part C and D proposed rule. The proposal, in part, would provide continuity of care protections and ensure additional clinical validity for prior authorization within the MA program. MGMA reiterates that CMS must finalize critical prior authorization policy reforms in the rule.

Electronic prior authorization and the Quality Payment Program (QPP)

MGMA opposes CMS' proposal to link prior authorization to the PI component of MIPS. This proposal, if finalized, would only work against CMS' goal of reducing physician burden by wasting medical staff time and increasing prior authorization-related costs. Relatedly, MGMA strongly opposes any expansion of prior authorization in Medicare fee-for-service (FFS).

Enforcement

MGMA applauds the agency's willingness to address prior authorization automation in MA. **However, we urge CMS to establish an oversight and enforcement plan to ensure implementation of these proposals when finalized.** It is critical that CMS confirm that plans are complying with these policies and that reports of such compliance are published publicly. Part of this enforcement plan should allow for automatic approval of prior authorizations if plans do not abide by the required timeframes. **The onus should not fall on group practices to enforce these requirements. CMS must take steps to ensure**

[7] MGMA Prior Authorization Questionnaire, March 2023

payer compliance. We also urge CMS to leverage its expertise and authority to educate stakeholders of these finalized policies.

Conclusion

MGMA appreciates the opportunity to provide input on the proposed rule and urges the agency to consider implementing our recommendations, which should better protect enrollees. As the voice for the country's medical group practices, MGMA remains committed to promoting policies that enhance the ability of our members to provide high-quality, cost-effective care to the millions of patients they serve routinely. Should you have any questions, please contact Claire Ernst at cernst@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs