February 10, 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–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

Dear Administrator Brooks-LaSure:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) thanks you for the inclusion of several critical and overdue reforms included in the Centers for Medicare & Medicaid Services' (CMS') Notice of Proposed Rule Making for Part C & Part D ("proposed rule") that will reform certain aspects of prior authorization and have a positive impact on patient care.

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.

Key Comments and Recommendations

MGMA urges CMS to:

- **Finalize many of the prior authorization proposals in this rule that address our long-established concerns.** Prior authorization is routinely the most burdensome issue facing medical group practices.
- **Apply the proposed clinical validity and transparency of coverage criteria policies beyond the current scope to include prescription drugs.**
- **Establish and implement an oversight plan that will hold plans accountable for noncompliance.**
- **Include additional prior authorization reforms in future rulemaking,** such as eliminating step therapy, requiring gold-carding programs, and exempting medical groups participating in value-based models from prior authorization requirements.

Prior authorization reform is a longstanding priority for MGMA and increasing prior authorization requirements are routinely identified among the top administrative challenges facing medical groups. Despite feedback from group practices regarding the unnecessary administrative burden, cost, and delay of treatment associated with prior authorization requirements, 79% of MGMA members report that these requirements increased over the previous 12 months.[1] In addition to rising requirements, medical groups also report a lack of automation in payers' prior authorization processes, slow responses from payers for approvals, and increased time spent by practice staff working to secure prior authorizations as challenges. Eighty-eight percent of medical groups reported that prior authorization is very or extremely burdensome — ranking it the most burdensome issue for medical groups in 2021.[2] Physician groups point to delays in prior authorization decisions, resubmission of prior authorization, inconsistent payer payment policies, issues with peer-to-peer authorizations, unsustainable prior authorization volumes, and prior authorizations for routinely approved items and services as some of the most challenging aspects of prior authorization.

In 2018, MGMA along with several provider groups and health plans partnered to publish a *Consensus Statement on Improving the Prior Authorization Process*.[3] 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. MGMA believes that the Medicare Advantage (MA) program is well-positioned to implement commonsense changes to reform prior authorization.

The Office of Inspector General (OIG) issued a 2022 report[4], which found that 13% of prior authorization requests denied by MA plans met Medicare coverage rules and 18% of payment request denials met Medicare and MA billing rules. OIG recommended CMS: (1) issue new guidance on the appropriate use of Medicare Advantage Organization (MAO) clinical criteria in medical necessity reviews; (2) update its audit protocols to address the issues related to the use by MAOs of clinical criteria and/or examining particular service types; and (3) direct MAOs to take steps to identify and address vulnerabilities that can lead to manual review errors and system errors. CMS concurred with all three recommendations. We support CMS proposing policies that act as a response to these findings and urge the agency to finalize most of these policies expeditiously. Specifically, MGMA supports CMS finalizing the following proposals and offers the following recommendations:

- Appropriate use of prior authorization. CMS proposes that prior authorization processes for coordinated care plans must be limited to the use of only confirming the presence of diagnosis or other medical criteria that are the basis for coverage determinations to ensure basic benefits are medically necessary. While we appreciate CMS' intent to limit the negative consequences of prior authorization by limiting its use to confirming the presence of a diagnosis, the real-life impact of prior authorization is that it inherently delays patient care. **Therefore, although we support CMS' intent to discourage prior authorization from being a tool to discourage care,**

[1] MGMA Stat, *Virtually all medical groups say payer prior authorization requirements aren't improving*, March 2, 2022
[2] MGMA Annual Regulatory Burden Survey, October 2021
[3] Consensus Statement on Improving the Prior Authorization Process
[4] U.S. Department of Heath and Human Services Office of Inspector General report, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, 2022

we do not believe that prior authorization is necessary to confirm diagnoses and therefore, MGMA opposes CMS' proposal which calls for this. CMS must establish guardrails to prevent high volumes of prior authorization requests by MA plans. This can be done via gold-carding programs and value-based care arrangements, as discussed below.

- Equitable access to items/services and transparency. MA beneficiaries must have access to the same items and services as they would under Traditional Medicare. If applicable coverage rules do not exist under Traditional Medicare, plans must use current evidence from widely used treatment guidelines or clinical literature for internal clinical coverage criteria, which must then be made publicly available. **MGMA urges CMS to finalize this proposal and ensure the definition of "clinical literature" meets the highest standard. We believe that MA plans should publish a publicly 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**— transparency is critical in ensuring that MA plans are developing and using coverage criteria in a way that aligns with Traditional Medicare. This published information should be readily and easily accessible to group practices.
- Continuity of care. MA plans' prior authorization approvals must remain valid for the duration of the approved course of treatment. MA plans would have to provide a minimum 90-day transition period for any active course of treatment after starting a course of treatment. **MGMA urges CMS to finalize this proposal and require that prior authorization be valid for the duration of the ordered course of treatment.**
- Utilization Management (UM) Committee. CMS proposes that MA plans must establish a UM Committee that would review clinical coverage criteria. Plans could not use any UM policy that was not approved by the UM Committee starting with plan year 2024. **MGMA urges CMS to finalize this proposal. Further, we advise that the UM Committees include enough provider types to adequately represent the provider community and the wide range of conditions they treat, and to require that more than one member of the committee be independent and free of conflict relative to MA plans. To that end, the review must be conducted with the participation of at least one UM Committee member who has expertise in the use or medical need for that specific item or service. We also believe that these UM policies and procedures must be developed in consultation with contracted providers and that the MA organizations should communicate information about practice guidelines and UM policies to providers.**
- Application of proposals to prescription drugs. CMS states in its proposed rule that prescription drugs are not included within the scope of these prior authorization reform proposals. **MGMA urges CMS to reevaluate that position and extend the proposed clinical validity and transparency of coverage criteria policies to prescription drugs.**
- Enforcement. MGMA applauds the agency's willingness to address the OIG's recommendations, as well as our longtime concerns regarding prior authorization in MA. However, without the necessary enforcement mechanisms, we are concerned that these policies will never be properly implemented. **We urge CMS to establish an oversight plan to enforce implementation of these new requirements.** We suggest CMS establish a portal for patients and providers to alert CMS to instances of health plan noncompliance. Once these rules are finalized, we recommend CMS take steps to educate stakeholders as to make certain OIG's findings do not continue.
- Real time prescription benefit. **MGMA supports CMS' proposal to require Part D plan sponsors to comply with the National Council for Prescription Drug Programs' (NCPDP) Real-Time Prescription Benefit standard version 12**, thereby allowing group practices to check prior authorization requirements at the point of prescribing. We reiterate that in the spirit of

making patient care more efficient and streamlined, CMS should apply the clinical validity and transparency of coverage criteria proposals to prescription drugs.

Consistency across other reform efforts

In addition to supporting the proposed policies within this rule, MGMA largely supports CMS' proposal to implement an electronic prior authorization program (ePA), with slight refining from the provider community. As we usher in an era of overdue, much-needed prior authorization reform, we would like to reiterate our support for the following and urge CMS to ensure alignment and consistency in its approach:

- **We urge CMS to finalize the 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 (CHIP) 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 proposed rule**, which would streamline processes related to prior authorization in MA plans. MGMA applauds CMS for the inclusion of MA plans within the scope of the rule — something that was left out in a previous version. Limiting the application of the previous rule to a small subset of health plans would do little to alleviate prior authorization burden. We will work with CMS to refine the proposal that health plans be required to respond to medical groups within 72 hours for an urgent prior authorization request and within 7 days for those authorizations deemed "standard." MGMA believes these timeframes are entirely too long. We also encourage the agency to implement the health plan transparency requirements before the proposed 2026 date.
- **We anticipate 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 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 bill would put commonsense parameters around prior authorization requirements and require transparency on the part of the health plans, similarly to the prior authorization and interoperability proposed rule referenced above.

Additional prior authorization reform efforts

MGMA applauds CMS for these prior authorization reform proposals and believes this is a critical step to ensuring patients are not denied necessary care. In addition to the much-needed guardrails 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. Eighty-nine percent of practices stated they did not have adequate staff to process the increasing number of prior authorizations.[5] 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. 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 require 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.

Conclusion

MGMA appreciates the opportunity to provide input on the proposed rule and urges the agency to consider implementing our recommendations, which should strengthen the MA program and 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

[5] MGMA Regulatory Burden Report, October 2022