March 2, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: 2021 Medicare Advantage Star Rating Program

Dear Administrator Verma:

The Medical Group Management Association (MGMA) is pleased to submit the following response to the Centers for Medicare & Medicaid Services (CMS) proposed *Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies – Part II.* Specifically, we offer comments on the Potential New Measure Concepts related to the issue of prior authorization. We commend CMS for recognizing the need to improve the current prior authorization environment and seeking to leverage the Star Rating Program in pursuit of that important goal.

MGMA is the premier association for professionals who lead medical practices. Since 1926, through data, people, insights, and advocacy, MGMA empowers medical group practices to innovate and create meaningful change in healthcare. With a membership of more than 55,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,500 organizations of all sizes, types, structures and specialties that deliver almost half of the healthcare in the United States.

CMS is authorized to make quality bonus payments to MA organizations that meet quality standards measured under a five-star quality rating system. The primary goal of the Star Rating system for MA is to encourage plans to continuously improve the quality of care provided to their enrollees. We agree with CMS when it states that prior authorization "is a critical aspect of plan performance since it affects how quickly plan enrollees can get needed care and services." Including prior authorization measures in the Star Ratings Program will be an effective tool to decrease the administrative burden associated with meeting MA plan requirements and ultimately improve the care delivered to Medicare beneficiaries.

Summary of Measure Recommendations

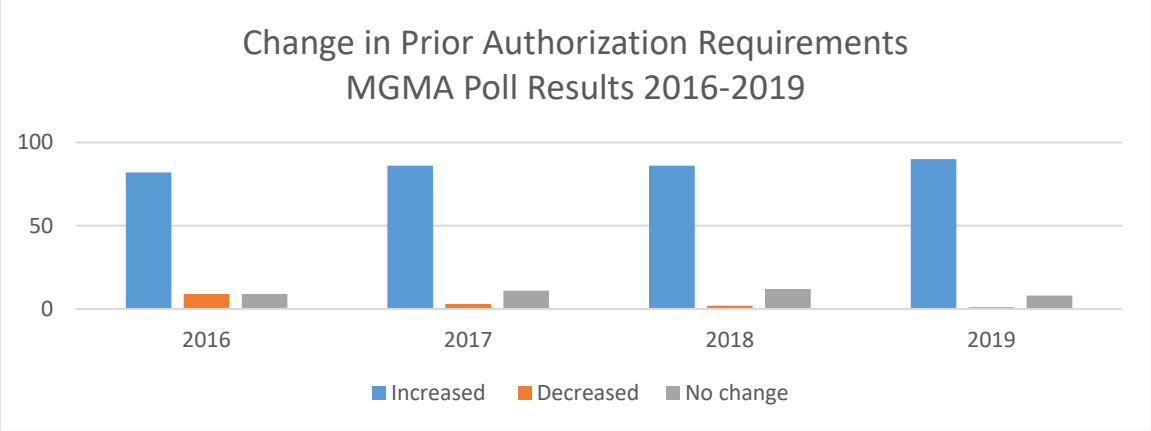
- MA plan adherence to CAQH CORE prior authorization rules and adherence to transparency requirements for listing services that require an authorization and their clinical documentation requirements.
- MA plan exclusion of prior authorization requirements for procedures undertaken during the perioperative period, for clinicians who adhere to clinical guidelines, and for clinicians who participate in risk-based contracts.
- MA plan thresholds for provider adoption of the electronic prior authorization and electronic attachments standards.

Current Prior Authorization Environment

Prior authorization continues to be one of the most onerous administrative processes faced by physician practices and MGMA advocates for a reduction in the volume of prior authorization requirements and automation of the remainder. As a cost-control process requiring providers to qualify for payment by obtaining approval before performing a service, prior authorization is overused, costly, inefficient, and can be responsible for delays in patient care.

Documentation requirements from health plans for items and services associated with prior authorization and ordering for certain medical services are also significant sources of administrative burden. Congress and the Administration can play an important role in evaluating and addressing administrative processes and clinical workflow factors contributing to this burden. While electronic health records, practice management system software vendors and other health IT solutions can also play a role in reducing this burden, prior authorization processes clearly suffer from a lack of standardization and common approaches from health plans.

Not only are prior authorization requirements challenging, but MGMA members also report that the requirements from health plans are actually increasing. In a poll conducted in September 2019 with almost 1,000 respondents, 90 percent reported that prior authorization requirements had increased in the past year, 9 percent stated that requirements had stayed the same, and one percent indicated they had decreased. Over the past few years, MGMA members have reported a consistent spike in prior authorization requirements (see below).



To put prior authorization into perspective and to compare this task with other administrative burdens facing medical practices, the MGMA regulatory burden survey asked practice executives to rate a number of administrative challenges from not burdensome to extremely burdensome. The survey results were released October 2019 and included responses from executives representing over 400 group practices.

Two-thirds of respondents are in practices with less than 20 physicians and 14 percent are in practices with over 100 physicians. Three-fourths of respondents are in independent practices. Survey respondents identified prior authorization as the leading regulatory burden facing their practice in 2019 (see below).

	Not burdensome	Slightly burdensome	Moderately burdensome	Very burdensome	Extremely burdensome	Very + Extremely
Prior authorization	2%	5%	10%	22%	61%	83%
Medicare quality payment program (MIPS/APMs)	4%	2%	17%	30%	47%	77%
Audits and appeals	1%	9%	23%	35%	32%	67%
Lack of EHR interoperability	5%	10%	20%	33%	32%	65%
Medicare Advantage chart audits	6%	10%	23%	26%	35%	61%
Translation and interpretation requirements	8%	14%	24%	26%	28%	54%
Medicare and Medicaid credentialing	4%	18%	31%	24%	23%	47%
HIPAA privacy and security	8%	15%	35%	28%	14%	42%
Federal fraud and abuse law	17%	22%	37%	18%	6%	24%

Prior authorization approval rates and practice costs

The utilization of medical services and medications should not significantly increase if prior authorization requirements are relaxed due to the fact that the majority of authorization requests are ultimately approved. In October 2019, MGMA took a poll of almost 200 physician practice executives asking a series of questions regarding prior authorization requests. We received the following responses:

- Seventy-two percent of prior authorization requests submitted to their health plans are approved during the first submission.
- Seventy-five percent of prior authorization requests that are not approved during the first submission process and are subsequently appealed are approved by their health plans following the appeal.
- Eighty-five percent of prior authorizations that require a peer-to-peer (practice clinician to health plan clinician) discussion are approved by your health plans.

Respondents reported that the majority of authorization requests are approved by the health plan the first time they are submitted and for those that are appealed by the practice following a denial by the health plan, again, the majority are approved. In those cases where the appeal requires a peer to peer (direct discussion between the practice clinician and a clinician designated by the health plan) consultation, the vast majority of authorizations are approved by the health plan.

Practice costs related to prior authorization include:

- Clinical and administrative staff time spent determining if an authorization is necessary for a particular service, test, or medication. Each health plan has their own proprietary medical necessity requirements, thus adding additional burden for practice staff. Some practices report they are forced to have staff assigned to specific health plans to conduct prior authorizations;
- Clinical and administrative staff time determining what documentation is required to support the individual plan's medical necessity requirements;
- Administrative staff time transmitting the prior authorization request and support documentation to the health plan (most often via mail, facsimile, or uploaded through a health plan's proprietary website);

- Clinical and administrative staff time spent responding to an authorization denial, which may include compiling and transmitting additional clinical documentation; and
- Clinical staff time to engage in a peer-to-peer discussion of the clinical issues.

We were pleased to see that the HHS final report "Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs," released February 21, identifies prior authorization as a critical challenge facing clinicians. On page 14, the report correctly states "EHRs and other health IT solutions can also help to mitigate this burden, but prior authorization processes suffer from a lack of standardization and common approaches." The report makes recommendations aimed at alleviating the burdens associated with practices meeting health plan prior authorization requirements, including:

- "Support automation of ordering and prior authorization processes for medical services and equipment through adoption of standardized templates, data elements, and real-time standards-based electronic transactions between providers, suppliers and payers."

- "Incentivize adoption and/or use of technology which can generate and exchange standardized data supporting documentation needs for ordering and prior authorization processes."

We assert that leveraging the Star Ratings Program and encouraging MA plans to increase the transparency of its prior authorization requirements and implement automation solutions will help address the concerns raised in the report and assist in operationalizing the recommendations laid out in the document.

Recommended Star Ratings Program Measures

As the Agency develops measures to apply to the Star Rating Program, the goal should be to reduce the administrative burden for physician practices associated with meeting MA plan prior authorization requirements and improve the care that practices deliver to Medicare beneficiaries.

We recommend the following measures be considered:

1. **Adherence to the CAQH CORE Phase V Operating Rules**. The Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE) was named in the Affordable Care Act as the authoring entity for operating rules that enhance the business functionality of mandated electronic transactions.

   In particular, the updated operating rule establishes the following maximum timeframes at key stages in the prior authorization process for both batch and real-time transactions:

   - Two-Day Additional Information Request: A health plan, payer or its agent has two business days to review a prior authorization request from a provider and respond with additional documentation needed to complete the request;

   - Two-Day Final Determination: Once all requested information has been received from a provider, the health plan, payer or its agent has two business days to send a response containing a final determination; and

   - Optional Close Out: A health plan, payer or its agent may choose to close out a prior authorization request if the additional information needed to make a final determination is not received from the provider within 15 business days of

communicating what additional information is needed.

2. **Receipt of the CAQH CORE Phase V Certification Seal**. CAQH CORE offers a certification process to test and ensure Operating Rule compliance for health plans. CAQH awards CORE Certification Seals to entities that create, transmit or use the healthcare administrative and financial transactions addressed by the CAQH CORE Operating Rules. CORE Certification means a health plan has demonstrated that its IT system is operating in conformance with applicable requirements of a specific phase(s) of the CAQH CORE Operating Rules. MA plans could be required to establish that they have been awarded the CORE Certification Seal for the full suite of prior authorization Operating Rules.

   Rationale: Phase V of the CAQH CORE Operating Rules focus on standardizing components of the prior authorization process, closing gaps in electronic data exchange to move the industry towards a more fully automated adjudication of a request. The Phase V CAQH CORE Operating Rules updated requirements in the CAQH CORE 278 Prior Authorization Infrastructure Rule and set national expectations for prior authorization turnaround times using the HIPAA-mandated standard to move the industry toward greater automation.

3. **Adherence with transparency requirements**. MA plans, not less frequently than annually and at a time and in a manner specified by CMS, would be required to submit the following information and also make available on a public section of its website:

   - A list of all items and services that are subject to a prior authorization requirement under the plan and

   - A template of the clinical information the plan requires in order to fully adjudicate the prior authorization request for all items and services that are subject to a prior authorization requirement.

   Rationale: Full transparency of what items and services require a prior authorization and the specific clinical documentation the practice is required to submit to support a prior authorization request will significant decrease the administrative burden associated with these processes. Further, access to this information will permit EHR and other vendors to develop automated prior authorization solutions that will decrease burden for the practice and reduce delays in the care delivered to Medicare beneficiaries.

4. **Adoption of a policy excluding prior authorization requirements for procedures undertaken during the perioperative period**. Adherence to a prohibition against imposition of prior authorization requirements with respect to any surgical procedure or otherwise invasive procedure (as defined by CMS), and any item furnished as part of such surgical or invasive procedure, if such procedure (or item) is furnished during the peroperative period of a procedure for which—(A) prior authorization was received from such plan before such surgical or otherwise invasive procedure (or item furnished as part of such surgical or otherwise invasive procedure) was furnished or (B) prior authorization was not required by such plan.

   Rationale: MA plan requirements that practice obtain a prior authorization for services furnished during the perioperative period can result in care being delayed to Medicare beneficiaries and additional administrative burden and cost for practices.

5. **Establishment of a "gold card" program excluding clinicians from prior authorization requirements**. The MA plan would establish a program to exempt a provider from the prior authorization process for services designated by CMS upon a provider's demonstration of compliance with the plan's coverage, coding and payment rules. The MA plan will exempt providers that achieve a prior authorization provisional affirmation threshold of at least 90 percent during a semiannual assessment.

   Rationale: Excluding clinicians who adhere to a plan's coverage, coding and payment rules from prior authorization requirements not only rewards those clinicians with decreased administrative burdens but can also serve as an incentive for other clinicians to more closely adhere to coverage, coding, and payment rules.

6. **Adoption of a policy excluding clinicians who are participating in a risk-based contract with the MA plan from prior authorization requirements**. The MA plan would establish a program to exempt a provider from any prior authorization requirements if they entered into a contract with the plan that required the clinician take on one or two-sided risk.

   Rationale: Excluding clinicians who have entered into a risk-based contract from prior authorization requirements is appropriate for two reasons. First, clinicians who are in an at-risk contract are already inherently incentivized to furnish cost-effective, high quality care and avoid overutilization of services. Second, waiving burdensome prior authorization requirements that are unnecessary in risk-based contracts will serve as an incentive to enter into these contracts.

7. **Meeting a threshold for provider adoption of the X12 278 electronic transaction**. The MA plan would be required to meet a threshold (established by CMS) of affiliated provider adoption of the X12 278 Request for Review and Response (prior authorization) electronic transaction.

   Rationale: The X12 278 is the federally mandated transaction that currently has a low adoption rate among providers and plans. According to the 2019 CAQH Index, only 13% of prior authorization transactions are conducted using the X12 278 electronic transaction, compared to 70% adoption of the X12 276 claim status transaction, 84% adoption of the X12 270/271 eligibility and benefit verification transaction, and 96% adoption of the X12 837 electronic claim.

   Increasing the adoption rate of the X12 278 transaction will significantly reduce cost for both practices and MA plans. According to the 2019 CAQH Index, practices will save $9.04 per prior authorization transaction when they use the X12 278 transaction compared to using the phone or fax to conduct the transaction. The Index also reports that plans will save $3.27 per transaction when using the X12 278 transaction compared to using the phone or fax to conduct the transaction.

8. **Adoption of the X12 275 electronic attachments standard**. The MA plan would implement this standard and offer providers the option of using the X12 275 transaction standard to transmit clinical documentation in support of a prior authorization.

   Rationale: Although not currently a federally mandated standard, plan adoption and support of the X12 275 electronic attachment standard will significantly decrease administrative burden and cost for the practice and reduce delays in the care delivered to

Medicare beneficiaries. We note that National Government Services, the Medicare Administrative Contractor for the J6 and JK jurisdictions, has implemented the X12 275.

In conclusion, MGMA supports the objective of leveraging the Star Ratings Program to help address some of the prior authorization challenges currently facing physician practices. However, it will be critical for CMS to select measures that serve to significantly enhance automation between practices and MA plans regarding prior authorization, decrease practice administrative burden and cost, and result in demonstratable improvements to the patient care delivery process.

We look forward to continuing to work with CMS and other federal agencies to reduce the volume of prior authorization requirements and automate the remainder. Should you have any questions regarding these measure recommendations, please contact Robert Tennant, Director of Health Information Technology Policy at 202.293.3450 or rtennant@mgma.org.

Sincerely,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs