RRC

Regulatory Relief Coalition

Protecting Patients' Timely Access To Care

August 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: [CMS–4203–NC] RIN 0938–AV01 Medicare Program; Request for Information on Medicare Advantage (MA RFI)

Dear Administrator Brooks-LaSure:

The Regulatory Relief Coalition (RRC) appreciates the opportunity to comment on the MA RFI referenced above. The RRC is a group of national physician specialty organizations advocating for regulatory burden reduction in Medicare so that physicians can spend more time treating patients. We aim to ensure that prior authorization (PA) is not a barrier to timely access to care for the patients our members serve.

The RRC is pleased that the MA RFI seeks feedback on MA plans' use of PA. The RFI solicits public comments on how MA plans use utilization management techniques, such as PA; the approaches used by MA plans to exempt certain clinicians or items and services from PA requirements; and the steps CMS could take to ensure utilization management does not adversely affect enrollees' access to medically necessary care, and each of these areas is addressed below.

How MA Plans Use PA

While utilization management tools have a legitimate role to play in ensuring that the care provided to Medicare enrollees is reasonable and necessary, over the past 10 years, MA and other health plans increasingly have used PA to reduce health care spending, substantially delaying medically necessary patient care and significantly increasing providers' administrative burden and related costs to comply with PA requirements. According to a July 2021 MedPAC report, nearly half of all Medicare beneficiaries are enrolled in MA plans,[1] and a 2021 Kaiser

[1] https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_SEC_v2.pdf.

Family Foundation Issue Brief[2] found that most (99%) MA enrollees are in plans that require PA for some services. An overwhelming majority (88%) of physicians report that PA interferes with continuity of care and a strong majority (84% and 84%, respectively) of physicians report that the number of PAs required for prescription medications and medical services has increased over the last 5 years.[3] According to an RRC survey, a majority of physicians report that PA results in patients' abandoning treatment altogether, and physicians overwhelmingly (87%) report that PA has a negative impact on clinical outcomes. In light of the growing enrollment of Medicare beneficiaries in MA plans, the increasing use of PA by MA plans, and the significant potential for PA to result in the delay or denial of needed health care services, we believe that it is critical for CMS to establish a maintain a robust system for continual oversight of MA plans' use of PA processes to ensure that Medicare beneficiaries enrolled in MA plans have the same access to covered services as those covered under Medicare Fee-for-Service (FFS), as required by the Medicare Act.

In 2018, the Office of the Inspector General (OIG) issued a study indicating that MA plans reverse 75% of their own denials, strongly suggesting that the PA process results in substantial delay of medically necessary care and that the criteria used for review of initial claims are flawed. A more recently released analysis[4] conducted by the OIG indicates that, in fact, MA plans' use of PA has resulted in the denial of medically necessary care that would be covered if provided to Medicare FFS beneficiaries. This study found that, among the PA requests that MA plans denied, 13% met Medicare coverage rules. The OIG report concludes:

> Our case file reviews determined that MAOs sometimes delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests met Medicare coverage rules. MAOs also denied payments to providers for some services that met both Medicare coverage rules and MAO billing rules. Denied requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers. Although some of the denials that we reviewed were ultimately reversed by the MAOs, avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs.

The burden noted in the OIG report is significant. The RRC's survey indicates that PA from various MA and other health plans typically requires physicians or their staff to spend the equivalent of 2 or more days each week negotiating with insurance companies — time that would better be spent taking care of patients. For most physicians (74%), it takes between 2 to 14 days to obtain PA, but for 15%, this process can take from 15 to more than 31 days. Most physicians (84%) report that the burden associated with PA has significantly grown over the past 5 years as insurers have increased the use of PA for procedures (84%), diagnostic tools (78%)

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[2] Kaye Pestaina and Karen Pollitz, *Examining Prior Authorization in Health Insurance (*May 20, 2022) https://www.kff.org/policy-watch/examining-prior-authorization-in-health-insurance/#:~:text=A%202021%20KFF%20Issue%20Brief,to%20a%20mental%20health%20service.

[3] https://www.ama-assn.org/system/files/prior-authorization-reform-progress-update.pdf.

[4] OIG Report, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care." Christi A. Grimm Inspector General April 2022, OEI-09-18-00260. https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

and prescription medications (80%). The burden associated with PA for physicians and their staff is now high or extremely high (92%), and in any given week, most physicians (42%) must contend with between 11 and 40 PA requests.

When considering the utility of PA as a utilization control mechanism, it is critical to note that physicians' services and procedures subject to PA are overwhelming approved. National data made available by eviCore, one of the largest companies in the country that performs PA for MA and commercial health plans, plainly indicates that for the vast majority of physicians services and procedures subject to PA, no cases were denied for medical necessity.[5] Overall, only 4.52% of cases were denied, 74% of which were in a single specialty area (radiology).

"Gold Card" Approaches

The RFI solicits comments on approaches used by MA plans to exempt certain clinicians or items and services from PA requirements. The 2018 *Consensus Statement on Improving the Prior Authorization Process*[6], which was endorsed not only by the American Hospital Association, the American Medical Association, the Medical Group Management Association and American Pharmacists Association (APhA), but also by health plan organizations (including the American Health Insurance Plans and Blue Cross Blue Shield Association), supports the use of such programs. However, little progress has been made since the *Consensus Statement* was issued. Only 9% of physicians included in the most recent AMA survey reported that the health plans with which they contract offer "gold card" exemptions from PA requirements. To address this issue, several states have adopted or are considering "gold card" laws that would require health plans to waive PA for services ordered by providers with a consistent track record of PA approval and such a law was recently enacted in Texas.[7]

Steps CMS Could Take

In light of the increased and increasing proportion of Medicare beneficiaries enrolled in MA plans and the ubiquitous use of PA by these plans, legislation was introduced in both the House and the Senate (S. 3018[8]/H.R. 3173[9]), the *Improving Seniors' Timely Access to Care Act,* which mandates increased oversight of MA plans' use of PA. These bills are endorsed by over 500 patient and provider organizations and co-sponsored by 350 members of Congress. In a bipartisan letter dated October 28, 2021, spearheaded by Senators Sherrod Brown (D-OH) and John Thune (R-SD), 29 Senators from both sides of the aisle urged CMS to use its regulatory authority to improve the PA process across health plans, in line with the *Improving Seniors' Timely Access to Care Act.*

We also urge CMS to implement the recommendations included in the April 22, 2022 OIG Report references above. In its Report, the OIG cited use of clinical guidelines not contained in

[5] https://www.evicore.com/-/media/files/evicore/footer-pages/national-level-summary-report-q1-2018.pdf?la=en.
[6] https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf.
[7] https://www.texmed.org/Template.aspx?id=59701.
[8] https://www.congress.gov/117/bills/s3018/BILLS-117s3018is.xml.
[9] https://www.congress.gov/117/bills/hr3173/BILLS-117hr3173ih.xml.

Medicare coverage rules as one reason for the improper denials, as well as managed care plans requesting additional unnecessary documentation. The OIG recommended (and the U.S. Department of Health and Human Services agreed) that CMS should take a closer look at the appropriateness of clinical criteria used by MA plans in making coverage determinations and issue instructions clarifying MA plans authority to adopt PA clinical guidelines that are narrower than those used under Medicare Fee-for-Service.

Furthermore, on December 10, 2020, CMS released a proposed rule titled "Reducing Provider and Patient Burden by Improving Prior Authorization Processes and Promoting Patients' Electronic Access to Health Information" (e-PA Proposed Rule). The e-PA Proposed Rule represented an important step forward in reducing the administrative burdens involved in PA while increasing transparency and included many of the reforms included in H.R 3173 and advanced by the RRC. However, the e-PA Proposed Rule failed to include MA plans, a concern raised in numerous public comments. The e-PA Final Rule is currently undergoing administrative review by CMS. We urge CMS to expand the scope of the requirements included in the e-PA Proposed Rule to MA plans and to publish the expanded e-PA Final Rule as soon as practicable.

Finally, we strongly urge CMS to establish closer oversight over MA plans use of PA more generally. Guidance to plans to reduce PA for routine procedures and services that are largely approved would improve timely access to care for beneficiaries and reduce unnecessary burdens and costs on medical practices across the country.

Without enhanced CMS oversight over MA plans' PA processes, it is doubtful whether any meaningful progress will be achieved. MA plans' PA processes should be reviewed at the time that they submit their bids to CMS based on clear criteria and their performance should be made public on the CMS website. Data on use of PA and approval/denial rates also should be collected (and made public) through ongoing oversight and special focus audits.

We appreciate the opportunity to comment on this critical issue and urge CMS to take prompt action to implement the PA reforms recommended by RRC and others in response to the MA RFI.

Sincerely yours,

American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Physical Medicine and Rehabilitation
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
Association for Clinical Oncology

Congress of Neurological Surgeons
Medical Group Management Association
Society for Cardiovascular Angiography and Interventions