August 31, 2022

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

Dear Administrator Brooks-LaSure:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) appreciates the opportunity to provide feedback on the Medicare Advantage (MA) program. We are particularly appreciative that the Centers for Medicare & Medicaid Services (CMS) is soliciting feedback on two issues of significant importance to MGMA members – prior authorization and value-based 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

- Prior authorization is routinely the most burdensome issue facing medical group practices. MGMA urges CMS to implement commonsense policies to reform prior authorization in the MA program, such as increasing oversight of MA plans prior authorization policies, reinstating the prohibition of step therapy for Part B drugs, requiring transparency of payer prior authorization policies, and implementing recent recommendations from HHS OIG.
- CMS can support robust participation in value-based payment arrangements in MA by considering how to better support value within the Medicare fee-for-service program. Providing clinicians with a glidepath in value-based care contracts will better prepare them for participation in higher-risk arrangements in MA.
- Practices furnishing care to underserved populations may not have the infrastructure to participate in more complex contracts. MGMA recommends CMS provide additional support for these practices to ensure historically underrepresented patient populations are receiving care from organizations engaged in value-based care practices.

Prior authorization

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 past 12 months.[1] In addition to rising requirements, medical groups also report 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. To that end, MGMA supports both the *Improving Seniors' Timely Access to Care Act* (S. 3018/H.R. 3173) and the *GOLD CARD Act* (H.R. 7995), which meaningfully address much-needed areas of reform.

Prior authorization reform

In 2018, MGMA along with several provider groups and payers partnered 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. MGMA believes that the MA program is well-positioned to implement commonsense changes to reform prior authorization.

We believe CMS can take the following steps to improve and reform prior authorization in the MA program, which would cut down on cost, burden, and delays in care. CMS should:

- **Publish the *Interoperability and Prior Authorization for MA Organizations, Medicaid and CHIP Managed Care and State Agencies, FFE QHP Issuers, MIPS Eligible Clinicians, Eligible Hospitals and CAHs* proposed rule**, which would streamline processes related to prior authorization in MA plans. A similar rule was published at the end of the previous Administration's term but did not include MA plans within the scope. By limiting the application of the previous rule to a small subset of health plans, MGMA believed it would do little to alleviate prior authorization burden. Preferably, the rule should cover MA plans and modify the original timeframe for which plans must respond. CMS proposed that health plans respond to medical groups within 72 hours for an urgent prior authorization and within 7 days for those authorizations deemed "standard." MGMA believes these timeframes are entirely too long.
- **Implement recommendations included in the April 2022 the Department of Health and Human Services (HHS) Office of Inspector General (OIG) report,**[3] which revealed that MA organizations delayed or denied MA beneficiaries' access to services, even though the requests met Medicare coverage rules. OIG, in part, recommended that CMS update audit protocols and take steps to address vulnerabilities that could lead to errors. The findings in the OIG report reflect physician practices' own experiences.

[1] MGMA Stat, *Virtually all medical groups say payer prior authorization requirements aren't improving*, March 2, 2022
[2] Consensus Statement on Improving the Prior Authorization Process
[3] HHS OIG, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, April 2022

- **Reinstate step therapy prohibition in MA plans for Part B drugs** as described in the September 17, 2012, HPMS memo *Prohibition on Imposing Mandatory Step Therapy for Access to Part B Drugs and Services*. Earlier this year, MGMA along with dozens of leading healthcare organizations wrote to CMS urging the agency to reinstate this prohibition. We are concerned that since the recission of the prohibition in 2019, patients have been harmed – including some of the most vulnerable in the MA program.
- **Increase oversight over MA plans' prior authorization processes.** In line with OIG's findings and recommendations, MGMA urges CMS to establish closer oversight over MA plans use of prior authorization.
- **Require transparency of payer prior authorization policies and establish evidence-based clinical guidelines available at the point of care.**

Along with the general comments regarding prior authorization reform, MGMA offers the following responses to CMS' specific questions below.

1. *How do MA plans use utilization management techniques, such as prior authorization? What approaches do MA plans use to exempt certain clinicians or items and services from prior authorization requirements? What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care?*

MA plans use utilization management techniques, such as prior authorization, primarily to control costs while promoting adherence to evidence-based guidelines. Obtaining prior authorizations requires significant clinical and administrative resources. The process is often manual depending on what clinical information is needed by a particular plan, requiring the practice to use the phone, fax, mail, or a health plan proprietary web portal. Further complicating the process, health plans typically have different medical necessity requirements, and the authorization submission and appeals process varies across payers. Kaiser Family Foundation (KFF) recently reported that nearly all enrollees are in plans that require prior authorization for some services in 2022.[4] Eighty-eight percent of medical groups report that prior authorization is very or extremely burdensome – ranking it the most burdensome issue for medical groups in 2021.[5] 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.

MGMA is deeply concerned about increasing prior authorization requirements. Medical groups report hiring full-time staff and redistributing the duties of existing staff just to keep up with processing prior authorizations. Another utilization management technique used by MA plans is 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

[4] KFF, Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings, August 2022
[5] MGMA Annual Regulatory Burden Survey, October 2021

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 MA plans for Part B drugs.

A commonsense approach to exempting certain clinicians or items and services from prior authorization requirements is implementing a "gold card" program. Gold card programs exempt providers from prior authorization requirements for certain services if they reach a particular approval rating over a period of time. States have embraced this approach - Texas and West Virginia have successfully passed gold card laws. However, gold card programs are largely underutilized. MGMA supports the above-referenced GOLD CARD Act, which would exempt physicians from MA plan prior authorizations if they had 90% of requests approved in the preceding 12 months.

Value-based Care in MA Contracts

As beneficiary enrollment in MA continues to increase, alignment in processes and procedures across MA payers and across the Medicare program will continue to rise in importance. In the 2022 MGMA DataDive Practice Operations survey, practices reported data related to participation in MA value-based payment arrangements and quality reporting requirements. Among the participating practices, more than 50% of nonsurgical single specialties, surgical single specialties, and multispecialty practices reported that all MA contracts included a risk arrangement, value-based reimbursement methodology, or incorporated quality into payment. However, the number of reported MA contracts incorporating similar value-based care methodologies was lower among primary care single specialty practices.[6]

Value-based care is an important tool within healthcare to ensure providers can provide the most clinically appropriate care, while ensuring practices are appropriately reimbursed for improved clinical outcomes. In contrast to fee-for-service (FFS) Medicare, MA has the additional flexibilities to meaningfully incorporate value-based care principles into payment arrangements to support the transition to greater participation in such models. MGMA appreciates the agency's continued focus on improving the MA program and critically evaluating how value-based care is an important tool within MA and can be improved in future rulemaking. Please find MGMA's responses to selected value-based care questions below.

1. *What factors inform decisions by MA plans and providers to participate (or not participate) in value-based contracting within the MA program? What data could be helpful for CMS to collect to better understand value-based contracting within MA?*

Value-based care within MA contracts varies greatly across plans, across practice types, and includes arrangements across the value spectrum from pay-for-reporting with quality bonuses, to episode-based payment, to total cost of care accountability. However, complexity of such value-based care arrangements can significantly impact the ability for practices to participate in MA contracts that incorporate value-based care payment mechanisms.

[6] 2022 MGMA DataDive Practice Operations Survey, August 2022

MGMA created best practices for practices to consider when evaluating new value-based contracts:

- Clearly define practice roles and responsibilities for contracting activities.
- Analyze contract performance thoroughly, establish proformas for value-based care arrangements.
- Establish baseline performance and review data before entering into contractual arrangements.
- Routinely monitor contract performance to proactively identify challenges.
- Focus on creating a collaborative relationship with payer partners and understand it will not be perfect for everyone.
- Focus on short- and long-term goals for the practice and the payer.
- Define routine communications pathways and stick to the plan.
- Celebrate success and continue to look for the next opportunity to build upon successes.
- Consider steps that will assist the practice in successfully participating in value-based arrangements.

Success in value-based care arrangements will vary significantly across practices. However, these principles provide a roadmap for the criteria practices must consider.

Additionally, a focus on primary care will be essential. According to our member survey, primary care practices are less likely to contract with MA plans that have a value component incorporated into the plan. Primary care is the backbone of the U.S. healthcare system and is critical to support shared goals to achieve success in value-based care. MGMA recommends CMS focus on supporting primary care MA contracts to ensure principles within MA align with larger CMS and stakeholder goals to advance value-based care.

While MGMA collects information from member practices related to value-based contracts within MA, we recommend CMS collect more robust information from MA plans about the application of such arrangements, such as the frequency of incorporation of value to payment methodologies and the successes of such arrangements. The information and data collected from MA can help support lessons learned in value-based care and can be applied elsewhere under the Medicare program.

2. *Are there ways that CMS may better align policy between MA and value-based care programs in Traditional Medicare (for example, Medicare Shared Savings Program Accountable Care Organizations) to expand value-based arrangements?*

MGMA recommends CMS collaborate with physician practices that have demonstrated success in value-based care to support the alignment of initiatives across the Medicare program and other payers. Redundancies across payers, including MA and FFS Medicare, can create unnecessary administrative burdens in value-based care. Incentives in providing high quality, coordinated care should be harmonized and in alignment.

MA is largely based on the structure, benefits, and design of FFS Medicare. As such, to support value-based care in MA, CMS can provide additional structure, strategic goals, and permanent participation

options in value-based care within traditional Medicare. While many practices are currently in engaged in value-based care, there are many with limited experience participating in any value payment arrangement. CMS should continue to develop a robust glidepath under the Quality Payment Program and through the CMS Innovation Center to create a wide range of participation options with the necessary technical support for small and rural practices to effectively participate and succeed in a value-based payment model. Creating these participation options will ensure new entrants and those with limited experience in value-based care have accessible participation options. By bolstering participation options within FFS Medicare, practices are more aptly prepared to expand value-based care participation into other markets and contracts.

3. *What steps within CMS's statutory or administrative authority could CMS take to support more value-based contracting in the MA market? How should CMS support more MA accountable care arrangements in rural areas?*

MGMA shares in CMS' strategic goal to advance health equity; with the additional flexibilities embedded in value-based care, expanding participation to rural and underserved regions within value-based care is critical to support this goal. CMS should consider its ability to provide greater technical resources to smaller and rural practices. Real-time and ongoing data analysis is essential for successful value-based care participation. Smaller practices are less likely to have access to the infrastructure to support such activities. In order to increase participation, MGMA recommends CMS evaluate how the agency can support and provide the data necessary to monitor ongoing participation in value-based care arrangements.

Conclusion

MGMA appreciates the opportunity to provide input on the MA RFI and urges the agency to consider implementing our recommendations, which should strength the MA program as well as 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