AMGA
Advancing High Performance Health

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Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Brooks-LaSure:

On behalf of AMGA, I appreciate the opportunity to comment on the Advancing Interoperability and Improving Prior Authorization Processes proposed rule, as published in the December 12, 2022 Federal Register. Prior authorization continues to be a costly barrier to patient access to care, and we support efforts to streamline these processes and minimize its adverse effects on patients.

Founded in 1950, AMGA represents more than 440 multispecialty medical groups and integrated delivery systems, representing about 175,000 physicians who care for one in three Americans. Our member medical groups work diligently to provide high-quality, cost-effective, patient-centered medical care.

CMS is working to improve the prior authorization process by creating the infrastructure to support faster, standardized processes for electronic communications among affected payers and hospitals, clinicians, and other healthcare providers to reduce administrative burdens and increase the timeliness of decisions. AMGA supports this goal but must emphasize that the most appropriate way to reduce the administrative burdens associated with prior authorization is to minimize and/or eliminate its use when at all possible, particularly in value-based models of care that have inherently different incentives than fee-for-service models and are designed to promote the most efficient use of resources.

We are pleased to offer the following recommendations on the Advancing Interoperability and Improving Prior Authorization Processes proposals on improvements to prior authorization and reforms to the application programming interface (API) standards.

Key Recommendations:

Prior Authorization Response Timelines: AMGA appreciates CMS is proposing to shorten the decision timeframes. However, the proposed 7-day response times for standard requests and 72 hours for expedited (urgent) requests are far too long and not reflective of care delivery models. AMGA recommends CMS require plans to shorten the timeframes to 48 hours for standard requests and 24 hours for urgent ones.

AMGA also disagrees with CMS' proposal not to require payers to default to a prior authorization request approval if the payer has not responded promptly. Prior authorization requests not resolved in the specified timeframe should be considered approved.

"Gold Carding" Providers: CMS should examine the success of Gold Carding at the state level and exempt providers who have demonstrated they deliver high-quality care from prior authorization requirements.

Provider Access API: CMS should expand its proposal to require payers to implement and maintain a Provider Access API. CMS should expand the proposal to include all providers that have a relationship with a plan's patient, even if the provider does not have a contractual relationship with the plan. Providers need access to all of their patients' data to have a full understanding of their healthcare needs.

AMGA is pleased to offer its detailed comments below.

Prior Authorization Response Timelines

AMGA appreciates CMS is proposing to shorten the decision timeframes. However, the proposed 7-day response times for standard requests and 72 hours for expedited (urgent) requests are far too long and not reflective of care delivery models. Instead, AMGA recommends CMS require plans to respond within 48 hours for standard requests and within 24 hours for expedited or urgent requests. Of note, the timeframe should be set in *hours,* not calendar or business days. Should a provider submit a request, for example, on a Friday evening, the timeframe must start immediately and not wait until Monday morning to be processed. Our providers deliver care 24/7/365. Health plan operations need to reflect this.

Delays in approving prior authorization requests result not only in administrative burdens. They also result in care delays. Therefore, in addition to the shorter timeframe, AMGA recommends any place of service referral that requires an overnight bed be considered expedited or urgent and be addressed within 24 hours. AMGA members report that delays for approvals to transfer hospitalized patients to a skilled nursing facility (SNF) are a leading contributor to increased hospital length of stays. A common example involves a request submitted to a health plan on a Thursday or Friday to approve SNF care. Payers are not approving the request by close of business on Friday afternoon and have no staff available to approve the authorization over the weekend. As a result, the patient remains in the hospital for an additional two to three days more than necessary. To prevent such "warehousing," AMGA recommends CMS require plans to consider transfer requests on an expedited basis and use hours, not days, as the measurement of time. A request submitted on Friday evening at 5:00 pm should be processed no later than Saturday at 5:00 pm.

AMGA also supports CMS' proposal to require payers to provide a specific reason for denied prior authorization decisions. CMS should further require payers to ensure any reason for denial has clear, actionable information so providers can possibly remedy the situation.

Payer Failure to Meet Deadlines

In the proposed rule, CMS writes that in the event a payer fails to make a decision within the allotted time, it is "not practical to require payers to default to an approval." Instead, CMS recommends providers contact the payer to obtain the status of the request and determine if additional documentation is needed or if a different issue is delaying the decision.

AMGA strongly disagrees with this proposed standard. The plan's failure to make a determination should not

shift the onus onto providers. Using Medicare Advantage (MA) as an example, based on CMS' data, the vast majority of prior authorization requests are approved either initially or on appeal. MA plans in 2021 received more than 35 million prior authorization requests. Of that amount, only about 2 million prior authorization requests were fully or partially denied by MA insurers. Effectively, MA plans approved about 94% of prior authorization requests. Further, of those requests the plans initially denied, 11% were appealed. However, among those requests providers appealed, 82% eventually were fully or partially approved. Ultimately, MA plans approve the vast majority of prior authorization requests, either initially or on appeal.

If plans do not take action on a prior authorization request within the specified timeframe, the request should be considered approved. Given CMS data indicates prior authorization requests overwhelmingly are approved, defaulting to an approved status would result in the most likely outcome anyway. Requiring the provider to contact the plan will add additional delays to treatment. In addition, AMGA is concerned that without defaulting to an approved status, the deadline will be one in name only. The deadline no longer would serve as an effective tool to ensure plans respond to prior authorization within the specified timeframes. Failure to meet the deadline should default to approved status for prior authorization requests.

"Gold Carding" Providers

CMS is proposing several changes to the way providers and patients interact through API technology, but as noted above and in earlier comments this year to the Office of the National Coordinator, AMGA recommends eliminating prior authorization when possible. In our comments to ONC, AMGA stated regulators and stakeholders should implement an electronic prior authorization process that automatically clears or waives prior authorization requirements for those providers that have demonstrated they deliver high-quality care.

AMGA also appreciates that CMS is encouraging the use of "Gold Carding" to reduce the overall number of prior authorization requests. Gold Carding uses data about a provider's record for compliance with prior authorization requests and their patterns of utilization of specific services. When providers meet a certain threshold standard, they may be designated as Gold Card providers and exempt from some or all prior authorization requirements, resulting in the services they prescribe being subject to prior authorization less often.

While AMGA maintains that prior authorization simply is not necessary in value-based models or plans, a Gold Carding program can be an effective tool to reduce the overall volume of prior authorization requests in other health plans. Implementing Gold Carding would be a highly effective and efficient method of addressing administrative issues related to prior authorization and further reduce the burden of prior authorization requirements for healthcare providers. This innovative solution would improve the quality of care and promote better outcomes for providers and patients.

CMS can examine the successes of Gold Carding at the state level. For example, West Virginia enacted a Gold Card policy in 2019 that exempts providers from prior authorization rules if they have a 100% approval rate on a certain service for six months. In addition, Texas recently enacted a law that exempts physicians who have a 90% prior authorization approval rate over a six-month period on certain services.

Provider Access API

CMS has proposed requiring payers to establish and maintain a Provider Access API for exchanging data on current patients. This would allow providers to efficiently access patient data before or during a visit, leading to more informed treatment decisions and potentially preventing duplicative services. AMGA appreciates and supports this proposal, as we have long supported policies that improve access to data for providers. However,

AMGA recommends that CMS build on this proposal and expand it to include all providers that have a relationship with a plan's patient, even if the provider does not have a contractual relationship with the plan. AMGA members repeatedly have indicated that access to timely Medicare and commercial payer administrative claims data is the most significant barrier to assuming risk.

AMGA is concerned that this proposal does not fully consider the diversity of potential care providers, as access would be restricted to only in-network providers. Because many patients receive care from multiple providers across various healthcare networks, this approach fails to fully consider the complexity and interconnectedness of the healthcare ecosystem.

Providers need access to all of their patients' data to have a full understanding of their healthcare needs. If they were able to access the Provider API, clinicians would have a broader perspective of what items the insurer has paid for, such as preventative screening exams and tests, even if those tests were not performed by the providers directly and are not recorded in their electronic medical records. Incorporating this additional data would give a more real-time look at the patient's individual progress, allowing providers to shift from getting tests done to getting the correct care for their patients. Incorporating all the data would reduce test redundancies and unnecessary procedures, thus increasing patient convenience and safety and reducing the cost of care.

The need to share data is particularly important for patients in underserved communities, as they often receive care from providers outside their networks due to limited access to in-network providers. By limiting data access only to in-network providers, the proposed regulation could hinder the ability of providers to collaborate and coordinate care effectively, which is crucial for ensuring positive patient outcomes.

AMGA recommends CMS require payers to share data on shared patients with providers, even if they not an in-network provider or have a provider agreement with the payer.

We thank CMS for consideration of our comments. Should you have questions, please contact Darryl M. Drevna, AMGA's senior director of regulatory affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,

Jerry Penso, MD, MBA
President and Chief Executive Officer
AMGA