

**Filed electronically**

November 30, 2020

Dear Mr. Kouzoukas:

The Regulatory Relief Coalition (RRC) is pleased to have the opportunity to comment on the Medicare Advantage (MA) advance notice of methodological changes for CY 2022 (the “2022 Advance Notice”). 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. Most recently, we have focused on common-sense reform of Medicare Advantage Organizations’ (MAOs) use of prior authorization. Our aim is to ensure that prior authorization (PA) is not a barrier to timely access to care for the patients we serve.

In its comments on the 2019 Advance Notice, the RRC had called for the inclusion of a measure related to PA in the Star Ratings, and we are delighted that CMS is taking action to develop appropriate measures. We were pleased that the 2021 Advance Notice indicated that CMS was beginning work to develop a measure for the display page related to PA and was considering proposing it in the future as a Star Ratings measure to support beneficiary access to necessary and reasonable care. We are extremely disappointed that the 2022 Advance Notice does not include any proposal to include a PA-related measure on the display page, nor does the 2022 Advance Notice include any other reference to the need to focus on MAOs’ performance with respect to PA.

While we understand that the need to address COVID-19 is the first priority for both MA and fee-for- service Medicare at this time, we strongly believe that the current crisis does not diminish, but rather reinforces, the need to monitor MAOs’ PA processes: Care already delayed due to the pandemic should not be further delayed to accommodate MAOs’ internal administrative processes. Moreover, the need to operate remotely on reduced staff has significantly delayed some MAOs’ PA approval processes, exacerbating the administrative delays involved.

We again urge CMS to formulate a multi-factored methodology to assess MA plans’ performance with respect to PA, with measures based on the PA standards set forth in H.R. 3107, the **Improving Seniors' Timely Access to Care Act of 2019,** pending legislation that focuses on improving Medicare Advantage plans’ prior authorization processes. This bipartisan bill now has over 262 cosponsors, including roughly equal numbers of Democrats and Republicans. The strong support for this legislation on both sides of the political aisle clearly indicates that the time has come for MA plans to be held accountable for PA processes that function as a barrier to timely access to care.

Consistent with the provisions of H.R. 3107, the RRC recommends that CMS consider quality measures that focus on:

* Whether the MA plan established an electronic prior authorization program that provides for the secure electronic transmission of a prior authorization request from a health care professional — including such clinical information as may be needed to support the request — and a response from the plan to the professional through:
* Meaningful use of HIPAA transaction standards (ASC X12N/005010X217 Health Care Services Review – Request for Review and Response (278) and the X-12 275 electronic attachments standard;
* Receipt of certification of compliance with the [CAQH CORE](https://www.caqh.org/core) [Phase V Operating Rule](https://www.caqh.org/core/phase-v-caqh-core-operating-rules), which was designed to strengthen the accuracy and consistency of the PA process; and
* Meeting a threshold for provider use of a Health Level Seven (HL7®) Fast Healthcare Interoperability Resources (FHIR®)-based API for PA requests, the submission of supporting clinical information, and MA plan responses.
* Whether the MA plan's electronic PA program facilitates real-time decisions on PA requests for items and services that are routinely approved by the plan.
* Whether the MA plan adheres to transparency requirements by, for example, publishing on a publicly available website a list of items and services subject to PA, along with the percentage of PA requests approved, appeal statistics, and time from request submission through the decision and making that website available to enrollees, potential enrollees and providers.
* Whether the MA plan provides to providers (in addition to the information described immediately above), specification of the clinical information necessary to support approval, and a description of PA policies and procedures?
* Whether the MA plan excludes PA requirements for surgical procedures undertaken during the peroperative period of a previously approved procedure.
* Whether, and to what extent, PA decisions are made by a professional in the same specialty as the requesting practitioner.
* Whether the MA plan excludes from PA requirements providers that have met gold card standards and those that undertake financial risk.

We look forward to working with CMS to ensure that display measures and star ratings promote the judicious use of prior authorization in a manner that dissuades unnecessary care while assuring timely access to medically necessary services.

Sincerely yours,

s/s

Diane Millman

Regulatory Counsel

Regulatory Relief Coalition