MARCH 2023

REGULATORY BRIEF

MEDICAL GROUP MANAGEMENT ASSOCIATION

RULE: Prior Authorization & Interoperability
STAGE: Proposed
AGENCY: Centers for Medicare & Medicaid Services (CMS)
TOPIC: Prior Authorization & Interoperability
SCOPE: Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges

SUMMARY

This proposed rule, in part, proposes to reform aspects of prior authorization within the Medicare Advantage (MA) program along with several other payers. The rule proposes to require affected payers to publicly publish aggregated prior authorization data, implement a process (PARDD API) to facilitate prior authorizations, shorten timeframes for returning prior authorization decisions, and provide specific reasons for prior authorization denials. Most of these provisions are set to go into effect in 2026.

MGMA KEY RECOMMENDATIONS TO CMS

- Finalize the inclusion of MA plans in the scope of this rule. When a similar rule was published at the end of 2020, MGMA urged for the inclusion of MA plans within the scope of the rule. MGMA is encouraged that CMS heeded our call, but we urge the agency to leverage its authority to continue reforming prior authorization. Automating prior authorization is only one part of achieving meaningful reform. Much work remains to be done, including efforts to provide greater transparency, reduce the overall volume of prior authorization requests, and improve peer-to-peer reviews.
- Finalize the proposal to require plans to provide specific reasons for prior authorization denials. MGMA supports CMS' intent to provide more clarity around prior authorization denials, but encourages the agency to require plans to provide more actionable information alongside the specific denial reasons.
- Shorten the proposed timeframes to 48 hours for standard prior authorizations and 24 hours for expedited prior authorizations. CMS' current proposal of 7 days for standard prior authorizations and 72 hours for expedited prior authorizations will do little to mitigate the current challenges involved with processing prior authorization requests in a timely manner as to not delay care. MGMA urges CMS to clarify in the final rule that these required timeframes refer to final decisions and to develop an enforcement plan that does not rely on medical groups to ensure plan compliance.

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MGMA KEY RECOMMENDATIONS TO CMS CONTINUED

- Finalize the proposal to require plan public reporting of prior authorizations. MGMA supports CMS' intent to require plans to provide more transparency around prior authorization practices. However, we do not understand the need to wait to implement this provision until 2026 — CMS should make these requirements effective immediately upon finalization of this rule.
- Encourage the usage of gold-carding programs in the MA program. MGMA supports gold-carding initiatives, and while gold-carding programs have the potential to reduce burden and delays in care, only 7% of practices report that MA plans have a gold-carding program available.
- Not link electronic prior authorization requirements to CMS' Quality Payment Program (QPP). To link prior authorization to the Promoting Interoperability (PI) component of the Merit-based Incentive Payment System (MIPS) would only exacerbate unnecessary burden and work against CMS' goal of reducing physician burden, medical staff time, and prior authorization-related costs.

NEXT STEPS

CMS will review comments that were submitted on or before March 13, 2023. We hope that CMS will finalize this rule with our recommendations before the end of the year. This rule is related to the MGMA-supported Improving Seniors' Timely Access to Care Act – we are working with our Regulatory Relief Coalition partners to reintroduce this bill in the 118th Congress.

RELATED LINKS

- MGMA's comments
- CMS fact sheet
- Proposed rule text
- MGMA position paper on prior authorization

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