RRC

Regulatory Relief Coalition

Protecting Patients' Timely Access To Care

September 13, 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

Subject: Medicare Program: 2023 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs etc. ("OPPS Proposed Rule" or "Proposed Rule")

Dear Administrator Brooks-LaSure:

The undersigned members of the Regulatory Relief Coalition (RRC), representing physicians throughout the country, are pleased to have the opportunity to comment on the OPPS Proposed Rule. The RRC is a group of national physician specialty organizations advocating for regulatory burden reduction in Medicare so physicians can spend more time treating patients. Our aim is to ensure that prior authorization (PA) is not a barrier to timely access to care for the patients we serve.

The RRC is very disappointed that the calendar year (CY) 2023 OPPS Proposed Rule proposes to expand the list of hospital outpatient services subject to PA to include facet joint interventions. The RRC is extremely concerned about CMS' incorporation of PA — traditionally a utilization control process used by managed care organizations — into the Medicare Fee-for-Service (FFS) Program. Over the past 10 years, health plans have increasingly used PA to reduce health care spending, substantially delaying medically necessary patient care and significantly increasing providers' administrative costs. Obtaining PA from various Medicare Advantage (MA) and other health plans typically requires physicians or their staff to spend the equivalent of two or more days each week negotiating with insurance companies — time that would better be spent taking care of patients.

According to an RRC survey, 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. A majority of physicians report that PA forces patients to abandon treatment altogether, and physicians overwhelmingly (87%) report that PA has a negative impact on patient clinical outcomes. Most physicians (84%) report that the burden associated with PA has significantly increased over the past five years as insurers have increased the use of PA for procedures (84%), diagnostic tools (78%) 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.

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[1]/H.R. 3173[2]), 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 the House and Senate. 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*. Given the clear consensus that the PA processes used by MA organizations need to be reformed, we do not believe that it is appropriate to further extend the use of these same processes under Medicare FFS.

In fact, the initial adoption of hospital outpatient PA requirements in the CY 2020 OPPS Final Rule (CMS-1717-FC) for five procedures[3] constituted a significant departure from traditional Medicare claims processing practices. Nevertheless, before the agency and the Medicare Administrative Contractors (MACs) had an opportunity to assess this new system, effective July 1, 2021, CMS added additional spine-related procedures to the list of hospital outpatient services subject to PA.[4]

Based on feedback from neurosurgical practices performing these spine procedures, the PA process is causing in significant delays of medically necessary care. Sixty six percent of survey respondents reported delays of over 10 days, and, of those, 55% reported delays of 11-20 days. Sixty- three percent of survey respondents reported that MACs had issued initial denials that requested additional documentation; 42% reported initial denials requiring engagement in peer-to-peer or other higher-level review; and 21 % reported final denials resulting in patient abandonment of surgical treatment options considered medically necessary by their surgeons. Over half the survey respondents reported that the process typically required requests for additional documentation to render PA decisions, including confusion about who is responsible for obtaining PA — the hospital or neurosurgical practice. In general, the survey responses support the view of one respondent who observed: "Prior authorization delays procedure, limits patient access and affects operating room scheduling and hospital efficiency and productivity."

Now, despite these ongoing problems with the system, CMS again proposes to extend the use of PA under Medicare FFS without clearly stating the standards to be used in identifying procedures to be subject to these burdensome new requirements.

For these reasons, we strongly disagree with CMS' decision to further expand PA requirements in 2023. Furthermore, we urge the agency to take the following actions:

- Immediately halt the PA requirements for the seven clinical areas currently subject to PA. At the very least, CMS must closely monitor the implementation of the current PA requirements to ensure that decisions are made promptly and, if not, clarify that the PA requirements are not barriers to payment for these services.
- Release the MACs' PA data to improve transparency.
- Clarify the process for removing services from the PA requirements.
- Suspend the use of PA for any additional services under all Medicare FFS programs.

[1] https://www.congress.gov/bill/117th-congress/senate-bill/3018
[2] https://www.congress.gov/bill/117th-congress/house-bill/3173.
[3] Blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty and vein ablation.
[4] Implanted spinal neurostimulators and cervical fusion with disc removal.

Thank you for considering our comments.

Respectfully,

American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Physical Medicine &Rehabilitation
American Association of Neurological Surgeons
American College of Cardiology
American College of Surgeons
American Osteopathic Association
Association for Clinical Oncology
Congress of Neurological Surgeons
Medical Group Management Association
North American Spine Society
Society for Cardiovascular Angiography & Interventions