



# MASSACHUSETTS MEDICAL SOCIETY

*Every physician matters, each patient counts.*

To: The Honorable Seema Verma, Administrator, Centers for Medicare & Medicaid Services,  
U.S. Department of Health and Human Services

From: Massachusetts Medical Society

Re: File Code CMS-9123-P. Medicaid Program; Patient Protection and Affordable Care Act;  
Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and  
Promoting Patients' Electronic Access to Health Information for Medicaid Managed Care  
Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, and  
Issuers of Qualified Health Plans on the Federally-facilitated Exchanges; Health  
Information Technology Standards and Implementation Specifications

Date: January 4, 2021

---

On behalf of our 25,000 physician, resident, and medical student members, the Massachusetts Medical Society (MMS) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the Reducing Provider and Patient Burden by Improving Prior Authorization Processes and Promoting Patients' Electronic Access to Health Information proposed rule, published in the *Federal Register* on December 18, 2020 (85 Fed. Reg. 82586).

The MMS appreciates the agency's commitment to supporting patients' access to quality care and promoting administrative simplification for health care providers, so that providers can focus more of their time on providing that care. The MMS has long supported policies to reduce delays in care for patients and lessen the administrative burden for physicians that prior authorization processes can cause—and we are largely supportive of the policies outlined in the proposed rule that align with these goals. For example, the proposed rule would place new requirements on Medicaid and CHIP managed care plans, state Medicaid and CHIP fee-for-service programs, and Qualified Health Plans (QHP) issuers on the Federally-facilitated Exchanges (FfEs) to improve the electronic exchange of health care data and streamline processes related to prior authorization. The MMS appreciates that the rule would improve the electronic exchange of health information among payers, providers, and patients, while allowing patients increased electronic access to their health care information.

In particular, we would like to provide comments related to the section on *"Reducing Burden and Improving Electronic Information Exchange of Documentation and Prior Authorization."*

The MMS generally supports the policies outlined in the rule that require impacted payers to:

- Build and maintain a Fast Healthcare Interoperability Resources (FHIR)-enabled Document Requirement Lookup Service (DRLS) API. This could be integrated with a provider's electronic health record (EHR) and allow providers to electronically locate prior authorization requirements for each specific payer from within the provider's workflow.
- Build and maintain an FHIR-enabled electronic Prior Authorization Support (PAS) API that has the capability to send prior authorization requests and receive responses electronically within their existing workflow (while maintaining the integrity of the HIPAA transaction standards).

- Include a specific reason for a denial when denying a prior authorization request, regardless of the method used to send the prior authorization decision, to facilitate better communication and understanding between the provider and payer.
- Publicly report data about their prior authorization process (such as the percent of prior authorization requests approved, denied, and ultimately approved after appeal and average time between submission and determination) to improve transparency into the prior authorization process.

To further improve the rule, we would like to suggest two key areas that could be expanded and strengthened:

**I. Include Medicare Advantage plans in the new prior authorization requirements.**

The MMS understands that this proposed rule was intended to make changes incrementally, focusing on Medicaid and CHIP managed care plans, state Medicaid and CHIP fee-for-service programs, and Qualified Health Plans (QHP) issuers on the Federally-facilitated Exchanges (FfEs). However, we believe that by excluding Medicare Advantage plans from the new prior authorization requirements, CMS will miss an opportunity to ensure widespread adoption of standards that could have a significant impact on patients. Furthermore, Medicare Advantage plans have more prior authorization requirements and cover a much larger proportion of patients than the plans currently in the scope of the proposed rule. We believe the prior authorization policies outlined in the proposed rule will have a positive benefit to patients. By including Medicare Advantage plans, you will further benefit a significant group of patients—and reduce possible misalignments between Medicaid and Medicare, particularly for patients who are dually eligible in Medicaid managed plans and a Medicare Advantage plan. Including Medicare Advantage plans is also critical to reduce administrative burden—consistency and uniformity across plans will help to streamline provider workflows.

**II. Shorten the prior authorization response timeframes further to 24 hours for urgent care and 48 hours for standard care.**

The proposed rule is a significant step forward in reducing the prior authorization approval timeframes. CMS is proposing to require impacted payers (not including QHP issuers on the FfEs) to send prior authorization decisions within 72 hours for urgent requests and 7 calendar days for standard requests, down from 14 days. However, the proposed rule does not go far enough to support patients that cannot afford to have their care delayed for 72 hours to 7 days. According to [a survey by the American Medical Association](#) (AMA)<sup>1</sup>, 91% of physician respondents said that prior authorization “sometimes, often, or always” results in a care delay—and 74% reported that the prior authorization process can “at least sometimes lead to treatment abandonment.” Prior authorization delays should not be a reason patients do not receive necessary care. Massachusetts law requires a prior authorization review and notification timeframe of [2 business days for standard care](#).<sup>2</sup> The Massachusetts policy was successfully implemented in the state without any undue challenge to the sustainability of health

---

<sup>1</sup> AMA 2019 Prior Authorization Survey: <https://www.ama-assn.org/system/files/2020-06/prior-authorization-survey-2019.pdf>

<sup>2</sup> AMA 2018 Prior Authorization State Law Chart: <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/pa-state-chart.pdf>

insurers. The MMS believes that prior authorization decisions should have an even shorter timeframe of 24 hours for urgent care and 48 hours for standard care, reflecting the policy outlined in the [AMA's Prior Authorization Reform Principles](#)<sup>3</sup>—this will help to ensure patients are not unnecessarily delayed in receiving treatments that could be potentially life-saving or alleviate pain and other medical complications. In the AMA survey mentioned above, 24% of physician respondents said that prior authorization has led to “a serious adverse event for a patient in their care.” Prior authorization delays should not get between physicians and their patients’ care—while the timeline outlined in the proposed rule is an improvement and we support having a policy that requires a response timeframe, 72 hours for urgent care and 7 days for standard care are still far too long for patients to wait for needed care.

**In addition to these MMS comments, we urge CMS to carefully consider the extensive and thoughtful commentary provided by the AMA, which are enclosed with these comments.** Furthermore, due to the short comment period and the complexity and importance of this rule, we encourage the agency to consider extending the comment period to allow for more comprehensive comments.

As always, the Massachusetts Medical Society appreciates the opportunity to provide comments and work with CMS on our shared goal of providing the highest quality health care to patients. The MMS’ comments and recommendations are guided by our policies, our membership, and our commitment to providing quality, equitable care to all patients. Should you have any questions, please contact Alexandria Icenhower, Federal Relations Manager, at [aicenhower@mms.org](mailto:aicenhower@mms.org) or 781-434-7215.

---

<sup>3</sup> AMA Prior Authorization and Utilization Management Reform Principles <https://www.ama-assn.org/system/files/2019-06/principles-with-signatory-page-for-slsc.pdf>