CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 4, 2021

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 314-G
Washington, D.C. 20201

SUBJECT: 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; Proposed Rule, Federal Register (Vol. 85, No.244), December 18, 2020

Dear Administrator Verma:

On behalf of its more than 400 member hospitals and health systems, the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule that would place new requirements on state Medicaid and Children's Health Insurance Program (CHIP) fee-for-service (FFS) programs, Medicaid managed care plans, CHIP managed care entities, and qualified health plan issuers on the federally facilitated exchanges in an effort to improve the electronic exchange of health care data, and streamline processes related to prior authorization, while continuing CMS' drive toward interoperability, and reducing burden in the health care market.

California hospitals – like providers across the country – experience significant challenges in obtaining timely prior authorizations for their patients. CHA members report that authorizations can be delayed and time consuming due to the need for multiple calls to plans to coordinate care or confusion regarding responsibilities for authorization between the plan and delegated medical groups. In addition, delays in obtaining authorizations for post-acute care – whether for a skilled nursing or inpatient rehabilitation facility – consistently add days to inpatient hospital stays. For example, following a hospitalization for injury or illness, many patients require continued medical and rehabilitative care either at home or in a specialized facility. Timely access to the most appropriate level of post-acute care is an important factor in a patient's ability to achieve and maintain optimal medical and functional outcomes. It is vital that we shorten these and other prior authorization processes.

CHA welcomes efforts by CMS to leverage existing standards – such as HL7 Fast Healthcare Interoperability Resources (FHIR) Application Programming Interfaces (APIs) – and interoperability and patient access requirements to improve prior authorization processes. The proposed rule includes a number of significant proposals related to the exchange of health care data that impact payers,

hospitals, and other providers. However, due to the condensed comment period, CHA will limit its comments to proposals on documentation and prior authorization burden reduction through APIs.

Documentation Requirement Lookup Service API

CMS proposes that impacted payers implement and maintain a FHIR-based documentation requirement lookup service API that is populated with the payer's list of covered items and services (not including prescription drugs and/or covered outpatient drugs) for which prior authorization is required, and with the organization's documentation requirements for submitting a prior authorization request, including a description of the required documentation. Providers often face significant challenges in understanding the clinical documentation required by plans, contributing to a burdensome back-and-forth process that delays patient care and often results in inappropriate denials. **CHA supports this proposal, which would allow providers to query the payer's prior authorization requirements for each item and service and identify in real time the specific rules and documentation requirements.**

Prior Authorization Support (PAS) API

CMS proposes to require that impacted payers implement a PAS API to facilitate a HIPAA-compliant prior authorization request and response, including any forms or medical record documentation required by the payer for items or services for which the provider seeks authorization. The PAS API would enable connection with a provider's electronic health record (EHR), integrating prior authorization requests and response into the provider's workflow. **CHA supports this proposal as it has the potential to replace the numerous web portals and fax numbers currently used to submit prior authorization requests. However, as noted below, CHA urges CMS to expand the PAS API requirements to include Medicare Advantage (MA) plans.** Providers may not be incentivized to update their EHRs and workflows to integrate these APIs if the processes only apply to a limited set of payers.

Requirements for Prior Authorization Timelines and Communications

CMS proposes to require that state Medicaid and CHIP FFS programs, Medicaid managed care plans, and CHIP managed care entities provide notice of prior authorization decisions as expeditiously as a beneficiary's health condition requires and under no circumstances later than 72 hours after receiving a request for expedited decisions, and no later than seven calendar days after receiving a request for standard decisions. Currently, Medicaid and CHIP programs may allow plans up to 14 days to respond to standard requests. **While CHA appreciates that CMS has reduced the timelines for these payers to respond to standard requests, we are concerned that the specified timelines will continue to delay access to necessary services and transfers to more appropriate care settings. We urge CMS to further reduce the timeline for these payers to provide responses for expedited decisions.**

Denial Notices

In response to longstanding provider concerns with a lack of sufficient information provided by payers for prior authorization denials, CMS proposes impacted payers would be required to provide a specific reason a prior authorization request is denied, so that a provider can determine what their best next steps may be to support getting the patient the care needed in a timely manner. CMS suggests that the reason for denial may indicate that the necessary documentation was not provided, that the services were determined not to be medically necessary, or that the patient exceeded allowed limits on care for the item or service. This proposal would apply to all prior authorization requests, regardless of the manner in which they are submitted. **CHA strongly supports this proposal, which will enable providers**

that receive prior authorization denials to re-submit requests with updated information, identify alternatives, appeal the decision, or better communicate the decision to their patients.

Application of Requirements to Medicare Advantage Plans

CMS notes that while its previous Interoperability and Patient Access final rule applied to MA plans, the requirements of this proposed rule would not be applicable to MA plans. CHA is concerned that if the requirements are limited to just a subset of payers, the administrative cost reduction hospitals will gain by taking advantage of the more efficient electronic prior authorization processes will not be sufficient to offset the significant costs they will incur to implement the updates to their EHRs and workflows to support these improvements. **While CMS says it will consider expanding the requirements to MA plans in future rulemaking, CHA urges CMS to reconsider and apply these requirements for MA plans along with the currently impacted payers in the final rule.**

CHA appreciates the opportunity to comment on the proposed rule. If you have any questions, please do not hesitate to contact me at mhoward@calhospital.org or (202) 488-3742, or my colleague Trina Gonzalez, vice president of policy, at (916) 552-7543 or tgonzalez@calhospital.org.

Sincerely,

/s/
Megan Howard
Vice President, Federal Policy