March 13, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

SUBJECT: CMS-0057-P, Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program, Proposed Rule (Vol 87, No 238), December 13, 2022

Dear Administrator Brooks-LaSure:

On behalf of more than 400 hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule that would place new requirements on Medicare Advantage organizations, state Medicaid and CHIP fee-for-service programs, Medicaid managed care plans, CHIP managed care entities, and qualified health plan (QHP) issuers on the Federally-facilitated Exchanges (FFEs) 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.

CHA appreciates CMS' increased attention to the challenges that patients and their providers face in obtaining timely and medically appropriate prior authorization decisions. In general, we support the proposals included in this rule that are intended to improve prior authorization processes. As noted in comments on the December 2020 CMS Interoperability and Patient Access proposed rule, efforts are welcome to leverage existing standards — such as HL7 Fast Healthcare Interoperability Resources (FHIR) Application Programming Interfaces (APIs) — to improve prior authorization processes.

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We are grateful to CMS for responding to stakeholder comments on the 2020 proposed rule by applying its proposed requirements to Medicare Advantage organizations, which had previously been excluded. Increased standardization of prior authorization processes across payers will better incentivize providers to invest in the technology necessary to implement the proposed electronic prior authorization processes.

Improving Prior Authorization Processes

Proposed Requirement for Payers: Implement an API for Prior Authorization Requirements, Documentation, and Decision

CMS proposes to require impacted plans to implement and maintain a FHIR-based Prior Authorization Requirements, Documentation, and Decision (PARDD) API to facilitate the prior authorization process for all prior authorization rules and requirements for items and services, other than drugs. The PARDD API would allow providers to query the impacted payer's system to see if prior authorization is required, as well as the necessary documentation. It would also automate compilation of data required to populate the HIPAA-compliant prior authorization transaction and allow payers to provide the status of the prior authorization request, including whether the request has been approved or denied. CMS proposes to require the use of certain Implementation Guides (adopted at 45 CFR 170.215) to implement the PARDD API. If finalized, CMS would also recommend using certain HL7 FHIR Da Vinci implantation guides. CMS proposes that payers must comply with the PARDD API requirements beginning Jan. 1, 2026. For Medicaid managed care plans and CHIP managed care entities, compliance would be required by the rating period beginning on or after Jan. 1, 2026. For QHP issuers on the FFEs, payers would need to comply with requirements for plan years beginning on or after Jan. 1, 2026.

Specifically, CMS proposes that the PARDD API would be required to:

- be populated with the payer's list of covered items and services, excluding drugs, for which prior authorization is required and accompanied by any documentation requirements
- include functionality to determine requirements for any other data, forms, or medical record documentation required by the payer for the items or services for which the provider is seeking prior authorization and while maintaining compliance with the HIPAA standard
- include information regarding payer approval (and for how long) or denial (with a specific reason) of the request or ask for more information from the provider to support the prior authorization request

CHA strongly supports the proposed PARDD API requirements, which have the potential to simplify the prior authorization process and improve patient experience and outcomes by avoiding unnecessary delays in care. Often, providers face significant challenges in understanding which services require prior authorization and what supporting clinical documentation is required by plans. This contributes to a lengthy back-and-forth process that delays patient care and often results in inappropriate denials. Further, the use of the PARDD API has the potential to replace the numerous proprietary web portals and fax numbers currently used to submit prior authorization requests. Under the proposal, providers could use the API to query the prior authorization requirements for specific items and services to identify necessary

documentation. They could also use the API to complete electronic forms and templates or to link elsewhere to submit the documentation. This would significantly improve the electronic flow of information needed to resolve prior authorization requests in a timely manner.

Requirement for Payers to Provide Status of Prior Authorization and Reason for Denial of Prior Authorizations

CHA strongly supports CMS' proposal that would require impacted payers to provide a specific reason for denied prior authorization decisions, other than for drugs, regardless of the method used to send the prior authorization request. As noted above, responses about a prior authorization decision sent through the PARDD API from the payer to the provider would have to include information regarding whether the payer approves (and for how long) or denies the prior authorization request or needs more information from the provider to support the request. The proposed policy addresses a common problem for hospitals, as providers and patients are often left with little to no information about why a prior authorization request was denied. Requiring payers to provide a specific reason why a prior authorization request is denied — such as indicating necessary documentation was not provided, the services are determined to not be medically necessary, or the patient has exceeded limits on allowable care for a given type of item or service — will enable providers to quickly determine the next steps to ensure patients receive the care they need in a timely manner.

Requirements for Prior Authorization Decision Time Frames and Communications

CMS proposes to require that impacted payers provide notice of prior authorization decisions as expeditiously as a beneficiary's health condition requires — and under no circumstances later than 72 hours — of receiving a request for expedited decisions. Also, notifications must be sent no later than 7 calendar days after receiving a request for standard decisions. Current federal regulations may allow plans up to 14 days to respond to standard requests. **While reductions in timelines for payers to respond to standard requests is a step in the right direction, the specified timelines will continue to delay access to necessary services and transfers to more appropriate care settings. In particular, CMS should consider requiring a more stringent timeline for payers to respond to urgent requests if a provider indicates (or the payer determines) that the standard time frame could jeopardize the patient's life, health, or ability to attain, maintain, or regain maximum function.**

Unnecessary delays in the prior authorization process have significant impacts on patient experience and outcomes. A major contributor to these delays is a lack of timely responses to prior authorization requests. Hospital case managers report difficulty reaching health plan personnel, lengthy hold times, no return calls, and other delays in responses to requests for prior authorization. While a hospital is caring for patients 24/7, many plans do not have available personnel who can provide prior authorization on the weekends. As such, requests made from Friday midday until Monday are frequently not reviewed until the following Tuesday, resulting in a spike in avoidable days. When plan personnel review requests, the need to make multiple follow-up calls and respond to questions and documentation requests further delay patient care across the continuum and contribute to a diversion of hospital resources from direct patient care, as well as workforce burnout.

The proposed PARDD API should reduce unnecessary delays by automating the process providers use to determine whether prior authorization is required, identifying prior authorization information and documentation requirements, and facilitating the real-time exchange of clinical documentation for prior authorization requests and decisions from their electronic health records (EHRs). When the proposed PARDD API is utilized, health plans should have the capability to determine whether the provider has met their established medical necessity threshold in a much timelier manner. **CMS should consider requiring plans to deliver prior authorization responses within 72 hours for standard, non-urgent services, and 24 hours for urgent services for transactions utilizing the proposed PARDD API. This will ensure patients are not forced to wait longer than necessary for care.**

Public Reporting of Prior Authorization Metrics

CHA strongly supports CMS' proposal to require impacted payers to publicly report certain aggregated prior authorization metrics on their websites. Under the proposal, payers would be required to report a list of all items and services that require prior authorization, along with aggregated metrics. This includes the percentage of approved prior authorization requests, the percentage of denied prior authorization requests, the percentage of prior authorization requests approved after an appeal, the percentage of prior authorization requests for which the timeline for review was extended, and the average and median time that elapsed between the submission of a request and a determination by the payer.

CHA appreciates that CMS has responded to stakeholder concerns about the lack of transparency in plan prior authorization processes. The public reporting of this information has the potential to foster payer accountability to improve timely prior authorization responses. However, reporting of this information on each plan's website, with no specified format could reduce the readability and accessibility of this information for patients and providers looking to compare plan performance. **CMS should explore a more centralized public reporting process that would facilitate comparisons of these data. Further, CMS should closely monitor the data to determine acceptable rates of performance and to establish enforcement mechanisms for plans that do not meet those standards.**

Electronic Prior Authorization for the Medicare Promoting Interoperability Program

To incentivize provider adoption of the PARDD API process, CMS proposes a new measure — Electronic Prior Authorization — for eligible hospitals and critical access hospitals under the Medicare Promoting Interoperability Program. The measure would be included under the health information exchange objective. It would assess the number of prior authorizations for medical items and services (excluding drugs) that are requested electronically from a PARDD API using data from certified EHR technology. CMS proposes to begin reporting on this measure with calendar year 2026 and would require hospitals to report a numerator of at least "1" for the measure or claim an exclusion to satisfy reporting requirements.

CHA does not oppose the inclusion of this measure and appreciates that CMS will not score the measure initially. While the PARDD API has the potential to expand electronic prior authorization, the implementation guides that support the PARDD API are evolving and have not

been subject to pilot testing. The incorporation of new technology is an extremely resource intensive process that requires not only upgrades to EHR systems, but also testing, staff education and training, and workflow adjustments. As hospitals continue to face extreme financial challenges emerging from the COVID-19 pandemic, it will be challenging to divert resources to the necessary technology updates, absent of widespread implementation by a broad group of payers that demonstrates an adequate return on investment to providers. **CMS should consider an attestation-only based scoring approach for this measure for several years until payers and providers have gained experience using the new PARDD API technology.**

CHA appreciates the opportunity to comment on the proposed rule. If you have any questions, please contact me at mhoward@calhospital.org or (202) 488-3742.

Sincerely,

/s/
Megan Howard
Vice President, Federal Policy