Minnesota Hospital Association

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March 13, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, DC 20201

Submitted electronically through www.regulations.gov.

RE: Comments on Proposed Rule CMS-0057-P: Medicare and Medicaid Programs: Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, etc.

Dear Administrator Brooks-LaSure,

On behalf of our member hospitals and health systems, the Minnesota Hospital Association (MHA) offers the following comments regarding the proposed rule on Advancing Interoperability and Improving Prior Authorization Processes.

We are pleased the proposed rule removes inappropriate barriers to patient care by streamlining prior authorization processes for impacted health plans and providers. Prior authorization has increasingly been an enormous burden on hospitals and health systems in Minnesota, and these regulations would be a significant improvement to existing processes.

While CMS' proposals are all critical steps forward in advancing patients' timely access to care and easing administrative burden, we urge CMS to provide the enforcement and oversight necessary to ensure health plan compliance and facilitate meaningful change. In addition, CMS should also consider applying these prior authorization requirements to prescription drugs to further the impact on patient care.

We also appreciate CMS' ongoing efforts to reduce administrative burden for health care providers and continue to urge the agency to streamline and condense regulatory requirements whenever possible. MHA members are overwhelmed by the different requirements and processes for different insurers, not only for prior authorization, and look to CMS to help with standardization and reduction of payment delay tactics.

Inclusion of Medicare Advantage

MHA applauds CMS' proposal to require Medicare Advantage (MA) plans to adhere to the rule. Given that 52% of Medicare beneficiaries in Minnesota are enrolled in a Medicare Advantage plan, this rule will impact a larger group of patients and help accelerate provider implementation of these new standards. Hospitals and health systems in Minnesota have experienced challenges with MA prior authorization requirements when medically justified inpatient stays have been denied, resulting in reduced provider reimbursement, and potentially impacting a patient's eligibility for needed post-acute care services. In addition, the appeals process, including peer-to-peer physician reviews have been largely favorable to MA plans due to lack of

oversight. We urge CMS to finalize the proposal to include MA plans to reduce inappropriate delays for patient care. As outlined in previous comments to CMS, we also reiterate the importance of standardizing MA policies and processes whenever possible to reduce the overwhelming administrative burden of needing to reference several different vendor rules and payer requirements.

Improving Prior Authorization Processes
Under the Health Insurance Portability and Accountability Act (HIPAA), HHS is required to identify a set of standards for health care organizations and providers to use when exchanging prior authorization data, but it is not consistently implemented across health plans. MHA appreciates CMS' proposals to better utilize electronic prior authorization processes to provide more up to date and accurate information for both providers and patients.

Currently, many MHA members utilize additional staff to handle prior authorization requests, since insurers often require many phone calls, forms, and other administrative work to grant an approval for a requested service. Timely access to patient care is impacted with delays in prior authorization due to communication and procedural variation across health plans and vendors. As payers outsource prior authorization processes, MHA members have found it challenging to adjust to each unique workflow implemented by different vendors. In addition, many of the current resources provided by payers and their vendors are not kept up to date, requiring additional verification by providers and their staff. Any information that can be provided regarding the status of an authorization including approval number, status, effective dates, network eligibility, and approved Current Procedural Terminology (CPT) codes would be beneficial to streamlining the processes and reducing call times.

MHA supports CMS' proposals to expand the Patient Access Application Programming Interface (API) and create new Provider Access and Payer-to-Payer APIs to improve the current arduous processes and reduce inefficiencies. Specifically, the Payer-to-Payer exchange of information will be useful if patients change plans, and it could also help provide context on medical necessity without having to get additional information from providers. Increased payer-to-payer communication could also help improve coordination between Minnesota's state Medicaid agency and managed care organizations.

MHA notes that the Provider Access API, known as the Prior Authorization Requirements, Documentation and Decision (PARDD) API in the proposed rule, will require hospitals and health systems to implement new technology. Before requiring any widespread investment and use, CMS should ensure the API is fully developed and tested to ensure usability and maximum benefit. MHA also encourages CMS to prioritize interoperability and streamlined guidance given the increased regulatory requirements regarding electronic exchange of information and APIs.

Reason for Denial of Prior Authorization
MHA appreciates CMS' proposal to require impacted payers to provide a specific reason for prior authorization denials. The proposal acknowledges that providers must understand why a request is denied so they can either resubmit it with updated information, identify treatment alternatives, appeal the decision, or communicate the decision to their patient. This proposal would help address a significant problem in health care, as providers and patients are often left without adequate explanation as to why a prior authorization request was denied. Specifically, MHA members have experienced challenges when prior authorization vendors do not always provide the level of specificity needed to get an approval. We support this proposal and encourage CMS to establish enforcement mechanisms to ensure that plans are compliant with its requirements. We also encourage CMS to consider implementing standardization

requirements for denial notices and appeal processes, since they are often as inconsistent from payer to payer as prior authorization processes.

Timeliness Standards
While we appreciate CMS' focus on reducing prior authorization timelines, the proposed timeframes are still too long given the direct impact on patient care. A prior authorization request is often the final step between a patient and the initiation of their care, making expeditious processing of such transactions extremely important.

The technology proposed under this regulation could effectively eliminate the delays caused by slow delivery of medical documents, as it has the potential to deliver clinical information in real time. As a result, health plans should have the capability to determine whether the provider has met their established medical necessity threshold in a much timelier manner. Patients should not be forced to wait to receive care. We recommend that plans be required to deliver prior authorization responses within 72 hours for standard, non-urgent services and 24 hours for urgent services for transactions utilizing the PARDD API.

In addition to establishing a timeline for responding to prior authorization requests, CMS should also consider clarifying the need to approve requests based on the service date, not the processing date. MHA members have had instances where requests were submitted in a timely manner but were approved as being effective the date the request was processed instead of the date of service. These situations are very time-consuming to resolve and are typically rectified due to the payer's error.

An enforced timeline of notification to changes in prior authorization requirements would also be helpful for many hospital and health system payment specialists. For example, payers could be required to provide a 60-day notification if there are procedures that now require pre-approval.

Prior Authorization Data Reporting Requirements
MHA supports CMS' proposal to require plans to report prior authorization process metrics. We believe that by requiring plans to report such metrics, the rule promotes much needed transparency and the opportunity to build accountability. While there is a significant amount of research that establishes the burden that inefficient prior authorizations have on patients and providers, there are limited resources available for determining particularly problematic plans. Data on retroactive denials and downgraded patient stays could also be incorporated as a reportable metric. However, prior authorization metrics buried on individual health plan sites add little to no benefit to patients. Instead, we believe it is important that CMS directly collect these data and make them publicly available and easily understandable on a single website, like other performance measures.

We also encourage CMS to create mechanisms whereby this data is used to guide oversight and enforcement activities. This would help ensure compliance with CMS rules, which have direct impacts on patient access to care and outcomes. Accordingly, we recommend that CMS regularly audit a sample of plan denials and timeframes, as well as use the data to target potentially problematic plans. Without this level of detailed auditing, there will be ample opportunity for bad actors to continue circumventing federal rules without detection, making the proposed patient transparency efforts and protections ineffective.

Incentivizing Provider Use of Electronic Prior Authorization
Minnesota hospitals and health systems are eager to adopt and use technology that improves the safety, quality, and efficiency of care. However, given the unprecedented financial and workforce strains on our members, we are concerned with adding another reporting requirement

burden through the federal Promoting Interoperability Program. If CMS is intent on moving forward with the inclusion of a measure reflecting provider use of the PARDD API, we encourage CMS to create an attestation-only measure.

In conclusion, we thank you for the opportunity to comment on these important topics and look forward to CMS finalizing this rule to ensure payer accountability and improve patient care. If you have any questions, please feel free to contact me at (651) 659-1415 or jschindler@mnhospitals.org.

Sincerely,

Joseph A. Schindler
Vice President, Finance Policy & Analytics