March 13, 2023

The Honorable Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: 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

Dear Administrator Brooks-LaSure,

The American Academy of PAs (AAPA), on behalf of the more than 168,300 PAs (physician assistants/associates) throughout the United States, appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) interoperability and prior authorization proposed rule. AAPA shares CMS's goals of improving electronic exchanges of data and streamlining the prior authorization processes. We believe that, if properly implemented, policies contained in the proposed rule can reduce administrative burdens for payers and health professionals leading to enhanced patient care. It is within this context that we draw your attention to our comments.

For your convenience, we have divided our comments among the two major subjects identified in the rule: interoperability and prior authorization.

Interoperability Provisions of the Proposed Rule

AAPA recognizes the importance of interoperability to improve the efficiency, quality, and functionality of patient health information and data. Effective interoperable systems have the capacity to assist in care delivery, enhance the patient experience, and support care coordination for the entire healthcare team. In the past, AAPA has communicated to CMS its support for increased interoperability between systems and has

advocated for the agency to provide necessary educational, financial, and logistical support to ensure widespread adoption of steps that would encourage interoperability. As such, AAPA is pleased CMS is proposing three primary interoperability provisions in the proposed rule focused on greater access to care information for patients, health professionals, and payers respectively.

Enhanced Interoperability Between Payers and Patients

CMS currently requires the existence of a Patient Access Application Programming Interface (API). APIs allow different software applications to communicate and, thereby, help facilitate the exchange of data between different parties. Patient Access APIs allow patients to retrieve their health information from a payer through a compatible health application. In the proposed rule, CMS intends to require payers to include information about a patient's prior authorization requests in the data available through the Patient Access API. The rule also proposes that payers be required to annually report to CMS aggregated, de-identified information on patient requests through the API.

AAPA supports policies that provide increased patient access to personal healthcare information. Patient access to information on a payer's prior authorization decisions will better help patients understand when and how care determinations are decided. AAPA suggests that to maximize patient understanding of the prior authorization process and how their health data is being used, all transfers of information relevant to their health data that occur under the Payer/Provider and Payer/Payer APIs (detailed below) should also be documented and accessible under the Patient Access API. This would also support a patient in determining whether they wish to opt out of having their information shared via a payer/provider or payer/payer API.

Enhanced Interoperability Between Payers and Health Professionals

In the proposed rule, CMS recommends requiring payers to develop and maintain a Provider Access API that would streamline the process of exchanging patient data between payers and health professionals in the payer's network. Some examples of the types of data exchange that may occur through the Provider Access API include prior authorization determinations, adjudicated claims, encounter data, and more. Once established, providers may request data from a payer through an Electronic Health Record, practice management system, or other information technology solution.

AAPA finds great value in a Provider Access API in streamlining communications between payers and health professionals. Ensuring a default method of communication between payer and provider may expedite decisions and the receipt of information health professionals need to provide care in a timely and efficient manner.

AAPA notes that CMS includes a section emphasizing the importance of ensuring proper attribution to guarantee a patient's data is only accessible to the health professional who provided their care. Specifically, CMS states:

"For the Provider Access API, we are proposing to require that payers develop an attribution process to associate patients with their providers to help ensure that a payer only sends a patient's data to providers who are requesting that data and who have a treatment relationship with that patient."

AAPA concurs with CMS's assessment of the importance of proper attribution. Unfortunately, some payers that fall under the purview of this rule have policies that hide the actual provider of care. For example, two state fee-for-service Medicaid agencies do not yet enroll PAs as rendering providers, a status that requires claims to be submitted attributing a service to the PA who actually provided the care. Instead, these Medicaid programs require claim submission under the name of a physician with whom the PA works. Similarly, some commercial payers that offer Qualified Health Plans (QHPs) in the Federally Facilitated Exchange (FFE) may not enroll PAs and instead require that claims for PA-provided services be submitted under a collaborating physician's name - - attributing all services to a physician. When this occurs, it is nearly impossible to accurately identify the type, volume, or quality of medical services delivered by PAs. Accurate data collection, appropriate analysis of workforce utilization, and the ability to determine who is providing care for the purpose of access to a patient's care information, as discussed in the proposed rule, is lost.

In addition, as CMS is requesting information regarding how the implementation of requirements in the proposed rule would translate to fee-for-service Medicare, we encourage the agency to reexamine its own policies that may contribute to the problem of hiding which health professional provided care to a patient. One example is "incident to," a Medicare billing provision that allows medical services personally performed by one health professional in the office or clinic setting to be submitted to the Medicare program under the name of another health professional. Of particular interest to us is "incident to" billing pertaining to services performed by PAs and nurse practitioners that are attributed to a physician. Services submitted under Medicare's "incident to" billing provision fall victim to the same problems listed above and run counter to CMS's stated goals of transparency and proper attribution. This lack of accurate attribution may then inhibit provider access to important patient data.

Consequently, AAPA requests that, in CMS's efforts to ensure appropriate attribution to protect patient data and improve the patient care experience, the agency should require all payers to whom this proposed rule applies to enroll PAs as rendering providers. AAPA further requests that CMS address the complications of inaccurate data collection caused by "incident to" by ensuring services are accurately attributed to the health professional who rendered the service.

Enhanced Interoperability Between Payers

In the proposed rule, CMS is proposing to require the implementation of a new payer-to-payer API to facilitate information exchange among payers upon request of a patient. This API would allow care data to follow a patient should they choose to change payers. This API would also be helpful to patients who have concurrent coverage with more than one payer, with the rule requiring data sharing between such payers at least quarterly.

AAPA supports the concept of a payer-to-payer API. If patients are able to access information on coverage decisions from all payers with whom the patient has received coverage, it would provide a longitudinal perspective that may prove clinically useful if shared with subsequent health professionals by enhancing understanding of which prior treatment options were selected. AAPA is also pleased with the proposal that the transfer of any personal data exchanged between payers can only occur if approved by the patient. These proposed reforms would grant patients greater access to, and control over, their health information.

Prior Authorization Provisions of the Proposed Rule

Prior authorization is a utilization management tool in which a payer requires a healthcare professional to receive approval for a medical or surgical service prior to providing care to a patient. It is established by payers to reduce the excessive utilization of services, ensure medical necessity, control costs, confirm standards of care are met, and verify service coverage. However, health professionals, and as a result, patients, have found that the additional administrative burden created by the prior authorization process can at times lead to delays in the timely provision of care. Patients may then wait longer to receive needed care or forgo care, potentially leading to an increase in payer expenditures and/or a deterioration of a patient's medical status and the need for additional, potentially more expensive care.

AAPA has advocated for reforms to the prior authorization process in prior comment letters to CMS. Reforms AAPA has recommended include objective assessments of which services may require prior authorization, data-driven assessments of whether certain prior authorization requirements are improving health outcomes or are merely being used to deter care, enhanced automation of the prior authorization process, and timely completion of reviews required for service approvals. AAPA reiterates these recommendations. We believe that the suggestions we have made will assist health professionals in providing necessary care to patients as efficiently as possible.

AAPA is pleased to see that some of the recommendations we have previously made are partially reflected in the policies CMS has put forward in the proposed rule. We commend CMS's efforts to address the long-standing concerns of the provider and patient communities.

Prior Authorization Requirements, Documentation, and Decision API

In the proposed rule, CMS is proposing to require all payers to implement and maintain a Prior Authorization Requirements, Documentation, and Decision API to streamline the prior authorization process. This API would automate one particularly cumbersome step of the prior authorization process: determining whether prior authorization is required for an item or service. The API would then provide the health professional with the payer's prior authorization requirements.

AAPA approves of these proposed functions of the API as we believe automating the determination of whether prior authorization is necessary and removing the need to research each respective payer's prior authorization process requirements, will save time on behalf of health professionals and patients. AAPA

encourages CMS to provide standards regarding clarity and a lack of ambiguity in statements from payers to health professionals regarding prior authorization submission expectations.

As proposed in the rule, the Prior Authorization Requirements, Documentation, and Decision API would go further than indicating necessity for prior authorization and provide the health professional with the payer's authorization requirements by automatically compiling portions of the required information a payer needs to process a prior authorization that can be found in the health professional's system. The API would also provide time-saving potential for the payer, auto-populating certain information required to be included in a response to a prior authorization request, such as a reason for denial. All API automation must comply with HIPAA standards.

If implemented properly, AAPA sees the value to health professionals in such automated collection of information, as long as it separately collects the information for review and submission at a later point, and does not interfere with the workflow of the health professional while with a patient. Similarly, AAPA sees the value to payers in the automated population of potential responses to prior authorizations requests. However, AAPA cautions that responses to prior authorizations requests not be fully automated, and that payers be required to individually review each prior authorization request including the auto-populated information. This would minimize the likelihood of false denials or approvals that would be retracted later by requiring someone to review the full context of a patient's medical condition submitted by health professionals that may not always trigger the correct automatic determination. As indicated in our previous recommendations to CMS, AAPA believes properly implemented, increased automation may expedite the prior authorization process to the benefit of patients waiting to receive approval for care. We are pleased that any such automation would still be required to comply with HIPAA standards.

Requirements Regarding Payer Response

In the proposed rule, CMS seeks to require that payers return a specific reason to health professionals for a prior authorization denial. AAPA approves of this requirement as clarity may elucidate whether a denial was based on the clinical context of the request or whether the denial is based upon a process issue. If the issue is rectifiable, clear indication of the reason for the denial may assist in more efficient communication between health professional and payer upon resubmission and allow patients to receive necessary care more quickly.

CMS also proposes to require that most payers, with the exception of the QHP payers on the FFE, return prior authorization determinations within a stated timeframe. Specifically, CMS proposes 72 hours for urgent requests, or 7 days for non-urgent requests. However, CMS in the proposed rule indicates that it may be open to shorter timeframes and gives the examples of 48 hours and 5 days respectively. While health professionals would prefer to see the most expedient timeframe possible, AAPA recognizes that the determination of just how many hours or days are needed may be complicated. Consequently, AAPA recommends that CMS convene a multi-stakeholder panel of health professionals and payer representatives to discuss the competing considerations and arrive at a timeframe that reflects sufficient time for review and timely patient access to care. This stakeholder group may also help CMS determine other policy changes that could accelerate the prior authorization process, such as identifying generally accepted metrics for when to remove

services from requiring prior authorization if they are frequently approved, thereby allowing payers to concentrate time and efforts on a more narrow and necessary set of services.

Prior Authorization Reporting

In the proposed rule, CMS proposes to require payers to publicly report certain prior authorization metrics. Examples of such metrics include the payer's volume of approvals and denials, the timelines for approval or denial, the number of appeals placed, among other requirements. AAPA approves of public reporting as it fosters accountability. We suggest that CMS further consider requiring reporting of approvals and denials by the types of medical and surgical services provided as the results may be instructive to health professionals on the likelihood of success with certain services under different payers.

CMS is also considering encouraging or requiring the use of "gold-carding," a process by which payers identify those health professionals who consistently comply with prior authorization requirements and relax or reduce prior authorization requirements for such health professionals in the future. AAPA supports this process as it would incentivize proper guideline compliance and hence may reduce the number of denials stemming from process deficiencies. However, we caution that no payer should be allowed to use the risk of a removal of gold-carding to discourage a health professional's appropriate appeal of denials.

Finally, CMS is proposing new metrics having to do with prior authorization under both the Merit-based Incentive Payment System (MIPS) program and under the hospital Medicare Promoting Interoperability Program. AAPA approves of adding these additional optional measures as we believe it may further incentivize health professional adoption and utilization of the electronic prior authorization processes that could save valuable time in the delivery of patient care.

The Payers to Which the Rule Applies

In the proposed rule, CMS indicates that its proposed policy changes would apply to a broad group of payers under its authority, including Medicare Advantage plans, Medicaid fee-for-service programs and managed care plans, CHIP fee-for-service and managed care entities, and QHP payers on the FFE. CMS also notes that, while the policies in the proposed rule do not apply to Medicare fee-for-service, the agency plans to implement similar policies for Medicare fee-for-service if the policies in the proposed rule are finalized.

AAPA endorses the wide-ranging applicability of the provisions in the proposed rule. Having a broad array of payers implement improvements to both the prior authorization process and interoperability standards will ensure that flexibilities to improve payer, provider, and patient experience are broadly applied. We encourage CMS to follow through by including the proposed standards to fee-for-service Medicare to emphasize Medicare's role as a leader on data exchange. We note that Medicare is often looked to as an example by payers, including many payers not currently captured under the purview of these proposed regulations. Consequently, AAPA believes adoption of similar standards by fee-for-service Medicare may encourage such payers to voluntarily adopt similar policies. This may be especially true for those payers that

offer both commercial plans not subject to the rule and plans that are under Medicare Advantage, Medicaid Managed Care, or the FFE.

Thank you for the opportunity to provide feedback on the interoperability and prior authorization proposed rule. AAPA welcomes further discussion with CMS regarding these issues. For any questions you may have please do not hesitate to contact me at michael@aapa.org.

Sincerely,

Michael L. Powe
Vice President, Reimbursement and Professional Advocacy