Society of Hospital Medicine
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March 13, 2023

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-0057-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator Brooks-LaSure,

The Society of Hospital Medicine (SHM), representing the nation's hospitalists, is pleased to offer our comments on the proposed rule entitled: *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 (CMS-0057-P).*

Hospitalists are front-line physicians in America's hospitals whose professional focus is the general medical care of hospitalized patients, many of whom are Medicare beneficiaries enrolled in Medicare Advantage (MA) plans. Due to their focus on the hospital setting, hospitalists are largely responsible for and involved in patient transfers between the hospital and other hospitals, post-acute settings, or home health care. As such, hospitalists frequently encounter issues with prior authorization requirements among MA plans and expend significant time and effort navigating these differing requirements to ensure patients receive the care they need.

Throughout the Public Health Emergency (PHE), hospitalists from across the country reported that the relaxation of prior authorization requirements facilitated the rapid transition of patients between sites. While these flexibilities helped ensure traditional Medicare patients received appropriate care and transfer, they also highlighted the inconsistencies and burdens associated with prior authorization under MA plans. For patients on MA, providers must navigate inconsistent, time-consuming prior authorization requests, denials, and appeals, which ultimately shifted and continue to shift significant resources away from direct patient care.

We appreciate CMS' acknowledgement of and interest in addressing the administrative burdens and care delays resulting from current prior authorization

practices, particularly in relation to MA plans. The current policies regarding prior authorization waste time, resources, and result in significant delays to patient care. In order to protect our patients, we must improve the transparency of prior authorization programs and eliminate unreasonable barriers to medically necessary care. As such, we are pleased to provide comments on this proposed rule.

Improving Prior Authorization Processes

CMS has proposed to implement the Prior Authorization Requirements, Documentation, and Decision (PARDD) Application Programming Interfaces (API) to support and streamline the prior authorization process. According to the proposal, this API will help ensure prior authorization requests receive a response within certain timeframes, will provide a clear reason for denials, and will require the public reporting of prior authorization authorizations, denials, and appeals. Required functionality of this proposed API includes:

- PARDD API populated with payer's list all covered services and items that require prior authorization
- PARDD API lists data, forms, or medical documentation required for a prior authorization request
- PARDD API responses to prior authorization requests must include information about approval, denial, or a request for more information. Denials must include a specific reason, and approvals must include details about how long the service will be covered.

If this proposal is finalized, the PARDD API implementation requirement begins will begin on January 1, 2026.

While we appreciate the intention behind this API, we are concerned that current Electronic Health Record (EHR) systems will not be set up to accommodate the requirements of this rule. Adherence will require significant time and financial investment in existing EHR systems at a time when many providers and institutions are still struggling from both staffing shortages and recovering from the COVID-19 pandemic. At a minimum, we ask that CMS monitor the progress and reported difficulty of implementation and adjust expectations accordingly.

CMS requested comments on whether CMS should phase in prior authorization rules and documentation requirements available on the API. While we acknowledge the variability and complexity of the prior authorization programs established by payers, we do not support a phased-in approach for the use of the PARDD API. **SHM supports the proposed implementation of the PARDD API for all prior authorization rules and requirements, excluding drugs, by January 1, 2026**. One of the hallmark challenges with prior authorization is the inconsistency of the processes and rules for prior authorization approval for a service, procedure, or transfer. Discrepancies exist both between payors and within plans managed by the same payer. A phased-in approach would exacerbate existing inconsistency issues and create more confusion during the phase-in years. Providers and support staff would have to navigate prior authorization requirements, some of which will use the API, while other services will utilize existing rules. It would be overly burdensome and confusing to require providers to track which items have migrated to the API each year. As an alternative, we suggest CMS encourage payers to use the time

between publishing the final rule and January 1, 2026 to implement and test processes and engage with stakeholders.

Prior Authorization Status and Reason for Denial Reporting Requirements

To improve the prior authorization process, CMS proposes payers would be required to provide timely and specific information as to why a prior authorization request was denied, such as missing documentation or coverage limitations. These coverage decisions would be sent via the PARDD API. SHM supports this proposal to require payers to clearly delineate the reason for a denial, as this will provide clarity for both provider and patient. We further ask for CMS to strengthen this provision by requiring that the information be clear and actionable enough to serve as a guide to next steps for follow-up with both the payer and the patient (providing additional information or documentation, necessity of appeals, identifying alternatives, etc.). Clearly delineating next steps will help ensure providers can quickly remedy any issues with their request. We believe transparent communication from payers in the prior authorization process will be a significant improvement to the status quo.

Prior Authorization Decision Timeframe Requirements

Excessive wait times for prior authorization create unnecessary care delays, negatively impact patient care, and can even make a life-or-death difference for some patients. MA plans are currently required to respond to prior authorization requests as "expeditiously as the enrollee's condition requires." They generally have up to 14 calendar days to respond to a request, and in certain circumstances, can extend that time frame. Expedited claims require a response within 72 hours. CMS proposed to reduce the maximum response time to 7 calendar days for standard requests. This proposal will not change the 72 hour time frame for expedited claims.

While we support reducing prior authorization response times, the newly proposed timeframes are still excessively long. The proposed shortened timeframe for standard requests does not reflect the realities of clinical practice or patient needs. Additionally, the failure to shorten the timeframe for expedited claims does not account for the true urgency of an expedited request. For example, a patient waiting six or seven days to transfer from acute inpatient to an acute-inpatient rehabilitation facility may see significant declines in their mobility and strength, which can have far reaching negative impact on their quality of life. An acute inpatient facility may not be best equipped to care for the patient's needs and is not the appropriate care setting. While we appreciate CMS recognizes the need to shorten the maximum timeframe for prior authorization requests, we ask that CMS reconsider the proposed timeframes. **A response to a standard prior authorization request should not exceed 48 hours and expedited requests should take no longer than 24 hours. Ideally, any requests should be responded to in as close to real time as possible. We also note that prior authorization delays resulting from requests made on weekends, outside of "business hours", or holidays should not be excluded from any mandated response timeframe.** Patients need hospital care 24 hours a day, on weekends, and holidays. Medical necessity does not take time off– MA payers should be held to the same standard.

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Prior authorization decisions, which often dictate aspects of patient care and treatment plans, must be given as close to real time as possible so care is not delayed or impeded. The timeliness of prior authorization decisions have a significant impact on patient experience, patient outcomes, and resource utilization. Patients who spend additional, unnecessary days in the hospital are at risk of poorer outcomes, and potentially even greater mortality, than if they were able to move to the next, most appropriate level of care. When patients spend more time in the hospital than necessary, there is a greater risk of nosocomial infections and other hospital acquired conditions, which requires hospitals and clinicians to devote additional time and resources toward preventing their occurrence. Delays in prior authorization decisions unnecessarily extend hospital stays, which is not only an expensive site of care but also occupies limited bedspace for other patients who require hospital-level care. This is a major contributing factor to increased rates of ED boarding and using hallways or other areas of the hospital for patients who require inpatient care while waiting for inpatient beds to be available. The time spent waiting for prior authorizations actively wastes healthcare resources.

We respectfully disagree with CMS' decision not to assume approval for prior authorization requests that do not receive a response within the requisite timeframes. We believe this is a missed opportunity to incentivize payers to respond to prior authorization requests in a timely manner and would help ensure patients can access the services and treatments deemed necessary by their care team without further delay. **We strongly urge CMS to implement enforcement incentives that push payers to adhere to required prior authorization response timeframes. Without proper enforcement incentives, payers will continue to delay and deny medically necessary care.**

An enforcement mechanism such as automatic approval for failing to meet timelines will incentivize payer compliance and also serve to help level the playing field when it comes to other aspects of the prior authorization process like payer requests for peer-to-peer meetings. Peer-to-peer timing is currently dictated solely by the payer, are requested at the last minute, and can be coupled with threats that if the peer-to-peer isn't completed by the stated time, the prior authorization request will result in an automatic denial. While this behavior is an area we recommend CMS address more fully, at a minimum, if a missed deadline on the part of the clinician can automatically result in a denial for the patient, a missed deadline on the part of the payer should result in an automatic approval. Without striking this balance, the party most often harmed will continue to be the patient.

In addition to our recommendation of shorter prior authorization processing deadlines and automatic approval for requests with missed deadlines, we also urge CMS to specifically state that health plans must provide <u>final PA determinations</u> within these requisite timeframes. Too often, health plans interpret a requirement for a "response" or "decision" within a certain timeline to allow return of a "pended" prior authorization status or a request for additional information. We firmly believe that health plans should be able to respond to initial PA requests immediately with a solicitation of any required supporting documentation; it is inappropriate for an insurer to wait 48 hours or longer simply to pend a PA request and solicit clinical data. We therefore urge CMS to further strengthen this provision by requiring plans to provide a final PA determination within the mandated timelines.

Public Reporting of Prior Authorization Metrics

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To improve transparency, CMS has proposed requirements that payers publicly report certain metrics. Specifically, this proposal requires public reporting of information such as: every item and service requiring prior authorization, the percentage of standard and expedited prior authorization claims that were approved, denied, or approved following appeal, as well as the average time it takes to receive a decision on prior authorization claims. These metrics must be posted directly on the payer's website or made publicly available via a hyperlink. CMS believes this will improve consumer transparency and enable payers to learn more about their own performance.

SHM supports the public reporting of prior authorization metrics by March 31, 2026 and strongly urges the agency to consider an earlier implementation of public reporting. This information will help Medicare beneficiaries and families make more informed decisions about the operations of their Medicare Advantage plan choices. It will also provide policymakers and other healthcare stakeholders more information about prior authorization programs and payer operations.

CMS' proposals for public reporting of prior authorization data would require only aggregated information. We encourage CMS to consider strengthening this proposal by including service or service category reporting of denial rates. CMS regularly reports on aggregated performance metric data throughout its other programs, while also making more detailed data available typically as a download through the CMS website. We believe the reporting of detailed denial data such as by item or service, or at least by category of service (e.g., imaging, physical therapy, etc.) would further enhance transparency and enable more informed decision-making by Medicare beneficiaries, providers, and policymakers.

Gold-Carding Programs

We support CMS' encouragement of gold-carding programs or similar prior authorization reduction programs that operationalize the trust built between providers and payers. We believe such an approach allows for some streamlining of prior authorization processes, particularly in advance of other policy changes in this space. Gold-carding can enable more rapid, real-time decision making at the bedside, while still working toward the prior authorization goals of efficiency and appropriate resource utilization. We are supportive of initiatives, like gold-carding, that reduce administrative burden.

We also support CMS' suggestion to add a gold-carding measure in quality star programs to drive payer implementation aimed at reducing physicians' administrative workload and minimize patient care delays. In addition, we support CMS' proposal to study the impact of gold-carding programs on diverse patient populations, such as those living with disabilities and chronic illnesses, and for providers serving rural and traditionally minoritized and marginalized communities.

Promoting Interoperability Performance Measure Proposal: Electronic Prior Authorization

CMS has proposed the adoption of a new measure under the Promoting Interoperability (PI) performance category of the MIPS. This "Electronic Prior Authorization" measure was developed to encourage provider adoption of the APIs used for electronic prior authorization. CMS is concerned that without provider buy-in on electronic prior authorization, the process will remain burdensome and

complex for both providers and payers. CMS believes this measure will maximize the potential to improve prior authorization and will further enable the electronic exchange of health information.

We strongly oppose the adoption of these measures. Prior authorization processes have been identified as a major administrative burden by providers and SHM believes that any reduction in those burdens would be readily welcomed. However, instituting new measures would be contrary to this effort by adding additional burden on providers and increased cost of EHR systems. Clinicians want their patients to get the care that is medically necessary and appropriate and, in the absence of coverage for a particular service, work with the patient to identify alternatives as quickly as possible. It is in the best interest of patient care to have these administrative decisions move as rapidly as possible. Furthermore, other pressures in the hospital, including shortages of staff and bed space, add to clinician's interest in more efficient prior authorization processes. If payer and EHR vendor implementation of these new rules are successful in streamlining and creating a more transparent process, providers will readily adopt and use the systems that further streamline it.

SHM believes it is inappropriate to measure providers on prior authorization and subject them to potential payment adjustments based on performance on these measures. In the context of broader philosophical shifts to align and reduce the number of measures in Medicare's provider pay-for-performance programs, we are unclear what value new measures for prior authorization would bring to the healthcare system. As part of the required reporting from payers, CMS could ask for the percentage of prior authorization requests that are not being completed through the API. If there are challenges with the uptake of use of the API, CMS can revisit these rules and adjust as necessary.

Conclusion

SHM appreciates the opportunity to provide our comments on this proposed rule and looks forward to continuing to work with the agency on these policies. If you have any questions, please contact Josh Boswell, Director of Government Relations at jboswell@hospitalmedicine.org.

Sincerely,

Rachel Thompson, MD, MPH, SFHM
President, Society of Hospital Medicine