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March 9, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

Re: Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule (CMS-0057-P)

Dear Administrator Brooks-LaSure:

On behalf of our more than 200 hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the Advancing Interoperability and Improving Prior Authorization Processes proposed rule. We applaud the Centers for Medicare & Medicaid Services' (CMS) efforts to mitigate inefficiencies in policies, processes, and technology that affect patients and their access to equitable healthcare. We believe this rule is a positive first step in fostering a more equitable health system.

We appreciate CMS' commitment to developing proposals based on stakeholder feedback and listening sessions, which reflect the input of patients, providers, payers, and vendors. Our comments focus on the technical and operational prior authorization (PA)-related proposals in this rule.

The Challenge for Illinois Hospitals

As acknowledged by CMS, variation in PA processes proves challenging for Illinois hospitals. Dissimilar payer requirements leads to provider workflow challenges. Inconsistent use of electronic standards means some payers employ a relatively efficient PA system, while others still rely on telephones and fax machines. Perhaps most puzzling is the lack of consistency in medical necessity determinations: the same patient could have an item or service approved by one payer and denied by another. All of these issues require providers to devote people, time, and money toward ensuring they are paid for the items and services their patients need.

CMS recognized that these administrative burdens divert hospital resources from patient care, causing CMS to ask payers to suspend PA requirements for providers early in the pandemic. Yet providers continue to experience long PA wait times, resulting in issues transferring patients from acute to post-acute care facilities, and

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delays in patient care when appealing PA denials.

Creating Solutions: Requiring PA Denial Reasons

IHA enthusiastically supports CMS' proposal to require payers to provide an understandable reason for a PA denial. Providing clear denial explanations will improve patient care, particularly when the reason is due to a patient exceeding limits on allowable covered care. Early and clear identification of this denial reason will allow the provider to expeditiously propose alternatives to the patient, improving access to timely care.

Providing a clear denial reason will also reduce provider burden. Under the current system, providers often have to make follow-up inquiries to determine the reason a PA request was denied. When a denial is due to inadequate documentation or disagreement in medical necessity, this inefficient follow-up unnecessarily delays care. This inefficiency is quantified by the fact that over 80% of Medicare Advantage denial appeals are ultimately decided in the favor of the provider.[1]

We urge CMS to expand on its proposed effort to provide clear denial reason codes by requiring a standardized set of reason codes. In the proposed rule, CMS acknowledges that some payers use denial codes from the designated X12 code list when denials are sent using the X12 278 standard. Other payers use a proprietary set of codes or text for denials. CMS calls for consistent use of both technology and terminology to communicate denial information, but has yet to commit to one set of denial reason codes. IHA urges the administration to decide on one, standardized code list to be used in communicating PA decisions. Allowing payers to utilize proprietary codes or text will further the current inefficiencies faced by providers.

PA Decision Timelines

Illinois hospitals consistently report excessive PA decision wait times, stating that payers have particularly inadequate response outside of core business hours and on weekends. This past winter during the tripledemic of COVID-19, respiratory syncytial virus infection, and influenza, many Illinois hospitals reported that delays in approving discharge and transfer of patients to post-acute care facilities resulted in a lack of beds for patients that desperately needed inpatient care. These extended decision times resulted in delays in patient care in appropriate care setting placement, and added healthcare workforce stress.

We support CMS' proposal to require MA organizations, applicable integrated plans, Medicaid fee-for-service (FFS) programs, and CHIP FFS programs to provide notice of PA decisions as expeditiously as a patient's health condition requires. The proposed rule outlines 7 calendar days for a standard request, and 72 hours for an expedited request. We urge CMS to consider shortening these timelines to 5 days for a standard request, and 24 hours for an expedited

[1] https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/

request. These timelines should be more than sufficient when coupled with the other electronic and automatic proposals in this rule.

We acknowledge that CMS did not propose PA decision timelines for individual or group market plans due to the required involvement of the Departments of Labor, Treasury, and Health and Human Services in such rulemaking. We strongly urge the administration to pursue regulations that align these plans with those covered by this proposal in the near future. Such requirements would further standardize the PA process, fostering a predictable environment for patients and providers as they navigate the healthcare marketplace and potentially move in and out of government-sponsored coverage.

We are also disappointed that CMS is not proposing an enforcement mechanism to ensure payer compliance with PA decision timelines. Specifically, the proposed rule says that "if a payer fails to meet the timeline for approval or other decision, **providers** should contact the payer to obtain the status of the request and determine if supporting documentation is needed to complete processing of the authorization or if there are other reasons for the delay in a decision." Providers should not be required to assist payers with meeting required decision timelines by following up with the payers, further delaying patient care. Failure to meet required decision timelines should result in defaulted approval, allowing the patients to proceed with care or placement. We urge CMS to closely monitor payers' adherence to finalized PA timelines, and develop appropriate enforcement actions, to prevent further patient care delays.

Prior Authorization Requirements, Documentation, and Decision Application Programming Interface (PARDD API)

Illinois hospitals consistently report confusion when it comes to PA requirements, documentation standards, and inconsistent medical necessity determinations across payers. Creating an API that allows the provider to quickly ask the payer whether PA is required for certain items and services is a simple but effective first step to mitigating provider frustration and uncertainty when attempting to deliver patient care. Requiring payers to proactively identify documentation requirements via the PARDD API will also result in efficiency gains.

IHA also agrees that a phased approach of PARDD API implementation would create confusion for providers. We support CMS' proposal that payers must implement the PARDD API for all items and services requiring PA by Jan. 1, 2026.

Medicaid and Federal Financing

As the Medicaid program is a single, uniform health insurance program for the state's most vulnerable individuals, the PA process implemented by states should be uniform and standardized for all PAs. States often utilize both FFS and multiple Medicaid Managed Care Organizations (MCOs), which can result in multiple distinct PA processes. MCOs often refer to their PA processes as the "secret sauce" to their operational business models and push back on attempts to require increased transparency. While PA programs in the commercial market

result in increased patient responsibility, in the Medicaid model, these programs often simply result in delayed patient care or increased provider losses.

As such, we encourage CMS to examine regulations, which would require state Medicaid programs to implement a single and independent third party PA program. Such standardization would result in greater consistency in the determination of medical necessity, reduced provider administrative burden and increased objectivity to assure that increased profit is not a driving factor in adverse determinations.

Furthermore, we encourage CMS to provide enhanced federal financial participation for states implementing such uniform PA programs. Such added administrative expenses currently clearly qualify for a standard administrative match rate, but providing for enhanced match would encourage greater adoption. The added value of having all PA decisions deriving from a single state entity, and having states report the progress of such uniform programs adds visibility, improving oversight opportunities for CMS and state Medicaid agencies.

Medicare FFS

IHA strongly supports standardization in PA requirements and communication across payers. Similar to the payer-to-payer data exchange proposed in this rule, requiring Medicare FFS providers to communicate on the same platform in a standardized way will improve patient safety and efficiency, particularly in situations where the ordering provider or supplier is different than the rendering provider. IHA welcomes the opportunity to work with the Administration to improve the electronic exchange of information in the Medicare FFS program.

Administrator Brooks-LaSure, thank you again for the opportunity to comment on this proposed rule. Please direct questions or comments to Cassie Yarbrough, Assistant Vice President, Health Policy and Finance, at 630-276-5516 or cyarbrough@team-iha.org.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association