March 13, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD  21244-8016

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 [CMS-0057-P]

Dear Administrator Brooks-LaSure:

On behalf of the more than 5,600 members of the American Academy of Hospice and Palliative Medicine (AAHPM), we would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the Advancing Interoperability and Improving Prior Authorization Processes proposed rule referenced above. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, and other health professionals deeply committed to improving quality of life for the expanding and diverse population of patients facing serious illness, as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have timely access to high-quality, equitable palliative and hospice care.

Summary of Key Messages and Recommendations

AAHPM offers the following key recommendations, which are further detailed in our comments below.

- CMS should require impacted payers to implement Patient Access and Provider Access application programming interfaces (APIs).
- CMS should monitor the impacts of implementing Patient Access and Provider Access APIs and update its policies, including physician payment policies, to account for potential increased burden and costs borne by physician practices.
- CMS should finalize a requirement for new payers to honor prior authorization approvals of previous payers for the full duration of treatment. CMS should clearly state that new payers must review prior authorization requests on their own merits, without consideration of previous payers’ prior authorization denials.
CMS should finalize its proposal to require impacted payers to implement and maintain a Prior Authorization Requirements, Documentation, and Decision (PARDD) API.

CMS should finalize its proposal to require impacted payers to provide specific reasons for prior authorization denials, regardless of the method used to send the prior authorization request.

CMS should finalize prior authorization decision timeframes of 48 hours for standard requests and 24 hours for expedited requests.

CMS should finalize a policy to require impacted payers to publicly report prior authorization metrics, which should include prior authorization data on specific categories of items and services, rather than just aggregate data.

CMS should extend policies intended to reduce prior authorization burden to prior authorization requests for prescription drugs.

CMS should establish and articulate strong enforcement mechanisms that ensure payers adhere to new requirements to improve prior authorization processes.

CMS should not finalize its proposal to add a new measure titled “Electronic Prior Authorization” to the Merit-based Incentive Payment System (MIPS) Promoting Interoperability performance category or the Medicare Promoting Interoperability Program.

CMS should prioritize the transparent collection of social risk data, including through provider education, support for providers to implement data collection processes, and incentives for reporting Z codes for either patients or clinical teams.

CMS should undertake a deliberate, transparent, and inclusive approach with respect to potential future incorporation of social risk data into risk adjustment, case-mix determinations, and quality measure stratification.

Patient Access API and Provider Access API

CMS proposes to require impacted payers to implement and maintain Fast Healthcare Interoperability Resources (FHIR) APIs that make patient data available to patients and to providers who have a contractual relationship with the payer and a treatment relationship with the patient. AAHPM recognizes the value of the Patient and Provider Access APIs and the ability of patients and providers to obtain access to patient data, including prior authorization information. However, we are concerned about potential burdens and costs that may arise for physician practices, for example related to higher frequency of patient inquiries, increased time spent reviewing patient data, and costs associated with technology upgrades. Therefore, AAHPM recommends that CMS monitor the impacts of implementing these new APIs and update its policies, including physician payment policies, as needed to account for such increased demands.

Payer-to-Payer Data Exchange on FHIR

CMS proposes to require impacted payers to implement and maintain a FHIR Payer-to-Payer API to make available a range of data. With respect to prior authorization, CMS specifies that the data available for exchange should include the status of the prior authorization, the date the prior authorization was approved or denied, the date or circumstance under which the prior authorization ends, the items and services approved, and the quantity used to date; for denied prior authorization requests, impacted payers must include specific information about why the denial was made. CMS also seeks comment on whether prior authorizations from a previous payer should be honored by a new payer.
AAHPM believes that the transfer of patient data between payers could help to reduce administrative burden and support effective patient care, particularly if prior authorization approvals remain in effect as patients transition across payers. **We therefore urge CMS to finalize a requirement for new payers to honor prior authorization approvals of previous payers, and we believe such approval should remain active for the full duration of treatment to best support continuity of care.** We note, however, that such a requirement should not apply for prior authorization denials. As recent Office of Inspector General reports have revealed, plans inappropriately deny prior authorization requests for medically necessary services far too often. **CMS should therefore clearly state that new payers must review prior authorization requests on their own merits, without consideration of previous payers’ prior authorization denials.**

### Improving Prior Authorization Processes

As we have previously commented, AAHPM members report significant burdens associated with prior authorization requirements, in addition to substantial harms to patients as a result of delayed or denied care. We therefore greatly appreciate the proposals CMS has included – both in this proposed rule and in the Calendar Year 2024 Medicare Advantage and Part D Policy and Technical Changes proposed rule – to streamline processes, increase plan accountability, and reduce overall burden associated with prior authorization, as further detailed below.

**AAHPM supports CMS’ proposal to require impacted payers to implement and maintain a Prior Authorization Requirements, Documentation, and Decision (PARDD) API.** We believe such a requirement would reduce prior authorization burden by providing transparency to providers regarding the items and services that require prior authorization and the documentation requirement to demonstrate the appropriateness of such items or services in the care of patients with serious illness. It would also facilitate greater access to those treatments subject to prior authorization.

**AAHPM also supports CMS’ proposal to require impacted payers to provide specific reasons for prior authorization denials, regardless of the method used to send the prior authorization request.** Finalizing this proposal would give providers clearer information when assessing whether to seek a redetermination. Additionally, this proposal is important for practices that may not have the technological capacity to submit prior authorization requests via a PARDD API. For example, many palliative care practices may not have access to certified electronic health record technology (CEHRT) needed to support a PARDD API given that – in the absence of payment incentives that have allowed the proliferation of CEHRT products elsewhere in the market – few electronic health record (EHR) vendors have developed CEHRT tailored for use in hospice and palliative care.

AAHPM also appreciates CMS’ interest in standardizing prior authorization decision timeframes. However, we are concerned that CMS’ proposed timelines – 7 days for standard requests and 72 hours for expedited requests – would not be sufficiently responsive to patients’ needs to access treatment.

---

Particularly for seriously ill patients who face severe, painful, and/or debilitating conditions, each day treatment is delayed may result in increased harm. As such, we recommend that CMS instead finalize prior authorization decision timeframes of 48 hours for standard requests and 24 hours for expedited requests.

AAHPM also supports CMS’ proposal to require impacted payers to publicly report prior authorization metrics. However, we recommend that CMS further refine its proposal to require public reporting of specific categories of items and services, rather than just aggregate data. Such information would help stakeholders better understand plans’ prior authorization practices and increase the efficiency around the submission of prior authorization requests. Standardization of reporting across plans also would facilitate stakeholders’ ability to compare and contrast plans on their prior authorization metrics and identify trends in the use of prior authorization across plans and regions.

We appreciate that CMS has expanded prior authorization requirements under this rule to include Medicare Advantage plans, which increasingly provide coverage for the Medicare beneficiaries our members treat. However, we are disappointed that the above proposals do not apply to prior authorization requirements for prescription drugs. Such prior authorization requirements contribute to significant burden for our members – and potential harm to their patients – particularly as they apply to medications needed to alleviate pain and other distressing symptoms associated with serious illness. Therefore, AAHPM urges CMS to extend its proposals aimed at reducing prior authorization burden to apply to prior authorization requests for prescription drugs.

Finally, we call on CMS to establish and articulate strong enforcement mechanisms that ensure payers adhere to the new requirements to improve prior authorization processes. While these requirements offer the potential to significantly reduce burden and increase access to care, it will be important to hold plans accountable to ensure that potential is realized.

Electronic Prior Authorization for the Merit-based Incentive Payment System (MIPS) Promoting Interoperability Performance Category and the Medicare Promoting Interoperability Program

AAHPM disagrees with CMS’ proposal to add a new measure titled “Electronic Prior Authorization” to the MIPS Promoting Interoperability performance category and the Medicare Promoting Interoperability Program, and we urge CMS not to finalize these changes. While we appreciate that the use of electronic prior authorization itself could reduce burden and facilitate greater access to patient care, we are concerned that requiring reporting of a measure on the use of electronic prior authorization will add undue burden without any meaningful benefit to providers or patients. Providers already have incentives to maximize the efficiency of prior authorization processes, including through the use of electronic prior authorization to the extent that it is available through their EHRs and plans can accommodate it. However, it is not clear that EHRs will incorporate this capability in a timely manner. We also are skeptical that such additional reporting will have a meaningful impact on patient access or quality of care.
Request for Information: Accelerating the Adoption of Standards Related to Social Risk Factor Data

AAHPM is dedicated to improving quality of life and quality of care for all people living with serious illness, as well as their families and caregivers, regardless of race, gender identity, sexual orientation, age, religion, ethnicity, socioeconomic status, or disability. This includes a commitment to promoting equitable care and tackling systemic discrimination and implicit bias, along with the many other social and physical determinants of health linked to health disparities and adverse outcomes. As such, we appreciate CMS’ interest in accelerating the adoption of standards related to social risk factor data.

AAHPM believes such information, including around housing scarcity, food scarcity, caregiver availability, spiritual identity, and more, is critical for managing patients’ health and well-being in a holistic manner. As CMS references, Z codes are available to report data on social risk, but many providers see little incentive to report these codes and find that reporting of social risks fails to translate into any action to address patients’ needs. Therefore, we encourage CMS to prioritize the transparent collection of social risk data, including through provider education, support for providers to implement data collection processes, and incentives for reporting of Z codes for either patients or clinical teams.

AAHPM also recommends that CMS take a deliberate and well-considered approach to potential future incorporation of social risk data into risk adjustment, case-mix determinations, and quality measurement stratification. We recognize that social risk factors can have a meaningful impact on cost and quality outcomes, and accounting for these factors can help ensure CMS is not penalizing providers who disproportionately serve socially at-risk populations. However, there is a high risk of unintended consequences with tying social risk data to payment, including the potential for social risk adjustment to actually mask disparities in care, to lower standards for disadvantaged patients (intentionally or unintentionally), and/or reduce incentives to either treat or improve care for vulnerable populations. Given the stakes for “getting it right,” we recommend that CMS undertake this work using a transparent and inclusive process, and AAHPM would be pleased to assist CMS in these efforts.

*****

Thank you again for the opportunity to provide feedback on this proposed rule. Please direct questions or requests for additional information to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org or 847-375-4841.

Sincerely,

Tara C. Friedman, MD FAAHPM
AAHPM President