March 13, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0057-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically

Dear Administrator Brooks-LaSure,

LeadingAge offers its support for the "Advancing Interoperability and Improving Prior Authorization Processes" proposed rule and its goals to make prior authorizations and data sharing more efficient. We see great potential for care coordination and less burdensome prior authorizations processes should this proposed rule be adopted and implemented by payers. We are particularly pleased to see that CMS is extending these payer provisions to include Medicare Advantage plans in addition to other payers and leveraging technology to reduce the current burden on providers from prior authorization processes.

The mission of LeadingAge is to be the trusted voice for aging. We represent more than 5,000 nonprofit aging services providers and other mission-minded organizations that touch millions of lives every day. Alongside our members and 38 state partners, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging and disability services. We bring together the most inventive minds to lead and innovate solutions that support older adults wherever they call home.

Our comments reflect the perspective and experiences of providers of post-acute care, long-term services and supports, and home and community-based services who contract with Medicare Advantage (MA) and Special Needs Plans (SNP) to provide services. Our comments will focus on issues that impact their ability to effectively deliver services and be paid for those services.

Data Sharing

Health information sharing is so critical to helping improve outcomes for Medicare and Medicaid beneficiaries and really all Americans. This rule would create a shared framework through a trinity of APIs – Provider Access API, Patient Access API, and Payer-to-Payer Data Exchange API – that would together bolster broader adoption of data sharing that is agnostic to the type of technology a provider or payer owns, while leveraging technology to simplify these transactions.

Together this framework via these APIs has great potential to improve care by providing a more comprehensive view of a patient and their needs.

LeadingAge and its provider members have long sought improvements to the prior authorization (PA) processes imposed by Medicare Advantage plans. PA processes pose an administrative burden on providers requiring them to hire staff for the sole purpose of submitting, tracking and compiling data to satiate this plan-imposed process. For providers, PA is not a single process but numerous different processes each with its own unique communication channels, required documentation, forms, etc. These proposed rules in conjunction with those proposed in CMS-4201-P have the potential to remedy some the current inequities and barriers our providers have observed. We support the use of FHIR API to ensure systems can easily speak to each other, gather, and compile available data without requiring providers to invest in new Electronic Health Record technology. However, we are concerned that providers will still retain the burden of navigating to multiple plan portals or websites to obtain the needed data and wonder if there might be a more streamlined process for accessing this data. In addition, as CMS strives to improve prior authorization processes overall, we request CMS continue to pursue efforts to reduce the administrative burden of these processes on providers. We believe one such way to achieve this goal is to establish a standardized process in cases where all payers must follow the same regulations without deviation. One such example would be a standard prior authorization form/process for approval of all traditional Medicare A & B services, given that plans must use the same coverage criteria for these services. Such standardization would go a long way to reducing administrative burden on providers, expediting plan decisions through a standardized data request, which in turn, could ensure beneficiaries more timely access to needed care and services.

Provider API: LeadingAge supports the proposal to require payers to implement and maintain a FHIR API to exchange data with Providers for patient data as of 1/1/2026 but encourage CMS to reconsider its position on limiting this patient data access to only in-network or enrolled providers.

Instead, to further CMS goals and the benefits of such an information sharing initiative, CMS should require payers to provide access to patient data for <u>all</u> providers regardless of enrollment or in-network status. We believe this is short-sighted as some managed care plans do not limit enrollees' access to care to in-network providers. For example, PPO plans allow enrollees to access care outside their network and as such, enrollees who access out-of-network providers should also benefit from their provider having broader access to their patient data for care coordination and quality improvement purposes. In addition, plans have an obligation to ensure access to needed care by allowing their enrollees to use out-of-network providers when in-network providers are unavailable.

Finally, patients may need to access out of network providers in emergent situations where sharing patient data is even more critical to prevent a bad drug interaction or other never event. In all these cases, we believe patient data sharing between payer and provider is appropriate and essential to achieve better outcomes for the individual and reduce unnecessary costs to the system. We encourage CMS to rethink its position limiting provider access to this data to just in-network providers. We believe appropriate safeguards can be established to permit sharing with out-of-network providers.

In this vein, CMS also discusses methods for payers to confirm attribution of a patient/beneficiary to a particular provider. We have concerns about the proposed approach of looking at prior claims data or an upcoming appointment. This may work in a physician/clinic setting but is less useful for post-acute care providers where the beneficiary may have no prior relationship with the provider and instead the need for care is triggered by a hospitalization. In the case of skilled nursing facilities and home health providers, attribution should be determined by a referral or admission. We offer an additional idea for consideration related to Medicare Advantage plans. Given that most MA plans require prior

authorization of post-acute care services, CMS could tie attribution via the prior authorization request, allowing service approval and access to patient data to be addressed in a single step.

On the issue of access to patient data, we suggest CMS consider permitting providers to not only obtain data through individual requests but also be able to submit a bulk authorization request for access to patient data by submitting a list of all of a payers' enrollees currently in their care. Bulk data requests could reduce administrative burden for both providers and payers. This could be particularly helpful at the beginning of a plan year when individuals may have changed their managed care plan or become newly eligible for Medicaid or Medicare and are receiving long-term services and supports.

CMS indicates that in-network providers must attest to the payer it will comply with HIPAA, we suggest CMS permit and encourage payers to include the HIPAA attestation by providers in the payer-provider contract instead of being required to attest every time they request new patient data. For out-of-network providers, we would understand if a separate request needed to be made. Access to patient data is equally important for post-acute care providers who are not only assisting an individual with recovery/rehabilitation for a particular diagnosis but must also manage their other chronic conditions. Access to patient information via the payer could assist in reducing duplicative tests, minimizing adverse drug interactions, etc.

Regarding which data payers must share with providers, we would argue in favor of all available claims and encounter data including longitudinal data that may have been obtained from previous payers. The goal is to attain as complete a picture as possible of an individual's needs and health, so we see no reason to restrict the data to that which was collected by the current payer. If the individual is newly enrolled in a payer, there would be little data to exchange if all data was not shared. Additionally, there would be limited benefit of the payer-to-payer data exchange requirement if this data could not be shared with providers. For this reason, we also support the proposal for the Payer-to-Payer API that allows for the collection of longitudinal data on a patient that follows them throughout their health care journey.

Support for Patient Opt Out Approach: We support CMS's approach to have patients opt out vs. opt-in to data sharing with their providers for the many reasons stated. For data sharing to be useful for both providers and patients, it is better to have more patients included which an opt-out option will foster. We also support the idea of allowing beneficiaries to choose a provider-specific opt out in lieu of a blanket opt out of data sharing with all providers.

CMS's Proposed Prior Authorization Process Improvements Align with LeadingAge Recommendations

We wish to thank CMS for acknowledging that prior authorization is "a major source of provider burnout and can become a health risk for patients if inefficiencies in the process cause care to be delayed." Prior authorization processes have led substantive administrative burden requiring our providers, as noted, to hire additional staff to meet myriad PA requirements that "vary across payers and navigate the multitude of submission and approval processes…" CMS's proposals for improving the prior authorization processes align with many LeadingAge recommendations for improvements in this area.

LeadingAge supports the requirement that payers include a specific reason when they deny a prior authorization request to facilitate better communication and understanding between plan and provider. We recommended something similar in our comments on CMS-4201-P suggesting payers issue a

Detailed Explanation of Non-Coverage at point of denial or termination of coverage. CMS also notes in the CMS-0057-P that its expectation is payers would need only communicate this information once either through the API or through a second channel (e.g., in writing). While we agree that there should be no need to send duplicate coverage determination notices, we think the requirement that plans provide a specific reason for denying care should be required regardless of which communication channel is used. Therefore, we ask CMS to clarify this proposal to state that all care denials must include a detailed reason.

In addition, our providers have seen notices from payers that provide a "specific" reason that is merely a form letter and is not sufficiently detailed related to the individual for whom the request was made. For this reason, CMS should clarify the level of specificity that plans should provide in their denials so that the information is actionable for the provider and patient. For example, there is a difference between noting that "there was insufficient information to support approval" vs. "the documentation provided did not specify diagnoses or include case notes for March 3." We believe the latter is the level of specificity that should be required. We agree with CMS that having this level of specificity will facilitate successful resubmissions of the request and help beneficiaries make better-informed decisions about appealing denials, which should ultimately improve timely access to needed care. This also holds plans accountable by requiring them to explain the rationale for the termination and demonstrate that they have appropriately considered all the factors necessary before making their determination.

Prior Authorization Timeframes: We agree with CMS that prior authorization turnaround times should be shorter. We agree that a reduction in standard requests to no more than 7 calendar days is a marked improvement, but we would support all efforts to further reduce all prior authorization timeframes. We strongly believe MA enrollees should not linger in a hospital awaiting a determination for post-acute care ordered by a licensed physician. The rule of thumb is for every day in a hospital, it takes 3-4 days to for the patient to return to their pre-hospitalization function. Therefore, all prior authorizations for PAC should be "expedited" with decisions made in no more than 24-48 hours after request. MA plans aren't motivated for quick discharges from the hospital because the hospital is paid a flat DRG rate regardless of the number of days, whereas PAC services are a new cost. No beneficiary should sit in a hospital because a timely determination of coverage has not been made.

Furthermore, plans often require providers to provide extensive updated patient data on a short turnaround (e.g., 4 hours) to authorize continued services or reconsider denial but then takes 2-3 days to notify coverage decision. Plans should be prohibited from setting these arbitrary and unreasonable data submission deadlines. In one situation, one of our providers reports that a SNF nurse submitted the required data even within the 4-hour window and the plan didn't "see" the information, so it denied the request and continued to deny the request after it was pointed out to them. If the patient data is submitted supporting the need for care regardless of timing, a plan should be required to cover the Medicare A & B benefits being requested. Without appropriate penalties, the egregious behavior of some plans will continue.

Prior Authorization Processes Need to be Adequately Staffed and Penalties Incurred for Failure to Meet Established Decision Timelines: Payers decide if they will have prior authorizations for certain services. This utilization management process presents a barrier to beneficiaries' and enrollees' timely access to care. Therefore, we feel the payers should be accountable for meeting the required timeframes for deciding on these requests and should staff this function appropriately to meet these

timeframes. We do not agree with CMS that the burden should fall on providers to follow up with the payer (which they already do) when the timeline for a decision is not met by a plan. We urge CMS to establish penalties for plans that consistently miss the prescribed deadlines or reconsider its position on automatic approvals for services when the payer fails to meet the required turnaround time. These prior authorization decisions are about medically necessary care. Hours matter, days matter and delays can have significant consequences for the individual awaiting that determination.

Prior Authorization Metrics Need to Be at the Plan Level and Categorical not Aggregate: LeadingAge supports CMS's proposal to require payers to report on a list of metrics related to prior authorization and that this information will be helpful to consumers. However, we are concerned with CMS's approach on two fronts. First, we believe aggregate level data will hide problems with prior authorizations in certain service areas and that consumers would want to know if services that they routinely receive will run into barriers. Instead, we recommend CMS reconsider and have plans report data by some defined service categories: acute care, physician care, post-acute care like SNF and HH, etc. to provide a more complete picture. Second, while we understand why CMS might suggest MA plans report at the organizational level, we have observed that even within national MA organizations that prior authorization denials, appeals, approval timelines, etc. can vary. In addition, MA plan behavior may vary by plan type – PPO vs. HMO vs. Dual SNP, etc. – as well as by providers. Some MA plans own a physician practice or home health agencies and may not even require prior authorizations for their owned-provider group. For these reasons, we think plans should report the metrics outlined in the proposed rule at the plan-level and this data should be reported on the Medicare plan finder to aid consumers in their decision making. Consumers shouldn't have to go digging for this information. Finally, for these reports to be truly useful, CMS really should standardize how the data is reported so consumers can compare across plans. Without this report standardization, consumers may be left confused and the data collection effort and reporting will be for naught.

Improving the Electronic Exchange of Information in Medicare FFS: LeadingAge appreciates the question about how exchange of information can be improved in Medicare FFS. We would like to be part of CMS's work in this area. For our aging service provider members – SNF and Home Health – would benefit from some investment in their health information exchange capabilities. They can capture important data from in-home and other assessments, and patient monitoring that can assist payers in improving on key quality measures (e.g., medication reconciliation). But unlike hospitals and physicians, this group of providers did not benefit from the financial investments for meaningful use. Therefore, for providers like SNFs and HHAs as well as hospices, IT infrastructure has been lacking, preventing the efficient and timely exchange of critical health information between these providers and plans. Providers like adult day and other Medicaid HCBS services likely have even less infrastructure. Payers should provide providers with ready access to their HIE systems and incentivize them through "pay for reporting" of health information. CMS should also encourage Congress to invest in health IT infrastructure for those providers that never received meaningful use dollars. In addition, as we have noted previously standardized processes or providing a share framework, alignment of these processes, terms, etc. across payers can go a long way to reducing administrative burden on providers.
Finally, LeadingAge recommends CMS finalize these rules with some additional refinements or improvements explained here and finalize the following prior authorization policy changes in CMS-4201 – P (see our comments on these rules):

- Limiting the use of prior authorizations to medical necessity and diagnoses confirmation

- Reduce the number of authorization requests that must be made by requiring plans to authorize an entire "course of treatment" and ensure the definition of "course of treatment" applies to post-acute care (PAC) services.

In addition, we ask CMS to add the following recommendations into any final rule on prior authorization policies:

- **Develop a standardized form for prior authorization requests for traditional Medicare benefits.** If all plans must follow the same coverage criteria for traditional Medicare benefits and are not permitted to have additional internal criteria for these services, then it would follow that it would be most efficient for all providers to submit the same information to every plan. Therefore, this is a case where CMS should create a standardized form to ensure all coverage criteria are followed for traditional Medicare and MA benefits. This approach could also reduce the administrative burden on providers by eliminating multiple different forms and processes to obtain the needed prior authorizations; streamline the approval process at the plan level as reviewers would know where to look for the critical information needed to authorize services; and result in more timely decisions speeding beneficiary access to needed services. In addition, it increases the likelihood that decisions are made correctly the first time, because the necessary information is easier to be found by the reviewer. Correct initial decisions are good for the beneficiary as it expedites their access to needed care and could minimize their need to appeal.

- **Examine additional ways to simplify and expedite appeals process.** In addition, we encourage CMS to look at other ways to simplify the appeal process for beneficiaries and providers who support their efforts. Perhaps something as simple as adding a check box to the DENC or Notice of Medicare Non-Coverage, where an enrollee can indicate by checking the box that they disagree with the plan determination and have a separate check box for the provider. This approach would require the document to then be submitted to CMS for tracking purposes. It might help in identifying plans who are struggling with access to care issues.

- **Require plans to conduct prior authorization reviews 365 days a year or authorize service automatically during weekends and holidays:** Plans often require prior authorizations for HH services and/or ordered durable medical equipment, but they do not staff prior authorization reviews over the weekend or holidays even though they are discharging an enrollee home. This can leave their enrollees without needed care and supports not only over a weekend but often for several additional days, delaying access to needed care. We ask CMS to consider adding a requirement that plans with prior authorization processes must either: 1) staff them 365 days a year because enrollees need care over weekends and holidays, in addition to weekdays; or 2) they can choose not to staff these functions over weekends/holidays, but then medically necessary services needed during these times would be automatically approved and paid until the plan made a determination on a weekday. Without these changes, prior authorizations and weekend termination of services only prevents enrollee access to needed services.

We appreciate that this proposed rule was the result of hearing and responding to stakeholder input. We thank CMS for taking steps to improve provider access to patient data, which can only improve the care and services individuals in our health care system receive. And most importantly, we support CMS's

efforts to address the flaws in the prior authorization systems and attempt to remove unnecessary barriers to care while reducing administrative burden for providers who deliver that care. We look forward to working with you as these rules are ultimately implemented.

Sincerely,

Nicole O. Fallon

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