January 4, 2021

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8016

Submitted Electronically

Dear Administrator Verma:

LeadingAge and the Visiting Nurse Associations of America are pleased to see important steps being made in the proposed rules CMS-9123, titled the Reducing Provider and Patient Burden by Improving Prior Authorization processes, and Promoting Patients' Electronic Access to Health Information, to reduce provider burden regarding prior authorizations, improve transparency and data sharing practices and provide consumers with more timely decisions on prior authorizations that can eliminate unnecessary out of pocket costs and allow them to make informed decisions about their care.

We appreciate the opportunity to share our feedback on the proposed rule, as LeadingAge represents more than 5,000 nonprofit aging services providers and other mission-minded organizations that touch millions of lives every day. Our membership encompasses the entire continuum of aging and disability services. We bring together the most inventive minds in aging services to make America a better place to grow old.

Overall, we support the intent of the proposed rule to improve the prior authorization processes not only for consumers but also providers and payers by placing new requirements on state Medicaid and CHIP fee-for-service (FFS) programs, Medicaid managed care plans, CHIP managed care entities and federal exchange plans. However, we think it falls short by not also requiring the same processes be established for Medicare managed care (Part C) plans and Medicare FFS. While we acknowledge the need for adopting these rules due to the churn for Medicaid and Medicaid managed care beneficiaries, we think that the fact that there is less churn in Medicare and Medicare Part C plans does not mean that data sharing between plans, plans and providers; patient access to their health information and simplification to prior authorization (PA) processes are any less important and needed for this population. Therefore, we encourage CMS to consider expanding the scope to Medicare managed care and FFS programs over a similar time frame.

It is very challenging for providers to keep up with the different payers' requirements related to prior authorizations as well as ensure they meet the required processes for submitting such requests. In some cases, payer approval timelines can far exceed the length of the service being requested for prior approval. We are aware that the current proposed rules only address Medicaid and CHIP programs. However, under Medicare Advantage plans, some short term rehabilitation providers may request a prior authorization for skilled nursing services seeking approval for 7-14 days of service but not receive

the approval or denial until 30 days later. By this time, the patient may have received the services not knowing if they will be covered by their plan. Without a PA approval in place at time of service initiation, the provider is obligated to notify the patient that they may be required to pay the full cost of the service because the prior authorization is pending. Based upon our members' experiences around the country, we support the rules' efforts to improve these processes and the patient experience by requiring shorter turnaround times on prior authorization decision making, tracking the reasons for denials when they occur, and ensuring greater transparency about the process.

We see many benefits to the requirements for payers to establish a Provider Access API. We appreciate that through the Provider API, providers would have the ability to submit both single and bulk patient information to the payers for approval. This allows for efficiency in submissions and recognizes that sometimes a single submission may also be necessary. We are pleased to see that the Provider API will include sharing of claims, encounter and some clinical data between payers and providers. We believe that this will give providers more comprehensive insight into their patients' needs and care, and ensure more optimal treatment and care coordination, which will also benefit the consumer. We appreciate and urge you to retain the language that ensures both in-network and out-of-network providers access to the Provider API and data.

We agree with CMS' proposal on page 66 that payers should make educational resources available to providers explaining how they can use the Provider API for both individual and bulk submissions and that these resources should be made available through established, regularly utilized communication channels used by the providers and payer.

We also support the various requirements identified within the proposed rule to reduce provider burden with regard to prior authorizations. In particular, we like the emphasis on using the HL7 FHIR Data Access for facilitating data exchange for bulk submissions and think it will be enormously helpful that the API be built to work with a provider's electronic health record (EHR) and within their existing workflow for both submitting and looking up prior authorizations. We feel the proposed PA timeframes for payers to make a decision are critically important and have been a missing piece of the puzzle to date. In addition, the PA metrics data collection will provide really useful insights into how these PA processes are really working, whether or not they are necessary in some cases and possible areas for further improvement.

While not directly impacted, we are pleased to see the requirement for payer-to-payer sharing of patient health information. This will definitely help to ensure continuity of care for those individuals changing plans.

We are also supportive of the Patient Access API, its inclusion of pending and active PA decisions, as well as the requirement that payers request a privacy policy attestation from third party app developers prior to obtaining access to the payer's Patient Access API. This is an important privacy protection for consumers. However, we would prefer CMS adopt an opt-out approach to the Patient Access API vs. the proposed opt-in. We have observed that states that have adopted an opt-out approach have a higher percentage of patient data being exchanged. The greater the amount of patient data being exchanged, the better the opportunity for providers and payers to avoid duplication of tests/labs/treatments,

improve quality of care and avoid unintended outcomes such as bad drug interactions. Aging services providers need more information to effectively treat the individuals they serve and by sharing information we can ensure we have a full picture of the care, diagnoses and needs of the individual being cared for. For this reason, we would also support CMS in expanding the information available through the API to include prescription drug and/or covered outpatient drug pending and active PA decisions.

With regard to advice on phasing out FAX technology, we would like to remind CMS that not all providers are physicians and hospitals, and as such not all providers benefitted from the financial incentives paid to providers via the HITECH Act. Aging services providers also need this level of data sharing with plans and other providers to be effective. Therefore, we would recommend CMS consider developing and adopting incentives for providers left out of the HITECH Act, to encourage their move away from FAX technology to the electronic exchange of information. These incentives could be tied to quality measures, for the use of standards-based interoperable electronic information exchange.

Additionally, it is important to recognize that for some providers the barrier to adopting electronic information exchange isn't preference for the current technology but actually affordable access to broadband/internet in their geography. This is especially true for those in rural and frontier communities in the U.S. So, as CMS seeks to pursue greater interoperability, we would recommend it concurrently pursue policies and funding to ensure that this disparity between urban and rural providers is addressed by ensuring access to affordable internet for these providers.

We appreciate the opportunity to lend our support to these efforts and offer our feedback on further improvements and opportunities for CMS to consider as it finalizes these proposed rules.

Please feel free to reach out with any questions.

Sincerely,

Nicole O. Fallon
Vice President, Health Policy & Integrated Services
Director, Center for Managed Care Solutions & Innovations
LeadingAge
nfallon@leadingage.org 202-508-9435