aapm&r

9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org

PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

March 13, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-0057-P
7500 Security Boulevard
Baltimore, MD 21244-8016

RE: 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 (CMS-0057-P)

Dear Administrator Brooks-LaSure:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), we appreciate the opportunity to submit comments to the proposed rule referenced above. AAPM&R believes that the prior authorization (PA) process is in urgent need of reform due to the barriers it creates for patients and the burdens it places on physicians. As such, AAPM&R appreciates work undertaken by the Centers for Medicare and Medicaid Services (CMS) in this proposed rule to engage stakeholders and ensure patients receive equitable, high quality, patient-centered care.

AAPM&R is the national medical specialty organization representing physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life. PM&R physicians routinely triage patients and, by definition, assess patient needs to determine the most appropriate placement in the various settings of post-acute care.

CMS has recently issued several proposed rules that, when adopted, have the potential to substantially reduce the administrative delay associated with PA and to expedite the provision of medically necessary care. These include not only the proposed rule being addressed by these comments, but also the 2024 Medicare Advantage (MA) and Prescription Drug Benefit Program Policy and Technical Changes Proposed Rule and a proposed rule that would adopt HIPAA compliant standards for clinical and other information that must be submitted to support both health care claims and PA transactions.

AAPM&R members have regularly reported significant burden and barriers to patient care as a result of PA requirements imposed by a wide range of payers. ***AAPM&R therefore strongly supports the regulatory changes set forth in the proposed rule, and applauds CMS for this and other recent efforts to streamline and reform the PA process.*** When finalized, the proposed regulatory changes will significantly reduce barriers to care for patients and lessen provider burden, significantly reducing unnecessary delays in providing patient care and increasing the time that physicians will be able to spend treating their patients.

Our comments below generally focus on the sections of the rule that aim to improve prior authorization processes. ***Overall, the AAPM&R supports CMS requiring payers to adopt standardized electronic processes to streamline prior authorization requirements, documentation, and decision-making.*** Below are comments on specific proposals.

Requirement for Payers to Provide Status of Prior Authorization and Reason for Denial of Prior Authorizations

CMS proposes that electronic responses from the payer to the provider must include information about the payer's approval (including the length of approval) or denial (including a specific reason) of the request or else request additional information from the provider***. AAPM&R supports this requirement, which will bring greater transparency and clarity to often opaque PA processes.***

CMS should also adopt policies to ensure that the information provided to clinicians is unambiguous and includes actionable next steps.

Requirements for PA Decision Timeframes

CMS proposes that impacted payers must provide notice of PA decisions as expeditiously as a beneficiary's health condition requires but no later than seven calendar days for standard requests and no later than 72 hours for expedited requests.

AAPM&R appreciates the intent of what CMS has proposed with regard to shortened timeframes for PA decisions but would ask that CMS adopt even shorter timelines for PA decisions to protect patient safety and ensure patients have timely access to appropriate care.

As CMS knows, hospitals are 24-hour operations, and a patient's condition does not pause during evenings and weekends. Despite the vulnerable state of patients in hospitals, payers frequently take several days to render decisions, even for routine and frequently approved services, and their operations often cease in the early evenings, on weekends and holidays. This means that physicians must block off large portions of their workday in order to attend to administrative PA requirements. Instead of devoting clinical work hours to direct patient care, physicians are all too often tied up in the

bureaucratic prior authorization process. Not only is this a burden on the physician's workflow, but it is also detrimental to patients.

Physiatrists also practice in many different settings across the post-acute care continuum, but have a special relationship with inpatient rehabilitation hospitals and units, often called "inpatient rehabilitation facilities" (IRFs). Physiatrists often serve as medical directors and attending physicians in the IRF setting. IRF care is, by definition, provided to patients who require intensive, interdisciplinary rehabilitation therapy coupled with close medical management to regain skills and functions lost to injury or illness. As such, timely access to IRF care is critical – lengthy delays in approval of medically necessary rehabilitation care can lead to significant, even permanent, deficits in health and function when recovering from an injury or illness. Patients awaiting IRF admission due to PA requirements have often been left to occupy inpatient hospital beds as their needs are too great to be discharged to another setting.

This pattern is a lose-lose proposition for all stakeholders – patients are adversely impacted by treatment delays, physicians are diverted from patient care, and extended hospital stays or additional care resulting from delays result in unnecessary and avoidable healthcare expenditures as well as barriers to new admissions for patients who would otherwise claim occupied beds.

Public Reporting of PA Metrics

The proposed rule would require payers to report certain aggregated PA metrics publicly. AAPM&R strongly supports public reporting of payer PA data, as transparency has the potential to make the PA process more navigable and to improve health outcomes.

However, AAPM&R is concerned that the proposed rule's public reporting requirements would allow data to be reported on an aggregate basis, which is likely to be meaningless to both patients and providers. AAPM&R would request that the final rule require reporting on an individual service basis, thereby facilitating patients' and providers' understanding of whether it is likely that PA requests for particular services are likely to be approved.

AAPM&R strongly urges CMS to include in the final rule requirements intended to ensure that the PA criteria of all payers are made public in advance of adoption, and that they are reviewed by physicians with expertise in the services involved prior to implementation. AAPM&R would also request that all payers be required to publicly and substantively report on PA approvals, denials, and appeals, and provide data on the top reasons for PA denials. Finally, CMS should make these metrics and reports available through a public and centralized site, as finding this information on individual payer websites would be challenging.

"Gold-Carding" Programs for Prior Authorization

The proposed rule indicates that CMS is considering the inclusion of a gold-carding measure as a factor in quality ratings for MA organizations and qualified health plans (QHPs) for future rulemaking as a way for these payers to raise their scores in the quality star ratings. The proposed rule also indicates that CMS is considering making the implementation of a gold-carding program a requirement in other payers' PA policies.

AAPM&R believes that providers who have demonstrated a track record of providing high quality care should be relieved of requirements to submit PA requests based on data indicating their adherence to submission requirements, appropriate utilization of items or services, or other evidence-driven criteria. During listening sessions, CMS heard about how prior authorization is frequently required for certain items and services that are almost always approved, and how requiring PA for these frequently approved services, and/or from the physicians who overwhelmingly get approval for these requests, serves as a barrier to providing care to patients. AAPM&R supports mechanisms to mitigate these challenges, including implementation of a comprehensive gold-carding program to remove unnecessary barriers to care.

AAPM&R strongly supports CMS taking steps in future rulemaking to implement gold-carding programs, and looks forward to providing constructive input to ensure that gold-carding programs effectively reduce the burden of PA, properly weight quality measures, and are fairly and standardly implemented.

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

The proposed rule would add a new measure beginning in 2026 titled "Electronic Prior Authorization" in the Merit-Based Incentive Payment System (MIPS) Promoting Interoperability performance category.

While AAPM&R understands CMS' interest in ensuring that electronic PA mechanisms are utilized, we believe that unless and until the Office of the National Coordinator for Health Information Technology's (ONC) Health IT Certification Program requires certified electronic health record technology (CEHRT) to include the functionality necessary to communicate through a Prior Authorization Requirements, Documentation and Decision (PARDD) Application Programming Interface (API), it is unreasonable to measure physicians' utilization of e-PA for MIPS payment purposes. The key objective of these APIs — particularly the PARDD API — is to provide value to physicians by making patient data more readily available and reducing administrative burden. If these APIs achieve those goals when implemented, and e-PA decreases physician burden, physicians and other clinicians will not need additional incentives to adopt them. They should not be subject to punitive action if they do not implement the requirements in time. Until CEHRT that includes this functionality is available, the full potential of the e-PA Proposed Rule's reforms will not be realized.

Additionally, AAPM&R believes that many provider's health information systems are unlikely to be capable of submitting the clinical data necessary to support PA requests by the proposed deadline of January 1, 2026. At this time, there is no HIPAA compliant standard for the clinical information necessary to support PA requests and the proposed rule which would adopt such a standard is not scheduled to go into effect until January 1, 2026. The systems generally available to providers at this time do not comply with this proposed standard. Under these circumstances, we do not believe that it is reasonable to measure providers' utilization of electronic PA beginning in the 2026 performance year.

Enforcement

AAPM&R is very much encouraged by CMS' interest in advancing PA reform across a variety of care settings and for a variety of payers and believes that finalization of this proposed rule, along with finalization of the requirements set forth in other recent proposals, is likely to significantly improve timely access to healthcare services provided through a broad range of government funded health plans.

However, it is unclear how these requirements will be enforced, since CMS does not describe any mechanism to ensure compliance with these proposed PA requirements.

When the final rule is promulgated, CMS should spell out clear enforcement mechanisms (whether new or existing) that can be utilized to ensure compliance with the PA requirements for both payers that are under CMS' direct jurisdiction (such as MA Plans), and those that share jurisdiction with states, such as Medicaid managed care and other Medicaid programs.

Regardless of which requirements or deadlines are adopted in the final rule, AAPM&R is extremely concerned that the proposed rule does not include a workable enforcement mechanism to ensure that the required PA deadlines are met. The preamble to the proposed rule indicates that if a payer fails to comply with a deadline for approval, it is then up to the provider to follow up with the payer or, alternatively appeal the failure to comply with the deadline. Requiring the provider to follow-up would cause undue burden when we are already witnessing record high rates of provider burden and burnout. AAPM&R would urge CMS to allow providers to treat a failure to respond in a timely fashion as a PA approval, thereby incentivizing payers to comply with PA requests as required by regulation.

The Improving Seniors' Timely Access to Care Act

Finally, AAPM&R would like to highlight that the proposed rule, along with other recent proposals from CMS, largely align with the intent and provisions of the *Improving Seniors' Timely Access to Care Act* (H.R. 3173/S. 3018), legislation that AAPM&R strongly endorsed as an individual organization and as a member of the Regulatory Relief Coalition and the broader provider community in the 117th Congress. If enacted, this bipartisan legislation would help protect patients in the MA program from unnecessary delays in care due to the overuse and misuse of PA in MA, providing much-needed transparency and relieving physicians of an onerous regulatory burden. AAPM&R appreciates that while not every provision of this legislation is covered in this rule or other recent proposals from CMS, the intent to improve patient care and reduce burden on physicians is shared across these efforts and extends beyond the MA program in this proposed rule.

Conclusion

Thank you for the opportunity to comment on this proposed rule, and for all CMS' efforts to reform the PA process and remove unnecessary barriers to patient care. Please consider AAPM&R a resource in your efforts moving forward, and if the Academy can be of further assistance please contact Chris Stewart, Director of Advocacy and Government Relations at AAPM&R at cstewart@aapmr.org or 202.256.6580.

Sincerely,

Prakash Jayabalan MD, PhD
Chair, AAPM&R Health Policy and Legislation Committee