



December 23, 2020

Alex M. Azar II
Secretary, Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Seema Verma
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

Re: CMS-9123-P; Medicaid Program; Patient Protection and Affordable Care Act; Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information for Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-facilitated Exchanges; Health Information Technology Standards and Implementation Specifications

Dear Secretary Azar and Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 136,700 family physicians and medical students across the country, I appreciate the opportunity to provide comments on the [proposed rule](#) on Reducing Provider and Patient Burden by Improving Prior Authorization Processes, as published in the December 20, 2020 version of the *Federal Register*.

General Comments

Reducing physicians' administrative burden is a top priority for the AAFP, and we commend the Centers for Medicare and Medicaid Services (CMS) for working to reduce the burden of prior authorization requirements. In a 2017 survey conducted by the AAFP, more than half of the family physicians who responded said administrative burden is the most pressing problem they face in their everyday practice.¹ A recent study confirms the survey results, finding that primary care physicians spend about half of their time on administrative tasks, which is more time than they spend on clinical activities.² The AAFP has developed [Principles for Administrative Simplification](#), which states administrative burden is one of the top reasons independent practices close and is the leading cause of physician burnout.

Prior authorization (PA) requirements are a significant and growing contributor to physicians' administrative burden. A recent survey found physicians and their staff spend an average of 14.5 hours, or almost two business days, each week completing PAs.³ Eighty-six percent of respondents reported PAs have increased in the last five years.⁴ Perhaps even more concerning is that about one out of four physicians report PAs have led to a serious adverse event for a patient in their care.⁵

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The AAFP [principles](#) call on policymakers to standardize, automate, and reduce PAs. We commend CMS for incorporating these principles into this rulemaking. Although we are largely supportive of this proposal, we again emphasize that streamlining and automating PA requirements will not be enough to meaningfully reduce physicians' administrative burdens and prevent unnecessary care delays. PAs must be limited to far fewer products and services than they are now. **The AAFP urges CMS to use future rulemaking to continue discouraging the use of PAs for services that are evidence-based and considered standard of care.**

While the AAFP strongly supports efforts to streamline and standardize PAs, we are disappointed CMS did not propose to include Medicare Advantage (MA) plans in this rulemaking. We are concerned that, by not standardizing PA across all payers governed by CMS, this rule will not meaningfully reduce the administrative burdens with which family physicians are grappling. It will also not be a worthwhile investment for physician practices to purchase a new electronic health record (EHR) system or update that is compatible with the new standards if it only interacts with a small number of their contracted plans. **The AAFP strongly recommends that CMS apply the same standardization and response requirements to MA plans, with the same effective date, in future rulemaking.**

The AAFP is also concerned that CMS did not include PAs for prescription and outpatient drugs in this proposed rulemaking. Family physicians report that PA requirements for medications are the most burdensome and excluding them from the required standards and APIs will severely limit the impact that this rule will have on improving patient care or reducing administrative burdens. The AAFP strongly urges CMS to include PAs for prescription and outpatient drugs in the final rule.

Patient Access Application Programming Interface (API)

CMS proposes to require, beginning January 1, 2023, state Medicaid and Children's Health Insurance Program (CHIP) fee-for-service, Medicaid managed care, and qualified health plan issuers (impacted payers) to include, as part of the already established Patient Access API, information about the patient's pending and active prior authorization decisions. The agency further proposes to promote standardization by requiring the use of specific implementation guides

The AAFP supports the proposal to promote patient access to their information, including information about pending and active PA requests, via API. Even though payers require and fulfill PAs, family physicians often report they and their staff bear the brunt of patients' frustration with PAs and the associated care delays. We believe allowing patients to see the status of their PAs may help alleviate some of the added burden on physicians and their staff.

We also support standardization of APIs using implementation guides from Da Vinci. When naming specific version standards and implementation guides, we believe it is important to allow a path forward for organizations to adopt and use subsequent standards. As CMS acknowledges in the proposed rule, the regulatory process can be slower than the emergence of new standards. We highly recommend industry be given flexibility to leverage alternative standard approaches when exchanging parties mutually agree. We see the role of regulation as improving standardization by setting a floor for all parties to use, as opposed to dictating the use of a certain version.

Provider Access API

CMS proposes to require impacted payers to build and maintain a Provider Access API for payer-to-provider data sharing of claims and encounter data (not including cost data), a sub-set of clinical data as defined in the U.S. Core Data for Interoperability (USCDI) version 1, and pending and active prior authorization decisions for both individual patient requests and groups of patients starting January 1, 2023. CMS is proposing the use of the HL7 FHIR Bulk Data Access (Flat FHIR) specification to facilitate the exchange of data for more than one patient at a time.

The AAFP strongly supports this proposal. We believe Provider Access APIs would be valuable to our members and facilitate participation in value-based care models. Claims and encounter data are particularly helpful in tracking population health and quality measure performance. Facilitating payer to provider sharing of clinical data could also help improve care management and coordination.

The AAFP wholeheartedly agrees physicians should not be required to use these APIs. Voluntary use by physicians will facilitate the development and implementation of APIs that provide value to physicians and meaningfully reduce administrative burden.

In the proposed rule, CMS seeks comment on how to promote the utilization of these APIs and alludes to implementing measures as part of the Merit Based Incentive Payment System (MIPS). We strongly discourage using MIPS to increase adoption. The key purpose of these APIs is to provide value to physicians by making patient data more readily available and reducing administrative burden. If these APIs achieve those goals when they are implemented, physicians and other clinicians will not need additional incentives to adopt them. CMS should instead focus on ensuring APIs are implemented within physicians' clinical workflow and supported by certified EHRs.

Documentation and Prior Authorization Burden Reduction Through APIs

Document Requirement Lookup Service (DRLS) API

CMS proposes to require, beginning January 1, 2023, the impacted payers implement and maintain a standard DRLS API populated with their list of covered items and services, not including prescription drugs and/or covered outpatient drugs, for which prior authorization is required, and with the organization's documentation requirements for submitting a prior authorization request, including a description of the required documentation. The physician would then be able to query the API to determine if a PA is required and what was required to submit a PA request.

The AAFP supports this proposal. Determining whether a PA is required and retrieving documentation requirements for each payer imposes a significant administrative burden on our members, as they typically contract with several payers. Forty percent of family physicians participating in a 2019 AAFP survey reported contracting with 11 or more payers.⁶ Implementing standard APIs could reduce the time required to manually find and apply these requirements, as well as the cost to physician practices.⁷ However, we continue to believe the utility of these standards will be limited unless they are required for MA plans.

CMS requests comments on whether requiring the posting of PA requirements on a website would provide a satisfactory interim solution to the challenge of accessing these requirements in advance of implementing the DRLS API. The AAFP does not believe posting PA requirements on each payer's

website would alleviate any burden. Physicians would have to know which payer provides coverage to each patient, maintain credentials at each payer web site, and navigate to the appropriate place on each site to identify and extract the needed information. However, we may support a more centralized solution in which physicians could query a single website for PA requirements across services and payers.

Prior Authorization Support (PAS) API

CMS proposes to require impacted payers implement a PAS API that facilitates a HIPAA compliant prior authorization request and response, including any forms or medical record documentation required by the payer for items or services for which the physician is seeking authorization. The PAS API would allow physicians to fulfill PA requests at the point of care and receive responses from payers through the EHR.

The AAFP is supportive of this proposal. Evidence suggests electronic PA requests are less burdensome and costly for physicians to fulfill.⁸ We also agree that, for the PAS API to work, payers must make them available to physicians and other clinicians. The successful implementation of these APIs would be highly valuable to family medicine and other physician practices, and therefore CMS should refrain from imposing mandates on physicians or other clinicians to use such APIs in future rulemaking.

CMS indicates in the proposed rule that information about denied or expired PA decisions were not included in this requirement because this could result in a significant amount of information being shared that may or may not be clinically relevant when the data are exchanged. We appreciate CMS is focused on improving the user experience and reducing the burden associated with finding PA requests and decisions. However, there are many situations in which access to denied and expired prior authorization decisions may be clinically relevant or otherwise valuable to physicians and other clinicians.

FHIR resources can be designed to allow queries based on parameters. This would allow physicians to query for only active PAs depending on what information they need. We recommend CMS require the inclusion of information about denied and expired PA decisions based on query parameters. We do not believe the solution provided in the proposed rule to leverage “change of status” is a viable alternative. This would necessitate a publication-subscribe model on top of the API standards.

CMS does not include any information or requirements in the proposed rule related to prescription drugs or drugs that are administered in the outpatient setting. The AAFP opposes this decision. Prior authorizations are regularly required by payers to prescribe and administer prescription and outpatient drugs. Excluding them from the required standards and APIs severely limits the impact that this rule will have on patient care or administrative burden. Prescription drugs should be included in all the proposals in this rule.

CMS proposes to require impacted payers publicly report data about their prior authorization process, such as the percent of prior authorization requests approved, denied, and ultimately approved after appeal, and average time between submission and determination. The AAFP supports this proposal, and we recommend CMS provide aggregate public reporting of these data as well. We believe added transparency regarding the volume of PA requirements and response time could drive process improvement and eventually reduce administrative burden and care delays. Further, we believe this

information would be valuable to patients and clinicians as they choose health coverage and the payers with which to contract.

Proposals to Address Timeframes for Prior Authorization Requests

CMS proposes to require Medicaid and CHIP fee-for-service, Medicaid managed care, and CHIP managed care entities respond to PA requests within 72 hours for urgent requests and 7 calendar days for standard requests. For Medicaid managed care plans, the agency proposes to maintain that an extension of 14 days is authorized if the enrollee requests it or a health plan determines additional information is needed. CMS does not propose to modify the time frames for PA claims processing for issuers of qualified health plans. If the requests are not fulfilled by the impacted payers within the required timeframe, the physician or patient would have to contact the payer.

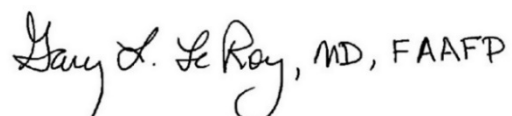
The AAFP agrees with CMS that it is vital to minimize care delays caused by PAs, and we appreciate the agency's efforts to improve PA response times. Family physicians report significant frustration with payer response time, and we believe outlining required timeframes could be beneficial. However, we remain concerned the proposed required timelines will not meaningfully improve payer response time. The AAFP and several of our partners have [previously recommended](#) non-urgent PAs be fulfilled within 48 hours, while urgent PAs should receive a response within 24 hours. We continue to believe that these timeframes would lessen care delays and administrative burden while also improving patient experience. Accordingly, we recommend that CMS require payers to respond to PAs within 48 hours for non-urgent requests and 24 hours for urgent requests.

We are opposed to the proposal to maintain that an extension of 14 days is authorized for Medicaid managed care plans if the plan determines additional information is needed. The AAFP is concerned that, by authorizing such an extension without stipulating conditions, many plans may apply the 14-day extension to most standard requests and response time will not improve. We strongly recommend the authorized extension time be reduced to no more than 7 days.

Additionally, this proposal places most of the burden of unfulfilled PA requests on the physician and patient instead of the plan that has failed to respond. This undermines much of the incentive for plans to respond to their own PA requirements within a timely manner.

Thank you for the opportunity to provide comments on this proposed rule. Should you have any questions or wish to discuss this proposal further, please contact Meredith Yinger, Senior Regulatory Strategist, at myinger@aafp.org or 202-235-5126.

Sincerely,



Gary LeRoy, MD, FAAFP
Board Chair
American Academy of Family Physicians

¹ American Academy of Family Physicians. 2017 Member Satisfaction Survey. 2017.

² Sinsky C, Colligan L, Li L, Prgomet M, Reynolds S, Goeders L, Westbrook J, Tutty M, Blike G. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. *Ann Intern Med*. 2016 Dec 6;165(11):753-760. Available at: <https://pubmed.ncbi.nlm.nih.gov/27595430/>

³ American Medical Association. 2019 AMA Prior Authorization Physician Survey. 2020. Available at: <https://www.ama-assn.org/system/files/2020-06/prior-authorization-survey-2019.pdf>

⁴ Ibid.

⁵ Ibid.

⁶ American Academy of Family Physicians. Value-based Payment Study. 2019.

⁷ 2019 CAQH Index Conducting Electronic Business Transactions: Why Greater Harmonization Across the Industry is Needed. Available at: <https://www.caqh.org/sites/default/files/explorations/index/report/2019-caqh-index.pdf?>

⁸ Ibid.