AMERICA'S PHYSICIAN GROUPS

March 13, 2023

Chiquita Brooks LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building 200 Independence Avenue, SW
Washington, DC 20201

Submitted via https://www.regulations.gov/document/CMS-2022-0190-0002

Re: Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule CMS-0057-P

Dear Administrator Brooks LaSure:

America's Physician Groups (APG) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule. We welcome the agency's openness to stakeholder input and its ongoing commitment to improving health care for all Americans.

Below, APG will first provide (I) a brief description of our organization, followed by (II) a summary of CMS's proposals, and then (III) our fuller comments and recommendations. Together they reflect the voice of our membership and our commitment to working with the agency to ensure that all Americans have consistently accessible, high-quality, person-centered health care; that health care be equitable; and that the health care system more fully embrace value-based care models in which providers are accountable for both the costs and quality of care.

I. About America's Physician Groups

APG is a national association representing more than 360 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models and Medicare Advantage (MA). APG members collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for roughly 90 million patients, including roughly 30 percent of all Medicare beneficiaries who are enrolled in MA.

Our motto, "Taking Responsibility for America's Health," underscores our members' preference for being in risk-based, accountable, and responsible relationships with all payers, including MA health plans, rather than being paid by plans on a fee-for-service basis. Delegation of risk from payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide. Several of our groups do have these delegated relationships with MA plans, while still others – despite their preference for delegated relationships – are in contractual relationships with plans in which they are paid on a fee-for-service basis. In either case, payment-related actions that affect MA plans will directly affect APG providers and their ability to provide optimal care to MA enrollees.

II. CMS Proposed Rule

In its Proposed Rule, CMS continues to advance the agency's interoperability goals and tackle process challenges related to prior authorization to increase efficiencies in health care. CMS's proposals would place new requirements on various "impacted payers" [Medicare Advantage (MA) organizations, state Medicaid and Children's Health Insurance Program (CHIP) Fee-for-Service (FFS) programs, Medicaid managed care plans and CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs)] to improve the electronic exchange of health care data and streamline processes related to prior authorization.

CMS proposes changes to the following:

- Patient access Application Programming Interface (API)
- Provider access API
- Payer-to-payer data exchange on Fast Healthcare Interoperability Resources® (FHIR®)
- Prior authorization processes, including
    - Prior Authorization Requirements, Documentation and Decision (PARDD) API
    - Denial reason
    - Prior authorization time frames
    - Prior authorization metrics
- Electronic prior authorization measure
- Interoperability standards for APIs

CMS also requests information (RFI) about these topics:

- Accelerating the adoption of standards related to social risk factor data
- Electronic exchange of behavioral health information
- Improving the electronic exchange of information in Medicare fee-for-service

- Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)
- Advancing interoperability and improving prior authorization processes for maternal health

III. Summary of APG's Recommendations

A. Recommendations Related to Patient Access Application Programming Interface (API)

- **APG recommends that CMS implement a measure or measures of the number and share of patients who experience barriers accessing, or problems utilizing, information through the Patient Access API.**

B. Recommendations Related to Prior Authorization Time Frames

- **APG recommends that CMS require prior authorization decisions no sooner than within 72 hours for expedited (i.e., urgent) requests and 7 calendar days for standard (i.e., non-urgent) requests. If CMS moves instead to require turnaround within 5 days, these should be normal business days (i.e., weekdays), not calendar days, to reduce the administrative and cost burden on providers.**

C. Recommendations Related to Accelerating the Adoption of Standards Related to Social Risk Factor Data

- **APG recommends that CMS continue to refine and test the use of multiple sources of standardized data on social risk factors for the purposes to which it proposes to apply them before settling on one definitive process for linking levels of payment and other interventions to low socioeconomic status.**

D. Recommendations Related to Improving the Electronic Exchange of Information in Medicare Fee-for-Service (FFS)

- **APG recommends that the Department of Health and Human Services expedite efforts to improve standardization and adoption of effective health IT beyond the community of providers that benefited from incentives in the HITECH portion of ARRA.**

IV. APG's Detailed Comments and Recommendations

Amid the ongoing provision of low-value care, utilization management techniques such as prior authorization are necessary and critical to assuring the value of health care for all stakeholders and the wellbeing and safety of patients. APG welcomes CMS's efforts to make the electronic prior authorization more efficient by addressing process challenges. APG's members appreciate the steps that CMS propposes to lessen the burden of prior authorization on physicians and improve the functionality of

prior authorization for patients. Below, APG offers some suggestions for finetuning the proposals to better achieve these goals.

APG members are especially grateful that CMS's proposals apply to multiple payers, and wholeheartedly endorses the agency's efforts to streamline prior authorization rules and processes across payers. Physicians often find it extremely problematic to comply with multiple payers' rules and processes.

As one APG member noted, multiple, often-conflicting requirements mean that "implementation is a nightmare." Physicians' efforts to stay on top of implementation for prior authorization and other tools required of medical practices requires time and resources that add to administrative costs. In fact, the multiple rules and application interfaces, along with the expertise needed to implement them, continue to drive physician consolidation as well as payer consolidation as the cost to implement these programs is the same for a solo physician practice as it is for 100-physician practice. Similarly, the cost is the same from a payer perspective for a 10,000-life plan as for a one-million-life plan.

Given ongoing pressure to keep costs low, such as contract negotiations with payers and medical loss ratio rules, it is essential that physician groups keep administrative costs as low as possible. Standardizing prior authorization rules and process across payers should help to keep administrative costs down.

APG members question how compliance with proposed rules and processes will be pushed downstream to delegated entities, such as is true among many of APG's California members that are in delegated relationships with health plans. These delegated physician groups, rather than the payers, are already responsible for addressing much of this interface and interchange today.

A. Patient Access Application Programming Interface (API)

The Interoperability and Patient Access 2020 final rule established a policy to require impacted payers to implement a Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) Patient Access API. CMS now proposes, starting on January 1, 2026, via the already-established Patient Access API, to require the regulated payers to make information available about patients' prior authorization requests and decisions (and related administrative and clinical documentation) for items and services (excluding drugs) to patients no later than 1 business day after the payer receives the prior authorization request, or there is another type of status change for the prior authorization. CMS expects that this process would help patients better understand their payer's prior authorization process and its impact on their care.

This proposed rule would also require impacted payers to report annual metrics to CMS about patient use of the Patient Access API, using aggregated, de-identified data. Specifically, CMS proposes that metrics include the following:

- The total number of unique patients whose data are transferred via the Patient Access API to a health app designated by the patient; and
- The total number of unique patients whose data are transferred more than once via the Patient Access API to a health app designated by the patient.

APG commends CMS's efforts to make prior authorization processes more transparent for patients. It is essential for patient engagement to improve information flows to patients and help them

better understand the specifics of their coverage. To more fully gauge patients's experience, APG suggests that, in addition to the two metrics proposed, CMS implement a measure of the number and share of patients who experience barriers accessing or problems utilizing information through the API.

- **APG recommends that CMS implement a measure or measures of the number and share of patients who experience barriers accessing or problems utilizing information through the Patient Access API.**

B. Provider Access API

CMS proposes to require impacted payers to build and maintain a Provider Access API to share patient data with in-network providers with whom the patient has a treatment relationship. CMS proposes that impacted payers make patient claims and encounter data (excluding cost information), data elements identified in the United States Core Data for Interoperability (USCDI) version 1, and prior authorization requests and decisions, available to in-network providers beginning January 1, 2026. CMS proposes to limit the required access to the Provider Access API to in-network providers, but solicits comments on potential future options to extend access to out-of-network providers.

Specifically, CMS proposes that beginning January 1, 2026 (for Medicaid managed care plans and CHIP managed care entities, by the rating period beginning on or after January 1, 2026, and for QHP issuers on the FFEs for plan years beginning on or after January 1, 2026), impacted payers would provide educational resources in nontechnical and easy-to-understand language on their websites and through other appropriate mechanisms for communicating with providers. These resources would explain how a provider may make a request to the payer for patient data using the FHIR API. APG also proposes that those resources must include information about the mechanism for attributing patients to providers.

As the patient data exchanged in the instances described aboe would be shared upon the provider's request, CMS also proposes to require payers to provide a mechanism for patients to opt out of making their data available to providers through this API, before the first date on which patient information is made available via the Provider Access API. CMS calls for the default option to be "opt in," but is not otherwise prescriptive about how the opt out process should be implemented. CMS notes that the agency "anticipate[s] that payers would make that process available by mobile smart device, website, and/or apps…[and] also anticipate[s] that mail, fax, or telephonic methods may be necessary alternatives for some patients, which payers would have to accommodate." CMS requests comments on whether the agency should establish more explicit requirements regarding the patient opt-out processes.

APG supports CMS's proposal to require impacted payers to build and maintain a Provider Access API to share patient data with in-network providers with whom the patient has a treatment relationship. Receiving as much up-to-date information about the care that patients receive is essential to effectively coordinating their care. CMS's proposal would help to close gaps in this information that exist today. Given privacy concerns, APG agrees with limiting the requirement to in-network providers at this time. However, APG recognizes that this limitation will prevent the Provider Access API from filling all information gaps, such as when a patient visits an out-of-network urgent care facility or emergency department. Therefore APG urges CMS to continue to consider options for expanding the requirement in future rulemaking.

APG acknowledges that having a default opt-in process, and requiring patients actively to choose to opt out of data sharing, is the better choice. APG is concerned, however, about the ability of all beneficiaries and enrollees to exercise their right to opt out. APG encourages CMS to consider either establishing more explicit expectations for how plans should accommodate beneficiaries and enrollees who have less ability to access opt-out options, or creating a metric to track the extent to which beneficiaries and enrollees encounter difficulties in choosing to opt out of data sharing.

C. Payer-to-Payer Data Exchange on FHIR®

The Interoperability and Patient Access 2020 final rule required that, at a patient's request, certain impacted payers exchange certain patient health information, and maintain that information, thus creating a longitudinal health record for the patient that is maintained with their current payer. FHIR API was encouraged but not required for this data exchange. In December 2021, CMS announced enforcement discretion for this policy until implementation challenges could be addressed in future rulemaking, which the agency does now.

CMS proposes to require that payers exchange patient data when a patient changes health plans with the patient's permission. These data would include claims and encounter data (excluding cost information), data elements identified in the USCDI version 1, and prior authorization requests and decisions. CMS is considering a proposal that would require this exchange only if the patient opts in to data sharing. CMS proposes that if an enrollee has concurrent coverage with two or more payers, these impacted payers must make the enrollee's data available to the concurrent payer at least quarterly.

APG notes that, when a patient changes health plans, the patient may also need to switch providers to be within a new plan's network. Therefore it seems more reasonable to have a default opt-in option that would require the patient's former health plan to exchange the patient's data with the new health plan unless the patient opts out. Such a system would in the long run be best for patients, as it would assure the smooth transfer of patients' data to the new plan and therefore also assist patients' new providers (who in theory will also have access to patients' electronic health records).

D. Improving Prior Authorization Processes

CMS notes that prior authorization has an important role in health care, in that it can ensure that covered items and services are medically necessary and covered by the payer. At the same time, CMS notes that patients, providers, and payers alike have experienced burden from the process. Prior authorization has been identified as a major source of provider burnout, and can become a health risk for patients if inefficiencies in the process cause care to be delayed. Providers expend resources on staff to identify prior authorization requirements that vary across payers and navigate the submission and approval processes, which could otherwise be directed to clinical care. Patients may unnecessarily pay out-of-pocket or abandon treatment altogether when prior authorization is delayed.

In an attempt to alleviate some of the burden of prior authorization processes and to improve the patient experience, CMS proposes four policies to help make the prior authorization process more efficient and transparent (see below). If finalized, these prior authorization policies would take effect January 1, 2026, with the initial set of metrics proposed to be reported by March 31, 2026.

i. Prior Authorization Requirements, Documentation and Decision (PARDD) API

CMS proposes to require impacted payers to build and maintain a FHIR Prior Authorization Requirements, Documentation and Decision API (PARDD API) that would automate the process for providers to determine whether prior authorization is required for certain items and services; identify prior authorization information and documentation requirement; and facilitate the exchange of prior authorization requests and decisions from their electronic health records (EHRs) or practice management systems. The API would also automate the compilation of necessary data for populating the HIPAA-compliant prior authorization transaction and enable payers to provide the status of the prior authorization request, including whether the request has been approved or denied.

CMS notes that under HIPAA, covered entities are required to use the current adopted standard for prior authorization transactions, which is the X12 278 version 5010. This proposed rule does not propose to modify the HIPAA rules in any way, nor would it hinder the use of that standard.

APG welcomes CMS's proposal to require impacted payers to build and maintain a FHIR PARDD API. Automating payers' prior authorization processes should help to reduce the significant time and resources that physician offices must expend managing these often different process for multiple payers. Automated processes will also help to eliminate the requirement for verbal acknowledgement for urgent authorizations.

APG recommends that CMS consider either requiring some degree of standardization in payers' PARDD API approaches or tracking the extent to which the implemented systems vary and produce differential impact on physicians' use of the APIs.

ii. Denial Reason

CMS proposes to require impacted payers to include a specific reason when they deny a prior authorization request, regardless of the method used to send the prior authorization decision. The goal is to facilitate better communication and understanding between the provider and payer and, if necessary, a successful resubmission of the prior authorization request.

CMS notes that impacted payers currently have the capability to send information to providers about the reason a prior authorization request has been denied either electronically or through other communication methods. For denials sent using the X12 278 standard, payers must use the codes from the designated X12 code list. For responses sent through portals, via fax or other means, payers may use proprietary codes or text to provide denial reasons. Consistent use of both technology and terminology (codes) to communicate denial information could mitigate some of the operational inefficiencies for providers so that they could more consistently interpret and react to a denied prior authorization request. Specifically, CMS proposes to require impacted payers to provide a specific reason for denied prior authorization decisions, excluding prior authorization decisions for drugs, regardless of the method used to send the prior authorization request.

CMS notes that some payers that would be affected by this proposed rule are required by existing Federal and state laws and regulations to notify providers and patients when an adverse decision is made about a prior authorization request. CMS's proposals would not alter or replace existing requirements to provide notice to patients, providers, or both.

APG supports CMS's proposal to to require impacted payers to provide a specific reason for denied prior authorization decisions. APG members find specific denial codes valuable in tracking and

understanding trends in denial reasons. It is unclear from APG's reading of the proposed rule if the agency will require payers to use the designated X12 code list of denial reasons when responses are sent through means other than the X12 278 standard, versus offering a "specific reason." If the proposal is the latter, APG is concerned that plans' interpretation of this requirement may risk perpetuating ambiguity and variation in plans' response practices. APG requests that CMS clarify in the final rule that the specific reason requirement must be met through use of the designated X12 code list of denial reasons.

iii. Prior Authorization Time Frames

CMS proposes to require impacted payers (not including QHP issuers on the FFEs) to send prior authorization decisions within 72 hours for expedited (i.e., urgent) requests and 7 calendar days for standard (i.e., non-urgent) requests. CMS also seeks comment on alternative time frames with shorter turnaround times, for example, 48 hours for expedited requests and 5 calendar days for standard requests.

APG strongly urges CMS to require prior authorization decisions **no sooner than** within 72 hours for expedited (i.e., urgent) requests and 7 calendar days for standard (i.e., non-urgent) requests. Many APG members already comply with the 72 hour/7 day time limit and find that doing so is challenging. Completing the process in 48 hours and/or 5 days would be even more challenging. The 72 hour timeline is reasonably well-established in the health care industry and meshes with existing California and other state law.

Most important, while APG shares CMS's desire to ensure that patients receive needed care in a timely manner, APG is concerned that the consequences of making a rushed decision to meet constrained time could adversely affect patients' quality of care. The consequences can also impact health plans and providers through significant liability if retrospective review of these decisions results in them being overturned.

Moving to shorter prior authorization time frames would greatly increase administrative costs. For example, an APG member with an MA population of 10,000 lives set a goal to have 95 percent of non-urgent prior authorizations responded to within 5 days compared to the standard 14 days. It cost the organization twice as much to staff the prior authorization team as making these determinations within the shortened response time curtailed their ability to spread the work between the peaks and valleys of requests. Some days there are 50 percent more requests than other days, which requires staffing the team adequately to accommodate closer to the peak volume rather than the average volume. Additionally, the organization saw three times higher turnover for the prior authorization team compared to the nursing team where the work is structured on standard turn-around times. The turnover was driven by burnout, as the team had increased overtime and stress caused by meeting the shorter turn-around time.

Given the current nursing shortage and additional stress levels put on nurses throughout the pandemic, the opportunity to assume prior authorization roles has offered some nurses respite from the demands of direct patient care. Adding stress to these prior authorization roles could further drive nurses' dissatisfaction, and would present an ongoing challenge and administrative expense for health care organizations.

While maintaining a 7-day or longer turn-around time for non-urgents is preferred, if CMS decides to require a 5-day minimum, it is essential that the requirement for turnaround be 5 business days rather than 5 calendar days. A 5-calendar-day rule would require either staffing on weekends or increased pressure, and staffing levels on Thursday and Fridays to clear all authorizations that would come due over the weekend. The result would again be increased administrative costs for health care organizations.

MA plans, unlike many other managed care plans, do not allow prior authorization requests to enter a "pending" status that pauses the turn-around time clock when all records are not complete. If CMS pursues tighter time requirements for prior authorization time frames, then the agency should consider adding a "pending additional documentation" option for MA plans that pauses the turn-around time clock.

- **APG recommends that CMS require prior authorization decisions no sooner than within 72 hours for expedited (i.e., urgent) requests and 7 calendar days for standard (i.e., non-urgent) requests. If CMS moves instead to require turnaround within 5 days, these should be normal business days (i.e., weekdays), not calendar days, to reduce the administrative and cost burden on providers.**

iv. Prior Authorization Metrics

CMS proposes to require impacted payers to publicly report on an annual basis certain prior authorization metrics by posting them directly on the payer's website or via publicly accessible hyperlink(s). This proposed reporting would be at the organizational level for MA, the state level for Medicaid and CHIP FFS, the plan level for Medicaid and CHIP managed care, and the issuer level for QHP issuers on the FFEs. CMS proposes that, for each metric listed, data would be reported in aggregate for all items and services, excluding drugs. Specifically, CMS proposes that impacted payers make reports available annually on all of the following:

- A list of all items and services that require prior authorization.
- The percentage of standard prior authorization requests that were approved, aggregated for all items and services.
- The percentage of standard prior authorization requests that were denied, aggregated for all items and services.
- The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.
- The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.
- The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.
- The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a

determination by the payer, plan, or issuer, for standard prior authorizations, aggregated for all items and services.

- The average and median time that elapsed between the submission of a request and a decision by the payer, plan or issuer, for expedited prior authorizations, aggregated for all items and services.

APG supports CMS's proposal to require impacted payers to publicly report the listed prior authorization metrics. These data should be a useful resource for physicians, beneficiaries, and enrollees who are interested in gaining insights into differences in plan performance on prior authorization. This transparency may also prove to motivate plans to focus on improving their performance over time.

E. Electronic Prior Authorization Measure

CMS proposes a new electronic prior authorization measure for Merit-Based Incentive Payment System (MIPS)-eligible clinicians under the Promoting Interoperability performance category of MIPS, as well as for eligible hospitals and critical access hospitals (CAHs) under the Medicare Promoting Interoperability Program. To meet the measure, a prior authorization must be requested electronically from a PARDD API using data from certified EHR technology (CEHRT).

Under this proposal, MIPS eligible clinicians, eligible hospitals, and CAHs would be required to report the number of prior authorizations for medical items and services (excluding drugs) that are requested electronically from a PARDD API using data from CEHRT. For the CY 2026 performance period/CY 2028 MIPS payment year for MIPS-eligible clinicians, CMS proposes that the Electronic Prior Authorization measure would not be scored and would not affect the total score for the MIPS Promoting Interoperability performance category.

In other words, for CY 2026, a MIPS-eligible clinician would be required to report a numerator of at least one for the measure or claim an exclusion, but the measure would not be scored. If MIPS-eligible clinicians do not report a numerator of at least one for the measure or claim an exclusion, they would receive a zero score for the MIPS Promoting Interoperability performance category. CMS intends to propose a scoring methodology for the measure in future rulemaking.

APG welcomes CMS's proposal to add an electronic prior authorization measure for MIPS-eligible clinicians and looks forward to CMS's future proposals regarding scoring methodology.

F. Interoperability Standards for APIs

In the 2020 Interoperability and Patient Access proposed rule, CMS proposed to require the use of certain Implementation Guides (IGs) for the implementation of the APIs. After careful consideration of these IGs, their development cycles, and CMS' role in advancing interoperability and supporting innovation, CMS is not ready to propose them as a requirement. IGs will continue to be refined over time as stakeholders have the opportunity to test and implement with their technology. CMS will continue to monitor and evaluate the development of IGs for future rulemaking consideration. CMS strongly recommends that payers use certain IGs for the Patient Access, Provider Access, Payer-to-Payer, and PARDD APIs, but CMS is not proposing to require their use.

As APG noted above, CMS may wish to consider either requiring some degree of standardization in payer's PARDD API approaches or tracking the extent to which the implemented systems vary and any

resulting impact on physicians' use of the APIs.

G. Requests for Information (RFI)

CMS includes five requests for information (RFI) in the proposed rule on 1) accelerating the adoption of standards related to social risk factor data, 2) electronic exchange of behavioral health information, 3) improving the electronic exchange of information in Medicare fee-for-service, 4) advancing the Trusted Exchange Framework and Common Agreement (TEFCA), and 5) advancing interoperability and improving prior authorization processes for maternal health.

i. Accelerating the Adoption of Standards Related to Social Risk Factor Data

CMS reissues an RFI on barriers to adopting standards, and opportunities to accelerate adoption of standards, related to social risk data. CMS recognizes that social risk factors (e.g., housing instability and food insecurity) influence patients' health and health care utilization. CMS further understands that providers in value-based payment arrangements rely on comprehensive, high-quality social risk data. Given the importance of these data, CMS looks to understand how to better standardize and enable use of these data. CMS seeks input on barriers that the health care industry faces to using industry standards, and opportunities to accelerate adoption of data collection standards related to social risk factor data, including exchange of information with community-based organizations.

APG agrees with CMS that data on social risk factors are essential to appropriately paying and planning for care across populations. APG shares CMS's interest in adopting standards related to social risk factor data. However, the pursuit of standardization must not be rushed. For instance, as APG noted in its comment letter on last year's Medicare Physician Fee Schedule's proposed rule, adoption of the Area Deprivation Index (ADI) in the Medicare Shared Savings Program (to determine which beneficiaries live in areas with high levels of socioeconomic deprivation) raises concerns for APG and its members, as use of the ADI as CMS finalized has not been appropriately evaluated and validated.

CMS should continue to refine and test use of the ADI, including comparing alternatives and potentially designing a blend of the ADI with other indices. Other indices CMS may want to consider include Z codes, a group of ICD-10-CM codes that identify a patient's socioeconomic status that have influenced a patient's health condition; the Social Vulnerability Index (SVI), developed by the Centers for Disease Control and Prevention (CDC); the Elder Economic Security Standard™ Index (Elder Index), developed by the Gerontology Institute at the University of Massachusetts Boston; and others.[1,2,3]

- **APG recommends that CMS continue to refine and test the use of multiple sources of standardized data on social risk factors for the purposes to which it proposes to apply them before settling on one definitive process for linking levels of payment and other interventions to low socioeconomic status.**

[1] USING Z CODES: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes. Accessed at https://www.cms.gov/files/document/zcodes-infographic.pdf
[2] CDC/ATSDR Social Vulnerability Index. Accessed at https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.
[3] Elder Index. Accessed at https://elderindex.org.

ii. Electronic Exchange of Behavioral Health Information

CMS reissues a request for information to inform potential future rulemaking on how to advance electronic data exchange among behavioral health providers. Behavioral health providers lag behind their peers in the ability to electronically share health information with other providers and with patients. CMS seeks comment on how CMS might leverage APIs, or other solutions, to facilitate electronic data exchange with behavioral health providers who have lagged behind other provider types in EHR adoption.

Understanding the time and cost of implementing an EHR system, CMS is interested in evaluating whether using other applications that exchange data using the FHIR APIs and do not require implementation of a full EHR system might be a way to help behavioral health providers use technology to exchange health data and to improve care quality and coordination in a more agile fashion.

Although APG has no suggestions specific to expanding electronic exchange of behavioral health information, APG urges CMS to be especially vigilant about patients' privacy rights. One APG member that operates clinics focused on serving the LGBTQ+ community expressed real concern about participating in any sort of data exchange in terms of where data may end up. Given how politicized public health and personal health decisions have become in the current political climate, especially in certain parts of the country, many patients and their providers face worrisome repercussions if data pertinent to such topics as substance use treatment, behavioral health, and family planning, are shared, even if the sharing occurs with good intentions.

iii. Improving the Electronic Exchange of Information in Medicare Fee-for-Service (FFS)

In the Medicare FFS program, the ordering provider or supplier can often be different from the rendering provider or supplier of items or services, a reality that creates unique obstacles to the coordination of patient care and exchange of medical information needed to ensure accurate and timely payment. The rendering provider or supplier must submit documentation of the patient's medical condition to justify why a patient requires a specific item or service and/or in order to meet CMS requirements.

This documentation requirement helps to ensure that beneficiaries are receiving medically necessary care that meets CMS requirements. This information is usually documented in the ordering provider or supplier's medical record. The rendering provider or supplier must obtain this information from the ordering provider or supplier to furnish the item, and submit a claim or prior authorization request.

Even in situations where both the ordering and rendering providers or suppliers do use health IT to exchange information, the compatibility of the systems may not allow for the easy and/or expeditious exchange of that information. The inconsistent use and lack of uniform health IT to exchange medical documentation will take time to resolve. In the interim, APG is interested in public comments on how Medicare FFS might best support improvements to the exchange of medical documentation between and among providers or suppliers.

Unlike their physician and hospital counterparts, providers such as home health agencies, Durable

Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, and ambulance providers were not included in the American Reinvestment and Recovery Act (ARRA) and HITECH Act programs, so they were not eligible for the same incentive payments for health IT adoption and interoperable data exchange as other providers. Thus, some providers or suppliers continue to use the U.S. Postal Service or fax machines to send patient information, and these methods can also lead to delays in the receipt of orders, prior authorization decisions, and payments.

CMS seeks comment on how Medicare FFS might best support improvements to the exchange of medical documentation between and among providers/suppliers and patients, as well as how CMS might best inform and support the movement and consistency of health data to providers for their use to inform care and treat patients.

APG shares CMS's concern about the inconsistent use and lack of uniform health IT and notes that the impact of this inconsistency is much broader than influencing prior authorization timelines. In fact, this inconsistency and underutilization of health IT presents an administrative burden for providers, a drain on the over-extended health care workforce, and a headwind to achieving high quality patient care.

APG acknowledges the truth of CMS's assertion that this issue will take time to resolve while simultaneously recognizing that this delay is not acceptable, especially now that nearly 20 years have passed since the Office of the National Coordinator for Health Information Technology was established. But APG cautions against accepting that the promise of health IT should be forever out of reach. Although providers and other stakeholders play an important role in seeking solutions on health IT use, shifting from multiple approaches to a unified solitions is an outcome that clearly calls for federal government leadership. APG urges the Secretary of the Department of Health and Human Services to expedite efforts to improve standardization and adoption of effective health IT.

- **APG recommends that the Department of Health and Human Services expedite efforts to improve standardization and adoption of effective health IT beyond the community of providers that benefited from incentives in the HITECH portion of ARRA.**

iv. Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)

In January 2022, ONC announced the release of the TEFCA Version 1. ONC's goals for TEFCA are as follows:

- Goal 1: Establish a universal policy and technical floor for nationwide interoperability.
- Goal 2: Simplify connectivity for organizations to securely exchange information to improve patient care, enhance the welfare of populations, and generate healthcare value.
- Goal 3: Enable individuals to gathertheir healthcare information.

CMS believes that the ability for stakeholders to connect to networks enabling exchange under TEFCA can support and advance the payer requirements that CMS proposes in this rule. CMS seeks comment on how enabling exchange under TEFCA can support these proposals, as well as policies in the CMS Interoperability and Patient Access final rule. CMS also seeks comment on their approach to incentivizing or encouraging payers to enable exchange under TEFCA.

Given the urgency needed to address inconsistent and underutilized health IT as noted above, APG welcomes ONC's TEFCA version 1.

v. Advancing Interoperability and Improving Prior Authorization Processes for Maternal Health

The Biden-Harris Administration has prioritized addressing the nation's maternity care crisis, with both the White House and CMS issuing coordinated approaches to addressing the crisis. CMS seeks comment from the public on evidence-based policies that the agency could pursue to employ health IT, data sharing, and interoperability to improve maternal health outcomes. CMS also seeks comment on using the USCDI to address maternal health, as well as improving prior authorization policies that can negatively affect maternal health outcomes.

V. Conclusion

Prior authorization is an essential component of strategies to address the problem of low-value health care and to reduce waste and unnecessary health care expenditures. However, the importance of prior authorization must be balanced against its unquestioned contribution to administrative burden and costs for health care providers, as well as the risk of delays that could impair the quality of care for patients.

APG appreciates and welcomes the fact that, in the Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule, CMS proposes prior authorization process improvements that will help to maintain this appropriate balance by assuring the greater efficiency of prior authorization and reducing the burdens and costs. APG looks forward to working with CMS on the implementation of these proposed changes on the provider level.

Sincerely,

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