HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

March 13, 2023

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
Re: CMS–0057–P
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Brooks-LaSure,

The Healthcare Business Management Association (HBMA) is pleased to provide comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule that would require certain federally regulated payers to create streamlined electronic prior authorization processes to reduce administrative burdens for providers. If finalized, these policies would take effect on January 1, 2026.

HBMA is a non-profit professional trade association representing the revenue cycle management industry in the United States. HBMA is a recognized revenue cycle management (RCM) authority by both the commercial insurance industry and the governmental agencies that regulate or otherwise affect the U.S. healthcare system. HBMA members collectively submit a significant percentage of all initial medical claims to the country's governmental and commercial payers. HBMA members also offer accounts receivable management, consulting, electronic medical record services and practice management functions.

HBMA appreciates CMS' acknowledgement that prior authorization processes create significant administrative and financial burdens on medical practices. We welcome these proposals which are intended to streamline this process for certain federally regulated payers. HBMA is overall in support of these proposals. Our comments suggest opportunities to improve certain proposals to maximize their burden reduction benefits.

Overly burdensome prior authorization requirements are both an administrative pain point for practices and a potential disruption for medically necessary patient care. Health plans are motivated to employ prior authorization requirements because they can reduce what they spend on healthcare benefits for their enrollees.

The Congressional Budget Office (CBO) acknowledges this in its score of the *Improving Seniors' Timely Access to Care Act*. The CBO says this bill, which includes very similar

provisions to this proposed rule, would add to the federal budget deficit because curtailing prior authorization increases access to care which will increase health plan spending on these benefits.

More and more research is showing that very few prior authorization requests are denied and that a substantial percentage of denied requests were medically necessary and should have been approved. To state it most simply, administrative processes such as prior authorization should not interfere with medical necessity. CMS should consider penalizing health plans that have a high rate of denying prior authorization requests that are approved upon appeal.

The proposed rule would require these payers to create a new FHIR-based API to facilitate interoperable, electronic prior authorization requests and responses. CMS would call this API the **Prior Authorization Requirements, Documentation and Decision (PARDD) API**.

We support how CMS intends PARDD to be used to:

- Automate the process for providers to determine whether a prior authorization is required,
- Identify prior authorization information and documentation requirements, and
- Facilitate the exchange of prior authorization requests and decisions from their electronic health records (EHRs) or practice management system.

CMS is proposing 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 seven calendar days for standard (i.e., non-urgent) requests. CMS specifically requests comments on these proposed time frames.

We believe CMS should require health plans to provide more timely responses than what is proposed. Almost all prior authorization requests are either approved or incorrectly denied. Therefore, it should not take a health plan seven business days to respond to a request. Additionally, giving health plans 72 hours to respond to an urgent request is far too much time. Health plans should be required to respond to expedited requests within 24 hours and non-urgent requests within 48 hours.

This also begs the question of why health plans are relying so heavily on prior authorizations when almost all of the requests are approved (or should have been approved). We believe CMS should incentivize health plans to utilize "gold card" programs to reduce the administrative burdens of prior authorization for clinicians with high approval rates.

CMS is proposing 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. We support the concept of this proposal but caution CMS to ensure health plans are complying with the spirit of the law and not just the letter of the law. Clinicians need useful information to make a determination about appealing a denied request or to understand how to fix mistakes with

requests for the future. We already see health plans provide vague, unhelpful information in remittance advice on claim adjudications. We worry this will also be an issue with this proposal.

As a hypothetical example, a payer could give "inadequate documentation" as a reason for a denied request. However, this hypothetical explanation does not specify what documentation is missing, incomplete, or incorrect. CMS must ensure that health plans are providing useful information about why a request was denied.

Additionally, it is important CMS understands health plans regularly state that prior authorization is not a guarantee of payment. Clinicians still must use the claim submission process after completing the prior authorization process. In some cases, health plans will then deny coverage for a service for which it granted a prior authorization. Requiring clinicians to utilize two administrative processes to receive payment for a medically necessary and covered service is an avoidable burden. If health plans are granting prior authorization, that should also serve an agreement that the health plan will cover and pay for that service after it is furnished.

Lastly, this proposed rule should be the starting point for more action to improve how payers use prior authorization. This proposed rule is intended to streamline the process, but it does not directly address the overutilization of prior authorization by health plans, which limits access to medically necessary care for their enrollees. While this proposed rule is helpful, we encourage CMS to take more action that addresses these underlying issues.

Thank you for considering our recommendations. Our organizations are happy to arrange a meeting to discuss our concerns and solutions in more detail. Please do not hesitate to contact Matt Reiter (reiterm@capitolassociates.com) or Brad Lund (brad@hbma.org) if you wish to discuss our recommendations further.

Sincerely,

Landon Tooke

Landon Tooke, CHC, CPCO
President
Healthcare Business Management Association