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Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9914-P
P.O. Box 8016
Baltimore, MD 21244-8016


The Children’s Hospital Association (CHA) appreciates the opportunity to comment on this proposed rule. We support this effort to provide appropriate access to complete health records for patients, providers and payers and improve prior authorization processes to reduce unnecessary administrative barriers to care.

Children’s hospitals are a vital safety net for all children, treating children across the country who are uninsured and underinsured, as well as those covered by Medicaid, CHIP or commercial insurance. A majority of the patients we treat are enrolled in the Medicaid program and many require highly specialized and complex care. Children’s hospitals are regional centers for children’s health, providing care across large geographic area. As leaders in local and regional pediatric health care, we are committed to electronic information exchange as a mechanism to improve administrative processes and advance high-quality children’s health care and outcomes. We are especially attuned to the value of and need for clear and uniform standards for the electronic exchange of information about prior authorizations across providers, plans and patients. Those standards are crucial to promoting the health of seriously ill children and the health of all children.

In particular, we note:

• Our general support for the electronic information exchange requirements for payers to patients, payers to providers, and payers to payers. We offer several recommendations to ensure confidentiality in that information exchange, particularly for adolescent patients and children in volatile family situations, and to further improve the prior authorization process.

• Our support for the standardization of electronic prior authorization processes and shortened timelines across plans. This important administrative simplification will reduce time and resources spent on prior authorizations and should ultimately lead to more timely care for patients. We highlight several aspects of prior authorization timing, processing and transparency that we believe can be further improved to support the care of our child patients.
We also believe that it is critically important that the electronic information exchange enhancements and streamlined timelines within this proposed rule apply to prescription drugs and covered outpatient drugs. We encourage CMS to include these drugs in the scope of the final rule or address the current cumbersome prior authorization procedures related to these drugs in subsequent rulemaking.

In addition, we encourage CMS to provide further clarity regarding the application of the requirements in this rule to the care of out-of-state Medicaid patients. Children on Medicaid whose needs cannot be met by health care providers in their home states often incur delays when they seek care in a different state due to numerous administrative hurdles, including prior authorization determinations and denials. Applying the electronic information exchange, transparency and timelines of this rule to these necessary out-of-state care situations will improve children’s access to essential specialty medical services.

Our comments on specific aspects of the proposed rule are below.

**Patient Access API**

We support the proposed requirement that plans add information about patients’ pending and active prior authorization decisions to the Patient Access API standards established under the CMS Interoperability and Patient Access final rule. Providing this information electronically to patients will not only empower those patients and their families with information they can use in the event of a denial, but could also be helpful to those who switch plans and need to facilitate their own transition of care with new providers.

We also respectfully caution that there may be issues specific to children and adolescents that need to be addressed by API developers as they add this capability to the Patient Access API. For example, proxy access to a minor child’s record must be incorporated into the API for both parents and guardians. There also must be privacy protections available—meeting federal, state and local standards—to manage parent/guardian access to a minor’s records when situations arise that require that access to be discontinued, such as some circumstances related to the care of adolescents (e.g., reproductive health, gender identity, drug use and genetic issues) and alternative guardian situations.

**Provider Access APIs; Documentation and Prior Authorization Burden Reduction through APIs**

We are pleased that CMS is expanding the standards for the Provider Access API to include new requirements that payers give providers a specific reason for a prior authorization denial and streamline timelines for prior authorization decision-making and notifications. These new requirements will reduce complexity related to the prior authorization process, decrease provider administrative burden and help ensure that patients receive the care they need when they need it.

The administrative burden that Medicaid prior authorization processes can create is acutely felt by the nation’s children’s hospitals and, most importantly, the families under their care. For example, one hospital has reported that most of its payers take up to 14 days to render a decision for the authorizations they submit for approval. Findings from another children’s hospital’s internal analysis of prior authorization denial adjudications showed a 33% increase in frontline prior authorization staff over the course of four years to keep up with those denials, at a cost of $4 million. According to that analysis, the final denial rate for cases that went through a prior authorization process was only 0.006%; 99% of denials were ultimately overturned because the payer agreed with medical staff that the denied services were appropriate. The delays in care that result from these types of complicated, and ultimately unwarranted, denial
adjudications can have serious implications for children’s long-term health and well-being, and can drive up health care costs.

These two examples of the burden on children’s hospitals of plans’ prior authorization requirements demonstrate the need for new measures, such as those included in this rule. Therefore, we support the proposed requirement that plans include capabilities in the Provider Access APIs to allow providers to electronically locate the plan’s prior authorization requirements and check the status of prior authorization requests. These are important steps towards a more streamlined and efficient adjudication process that will directly benefit patient care. We also support the requirement that plans provide a reason in the Provider Access API for any denial, as this would expedite needed corrections of administrative errors by the provider and support providers and patient families as they determine if and when to engage in an appeals process. We encourage CMS to establish enforcement mechanisms to ensure that plans comply with these requirements and recommend that the final rule clarify that the denial reason that the payer provides includes all relevant information, such as appropriate clinical justification and information about appeals rights and deadlines.

We also are pleased that the proposed rule establishes standard expectations related to turnaround times for prior authorization decisions, but recommend further tightening of these standards. Specifically, we recommend that plans be required to deliver prior authorization responses within 72 hours for standard requests and 24 hours for urgent requests, rather than the seven-day standard/72-hour urgent response timeline proposed under this rule. As noted above, lengthy adjudication timelines reduce efficiency, delay the initiation of treatment plans and ultimately compromise care and outcomes. With the technological capacity for the electronic exchange of prior authorization documentation and decisions, which is established under this proposed rule, these tightened timelines are feasible and necessary to assure that care is not delayed. In addition, we note that appeals processes can be time-intensive and recommend that CMS adopt similar, standardized streamlined timelines for formal appeals in the final rule.

Finally, we support the proposed requirement that payers publicly report data about their prior authorization processes. We believe it is critically important that CMS collect specific data on denial and approval rates, as well as require plans to report on the extent to which their prior authorization decisions are delayed and the reasons for delays and denials. We also respectfully note that some plans are beginning to require prior authorizations on procedures that historically required no authorizations and urge CMS to require plans to break down their data to allow CMS to assess and address potential logjams related to certain clinical conditions, types of patients and providers. Data categories should be specified and include, at a minimum, provider types, type of items and services, case mix, patient age and plan use of third-party prior authorization vendors. We also recommend that the final rule delineate benchmark metrics to assess plan performance, with specific enforcement and oversight mechanisms in the event a plan has sub-par metrics.

Payer-to Payer Data Exchange

We support the proposed requirements for payer-to-payer electronic exchange of patient claims, encounter data, and pending and active prior authorization decisions when a patient newly enrolls in a plan. This information exchange is key to care coordination and continuity. However, we are concerned that the rule does not go far enough to ensure that ongoing care is not disrupted when a patient changes plans or moves between a QHP, Medicaid and/or CHIP. Specifically, we recommend that the final rule require new plans to carry over and honor authorizations from the prior plan to assure care is continued. This type of prior authorization carry-over policy was implemented at the launch of the MassHealth ACO program, which required all participating Medicaid ACOs to honor existing authorizations from patients’ prior Medicaid
plans for a continuity of care grace period. The grace period ensured that patients with ongoing care needs or procedures that were already scheduled to occur after the plan transition did not have their care disrupted as they established care with new in-network providers and secured prior authorizations with their new plans. We encourage CMS to establish similar carry-over policies in the final rule.

There are several other ways to support care continuity, reduce patient and provider administrative burdens related to prior authorizations and, ultimately, improve care and outcomes. In particular, we urge CMS to limit plans’ imposition of prior authorization requirements for nationally recognized, evidence-based standard-of-care services for chronic and acute conditions. CMS should also require plans to reduce or eliminate repeat prior authorizations for specific services and procedures that are part of an already-approved plan of care. Finally, it is not uncommon for individual plans to continually change and expand their prior authorization requirements, adding to the overall administrative complexity without necessarily improving care. Standardization of documentation requirements across plans will further simplify and reduce the burden of administrative processes and support timely patient care.

Requests for Information – Methods for Enabling Patients and Providers to Control Sharing of Health Information

In response to the request for comment on whether and how patients and/or providers should have control over the sharing of patient records, we urge CMS to consider the special and complex confidentiality and privacy issues in pediatrics. Protecting privacy and confidentiality are critically important in the care of adolescents, particularly related to issues such as behavioral health, reproductive health, gender identity, drug use and genetic issues. For example, the provision of electronic health information (EHI) via the Patient Access API can be a concern when the patient is a minor, as they may not fully understand the implications of downloading and sharing their EHI.

In addition, there are varying state rules and regulations about parent/guardian access to sensitive adolescent data (e.g., substance use, reproductive health care), and there is potential significant harm in parents/guardians inadvertently being given access to that data without the adolescent patient’s consent. This can be a particular concern when there are volatile family dynamics, such as contested guardianship situations. Therefore, any future rulemaking must include mechanisms to prevent parental access to an adolescent’s information without proper authorization; allow the provider, in consultation with the adolescent patient, to limit access to information regarding certain medications, given their confidential nature; and address adolescents’ use and understanding of the information in the API.

In conclusion, we appreciate your work to improve the prior authorization and electronic information exchange processes between payers, between payers and providers, and between payers and patients. We look forward to working with you to further reduce the complexity of these systems to improve patient care and outcomes and reduce costs. Please contact Jan Kaplan at 202-753-5384 with any questions.

Sincerely,

Aimee Ossman
Vice President, Policy Analysis
Children’s Hospital Association