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March 10, 2023

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

RE: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; 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, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program (CMS-0057-P)

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the prior authorization related provisions within the above referenced proposed rule and requests for information.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 228,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

ASHA appreciates the Centers for Medicare & Medicaid Services (CMS) proposing improvements to the prior authorization and related processes applicable to Medicare Advantage plans, Medicaid managed care plans, Medicaid fee-for-service (FFS) plans, Children’s Health Insurance Program (CHIP) managed care and FFS arrangements, and Qualified Health Plans (QHP) on the federally facilitated health insurance marketplace (i.e., healthcare.gov). ASHA further appreciates CMS seeking to reduce the administrative burdens and related barriers to accessing care that prior authorization may cause.

ASHA supports the intent of the proposed rule as well as many of the provisions that: 1) reduce prior authorization burden on providers and payers; 2) expedite the prior authorization process to minimize patient harm; and 3) publicly report prior authorization metrics annually.

This letter includes ASHA’s comments on the following provisions and requests for information (RFI) discussed in the proposed rule:

- Provider Access API/Improving Prior Authorization Processes
- Electronic Prior Authorization for the Merit-Based Incentive Payment System (MIPS) Promoting Interoperability Performance Category and the Medicare Promoting Interoperability Program
- Accelerating the Adoption of Standards Related to Social Risk Factor Data

Provider Access API/Improving Prior Authorization Processes

ASHA supports the use of a standardized interface for prior authorizations using a specific Application Programming Interface (API.) APIs represent an opportunity to achieve interoperability while minimizing the financial impact on health systems and providers who have invested heavily in existing health information technology (HIT) infrastructure. There is a clear need for a uniform standard for ensuring the ability of systems to communicate with each other and the API proposal creates a pathway to achieving that goal.

We also strongly recommend that impacted payers incorporate data elements identified in a newer version of United States Core Data for Interoperability—USCDI V.3—instead of the proposed USCDI V. 1. ASHA maintains that USCDI V.1 does not constitute an elaborated list of data elements compared to the most recent versions, which incorporate elements that play a critical role in electronic data exchange including information related to interactions between health care providers and patients listed under the data class "encounter information"; data related to individual's insurance coverage listed under data class "Health Insurance Information"; clinical documentation from different health care providers listed under data class "Clinical Notes"; and assessment of health-related matters, especially functional status, disability status, and mental/cognitive status of a patient listed under data class "Health Status Assessments".

ASHA welcomes CMS's emphasis on improving transparency in the prior authorization process as facilitated by the standardization and use of APIs. This API would be populated with the payer's list of covered items and services for which prior authorization is required, and documentation requirements. The API would also be used to communicate prior authorization decisions. The ability of providers and payers to seamlessly communicate prior authorization requirements and decisions will save administrative costs by reducing the submission of incomplete information and negating the need for follow-up contacts to confirm decision status.

Delays in prior authorization requests, document submission, decision making, and communication can result in delays in patient care that have a negative impact on patient outcomes. In some cases, lengthy prior authorization processes can lead patients to abandon recommended care.[1] In order to minimize patient harm, the proposed rule establishes baseline requirements for coverage decisions of 72 hours for urgent requests and seven calendar days for nonurgent requests. While ASHA believes these timelines should be shorter because of the efficiencies created by HIT and EMRs, 24 hours and 72 hours respectively, we appreciate establishing baselines to create a federal floor for compliance and to broaden adoption of all related requirements. In addition, ASHA supports requiring payers to include a specific reason for a denial when denying a prior authorization.

In order to monitor and enforce ethical use of prior authorization, ASHA also supports the mandated reporting of payer prior authorization decision metrics through publicly reported aggregated data on an annual basis. This would include the percentage of prior authorization requests approved, denied, and approved after appeal, and average time between submission and decision. Bringing transparency to prior authorization through metric reporting would provide greater transparency to providers and consumers regarding the expectations of prior authorization review. Such details will not only help providers but also allow consumers to better understand prior authorization and how plans use it to make coverage determinations. ASHA maintains that consumers have the right to know this information because their health insurance premiums, deductibles, and copayments pay for these covered benefits.

Electronic Prior Authorization for the Merit-Based Incentive Payment System (MIPS) Promoting Interoperability Performance Category and the Medicare Promoting Interoperability Program

ASHA is in favor of the proposal to add a new measure, called Electronic Prior Authorization, to the Medicare Promoting Interoperability Program and QPP – MIPS to incentivize clinician and hospital use of the Prior Authorization Requirements, Documentation, and Decision (PARDD) API starting Calendar Year (CY) 2026.

Accelerating the Adoption of Standards Related to Social Risk Factor Data

Social determinants of health (SDOH) directly influence health outcomes and impact the ability of providers, payers, and the health care system to meet the needs of consumers effectively and efficiently. As the national association with a vision of "making effective communication, a human right, accessible and achievable for all," ASHA recognizes communication as not only a critical health outcome, but also a social determinant of health impacting the effectiveness of other health interventions and a range of health care, economic, and social factors.

As such, ASHA supports CMS working to identify effective means to collect, aggregate, and analyze social risk data, and share it publicly to inform public and private health care as well as social programs. A possible strategy for obtaining additional data could include mandating reporting of social determinant factors on medical claims using associated "Z" codes from Chapter 21 of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) code set. To enhance provider awareness, CMS could partner with professional associations to provide education on the importance of identifying social risk factors to help improve health outcomes and reduce the overall public health burden. ASHA recognizes the importance of such activities not only for our health system but for reducing health disparities and promoting health equity through targeted interventions.

ASHA also recommends payers use USCDI V.3 or a newer version to capture data elements related to SDOH. USCDI V.3 incorporates multiple data elements on SDOH such as SDOH assessment, SDOH problems/health concerns, SDOH goals, and SDOH interventions. Utilizing a standard data exchange implemented uniformly by all impacted payers will assist in accelerating the adoption of data and standards related to social risk factors.

Thank you for the opportunity to respond to the provisions within the proposed rule as well as to the specific requests for information. If you or your staff have any questions, please contact Rebecca Bowen, ASHA's director of health care policy, value, and innovation, at rbowen@asha.org.

Sincerely,

Robert M. Augustine PhD. CCC-SLP
2023 ASHA President

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[1] American Medical Association. (2018). 2017 AMA prior Authorization Physician Survey. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc/prior-auth-2017.pdf.