



March 13, 2023

Chiquita Brooks-LaSure
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

On behalf of the nation's Medicaid Directors, NAMD is pleased to offer comments on the proposed rule, [Advancing Interoperability and Improving Prior Authorization](#) [CMS-0057-P]. In this rule, CMS proposes to extend the Patient Access application programming interface (API) to include prior authorization information and require Medicaid agencies to implement new Provider Access, Payer-to-Payer, and Prior Authorization Requirements, Documentation, and Decision (PARDD) APIs. The rule would also create new timeframes for prior authorization decisions.

Although Medicaid agencies support CMS' aim of streamlining access to health care information, they report concerns about the feasibility of implementing three new APIs and significantly changing prior authorization operations, given existing bandwidth challenges and competing priorities. To address these concerns, CMS should extend the implementation deadline to at least January 1, 2027 and provide Medicaid agencies with the opportunity to apply for two one-year extensions. CMS would also need to provide Medicaid agencies with significant technical assistance and other resources.

NAMD is a bipartisan, nonprofit, professional organization representing leaders of all Medicaid agencies across the country. NAMD represents, elevates, and supports state and territorial Medicaid leaders to deliver high value services to the millions of people served by Medicaid and CHIP so they can achieve their best health and thrive in their communities.

Implementation Dates for APIs and Prior Authorization Provisions

CMS proposes an implementation date of January 1, 2026 for most of the provisions in this rule, including the Patient Access API prior authorization provisions and implementing the new Provider Access API, Payer-to-Payer API, and Prior Authorization Requirements, Documentation, and Decision (PARDD) API.

This implementation timeline would not be feasible for all Medicaid programs. Agencies note the significant resources, including fiscal resources and staff time, that would be required to implement the new APIs and prior authorization provisions. In many cases, this would require new budget requests to legislatures, including requests for additional employees. Given these dynamics and competing systems priorities at state agencies, **CMS should consider extending the implementation date to at least January 1,**

2027. This extended implementation timeline would also give providers adequate time to adjust to these new processes.

Medicaid agencies also raise questions about the value of existing APIs to Medicaid members, when compared with the effort and cost of implementation. CMS should evaluate member utilization and perception of the existing Patient Access API to inform new API requirements. Extending the implementation date to at least January 1, 2027 would give CMS time to conduct this evaluation.

In the rule, CMS proposes a one-time, one-year extension for Medicaid agencies. **CMS should allow Medicaid agencies to apply for a second one-year extension.**

Medicaid fee-for-service (FFS) programs often face challenges unique to the public sector, including state/territory budget cycles, intensive procurement processes, and APD submission and approval; these factors may prolong implementation time for reasons that are outside of the Medicaid agency's control.

CMS seeks comment on if this one-time, one-year extension should be offered to managed care plans. Many states report that their MCOs have greater resources than FFS Medicaid and would likely be able to implement this rule timely. **CMS should, however, consider granting Medicaid agencies the ability to offer their MCOs a one-year extension.** Medicaid agencies have the best line-of-sight into managed care contracts, so should be given the authority to control extension decisions. Agencies would likely look at enrollment size, plan size, and any implementation challenges reported by the MCO when making these decisions.

Some agencies note that they are likely to procure, and not independently develop, solutions. Implementation time in these states would depend on the availability of appropriate vendors. CMS could consider allowing staggered implementation, as requiring concurrent implementation of multiple APIs may overload both state and vendor staff.

Other Implementation Considerations for APIs and Prior Authorization

Medicaid agencies would need significant technical assistance to implement these APIs. Agencies note that resources on technical specifications, including on attribution-related issues, and on API systems testing would be particularly valuable. Agencies also anticipate that MCOs will need technical assistance.

In the rule, CMS proposes a "one business day" requirement for the Patient Access, Provider Access, and Payer-to-Payer APIs, such that payers would need to update the Patient Access API within one business day of receiving new data (including prior authorization data) and respond to requests from providers and payers within one business day. This timeline would not be feasible for all Medicaid agencies, especially in fee-for-service programs. Agencies would need to update their MMIS systems and internal processes, and even with these updates, report that the one business day

requirement would be difficult to meet for requests that arrive at the end of the day. Some agencies also report that their interfaces with other systems primarily conduct batch uploads overnight, meaning that updates would extend to two business days in many circumstances, and that receiving pharmacy data from pharmacy benefit managers also typically requires two business days. **CMS should consider a two business day timeframe to address these concerns.**

Implementing this rule would require significant resources, including new vendor contracts and additional Medicaid agency staff. CMS should clarify if enhanced systems match will be available to support implementation.

In the rule, CMS proposes an exception to the API requirements for Medicaid agencies with at least 90% of their members enrolled in managed care. NAMD appreciates this exception and urges CMS to use a flexible interpretation for this exception process. For example, some agencies report having a high number of FFS enrollees in the Federal Emergency Services program, such that less than 90% of their members are technically enrolled in managed care. It would not be reasonable to require a state to build out APIs almost entirely for their Federal Emergency Services program, as these members by definition can only access emergency care.

Patient Access API

In the May 2020 final rule, CMS adopted regulations requiring payers – including Medicaid agencies – to implement and maintain Patient Access APIs. In this rule, CMS proposes to require that these Patient Access APIs are expanded to include information about prior authorizations.

Medicaid agencies are differently situated in their ability to expand the Patient Access API to include prior authorization data. Some agencies report that, on their fee for service side, prior authorization is handled manually and by batch processing, which would make implementation significantly more resource intensive. Other agencies highlight questions around the technical specifications for denial reasons, including if CMS will provide standardized denial codes and how much flexibility agencies will have on defining denial reasons. As discussed above, **CMS should consider extending implementation timelines and offering a second extension to account for these challenges.**

In the rule, CMS proposes to require impacted payers, including Medicaid agencies, to report aggregate, de-identified metrics on the Patient Access API. CMS seeks comment on if they should publish these aggregate, de-identified metrics (without state/territory names attached) and on if Medicaid agencies should also be required to report any Patient Access API metrics publicly. Medicaid agencies are generally in favor of this public reporting, as it would provide useful data on patient adoption and return on investment. If Medicaid agencies are required to report metrics to CMS annually, CMS

should consider publishing these metrics on behalf of agencies to reduce administrative burden, streamline reporting, and promote consistency.

Medicaid agencies do report serious concerns, however, with the feasibility of reporting demographic information associated with the API metrics. This would create significant additional work, as APIs would need to integrate member demographic data with the API metrics. Medicaid agencies report challenges collecting reliable race, ethnicity, and language data from Medicaid members, so **CMS should revisit this proposal in the future when data completeness is improved.**

In the rule, CMS requests comment on the privacy and security of using health applications (“health apps”) to access the Patient Access API. Medicaid agencies report the need for regulatory oversight of health apps, including notifications when privacy policies change and opportunities for patients to easily revoke permission for health apps to access data. However, Medicaid agencies do not have the capacity to regulate health apps. CMS should consider working with the Federal Trade Commission on safeguards for members. Medicaid agencies also seek clarification on interactions between the Patient Access API and the HIPAA Privacy Rule, including if the Patient Access API would satisfy patient Right of Access requirements.

CMS seeks comment on if payers should be required to report the names of all health apps that patients use to access the Patient Access API each year. Medicaid agencies generally report that this would be feasible but have divergent views on the utility of this data. Some agencies believe public reporting would provide important information to Medicaid members and help with tracking if issues arise with a certain health app, while other agencies thought the utility would be limited and may inadvertently provide publicity for applications. Regardless, Medicaid agencies should not be required to report on the number of users of each app, as this could increase vulnerability to cybersecurity threats.

Provider Access API

In this rule, CMS proposes to require payers to implement and maintain a Provider Access API that makes patient data available to providers who have a contractual relationship with the payer and a treatment relationship with the patient.

Some Medicaid agencies highlight concerns about the feasibility of this proposal. Most of these concerns center around developing an attribution process to associate patients with their provider; agencies report that while they have the ability to associate a patient with their provider via a claims history, developing a proactive process for providers who will be seeing a patient is more challenging. **If CMS moves forward with this proposal, they should provide an extended implementation timeline, a second one-year extension, and significant technical assistance.**

Some Medicaid agencies report concerns about duplication with health information exchanges, which also allow providers to access patient data. Duplication would be an inefficient use of resources, could confuse providers, and may inhibit efforts to expand health information exchanges. **CMS should create an exception process for Medicaid agencies in states or territories with robust health information exchanges that provide access to the same data.**

CMS seeks comment on using an opt-out process for the Provider Access API, including the feasibility of granular opt-out processes to allow patients to restrict data sharing to certain providers. **Medicaid agencies report that allowing members to opt out for all providers is technically feasible, but that a more granular opt-out process would be extremely challenging to implement.** A more granular opt-out process would require patients to uniquely identify providers, such as through the use of a provider's NPI, which members are unlikely to know; there would also be challenges with maintenance, as provider networks are frequently updated.

If CMS does move forward with the opt-out process, they should only require Medicaid agencies to provide information on the Provider Access API opt-out policy upon member enrollment and annually. Medicaid agencies note that they could include this information in the annual redetermination process; requiring that this information to be shared more frequently would necessitate building out new workstreams and member outreach processes. This would be especially challenging and resource intensive in states and territories with eligibility and enrollment functions outside of their Medicaid agency.

In the rule, CMS discusses the need to provide educational resources for providers on requesting data through the Provider Access API; CMS should provide agencies with recommendations and templates. Medicaid agencies should, however, have the flexibility to develop their own educational resources if they wish.

Payer-to-Payer API

In this rule, CMS proposes to rescind the May 2020 payer-to-payer exchange policy and instead require that impacted payers implement a new API with greater technical uniformity. Specifically, impacted payers – including fee-for-service Medicaid and CHIP – would need to implement a FHIR payer-to-payer API. This API would create a “cumulative record” that would follow patients between payers and be available to the patient and their providers.

Medicaid agencies report that they would need technical assistance to implement the payer-to-payer API. Establishing data sharing with QHPs and other payers outside of MCOs will be new for many agencies, so sufficient implementation time and resources would be crucial. **Again, CMS should consider an extended implementation timeline, a second one-year extension, and significant technical assistance.**

Agencies report specific questions about the process to identify previous and concurrent payers. This process seems to rely mainly on gathering information from Medicaid members, and it may be challenging for members to report the full names of their previous and concurrent payers, given that there are hundreds of plans with similar names. Relatedly, different payers have unique ways to identify patients (e.g., different client IDs) so CMS should provide technical assistance on how to crosswalk these unique identifiers.

This payer-to-payer API would include information on prior authorization (PA), and CMS seeks comment on if payers should be required to honor PA decisions from previous payers. Medicaid agencies report serious concerns with this potential requirement, especially if it is applied to payers from outside the Medicaid program. Medicaid agencies, Medicaid-contracted MCOs, and outside payers often have different technical and clinical standards for prior authorization, along with different benefit packages, and, in some cases, programmatic and policy differences between payers may be irreconcilable. Implementing this proposal would require significant programmatic, systems, and operational changes.

In the rule, CMS proposes an opt-in approach for the Payer-to-Payer API. **Medicaid agencies are in favor of the opt-in approach.** As with the Provider Access API, agencies would likely integrate the choice to opt-in into existing eligibility and enrollment processes. This would streamline reporting for members, as they could complete the opt-in during their enrollment process and not need to separately report their preferences to the Medicaid agency. In states and territories where the Medicaid agency does not conduct these processes, this would require significant work with sister agencies; CMS should ensure implementation timelines account for this.

In the rule, CMS proposes that payers be required to request a patient's data from their previous and/or concurrent payers no later than one week after start of coverage. Medicaid agencies report that this initial timeline should be feasible, but that requiring payers to send any additional data received after the initial transfer would be technically challenging. CMS proposes that, for patients with concurrent payers, payers would be required to exchange data within one week of the start of coverage and then exchange data at least once quarterly. Medicaid agencies report that a quarterly data exchange is the most appropriate frequency.

More broadly, Medicaid agencies raise questions around the utility of this proposal if private previous or concurrent payers do not elect to send patient data. Developing a Payer-to-Payer API will take significant resources and the usefulness of the API may be limited if private payers do not elect to share patient data.

Prior Authorization API and Decision Timeframes

CMS proposes to require payers to adopt a variety of prior authorization provisions, including implementing prior authorization APIs, responding to prior authorization

requests within a certain number of days, providing clear reasons for prior authorization denials, and publicly reporting on certain prior authorization metrics. These provisions apply to medical services and items, but not to drugs.

First, CMS proposes to require impacted payers to implement and maintain a FHIR Prior Authorization Requirements, Documentation, and Decision (PARDD) API. Medicaid agencies report that this is generally feasible but would require time and resources to implement. If CMS issues standard denial codes and definitions, that may increase implementation time and staff training demands, as agencies would need to update their existing PA processes and denial codes to reflect CMS' standardized process.

Next, CMS proposes to establish new timeframes for prior authorization decisions and communications. Although some agencies report that meeting the proposed seven calendar day limit for standard requests and 72-hour limit for expedited requests is feasible, others report serious concerns. Some agencies would need to significantly increase their number of staff to meet these timelines, which would require legislative approval. **Meeting a shorter timeline, such as the five day/48-hour proposal discussed in the rule, would not be feasible for these agencies.**

CMS seeks comment on extending these prior authorization provisions to drugs in future rulemaking. Medicaid agencies report that this would require building data linkages to additional systems but would generally be feasible. One agency notes, however, that the proposed 72-hour limit would be difficult to meet for pharmacy-initiated PA requests. Pharmacies often do not have all of the documentation needed to make a PA determination on hand, so Medicaid agencies frequently have to request additional information, extending decision timeframes.


CMS seeks comment on a phased-in approach for the PARDD API. This approach would require payers to make 25 percent of their prior authorization rules and documentation requirements available through the API starting in 2026, then 50 percent in 2027, and 100 percent in 2028. Medicaid agencies report some ambivalence about this proposal. A phased-in approach would be beneficial for Medicaid agencies, as converting PA rules into structured documents would be time consuming and may require navigation of copyright concerns for certain standardized materials (Interqual, MCG Health, etc.). However, Medicaid agencies agree that this approach would increase complexity for providers, and providers may not begin fully utilizing the API until all content is available. **Because of these concerns, NAMD recommends that CMS consider extending the implementation timeline for full implementation of this proposal to January 2028 instead of using a phased-in approach in order to balance agency implementation lead time with maximal provider uptake.**

In this rule, CMS seeks to clarify that advance notice and fair hearing requirements apply to prior authorization decisions. Medicaid agencies report that they typically already provide fair hearings rights for prior authorization decisions.

CMS would also require payers to publicly report certain aggregated metrics about prior authorization. Although Medicaid agencies report this is likely technically feasible, there are questions about the utility of this reporting. If CMS decides to move forward with this requirement, NAMD recommends that Medicaid agency reporting requirements begin one year following implementation of the API. This would give agencies and CMS time to ensure data quality.

Thank you for the opportunity to provide comments on this proposed rule. NAMD looks forward to continuing to work with HHS to improve interoperability and prior authorization processes, with the goal of streamlining care for Medicaid members.

Sincerely,



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Director of Medicaid
Indiana Family and Social
Services Administration



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