March 25, 2022

<u>**VIA E-MAIL FILING**</u>

Office of the National Coordinator for Health Information Technology
Attention: Request for Information: Electronic Prior Authorization Standards, Implementation
Specifications, and Certification Criteria
Mary E. Switzer Building
Mail Stop: 7033A
330 C Street SW
Washington, DC 20201

RE: **RIN 0955-AA04 - Request for Information: Electronic Prior Authorization Standards, Implementation Specifications, and Certification Criteria**

The American Association of Hip and Knee Surgeons (AAHKS) appreciates the opportunity to submit comments to the Department of Health and Human Services (HHS) Office of the National Coordinator for Health IT (ONC) on its Request for Information (RFI) on *"Electronic Prior Authorization Standards, Implementation Specifications, and Certification."[1]*

AAHKS is the foremost national specialty organization of more than 4,600 physicians with expertise in total joint arthroplasty procedures. Many of our members conduct research in this area and are experts in using evidence based medicine to better define the risks and benefits of treatments for patients suffering from lower extremity joint conditions. In all of our comments, AAHKS is guided by its three principles:

- Payment reform is most effective when physician-led;
- The burden of excessive physician reporting on metrics detracts from care; and
- Patient access, especially for high-risk patients, and physician incentives must remain a focus.

Our general comments are summarized as follows:

- **AAHKS supports ONC's continued efforts to reduce barriers and burdens associated with prior authorization as it considers adoption of standards, implementation specifications, and certification criteria to advance electronic prior authorization**

- **Nevertheless, AAHKS urges the Secretary of HHS to prioritize addressing pressing issues of payor prior authorization policies as a central component of its strategy to tackle prior authorization burdens**

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[1] *See* ONC, Request for Information: Electronic Prior Authorization Standards, Implementation Specifications, and Certification Criteria, 87 Fed. Reg. 3475 (Jan. 24, 2022).

- **AAHKS believes that improving health IT functionality without addressing the urgent, underlying issues associated with payor prior authorization policies would further build upon a broken system that creates barriers for patients and over-burdens providers**

- **Shifting the center of care back to the patient-provider relationship and away from payer-imposed administrative burdens should be a paramount consideration in any policy ONC ultimately adopts**

- **Therefore, if ONC proceeds to propose the adoption of standards, implementation specifications, and certification criteria for electronic prior authorization, AAHKS urges HHS to offer providers incentives and implement policies to ensure providers have adequate financial support. Providers should not be asked to bear a disproportionate amount of the costs or burdens of system-wide standards enhancements**

I.   **Certified Health IT Functionality**

AAHKS urges HHS to improve alignment of the burdensome prior authorization policies payors impose on providers that vary in requiring when payors require prior authorization, the methods payors require providers to use to make prior authorization requests, the clinical criteria on which payors base their prior authorization standards, and the qualifications of individuals reviewing prior authorization requests for payors.

AAHKS has a positive view regarding the core set of the functional capabilities ONC lists in the RFI and believes thoughtful, patient and provider-focused adoption of such capabilities to be critical to improving providers' interactions with payor systems. However, AAHKS considers improvements to health IT functionality to be merely one component of greater policy reforms needed to reduce providers' prior authorization burdens. As the RFI notes from the *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs* ("ONC HIT Strategy"), payors' and health IT developers' attempts to address prior authorization in an ad hoc manner has resulted in a diversity of payor standards that reflect individual payer's technology considerations, lines of business, and customer-specific constraints.[2] AAHKS believes this wide variation of payor prior authorization standards currently poses more immediate and significant burdens on providers and barriers for patients.

As ONC specifically cites in its RFI, some of the key challenges ONC identified in its ONC HIT Strategy included "(i) [d]ifficulty in determining whether an item or service requires prior authorization; (ii) difficulty in determining payer-specific prior authorization requirements for those items and services; (iii) inefficient use of provider and staff time to navigate communications channels such as fax, telephone, and various web portals; and (iv) unpredictable and lengthy amounts of time to receive payer decisions."[3] Comprised of challenges beyond the scope of what can be solved through improved certified health IT functionality alone, this list emphasizes the importance of HHS expanding its efforts to a multi-faceted approach to reduce prior authorization burdens on patients and providers.
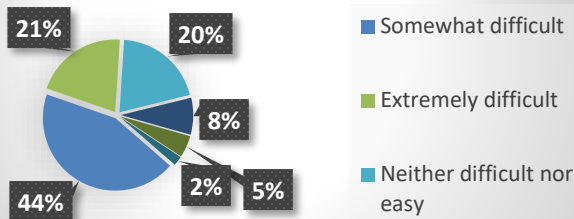
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[2] *See* ONC. Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs, (Feb. 2020'), https://www.healthit.gov/sites/default/files/page/2020-02/BurdenReport_0.pdf [hereinafter "ONC HIT Strategy"].
[3] *See* 87 Fed. Reg. at 3476 *citing* ONC HIT Strategy at 25.

1. **Issues Regarding When Payors Require Prior Authorization.** As a threshold matter, approximately 65% of respondents to a March 2022 poll of AAHKS members (the "2022 AAHKS Survey") reported determining whether certain treatments require prior authorization to be either "somewhat difficult" or "extremely difficult." *See* Figure 1(A). Further concerning, approximately 95% of AAHKS' respondents reported that the proportion of cases requiring prior authorization "increased significantly" or "increased somewhat" over the past 5 years. *See* Figure 1(B). **AAHKS urges HHS to ensure payors improve clarity regarding their respective standards so providers and patients understand when prior authorization may be required ahead of time, which would better enable providers and their patients to improve their planning and coordination to focus on the patient-provider relationship without an unexpected need for prior authorization interrupting providers' workflow and impeding patients' care.**
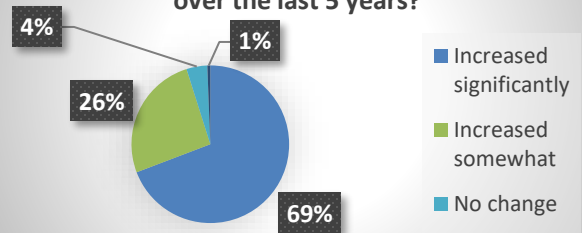
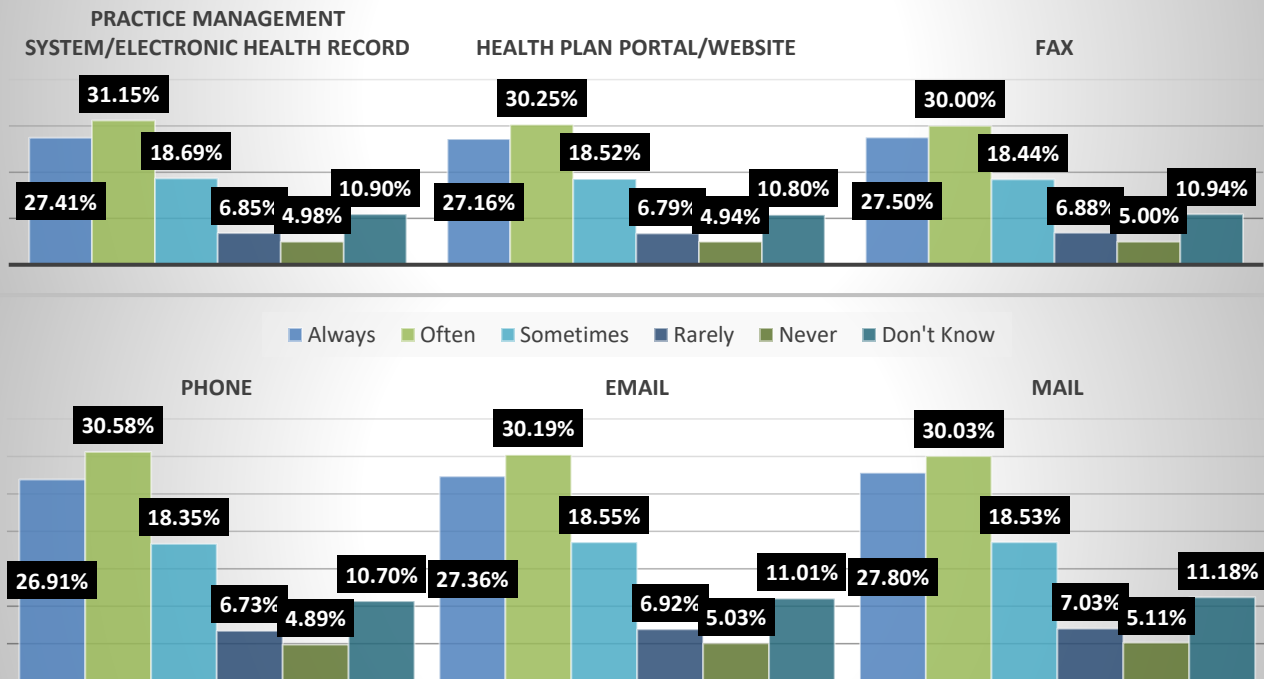Figure 1: 2022 AAHKS Survey Results – Concerns with Payor Prior Authorization Standards

2. **Methods Payors Require Providers to Use to Make Prior Authorization Requests.** The information in Figure 1(C) highlights the inefficiency underlying the current prior authorization system with respect to the varying methods providers use to complete prior authorizations for surgeries. Approximately one-third of AAHKS' respondents "always" use each mode of communication noted on the 2022 AAHKS Survey—including practice management systems, electronic health records (EHRs), health payor portals/websites, fax, phone, email, and mail—to complete prior authorizations for surgeries. While these results indicate the need for more standardized communication between payors and providers, it also highlights the many different modes of communication pathways providers must use to complete prior authorization. Respondents complained of experiencing long hold times and dropped calls when attempting to complete prior authorization by phone, which highlights the current inefficiency of existing communication methods. Additionally, only approximately one-third of respondents stated they "always" use practice management systems/EHRs or health payor portals/websites, which may indicate that a significant portion of providers may face issues transitioning to electronic prior authorization.

   AAHKS urges HHS to encourage payors to improve and better streamline existing provider-payor communications pathways, which AAHKS believes might be a step towards decreasing providers' prior authorization burdens without first requiring broad and burdensome system-wide implementation of electronic prior authorization standards.

3. **Clinical Criteria on Which Payors Base their Prior Authorization Standards.** Less than 1% of respondents to the 2022 AAHKS Survey stated health payors always base prior authorization criteria on evidence-based medicine and/or guidelines from national medical specialty societies, while a significant 46% of respondents stated payors rarely used such data in prior authorization criteria. Approximately 87% of 2022 AAHKS Survey respondents perceive prior authorization of having a "significant negative impact" or a "somewhat negative impact" on clinical outcomes. *See* Figure 2. While these are merely survey results, AAHKS believes these findings and the overall inconsistency and lack of transparency regarding the criteria and expertise upon which payors develop their prior authorization standards indicate a significant need to streamline prior authorization according to the best evidence-based practices.

   AAHKS encourages HHS to recommend payors base prior authorization criteria on peer-reviewed, evidence-based medicine and guidelines from national medical specialty societies reviewed by qualified experts to ensure better alignment with the clinical process and enable providers and their patients to better understand the criteria payors use to make prior authorization determinations.

4. **The Qualifications of Payor Staff Reviewing Prior Authorization Requests for Payors.** AAHKS also recommends HHS ensure that the payor staff who review and make determinations in response to prior authorization requests have the adequate, appropriate, and specific qualifications required to be able to make such determinations using payors' evidenced-based clinical criteria.
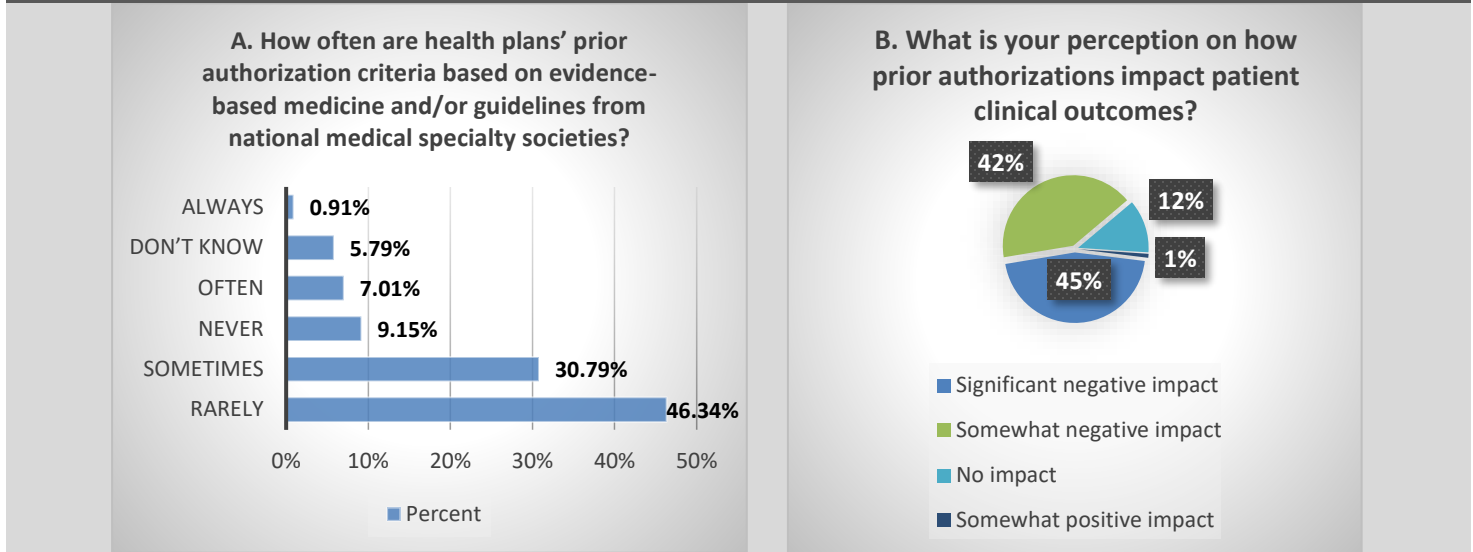
II.   Healthcare Attachment Standards

AAHKS supports further testing of both attachment standards in the context of prior authorization and encourages that adoption of any one standard should coincide with other policy solutions that address underlying payor policies and the burdens providers may face implementing Health IT systems that incorporate such attachment standards.

As ONC cites in the IFR, both the document-based exchange Consolidated Clinical Document Architecture (C-CDA) base standard and the FHIR base standard that uses standardized application programming interfaces (APIs) lack testing and implementation specific to prior authorization. As both enable interoperable exchange and have their respective benefits, as well as anticipated drawbacks, AAHKS supports use of the least burdensome standard that would speed up or simplify the prior authorization process. As such, AAHKS encourages ONC to consider provider burdens in the context of prior authorization as it examines both attachment standards.

III.   Impacts on Patients

AAHKS urges ONC to consider anchoring adoption of any standards, implementation specifications, and certification criteria to advance electronic on being patient-centered with regard to efficiency and simplicity. The current prior authorization framework imposes barriers and delays for patients that may jeopardize patients' health. Approximately 57% of respondents to the 2022 AAHKS Survey indicated patients whose treatment requires prior authorization always or often experience delays in access to care. While 37% of respondents indicated prior authorization would rarely change the care the provider would provide to their patient, almost one-third answered "sometimes." Additionally concerning, 54% of respondents stated issues related to prior authorizations sometimes lead to patients abandoning their recommended course of treatment. *See* Figure 3. As such, if ONC proposes to adopt new standards, AAHKS encourages standards that expedite and simplify the prior authorization process to reduce distractions that draw providers' focus from their patients. Prior authorization standards should minimally impact covered services, which—by definition—should be covered under a patient's health payor and

should not be subject to delays of prior authorization. Additionally, AAHKS urges HHS to impose timelines on payors to reduce delays to patient care that result from prior authorization requirements.

Figure 3: 2022 AAHKS Survey Results – Patient Impacts Associated with Prior Authorization
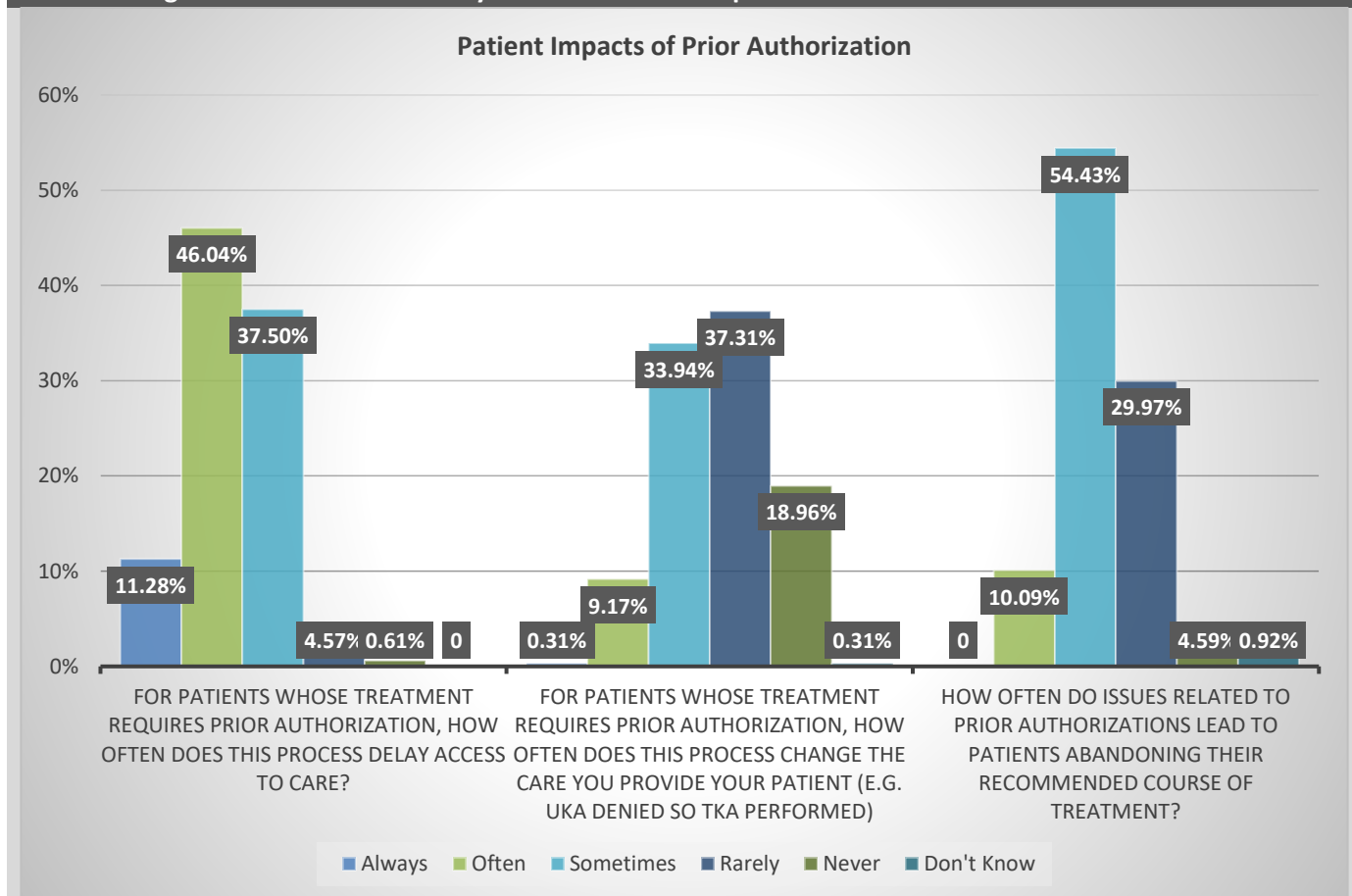
IV.   Impact on Providers

AAHKS urges HHS to consider the already high burdens providers face under current payer prior authorization requirements as it considers standards that could potentially lead to imposing additional burdens. Providers already face high administrative burdens when complying with current prior authorization requirements. Approximately 52% of respondents to the 2022 AAHKS Survey describe burdens associated with the prior authorization as being "extremely high," while 42% of respondents described the burdens to be "high." *See* Figure 4. Approximately 70% of respondents reported employing full-time staff dedicated exclusively to prior authorization. The ONC HIT Strategy noted prior authorization as a cause of burnout for providers.[4]

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[4] *See* ONC HIT Strategy at 23.

Figure 4. 2022 AAHKS Survey Results - Provider Burdens Associated with Prior Authorization
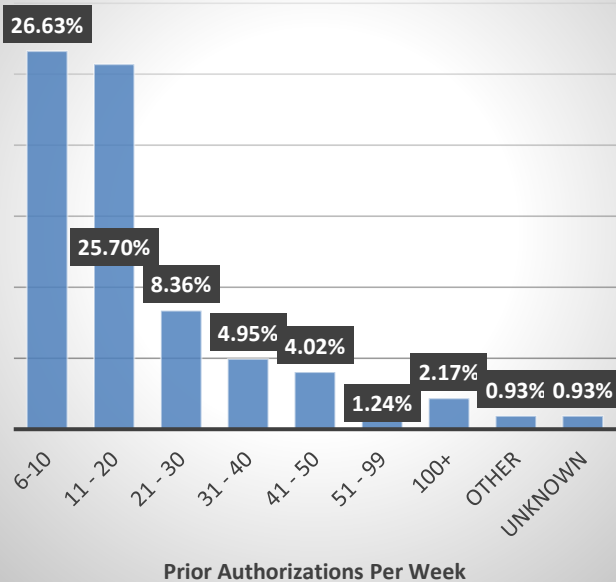
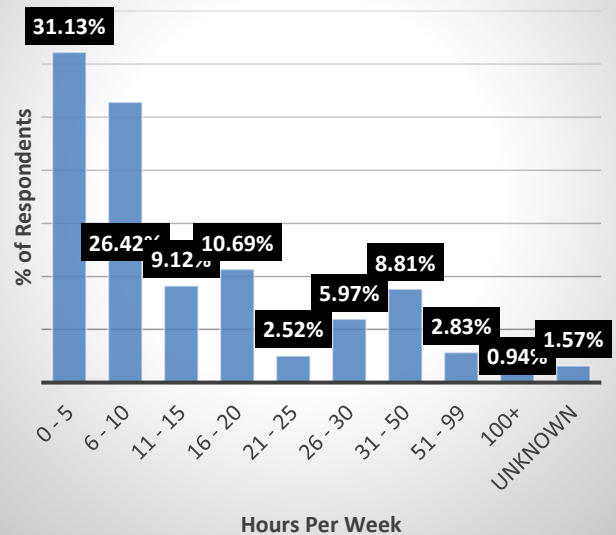**A. How would you describe the burden associated with prior authorizations in your practice?**

- High 41%
- Extremely High 52%
- Extremely low 0%
- Neither High Nor Low 6%
- Low or Extremely Low <1%
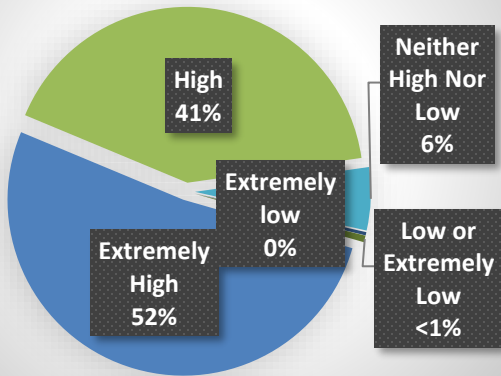
B. Do you have staff members in your practice who work exclusively on prior authorizations?

- Yes 70%
- No 27%
- Don't know 3%
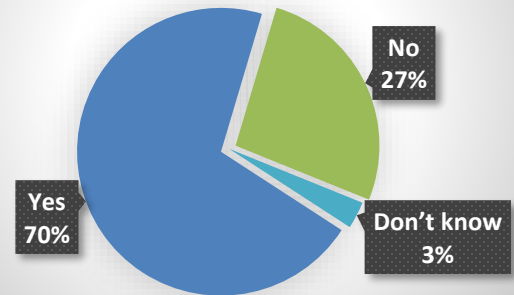
C. On average, how many prior authorizations do you or your staff complete each week for your patients?

Prior Authorizations Per Week	%
6-10	26.63%
11 - 20	25.70%
21 - 30	8.36%
31 - 40	4.95%
41 - 50	4.02%
51 - 99	1.24%
100+	2.17%
OTHER	0.93%
UNKNOWN	0.93%

D. On average, how many hours per week do you or your clinical staff spend completing prior authorizations for your patients?

Hours Per Week	% of Respondents
0 - 5	31.13%
6 - 10	26.42%
11 - 15	9.12%
16 - 20	10.69%
21 - 25	2.52%
26 - 30	5.97%
31 - 50	8.81%
51 - 99	2.83%
100+	0.94%
UNKNOWN	1.57%

AAHKS believes the additional burdens ONC would impose through mandated adoption of standards, implementation specifications, and certification criteria to advance electronic prior authorization justifies support to ensure providers do not entirely bear the costs of system-wide adoption. Under the current framework of payors creating prior authorization standards and ONC creating corresponding certified EHR standards in response to payor covered standards, certified EHR developers pass costs on to providers who must purchase these systems. AAHKS believes the costs of removing patient barriers should not be born solely by providers who would need to upgrade their EHR systems to implement new ONC standards that help increase efficiency for payors to continue building

upon the already broken system of payor prior authorization standards. As AAHKS believes in keeping patients and the patient-provider relationship at the center of care, AAHKS urges HHS to create incentives and financial support for providers to upgrade their EHRs, which would encourage and expedite putting any newly adopted functionalities into practice.

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AAHKS appreciates your consideration of our comments. If you have any questions, you can reach Mike Zarski at mzarski@aahks.org or Joshua Kerr at jkerr@aahks.org.

Sincerely,

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President

Michael J. Zarski, JD
Executive Director