March 24, 2022

The Honorable Micky Tripathi
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology (ONC)
U.S. Department of Health and Human Services
330 C St SW Floor 7
Washington, DC 20201

Re: Office of the National Coordinator for Health IT Request for Information: Electronic Prior Authorization Standards, Implementation Specifications, and Certification Criteria

Dear Dr. Tripathi:

Thank you for the opportunity to comment on electronic standards for prior authorization. We fully support efforts to make the process more efficient and effective for patients, providers and payers.

As a physician executive with more than 30 years in managed care and hospital administration, Jerry Frank MD brings extensive experience with prior authorization from the perspectives of both providers and health plans. In his role as chief medical officer at two health plans, he led major efforts that significantly improved prior authorization, including reducing the number of procedures that required prior authorization by two-thirds, from roughly 12,000 to 4,000. The overhauls were designed to ensure that patients receive the right care at the right time and in the right place while reducing physician and other provider abrasion caused by the process.

Lesley Reeder, RN has nearly 20 years of experience in value-driven health care, serving complex populations across the continuum of health care services. Throughout her career, she has overseen and developed care management and utilization management programs for a variety of health care provider organizations and health plans.

As executive leaders and experts in value-based care and payments at COPE Health Solutions, we work with payer organizations; risk-bearing entities such as IPAs, ACOs and CINs; and health systems and provider groups to de-risk and accelerate success in advanced value based payment models. This work includes the development and implementation of streamlined, digital prior authorization processes that are both patient-centered and efficient.

Based on our first-hand knowledge and experience, there are four key levers for reinventing prior authorization.

1. Rationalize procedures subject to prior authorization.

While technology and automation have crucial roles to play, the actual process itself needs to be reworked and streamlined first. It begins with winnowing the procedures to only those for which the process can be effective. Too often, there are thousands of codes requiring prior authorization for which health plans will not take any action.

Codes that can safely be removed, saving time and effort while speeding needed care, include:

- Those for which plans will not take action, such as routine office-based procedures such as incision and drainage of an abscess.
- Inpatient procedures or elective hospitalizations that are not typically denied for medical necessity reasons. These procedures could be converted into a new "notification" category. Procedures for this category include those that can only done inpatient and that the plan would like to know about in order to do appropriate discharge planning and monitoring for complications, including heart valve replacements or removal of cancerous tumors.

What remains on the prior authorization list are still thousands of codes where an action might be taken because of questions about medical necessity or appropriate place of service, such as inpatient versus outpatient setting.

Once this list is culled, organizations should move the other levers to improve the overall process and reduce the administrative burden.

2. Standardize the request process.

Instead of each plan having its own process, create a single standard process across plans. It would standardize the clinical information required, step-therapy requirements, expected conservative management and other key areas so that there is no variation between plans. Importantly, this standardization needs to ensure that members (patients) qualify for the same procedure if they change insurance plans. To ease provider burden and accelerate the process, there also should be a standard format for the authorization request.

3. Require digital portals and self-service.

Direct access to digital portals and self-service by provider staff can reduce on-hold times, dealing with personnel who may not be aware of clinical terminology or procedures that leave too many items open to interpretation. Creating guidelines used to interpret appropriateness of the procedure should be made available on the portal to improve compliance with the process and allow physicians and other providers to work more closely with their patients in getting the request completed.

Self-service allows providers to go online, directly to the procedure they are requesting and bypass ancillary processes. Autofill on member information and of the limited number of codes that some providers continuously request will further expedite the process and relieve administrative burdens.

For plans or other organizations that do not have portals, an ample timeframe should be set for development of one. Until that time, the plan should have a simple process for completing the prior authorization process online using a secure website with the same criteria as noted above.

4. Accelerate approvals using automation.

Automating processing of the request can build in quick turnaround of approvals when members (patients) meet all the necessary qualifications for a procedure, ideally during the provider's same online session. For any procedure that falls into the proposed notification category, that submission also could be completed and approved in the portal in real-time or near real-time, with the assignment of a notification "number" and no further work to be done.

Keeping the process patient-focused and cost-efficient with a reduction in administrative burden aligns all stakeholders across the continuum of health care.

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