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March 25, 2022

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RE: Electronic Prior Authorization Standards, Implementation Specifications, and Certification Criteria

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The American Psychiatric Association (APA), the national medical specialty society representing more than 37,000 psychiatric physicians, appreciates the opportunity to submit comments on the Office of the National Coordinator for Health Information Technology's (the ONC) *Request for Information: Electronic Prior Authorization Standards, Implementation Specifications, and Certification Criteria*. We have frequently advocated reducing provider burden and improving patient outcomes by streamlining the electronic prior authorization (ePA) process and improving interoperability between providers and patients who use electronic systems to facilitate care. Previously, we submitted comments to the Center for Medicaid and Medicare's Notice of Proposed Rulemaking (NPRM; unfinalized) on *Reducing Provider and Patient Burden by Improving Prior Authorization Processes* (comments submitted December 2020). Our comments for this RFI are similar to our previous comments to CMS in that APA acknowledges that modernizing data standards could improve clinical workflows and patient outcomes. Whereas CMS' 2020 NPRM provided an opportunity for APA to comment on payer standards, APA welcomes the opportunity to share clinicians' perspectives on ePA.

First, with respect to including an ePA standard within ONC's Certified Electronic Health Record Technology (CEHRT) program, we would like to reiterate our comments that APA generally supports increasing standardization within Health IT products, as this has the potential to improve interoperability between and within systems. While including an ePA standard in CEHRT products would be a step in this direction, we are concerned about the timing of when such a standard would be required. Specifically, as ONC prepares to release its CURES-mandated, 2015 Edition CEHRT, we are concerned that releasing an ePA standard for CEHRT would place a burden on developers to appropriately test and deploy this technology. This would have negative administrative, financial, and clinical consequences downstream on clinicians, who would then face the burden of integrating the updated CEHRT systems into their practices—especially for those who use CEHRT products for federal quality

reporting programs, such as the Merit-Based Incentive Payment System (MIPS). **APA recommends that, if ONC moves forward with including an ePA standard in CEHRT, that full implementation is not required until the end of 2023.** Giving developers the time to adequately test the ePA APIs is imperative to ensuring their functionality maps onto their clinical workflows without adding more administrative and clinical burden to healthcare entities which adopt them.

Second, as we have stated in previous letters, APA remains supportive of the use of FHIR APIs to increase interoperability between systems. In its 2020 NPRM on the use of APIs in ePA, CMS proposed to require affected payers (Medicare and Medicaid) to build and maintain a Document Requirement Lookup Service (DRLS) API using FHIR that could be integrated with a clinician's electronic health record (EHR). This would allow providers to electronically locate prior authorization requirements from within the clinician's workflow. One concern of APA's was that if only certain members of the payer community—Medicare and Medicaid—were required to develop and use APIs, this would only be useful for those payers who actually adopted the APIs into their technology. Presently, many organizations, especially small group and solo practices, are not incentivized to adopt the technology and use ePA. With respect to this RFI, **APA welcomes added incentives provided by the ONC to encourage other payers (e.g., Medicare Advantage, and the private sector) to adopt ePA APIs, but cautions that any mandates around ePA APIs not be burdensome with respect to the timeline.**

While we cannot respond specifically to ONC's question, "how could potential changes reduce the time for patients to receive needed healthcare services, reduce patient non-adherence, and/or lower out of pocket costs?", we can offer several examples of how the ePA process itself is often burdensome. We have repeatedly heard from our members that the entire PA process must be overhauled in order to alleviate burden and address patient harm caused by it. The ONC has an opportunity to think more broadly than as just a certifying entity for health IT, and instead to consider the healthcare ecosystem as whole.

For instance, many patients with serious mental illness require repeated treatments over time that do not change, such as with longstanding maintenance medications (e.g., antipsychotic medications, opioid antagonist medications) that do not need repeated ePA requests in order to continue therapy. An established course of care should be available between a patient and provider, when warranted, without necessitating a duplicative electronic prior authorization process to be initiated between providers and payers. Some of the proposals outlined in this RFI could facilitate that. Prior ePA decisions from previous claims can be used to limit these duplicative efforts, easing provider burden and other barriers to patient care. Moreover, psychiatrists attempting to address emergent issues with a patient require a faster turnaround from payers via ePA to address patients who are in acute crisis. Better integrated ePA API standards could support such processes. **APA encourages ONC to continue to work with all bodies within HHS and with other stakeholders to identify the current gaps in the PA process and then bake these into any future ePA standards.**

One final way in which ePA API standards could reduce time for needed services and patient non-adherence is ensuring that any standards that are implemented facilitate the transmission of a complete list of patients' medications between systems. Achieving complete and accurate medication lists between

EHR systems has been an historic challenge within the movement for interoperability. APA has previously written in support of requiring systems to adopt the newest NCPDP electronic prescribing/electronic prior authorization standards **and encourages ONC to work with NCPDP to prioritize ePA API data standards to ensure that medication lists are complete and accurate between systems.**

One such ePA API standard could address ePAs that require knowledge of previously tried treatments. In this scenario, the insurer is more likely to have more access to that information than the clinician. Thus, clinicians should be able to query external prescribing databases (e.g., surescripts) by drug category or drug name for an individual patient to quickly verify dates of prior trials. At the very least, an ePA standard should allow the system to alert the prescribing physician whether a prior authorization will be required when the prescriber is preparing to place in order within an EHR system. An example of this would be having the pharmacy system immediately pinging the prescribing physician with a message that an ePA is required and then linking directly to the prior authorization web site (if the ePA functionality is not embedded within the EHR itself).

APA continues to support the federal government in increasing standardization throughout the healthcare IT ecosystem as a way to bolster interoperability. This will improve clinical workflows and improve patient outcomes. However, as ONC works to create standards around ePA APIs, APA urges ONC to be mindful of how any new programs might ultimately increase burden on clinicians, especially those in small and solo practices. If you have any questions, please contact Michelle Dirst, Director, Practice Management and Delivery Systems Policy (mdirst@psych.org).

Sincerely,

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