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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: CMS 0057-P, 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

Dear Administrator Brooks-LaSure:

On behalf of the Suburban Hospital Alliance of New York state, which represents public and not-for-profit hospitals on Long Island and in the Hudson Valley, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Advancing Interoperability and Improving Prior Authorization Processes proposed rule.

We are pleased the proposed rule includes important policies to remove inappropriate barriers to patient care by streamlining prior authorization processes for impacted health plans and providers. These regulations would be a significant improvement to existing processes, helping clinicians focus their limited time on patient care rather than paperwork.

CMS' proposals are critical steps forward in advancing access to care and easing administrative burdens, but we urge CMS to provide the enforcement and oversight necessary to ensure health plan compliance to facilitate the meaningful changes intended. In addition, while our member hospitals appreciate CMS' effort to improve the electronic exchange of care data, we urge CMS to ensure that electronic standards are adequately tested and vetted prior to mandated adoption.

Inclusion of Medicare Advantage Plans. We applaud CMS' proposal to require Medicare Advantage (MA) plans to adhere to the rule. This will significantly increase the number of plans that must adhere to the new requirements and thus the number of patients who will benefit from these proposals. The inefficient prior authorization processes currently in place have resulted in administrative burdens and unnecessary

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care delays for patients. Hospital beds are too often occupied by patients no longer needing hospital-level care while they await authorization to transfer to post-acute care. Standardized electronic prior authorization transactions have the potential to save patients, providers and utilization review entities significant time and resources and can speed up the care delivery process. **We urge CMS to finalize the proposal to include MA plans.**

Improving Prior Authorization Processes. Prior authorization policies burden providers and divert valuable resources from patient care. Our member hospitals must manage excessive documentation requests, often with paper-based submission processes that vary from plan to plan, causing delays in patient treatment and discharge and draining scarce resources. **Considering these burdensome realities, we strongly support prior authorization reform, including adoption of electronic prior authorization processes that can streamline the arduous process to improve patient care and reduce provider burnout.**

The Prior Authorization Requirements, Documentation and Decision (PARDD) Application Programming Interface (API) discussed in this proposed rule has the potential to support the necessary transition to electronic prior authorization. However, implementing new technology can be extremely resource-intensive for hospitals, particularly in the midst of the current workforce shortage. Many of our hospitals are also experiencing a fiscal crisis due in part to the pandemic, but also due to the impact that inflation has had on pharmaceuticals, energy, supplies and staffing costs. While we fully support the ongoing development in technologies to meet industry needs, we also believe it is **critical that any solution be fully developed and tested prior to wide scale industry rollout and required usage**. This process should include careful consideration as to the transactions' scalability, privacy guardrails and ability to complete administrative tasks in a real-world setting.

Reason for Denial of Prior Authorization. We support CMS' proposal to require impacted payers to provide a specific reason for prior authorization denials. The proposal acknowledges that providers must understand why a request is denied so they can either resubmit it with updated information, identify treatment alternatives, appeal the decision or communicate the decision to their patients. This proposal would help address a significant problem, as providers and patients are often left without an adequate explanation as to why a prior authorization request was denied. We support this proposal and encourage CMS to establish enforcement mechanisms to ensure that plans are compliant with its requirements.

Timeliness Standards. We support CMS' focus on reducing prior authorization timelines; however, the proposed timeframes are too lenient. Unlike other transactions between providers and health plans, prior authorizations have a direct impact on patient care. A prior authorization request is often the final step between a patient and the

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initiation of their care, making expeditious processing of such transactions extremely important. Prior authorization has been shown to cause significant delays in care, frequently leading to negative clinical outcomes for patients. It is not uncommon for a patient to become frustrated with the process and abandon treatment altogether.

The technology proposed under this regulation could effectively eliminate the delays caused by slow delivery of medical documents, as it boasts the ability to deliver clinical information in real time. As a result, health plans should have the capability to determine whether the provider has met their established medical necessity threshold in a much timelier manner. Patients should not be forced to wait to receive care. **We recommend that plans be required to deliver prior authorization responses within 72 hours for standard, non-urgent services and 24 hours for urgent services for transactions utilizing the PARDD API.**

Prior Authorization Data Reporting Requirements. CMS' proposal requires plans to report prior authorization process metrics, which we strongly support. By requiring plans to report such metrics, the rule promotes health plan transparency and the opportunity to build accountability. While there is substantial research demonstrating the burden that inefficient prior authorizations have on providers and their patients, there are limited resources available for determining particularly problematic plans. Plan prior authorization metrics buried on individual plan sites are of little to no benefit to patients. It is important that CMS collect these data directly and make them publicly available on a single website, like other performance measures**.**

Further, we encourage CMS to create mechanisms whereby this data is used to guide oversight and enforcement activities. This would help ensure compliance with CMS rules, which have direct impacts on patient access to care and outcomes. Accordingly, we recommend that CMS regularly audit a sample of plan denials and timeframes, as well as use the data to target potentially problematic plans. Without this level of detailed auditing, there will be ample opportunity for certain health plans to continue circumventing federal rules without detection, rendering the proposed patient transparency efforts and protections ineffective. Moreover, this will enable meaningful change to take place where it is needed most.

Incentivizing Provider Use of Electronic Prior Authorization. Hospitals and health systems are eager to adopt and use technology that improves the safety, quality and efficiency of care. Generally, in instances where adoption is slower, it is due to excessive financial cost or workforce burden that cannot be borne by the provider at that time. While we understand CMS' desire to incentivize the use of the PARDD API, we believe utilizing a heavy-handed regulatory lever, such as the hospital Promoting

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Interoperability Program, is unnecessary. Given the already significant draws on limited IT resources for hospitals, health systems and clinicians, the burden of reporting the measure likely would outweigh the benefit of its use. If CMS is intent on moving forward with the inclusion of a measure reflecting provider use of the PARDD API, we encourage CMS to create an attestation-only measure to mitigate provider burden.

We thank you for the opportunity to comment on these important topics. We particularly appreciate CMS' thoughtful proposals to alleviate provider burden and improve patient care and access and appreciate your consideration of our recommendations. **We urge CMS to expeditiously finalize the Advancing Interoperability and Improving Prior Authorization Processes proposed rule and adopt our recommended modifications to improve timeliness standards and develop enforcement mechanisms to ensure payer accountability.**

Sincerely,

Wendy D. Darwell
President and Chief Executive Officer

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