The Hospital + Healthsystem Association of Pennsylvania

Leading for Better Health

March 13, 2023

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 0057-P
P.O. Box 8013
Baltimore, MD 21244-8013

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 235 member hospitals, health systems, and other health care organizations, The Hospital and Healthsystem Association of Pennsylvania (HAP) is grateful for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Advancing Interoperability and Improving Prior Authorization Processes proposed rule. Our members range from large academic medical centers in urban areas, to small critical access hospitals in rural Pennsylvania.

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.

While CMS' proposals are all critical steps forward in advancing patients' timely access to care and easing administrative burden, HAP strongly urges CMS to provide the enforcement and oversight necessary to ensure health plan compliance and facilitate meaningful change. In addition, while hospitals and health systems appreciate CMS' effort to improve the electronic exchange of care data to reduce provider burden and streamline prior authorization processes, we urge CMS to ensure that electronic standards are adequately tested and vetted prior to mandated adoption.

Inclusion of Medicare Advantage

HAP applauds 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. This increased volume

also serves to stimulate provider implementation of these new standards. Inefficient prior authorization processes cause administrative burden for providers and inappropriate care delays for patients, and providers are eager to adopt more streamlined approaches.

Pennsylvania passed Act 146 of 2022 to address prior authorization delays and barriers for Medicaid (MA), the Children's Health Insurance Program (CHIP), and commercial insurance patients; HAP and our members are pleased to see that CMS is now addressing these issues with MA plans.

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. **HAP urges 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. The current administrative process is cumbersome at best, and often requires several back and forth exchanges between the plan and provider before an authorization can be obtained. This process can take weeks and months, and all the while the patient is waiting for care. **Considering these burdensome realities, HAP strongly supports 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 needed transition to electronic prior authorization. Nonetheless, implementing new technology can be extremely resource-intensive for hospitals.

HAP believes more testing is necessary to ensure the maturity of the API and to create the data needed to show providers that the investments and workflow changes needed to implement this solution will result in the projected process improvements. This is particularly true amidst the extreme financial strain that the ongoing pandemic has placed on hospitals. We fully support the ongoing development to ensure that the technology meets industry need and 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

HAP appreciates CMS' proposal to require impacted payors 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 patient. This proposal would help address a significant problem in the field, as providers and patients often are left without adequate explanation as to why a prior authorization request was denied. It also would be consistent with requirements included in the Pennsylvania legislation for Medicaid, CHIP, and commercial insurers. **HAP supports this proposal and encourages CMS to establish enforcement mechanisms to ensure that plans are compliant with its requirements.**

Timeliness Standards

While we appreciate CMS' focus on reducing prior authorization timelines, the proposed timeframes are unreasonably lenient. Unlike other transactions between a provider and health plan, prior authorization has a direct impact on patient care. A prior authorization request is often the final step between a patient and the initiation of their care, making expeditious processing of such transactions extremely important. Current prior authorization practices have been shown to cause significant delays in care, frequently leading to negative clinical outcomes for patients.

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. **HAP recommends 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

HAP strongly supports CMS' proposal to require plans to report prior authorization process metrics. We believe that by requiring plans to report such metrics, the rule promotes much needed transparency and the opportunity to build accountability. While there is a significant amount of research that establishes the burden that inefficient prior authorizations have on patients and providers, there are limited resources available for determining particularly problematic plans.

Plan prior authorization metrics buried on individual plan sites add little to no benefit to patients. Instead, we believe it is important that CMS directly collect these data 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. Again, this would be consistent with some requirements that Pennsylvania passed during 2022 for Medicaid, CHIP, and commercial

plans. Accordingly, **HAP recommends 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. However, regular auditing coupled with enforcement action 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 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. **HAP urges 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 payor accountability.**

Sincerely,

Jolene H. Calla

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