March 10, 2023

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

Submitted electronically

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 our 26 acute care hospitals and our five specialty hospitals, the New Hampshire Hospital Association (NHHA) appreciates 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.

In addition to our comments below, we support the detailed comments submitted by the American Hospital Association.

While CMS' proposals are all critical steps forward in advancing patients' timely access to care and easing administrative burden, we urge 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.

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Inclusion of Medicare Advantage in the Rule
NHHA 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. Providers are eager to adopt more streamlined approaches. Currently, many of the MA plans' prior authorization procedures create barriers to timely transitions to post-acute care services. Perhaps most concerning is for patients who have suffered a stroke. Evidence based guidelines recommend acute rehab for stroke patients **as soon as possible** in order to maximize neuroplasticity of the brain in the recovery practice. However, all MA stroke cases must go through inefficient and cumbersome authorization processes which delay transfers for up to 10 days, which is medically unacceptable.

Standardized, electronic prior authorization transactions have the potential to save patients, providers, and utilization review entities significant time and resources while also reducing delays in the care delivery process. **We urge CMS to finalize the proposal to include MA plans.**

Improving Prior Authorization Processes
Current prior authorization policies burden providers and divert valuable resources from patient care. The administrative process associated with prior authorization of post-acute care by the MA plans **typically adds up to four days to hospitalization and even more if the request is initiated on a Friday or weekend.** Each prior authorization request requires hours of staff time to demonstrate medical necessity to the MA plan. These delays contribute to a decline in the patient's condition and waste costly 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 needed transition to electronic prior authorization. Nonetheless, implementing new technology can be extremely resource-intensive for hospitals. We believe 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.[1] 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.

[1] https://www.nhha.org/wp-content/uploads/2023/02/NH_Hospitals_Face_Difficult_2023_FINAL.pdf

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Reason for Denial of Prior Authorization
NHHA appreciates 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 patient. This proposal would help address a significant problem in the field, as providers and patients are often left without 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
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. Prior authorization has been shown to cause significant delays in care, frequently leading to negative clinical outcomes for patients. Time is of the essence for patients in need of medical procedures or for post-acute care. The administrative delay preventing patients from obtaining timely, medically necessary care negatively impacts MA beneficiaries. Further, in the case of authorization delays for post-acute care, it also means that other patients in need of that acute care bed cannot be served. While delays in patient transitions from acute care to a post-acute care setting have always been a concern, they have been particularly egregious since the onset of the COVID-19 pandemic as hospitals have been dealing with unprecedented occupancy rates.[2] These unnecessary delays negatively impact patients and add unnecessary strain on an overburdened healthcare system.

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
NHHA 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.**

[2] Barriers-to-Discharge-2022-FINAL-1.pdf (nhha.org)

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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 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.

Prior Comments

We appreciate CMS' continued focus on MA plans. As we stated in our comments on proposed rule, ***CMS-4201-P – Medicare Program; Contract Year 2024,*** that closed for comment February 13, 2023, we are extremely concerned with MA plans' expansive use of prior authorizations. We wish to reiterate our support CMS' efforts to reduce non-clinical barriers to care and requirements for MA plans to adhere to Traditional Medicare coverage policies.

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.** If you have any questions, please feel free to contact me or Brooke Belanger, Vice President, Financial Policy and Compliance at (603) 415-4253 or bbelanger@nhha.org.

Sincerely,

Steve Ahnen
President

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