ALLIANCE of SAFETY-NET HOSPITALS

info@safetynetalliance.org
(703) 444-0989
safetynetalliance.org
21351 Gentry Dr, Ste 210, Sterling, VA 20166

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Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Subject: Centers for Medicare & Medicaid Services, 42 CFR Parts 422, 431, 435, 438, 440, and 457; Office of the Secretary; 45 CFR Part 156 [CMS–0057–P], RIN 0938–AU87 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

Attention: File Code CMS-0057-P

To Whom it May Concern:

I am writing on behalf of the *Alliance of Safety-Net Hospitals,* a group of private community safety-net hospitals that serve economically disadvantaged and underserved communities, to convey to the Centers for Medicare & Medicaid Services (CMS) our views on selected aspects of a proposed rule that would establish new requirements for Medicare Advantage organizations, state Medicaid fee-for-service programs, state Children's Health Insurance Program (CHIP) fee-for-service programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plans on the federally facilitated exchange. The stated purpose of this proposed regulation is to improve the electronic exchange of health care data and streamline processes related to prior authorization while improving interoperability. The proposed rule also would add a new measure for eligible hospitals and critical access hospitals under the Medicare Promoting Interoperability Program and for Merit-based Incentive Payment System (MIPS)-eligible clinicians under the Promoting Interoperability performance category of MIPS. This proposed rule was published in the *Federal Register* on December 13, 2022 (Vol. 87, No. 238, pp. 76238-76371).

The Alliance of Safety-Net Hospitals (ASH) would like to bring to your attention our views on two aspects of the proposed rule: improving prior authorization processes and establishing an electronic prior authorization measure for MIPS-eligible clinicians and eligible hospitals under the Medicare Promoting Interoperability Program.

Improving Prior Authorization Processes

In the proposed rule, CMS calls for requiring affected payers to build and maintain a prior authorization requirements, documentation, and decision application programming interface (API) that would automate the prior authorization process for providers by automatically compiling some of the necessary data; help the provider determine whether prior authorization is required; identify prior authorization information and documentation requirements; and facilitate the exchange of prior authorization requests and decisions from the provider's electronic health record or practice management system. ASH supports this proposal in concept but urges CMS to ensure that the documentation requirements are not excessively burdensome for providers. Providers have learned from experience that plans often make unreasonable documentation requirements that delay providers' ability to deliver the care their patients need in a timely and medically appropriate manner. In ASH's view, review should be limited to the diagnosis and whether the patient's condition meets criteria for approval – and no other considerations. In keeping with this concern, ASH also urges CMS to require payers to use criteria developed by professionals with the education and experience needed to play such an important role in this process and that these criteria be subject to regular review, again by experts.

The proposed rule also calls for requiring payers to provide a specific reason for denying. ASH supports such a requirement and thanks CMS for proposing it.

CMS attempts to address another important aspect of the prior authorization process by requiring payers – not including plans on the exchange – to make and transmit their prior authorization decisions within 72 hours of expedited requests and seven calendar days for standard requests. While ASH supports requiring payers to meet specific time limits for making and sending their prior authorization decisions, we strongly oppose these particular time parameters: in our view, 72 hours for expedited requests and seven days for standard requests are both entirely too long. Instead, we urge CMS to adopt a standard of a 24-hour response for expedited requests and 48 hours for standard requests; further, we urge CMS to introduce this same standard for exchange plans as well. Too often we have seen delayed responses to prior authorization requests jeopardize the health of community safety-net hospital patients and believe a more expedited process would constitute a major step toward addressing and even solving this problem.

The proposed rule also calls for providers, when they do not receive prior authorization decisions in a timely manner – regardless of the time parameters ultimately decided – to reach out to payers to ascertain the status of unaddressed requests. ASH believes this proposal is insufficient, that it does nothing to compel payers to play their part in this vital process in a timely manner. Patients' health and in some cases patients' lives are at stake, and for this reason, ASH urges CMS to include in its final regulation a provision that bypasses this step in favor of establishing a standard that any prior authorization request that does not receive a response in the stipulated period of time – and as noted, our preferred parameters are 24 hours for expedited requests and 48 hours for all others – automatically stand approved for action by providers. This, we believe – again, based on our hospitals' experiences with payers – is the only way to compel payers to play their part in the delivery of care to people who are entrusting us, and those payers, with their health and care.

Electronic Prior Authorization Measure

Another CMS proposal designed to improve the prior authorization process would be a new electronic prior authorization measure for MIPS-eligible clinicians, eligible hospitals, and critical access hospitals under the Medicare Promoting Interoperability Program. This measure would quantify how many prior authorization

requests for medical items and services are made electronically through a prior authorization requirements, documentation, and decision API using data from certified electronic health record technology. ASH supports this proposal.

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ASH appreciates the opportunity to submit these comments and welcomes any questions you may have about them.

Sincerely,

Ellen Kugler, Esq.

About the Alliance of Safety-Net Hospitals

The Alliance of Safety-Net Hospitals is a coalition of like-minded community safety-net hospitals without dedicated sources of public funding that work together to advocate policy decisions on government health care programs, most notably Medicare and Medicaid, that ensure equitable access to care for the medically vulnerable residents of the communities they serve and adequate public resources for the safety-net hospitals that serve those communities.