March 13, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: 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 Proposed Rule [RIN: 0938-AU87]

Dear Administrator Brooks-LaSure:

On behalf of the American College of Physicians (ACP), we are pleased to share our comments on the Centers for Medicare & Medicaid Services' (CMS) notice of proposed rulemaking regarding advancing interoperability and improving prior authorization processes. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 160,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP has long supported CMS' goal of expanding interoperability in the healthcare system through improvements to the electronic exchange of healthcare data and the streamlining of processes related to prior authorization. These concepts are consistent with ACP's *Patients Before Paperwork* initiative, which seeks to reinvigorate the patient-physician relationship and improve patient care by challenging unnecessary practice burdens. The current processes for prior authorization approval are burdensome and costly for physician practices and can take time away from patient care. These issues are exacerbated by individual payers, each of whom have their own approaches, rules, and requirements for prior authorization. Studies show the average annual cost for prior authorization approval on primary care practices ranged from $2,161 to $3,430 per full-time physician. These issues are of great concern to all practicing physicians, but they're particularly burdensome for smaller practices that may not have the staff or workflows available to address the additional administrative work, potentially impeding access to care in underserved areas with clinician workforce shortages. Furthermore, there may be situations where prior authorization requests are unnecessary and could be eliminated altogether. ACP urges CMS and HHS to consider instances where the drain on resources from prior authorization could be avoided from the outset and to consider opportunities for related rulemaking.

The College has advocated strongly in favor of standardizing and streamlining prior authorization processes over the years. In a 2015 policy paper, *Putting Patients First by Reducing Administrative Tasks in Health Care*, ACP advocated that, "Administrative tasks that cannot be eliminated from the health care system must be regularly reviewed, revised, aligned, and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved[.] Payers, public and private oversight entities, and vendors and suppliers must work together and actively engage with clinician societies and frontline clinicians to harmonize their administrative policies, procedures, processes, and forms regarding such issues as prior authorizations, payment reviews, reporting requirements, and others." The College has also repeatedly voiced support for the Improving Seniors Timely Access to Care Act, first introduced in 2019, which would simplify the prior authorization process to determine if a prescribed procedure, service, or medication is covered by a health plan in Medicare Advantage (MA).

ACP believes health information technology (IT) can and should be an integral tool in facilitating burden reduction, including sharing useful and meaningful electronic health information and streamlining the prior authorization process. The adoption and consistent implementation of standards would help reduce variability across electronic health records (EHRs) and health IT systems – and ACP commends CMS for helping to move the policy needle in this direction. The College has advocated for increased interoperability and consistent standards adoption through our 2022 feedback on electronic prior authorization standards to the Office of the National Coordinator for Health Information Technology (ONC), as well as in our comments on CMS' 2022 proposed rule, *Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information*. ACP believes it is crucial for stakeholders within healthcare to be united on how to reduce prior authorization burden, including vendors being willing to incorporate new functionalities into their systems and organizations having the necessary resources to implement those functionalities in a timely way.

The College urges CMS to foster and incentivize the development of systems that would provide timely responses to physicians from payers regarding prior authorization. ACP commends CMS for several aspects of this proposed rule, including requiring many federal health care programs to implement specific processes intended to improve the electronic exchange of health care data and streamline prior authorization systems. The College also supports the proposal to require covered payers to implement electronic prior authorization standards and to better utilize and share patient data to streamline prior authorization processes. Additionally, ACP strongly supports the proposal to require covered payers to provide a specific reason when a prior authorization request is denied and to adhere to specific time frames depending on the urgency of the request, though the College believes the proposed time frames are too lenient and should be shorter for the sake of patient care and welfare. ACP also believes the proposals, if finalized, can and should be implemented even earlier than the proposed effective date of January 1, 2026. Separately, the College supports proposed payer rules that would enable and facilitate a longitudinal health record, if a patient opts in to sharing their data.

Patient Access Application Programming Interface (API)

ACP is disappointed that CMS' proposals apply to neither Medicare Fee-for-Service (FFS) nor drugs. The College fears these omissions will render the proposals less effective. For the proposed rule to meaningfully alleviate the high levels of prior authorization burden our members experience, ACP urges CMS to expand the rule's applicability to include Medicare FFS and drug prior authorization requests.

Ultimately, the College wishes to strongly emphasize the need for public and private payers to follow a unified process when it comes to prior authorization requests. Any variation between public and private

payers' prior authorization processes will create too much confusion and additional work for already severely overburdened clinicians.

Provider Access API

ACP believes that clinicians should have access to their patient's clinical data irrespective of payer contracts, to the extent permitted by law, when a verifiable patient-physician relationship exists. It is important for internal medicine physicians to have a complete picture of their patients' health and treatment history—and therefore all relevant clinical data—to be able to effectively diagnose and treat them. This access must be patient-centric, however, and the College encourages the use of existing HIPAA-compliant systems to determine whether a patient-physician relationship exists.

Improving Prior Authorization Processes – *Prior Authorization Time Frames*

There is a need for real-time decisions with respect to prior authorization requests, as receiving a response to a prior authorization request after the patient has left the office causes additional, unnecessary administrative work outside of the patient visit and can delay appropriate treatment for the patient. A timely response at the point of care is integral to streamlining this process. Additionally, CMS should require that if the payer's response is a negative coverage decision, the response should be required to include precisely what documentation is needed from the clinician in order for the payer to reverse the decision. This is similar to step therapy and nonmedical drug switching policies, which can also monopolize time and practice resources with lengthy appeal and exception request policies that can further delay patient treatment. For prior authorization to be most useful to the clinician, decrease burden, and improve patient care, the response from the payer must contain actionable information so the clinician can either easily provide any missing information or provide a clinically appropriate alternative to the initial prescription. Furthermore, ACP opposes prior authorization requirements for "wet" instead of digital signatures.

ACP supports the idea of displaying standardized responses for clinicians to select (e.g., a drop-down menu with options such as, "Patient failed X alternative drug" or "Patient has X co-morbidity, necessitating this drug"). Additionally, when a payer issues a denial, they should be required to provide a list of generic/alternate drugs that would be covered under the patient's insurance plan.

As noted, ACP strongly supports the proposed rule requiring covered payers to provide a specific reason when a prior authorization request is denied. While the College appreciates CMS proposing firm time limits for prior authorization decisions, we believe the proposed limits of 72 hours for urgent requests and seven calendar days for nonurgent requests should be shorter. ACP instead supports limits of 24 or 48 hours for urgent requests and five calendar days for nonurgent requests.

ACP greatly appreciates the opportunity to share our perspective and provide feedback on advancing interoperability and improving prior authorization processes to improve the healthcare system for all stakeholders, particularly physicians and patients. The College continues to welcome partnership with CMS and Congress to enhance regulatory policies and inform future rulemaking and legislation to improve prior authorization processes.

Sincerely,

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