March 13, 2023

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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

Submitted electronically via: Regulations.gov

Ms. Brooks-LaSure:

My name is Gerard Isenberg, MD, and I am President of the Academy of Medicine of Cleveland and Northern Ohio (AMCNO) and a practicing gastroenterology physician at a major health system in Cleveland.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO), founded in 1824, is the region's professional medical association and the oldest professional association in Ohio. We are a non-profit 501(c)6 representing physicians and medical students from all the contiguous counties in Northern Ohio. On behalf of our 6,000 members. I thank you for the opportunity to comment on changes in prior authorization requirements.

The current prior authorization system in the United States is extremely laborious, and a huge administrative burden for physicians, one that delays necessary care for patients. We applaud the administration for looking to reform this onerous system. As an organization representing physicians, we are particularly worried about the burden the prior authorization system places on our physicians, particularly amid workforce shortages and an epidemic of health care worker burnout.

Indeed, the prior authorization system has become so intensive that 40% of physicians report having staff who work exclusively on prior authorizations.[1]

[1] https://khn.org/news/article/prior-authorization-patient-frustration-federal-regulations/?utm_campaign=KHN%3A%20Daily%20Health%20Policy%20Report&utm_medium=email&_hsmi=249976452&_hsenc=p2ANqtz-9y3RFTjtivM8SllkIUndH6mpuasSQsw69PHYp7l0whp0rJIj7wzKwSxeZGFzYtq11cAWEJ1wNJUD1tFHoQFCOArp4tzQ&utm_content=249976452&utm_source=hs_email

Beyond the issues of burnout, prior authorization causes increased costs to the system, and serious consequences for patients and their health. Indeed, we know that colon cancer rates are increasingly in the United States, particularly amongst younger people, and at more advanced stages of the disease[2]. Incredibly, at the same time, United Healthcare recently announced it would be establishing prior authorization requirements for all diagnostic colonoscopies effective June 1, 2023[3].

While we understand the proposed changes by CMS apply only to government-sponsored insurance, we hope this example illustrates that often the most damaging side effect of this broken unchecked system is the impact it has on our patients, some of whom must delay care substantially while waiting for prior authorization approvals.

We applaud the administration for proposing to streamline prior authorizations for CMS-governed health plans, specifically by leveraging the electronic exchange of health care information. It is a significant step in reducing unnecessary barriers to patient care and providing administrative relief.

As proposed, beginning January 1, 2026, CMS would require impacted payers to include information about prior authorization requests and decisions via the Patient Access Application Programming Interface (API), no longer than one business day after the payer receives a prior authorization request or there is a status change to a prior authorization. We support this change. **We also recommend the administration create uniform standards for prior authorization across plans**. Because prior authorization rules vary by different payers, physicians spend significant time navigating inconsistent workflow processes and submission of additional required and differing information. A uniform standard would greatly increase efficiency and reduce burden and cost.

The proposed rule also states that starting in 2026, plans must respond to a standard prior authorization request within seven days, typically, instead of the current 14, and within 72 hours for urgent requests. While we appreciate the shortening of this time period, we encourage the administration to considering shortening the time period further, as in cases like cancer[4], even a 7 day delay in care can have devasting effects. With the increased efficiencies provided by the API and the standard prior authorization request, there is no reason plans need 7 days to approve medically necessary procedures. **We recommend that CMS require all payers to deliver prior authorization decision notifications within 72 hours for standard requests and 24 hours for expedited, urgent requests.**

---

[2] https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21772

[3] https://urldefense.com/v3/__https:/gi-org.lt.acemlna.com/Prod/link-tracker?redirectUrl=aHR0cHMlM0ElMkYlMkZ3d3cudWhjcHJvdmlkZXIuY29tJTJGZW4lMkZyZXNvdXJjZS1saWJyYXJ5JTJGbmV3cyUyRjIwMjMlMkZuZXctcmVxdWlyZW1lbnRzLWdhc3Ryb2VudGVyb2xvZ3ktc2VydmljZXMuaHRtbA==&sig=42Ge7rY5HvrYzpsb9828Jcax4WAg7oJ5HbUxjJSorDB7&iat=1678536179&a=*7C*7C90816434*7C*7C&account=gi-org*2Eactivehosted*2Ecom&email=aMMoWUMqFBUvXUV6hL7QywMP3*2BeE*2FwtD3mwdxptkmbmQfcF7aKgeVBNLFZmUcqE*3D*3Agmv0DLM4KD1trujeSaNlUs1iUfDzjRmc&s=548dadca3fe7ec878b41e9deb3eabc43&i=1105A1217A6A15014__;JSUlJSUlJSUlJQ!!IuDQRY6mOWG9IlqcpA!WSTtTS_TFfoYpFx7smiybWVoGXE76X1g6GCRDHZ0dZFv-eWHOTE0cnwganNKhFoPHs4k9W_QJjdxOPrekgŚ

[4] https://www.gynecologiconcology-online.net/article/S0090-8258(22)01858-3/fulltext

Doctors do not close their offices or hospitals during patient emergencies, and insurance companies responsible for insuring patient lives should not be able to abandon their members in times of urgent need. Finally, we recommend “hours” be used as a more appropriate way to establish time versus “days,” as days could be easily misinterpreted as business days.

Creating a streamlined process will allow physicians to spend more of their time doing what propels them—taking care of the patients who need them. As physicians we take an oath—do no harm—and we ask that you implement these proposed changes and continue to address the burden of prior authorization process to allow us to do just that.

Thank you again for the opportunity to comment on this important issue.

Sincerely,

Gerard Isenberg, MD