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March 8, 2023

The Honorable Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

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 [CMS-0057-P]

Dear Administrator Brooks-LaSure,

On behalf of The Society of Thoracic Surgeons (STS), I write to provide comments on Advancing Interoperability and Improving Prior Authorization proposed rule issued by the Centers for Medicare & Medicaid Services. Founded in 1964, The Society of Thoracic Surgeons is a not-for-profit organization representing more than 7,600 surgeons, researchers, and allied health care professionals worldwide who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lungs, and esophagus, as well as other surgical procedures within the chest.

Provider Access API for Individual Patient Information

CMS proposes that beginning January 1, 2026, it would require impacted payers to implement and maintain a FHIR API that makes patient data available to providers who have a contractual relationship with the payer and a treatment relationship with the patient. The Provider Access API would enable current patients' information to be exchanged from payers to providers that are in that payer's network, at the provider's request.

STS supports this proposal and believes that providers should have access to a patient's health information, without technological barriers, to help produce better outcomes.

Reason for Denial of Prior Authorization

CMS proposes that, beginning January 1, 2026, impacted payers would be required to provide a specific reason for denied prior authorization decisions, excluding prior authorization decisions for drugs, regardless of the method used to send the prior authorization request.

STS supports the CMS proposal to require payers to provide specific reasoning for denials to help address issues in access to care caused by prior authorization. Utilization management tools such as prior authorization have a large impact on the availability and outcome of care. For patients and providers prior authorization requirements can cause unnecessary burden, care delays, and negative outcomes. A recently published survey from the American Medical Association (AMA) found that more than four in five physicians (82%) said patients abandon treatment due to authorization struggles with health insurers. A Kaiser Family Foundation analysis found Medicare Advantage plans denied two million prior authorization requests in whole or in part, representing about 6% of the 35 million requests submitted in 2021. While about 11% of denials were appealed, the vast majority (82%) of appealed denials were fully or partially overturned, raising serious concerns about the appropriateness of many of the initial denials.

If insurers are going to continue to use prior authorization as a utilization management tool, they need to provide more transparent information to patients and providers to make the process easier to navigate.

Proposals to Address Timeframes for Decisions on Standard and Expedited Prior Authorization Requests

To address prior authorization decision timeframes, CMS proposes to require, beginning January 1, 2026, that MA organizations and applicable integrated plans, Medicaid FFS programs, and CHIP FFS programs must provide notice of prior authorization decisions as expeditiously as a beneficiary's health condition requires (for CHIP FFS, alternatively stated as in accordance with the medical needs of the patient), but no later than 7 calendar days for standard requests. Medicaid FFS and CHIP FFS programs must provide notice of prior authorization decisions as expeditiously as a beneficiary's health condition requires (for CHIP, alternatively stated as in accordance with the medical needs of the patient), but no later than 72 hours for expedited requests unless a shorter minimum time frame is established under state law.

Prior authorization requirements have proven to cause delays in care and have led to worse health outcomes. In the AMA's recently published survey, data shows that 93 percent of physicians report care delays or disruptions associated with PA and that 34 percent of physicians report that PA has led to a serious adverse event (e.g., hospitalization, permanent impairment, or even death) for a patient in their care. The survey also showed 91 percent of physicians see PA as having a negative effect on their patients' clinical outcomes. **STS supports the proposal to improve the response time for PA requests, however, we feel that payers should be held to more rigorous response time standards.** According to the AMA, many states, including Alaska, Colorado, and Illinois, require that non-emergency response times are 72 hours and expedited requests are returned within 24 hours. Additionally, this timeline would maintain consistency with H.R. 3173, the Improving Seniors' Timely Access to Care Act of 2021, which advanced the House of Representatives in the last Congress. We believe the use of electronic PA to accelerate the process should enable payors to accommodate a faster turn around time, which would allow for patients and providers to avoid delays in care and possible negative outcomes.

Thank you for the opportunity to provide these comments. Please contact Molly Peltzman, Associate Director of Health Policy, at mpeltzman@sts.org or 202-787-1221 or Derek Brandt, Vice President of

Government Relations at dbrandt@sts.org or 202-787-1223 should you need additional information or clarification.

Sincerely,

Thomas E. MacGillivray, MD
President