Ohio State Medical Association

Bringing physicians together for a healthier Ohio

March 13, 2023

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

Re: File Code 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 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 the Ohio State Medical Association (OSMA), the state's oldest and largest professional organization representing Ohio physicians, medical residents, and medical students, I am pleased to submit comments on the Centers for Medicare and Medicaid Services ("CMS"} proposed rule concerning electronic prior authorization and electronic exchange of healthcare data, published in the Federal Register on December 13, 2022 (87 Fed. Reg. 76238) ("*Proposed Rules*"). OSMA is encouraged by the improvements to the prior authorization process promulgated by CMS in this rule. According to the American Medical Association ("AMA"), 93% of physicians report that the current state of the prior authorization process cause delays in care, 82% report that prior authorization can lead to treatment abandonment, and 51% report that prior authorization has interfered with patient's ability to resume their job duties. It's clear the prior authorization process hurts patients. AMA also states that physicians and staff spend nearly two business days a week on prior authorizations, and 40% of physicians report hiring staff to solely handle prior authorizations in their practice. It's clear that prior authorization is unnecessarily costly and hurts private practice physicians and their staff.

One of the biggest concerns voiced by physicians regarding patient care is the turnaround times of prior authorization decisions. As indicated above, unnecessarily long approvals or denials cause delays in care to patients, in turn creating potential for working or additional conditions of the patient's health. OSMA is encouraged by the

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shortened time frames required for impacted payers to send prior authorization decisions, specifically 72 hours for an urgent request and seven days for a standard request. *Proposed Rules*, at page 76296. We note, however, that even under these time frames that patient care will continue to be hurt. We suggest, as does AMA, that urgent requests should have a 24 hour time frame, and standard requests should have a 48 hour time frame. This would allow for appropriate time to begin treatment or medical services if the request is approved, and the engagement of other treatments or services should the request be denied.

OSMA is also encouraged by the provisions in the rule requiring additional transparency of data surrounding decisions of prior authorizations. *Proposed Rules*, at page 76292. It is important both for the patient and physician to receive the same information from the impacted payer as to the reasoning for a denial of prior authorization. Proper patient care relies on the ability for the patient and physician to communicate clearly about potential treatments and services, and lack of clear reasons and basis of denial of a prior authorization request to both the patient and the physicians. OSMA encourages CMS to require identical information on a denial to be sent to both the patient and the physician.

OSMA commends CMS for inclusion of provisions that require aggregate metrics from impacted payers to be reported publically, such as listing items and services requiring prior authorization, percentages of approved and denied prior authorization decisions, average and median processing times prior authorization requests, among other metrics. *Proposed Rules*, at page 76304. We, like the AMA, encourage CMS to consider requiring plans to include more detailed metrics such as categories of items and services so that physicians can determine which items and services will require prior authorization as compared to that physician's specialty. OSMA also encourages CMS to require plans to produce these metrics in a central location rather than on the plan website, allowing for ease of patient and physician access.

Finally, retroactive denials of prior authorization create big problems for patient care. It is unacceptable that a patient receive an approval of a prior authorization request, the physician and patient going down the path of engaging in that requested treatment or service, only to find that later in time that treatment or service has been changed to a denial. Patients deserve to know that once they have been approved for a treatment or medical service, that they can count on engaging that treatment or service to improve their health. In the same vein of delayed decisions, if a request will be denied, it is crucial to patient's health to determine alternative treatment or services as soon as possible to avoid poor health outcomes. OSMA encourages CMS to consider prohibiting these retroactive denials.

Again, OSMA appreciates the opportunity to comment on this very important rule. Please do not hesitate to contact us if we can provide any additional information or input.

Sincerely,

Todd Baker
Chief Executive Officer