March 13, 2023

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
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)

The National Health Care for the Homeless Council (NHCHC) is a membership organization representing HRSA-funded Health Care for the Homeless (HCH) health centers and other organizations providing health care to people experiencing homelessness. Our members offer a wide range of services to include comprehensive primary care, mental health and addiction treatment, medical respite care, supportive services in housing, case management, outreach, and health education, regardless of an individual's insurance status or ability to pay. Last year, 300 HCH programs served approximately 1 million patients in over 2,000 locations across the country. **As a network of health care providers caring for very vulnerable adults, children, and families, we appreciate the significant impact this rule would have on our patients' ability to access the care they need.** We work every day to meet our patients where they are so they have a chance at escaping homelessness.

Thank you for the opportunity to comment on the *Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule.* **Our comments focus solely on the Prior Authorization Process section of the proposed rule because of the specific impact—and critical importance—these measures have for the care provided in the Health Care for the Homeless community.** For comments on other sections of the rule, specifically on Patient Access API and Provider Access API, we endorse the comments submitted by our partner, the National Association of Community Health Centers (NACHC).

The prior authorization process is a barrier to care for many of our patients and serves as nothing more than bureaucratic red tape for providers trying to care for a very vulnerable population. People who are homeless have unique challenges to accessing health care, most specifically because they are focused on meeting their basic daily needs such as food, shelter, and safety. Accessing health care is understandably secondary to these needs, yet is also challenging due to a lack of access to transportation, paid leave from employment, or a host of other factors. **Important to this rule, cumbersome health insurance rules alienate patients and make it harder for them to access care, even when they have insurance and a regular health care provider.** This can

have deadly consequences, especially for those struggling with substance use disorders and are at risk of overdose.

It is also vital to emphasize the ethnic/racial disparities that are inherent in the prior authorization process. Black, Indigenous, and People of Color (BIPOC) populations are already over-represented among those experiencing homelessness—and the health care system holds a significant responsibility for further compounding the discrimination based on housing status with a systemic alienation of people due to their race/ethnicity. **The structural barriers to care created by prior authorizations (as illustrated in this letter)—and the insistence on completing administratively burdensome steps—only continue current and historic trends to underserve BIPOC people.**

NHCHC supports many of the proposals in this proposed rule because of their intent to increase the efficiency of the prior authorization process by making it electronic. The standardization of the process across payers will cut down on the cumbersome process health centers have faced when trying to comply with differing prior authorization processes and forms. We appreciate these proposed changes and hope they will provide clarity for both patient and providers and are hopeful these changes will result in enhanced access to care for patients.

HCH PROVIDER PERSPECTIVES: Before responding to the specific questions contained in the rule, **it is important to more fully depict the administrative burden—and risks to patient health and well-being—that prior authorizations (PAs or "prior auths") pose to the Health Care for the Homeless community.** The following are direct responses from health care providers in the field *(note that extensive focus groups were held with staff at the Baltimore HCH program)*:

PERSPECTIVES ON PRIOR AUTHORIZATIONS FROM HCH HEALTH CARE PROVIDERS IN THE FIELD:

- **"**We have four FTEs just to handle prior authorizations. That's evidence of a problem itself." **~ Thomas Huggett, MD, MPH, Medical Director--Mobile Health, Lawndale Christian Health Center, Chicago, Illinois**

PATIENT STORY: PRIOR AUTHORIZATION BARRIERS TO BUPRENORPHINE

"I have been serving a 35-year-old woman living with PTSD related to a significant trauma history including the recent murder of her 17-year-old son this past fall. She has been in recovery from opioid use disorder for several years with the support of Suboxone and was able to sustain her recovery through this recent tragedy. She has been doing well on Suboxone with no relapses, misuse or early refills and has been taking it as prescribed. She was due for a refill last Friday. I spent over 2 hours on the phone trying to get through for the prior authorization on the Wednesday before and confirmed the PA was approved. Unfortunately, my patient went to the pharmacy to get the medication, was told it required a PA, and was unable to obtain her Suboxone. Over the weekend her withdrawal symptoms worsened (nausea, vomiting, diarrhea, muscle aches, chills) and she was seen in the hospital for withdrawal management. Overall, this resulted in medical complications, jeopardized her sustained recovery, and risked the trust and confidence she had in her psychiatrist. In the end, I was told that while my PA had been approved, they had *forgotten* to cancel the previous one which had a few days remaining on it. It wasn't enough for the refill but enough to interfere with the new PA. **Prior authorizations interfere with care, jeopardize a person's well-being, and add a significant administrative burden to providers.**"

~ Jamie Spitzer, MD, Psychiatrist, Health Care for the Homeless, Baltimore, Maryland

- Pursing prior authorizations for patients who are homeless is time-consuming for the entire organization and compromises the care we provide. Perversely, the entire exercise only serves as a financial incentive for clinics to focus on more stable populations who are better able to navigate these administrative complexities. However, we are dedicated to providing timely, high-quality care to those most vulnerable, and it would be great if the larger health care system could support us better in that role. **~ Kevin Lindamood, MSW, President & CEO, Health Care for the Homeless, Baltimore, Maryland**
- "Clients experiencing homelessness do not get the care they need if a PA is required for service/prescriptions. Our team does not have a dedicated person working with PAs so often the process is lost on our staff and clients. Clients continue to access emergency and urgent care services, which often increases state/county payouts for their ongoing care." **~ Amy Gordon, DNP, NP-C, Hennepin County Healthcare for the Homeless, Minneapolis, Minnesota**
- It used to take 5 minutes to call and get a PA—but now it takes an hour+. You're on hold, you don't want to get out of line, and you have patients piling up. You're just a prisoner to the prior authorization system and that doesn't feel good. The outcome is rarely no—but it's just a waste of time and money for us as medical providers to spend our day doing this." **~ Meredith Johnston, MD, Director of Psychiatry, Health Care for the Homeless, Baltimore, Maryland**

PATIENT STORY: PRIOR AUTHORIZATION BARRIERS TO HEPATITIS C TREATMENT

"My patient is a 23-year-old Native man with newly diagnosed Hepatitis C virus. Current guidelines show early treatment of high-risk individuals reduces transmission rates. He was motivated and coming to clinic weekly for engagement. Unfortunately, he was denied treatment twice over two months due to the timing of his labs, and started to lose interest because he couldn't get care. I formally applied to appeal in the courts and was in process to share a statement on his behalf when he decided to move closer to family in northern Minnesota. During the 2-3-month denial process (with multiple appeals) we could have treated him successfully—but instead he moved north without treatment and is now a risk for Hepatitis C virus transmission to others. **I would like to see a waiver of prior authorizations for homeless patients to ensure timely treatment.**"

~ Amy Gordon, DNP, NP-C, Hennepin County Healthcare for the Homeless, Minneapolis, Minnesota

- "One of our insurance plans requires authorization for all consultations. Others use different online portals, and some insurances even use more than one portal! For example, one plan requires one portal for radiology prior auths and another for cardiac testing. Our team has to submit paperwork and answer questions in all these systems." **~ Kari Roland, Referral Coordinator Manager, Lawndale Christian Health Center, Chicago, Illinois**
- "The need for communication between all the entities—the patient, pharmacy, and plan—is so cumbersome and taxing. It takes a lot of provider time to do all this, and it's especially hard for patients experiencing homelessness, particularly when the insurer insists on direct patient communication." **~ Catherine Fowler, MPH, BSN, RN-BC, Director of Nursing, Health Care for the Homeless, Baltimore, Maryland**
- "We lose patients to care when we force them to continue through unnecessary tests just for the purposes of getting a prior authorization. Our determination that someone needs treatment is based on clinical assessment—and additional tests for authorization create barriers to necessary healthcare. Please let our patients have what they need." **~ Lynea Seiberlich-Wheeler, MSW, LCSW, Associate Director of Behavioral Health, West County Health Centers, Guerneville, California**
- "Prior authorizations are predicated on managing costs, but what about the harms that happen when people aren't able to access medications—what's the cost of that? When someone keeps going to the ED [emergency department] because they can't get their diabetes medication--are we thinking of the cost to the larger health care system? Are we considering the cost to the person's life and their health and wellness? What about the costs of health care providers' time? These never get factored into these conversations. When you have systems that don't work as they should, the reaction is to hire more folks to prop up a broken system—but that only maintains a bureaucracy that isn't working. **~ Lawanda Williams, MPH, LCSW-C, Chief Behavioral Health Officer, Health Care for the Homeless, Baltimore, Maryland**

- "I may know that an x-ray will give me no information, so I order a CT scan. But to get the authorization, my patient still needs to go through an x-ray before I can get them an MRI. Clinically there's no utility to getting that extra procedure (and extra radiation) when it's not relevant. If my patient is prioritizing their health over their basic needs by coming in to see me, I have to deliver care right then and there or they may never get care at all. We alienate patients with unnecessary tests." **~ Catherine Crosland, MD, Director of Homeless Outreach Development, Unity Health Care, Inc., Washington, DC**
- "There's no parity between behavioral health (BH) and medical visits when it comes to prior authorizations. For BH visits, we need to submit a lot of information, get an assessment and the right codes to request, and then wait for a response. Sometimes, we have to wait for the patient to be in front of us before all this is complete. However, for diabetes patients, they can come to a primary care visit without getting permission from the plan. Why is there a bottleneck just for behavioral health visits? We need to take the prior auth out so all patients can get quicker access to services they need—especially those with behavioral health conditions." **~ Muhammed Mamman, Director of Client Access, Health Care for the Homeless, Baltimore, Maryland**
- "My patient can get 10 CT scans in the ED so why am I the one that gets the runaround at an FQHC? We provide the best, most cost-effective care and spend so much less money than hospitals but we're the ones that always get the squeeze on prior authorizations. I would like to see FQHCs exempted from prior authorization requirements." **~ Courtney Pladsen, DNP, FNP-BC, RN, NHCHC Director of Clinical and Quality Improvement**
- "Our agency has four staff focusing on prior authorizations plus a lot of the providers do the authorizations themselves. The means to request an authorization can vary by plan and some use different terminology so it can be confusing. We often don't understand what we even need authorization for—and that requires more staff than we are able to hire. It's the #1 thing from a revenue perspective. As a non-profit agency, we lose a lot of time and money obtaining authorization and/or appealing denials. Hands down this is the biggest administrative burden. It needs to be uniform across all plans, and policies need to be implemented in a standard way across the board." **~ Chris Bloskey, Revenue Cycle Manager, Health Care for the Homeless, Baltimore, Maryland**
- "Prior authorizations are a highly ineffective use of provider time, especially in offices with one RN or MA [medical assistant], which creates delays in treatment, patients lost to follow-up care, and decreased medication adherence due to delay in prescription renewals (most frequently mental health medications). The basic challenge of high no-show rates for homeless populations means that all treatment is urgent and important, especially if I'm to establish trust with a patient and get them to follow up on care." **~ Regina Olasin, DO, FACP, FAAP, Chief Medical Officer, Care for the Homeless NYC, New York, New York**

Improvements to the Prior Authorization Process: Responses to CMS Questions

Prior Authorization Requirements, Documentation, and Decision (PARDD) API so providers can see which items and services may be subject to prior authorization and identify documentation requirements: We agree that having such a system will decrease provider burden by ensuring providers can preemptively gather documentation, hopefully expediting the prior authorization approval process. The PARDD API has the potential to alleviate provider burden in instances like these by providing transparency about which services may be subject to prior authorization.

PARDD API allowing payers to share with providers the status of the prior authorization request and whether the request has been approved or denied: We reiterate the importance of including prescription drugs in these proposals, including the PARDD API, given that providers have seen a dramatic increase in prior authorizations for prescription drugs. Having access to what documentation may be needed, or which drugs are subject to prior authorization, would enable providers to make better judgement calls when helping their patients. Lack of information on prescription drugs could create a chilling effect on providers recommending certain prescriptions as well. **We recommend CMS extend these positive PAARD API proposals to include prescription drugs, as this would expedite the entire prior authorization process as well.**

The burden of prior authorizations for prescription drugs specifically—and the barrier to timely care they specifically pose for patients experiencing homelessness are so significant that it prompted a strong response in focus group discussions with providers in the field.

The following is direct feedback on the issue of prescription drugs:

PERSPECTIVES ON PRIOR AUTHORIZATIONS FOR PRESCRIPTION DRUGS FROM HCH HEALTH CARE PROVIDERS IN THE FIELD

- "We call it 'the January surprise'—when a medication that a patient has been on for 10 years—and cost pennies—suddenly needs a PA. I spent four hours last week on hold for a buprenorphine PA. It was miserable. There are no words to spare when you can't get someone Suboxone when they are in withdrawal. If I can't provide same-day care, I might not see the patient again. I also can't miss a chance to give a long-acting injectable medication because I don't know when I'll get another chance with this patient. And if they don't get it, they end up in the ED and it costs more money—what's the sense of that?" **~ Meredith Johnston, MD, Director of Psychiatry, Health Care for the Homeless, Baltimore, Maryland**
- "I have been a MAT prescriber for about 5 years and I know that waiting on a prior auth to prescribe someone Suboxone can make a huge difference in their treatment success. Often people are seeing us in active withdrawal to get their first prescription and this is the most important time to engage them. If they are unable to get their meds that same day, most of them never end up coming back. It is a ridiculous hurdle to have when you are trying to prescribe literally life-saving medications for patients." **~ Samantha Cook, PA-C, Hennepin County Healthcare for the Homeless, Minneapolis Minnesota**
- "As a provider, prior authorizations compromise optimal care. For example, I might want to prescribe a medication for three times a day—which is clinically indicated—but it would require a prior auth. So now I might only prescribe for twice a day—which might be inadequate, but you won't be on the phone for two hours trying to get permission to give anything at all and risk the client leaving in frustration." **~ Anonymous, Health Care for the Homeless, Baltimore, Maryland**
- "Formularies change all the time. I'm willing to consider another medication but I can't keep up with the formulary changes and keep up with all the available drugs. Sometimes that's more cumbersome than filling out the form for a PA." **~ Colleen Ryan, RN, MSN, FNP-BC, Family Nurse Practitioner/Lead Clinical Provider, Heartland Alliance Health, Chicago, Illinois**
- "Our patients are caught in the crosshairs of system dysfunction. Prior auths are a barrier to the day-to-day care for diabetes and hypertension. Our clients often can't come back for another visit, and are confused why the pharmacy denied them. We take care of people with many different insurances and changing formularies—it's not possible for a provider to keep up with all that. It's also frustrating when we take an hour of staff time to get the authorization after the patient spent a day trying." **~ Iris Leviner, MD, Interim Senior Medical Director, Health Care for the Homeless, Baltimore, Maryland**
- "We've had patients die because they were told their insulin "wasn't covered" and they couldn't get it. It would be great if there's some way to automatically know what medication is approved and then have the pharmacy dispense that with a note to me so I know. A number of the insulins are the same so it's ridiculous to have to play this game." **~ Catherine Crosland, MD, Director of Homeless Outreach Development, Unity Health Care, Inc., Washington, DC**
- "Our patients don't get the medication from the pharmacy and often do not know why—and we don't find out about it until the next appointment. It would be great if the EHR can just automatically tell us that a prescription is covered or not covered. As a physician, I don't know the costs of the medications—and I shouldn't—but can't alternatives be automatically suggested to me? We absolutely need to remove PAs for buprenorphine and other immediate-need medications." **~ Tyler Gray, MD, Senior Medical Director - Community Sites, Health Care for the Homeless, Baltimore, Maryland**
- "Even in Massachusetts, every ACO or insurance plan has a different formulary. At the health center, there might be 15 different plans and those are all different and constantly changing. There's no standardization between plans, and

the docs can't know what's covered and what's not. **~ Brian Bickford, MA, LMHC, Central Mass PATH Regional Manager, Eliot Community Human Services, Worcester, Massachusetts**

- "There should be a prohibition on PAs for Suboxone—they are contrary to the federal goals to facilitate access to care." **~ Elizabeth Goldberg, CRNP, Psychiatric Nurse Practitioner, Health Care for the Homeless, Baltimore, Maryland**
- "Authorizations for prescriptions take a lot of time for nurses and medical providers—and PAs for referrals impede us from getting clients care in a timely fashion. You might be a month waiting on a referral authorization before you can even start the process of getting the appointment scheduled." **~ Mona Hadley, Senior Director of Practice Operations, Health Care for the Homeless, Baltimore, Maryland**

OUR REQUEST ON PRIOR AUTHORIZATIONS FOR PRESCRIPTION DRUGS

For the reasons outlined above, we not only request the CMS extend the current regulatory proposals to prescription drugs, but we further request that waivers be issued for obtaining prior authorizations for patients who are homeless. **Documenting a Z59.0 ICD-10 code (for homelessness) should waive the need for prior authorization—if only for prescription drugs—in order to eliminate barriers to timely care.** At a bare minimum, this should specifically extend to prescriptions for buprenorphine/Suboxone to reduce overdose deaths.

Expediting the prior authorization process for standard requests: We agree reducing the current timeline from 14 days to 7 days is a step in the right direction for standard requests; however, obviously the shorter timelines proposed (such as CMS' example of 48 hours (versus 72 hours) for an expedited prior authorization, and 5 days for standard requests) would be even better. Frankly, we believe that the vast number of prior authorizations should be eliminated altogether given they increasingly are for low/medium-cost services and because there's little evidence they effectively reduce costs while not compromising clinical care/outcomes. **We would like to see CMS require insurance plans to better justify the prior authorizations they currently require.** Similarly, there should be standardization on the appeals process across all plans.

PERSPECTIVES ON TIMELINESS OF PRIOR AUTHORIZATIONS FROM HCH HEALTH CARE PROVIDERS IN THE FIELD

- "A 3-7-day timeframe for PA requests is difficult with a patient population experiencing homelessness as they are often seeking care in the moment of crisis and cannot follow up as planned to determine if a PA was approved or denied. For us as providers, it is difficult to notify patients about PAs because they may not have a way to communicate with us—this is a significant barrier to completing a PA if it is approved (or working through an appeal if denied)." **~ Amy Gordon, DNP, NP-C, Hennepin County Healthcare for the Homeless, Minneapolis, Minnesota**
- "We need same-day approvals to care for our homeless population due to challenges with consistent ability to assure follow-up." **~ Regina Olasin, DO, FACP, FAAP, Chief Medical Officer, Care for the Homeless NYC, New York, New York**
- "Waiting 3 days for a prior authorization to come through would tax our nerves tremendously. Patients who are homeless can't wait—we need to get immediate approval." **~ Brandon Cook, MBA-HA, Health Care for the Homeless and Medical Respite Program Director, New Horizon Family Health Services, Inc., Greenville, South Carolina**

Standardization of the appeals process: We urge CMS to recommend standardizing the appeals process for payers. If a prior authorization request is denied, payer protocol oftentimes dictates that providers complete a peer-to-peer review. This process requires physicians to discuss the need for a specific procedure or drug with another physician in the payer's network to obtain prior-authorization or reverse a denial of a prior authorization. While well-intentioned, this process is only for the benefit of the insurance plan—and not for the provider or the patient. It can take significant provider time to not only schedule the peer-to-peer review but then complete it. This administrative task takes valuable provider time away from patients, resulting in decreased patient access. The appeals process currently varies from payer to payer. Improper denials can lead to high out-of-pocket costs for patients (which is out of the question for homeless patients, and a significant budgetary strain for safety net providers) or can lead to patients not seeking care altogether. **We strongly recommend streamlining and standardizing the appeals process to reduce provider confusion and decrease patient delays in care.**

PERSPECTIVE ON THE APPEALS PROCESS FROM HCH HEALTH CARE PROVIDERS IN THE FIELD

- "Then the next frustration is the appeals. We don't have enough staff to help providers with these and the insurance company only gives providers 2-3 days to respond, which is not really feasible. **~ Kari Roland, Referral Coordinator Manager, Lawndale Christian Health Center, Chicago, Illinois**

Timeliness of appeals: To further decrease instances of care delays, we also recommend implementing a timeliness requirement for payers to respond to an appeal, in the event of a prior authorization denial. There is often a quick turnaround time required between a denial and a provider completing this peer-to-peer, yet there are disparate timeframes imposed on the payer to make a decision after a provider appeals a prior authorization denial. CMS should work with different payer stakeholders to create timeliness standards in responding to appeals to decrease delays in patient access to care.

Discerning a "standard" from "urgent" requests: We recommend CMS issue guidance to payers on what defines a standard prior authorization versus an expedited prior authorization. The lack of common definition leads to discrepancies between what a payers and providers consider "urgent." This lack of standardization can adversely affect patient care, especially for a patient population experiencing homelessness. **All care in the HCH community is urgent.** If a payer has a stricter definition of what constitutes an expedited prior authorization, this could lead to the patient waiting up to 7 days for a decision, and delay access to care further if prior authorization is denied. CMS should release guidance on definitions to facilitate more alignment for payers and strengthen patient access by minimizing variation between network standards on what is considered "urgent" versus "normal." **Of course, we reiterate our above request to exempt homeless patients from any prior authorizations.**

Public reporting of prior authorization metrics: We support the proposal to require payers to publicly report prior authorization metrics. Having metrics available (such as the percentage of approvals and denials for both standard and expedited requests, reasons for denials, etc.) could help cut down on the items and services subject to prior authorization. Additionally, publishing the average time elapsed between submission and decision of prior authorization will also help payers remain accountable to the standards in place when these regulations are finalized. We also recommend CMS put out guidance on how to best address instances if payers do not abide by the published timeline requirements. Currently, the burden falls on the provider to follow-up with the payer if prior authorization requests are not addressed. This process takes significant time and the provider should not be responsible for holding payers accountable for compliance. We also believe

these prior authorization metrics these data will help inform policies such as gold-carding for providers (as discussed below).

Gold-card status: We support CMS' stated encouragement to payers to adopt gold-card approaches to allow certain providers who have demonstrated compliance with prior authorization requirements to receive exemptions or more streamlined reviews. We recommend CMS put out guidance formally recommending payers to implement gold card type initiatives and ensure that gold carding privileges extend to all items and services for eligible providers, not just specific service categories. This will ensure that providers and their patients will experience the full benefits of this strategy to decrease unnecessary prior authorizations. Gold-carding would help decrease the amount of time staff and providers would need to spend on prior authorization. Prior authorization is an expensive process for health care organizations that in many cases significantly restricts patients' ability to access needed care. It can take weeks to adjudicate the request, resulting in costing hundreds of dollars in staff and provider time at a health care organization for a single therapy for a single patient. Notably, this effort is not reimbursed and takes valuable staff resources. **HCH health center patients often have health insurance plans that demand more frequent prior authorization than plans for higher income patients (a problem unto itself). Prior authorizations can exacerbate health care inequities for patients while also increasing the burden of cost for prior authorization on health centers who already provide lower cost care with fewer resources.** Gold-carding would decrease these burdens and we support gold-carding as a strategy to enhance patient access to care.

Thank you for considering our comments and recommendations. Please contact me at bdipietro@nhchc.org if you have any questions or would like to discuss further the impact of prior authorizations on the HCH community.

Sincerely,

Barbara DiPietro, Ph.D.
Senior Director of Policy