HANYS®
Always There for Healthcare

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June 12, 2026

Robert F. Kennedy Jr.
Secretary
U.S Department of Health and Human Services
Attention: CMS-9884-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically: www.regulations.gov

RE: CMS 0062-P: Interoperability Standards and Prior Authorization for Drugs for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-Faciliated Exchanges.

Dear Secretary Kennedy:

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, appreciates the opportunity to comment on CMS' proposed prior authorization rule.

HANYS commends CMS for taking important steps in this proposal to remove barriers to patient care by streamlining the prior authorization process for prescription drugs covered by many health insurers. HANYS supports the process improvements that would require electronic prior authorizations, set decision deadlines and promote transparency through reporting metrics. HANYS advocated for the inclusion of prescription drugs in our comments on the 2024 rule and we are pleased to see this new proposed rule includes them.

Healthcare providers' number one priority is delivering high-quality patient care. However, unnecessary administrative burdens imposed by health insurers divert precious time and resources away from bedside care. Prior authorization requirements and processes vary widely (even among different health plan products offered by the same issuer) and can create dangerous delays in care delivery.

Hospitals devote enormous resources of time and money to resolve conflicts over care and payment that are driven by adherence to complex administrative rules.[1] Inappropriate PA and payment denials result in significant disruption for hospitals and health systems, challenging their ability to continue caring for their communities.

[1] American Hospital Association (2022) Commercial Health Insurance Practices that Delay Care, Increase Costs. https://www.aha.org/system/files/media/file/2022/10/Survey-Commercial-Health-Insurance-Practices-that-Delay-Care-Increase-Costs.pdf

While CMS' proposals take critical steps forward in advancing patients' timely access to care and easing administrative burdens, to facilitate meaningful change we strongly urge CMS to prioritize the enforcement and oversight necessary to ensure payer compliance. In addition, while hospitals and health systems appreciate CMS' effort to improve the electronic exchange of care data to reduce provider burden and streamline PA processes, we urge CMS to ensure that electronic standards are adequately tested and vetted prior to mandated adoption.

HANYS offers the following specific comments on the proposed rule.

Electronic prior authorization for drugs

In the 2024 CMS Interoperability and Prior Authorization rule, CMS limited the PA application programming interface to non-drug items or services and excluded prescription drugs. With the current proposal, CMS would require payers to support electronic PA for all drugs by following the PA API standards.

HANYS supports this effort as it creates consistency with PA requests with both non-drug items and services and drugs.

Improving PA processes

CMS proposes to require impacted plans to implement and maintain a Fast Healthcare Interoperability Resources-based Prior Authorization Requirements, Documentation, and Decision API. The PARDD API would allow providers to ascertain whether PA is required for a particular item or service, query and identify in real time the specific PA rules and documentation requirements for a particular service and obtain PA forms directly from the provider's electronic health record or practice management system.

HANYS supports this proposal as it has the potential to improve efficiency, reduce the number of unnecessary requests and minimize follow-up.

In addition, HANYS recommends that the standards for the PARDD API be aligned with the HIPAA minimum necessary standard to ensure that the data payers automatically collect is necessary to complete a particular transaction and they are not collecting extraneous data that may be used to inappropriately justify a denial or prolong the approval process.

As part of its proposal, CMS is considering the appropriateness of a phased-in approach to allow impacted payers additional time to program all existing PA rules and requirements into the PARDD. **HANYS does not support a phased-in approach, as it is likely to contribute to provider confusion and delays.**

Requirement for payers to provide status of PA and reason for PA denial for drugs

HANYS appreciates that CMS acknowledges the importance of providers receiving sufficient information regarding a PA denial. Providers need to understand a denial so they can properly resubmit with updated information, identify care alternatives and appeal or communicate the decision to their patients.

CMS proposes to extend the requirement that health plans provide specific reasons for denying PA requests to include any drugs (in addition to non-drug items and services).

HANYS strongly supports this proposal and believes that requiring a clear and specific reason for a denial will facilitate better communication and enable providers and beneficiaries to better appeal the denial. Additional clarity in situations where a payer needs more information to process a request will improve a system that is often confusing and lacks transparency.

HANYS urges CMS to develop robust requirements defining the term "specific reason" in relation to a PA denial. Payers should be required to specifically identify the reason for the denial in as precise terms as possible, with actionable information for providers. If payers' denial reasons continue to be vague, considerable administrative burdens will remain on providers to obtain clarity on the actual reason for the denial and what action is needed. **HANYS encourages CMS to establish enforcement mechanisms to ensure that payers comply with these requirements.**

Requirements for PA decision timeframes and communications

HANYS applauds CMS for acknowledging that PA processes are directly affecting patient care by delaying access to services or deferring care because of complex PA processes. The large variation in payers' PA policies for the same items and services increases confusion and contributes to delays in care.

HANYS strongly supports efforts to ensure PA requests are processed quickly and believes it is necessary to hold payers accountable for adhering to timely PA determinations. However, the proposed timeframes remain too lenient.

CMS proposes the following specific timeframes for PA decisions:

- State Medicaid FFS programs, Medicaid managed care plans and Children's Health Insurance Program managed care entities would be required to make PA decisions for all drugs within a timeframe that aligns with existing decision timeframe requirements for covered outpatient drugs (no later than 24 hours after receiving a PA request) or items and services (seven days for standard requests, 72 hours for expedited requests).
- State CHIP FFS programs would be required to provide notice of a PA decision no later than 24 hours after receiving a PA request for any prescription drugs for which federal financial participation is available.
- State CHIP FFS programs would be required to provide notice of a PA decision no later than 24 hours after receiving a PA request for any prescription drugs for which federal financial participation is available.

In addition, CMS clarifies the following decision timeframes for non-drug items and services by Qualified Health Plan issuers on the federally-facilitated exchanges: CMS proposes requiring notification of PA decisions for non-drug items and services as expeditiously as the enrollee's condition requires, but no later than seven calendar days for standard requests and 72 hours for expedited requests.

HANYS strongly urges CMS to adopt a shorter timeframe than seven calendar days. Delays in decision-making can have significant real-world consequences for patients. CMS should prioritize policies that require timely determinations.

HANYS also recommends that CMS adopt the policy that failure of a plan to respond to a PA request is an approval of the services rather than a denial. Treating a non-response from plans within the required timeframes as a denial wrongly shifts the burden to providers and forces them to appeal

the denial from a difficult position: plan silence. Furthermore, waiting for a plan to respond and delaying treatment for a patient can have unnecessary, negative consequences.

Ensuring timely response to PA requests is critical. Allowing plans to deny services by simply sitting on the timeframe and not make a determination creates an incentive for insurers to delay or ignore future requests. A non-response should be an approval of the PA request.

HANYS asks that CMS consider additional policies that would prevent payers from denying claims for preauthorized, approved services.

Public reporting of PA metrics

CMS proposes to expand the requirement of impacted payers to publicly report certain aggregated metrics on their websites, to include the numeric count of PA requests and percentages for certain existing metrics. This is in addition to the current metric reporting requirements that include the percent of requests approved, denied and ultimately approved after appeal, and average time between submission and determination.

In addition, CMS proposes to add the following four metrics:

- total number and percentage of standard PA requests denied after appeal;
- total number and percentage of expedited PA requests that remain denied after appeal;
- total number and percentage of standard PA requests for which the timeframe for review was extended and the request was denied; and
- total number and percentage of expedited PA request for which the timeframe for review was extended and the request was denied.

HANYS strongly supports this recommendation. Increased transparency regarding the volume of PA requirements and response time could reduce administrative burden and care delays.

However, HANYS urges CMS to require payers to report on categories of items and services as well. Disclosure on a service-specific basis would aid in identifying services for which there is a high rate of approval and for which PA requirements may no longer be necessary.

HANYS recommends that CMS adopt an enforcement mechanism and implement penalties for payers that fail to report or report sub-par metrics. HANYS also requests that CMS regularly audit a sample of payer denials and timeframes and use the data to target potentially problematic plans.

Patient access application programming interface

CMS' proposed rule builds on the requirements established in the 2024 Interoperability and Patient Access final rule. Under the patient access API, MA plans, Medicaid and CHIP FFS programs, Medicaid and CHIP managed care plans, and qualified health plans on the federally-facilitated exchanges must minimally make available:

- adjudicated claims;
- managed care encounters; and
- clinical data, including laboratory results, with a date of service on or after Jan. 1, 2016, as maintained by the payer.

Payers must make these data available via the patient access API no later than one business day after a claim is adjudicated or encounter or clinical data are received.

CMS proposes extending these requirements on small group market QHP issuers on the Federally-facilitated Small Business Health Options Program starting Jan. 1, 2028, to use the already-established patient access API to include information about patients' PA decisions to help patients better understand their payer's PA process and its impact on their care. The rule would require payers to report annual metrics to CMS about patient use of the patient access API. Payers would also have to include this PA information in the provider access API and the payer-to-payer API.

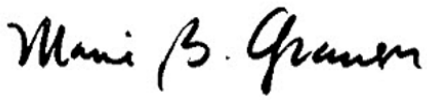
HANYS supports CMS' proposal to include information about patients' pending and active PA decisions in the API. Allowing patients to see the status of their PAs may help alleviate some of the added burden on providers and their staff. Furthermore, utilization management requirements are often difficult to navigate, leaving patients confused regarding the status of requests, approvals and denials. Increased transparency will allow patients to be better informed regarding their own care.

However, HANYS cautions against a rule that creates any expectations for patient involvement in the PA process. HANYS encourages CMS to explore strategies to promote access to timely PA-related information for patients who are uncomfortable or unable to use the underlying technology.

HANYS appreciates CMS' efforts to address the PA burdens faced by patients and providers. HANYS supports CMS' efforts to improve electronic PA processes and promote standards across payers. Reducing these burdens would reduce costs and improve patient outcomes by allowing providers to focus more of their time on patient care rather than administrative tasks.

If you have questions, contact me at bgrause@hanys.org or 518.431.7765 or Victoria Aufiero, vice president, insurance, managed care and behavioral health, at 518.431.7889 or vaufiero@hanys.org.

Sincerely,



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