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December 29, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicaid Program; Patient Protection and Affordable Care Act; Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information for Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-facilitated Exchanges; Health Information Technology Standards and Implementation Specifications [CMS-9123-P]

Dear Administrator Verma,

The American Academy of Neurology (AAN) is the world's largest neurology specialty society representing more than 36,000 neurologists and clinical neuroscience professionals. The AAN is dedicated to promoting the highest quality patient-centered neurologic care. A neurologist is a physician with specialized training in diagnosing, treating, and managing disorders of the brain and nervous system. These disorders affect one in six people and include conditions such as multiple sclerosis (MS), Alzheimer's disease, Parkinson's disease, stroke, migraine, epilepsy, traumatic brain injury, ALS, and spinal muscular atrophy.

Physicians in the United States complete an average of 33 prior authorization (PA) requests every week, taking an average of 14.4 hours to process.[1] PA is one of the most time consuming and expensive administrative requirements preventing physicians from spending more time with patients. 86% of surveyed physicians described the burden of PA as either high or extremely high.[2] This burden is detrimentally impacting patients, with 90% of physicians reporting that PA requirements have a negative impact on patient clinical outcomes and 74% of physicians reporting that issues associated with PA can lead to patients abandoning a recommended course of treatment.[3] 24% of physicians report that PA has led to a serious adverse event for a patient in their care and 16% of physicians say that PA has led to a patient's hospitalization.

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[1] 2019 AMA Prior Authorization (PA) Physician Survey. American Medical Association, June 2020, www.ama-assn.org/system/files/2020-06/prior-authorization-survey-2019.pdf.
[2] Id.
[3] Id.

Documentation and Prior Authorization Burden Reduction through APIs

The AAN appreciates the Centers for Medicare and Medicaid Services' (CMS) attention to the issue of PA related burden and lauds the agency for implementing rulemaking aimed at improving the electronic exchange of health care data, and streamlining processes related to prior authorization. The AAN notes that the provisions of this proposed rule are limited to Medicaid and Children's Health Insurance Program (CHIP) managed care plans, state Medicaid and CHIP fee-for-service programs, and Qualified Health Plans (QHP) issuers on the Federally-facilitated Exchanges. We support the below provisions and urge the agency to extend these proposed requirements to Medicare Advantage (MA) and Medicare Part D plans.

The AAN supports CMS' proposal to require Medicaid and CHIP programs and Medicaid and CHIP managed care organizations to send prior authorization decisions within 72 hours of the request for urgent requests. For non-urgent standard requests, the entities would be required to respond within seven days. The AAN believes it is necessary to hold plans accountable for making timely PA determinations. The data indicates that the PA process leads to delayed care, with 91% of surveyed physicians reporting care delays associated with the PA process.[4] Extending these policies to QHP issuers, MA plans, and Part D plans would ensure that a larger swath of patients are not harmed by care delays due to drawn out PA request processes.

The AAN also supports CMS' proposal for payers to be required to include a specific denial reason in their response to a denied prior authorization, regardless of the medium through which the prior authorization is transmitted. The AAN concurs with CMS that requiring a clear and specific reason for a denial will facilitate better communication and understanding between the provider and payer, which has the potential to reduce PA burdens over the long term. The AAN believes that this rationale extends to MA and Part D plans and that extending this policy would benefit Medicare beneficiaries.

The AAN also supports CMS' proposal for payers to be required to report data to CMS on the percentage of prior authorization requests approved, denied, and approved after appeal. Under this proposal, payers would also be required to report the average time between submission and determination. The AAN believes that this proposal will improve transparency and help to ensure that PA is not being used as a means to dissuade the provision of covered items and services. The AAN believes this policy should be implemented and extended to MA and Part D plans.

Furthermore, the AAN believes that the use of mandatory PA should be limited to those items and services for which there is clear evidence of potential overutilization and that meet specific criteria developed by CMS in collaboration with the provider community. Additionally, the AAN recommends that CMS should require plans to adopt transparent prior authorization programs that are reviewed annually, adhere to evidence-based medical guidelines, and include continuity of care for individuals transitioning between coverage policies to minimize any disruption in care. The AAN also recommends that the agency ensure that appeals can be completed electronically. The AAN is concerned that absent a

[4] Id.

clear appeal process via electronic means, some patients may end up not receiving care due to providers' lack of understanding of the appeal process.

Adoption of Health IT Standards and Implementation Specifications

The AAN supports CMS' and the Office of the National Coordinator's adoption of health IT standards and implementation specifications to reduce burdens and improve patient care. The AAN concurs with CMS that the specified implementation guides to support implementation of the proposed Application Programming Interfaces (APIs) will promote full interoperability of the APIs and reduce implementation burden. The AAN notes that this process is likely to take a long time and have costs associated with development, which should be supported by ONC, and through federal and state funding. This is needed so that costs borne by electronic health record (EHR) vendors are not passed onto providers. It is important that the burdens of implementation are not borne by providers and that vendors have sufficient time to implement these changes.

Leveraging Information about Pending and Active Prior Authorization Decisions during Patient Transitions

CMS is seeking comment on the extent to which impacted payers should be limited from requiring patients to undergo repeat evaluations for the purposes of reaffirming coverage or prior authorization decisions without first reviewing the medical records and notes of the previous payer to determine if and why a repeat test is needed. The AAN strongly believes this review should be mandatory and that the agency should consider penalties for payers who fail to do so. When a patient transitions between payers, if the request is from the same provider, efforts should be made to limit the need for resubmission work on the part of the provider through required interoperable elements.

Requests for Information

Methods for Enabling Patients and Providers to Control Sharing of Health Information

CMS is seeking comment for potential future rulemaking on the role patients and providers would like to have in granular control over the sharing of patient health information. First and foremost, the AAN believes that any agency action on this topic must be in concordance with the current information blocking regulations so as to not increase burden. The AAN recommends that in most cases, patients should be able to indicate whether they want to share information with others in an "all or none" manner. When a portion of the record is requested to be blocked it can be very difficult to ensure that specific portion is not copied forward or documented elsewhere in the patient's medical record and then inadvertently shared. As it currently stands, data segmentation can be very burdensome. As the agency examines specific cases related to sensitive information that may need to be segmented, the AAN recommends that the agency include results from genetic testing, including Huntington's Disease test results, in its considerations on data that may necessitate segmentation.

Reducing Burden and Improving Electronic Information Exchange of Documentation and Prior Authorization

The agency is seeking input on reducing burdens and improving electronic PA transactions. The AAN strongly supports CMS' efforts to reduce the burdens associated with electronic PA. The AAN does not support including an improvement activity under the Merit-based Incentive Payment system to support the use of the PA support API by providers. The AAN fears that this will place additional burdens on providers and believes that the responsibility of implementing the use of the PA support API should be on EHR vendors to ensure integration and that processes are streamlined.

Reducing the Use of Fax Machines for Health Care Data Exchange

The agency is seeking comment on how CMS can reduce the use of fax technology for health care data exchange across programs. The AAN notes that significant fax issues are currently associated with any item that requires a "wet" signature or forms to be completed, such as home health and disability forms. Since many EHRs do not have form completion ability or the interface is cumbersome to do so, providers are forced to complete forms by hand, which then get scanned and faxed. The AAN believes that electronic signature standards would help greatly and that the burdens of implementing these necessary changes should not fall on providers, but rather on vendors.

Accelerating the Adoption of Standards Related to Social Risk Data

CMS is seeking information on barriers to adopting standards, and opportunities to accelerate adoption of standards, related to social risk data. As vendors develop capabilities to capture this information within their systems, the AAN recommends that this information should be able to be shared through interoperable platforms and captured discretely into the electronic health record (EHR), as is possible in most EHRs with allergies, medications, and immunizations.

Conclusion

Regulatory relief is a top priority for the AAN. The AAN appreciates CMS' commitment to relieving the regulatory burdens faced by physicians across the country. The AAN believes that reducing PA-related burdens will reduce costs and improve patient outcomes by ensuring that paperwork does not interfere with clinically necessary care. Please contact Matt Kerschner, the AAN's Government Relations Manager at mkerschner@aan.com or Daniel Spirn, the AAN's Senior Regulatory Counsel at dspirn@aan.com, with any questions or requests for additional information.

Sincerely,

James C. Stevens, MD, FAAN
President, American Academy of Neurology