January 4, 2021

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9123-P
P.O. Box 8016
Baltimore, MD 21244-8016

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

Dear Administrator Verma:

The American Academy of Sleep Medicine (AASM) appreciates the opportunity to comment on the proposed rule regarding prior authorization and patient access to electronic health information. The comments included in this response reflect the needs of our over 9,000 individual members and 2,500 accredited sleep centers, providing sleep medicine services to the Medicare and Medicaid population.

Prior authorization remains a point of contention for many physician practices. As a reminder, the American Medical Association (AMA) identified prior authorization as a challenge to practicing physicians. In short, the cost control process requiring health care providers to qualify for payment is overused and existing processes present significant clinical and administrative concerns. In 2016, the AMA convened a workgroup of 17 state and specialty societies, national provider organizations and patient representatives to develop best practices for prior authorization. The 21 Principles, which are divided into five categories, clinical validity, continuity of care, transparency and fairness, timely access and administrative efficiency, and alternatives and exemptions, highlight real world solutions to the bureaucracy which interrupts or delays appropriate care.[i] The varied prior authorization requirements of private insurance carriers across the United States also cause a significant amount of burden for patients and providers.

While it appears that CMS has attempted to address some of the issues outlined by the AMA document, some areas require additional improvements.

**Clinical Validity:** While the proposals put forth aim to ensure that reasons for prior authorization denials will be shared, AASM does not believe the rule adequately addresses the need for prior authorization decisions to be made based on the most up-to-date clinical criteria, per evidence in the medical literature. In some instances, prior authorization decisions are made based on potential cost, which is not always in the best interest of the patient and does not support the provision of high-quality care. Additionally, the rule does not adequately address the prior authorization appeals process. The proposed Patient and Provider Access Application Programming Interfaces (APIs) should absolutely include the functionality that allows for the timely submission of appeals, including explicit criteria for submitting these appeals.

**Continuity of Care:** AASM supports the proposed implementation of Patient and Provider Access APIs, which will allow patients and providers access to information regarding the status of prior authorization submissions, as well as the outcome of each review, with the patient's consent, via the proposed opt-in policy. Implementation of the payer-to-payer data exchange would also allow patients to consider allowing payers to share relevant information regarding prior authorizations. However, we urge CMS to consider the potential impact of therapy and disease management interruptions due to pending prior authorization reviews and suggest implementation of policies that will eliminate potential delays or coverage denials that may impact current treatment being provided to patients during a course of therapy.

**Transparency and Fairness:** The proposed data exchange policies directly address transparency, as providers, payers, and patients will all have access to the prior authorization status and outcome for each patient, assuming the opt-in policies are finalized. The AASM fully supports these proposals, along with the proposal to require that statistics regarding prior authorization decisions be shared. Again, the proposals do not do much to address fairness, as there is no information in the proposed rule regarding factors that should be considered when making determinations regarding prior authorizations. AASM suggests that CMS create policies that mandate the availability of clear and concise prior authorization review criteria and supporting document requirements, which can be filtered by specialty or category (e.g., therapeutics, diagnostic testing).

**Timely Access and Administrative Efficiencies:** AASM supports the proposals regarding timelines in the prior authorization process, as decisions have historically taken a significant amount of time, causing frustration for both providers and patients due to delays in care. We believe that the proposed 72-hour response timeframe for expedited reviews should be reduced to 48 hours for non-urgent care and suggest a 24-hour response time in the instances of urgent care. We also suggest that prior authorization requirements be completely waived in the instances that emergency care is required.

**Alternatives and Exemptions:** The AASM supports the implementation of Gold-Carding Programs, as outlined in the proposed rule, to create exemption programs and/or streamline prior authorization requirements for providers that have demonstrated consistent patterns of compliance. Establishment of

this type of program would greatly reduce the volume of prior authorizations requiring payer review, thereby also reducing the burden on payers, providers, and patients.

Although the AASM believes that the proposed rule is a great start for reducing administrative burden and streamlining prior authorization processes, we suggest that CMS consider establishing several additional policies regarding prior authorization requirements for chronic conditions, as follows:

- Implementation of long-term authorizations for chronic conditions and terminal conditions, to eliminate the need for repeat reviews
- When a prior authorization decision is reached for a chronic or terminal condition for one payer, the data exchange will allow the decision to be shared and should remain valid if a patient changes payers.

Thank you for your consideration of these comments. The AASM appreciates the Agency's efforts to address the burden of prior authorization and to increase patient access to electronic health information in order to prioritize clinical care for patients, while continuously working to reduce administrative burden. We encourage the Agency to adopt the recommendations summarized in this letter. Please feel free to contact Diedra Gray, AASM Director of Health Policy, at dgray@aasm.org or 630-737-9700, for additional information or clarifications.

Sincerely,

Kannan Ramar, MD
AASM President

cc: Steve Van Hout, AASM Executive Director
Sherene Thomas, AASM Assistant Executive Director
Diedra Gray, AASM Director of Health Policy

[i] OReilly K. (January 25, 2017). 21 principles to reform prior-authorization requirements [News article]. Retrieved from: https://www.ama-assn.org/practice-management/sustainability/21-principles-reform-prior-authorization-requirements