PAN Foundation

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March 13, 2023

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Prior Authorization Proposed Rule [CMS-0057-P]

Dear Administrator Brooks-LaSure:

On behalf of The Patient Access Network (PAN) Foundation, one of the nation's largest charities, I write to provide comments on the Centers for Medicare & Medicaid Services' (CMS proposed rule related to improving prior authorization processes (proposed rule). PAN greatly appreciates your leadership in removing barriers in access to care and treatment for enrollees in Medicare Advantage, Fee-For-Service and managed care Medicaid and CHIP arrangements, and ACA marketplace plans.

PAN is an independent, national 501(c)(3) organization dedicated to helping federally and commercially insured people living with life-threatening, chronic, and rare diseases with the out-of-pocket costs for their prescribed medications. PAN provides patients with direct assistance through nearly 70 disease-specific programs and collaborates with national patient advocacy organizations to provide patients with education and additional support. Since 2004, we have helped more than 1 million underinsured patients.

PAN provides the following comments on the proposed rule:

Improving Prior Authorization Processes

Overall, PAN is supportive of any policy changes that streamline prior authorization and remove administrative burdens on providers. While prior authorization's goal is to contain health care costs by ensuring that services are medically necessary prior to approval for payment, the requirements currently in place for prior authorization create barriers to care which lead to confusion, delays, and potential harm to patients.[1] As CMS states in the accompanying fact sheet to the proposed rule, prior authorization has also been identified as a major source of provider burnout and causes providers to expend resources on staff to identify prior authorization requirements that vary across payers and navigate the submission and approval process, which could otherwise be directed to clinical care.[2] In

[1] Jeannie Fuglesten Biniek and Nolan Sroczynski, Over 35 Million Prior Authorization Requests Were submitted to Medicare Advantage Plans in 2021, Kaiser Family Foundation, February 2, 2023. Accessed at: https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/#:~:text=Prior%20authorization%20is%20intended%20to,covered%20by%20a%20patient's%20insurance.

[2] CMS. Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule CMS-0057-P: Fact Sheet, December 6, 2022.

2021 alone, Medicare Advantage plans made 35 million requests for prior authorization.[1] In all, prior authorization can cost an estimated $2,140 to $3,430 annually per full time physician.[3]

Additionally, and most importantly, is that prior authorization requirements can lead to poorer health outcomes for patients. For example, a study published in the *Journal of Managed Care Pharmacy* examined the records of more than 4,000 patients with Type 2 diabetes who were prescribed costly, newer medications requiring prior authorization. Those who were denied the medications had higher overall medical costs during the following year. Failure to receive and take medically necessary medications could be a factor contributing to inadequate control of diabetic conditions, which may result in an excess of resource utilization and increase costs for treating the disease and other comorbidities.[4] PAN shares CMS' goal of patient centered care and applaud the proposed changes made to streamline prior authorization requirements. Specifically, PAN agrees that:

- **Payers should be required to build and maintain Prior Authorization Requirements, Documentation, and Decision Application Programming Interface (PAARDD API).** Such an API would significantly relieve provider burden by automating the process for providers to determine whether a prior authorization is required, identifying prior authorization information and documentation requirements, as well as facilitate the exchange of prior authorization requests and decisions from their electronic health records or practice management system. Ultimately, this API would standardize the prior authorization process, which would ensure patient access to timely, evidence-based care.[5]

- **Payers should be required to provide a reason for denial for a given prior authorization request.** The American College of Cardiology developed a tool to collect prior authorization denial information and preliminary data established that many requests are denied even though such services are deemed "appropriate" based on appropriate criteria.[6] Furthermore, greater than 50% of denials do not lead to additional peer-to-peer discussion or are denied despite appeals.[7] Requiring a reason will help curb these rampant denials and also further assist providers in treating patients by allowing them to determine the next course of action for a patient's care plan. Additionally, it will ensure that patients understand why a service is being denied and providing them with agency to appeal the request if they so choose.

- **Prior authorization requests should be addressed by payers quickly.** Often, patient health is negatively impacted because a payer took too long to respond to a prior authorization request.

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[3] Morley CP, Badolato DJ, Hickner J, Epling JW. The impact of prior authorization requirements on primary care physicians' offices: report of two parallel network studies. *J Am Board Fam Med***.** 2013; 26:93–95. doi: 10.3122/jabfm.2013.01.120062

[4] Ani Turner, George Miller, Samantha Clark, Impacts of Prior Authorization on Health Care Costs and Quality, Altarum's Center for Value in Health Care, p. 10, November 2019. Accessed at: https://www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf.

[5] Eugene Yang, MD, MS and Sushan Yang, MD. JACC Case Rep. 2020 Aug; 2(10): 1466–1469; Published online 2020 Aug 19. doi: 10.1016/j.jaccas.2020.05.095

[6] *Id.*

[7] *Id.*

In fact, a 2018 physician survey reported receiving a response within one business day for just under half of all PA requests (48%). Another 19% of requests received a response in two days, and 26% required three business days or longer (7% reporting not knowing average wait times).[8] To avoid such delays, PAN advocates for shorter of the two turnaround times proposed by CMS, 48 hours for expedited request and five calendar days for standard requests.

- **Payers should be required to publicly report prior authorization metrics.** PAN supports making prior authorization metrics public so providers and individuals can understand how prior authorization decisions are made. This will allow providers to efficiently make changes to a care plan before a prior authorization is even filed.

Once again, PAN lauds your continued efforts to seek solutions to increase access and affordability for care and treatment. Thank you again for the opportunity to comment on this important proposed rule. If you have any questions, please contact please contact Amy Niles, Chief Advocacy and Engagement Officer, Patient Access Network Foundation at aniles@panfoundation.org.

Sincerely,

Kevin L. Hagan
President and Chief Executive Officer

[8] Ani Turner, George Miller, Samantha Clark, Impacts of Prior Authorization on Health Care Costs and Quality, Altarum's Center for Value in Health Care, p. 9, November 2019. Accessed at: https://www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf.