January 4, 2021

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS–9123–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Submitted electronically via regulations.gov

Dear Administrator Verma,

The American Academy of Dermatology Association (AADA) represents close to 14,000 dermatologists nationwide. We are writing to provide comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule entitled *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*. The AADA is committed to excellence in the medical and surgical treatment of skin disease; advocating for high standards in clinical practice, education, and research in dermatology and dermatopathology; and driving continuous improvement in patient care and outcomes while reducing the burden of disease. We appreciate the opportunity to provide comments on the proposed rule and urge CMS to take these recommendations and concerns into consideration when developing the final rule and formulating future policy.

Introduction

We appreciate this detailed and extensive effort to implement regulatory changes to improve the prior authorization processes and increase patient and physician access to health and

CORRESPONDENCE
PO Box 1968
Des Plaines, IL 60017-1968
EMAIL: mrc@aad.org
WEB: aad.org

ROSEMONT, IL OFFICE
9500 W Bryn Mawr Avenue, Suite 500
Rosemont, IL 60018-5216
MAIN: (847) 330-0230
FAX: (847) 240-1859

WASHINGTON, DC OFFICE
1445 New York Avenue, NW, Suite 800
Washington, DC 20005-2134
MAIN: (202) 842-3555
FAX: (202) 842-4355

billing information. While prior authorization requirements may occasionally be useful for ensuring appropriate utilization of medical resources, the experiences of our members and their patients have shown that it is often simply a time and resource consuming impediment to needed care.

The AADA has conducted multiple surveys to assess the impact of prior authorization requirements on dermatology practices. We have found that prior authorization requirements have resulted in the need for additional staff to manage the process at an average cost of $40K per practice. Administrators in these practices believe they could schedule 5 additional patients per day in exchange for the time spent on prior authorizations. While streamlining and automating the prior authorization process is a move in the right direction, the real solution is minimizing the prior authorization burden, which results in delays for needed treatment and reduced access to care. This is particularly important for inexpensive, commonly used generic medications.

We recognize the agency's desire for rulemaking to address one of the leading administrative challenges. However, due to the complexity and importance of this proposed regulation we were very disappointed that the comment period was limited to 18 days from the December 18, 2020 publication date in the Federal Register. This does not allow commenters sufficient time to complete a review of the regulatory requirements or the five requests for information (RFIs) in the proposed rule. ***We recommend that CMS extend the comment period for at least 30 days or open an additional comment period of 30 or 60 days***.

Comments and Recommendations

Starting January 1, 2023, CMS would require impacted payers to include, as part of the already established Patient Access API, information about the patient's pending and active prior authorization decisions to ensure patients have a better understanding of the prior authorization process and its impact on their care. This rule would also require impacted payers to report metrics quarterly about patient use of the Patient Access API to CMS to assess the impact the API is having on patients.

CMS proposed to require impacted payers to build and maintain a Provider Access API for payer-to-provider data sharing of claims and encounter data (not including cost data), a sub-set of clinical data as defined in the U.S. Core Data for Interoperability (USCDI) version 1, and pending and active prior authorization decisions for both individual patient requests and groups of patients.

CMS also proposes an additional API to allow providers to electronically locate prior authorization requirements for each specific payer from within the provider's workflow. Impacted payers must build and maintain an up to date and accurate Prior Authorization Support API that has the capability to send prior authorization requests and receive responses electronically within their existing workflow.

CMS proposes requiring impacted payers to include specific reasons when denying a prior authorization request, regardless of the method used to send the prior authorization decision.

We support providing access to this additional information to both patients and physicians.

Payers should also be required to provide clear guidance in a standardized format on covered alternatives if medications or treatments are denied.

CMS is proposing to require impacted payers, not including Qualified Health Plan insurers on the Federally Funded Exchanges, to send prior authorization decisions within 72 hours for urgent requests and 7 calendar days for standard requests.

The AADA supports faster prior authorization decisions, but these timeframes are not short enough. ***Payers should be limited to 24 hours for urgent decisions and 72 hours for standard requests. If payers are unable to meet these requirements they must eliminate or waive the prior authorization requirements***.

CMS is proposing to require impacted payers publicly report data about their prior authorization process, such as the percent of prior authorization requests approved, denied, and ultimately approved after appeal, and average time between submission and determination, to improve transparency into the prior authorization process.

While the AADA supports public reporting of prior authorization data, we encourage CMS to utilize the data from this reporting to develop additional restrictions on prior authorization requirements. Surveys by the AADA and other organizations demonstrate the burden of prior authorization and the need to not only simplify the process but also to reduce how frequently prior authorization is being required. Dermatologists have experienced prior authorization requirements on medications such as topical triamcinolone acetonide, adapalene, and oral terbinafine that seem designed to create arbitrary barriers to care rather than their stated purpose of ensuring appropriate use of medications.

These requirements in this proposed rule are limited to Medicaid, CHIP, and health plans on the Federal exchanges. ***The AADA encourages CMS to extend the prior authorization requirements in this rule to all Medicare Advantage plans***.

Conclusion

Please contact James Scroggs, jscroggs@aad.org or 202-712-2617, if there are any questions about the recommendations in this letter. We appreciate the opportunity to work with CMS on this important proposal, but our comments are limited and incomplete due to the unreasonable short time between publication and submission dates.

Sincerely,

Bruce H. Thiers, MD, FAAD
President, American Academy of Dermatology Association