American Society of Regional Anesthesia and Pain Medicine
Advancing the science and practice of regional anesthesiology and pain medicine to improve patient outcomes through research, education, and advocacy
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January 4, 2021

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9123-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted Electronically to http://www.regulations.gov

Re: ***CMS-9123-P - 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 Society of Regional Anesthesia and Pain Medicine (ASRA) is a voluntary organization representing chronic and acute pain medicine physicians both nationally and internationally. In particular, we are highly dedicated to the use of evidence-based, medical therapies in treating patients with chronic and acute pain when appropriate. Our membership, of over 5,000 practitioners, includes solo practitioners, small group practice members, and practitioners in large private and academic healthcare systems. We appreciate CMS' efforts to streamline the prior authorization process for Medicaid and CHIP fee-for-service (FFS) programs, Medicaid managed care and CHP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally-facilitated Exchanges (FFEs) and are pleased to offer the comments below.

The extensive use of prior authorization in the coverage and payment of health care services in the United States has contributed to significant burden for patients and providers who are aligned in the goal of providing patients with timely access to the best possible medically necessary and appropriate care. For providers, the burdens associated with prior authorization are manifold, taking valuable time and resources away from patient care and significantly contributing to physician and staff burnout. A recent American Medical Association (AMA) 2019 survey of physicians found that 86 percent of respondents described the burden associated with prior authorization as high, with respondents reporting on average completing 33 prior authorizations per physician per week, and physicians and their staff spending an average of almost two full business days per week completing prior authorizations. In addition, a recent article published by the AMA discusses how prior authorizations have contributed to significant practice costs – upwards of $10 million dollars every year incurred by the Cleveland Clinic alone.

More importantly, prior authorization reduces patient access to care as payers routinely limit access to treatment options, including interventional pain and surgical procedures that our members furnish. The same AMA survey found that prior authorization significantly delayed patient access to necessary care (for 91 percent of respondents) and sometimes or often led to treatment abandonment (for 74 percent of respondents).

Clinical outcomes were also negatively impacted according to the vast majority of physicians surveyed (90 percent). To understand how this affects patients, consider this scenario that occurred in the context of a private payer's prior authorization program. Here, prior authorization delays for a spinal cord stimulator resulted in eight months of pain, depression, and anxiety for a patient with serious back pain, not to mention hours of physician time away from patient care.

In recognition of these substantial burdens associated with prior authorization, we welcome the opportunity to offer comments on the aforementioned proposed rule, which include the following recommendations:

1. *Finalize proposals to require payers to implement the document requirement lookup service (DRLS) and prior authorization support (PAS) application programming interfaces (APIs).*
2. *Expand proposals for DRLS and PAS APIs to apply to prescription drugs and covered outpatient drugs.*
3. *Minimize the use of prior authorization under the fee-for-service (FFS) Medicare program.*
4. *Support requirements for payers to implement "gold-carding" programs that remove or reduce prior authorization burden for providers with a history of compliance.*

ASRA also offers comments in response to CMS' requests for information.

ASRA's comments reflect our strong desire to partner effectively and efficiently with CMS to provide high-quality care to Medicare beneficiaries.

Reducing the Burden of Prior Authorization through APIs

Recommendation: ASRA recommends that CMS:

- **finalize its proposals to require payers to implement the document requirement lookup service (DRLS) and prior authorization support (PAS) APIs; and**
- **expand these proposals to apply to prescription drugs and covered outpatient drugs.**

ASRA supports CMS' efforts to implement standardized APIs that make payers' prior authorization and other documentation requirements electronically accessible to providers at the point of care, and that support a more streamlined prior authorization request and response process. In particular, ASRA supports CMS' proposals to:

- Require impacted payers to implement and maintain a Fast Healthcare Interoperability Resources® (FHIR) based DRLS API that is populated with information on which items and services require prior authorization and on documentation requirements for submitting prior authorization requests. ASRA also supports requiring payers to post, on a public-facing website, the same information as would be available through the DRLS, to ensure that such information is easily accessible and available to the general public. The availability of such information would enable providers to more readily ascertain whether an item or service will be covered by a payer, before undertaking efforts to obtain prior authorization.
- Require impacted payers to implement a PAS API that facilitates HIPAA-compliant prior authorization requests and responses, including any forms or medical record documentation required by the payer for items or services for which the provider is seeking authorization.

While ASRA agrees with CMS that if APIs are successfully implemented by impacted payers as proposed, the demand for this functionality would motivate electronic health record (EHR) vendors to invest in integrating DRLS and PAS APIs directly into a provider's workflow. However, we also believe that in order to ensure that health IT developers actually implement these functions within EHRs, CMS should consider adding certification criteria to the ONC Health It Certification Program that address these functionalities. Integration of prior

authorization requirements with EHR systems is critical to ensuring that providers can track and manage active prior authorizations with minimal burden and submit requests electronically.

ASRA also urges CMS to expand these policies to apply to prior authorizations for prescription drugs and covered outpatient drugs. ASRA members routinely experience challenges when prescribing medications for their patients, where formulary considerations and prior authorization requirements lead to challenges for patients to access clinically effective medications and instead are replaced with unsuitable or less effective substitutes. For example, rather than covering prescriptions for sustained release, transdermal, or tamper-resistant opiates and anti-epileptics, payers instead require patients to take medications three or four times daily, reducing adherence or increasing the likelihood of diversion or abuse. A 2009 study by Casalino et al.[1] found that formulary issues represented the type of interaction with health plans that physician offices spent the most time addressing. Not including prescription drugs, therefore, would overlook the most significant contributor to prior authorization-related burden for many providers.

Limiting the Use of Prior Authorization

Recommendation: ASRA recommends that CMS minimize the use of prior authorization, including under the Medicare FFS program. ASRA also supports requiring payers to implement "gold-carding" programs.

While ASRA supports CMS' efforts to reduce burden associated with prior authorization, potentially the most effective solution would be to minimize the use of prior authorization altogether, including for the Medicare FFS program. ASRA was disappointed to see final policies in the calendar year 2021 Outpatient Prospective Payment System Final Rule finalizing the addition of two new codes that would be subject to prior authorization: cervical fusion with disc removal and implanted spinal neurostimulators. This policy appears to be at odds with CMS' efforts to reduce burden associated with prior authorization, as demonstrated by this proposed rule. Furthermore, it uses a blunt tool to address a small subset of providers who may be the most egregious offenders responsible for the largest proportion of inappropriate service utilization. As such, we continue to urge CMS to limit the use of prior authorization in the Medicare FFS program.

Additionally, CMS seeks comment on "gold-carding" programs to relax or reduce prior authorization requirements for providers that have demonstrated a consistent pattern of compliance. ASRA believes such compliant providers comprise the majority of physicians, who in the absence of such programs are routinely subject to onerous prior authorization requirements. Therefore, "gold-carding" programs would contribute significantly to burden reduction. As such, ASRA supports requiring payers to implement "gold-carding" programs that would waive prior authorization requirements for providers that have a demonstrated history of compliance with coverage requirements.

Requests for Information

CMS highlights several challenges that continue to vex providers seeking to manage their patients' care efficiently and effectively and seeks information from stakeholders on these issues, including:

- The practice of payers denying claims for prior authorization approved services.
- The need to better manage prior authorization for individuals with chronic medical conditions.
- Challenges with prior authorizations following patients if they switch health plans.
- The need to standardize prior authorization forms across payers.

[1] Casalino LP, Nicholson S, Gans DN, et al. What does it cost physician practices to interact with health insurance plans? *Health Affairs.* 2009; 28 (4):2533-2-543.

ASRA agrees that these challenges impose significant burden and contribute to provider burnout. Our members report, for example, that bills for prior authorized services are regularly denied when payer databases have not been updated with prior authorization information in a timely fashion, when payers require patients to sign a "coordination of benefits" form, or when payers seek additional information from providers – often information that providers have already furnished. In such cases, manual appeals and numerous hours of staff time are required to obtain payment, and issues may not be resolved for weeks due to limited availability of health plan staff to resolve open cases – with the latter being a pervasive issue for initial prior authorization requests as well. While we appreciate that the proposals in this rule aim to improve the timeliness for obtaining a response to a prior authorization request, we are concerned that they do not go far enough in terms of payer compliance. For example, CMS proposes to shorten some of the timeframes within which a payer must respond to a prior authorization request, but then clarifies that it is "not proposing that a prior authorization would be automatically approved should the impacted payer fail to meet the required timeframe. If the deadline is missed, providers may need to contact the payer to determine the status of the request and whether additional information is needed." We urge CMS to adopt a mechanism by which it can enforce non-compliance with these deadlines, in addition to considering additional policies that would prevent payers from denying claims for approved services. With respect to standardization of prior authorization forms across payers, ASRA believes such standardization would help to reduce time and effort spent on prior authorization, and we support CMS leading a standardization effort that is transparent and inclusive of stakeholders across the payer community. Furthermore, we welcome the opportunity to engage with CMS on all of the above-listed issues in greater depth.

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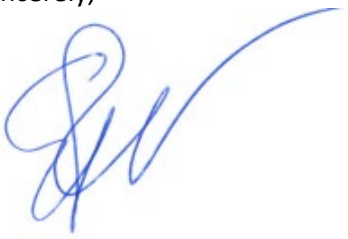
Conclusion

In conclusion, ASRA appreciates your consideration of our comments on the aformentioned proposed rule, which we believe will reduce provider burden and support access to evidence-based, non-opioid pain management techniques in the treatment of acute and chronic pain and safe use of opioids according to evidence-based guidelines in patients for whom it is medically appropriate. If you have any questions about these comments or other issues of concern, please do not hesitate to contact Angela Stengel at 412-471-2718 or astengel@asra.com.

Sincerely,



Eugene R. Viscusi, MD
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