August 16, 2019

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244  

RE: [CMS-4189-P] Medicare Program; Secure Electronic Prior Authorization for Medicare Part D

Dear Administrator Verma,

The American College of Rheumatology (ACR), representing over 9,500 rheumatologists and rheumatology inter-professional team members, appreciates the opportunity to provide input on the Medicare Program; Secure Electronic Prior Authorization for Medicare Part D proposed rule. Rheumatologists provide care for millions of Americans, both adults and children, and are the experts in diagnosing, managing and treating arthritis and rheumatic diseases. These lifelong, chronic conditions include rheumatoid arthritis, systemic lupus erythematosus, and vasculitis, among many others. Rheumatic diseases and arthritis are the leading cause of disability in the United States. Early and appropriate treatment by a rheumatologist is vital to controlling disease activity, preventing and slowing progression, improving patient outcomes, and reducing the need for costly downstream procedures and care. Rheumatologists practice in every state, the District of Columbia, and Puerto Rico, and in all communities, both urban and rural. They provide critical care for people with diseases that can be crippling, life changing, and life threatening.

We are encouraged to see CMS focusing on reducing the burden of prior authorization for patients and physicians. Under the proposed change, clinicians would be able to choose to complete prior authorizations online. This option offers a more streamlined process for performing prior authorization for Part D prescriptions and reduces burden for providers. Clinicians who select the electronic option will typically be able to satisfy the terms of a prior authorization in real time and before a prescription is transmitted to a pharmacy. A prior authorization process that is smooth, streamlined, and easy to perform by staff and physicians would be a welcome addition to the practice of rheumatology.

The ACR has long supported reducing the burden of prior authorization. It is a time-consuming process that often involves a patient going to the pharmacy only to be turned away because the prior authorization has not been attained. Most requests are eventually approved—nearly 100% of some treatments—yet prior authorization can delay treatment for weeks or even months. When treatment is delayed or the patient must return for the prescription, the consequences
can be devastating. According to a 2018 AMA survey, 91% of physicians reported that prior authorization caused delays in their patients’ care, and 75% reported that prior authorizations sometimes led to treatment abandonment. Additionally, prior authorization burdens physicians who spend time away from patient care or need to hire staff dedicated to seeking approval from insurers for medications they determined their patients need.

The proposed rule would implement new prior authorization transaction standards for the Part D e-Prescribing program as required by the SUPPORT for Patients and Communities Act. The proposed standards would begin in January 2021. If finalized, all Medicare Part D plans would be required to support electronic prior authorization transaction standards that were developed by the National Council for Prescription Drug Plans (NCPDP). While the ACR supports a uniform electronic PA process, we do have concerns that requiring the PA work at the point of prescription could change prescribers' work flow and shift the delays from the pharmacy counter to the clinic schedule, and thus delay access to care by lengthening wait times to see a doctor. Currently, providers employ staff or engage with third party vendors to perform much of the work of prior authorization. Any implementation of this proposal that requires doing the PA work at the point of prescription could have a negative impact on patient care if not implemented in a smooth, non-burdensome manner. Providers are already feeling the burden of cumbersome EHR systems with many time-consuming and unnecessary administrative tasks. We encourage CMS to consider how much additional work would be needed to utilize this system in real time, as well as the true impacts for providers and their patients.

While a faster and more streamlined prior authorization process is certainly needed and welcomed, we are concerned that there could potentially be unintended consequences. We recommend that insurance plans work with electronic health record vendors to take advantage of automation and avoid any need for additional data entry work by prescribers. To that end, CMS could work with the ONC to require CEHRT vendors to create an open API that allows for sending and receiving PA transactions. Making this a vendor requirement would allow the provider to capture the information and send the PA in a single step when sending the prescription. We hope to work closely with CMS on this proposed plan so that the current practice environment is accurately considered. We do believe electronic PA is an excellent first step in reducing burden, but it should be viewed as only an initial option.

An additional concern we have is accuracy. We encourage CMS to consider a scenario in which a prescriber changes the prescription at the point of care based on faulty information in the real time tool. It is the ACR’s position that all patients should have safe, convenient and affordable access to rheumatology treatments that control disease activity and prevent permanent joint and organ damage, thereby limiting disability and early death. We hope that CMS will consider how this tool reaches the goal of improving patient access to care while reducing physician burden, but also considers any unintended consequences such as a disruption of workflow and delayed patient care. We support policies rooted in scientific evidence that support shared decision-making between patients and providers and that decrease barriers to patients accessing treatment.
Finally, under the current system, providers who include the words “Medicare D” and a diagnosis on the prescription fulfill the prior authorization requirement for medications that can be covered by Part B. As a result of this policy, providers no longer have the forms to complete. We hope that this proposal will not interfere with the prescribing of drugs that have both Part B and Part D indications and will not result in new PA requirements for such drugs when used under Part D.

The American College of Rheumatology appreciates the work that CMS does and the opportunity to respond to this proposed rule. We look forward to being a resource to you and to working with the agency. Please contact Kayla L. Amodeo, Ph.D., Director of Regulatory Affairs, at kamodeo@rheumatology.org or (202) 210-1797 if you have questions or if we can be of assistance.

Sincerely,

Paula Marchetta, MD, MBA
President, American College of Rheumatology