March 13, 2023

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

Re: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program [CMS-0057-P]

Dear Administrator Brooks-LaSure:

On behalf of the American Association of Psychiatric Pharmacists (AAPP) (f.k.a. the College of Psychiatric and Neurologic Pharmacists), we appreciate the opportunity to provide feedback on the Centers for Medicare and Medicaid Services' (CMS) proposed rule related to improving prior authorization processes (proposed rule). We appreciate your leadership in removing barriers in access to care and treatment.

About AAPP

AAPP is a professional association of nearly 3,000 members who envision a world where all individuals living with mental illness, including those with substance use and neurologic disorders, receive safe, appropriate, and effective treatment. Members are specialty pharmacists, and most are Board Certified Psychiatric Pharmacists (BCPPs) who specialize in psychiatry, substance use disorders (SUDs), and psychopharmacology. With a significant shortage of mental health care professionals, psychiatric pharmacists offer another resource to improve outcomes for patients with psychiatric and SUDs.

Role of Psychiatric Pharmacists

Pharmacists graduate with a Doctor of Pharmacy degree, requiring six to eight years of higher education to complete, and have more training specific to medication use than any other health care professional. Psychiatric pharmacists, a specialty within clinical pharmacy, are primarily board certified and residency-trained mental health care practitioners who have specialized training in providing direct patient care and medication management for the complete range of psychiatric disorders and SUDs. Psychiatric pharmacists work as treatment team members but also in decision-making and leadership roles in state and federal organizations, academia, and industry.

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Psychiatric pharmacists are important members of the health care team working in collaboration with the patient and other health care providers including, but not limited to, psychiatrists, other physicians, therapists, social workers, and nurses (including advanced practice nurses). Psychiatric pharmacists provide expert, evidence-based Comprehensive Medication Management (CMM) services for the most complex patients with mental health disorders and SUDs. Psychiatric pharmacists increase capacity of the health care team to provide care and psychopharmacology expertise, as well as improve patient outcomes and reduce overall health care costs. As medication experts, psychiatric pharmacists are uniquely positioned to facilitate medication access and adherence by identifying and helping to address potential treatment barriers, including prior authorizations and high out-of-pocket patient costs.

Psychiatric pharmacists have a deep understanding of Medications for Opioid Use Disorder (MOUD) that extends beyond that of most other health care providers. When included in the provision of MOUD services through a collaborative practice arrangement, psychiatric pharmacists' involvement has been demonstrated to improve patient adherence and success with buprenorphine treatment for opioid use disorders; reduce per patient dosage of buprenorphine through improved medication management, monitoring and titration; and reduce overall costs. Furthermore, given the insufficient number of providers in addiction medicine, psychiatric pharmacists increase access to SUD treatment by providing medication management, education, monitoring, and follow-up care.

AAPP Comments on Proposed Rule

Improving Prior Authorization Processes

Overall, AAPP 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 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

[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.

[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

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] AAPP shares CMS' goal of patient centered care and applauds the proposed changes made to streamline prior authorization requirements. Specifically, we agree 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. 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, AAPP 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.** AAPP 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.

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[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.*

[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.

Request for Information: Electronic Exchange of Behavioral Health Information

As CMS notes in its preamble, the adoption of electronic health records (EHRs) has been slow in the mental health context. This is likely due in part to concerns regarding the collection of sensitive information, the standardization of mental health data, and the risk of negatively affecting therapeutic relationships.[9] Furthermore, the federal government has not financially supported the adoption of EHRs by mental health providers as they did with physical health providers.[10] However, as behavioral health becomes more integrated into physical health, it becomes critical that the use of EHRs is more standardized. A literature review of EHRs for mental health records by the National Institutes of Health (NIH) revealed that EHRs in the mental health context affect clinicians' information practices, which have implications for how care is provided.[11]

To better support mental health providers, we urge CMS to first work with Congress to highlight the need for funding for behavioral health practices to adopt EHRs. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) provided incentives to eligible providers a financial incentive to adopt EHR technologies for their practices. Unfortunately, behavioral health providers were not eligible for the financial incentives in the HITECH Act. Therefore, before any changes can be made to how CMS leverages APIs to facilitate electronic data exchange with behavioral health providers, we recommend an incentive program to help behavioral health providers bring EHR technologies to their practices and other health care settings.

Thank you again for the opportunity to comment on this important proposed rule. If you have any questions, please do not hesitate to contact me at bschimenti@aapp.org or our Health Policy Consultant, Laura Hanen at lahanen@venable.com.

Sincerely,

Brenda Schimenti

Brenda K. Schimenti
Executive Director

[9] Timonty Charles Kariotis, BSocSC, BNurtSC, BA, MPH, et.al, Impact of Electronic Health Records on Information Practices in Mental Health Contexts: Scoping Review, JMIR, J Med Internet Res. 2022 May; 24(5): e30405; Published online 2022 May 4. doi: 10.2196/30405.

[10] Howard Burde, JD, The HITECH ACT: An Overview, *Virtual Mentor.* 2011;13(3):172-175. doi: 10.1001/virtualmentor.2011.13.3.hlaw1-1103.

[11] Timonty Charles Kariotis, BSocSC, BNurtSC, BA, MPH, et.al, Impact of Electronic Health Records on Information Practices in Mental Health Contexts: Scoping Review, JMIR, J Med Internet Res. 2022 May; 24(5): e30405; Published online 2022 May 4. doi: 10.2196/30405.