



March 13, 2023

Submitted via regulations.gov

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244-8016

Re: RIN 0938–AU87

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

Dear Administrator Brooks-LaSure:

The Consortium for Constituents with Disabilities (CCD) is the largest coalition of national organizations working together to advocate for Federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society free from racism, ableism, sexism, and xenophobia, as well as LGBTQ+ based discrimination and religious intolerance. Since 1973, CCD has advocated on behalf of people of all ages with physical and mental disabilities and their families. CCD has worked to achieve federal legislation and regulations that assure that the millions of children and adults with disabilities are fully integrated into the mainstream of society.

The undersigned members of CCD’s Health and LTSS Task Forces appreciate the opportunity to provide these comments on the Department of Health and Human Services’ (HHS) proposed rule on prior authorization and interoperability in Medicaid, the Children’s Health Insurance Program (CHIP), and Qualified Health Plans (QHPs) sold through the Affordable Care Act (ACA) Marketplaces (hereinafter “Prior Authorization Proposed Rule”).¹

¹ U.S. Dept. of Health & Human Svcs., Proposed Rule - 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

We welcome HHS's efforts to streamline and facilitate processing of prior authorization requests. The Prior Authorization Proposed Rule is an important first step in bringing greater accountability to prior authorization through improved transparency and data reporting. We urge HHS to go further in future regulatory action to curb the abuse of prior authorization as a cost savings strategy that endangers patients' health.²

Insurers and states often use prior authorization to unreasonably and unlawfully deny medically necessary care. Egregious abuses documented in painstakingly detailed media reports surface with disturbing regularity. A college student with a severe gastro-intestinal condition finally finds the medication combination necessary to control his illness, only to face a years-long battle with an insurer who decided those medications cost too much, recommending instead a cheaper dosage that had already failed.³ A foster baby who needs constant nursing care to monitor his trach tube, which he regularly dislodges, suffers cardiac arrest when his nurse is not present after the managed care company cuts back his hours by a third.⁴ A woman almost completely paralyzed from the neck down remains bedridden for nearly two years waiting for equipment to transfer her to her wheelchair, a specialized mattress to prevent pressure ulcers and relieve chronic pain, and voice activated lights and thermostat.⁵ Her managed care company cut her daily personal care hours from 12 to 7 per day. Only after reporters from the *Dallas Morning News* inquire about her case does that equipment arrive.⁶

These stories are too frequent to be anecdotal, too searing to be ignored. The needless suffering marks the cruel consequences when misguided financial incentives meet lax oversight, when bureaucratic inefficiency actually rewards the payer. These cases we hear about – they are the lucky few with the support to fight through the bureaucratic hurdles, the resources to call a lawyer or contact a reporter, or be a reporter themselves.⁷ Our coalition represents people with disabilities who lose weeks and months of their lives fighting bureaucracy to get the care they need. They live with everyday anxiety knowing

Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program, 87 Fed. Reg. 76238 – 76371 (Dec. 13, 2022), <https://www.govinfo.gov/content/pkg/FR-2022-12-13/pdf/2022-26479.pdf>.

² In these comments, we use the term “patient” and “enrollee” interchangeably, recognizing that HHS largely uses the term “patient” in the Prior Authorization Proposed Rule. We note, however, that individuals who need health care services, including those with serious or chronic health conditions, may not necessarily identify themselves as patients. See, e.g., *The Denver Principles* (1983), “We condemn attempts to label us as “victims,” a term which implies defeat, and we are only occasionally “patients,” a term which implies passivity, helplessness, and dependence upon the care of others. We are people with AIDS.” https://data.unaids.org/pub/externaldocument/2007/gipa1983denverprinciples_en.pdf.

³ David Armstrong, et al., *UnitedHealthcare Tried to Deny Coverage to a Chronically Ill Patient. He Fought Back, Exposing the Insurer's Inner Workings*, Pro Publica (Feb. 2, 2023), <https://www.propublica.org/article/unitedhealth-healthcare-insurance-denial-ulcerative-colitis>.

⁴ J. David McSwane and Andrew Chavez, Dallas Morning News, *Pain & Profit Part 1: When a Giant Health Care Company Wanted to Save Money, a Foster Baby Paid the Price* (June 3, 2018), <https://interactives.dallasnews.com/2018/pain-and-profit/part1.html>.

⁵ J. David McSwane and Andrew Chavez, Dallas Morning News, *Pain & Profit Part 2: As Patients Suffer, Companies Profit* (June 3, 2018), <https://interactives.dallasnews.com/2018/pain-and-profit/part2.html>.

⁶ *Id.*

⁷ Carolyn Y. Johnson, *I wrote about high-priced drugs for years. Then my toddler needed one.*, Wash Post (Jan. 3, 2023), <https://www.washingtonpost.com/wellness/2023/01/30/high-priced-drugs-step-insurance-policies/>.

the potential consequences if their next prior authorization gets denied. We all know people whose needed treatment has been delayed or abandoned due to endless hassles with a payer. Vanishingly few denied claims ever get challenged – only 2 in 1000 in ACA Marketplace plans.⁸ Broader reviews that look behind these cases reveal systemic problems with claims denials. One review of 1042 New York managed Long Term Services & Supports (MLTSS) plan fair hearings related to personal care hours reductions found that 90% were overturned, often when health plan representatives immediately withdrew the cuts or did not even show up in court to defend their decision (64%).⁹ This suggests a strategy of deliberate denials to reduce costs.

People with disabilities typically have higher service needs and are even more profoundly affected by the barriers caused by overuse of prior authorization. The challenges magnify for other underserved communities – people with low incomes or with Limited English Proficiency, people who face everyday discrimination due to their race, ethnicity or sexual orientation. We ask you to keep their stories in the front of your mind as you consider our recommendations to strengthen this proposed rule and further rein in the all too common abuses of prior authorization.

Extend the Prior Authorization Rule to Cover Prescription Drugs

While we recognize that the processes and standards of prior authorization for drugs differ from those for items and services, we urge CMS to include prescription drugs in future rulemaking on prior authorization. CMS should require impacted payers to include information about prior authorization for medications in the Patient Access Application Programming Interface (API), Provider Access API, and Payer-to-Payer API. We also urge CMS to include beneficiary protections similar to those found in this rule, including timelines, specific reasons for denials, and public reporting on processing and denials.

We also recommend creating guardrails around prior authorization for treatments that are already underway and for maintenance medications. Many people with disabilities take the same medications for decades, such as anti-seizure medications or antiretroviral therapy to treat HIV. Despite the standard medical care stating that certain medications must be taken for life, people still face “prior” authorization to continue taking these medications. Enrollees and physicians consistently report yearly or “surprise” prior authorization requirements for medications that the enrollee is already taking. Enrollees often only discover a new prior authorization requirement when they contact the pharmacy for a refill, risking a gap in care. Such gaps in care can exacerbate symptoms and cause avoidable emergency department visits. Provider and Patient Access APIs could help providers and patients be alerted to new prior authorization requirements before the patient has run out of medication. Further, a Payer-to-Payer API should require payers honor existing authorizations for medications. Finally, CMS should go beyond

⁸ Karen Pollitz et al., *Claims Denials and Appeals in ACA Marketplace Plans in 2021*, Kaiser Fam. Found. (Feb. 9, 2023), <https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/>.

⁹ Valerie Bogart et al., *Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans June - Dec. 2015*, (2016), <https://medicaidmattersny.org/mltc-report/>.

creating API requirements and put guardrails on the use of prior authorization that is contrary to the standard of care.

Facilitating Prior Authorization Processing and Data Access through APIs

While we remain skeptical of prior authorization's value as a utilization management and care coordination tool, we agree with HHS that the process should be as transparent, efficient, and simple as possible to ensure it does not cause unnecessary delay or wrongful denials. We generally support proposals to include prior authorization information in the beneficiary API as close to real time as possible. We urge HHS to ensure that enough information and supporting documentation is included in the API so beneficiaries can understand the process, the timing, and most importantly, the justifications for any decisions and the steps they need to take if they would like to appeal that decision.

We also recommend that HHS clarify in the final rule payers' responsibilities to ensure the prior authorization documentation requirements, supporting information, and decision results provided through the API are fully accessible to people with disabilities and people with limited English proficiency and comply with appropriate laws and standards for language access and alternative formats.

Clarifying the Specific Reason for Denial of Prior Authorization Request

The proposed rule would require impacted payers to provide a specific reason for prior authorization denials, regardless of the method used to send the prior authorization request. Responses sent through the new automated system from the payer to the provider would include information about whether the payer approves the request, needs more information, or if the request is denied. If the request is denied, the proposed rule requires the payer to state the reasons for the denial. Existing regulatory guidance that Medicaid managed care, CHIP, and Medicare Advantage plans are required to send a written denial notice would remain in place.

This proposed regulation would greatly benefit patients with disabilities and providers working with people with disabilities. CCD hears frequently from patients who are denied prior authorization without a clear reason. When an individual receives a denial that cites only that the item or services is considered "medically unnecessary" by the payer, it is impossible to understand the true reason for denial and makes appealing the decision more challenging. Vague phrases like "the patient could be treated in a less intensive setting" are not an appropriate reason for denial of care. Such lack of specific support for such reasoning creates barriers for providers and patients seeking to appeal the decision, particularly in urgent situations. In these opaque processes, the power rests entirely with the payer to give further details so the provider can meaningfully address the denial reason. Too often, providers and patients are left to speculate the reasons for denial instead of receiving a clear response that allows for a reasonable chance at appeal.

While we support the requirement that any adjudicated authorization denial should specify the reason, that reason must be based on ascertainable standards that include any clinical criteria, processes, strategies, evidentiary standards, or other factors used to reach that decision.¹⁰ HHS should also strengthen requirements to help ensure that enrollees (and their providers) can access and evaluate clinical criteria, processes, strategies, evidentiary standards, or other factors used to support prior authorization documentation requirements through the API. Payers should have to provide enrollees and their providers with supporting documentation so they can understand and evaluate how to proceed. If payer denies a prior authorization for not being “medical necessary,” for example, the API should also make available documentation explaining the clinical basis for that decision.

We support the requirement that payers must provide a list of covered services that require prior authorization along with the documentation required for authorization at proposed § 431.80(b)(1), but payers should also be required to detail the criteria for prior authorization approval in their notice of denial and provide a pathway for possible approval for providers and patients. This clarification is essential to individuals with disabilities seeking care who are denied prior authorization for “lack of medical necessity” and must appeal the decision quickly to avoid prolonged wait times for essential items and services.

We also note that for youth covered by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), Medicaid law requires that states cover any medically necessary service that could be covered under the Medicaid state plan, using a standard for medical necessity appropriate for this age group.¹¹ The API should thus include access to the prior authorization documentation requirements and criteria for all the services that these young beneficiaries may need, even if those services are not covered under the State plan for adults.

Timely Posting of Status Changes to the API

The standard for posting changes in PA request status to the API should be accelerated for expedited prior authorization requests. If a payer makes a decision on the Friday before a long weekend, the result might not post to the API until four days later under the current proposal. This could make it harder for that individual and their provider to find information on the status of their request, and whether the enrollee should challenge the decision. We suggest that expedited prior authorization requests should meet a higher timeliness standard. Changes in status on such requests should be made available through the API within twenty-four hours. This shift in timeline should also apply to the provider and payer-to-payer APIs described in § 431.61 and across other federal health programs.

Tracking and Reporting API uptake and utilization

Finally, reporting of the aggregate data API utilization at proposed § 431.60(h) will provide a hazy picture of how widespread the use of health apps and patient portals in the

¹⁰ Jane Perkins, *Demanding Ascertainable Standards: Medicaid as a Case Study*, CLEARINGHOUSE REV. (2016), <https://healthlaw.org/resource/demanding-ascertainable-standards-medicare-as-a-case-study/>.

¹¹ 42 U.S.C. § 1396d(r)(5).

Medicaid population is and how actively beneficiaries engage with their health data electronically. We support beginning to track this information to gauge the effectiveness of APIs at streamlining the prior authorization process, but we do not think the two listed data points go far enough. States will have nearly three years to implement this rule and will likely have to substantially revamp both state and plan data infrastructure to comply, but once they have done so there will be little incentive to go back and add new capacity a few years later. We therefore very strongly encourage HHS to require states in the final regulation to require the new APIs to have the capacity to track and report the frequency of beneficiary data transfers by key demographic features – such as race, ethnicity, preferred language, disability, sex, income, and geographic area – not just in the aggregate.

We suspect that use and uptake of these health apps will be uneven across some of these communities – particularly for people with Limited English Proficiency (LEP) and people with disabilities who may encounter accessibility barriers in various health apps. Building in the capacity to track and report this data at a more granular level could provide important insights about equitable access and help to target future outreach more effectively.

Limiting Exemptions to API development for Medicaid Fee for Service (FFS)

We are concerned that the proposed exemption process at § 431.61(c)(2) and § 431.80(c)(2) will leave some Medicaid FFS Medicaid populations – which include a disproportionate share of people with disabilities – without comparable access to any benefits derived from streamlining the prior authorization process through APIs. While we recognize the potential challenges of developing and maintaining the necessary data infrastructure for a relatively small FFS population, we think this exemption creates an unfair, two-tiered system that may leave behind people with disabilities who already face high barriers to care posed by the administrative burdens and uncertainties that prior authorization can cause. In many states, people receiving Home and Community Based Services (HCBS) through waivers are carved out of managed care and may be exactly the individuals who would fall under the exemption and thus fail to benefit from the streamlined process in this regulation.¹²

As of 2020 (the most recent available information), eight states had small FFS Medicaid populations that totaled just under ten percent of all Medicaid beneficiaries.¹³ Several others were within two or three percent of the ten percent exemption threshold. As these numbers fluctuate from year to year, states on either side of this arbitrary threshold may cross back and forth, leading to uncertainty about whether their exemption would continue. We foresee the possibility that states near the threshold may force people into managed care based solely on their desire to seek or maintain a FFS exemption to avoid the expense of creating new API data infrastructure. In 2020, half of all states (25) had

¹² Kathleen Gifford et al., Kaiser Fam. Found., *A View from the States: Key Medicaid Policy Changes: Results for a 50-State Medicaid Budget Survey for State Fiscal Years 2019 and 2020* (Oct. 18, 2019), <https://www.kff.org/report-section/a-view-from-the-states-key-medicaid-policy-changes-delivery-systems/>.

¹³ Kaiser Family Found., Total Medicaid MCO Enrollment 2020 (last visited Mar. 4, 2023), <https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Percent%20of%20State%20Medicaid%20Enrollment%22,%22sort%22:%22desc%22%7D>.

comprehensive managed care enrollment rates exceeding eighty percent that put them in range of this exemption threshold.¹⁴

Several large states (TX, PA, NJ, VA) are among the states that currently likely qualify for an exemption. Even if the relative percentage of FFS beneficiaries is small in these states, the total number of FFS beneficiaries who fall in the exception exceeds the entire Medicaid population of some smaller states. For example, based on 2020 enrollment, Texas would have roughly 216,000 beneficiaries in FFS for whom it would not be required to make prior authorization information available via the APIs.¹⁵ But Kansas, which sits just below the threshold at eighty-eight percent would have to develop API infrastructure for all of its 48,000 FFS enrollees.¹⁶

States should receive a ninety percent federal match to update their computer systems to implement this API infrastructure, and the process projects to save ten to twenty billion dollars in administrative costs over the first decade of implementation.¹⁷ We strongly recommend that HHS finalize regulations that require states to make these new APIs available to every Medicaid beneficiary without exemption, regardless of their care delivery system. States may need a little extra time to implement the system for smaller populations in FFS, as long as states justify the need and limit the extension. We strongly believe that the regulation should not create a de facto two-tiered system that allows for semi-permanent exemptions from implementing the API system for large groups of beneficiaries, as this could lead to people with disabilities and others covered in state FFS programs to have lower timeliness and access standards.

If HHS does not agree to require states to make prior authorization APIs available to all FFS Medicaid beneficiaries, we recommend that the current threshold be increased to at least ninety-five percent of all beneficiaries in comprehensive managed care and that states would also have an absolute threshold, such as no more than 40,000 FFS Medicaid beneficiaries, to qualify for an exemption. This would avoid placing unfair burdens on smaller states with fewer resources and would be less likely to carve out substantial groups of Medicaid beneficiaries.

Finally, if HHS retains the exception process for creating these APIs, the language and detail around a state's alternative plan for keeping FFS beneficiaries, providers, and payers informed of prior authorization decisions must be strengthened. The alternative described at proposed § 431.61(c)(2)(ii) must not only ensure that enrolled FFS providers have "efficient electronic access to the same information," but should require that their electronic access is comparable in detail, quality, and timeliness to the access afforded providers using the state's API system.¹⁸

¹⁴ *Id.*

¹⁵ CMS, *Managed Care Enrollment by Program and Population 2020* (last visited Mar. 3, 2023), <https://data.medicaid.gov/dataset/e2ce0d2f-07c5-5213-947a-31e19bc649f6/data?conditions%5b0%5d%5bresource%5d=t&conditions%5b0%5d%5bproperty%5d=year&conditions%5b0%5d%5bvalue%5d=2020&conditions%5b0%5d%5boperator%5d==>.

¹⁶ *Id.*

¹⁷ 87 Fed. Reg. 76351.

¹⁸ 87 Fed. Reg. 76262.

Due Process: Defining an Appealable Action

We support HHS's revision of the definition of an "action" to clarify that it includes termination, suspension of, or reduction in benefits or services for which there is a current approved prior authorization. We also support HHS's clarification that prior authorization decisions are one of the situations in which a state must provide an opportunity for a fair hearing when a beneficiary believes the agency has taken an adverse action. Making this requirement explicit will ensure that they have access to a hearing when the state has not acted on a request for prior authorization. We appreciate HHS noting in the preamble that the failure to act on a claim, which gives rise to notice and hearing rights, includes failure to act on a request for prior authorization.¹⁹ We recommend that HHS revise the regulatory language to make this explicit.

We also urge CMS to consider further clarifying definitions of "approval" and "denial" of a prior authorization request in the various programs covered by this proposed regulation. Some payers amend prior authorization requests. For example, a provider might prescribe 8 physical therapy sessions for a given patient and request prior authorization from a payer for 8 sessions. The payer "approves" the request but only for 2 physical therapy sessions. Such a decision should be considered a partial denial and should be treated as an adverse action. This comes as close to the payer practicing medicine as any utilization review technique, and it should be prohibited by these final regulations.

This issue intersects with the CMS Medicare Advantage (MA) proposed rule (CMS-4201) which would prevent MA plans from subjecting a patient to prior authorization for an ongoing treatment after an initial authorization for a "course of treatment" has been granted. As in the MA proposed rule, CCD hopes that CMS offers more detailed definitions in the final rule that clarify who decides the course of treatment. CCD would like to ensure that providers and patients are the decision-makers for the course of treatment and that impacted plans do not inappropriately label amended prior authorizations as "approvals" both in communication to providers and patients and in public reporting of prior authorization data.

Decision Timeframes for Prior Authorization

CCD recommends CMS consider a shorter timeframe for expedited or urgent prior authorization requests and identify specific types of services that should always be considered for expedited review. For patients in need of care, delays in receiving prior authorization can result in serious health consequences or even abandoning care at an appropriate level and intensity. The need for emergency or expeditious access to health care services takes place every hour of every day and medical care must be available to respond to those emergencies, including on weekends and holidays.

An urgent request for prior authorization should be evaluated by the end of the day in which the request was made but in no event more than 24 hours from the time of the request, whether or not the request is made on a Friday of a business week. It is not

¹⁹ 87 Fed. Reg. 76299, citing 42 C.F.R. § 431.220(a)(1).

appropriate for payers to decide a timeline for emergency medical care. Rather, those decisions should rest with trained providers treating patients in real time. CCD recommends shortening the timeframe for expedited prior authorization requests, requiring decision to be made by payers on weekends and holidays, and requiring impacted payers to identify in the Prior Authorization Requirements, Documentation, and Decision (PARDD) API which specific services qualify as expedited or urgent requests.

For non-urgent requests, CCD recommends a shorter timeframe of 72 hours for payers to respond to requests, rather than the seven days proposed in the rule. CCD recognizes that payer approval within 24 hours is not necessary for all items and services. We also recognize that an approved prior authorization can help reduce the likelihood of a claim denial after services have been provided by the provider, forcing the patient and provider into an inefficient administrative appeals process that is often burdensome and time-consuming. Such appeals also take valuable time away from frontline providers who could instead spend that time addressing current patient needs.

The shortened timelines we recommend are particularly appropriate given the additional changes intended to streamline prior authorization in this proposed rule and the Medicare Advantage proposed rule (CMS-4201-P). If the MA rule is finalized as proposed, payers would be prohibited from using internal coverage criteria that is stricter than Medicare FFS for items and services covered by Medicare. MA plans with supplemental benefits beyond Medicare FFS would be required to post publicly the prior authorization requirements for providers to see. Since the standards of prior authorization would be either consistent with Traditional Medicare or publicly available, evaluating prior authorization would be simplified for plans and providers, justifying a shorter timeframe. Also, providers can utilize the PARDD API to check requirements and deliver the correct documents quickly to payers through an electronic system without navigating phone calls and fax machines. Payers will be easily able to reference the documentation, consult established publicly available criteria, and render a decision. All these changes in the two proposed rules would streamline workflows and establish more efficient and responsive systems.

In summary, CCD supports shorter timeframes for evaluating prior authorization requests and recommends that CMS considers a 24-hour timeframe for urgent requests and a 72-hour timeframe for non-urgent requests given the workflow solutions offered through this proposed rule and the proposed rule for Medicare Advantage plans (CMS-4201-P).

Public Reporting on Prior Authorization Decisions and Appeals

As noted above, various recent reports have made clear, the prior authorization apparatus has created enormous administrative hurdles that lead to unnecessary and unjustified coverage delays and denials. One approach to rein in overuse and abuse and to streamline PA bureaucratic processes is to increase transparency and oversight. The proposed rule would require plans to publicly report data on the use and outcomes of prior authorizations of care, including the frequency and outcomes of prior authorization

denials. Shining a light on the frequency of denials has been instrumental to identifying, preventing, or correcting such abuses.²⁰

CCD strongly supports these data transparency requirements for all plans

impacted by this rule. For an individual with a disability seeking a new plan with higher prior authorization approval percentages, that person would have the ability to research an organization and its prior authorization practices before choosing. A publicly available resource would also serve to hold impacted payers accountable to enrollees, providers, and the public for its practices.

However, **CCD urges CMS to consider requiring data reporting at a more granular level than in an aggregated format.** Only with greater specificity will patients and providers be able to assess which services are routinely denied, appealed, and overturned in favor of patients and providers. CCD is concerned that prior authorization denials in the post-acute care sector are more common than in other settings and that these disparities in approvals would be concealed in an aggregated data reporting requirement. A prospective enrollee or beneficiary will be able to make a more informed decision if they can compare multiple payers' prior authorization metrics at the setting of care level.

Moreover, reporting aggregated data about approved and denied authorizations will mask cases where denials are targeted to a less common but particularly expensive services, or even by targeting individuals or groups of individuals with particularly high service needs.²¹ We recommend that HHS require plans to report on prior authorizations at the plan level and for specific categories of services, rather than overall aggregate rates. This would permit states to more easily link prior authorization practices with utilization rates for specific services – an important oversight tool.

We also recommend that CMS add to its list of required reporting to include:

1. The total absolute number of prior authorization requests along with the absolute number of denials, extensions, and approvals, not just the percent that were approved or denied, for each category of services.
2. The total number and the percentage of appeals related to prior authorization denials; and
3. The average time between a prior authorization approval and the actual provision of the approved treatment or service.

²⁰ After Dallas Morning News published a major exposé of rampant care denials by Superior Health, a Medicaid managed care plan in Texas covering foster kids, the state required the plan to begin reporting its denials. J. David McSwane and Andrew Chavez, *Pain & Profit Part 6: 'Recipe for Disaster: How a Company's Refusals to Cover Medical Costs is Hurting Sick Foster Kids in Texas*, Dallas Morning News, Aug. 26, 2018, <https://interactives.dallasnews.com/2018/pain-and-profit/part6.html>.

²¹ David Armstrong, Patrick Rucker & Maya Miller, *United Healthcare Tried to Deny Coverage to a Chronically Ill Patient. He Fought Back, Exposing the Insurer's Inner Workings.*, (2023), <https://www.propublica.org/article/unitedhealth-healthcare-insurance-denial-ulcerative-colitis>.

The current list of required data refers only to percentages, but does not include the absolute numbers of PA requests, which are necessary to understand the scope of this utilization management practice.

We also recommend that states consider building in the infrastructure capacity to report this data stratified by key demographics, even if that reporting is not required immediately. Stratified reporting to identify disparities in access should be the expectation for all federal health quality and oversight reporting, so long as risks and data privacy are adequately accounted for. Electronic data systems are much more difficult to change retrospectively, so building in the necessary fields and capabilities could save time down the road even if that reporting is not required right away.

Promote and Monitor Gold-Carding Programs

In the proposed rule, CMS encourages payers to adopt gold-carding to reward providers who properly use PA by exempting them from utilization management practice. CMS requested feedback on how gold-carding can benefit diverse and underserved populations as well as the providers they serve. CMS further requested information on how gold-carding can be integrated in quality-ratings for MA organizations and QHPs.

Utilization management targets people with disabilities who are frequent users of the healthcare system by interfering with their continuity of care. For people with complex diseases and disabilities, who are often part of underserved and diverse populations, disruptions in the continuity of care directly affects their quality of life and can lead to worse health outcomes. Gold-carding serves as an active way to exempt high-performing providers and give patients with disabilities quicker access to medical care without unnecessary delays. However, in a survey by the American Medical Association, only 9% of physicians reported contracting with health plans that offer programs that exempt providers from prior authorization. In this, CCD supports the wider adoption of gold-carding and other similar programs (e.g., preferred provider programs) as a tool to create efficiencies within the medical necessity review process and reward providers who consistently and correctly recommend appropriate services for people with disabilities.

Prior Authorization Enforcement Mechanisms

As stated throughout these comments, CCD greatly appreciates CMS' attention to solving critical issues in current prior authorization processes and CMS's proposals to ensure that beneficiaries are able to access the medically necessary care to which they are entitled in a timely manner. These technological and system improvements will be a significant task for impacted payers to complete, implement, and maintain. CCD has concerns about the monitoring and oversight of impacted payers' adherence to these new standards. Therefore, we encourage CMS to consider detailing the expected enforcement mechanisms for these new requirements in the final rule, to ensure that beneficiaries are able to see the full impact of these proposals reflected in practice.

Shorten the Implementation Timeline

Most of the provisions in this proposed rule would take effect in January 2026, including reforms to prior authorization practices without technology requirements. While we recognize that the technological rollout of some provisions could require more time for development and testing, several of the most impactful provisions for patients could be implemented within the next 12 months, including shortening timeframes for prior authorization decisions, requiring specific reasons for denials of prior authorization, and reporting prior authorization metrics publicly. Three years is too long to wait for these reforms. As demonstrated throughout this letter, the misuse and overuse of prior authorization is an immediate and serious harm for patients, particularly for patients in rehabilitation settings. **We urge CMS to shorten the implementation timeframe for as many, if not all, provisions of this rule.**

Conclusion

Thank you for your consideration of our recommendations. If you have any questions, please contact David Machledt (machledt@healthlaw.org).

Sincerely,

The undersigned members of CCD's Health and LTSS Task Forces:

Access Ready
American Association on Health and
Disability
American Occupational Therapy
Association (AOTA)
American Physical Therapy Association
American Speech-Language-Hearing
Association
The Arc
Autistic People of Color Fund
Autistic Self Advocacy Network
Autistic Women & Nonbinary Network

Center for Medicare Advocacy
Cure SMA
Dialysis Patient Citizens
Disability Rights Education and Defense
Fund (DREDF)
Epilepsy Foundation
Justice in Aging
Lakeshore Foundation
National Disability Rights Network (NDRN)
National Health Law Program
Pandemic Patients
United Spinal Association