



March 13, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Centers for Medicare & Medicaid Services Proposed Rule CMS-0057-P

Dear Administrator Brooks-LaSure:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, is pleased to submit the following comments on the proposed rule that focus on provisions related to prior authorization in the Medicare Advantage (MA) program.

Improving Prior Authorization Process

Millions of older Americans rely on MA for their health coverage. We were very concerned with the April 2022 report published by the Department of Health & Human Services Inspector General (HHS OIG) that found millions of MA enrollees are denied coverage and prior authorization requests required for services that are routinely permitted in traditional Medicare. Denials of coverage and prior authorization requests contribute directly to the quality – or lack thereof – of care an enrollee experience within the context of any health insurance arrangement, not just MA. We agreed with the conclusion of the HHS OIG report that this is “an opportunity for improvement to ensure that MA beneficiaries have timely access to all necessary health care services...” To that end, last Congress we supported the bipartisan “Improving Seniors Timely Access to Care Act of 2022” which sought to better protect enrollees from inappropriate denials of prior authorization requests. The legislation would have taken an important step in implementing the HHS OIG’s recommendations to improve oversight of prior authorization requests submitted to MA providers.

We appreciate CMS’s proposed rule that continues the work begun by Congress last year to ensure more seniors can access needed care. To that end, we agree that the prior authorization process could be improved through better communication between MA plan providers and medical professionals. AARP supports the proposal to require MA plans to provide medical professionals with a specific reason for denied prior authorization decisions. This will go a long way towards improving the beneficiary experience by facilitating better communication and understanding between MA plans and medical professionals while allowing for successful resubmission of the prior authorization request in a timely manner (if necessary).

Additionally, we support CMS's proposals to shorten prior authorization wait times. Under current regulations, the standard prior authorization wait time is no later than 14 calendar days after receiving the request for items of services, while expedited prior authorization request wait time is no later than 72 hours. The proposed rule would shorten standard wait times to 7 calendar days while leaving intact the 72 hours wait for expedited requests. The shortened wait time will help improve the beneficiary experience not just by addressing their health needs in a timelier way, but by giving them peace of mind that the decision will come within just one week as opposed to two. As discussed in the proposed rule, AARP would also support even shorter turnaround times as suggested by CMS, such as 48 hours (about 2 days) for expedited requests and five calendar days for standard requests. AARP supports these improvements to eliminate uncertainty and risk for a beneficiary when attempting to access the health care they need.

Finally, we support the proposed requirement that MA plan providers publicly report certain aggregated metrics about prior authorization by posting them directly on the payer's website or via a publicly accessible hyperlink(s). The proposed elements of the public report – especially a list of items and services that require prior authorization along with the percentage of both standard and expedited prior authorization requests – will help improve the overall understanding of the prior authorization process and potentially ways to improve it. However, we would like CMS to consider requiring that this data also be submitted on a regular basis to the agency so that it can be better analyzed and contextualized for both policymakers and the public at large. While we agree that making this information available publicly on an MA plan providers' website may be helpful for some patients when making enrollment decisions, the amount of information a potential enrollee must process when making an informed decision about their health care options can be daunting. We encourage CMS to explore ways in which this information can be reported and conveyed in a more meaningful way to current and potential MA beneficiaries.

We thank you for the opportunity to comment on this important proposal to improve the MA program and, by extension, the beneficiary experience. If you have any questions, please do not hesitate to contact me, or have your staff contact Brendan Rose on our Government Affairs staff at 202-434-3770 or brose@aarpp.org.

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner", with a stylized flourish at the end.

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs