March 13, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-0057-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule CMS-0057-P, ANCOR Written Comments

Dear Administrator Books-LaSure:

On behalf of the American Network of Community Options and Resources (ANCOR), thank you for the opportunity to provide feedback to the Centers for Medicare & Medicaid Services (CMS) proposed rule on *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 (Prior Authorization Rule).

Founded more than 50 years ago, ANCOR is a national, nonprofit association representing 2,000 private community-based providers of long-term supports and services to people with I/DD, as well as 56 state provider associations. Combined, our members support more than one million individuals with I/DD across their lifespan and are funded almost exclusively by Medicaid. Our mission is to advance the ability of our members to support people with I/DD to fully participate in their communities.

We understand and support CMS's broad goals to increase transparency and efficiencies in healthcare. However, our comments at this time are limited to the proposed regulations seeking to improve the prior authorization processes and current impacts to community-based providers supporting people with intellectual and developmental disabilities (I/DD). We appreciate CMS's recognition that without clear standards and due process guardrails, the prior authorization process can present significant administrative burden to community-based providers and barriers to connecting people with requisite services and supports.

ANCOR offers the following comments and context in response to the proposed Prior Authorization Rule. Our comments are framed to support increased transparency and efficiency in the prior authorization process with focus to the impact on community-based providers and people relying on their services and supports. We have organized our feedback by section below, touching upon broad themes and specific recommendations that arose within those topics.

Direct Support Workforce Crisis

There is, and has been for many decades, a workforce crisis in community-based settings, due in large part to stagnant reimbursement rates and the inability of providers to offer wages that enable them to compete with industries offering entry-level positions, such as fast-food restaurants or retail and convenience stores. This crisis is one of the greatest barriers to accessing community-based supports and services. The effects of underinvestment in the direct support workforce can be seen in turnover rates of approximately 44% nationally.[1] With the onset of COVID-19, new pressures and hazards of providing essential, close-contact services further exacerbated and accelerated the workforce crisis with full-time vacancy rates rising to 16.5% in 2021—a roughly 94% increase from 2019.

At approximately $14 per hour, the median wage for direct support professionals nationally is simply insufficient to slow the exodus of direct support professionals from the field and the closure of programs which threatens access to long term services and supports. Because these rates are set by Medicaid, they are outside of the normal market system. While many in the private sector pivoted by offering increased wages and hazard pay, community-based providers—who rely almost exclusively on Medicaid funding and are thus beholden to paying wages that state Medicaid reimbursement rates will permit—lack the resources to fund these kinds of unanticipated programmatic costs.

Without sufficient staffing, community-based providers have been forced to close programs and reject referrals. The recent results of *The State of America's Direct Support Workforce Crisis* found that 83% of providers are turning away new referrals, 92% of providers are struggling to achieve quality standards, and 71% of case managers are struggling to find available providers to connect families with services.[2] As a direct consequence of the workforce crisis, 63% of providers are discontinuing programs and services now with 55% of providers considering additional service discontinuations at the current rate of turnover and vacancy. This represents a staggering 85.3% increase in service closures since the beginning of the COVID-19 pandemic.

The current fragility of access to community-based services has created a constant state of flux in service availability. Unnecessary or overly burdensome administrative requirements on community-based providers must be approached cautiously with recognition for the workforce

[1] *National Core Indicators Intellectual and Developmental Disabilities 2021 State of the Workforce Survey Report*. Alexandria, VA: National Core Indicators, 2023.
[2] *The State of America's Direct Support Workforce Crisis 2022*. Alexandria, VA: ANCOR, 2022

crisis and the impact on the already limited personnel and resources. Community-based providers are stretched to capacity with most providers undergoing and considering additional service closures. Administrative workload without commensurate adjustment to reimbursement rates can unintentionally cause additional closures and further reduce already diminishing access to community-based services.

Prior Authorization Process

We appreciate CMS's attention to the prior authorization process and the impact it can have on access to services. Without clear guardrails, the prior authorization process can unnecessarily burden community-based providers and present barriers to community-based services, further risking unnecessary institutionalization. As most of the proposed rule would not take effect until January 2026, we urge consideration of a much shorter timeframe of implementation for the below prior authorization reforms, which are not reliant on creation of new technological infrastructure.

1. *ANCOR supports requiring impacted payers to provide clear response to prior authorization requests, including a specific reason when there is a denial.*

We support regulations that would require that the payer responds to the provider with specific information about prior authorization requests, including a clear statement of whether the payer has approved, denied, or requested additional information related to the prior authorization request. We also support requirements that indicate the specific reason for any denial. Although there is existing regulatory structure requiring written notice of any such denial, these requirements can become distorted during the prior authorization process necessitating explicit direction. For these reasons, we also support the proposed clarifications to include adverse actions in prior authorization as an opportunity for a fair hearing.

For example, the direct support workforce crisis routinely makes it difficult for beneficiaries to access the full number of hours of support they are eligible for due to insufficient staffing. This will often prompt discussion from the prior authorization entity when the full number of hours are requested after months of partial utilization. Instead of approving or denying the request, the prior authorization entity will contact the provider to determine whether staffing is available. If it is not, the prior authorization entity will approve a lower number of hours and record that the provider agreed to amend the request thereby usurping the beneficiary of appeal rights and making it more difficult to seek authorization if staffing becomes available.

In the event a denial is recorded to reflect the reduction, it will often cite to a generic boilerplate, such as "the service is not medically necessary." Without written and specific response with disqualifying information, it can be incredibly difficult for both the provider and beneficiary to determine whether there is a denial and the underlying cause for the denial. This similarly can lead to misunderstandings regarding appeal rights, opportunities for administrative hearings, and an inability to challenge the denial at a later time.

2. *ANCOR supports requiring impacted payers to send prior authorization decisions within at least 72 hours for expedited requests and seven calendar days for standard requests.*

Without standards for prior authorizations, processing times for certain community-based services can take months. This implicitly places community-based providers and beneficiaries between a rock and a hard place. If the beneficiary is reliant on the community-based provider for home and community-based services, withholding support while waiting for authorization increases the risk of undue institutionalization. However, providing services without funding and authorization puts further fiscal strain on a fragile system of care and liability for services provided outside of the authorization process.

While the proposed timelines would vastly improve the prior authorization process, we urge continued consideration of shorter timeframes, with focus to expedited or urgent requests which would otherwise increase risk of hospitalization or institutionalization. The diminishing community-based provider networks makes it especially difficult to maintain community-based supports during acute periods of institutional services or to find a new community-based provider to transition to after discharge. Ensuring these types of requests are reviewed and responded to with as much immediacy as possible is both cost effective and in keeping with the principles of community integration within the *Olmstead* decision.[3]

3. *ANCOR supports requiring impacted payers to publicly report certain prior authorization metrics by posting them directly on the payer's website or via publicly accessible hyperlinks on an annual basis.*

Increasing transparency of the prior authorization process and outcomes is critical to identifying denial trends and disparities in impact on both a small and global scale. Including a list of all items and services that require prior authorization would better assist providers, beneficiaries, and service coordinators to account for the time necessary to secure authorization for a needed item and service. From a systems perspective, the ability to review percentages and timeframes for denials also supports critical oversight and accountability.

We request further clarity on the use of the phrase "aggregated for all items and services." If it is intended to produce a single percentage or metric for any use of the prior authorization process, we urge consideration of a more granular approach. It is crucial for both individual planning and advisory oversight that these data points are disaggregated, at minimum, by category of service or item. This will assist in identifying trends in denials or extended timelapses targeted to specific services with disparate outcomes. This is in keeping with the CMS Framework for Health Equity, including its first priority to expand the collection, reporting, and analysis of standardized data and second priority to assess causes of disparities within CMS programs and address inequities in policies and operations.

[3] *Olmstead v. L.C.,* 527 U.S. 581, 600 (1999)

Conclusion

We support CMS's broad goals to increase transparency and efficiencies in healthcare through the prior authorization process. Though our comments are limited to support for the proposed regulations seeking to improve the prior authorization processes, this should not be construed as opposition to other provisions of the proposed rule. However, immediate reform and inclusion of guardrails to the prior authorization process are necessary to relieve administrative pressure on the community-based services infrastructure.

Thank you for this opportunity to provide comment. Please reach out to me at ldawson@ancor.org if we can provide further clarification or information regarding the above.

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