American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

September 29, 2025

The Honorable Robert F. Kennedy Jr.
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Health Insurer Commitment to Improved Prior Authorization Processes

Dear Secretary Kennedy and Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) thanks you for your role in facilitating the health insurer pledge to reform prior authorization processes announced on June 23.

The AHA commends the administration for convening health insurance industry leadership and enabling their potentially transformative reform commitments. By establishing a shared and measurable commitment to improving prior authorization processes through standardization, volume reductions and minimizing care delays and disruptions, the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) have empowered plans and providers to collaboratively transform care delivery and improve patient health outcomes. The insurance industry's commitments also have the potential to significantly reduce administrative burden on providers. We offer the following insights and recommendations to ensure the pledge achieves these important outcomes.

Additionally, we thank the administration and the Assistant Secretary for Technology Policy/Office of the National Coordinator (ASTP/ONC) for establishing new certification

criteria to support electronic prior authorization within the Health Data, Technology, and Interoperability: Electronic Prescribing, Real-Time Prescription Benefit and Electronic Prior Authorization (HTI-4) final rule. The AHA strongly supports an end-to-end automated prior authorization process that integrates with clinicians' electronic health records workflow. The ASTP/ONC certification criteria will bridge the gap between payer and provider systems and enable the successful exchange of the essential information needed to streamline prior authorizations.

As you recognized in the announcement of this pledge, prior authorization is too often used in a manner that leads to dangerous delays in treatment, clinician burnout and waste in the health care system. Prior authorization requirements often delay patient access to necessary care or lead to treatment abandonment, thereby worsening health outcomes and putting patients at risk. The process places an especially heavy burden on those with chronic or serious conditions.[1] In response to a recent AHA member survey, 95% of hospitals and health systems reported that the amount of staff time spent seeking prior authorization approval from health plans has increased in the last year. And the resource-intensive staff time spent managing health policies adds tremendous cost and burden to the health care system, including an estimated $26.7 billion spent by providers each year.[2] Moreover, the administrative delays and denials associated with prior authorization can intensify patient frustration, which in some cases has escalated into hostility toward health care workers. Our member hospitals note that the burdens of prior authorization contribute to heightened tensions in clinical settings, placing medical staff at increased risk of workplace violence.

As a result of the enormous detrimental impact that certain prior authorization practices routinely place on patients, physicians and hospitals, the AHA has been actively pushing for reforms in this area for a long time and working with health plans to collaboratively reduce the burdens associated with these programs.[3] In 2018, the AHA signed a joint consensus statement with AHIP, Blue Cross Blue Shield Association, the American Medical Association, the American Pharmacists Association, and the Medical Group Management Association in which the participants agreed to pursue a reduction in prior authorization volume, increase programmatic transparency, implement protections with continuity of care for patients, and establish standardized methods of completing prior authorizations.

However, despite the commitments expressed in the 2018 consensus statement, providers have seen minimal voluntary reforms by commercial plans. Prior authorization volume has continued to increase, patients continue to experience care disruptions

---

[1] https://www.kff.org/affordable-care-act/consumer-problems-with-prior-authorization-evidence-from-kff-survey/
[2] https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00036
[3] More information about AHA resources on prior authorization and health plan accountability can be found at: https://www.aha.org/issue-landing-page/2024-01-22-health-plan-accountability

when switching plans, the medical criteria used to process authorizations are still not clear for providers and prior authorization processes remain fractured. **Therefore**, **we encourage CMS to actively monitor plans' progress to ensure they honor these commitments, including full implementation of existing regulations such as the Interoperability and Prior Authorization final rule and reforms issued in the 2024 Medicare Advantage final rule.** In addition, attached we offer more detailed recommendations for areas of oversight that warrant particular focus based on our members' experience.

We thank you again for your timely focus on this critically important issue. Please feel free to contact me if you have any questions or have a member of your team contact Terrence Cunningham, AHA's senior director of administrative simplification policy, at tcunningham@aha.org.

Sincerely,
/s/
Richard J. Pollack
President and Chief Executive Officer

Attachment A: Recommendations to Oversee and Track Health Insurance Plans' Pledge to Reform Prior Authorization Practices

Recommendations to Oversee and Track Health Insurance Plans' Pledge to Reform Prior Authorization Practices

In the pledge, the health insurance plans commit to undertaking meaningful reform to eliminate some of the frustration felt by providers and patients with current prior authorization processes. Specifically, signatory plans commit to:

1. Standardizing electronic prior authorization.
2. Reducing the scope of claims subject to prior authorization.
3. Ensuring continuity of care when patients change plans.
4. Enhancing communication and transparency on denials and determinations.
5. Expanding real-time responses.
6. Ensuring medical review of nonapproved requests.

We agree with plans that each of these areas is particularly ripe for reform. To ensure the success of these commitments, we offer the following recommendations for prioritized oversight and programmatic tracking.

STANDARDIZING ELECTRONIC PRIOR AUTHORIZATION

Digitization of Medical Necessity Criteria

Although the insurers' announcement indicated that providers are the primary obstacle preventing the realization of automated prior authorization processes, the current technological landscape is much more complex. The HTI-4 final rule was a necessary step to enable provider systems to interact with the Fast Healthcare Interoperability Resources (FHIR) prior authorization application programming interfaces (API) committed to in the pledge and required by the Interoperability and Prior Authorization final rule Health plans, however, also must dedicate significant resources to implementing the necessary APIs before their processes satisfy the promises of the pledge. Specifically, for the FHIR technology to achieve efficient authorization reviews, plans must digitize their medical necessity policies so that incoming clinical data can be properly assessed for a coverage determination. Without this digitization, plans will need to manually compare clinical data against policies, maintaining the cumbersome protocol currently used that impedes timely access to treatment.

Despite forthcoming regulatory compliance deadlines, many health plans have not engaged in this work. Such stagnation not only prevents plans from fine-tuning their programs prior to the Jan. 1, 2027, implementation deadline, but it also disincentivizes provider implementation, as providers do not want to invest in a technology that plans will not support. **To ensure that plans implement the reform to which they are committed, we urge CMS to actively monitor and require demonstrable progress in digitizing plan medical necessity criteria in a manner that leverages the clinical information shared in the FHIR prior authorization standards**.

REDUCING THE SCOPE OF CLAIMS SUBJECT TO PRIOR AUTHORIZATION

Prior Authorization of Post-acute Care Services

Plans pledge to reduce prior authorization in areas where it is appropriate. Post-acute care is a specific area in need of reduced prior authorization requirements and delays. The ability to transfer a patient to an appropriate post-acute care setting, such as a skilled nursing facility, inpatient rehabilitation facility or long-term acute care hospital (LTACH), is an essential step in many patients' recovery processes. Most health plans require prior authorization before a patient can be transferred from a short-term hospital to a post-acute facility. Unlike many services scheduled in advance of treatment, post-acute care is requested while the patient is already in a hospital, and prior authorizations typically require specific, up-to-date clinical information regarding the patient's current status. As a result, prior authorization requests cannot be submitted in advance, instead occurring when the patient is ready to be transferred to the appropriate facility to continue their rehabilitation. Delays experienced while awaiting an authorization slow down the patient's recovery, prevent the patient from recovering in a setting most appropriate to meet their needs and tie up acute care beds and resources that could be used for other patients in need.

For example, patients who are dependent on ventilator-assisted breathing frequently require transition to a LTACH, which have specialization in weaning patients off ventilators. Transitions to LTACHs generally require prior authorization, which can cause unnecessary extensions of stays at acute care facilities and delay important weaning processes. These delays have been clinically shown to result in lower ventilator weaning success rates, which increases the patient mortality rate.[4]

Therefore, we urge HHS and CMS to eliminate inappropriate prior authorization requirements from post-acute care. Additionally, we encourage any authorizations to prioritize real-time response capabilities for post-acute care patients.

EXPANDING REAL-TIME RESPONSES

The AHA appreciates the plans' pledge that at least 80% of prior authorization approvals will be delivered in real time when providers submit requests electronically and include the required clinical documentation. To help achieve this, we once again reiterate the importance of standardized data and submission elements across plans to help ensure that providers are more easily able to identify the required clinical documentation accurately and consistently.

---

[4] https://pmc.ncbi.nlm.nih.gov/articles/PMC11629167

To truly realize the benefits of real-time authorization, it is imperative that the services subject to these prior authorizations are areas where plans have legitimate concerns about overutilization or patient harm. Our chief concern is that health insurers could attempt to require prior authorization on services that otherwise should not be scrutinized solely to enable them to approve those requests in real-time, thereby achieving compliance with the 80% figure. This would greatly reduce the impact of this reformation pledge, and **we urge the administration to monitor the services on which plans require prior authorization to ensure that their application is legitimately designed to reduce inappropriate utilization.**

ENSURING MEDICAL REVIEW OF NONAPPROVED REQUESTS

The pledge includes a commitment that all nonapproved requests based on clinical reasons will be reviewed by medical professionals, which is consistent with current CMS requirements and many state laws. This is particularly important due to increased insurer reliance on artificial intelligence (AI) tools in utilization management. While AI tools may serve a role in prior authorization processing, some insurers have utilized AI as the decision-making authority on which prior authorization denials are based — essentially removing the role of the clinician reviewer who is to make the appropriate medical necessity determination based on a patient's specific characteristics and tailored provider-recommended treatment. For example, numerous signees of the pledge are currently facing class-action lawsuits alleging reliance on such AI algorithms to inappropriately deny care without requisite clinician review. One such lawsuit alleges that one of the large national insurer signees denied more than 300,000 claims in a two-month period, amounting to about 1.2 seconds for each physician-reviewed claim. **The AHA is strongly against such a practice, which can lead to inappropriate denials of patient access to medically necessary care.**

To protect access to patient care, insurer physician reviewers must meaningfully review any decision that results in a partial or full denial of the requested items or services. While the use of AI tools to more quickly process prior authorizations is not inherently problematic, it is imperative that any recommendation to deny care, whether it is or is not AI-generated, be independently reviewed by a clinician for review. Further, reviewers must have the requisite training and expertise to engage in an informed medical decision about a patient's condition and the proposed treatment plan.

We applaud CMS for its attention to ensuring that clinician reviewers with the appropriate qualifications and expertise meaningfully review prior authorization requests and that the use of any automated tool to process prior authorization augments — rather than replaces — the decision of a trained clinician. **We urge HHS to actively monitor plans to ensure that all denials are being independently reviewed by physicians who typically manage the medical condition or disease, provide the health care services involved in the request, or have experience in the treatment being recommended by the patient's provider**.

IMPLEMENTING METRICS AND AUDITS

To best protect patient access to care, it is critical that CMS actively collect data and engage in audit protocols that will provide critical feedback about plan compliance with both CMS' Interoperability and Prior Authorization final rule (CMS-0057-F) and the industry pledge. We reiterate our support for CMS 0057-F's requirement that plans report metrics on their prior authorization processes, including the percentage of prior authorization requests approved, requests denied, denials overturned on appeal and the average time between submission and determination. This action has the potential to promote much-needed transparencies and the opportunity to build accountability. However, allowing plans to bury prior authorization metrics on individual plan sites adds little to no benefit to patients. Instead, we encourage CMS to directly collect these data and make them publicly available on a single website, like other performance measures.

Further, we encourage CMS to create mechanisms whereby this data is used to guide oversight and enforcement activities. The information gathered by CMS through the proposed data collection, reporting and audit protocols would provide critical feedback about plan performance and compliance with important federal rules designed to protect beneficiaries. Accordingly, we recommend that CMS regularly audit a sample of plan denials and timeframes, as well as use the data to target potentially problematic plans. Without this level of detailed auditing, there will be ample opportunity for certain health plans to continue circumventing federal rules without detection, rendering patient transparency efforts and protections ineffective. Such auditing will ensure realization of the full value of the proposed improvements to plans' prior authorization programs, thereby protecting patients' needed access to care.

CONCLUSION

We believe it is important to ensure that the commitments made in the pledge are actively monitored and upheld. We would welcome the opportunity to meet with you and your staff on a routine basis to review and discuss the progress and accountability of these commitments.