

CMS RFI Sample Comment Letters

There are three sample letters (version 3 is oncology focused) and key talking points. When submitting your public comments, please customize it so that the responses are unique to your organization. .

Sample Letter #1

Public Comment Submission

Date: [Insert Date]

To: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services

Attention: Docket ID: CMS-2026-1255

Reference: RFI for Prior Authorization and Access to Laboratory Testing (Section III.E of CMS-0062-P)

Submission Portal: Regulations.gov **Re:** Comment on RFI for Prior Authorization and Access to Laboratory Testing

To Whom It May Concern:

My name is **[Your Name]**, and I am writing as a **[patient/caregiver/patient advocate/healthcare provider]** to urgently request that CMS protect patients from critical care delays and denials caused by rigid prior authorization requirements for laboratory testing.

[Insert 1–2 sentences about your organization or personal background here].

While we commend CMS's efforts to modernize prior authorization, current rules inflict severe, unintended clinical consequences. Many health plans deny coverage unless prior authorization is approved strictly on or before the exact date a specimen is collected. When administrative reviews lag, viable specimens must often be discarded, forcing vulnerable patients—especially those battling cancer or rare diseases—to undergo unnecessary, repeated blood draws. This delays time-sensitive treatment decisions and places disproportionate financial and geographic burdens on rural and low-income populations.

To align insurance policies with real-world clinical workflows, **I strongly urge CMS to mandate that health plans:**

- **Allow Retroactive Approvals:** Permit prior authorizations to be processed *after* specimen collection. Oftentimes biomarker testing and other specialty labs are collected at the providers office, but sent to another lab for processing. Because the 'date of service' is the date the specimen was collected, not when it is processed, there can be delays or denials leading to repeat blood draws.

- **Prohibit Timing-Based Denials:** Stop denying medically necessary tests solely because paperwork was not finalized before the draw date.
- **Eliminate Redundant Testing:** Prevent forced, repeated blood draws when a valid specimen is already available.
- **Establish Expedited Pathways:** Accelerate turnaround times for oncology and other time-sensitive diagnostics.
- **Protect Patients Financially:** Insulate patients from surprise out-of-pocket liabilities when acting in good faith.

Patients deserve swift, uninterrupted access to laboratory insights. Prior authorization frameworks should facilitate health, not serve as bureaucratic roadblocks.

Thank you for your consideration.

Sincerely,

[Your Signature / Name] [Your Title / Role]

[Your Organization, if applicable]

[City, State]

Sample Letter #2

Public Comment Submission

Date: [Insert Date]

To: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services

Attention: Docket ID: CMS-2026-1255

Reference: RFI for Prior Authorization and Access to Laboratory Testing (Section III.E of CMS-0062-P)

Submission Portal: [Regulations.gov](https://www.regulations.gov)

Re: Comment on RFI for Prior Authorization and Access to Laboratory Testing

Sample Letter (please customize to make this uniquely your own)

To Whom It May Concern:

My name is **[Your Name]**, and I am writing as a **[patient/caregiver/patient advocate/healthcare provider, etc.]** to urgently request that CMS protect patients from critical care delays and denials caused by rigid prior authorization requirements for laboratory testing.

[Insert 1–2 sentences about your organization or personal background here, e.g., "As an organization representing oncology patients, we see firsthand..."]

We commend CMS for its ongoing efforts to modernize and streamline prior authorization processes. We also deeply appreciate the opportunity to provide specific feedback via the Request for Information regarding the impact of prior authorization on timely patient access to medically necessary laboratory testing, as referenced in Section III.E of CMS-0062-P.

The Real-World Impact of Administrative Timing

Prior authorization rules currently inflict severe, unintended consequences on patients and their clinical care pathways. When a physician orders a blood test, patients reasonably assume the diagnostic process moves forward once their blood is drawn. However, many health plans require prior authorization to be approved strictly based on the exact date the biological specimen was collected.

This causes immediate operational failures when a blood draw occurs before the laboratory physically receives the specimen or before the insurer's administrative review is complete. This issue is especially prevalent for high-complexity biomarker tests and advanced specialty laboratory diagnostics. Patients should never have their healthcare compromised because of paperwork timing that is entirely outside their control.

The Harm of Unnecessary Delays and Repeat Procedures

If a prior authorization is not processed and approved promptly, an otherwise perfectly valid blood specimen may be delayed, rejected, or entirely discarded by the laboratory due to viability windows. Consequently, vulnerable patients are forced to undergo repeat blood draws.

For individuals battling cancer, rare diseases, or other serious health conditions, this does not just mean another needle stick; it delays definitive test results needed to make time-sensitive decisions about:

- Initial treatment selection or modification
- Monitoring disease progression or recurrence
- Determining clinical trial eligibility

These administrative barriers cause profound, unnecessary psychological stress and physical harm. Waiting for diagnostic results is already deeply agonizing for families; health systems should not artificially prolong this period.

Disproportionate Hardships on Vulnerable Populations

This burden falls heaviest on rural patients, low-income families, and those living far from major medical centers or specialty clinics. A repeat blood draw is not a minor inconvenience. It often requires taking additional time off work, arranging transportation, paying for fuel and parking,

securing childcare, and traveling long distances while ill or undergoing grueling treatments. For these populations, administrative hurdles are an outright barrier to care.

Policy Recommendations for CMS

I strongly urge CMS to require health plans to adopt patient-centered prior authorization rules tailored to laboratory testing workflows. Specifically, CMS should mandate that health plans:

- **Allow Retroactive Approvals:** Permit prior authorization requests to be submitted and approved *after* a specimen is collected, provided the laboratory had no control over the timing or location of the initial draw.
- **Prohibit Timing-Based Denials:** Prevent health plans from denying coverage or delaying a medically necessary laboratory test solely because the authorization was not finalized on or before the specimen collection date.
- **Eliminate Redundant Testing:** Stop forcing patients to undergo repeat blood draws when a viable, valid specimen is already available and awaiting analysis.
- **Establish Expedited Pathways:** Require accelerated prior authorization turnaround times for oncology and other highly time-sensitive diagnostic testing.
- **Standardize Documentation:** Ensure health plans accept standard, appropriate clinical documentation from ordering physicians and testing laboratories to verify medical necessity.
- **Protect Patients Financially:** Insulate patients from surprise billing and out-of-pocket liabilities when the patient, physician, and laboratory all acted in good faith.

Patients require swift, uninterrupted access to laboratory metrics so they and their care teams can make informed, life-saving clinical decisions. Prior authorization frameworks must align with real-world clinical workflows rather than serve as bureaucratic roadblocks.

Thank you for your time, leadership, and consideration of these comments.

Sincerely,

[Your Signature / Name]

[Your Title / Role]

[Your Organization, if applicable]

[City, State]

Sample Letter Oncology Focused #3

Public Comment Submission

Date: [Insert Date]

To: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services

Attention: Docket ID: CMS-2026-1255

Reference: RFI for Prior Authorization and Access to Laboratory Testing (Section III.E of CMS-0062-P)

Submission Portal: [Regulations.gov](https://www.regulations.gov)

Re: Comment on RFI for Prior Authorization and Access to Laboratory Testing

Sample Letter (please customize to make this uniquely your own)

To Whom It May Concern:

My name is **[Your Name]**, and I am writing as a **[patient/caregiver/patient advocate/healthcare provider, etc.]** to urgently request that CMS protect patients from critical care delays and denials caused by rigid prior authorization requirements for laboratory testing.

[Insert 1–2 sentences about your organization or personal background here, e.g., "As an organization representing oncology patients, we see firsthand..."]

We commend CMS for its ongoing efforts to modernize and streamline prior authorization processes. We also deeply appreciate the opportunity to provide specific feedback via the Request for Information regarding the impact of prior authorization on timely patient access to medically necessary laboratory testing, as referenced in Section III.E of CMS-0062-P.

I urge CMS to protect oncology patients from delays and denials caused by prior authorization requirements for medically necessary laboratory and biomarker testing.

In cancer care, timing is critical. Biomarker and specialty lab results often guide treatment selection, treatment changes, disease monitoring, and clinical trial eligibility. When prior authorization rules require approval before or on the exact specimen collection date, valid specimens may be delayed, rejected, or discarded—even when the patient, physician, and laboratory acted in good faith. This can force repeat blood draws and delay urgent cancer care.

CMS should require health plans to:

1. Allow retroactive authorization when specimens have already been collected.
2. Prohibit denials based solely on authorization timing.
3. Prevent unnecessary repeat blood draws when a valid specimen is available.
4. Require expedited review for oncology-related diagnostic and biomarker testing.

5. Protect patients from surprise costs when delays are administrative.

Cancer patients need timely access to laboratory testing so they and their care teams can make informed, potentially life-saving treatment decisions without unnecessary administrative barriers.

Sincerely,
[Name]

[Your Signature / Name]

[Your Title / Role]

[Your Organization, if applicable]

[City, State]

CMS Comments: Strategic Talking Points

Key Message: Patients should not face care delays, redundant blood draws, denied coverage, or unfair financial burdens due to arbitrary administrative prior authorization timing rules that are entirely outside their control.

1. Critical Delays in Patient Care

- Prior authorization bottlenecks delay laboratory testing, stalling vital treatment decisions.
- Oncology patients and individuals with acute, serious illnesses rely heavily on rapid laboratory turnaround times to guide treatment.

2. The Burden of Redundant Blood Draws

- If approval is not granted before the exact date of collection, laboratories are often forced to discard valid specimens.
- Patients endure the physical discomfort and health risks of unnecessary repeat procedures solely to meet administrative timelines.

3. Misalignment of Administrative vs. Clinical Priorities

- Patients, physicians, and laboratories acting in good faith are routinely penalized by insurers' processing delays.
- Administrative technicalities and clerical deadlines should never override documented medical necessity.

4. Financial Strain on Patients

- Insurance complexities leave patients vulnerable to unexpected out-of-network bills and coverage denials.
- Repeat testing forces patients to incur compounding secondary costs, including lost wages, travel expenses, and childcare costs.

5. Disproportionate Impacts on Vulnerable Communities

- Rural, low-income, and medically underserved patients face geographic and financial barriers when they are forced to return to a clinic for repeat testing.
- Immunocompromised or severely ill patients experience heightened physical and emotional exhaustion from repeated, avoidable clinic visits.

6. The Need for Modernized Review Standards

- Time-sensitive testing (e.g., cancer recurrence monitoring, medication management, and clinical trial screening) requires dedicated, expedited review pathways.
- CMS must require insurance plan policies to align with actual, real-world laboratory workflows rather than rigid, linear timelines.