MISSOURI HOSPITAL ASSOCIATION

Herb B. Kuhn
President and CEO
P.O. Box 60
Jefferson City, MO 65102

January 4, 2021

Ms. Seema Verma
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9123-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicaid Program; Patient Protection and Affordable Care Act; Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information for Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-facilitated Exchanges; Health Information Technology Standards and Implementation Specifications (CMS-9123-P)

Dear Ms. Verma:

On behalf of its 140 hospital members, the Missouri Hospital Association offers the following comments in response to the Centers for Medicare & Medicaid Services' proposed rule addressing prior authorization processes.

Hospitals throughout the country have employed staff and dedicated many resources to ensure third-party utilization review and prior authorization processes are followed. The cost incurred by hospitals to provide such services to patients is significant. MHA applauds CMS' efforts to minimize the burdens on providers; specifically, the requirement to establish information sharing through the implementation of the Fast Healthcare Interoperability Resource, the requirement to build and maintain a Provider Access Application Programing Interface to help facilitate the coordination of care, the proposal to make the prior authorization process more efficient and transparent, the proposal to include a maximum of 72 hours to issue decisions and expanding payer-to-payer data exchanges are appreciated.

Conversely, MHA is very disappointed that CMS is excluding Medicare Advantage plans from the requirements outlined in the proposal. Hospitals report significant issues with the prior authorization process for patients who have enrolled in a Medicare Advantage product, and the COVID-19 pandemic has illuminated the problematic, burdensome and inefficient MA prior authorization processes.

As an example, a hospital reported that between October 1 and December 8, 55 MA patients were referred to the institutional provider. During that time, 75 percent of the patients were denied admission by the MA plan prior authorization contractor. After appealing to the carrier,

100 percent of those appealed were approved for admission. The multilayered process caused an unjustified delay in patient treatment. Such tactics are doing nothing more than delaying services. CMS should include the MA plans within the proposed prior authorization rule.

Thank you for the opportunity to comment and for your consideration of this issue.

Sincerely,

Daniel Landon
Senior Vice President of Governmental Relations

dl/djb