Maryland
Hospital Association

March 13, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244
Submitted via https://www.regulations.gov

Re: CMS 0057-P, 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

Dear Administrator Brooks-LaSure:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Advancing Interoperability and Improving Prior Authorization Processes proposed rule.

We are pleased the proposed rule includes important policies to remove inappropriate barriers to patient care by streamlining prior authorization processes for impacted health plans and providers. Prior authorization policies burden providers and divert valuable resources from patient care. We strongly support prior authorization reform that can streamline the arduous process to improve patient care and reduce provider burnout.

While we appreciate CMS' focus on reducing prior authorization timelines, the proposed timeframes are unnecessarily lenient. Under existing regulations, Medicare Advantage (MA) organizations have up to 14 calendar days to decide on standard prior authorization requests and must make an expedited prior authorization decision within 72 hours. The proposed rule would require MA organizations, beginning Jan. 1, 2026, to make standard prior authorization decisions within seven calendar days.

MHA believes MA organizations can determine whether the provider has met their established medical necessity threshold in a much timelier manner. In Maryland, commercial health care insurers must generally determine prior authorization requests within two business days after receiving all relevant information, and reforms have been introduced to expedite the requirement to two calendar days. Since many Maryland commercial carriers and Maryland MA organizations overlap, MA organizations should have the capability to determine prior authorization more quickly than CMS' proposal. We therefore recommend that MA

organizations be required to deliver prior authorization responses within 72 hours for standard, nonurgent services and 24 hours for urgent services.

Thank you again for this opportunity to comment. We appreciate the chance to work with CMS to advance policies that improve Medicare beneficiary access to medically necessary care in Maryland. Please do not hesitate to reach out to Steven Chen, MHA's Director of Policy, should you have any questions.

Sincerely,

Nicole Dempsey Stallings
Executive Vice President & Chief External Affairs Officer