Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

To whom it may concern,

Blue Cross Blue Shield of Michigan appreciates the opportunity to provide feedback on the Medicare Part C Utilization Management Annual Data Submission and Audit Protocol Data comment period.

We thank you in advance for your review of our comments and clarification requests below.

UM Annual Data Submission Plan Comments

- Plan is seeking clarification whether CMS will be expecting that plans submit the annual data at a parent organization level or contract level.
- It is the plan's opinion the estimated burden provided by CMS (20 hours on average) severely underestimates administrative requirements to assemble and submit this requested information timely.
- Plan is seeking clarification on the required format for Column ID C, Date of Most Recent Approval. The examples provided in the UMAS Record Layout with Examples document do not match the proposed date format of "CCYY/MM/DD" published in the Medicare Part C Utilization Management Annual Data Submission Record Layout.
- Plan members are eligible to receive services in MAC jurisdictions, outside of the local MAC jurisdiction. Plan is seeking clarification if only the local MAC jurisdiction would be expected in Column ID D, Medicare Administrative Contractor (MAC) Jurisdictions (*e.g.* BCBS of Michigan internal coverage criteria would only include Michigan applicable MAC)?

UM Audit Protocol Plan Comments

- It is the plan's opinion that proposed 50 targeted services in conjunction with the proposed turnaround times will place a significant burden on plan's ability to meet all proposed deadlines and audit requirements.
- Regarding the UM Supplemental Questions, the plan is seeking clarification on question 4, "Can members, non-members, and providers clearly identify which services the organization has internal coverage criteria for, and which services do not have internal coverage criteria? Please explain." Plans are not currently required to maintain a crosswalk of this nature and the plan is seeking clarification how CMS expects plans to respond.
- Regarding the UM Supplemental Questions, the plan is seeking clarification on question 8 regarding "redeterminations" verbiage. Historically, the term "redetermination" has been utilized when referring to Part D services. Plan seeking clarification if this is intended to reference "redeterminations", "reconsiderations" or both?
- Plan is seeking clarification of how CMS is defining a "Service Area", specific to the description in Column ID B "Fully Established". How are plans are expected to populate this field when the plan consists of several EGWPs that have a nationwide service area where requirements may vary across jurisdictions?

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- It is the plan's opinion the 15-business day turnaround time for Initial Submission is too restrictive, given it is the first time plans will be expected to meet these audit requirements.
- It is the plan's opinion the 10 business days to turn around time for Evidentiary Sources Submission is too restrictive, given it is the first time plans will be expected to meet these audit requirements.
- It is the plan's opinion that CMS should standardize the impact analysis timeframe, and that the current proposal to limit the IA timeframe based on the service would be overly burdensome to plans.
- These protocols note the expectation that plans are able to provide internal coverage criteria documentation to justify approvals and denial decisions for beneficiary hospital stays. As CMS is aware, there are a myriad of reasons why a beneficiary might be admitted for a hospital stay and approval decisions are informed by a complex structure of internal and vendor medical policies. Plan requests CMS further clarify what documentation CMS expects to receive to satisfy this expectation.
- Plan would like to confirm if there will be any UM focused audits in 2025, or should plans be prepared beginning 2026?
- It is the plan's recommendation that during the CMS review and data validation process, CMS provide plans with specific procedure codes should plans be required to search for and provide denial information for selected services. Locating specific services by name can present significant challenges for plans due to service descriptions being labeled in various ways (e.g. short description, long description, beneficiary-friendly description, etc.). Specific procedure codes would ensure plans are able to better meet CMS requirements during this phase of an audit.

Thank you again for taking the time to consider and respond to our feedback.

Sincerely

Kaitlin Stretch
Manager, Regulatory Oversight & Compliance
Blue Cross Blue Shield of Michigan