MAYO CLINIC

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SUBMITTED ELECTRONICALLY

June 26, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2744 and CMS-10905

Re: Document Identifier CMS-2744 and CMS-10905: Agency Information Collection Activities: Submission for OMB Review; Comment Request (Federal Register Vol. 90, No. 103)

Dear Administrator Oz:

On behalf of Mayo Clinic, we want to thank you for the opportunity to share our comments on the Agency Information Collection Activities for: Service Level Data Collection for Part C and D Reporting Requirements for Initial Determinations and Appeals. For over 150 years, Mayo Clinic has been committed to our mission of putting the needs of the patient first. Mayo Clinic provides care for approximately 1.3 million patients who visit Mayo Clinic campuses from over 130 countries every year. Patients come to Mayo Clinic to receive the highest quality care at sites in Minnesota, Arizona, Florida and Wisconsin. As the largest integrated, not-for-profit medical group practice in the world, Mayo Clinic is dedicated to finding answers for patients through medical care, research and education. Mayo Clinic brings together teams of specialists with a relentless and unwavering commitment to excellence. Transforming healthcare for the future, Mayo Clinic continues our rich history of solving the most serious and complex medical challenges – one patient at a time. Mayo Clinic is proud to be top-ranked for quality more often than any other healthcare organization and is top-ranked in more specialties than any other U.S. hospital.

We thank you again for the opportunity to provide feedback.

Comments on Specific Notice of Service Level Data Collection for Part C and D Reporting Requirements for Initial Determinations and Appeals

2. Type of Information Collection Request: New collection (Request for a new OMB control number)
Title of Information Collection: Service Level Data Collection for Initial Determinations and Appeals
Use: The Part C and D Reporting Requirements

After a level one appeal to a Medicare Advantage Plan (Plan) by a non-contracted provider or a member (either by the member or an appointed representative) that is in any way adverse to the provider or member, the Plan is required by 42 CFR Part 422 Subpart M and CMS Parts C & D Appeals Guidance Section 60.1 to gather all

pertinent information and forward to the Independent Review Entity for independent review. Some Plans are failing and/or refusing to take this required step. Based on this, we recommend that the data collection include sufficient information to ensure Plan compliance with this crucial step in the appeal process.

The Plan is required to provide its members with the same coverage of services that the member would have if the member was a traditional Medicare beneficiary. We suggest that the data collection include sufficient information to ensure that Plans are appropriately approving and covering services for their members in accordance with this requirement.

A concerning situation exists when the Plan denies prior authorization for a member to discharge to a skilled nursing facility when the member is medically ready for discharge from a qualifying 72-hour inpatient hospital admission. If the member had traditional Medicare, the member would enjoy a presumption of medical necessity of the need for skilled nursing facility care (assuming the appropriate physician determination) and would be able to discharge to the skilled nursing facility without needing a prior authorization. By denying the prior authorization, the Plan is either delaying the member's discharge or forcing the member to discharge to a level of care that will not meet the member's needs. Even with the expedited appeal process, this can delay the member discharge by 6 days (72 hours for the expedited appeal to the Plan and 72 hours for the expedited appeal to the Independent Review Entity). We recommend that the data collection include sufficient information to determine if Medicare Advantage Plans are utilizing the prior authorization process to delay or prevent its members from getting the appropriate level of care following a 72-hour qualifying stay that the member would have access to if the member had traditional Medicare.

Conclusion

Mayo Clinic continues to drive innovation for our patients and across the healthcare system more broadly and is honored to serve as a leading voice in shaping the healthcare system of the future. For more information, please feel free to reach out to me at Lindor.Rachel@mayo.edu or Sarah Meier, Director of Payment and Care Delivery Policy, at Meier.sarah@mayo.edu.

Sincerely,

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