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 (BCBSM) appreciates the opportunity to submit comments regarding CMS' intention to collect service level data for initial determinations and appeals. Generally, BCBSM is concerned that the finalization of these requirements for CY2026 would be an immense burden to Plans given the level of detail being requested.

BCBSM is seeking clarification and additional direction from CMS regarding the following element within the required reporting:

General Plan Comments & Feedback

- BCBSM appreciates the additional details provided in the updated reporting technical specifications and requests additional clarification from CMS on the following:
    - Information regarding the timeline CMS anticipates for finalizing requirements and submission due dates for Plans, inclusive of a finalized file layout.
    - Clarification on the file type requirements for submission via HPMS.
    - Clarification on the inclusion or exclusion of reopening's that are handled by the Plan.
    - Clarification on how to populate an element when the criteria requested are not applicable or does not fit into a CMS-provided value. For example, diagnosis codes, not all cases will contain a diagnosis code. Should Plans leave this field blank, or should it be populated with "None"?
- BCBSM recommends CMS consider initial determinations (payment decisions) be reported at the claim header level instead of the line level. The reason for this recommendation is due to the size of the data set. Pulling payment decisions (claims) at the line level is overly burdensome to Plans.
- The finalization of these requirements for CY2026 would be an immense burden to Plans given the level of detail being requested. The Plan requests CMS to consider a longer implementation runway if these requirements are finalized as currently written.

Initial Determinations – Coverage Decisions (Subsection 1.A)

- BCBSM is seeking clarification for element P (Decision Rationale):
    - What should the Plan populate if the rationale does not correlate with one of the reasons provided, such as ineligibility?
    - What differentiates reason 05 (Lack of Medical Necessity) and 07 (Not Deemed Reasonable and Necessary)?
    - Can multiple values be noted if multiple values apply?

Initial Determinations – Payment Decisions (Subsection 1.B)

- BCBSM is seeking clarification for element T (Decision Rationale):

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    - What should the Plan populate if the rationale does not corelate with one of the reasons provided, such as ineligibility?
    - What differentiates reason 05 (Lack of Medical Necessity) and 07 (Not Deemed Reasonable and Necessary)?
    - Can multiple values be noted if multiple values apply?
- BCBSM is seeking clarification for element U (Reviewer Qualification):
    - It is uncommon for a health care professional to review a payment request; Plan is seeking clarification on how to populate this element for payment decisions if the request is auto-adjudicated.

BCBSM is appreciative of CMS's collection of plan feedback as well as the evaluation of our requests.

Sincerely,

Kaitlin Stretch

Manager, Regulatory Oversight & Compliance

Blue Cross Blue Shield of Michigan