June 30, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

SUBJECT: CMS-10905, Service Level Data Collection for Initial Determinations and Appeals, Paperwork Reduction Act (PRA) Listing

Dear Administrator Oz:

In California, a growing majority of Medicare beneficiaries — 56% — are enrolled in Medicare Advantage Organizations (MAOs), with Medicare Advantage (MA) penetration as high as nearly 75% in some counties. Additionally, California is home to 1.4 million individuals dually eligible for both Medicaid (Medi-Cal in California) and Medicare.[1] Many of these beneficiaries are enrolled in high-quality MAOs that are part of tightly integrated delivery systems fulfilling the promise of MA plans to provide cost effective care.

However, as the senior population grows — and as California moves to enroll the most vulnerable seniors and individuals with disabilities into MA plans — **it is critical that the Centers for Medicare & Medicaid Services (CMS) take steps to ensure that all MAOs employ policies and practices that expand access to care, ensure care is provided in the most clinically appropriate setting, and align with providers' efforts to deliver timely and coordinated services across the continuum of care.** Further, as enrollment in the MA program reaches record levels, it is important now, more than ever, to establish and implement stronger beneficiary protections and oversight mechanisms to ensure these steps are being taken.

On behalf of nearly 400 member hospitals and systems, the California Hospital Association (CHA) offers the following comments on CMS' "Service Level Data Collection for Initial Determinations and Appeals" proposal. **Hospitals support CMS' proposals to increase MAO transparency and accountability by implementing additional data collection and audit procedures for utilization management policies and tools.** Specifically, CHA applauds CMS' proposals to collect more granular data related to MAO adjudication of requests for coverage and plan procedures for making service utilization decisions. This

[1] https://atiadvisory.com/wp-content/uploads/2022/02/Profile-of-the-California-Medicare-Population.pdf

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includes collecting more timely data with greater frequency, enhancing audit activities to ensure plans are operating in accordance with CMS guidelines, and ensuring appropriate access to covered services and benefits. As CMS describes, this information is needed to monitor health plans and hold them accountable for their performance while also providing valuable information about beneficiary access to Medicare-covered services. **Most importantly, increased scrutiny and evaluation of MAO performance and compliance with existing federal regulations will help protect Medicare beneficiaries from inappropriate delays and denials of Medicare-covered services.** Detailed comments on CMS' proposed "Service Level Data Collection for Initial Determinations and Appeals" are provided below.

The Need for Additional Data Collection and Oversight

Hospitals and health systems have written extensively to CMS and other federal agencies in recent years articulating serious concerns about the negative effects of certain MAO practices and policies. These include:

- Abuse of utilization management programs
- Inappropriate denial of medically necessary services that would have been covered by traditional Medicare
- Use of overly restrictive proprietary medical necessity criteria that are not transparent to patients or providers
- Requirements for unreasonable levels of documentation to demonstrate clinical appropriateness, inadequate provider networks to ensure patient access, and unilateral restrictions in health plan coverage applied in the middle of a plan year

These practices unequivocally impede patient access to health care services, create inequities in coverage between Medicare beneficiaries enrolled in MA compared to those enrolled in traditional Medicare, and, in some cases, directly harm Medicare beneficiaries through unnecessary delays in care or outright denial of covered services. They also add billions of wasted dollars to the health care system and are a major driver of burnout among health care workers.[2]

Further, the need for additional oversight of MAOs is underscored by results from several investigations, including a 2018 U.S. Health and Human Services Office of Inspector General (OIG) report[3] that found MAOs overturned 75% of their own denials, as well as a subsequent 2022 OIG report that raised concerns about beneficiary access to medically necessary care in certain MA plans.[4] A 2023 survey of CHA members found that patients covered by MA plans are nearly twice as likely to experience a discharge delay than those with traditional Medicare, raising serious questions about access to medically necessary post-acute care for MA enrollees.[5]

Priority Areas for Data Collection and Reporting

CHA broadly supports CMS' intended areas for data collection, reporting, and auditing. However, five specific areas warrant the greatest attention and scrutiny with respect to auditing plan compliance:

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[2] https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf
[3] https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp
[4] https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/
[5] https://calhospital.org/wp-content/uploads/2024/01/Impact-of-Inadequate-Networks-CHA-Analysis-FINAL.pdf

- MAO use of internal coverage criteria
- Hospital inpatient admissions and compliance with the two-midnight benchmark
- Post-acute care access
- Use of automated utilization management tools
- Oversight of third-party vendors

These areas present persistent challenges for patients and providers with respect to securing coverage and payment for Medicare-covered services consistent with CMS regulations, and should be prioritized in data collection, reporting, and auditing efforts.

MAO Use of Internal Coverage Criteria. In the calendar year (CY) 2024 final rule, CMS codified that MA organizations must make medical necessity determinations in accordance with all traditional Medicare coverage requirements, including rules established in statute, regulation, National Coverage Determinations (NCDs), and Local Coverage Determinations (LCDs). Further, the CY 2024 rule establishes that MAOs may only utilize internal criteria when Medicare coverage criteria are not fully established under traditional Medicare. In such instances, MA organizations may utilize internal coverage criteria if they: (a) are publicly available, (b) are based on current evidence in widely used treatment guidelines or clinical literature, and (c) provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services.

CHA members report that many MAOs consistently fail to meet some or all of the requirements for using internal coverage criteria codified at § 422.101(b)(6).In some cases, the criteria are not easily or publicly accessible, in others MAOs utilize sources that are neither widely used guidelines nor peer-reviewed literature, and in still other instances MAOs altogether ignore the requirement to demonstrate that the additional criteria used provide an identifiable clinical benefit that outweighs potential patient harm from delayed or decreased access to services. CMS' focus on increasing oversight and compliance with these important provisions, supported by its intended data collection and auditing mechanisms, has strong potential to improve plan adherence and improve MA beneficiaries' access to care.

Given the ongoing challenge of MAO compliance with internal coverage criteria requirements, CMS should further strengthen the proposed reporting requirements to:

- Require MAOs to demonstrate how they are meeting the requirements of § 422.101(b)(6) for each specific clinical condition for which the MA plan adopts an internal coverage criterion.
- Collect plan-level information on the total number and percentage of medical necessity determinations that are made using internal coverage criteria. This information is necessary to evaluate whether certain MAOs continue to apply internal coverage criteria broadly as a blanket practice or whether they are only doing so in the limited set of circumstances where permissible.
- Clarify that, for the purposes of this data collection protocol, reporting on internal coverage criteria also applies to MAO internal criteria for **payment policies**.
- Provide more specific guidance on the limited set of circumstances for which Medicare criteria are not fully developed and ensure that the agency is serving as the ultimate arbiter of MAO compliance with this standard. This could include identifying and publishing — either proactively or through a review of information collected in this process — guidelines that CMS uses to determine whether criteria are fully established, citing specific examples of situations in which additional criteria would be permissible or prohibited.

Hospital Inpatient Admissions and Compliance with the Two-Midnight Benchmark. The CY 2024 final rule requires plans to adhere to the two-midnight benchmark, referring to the inpatient admission criteria for traditional Medicare in 42 CFR § 412.3, which is used by Medicare to determine whether inpatient hospital care is medically necessary.

While requiring MAOs to adhere to the two-midnight benchmark was an important step forward in achieving coverage parity between MA and traditional Medicare, securing MAO approval for inpatient hospital admissions remains another area of persistent struggle for patients and their providers. CHA members continue to report widespread frustrations with the denial of inpatient hospital care that extended over two midnights (and frequently over multiple days). In some cases, these denials for long-stay cases occur without sufficient explanation as to why the admitting clinician's expectation that care would span two midnights was incorrect or unreasonable. Many hospitals and health systems report little to no change in the volume of initial inpatient denials, even if a greater number of them are being overturned later in the appeals process.

While CMS' proposed data collection and reporting requirements would broadly capture procedures MAOs use to evaluate the medical necessity for inpatient hospital admissions, **CHA strongly recommends that CMS create supplementary requirements specifically intended to assess compliance with the two-midnight benchmark given the importance of this provision and the history of non-compliance.** For example, CMS should consider:

- Collecting data on requests for inpatient hospital authorizations as a category rather than data by Current Procedural Terminology or Healthcare Common Procedure Coding System code to ensure denied or downgraded requests for inpatient hospital admissions are appropriately captured
- Collecting data on MA plan level of care determinations that downgrade care from inpatient to observation status, including the rationale
- Collecting and monitoring additional data on length of stay for observation cases between MA and traditional Medicare and denials of inpatient cases exceeding two days at the plan level
- Conducting targeted audits of plans with outlier values for observation length of stay or long-stay inpatient denials
- Conducting targeted audits to assess whether MAOs are reviewing **only** permissible factors when making a medical necessity determination for inpatient hospital care — i.e., that the admitting physician's decision that care would extend beyond two midnights was reasonable and appropriately documented in the medical record — and not applying additional criteria where prohibited by CMS rules

Post-Acute Care Access. Hospitals and health systems continue to report persistent challenges with MAO practices that inappropriately deny MA beneficiaries access to covered post-acute care services. These challenges remain unresolved despite CMS rulemaking and clarifying guidance specifically addressing MAO obligations to provide access to post-acute care services consistent with Medicare coverage requirements. These findings and experiences have been further corroborated by a 2022 report from the OIG on MAO use of prior authorization, which found disproportionately high rates of inappropriate denials for post-acute care, and a more recent report from the U.S. Senate Permanent

Subcommittee on Investigations (PSI), which found that post-acute care is subject to excessive rates of prior authorization review and denials that have increased in recent years.[6,7]

To address these concerns, the proposed data collection and audit protocol should include specific submission requirements related to post-acute care services. In particular, CMS should collect the following information for authorization requests for **each type** of post-acute care admission to inpatient rehabilitation facilities (IRFs), long-term care hospitals, skilled-nursing facilities (SNFs) and home health agencies:

- Total number of requests and the approval and denial rate of those requests
- Number of appeals of denied requests at each appeal level, and the outcomes of those appeals
- The ultimate discharge disposition of requests that were denied
- Detailed information about the rationale for denied requests
- The acute care hospital length of stay for patients both approved and denied for post-acute care admissions.
- Emergency department utilization and readmissions rates for patients approved and denied for post-acute care admissions
- Overall utilization rates of post-acute care for MAO beneficiaries compared to traditional Medicare beneficiaries

In addition, access to post-acute care settings can be challenging to measure given that patients are typically transferred from an acute-care setting and may experience denials or delays in authorization for post-acute care that preclude them from accessing Medicare-covered services altogether or result in the patient receiving a lower-acuity level of care than clinically appropriate. For example, if a patient is recommended for IRF care, but the MAO denies the IRF admission and delays long enough, the patient may end up being forced to go home without medically necessary rehabilitative care that is covered by Medicare. In other cases, the plan may seek to transfer the patient to a lower-acuity post-acute setting to avoid paying for a higher-cost setting, even if this is contrary to the recommendation of the patient's treating physician. These types of delays, denials, and patient steering are difficult to capture through traditional data collection methods that focus on single-setting denials of a specific service as opposed to denial of a transfer to a secondary setting. As a result, **CMS should establish a protocol for conducting targeted audits of authorization decisions for all post-acute admissions**. Specifically, these audits should:

- Look comprehensively at admission determinations for post-acute care services, including a close examination of the criteria used to evaluate requests and consistency with traditional Medicare rules
- Examine the qualifications of the MAO reviewers issuing adverse determinations and whether they have training and experience in post-acute care services as required
- Evaluate whether denial rationales apply the relevant Medicare criteria to the specific circumstances of the patient and are not no general that the provider and patient cannot determine why the care was denied
- Ensure post-acute care cases are being treated consistently within the same plan and across different MAOs

[6] https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/
[7] https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000873.asp

- Examine disenrollment data to identify the prevalence of cases where beneficiaries sought to change Medicare plans or coverage options after being denied post-acute care services

Artificial Intelligence (AI) and Automated Utilization Management Tools. In the last decade, the use of algorithms has become prevalent in the MA claims review process, and CHA routinely hears concerns from member hospitals about plan AI tools or software that automatically deny large volumes of claims. While a plan may indicate it uses AI as a guideline, it appears that in some cases these tools are amounting to a de facto standard for coverage determinations. This raises serious concerns about access to care for MA beneficiaries and parity with coverage under traditional Medicare, where such tools are not used. For example, certain AI tools predict how many days an MA enrollee would need care in an IRF or SNF before being ready for discharge. Using this prediction definitively to terminate coverage of services on that date irrespective of any individual patient's circumstances or the recommendation of the treating medical team, is of grave concern. Further, the aforementioned report from the U.S. Senate PSI called into question the use of algorithms, AI, and automation as part of MA plans' utilization management policies.

CMS should consider certain safeguards to address concerns about how AI tools could restrict or deny access to medically necessary care for beneficiaries enrolled in MA plans as the technology continues to evolve. Specifically, **CMS should ensure that its data collection captures information on how plans use AI and other predictive technologies to make prior authorization determinations. Data collection should also audit the data to ensure that the use of AI does not result in determinations that are more restrictive than Medicare fee-for-service requirements.** Such data collection and auditing may include:

- Requiring MA plans to disclose the use and performance of auto-denial software to beneficiaries, providers, regulators, and the public — including the criteria, data, algorithms, and outcomes of the software
- Requiring MAOs to report on how their processes comply with CMS guidance requiring the patient's individual circumstances, as well as their medical teams' recommendations, to be considered in making coverage determinations to ensure that these important factors are not overridden by automatic or algorithm-assisted denial software
- Requiring MAOs with a history of inappropriate denials to report data on the amount of time a human reviewer spends examining an adverse organizational determination prior to signing off on a denial
- Requiring MAOs to report on whether clinicians reviewing algorithm-assisted denials receive any type of financial compensation that is based upon the volume of denials they approve or uphold

Oversight of Third-Party Vendors. Many MAOs rely on subcontractors to administer portions of their benefits, conduct utilization management processes, or conduct other types of coverage and payment audits. For example, MAOs frequently subcontract to vendors to manage prior authorization adjudication for services such as rehabilitation or behavioral health. While federal guidance requires MAOs to ensure that their vendors or benefits managers adhere to all program rules, hospitals and health systems frequently find that MAOs and their vendors are not consistent in their knowledge or application of MAO rules and processes.

CHA supports CMS' proposal to require MAOs to report on whether a third-party vendor "participated, in any capacity, in the determination's review or decision-making" in the proposed quarterly collections. However, **CHA encourages CMS to go further by extending its direct oversight to MAO vendors and**

holding MAOs accountable when their vendors delay or restrict patient access to care. Specifically, CMS should consider conducting audits on MAO third-party vendors directly and/or require the reporting of vendor practices and outcomes related to MA organization determinations to be added to the proposed data collection protocol. CMS may also wish to collect data to examine whether certain outcomes, such as denial or overturn rates, vary by whether the MAO itself conducted the determination or a third-party vendor was responsible for the review.

Promoting Actionable Data Collection and Reporting

In considering any additional reporting requirements, CHA recommends that CMS make every effort to design data collection elements to minimize administrative burden on the health care delivery system and ensure required reporting is both meaningful and actionable. Specifically, CMS should:

- Ensure that **required data elements have specific and clear purposes**.
- Conduct meaningful auditing of MAO submissions to **assess the accuracy and completeness of plan-reported data**.
- Make information collected under this notice **publicly available** to increase transparency for patients, providers, beneficiaries, advocates, and other stakeholders, while lending appropriate consideration to preventing disclosure of proprietary information where possible.
- **Enable comparison of reported data between traditional Medicare and MA** given the ultimate objective to ensure beneficiary parity in coverage and access between programs.
- Consider and **reflect the uniqueness of integrated delivery systems in any reporting requirements** by recognizing that they may collect and maintain data that are structured differently from traditional health insurance carriers.

CHA commends CMS for its recognition of the widespread and systemic problems with certain MAO utilization management practices and the resulting impact on beneficiary access to care. Hospitals strongly support the agency's proposals to implement additional data collection to ensure that all Medicare beneficiaries have appropriate and timely access to Medicare services.

If you have any questions, please contact me at mmillerick@calhospital.org or (771) 224-7224, or my colleague Patricia Blaisdell, vice president, policy, at pblaisdell@calhospital.org or (916) 552-7553.

Sincerely,

/s/

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