FLORIDA HOSPITAL ASSOCIATION
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HOSPITALS & HEALTH SYSTEMS

June 30, 2025

The Honorable Mehmet Oz, M.D., Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Submitted via www.reginfo.gov/public/do/PRAMain

Re: CMS Information Collection – Service Level Data Collection for Initial Determinations and Appeals (CMS-10905)

Dear Administrator Oz:

On behalf of our more than 200 member hospitals and health systems, the Florida Hospital Association ("FHA") appreciates the opportunity to comment on CMS's Information Collection regarding Service Level Data Collection for Initial Determinations and Appeals (CMS-10905).

The FHA supports CMS's proposed data collection for Medicare Advantage (MA) organizations' initial determinations and appeals. For years, providers have expressed concerns about inappropriate denials by MA organizations. The concerns raised by providers are substantiated by investigations and findings made by both the Department of Health Human Services Office of Inspector General (OIG) and bipartisan committees of Congress.

The proposed data elements will help to further inform CMS about MA plan behavior and ensure CMS has the information it needs to protect beneficiaries' access to timely and medically necessary care. In addition to the data elements proposed, the FHA suggests additional data elements that would further assist CMS in its oversight of MA organizations.

I. INTRODUCTION

According to the Kaiser Family Foundation, in 2024, more than half, or 54%, of the eligible Medicare population were enrolled in an MA plan.[1] Despite this significant enrollment, over the last decade, concerns surrounding MA organizations have abounded, particularly with respect to MA organizations' decisions on coverage determinations.[2]

In 2018, the OIG found that when beneficiaries and providers appealed preauthorization and payment denials, MA organizations overturned their own denials 75% of the time. During that same period, independent reviewers at higher levels of the appeals process overturned additional denials in favor of beneficiaries and providers. As the OIG observed, this raised concern that MA organizations were initially denying services and payments that should have been provided. Additionally, and notably, the OIG observed that CMS audits "highlight widespread and persistent MAO performance problems related to denials of care and payment." Although CMS took enforcement action against some MAOs, the OIG noted that "more action is needed to address these critical issues." The OIG recommended that CMS "address persistent problems related to inappropriate denials."[3]

Just several years later, in 2022, the OIG found that MA organizations "sometimes delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests

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[1] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/

[2] *See, e.g.*, U.S. Dep't of Health & Human Services Office of Inspector General, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, Report No. OEI-09-18-00260 (Apr. 2022); U.S. Dep't of Health & Human Services Office of Inspector General, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials*, Report No. OEI-09-16-00410 (Sep. 2018).

[3] U.S. Dep't of Health & Human Services Office of Inspector General, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials*, Report No. OEI-09-16-00410 (Sep. 2018).

met Medicare coverage rules and MAO billing rules." The OIG observed that "[d]enying requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers." The OIG further noted that although some of the denials were ultimately reversed by the MA organizations, "avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs." The OIG recommended that CMS "issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews" and "update its protocols to address the issues identified in this report, such as MAO use of clinical criteria and/or examining particular service types."[4]

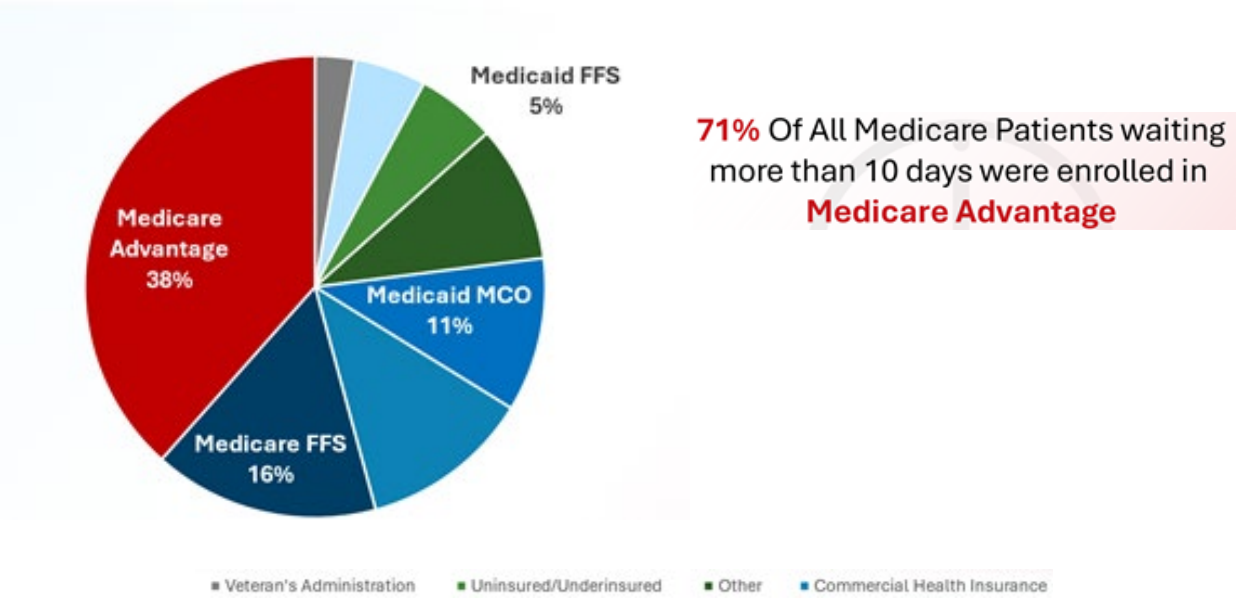
In 2023, CMS took great steps to implement these recommendations through its 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F). Unfortunately, problems continue to persist. Just last year, the U.S. Senate Permanent Subcommittee on Investigations issued a report investigating issues surrounding MA enrollees' access to medically necessary post-acute care.[5]

These reports are consistent with the experiences of our member hospitals. The following graph illustrates that, in 2024, the vast majority of discharge delays in Florida were attributable to MA organizations:[6]

[4] *See, e.g.*, U.S. Dep't of Health & Human Services Office of Inspector General, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, Report No. OEI-09-18-00260 (Apr. 2022).

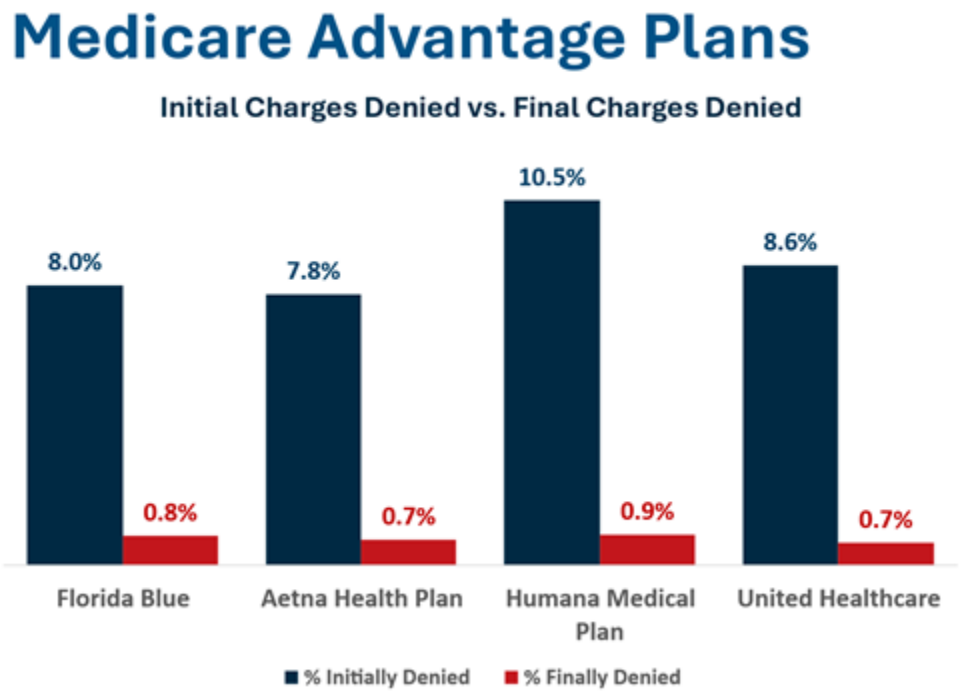
[5] *See* U.S. Senate Permanent Subcommittee on Investigations, *Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care* (Oct. 17, 2024).

[6] These data represent 44% of Florida hospital beds.



Additionally, as illustrated in the following graph, when Florida hospitals appealed initial denials by MA organizations, they were successful the vast majority of the time, demonstrating that the initial denials were improper:[7]

[7] These data include 120 hospitals and represent 45% of Florida hospital beds.



Although these initial denials were ultimately reversed, as the OIG noted in its 2022 Report, they cause a significant administrative burden for providers and beneficiaries, who must expend time and resources to challenge the initially erroneous denial.[8]

II. PROPOSED INFORMATION COLLECTION

The Social Security Act empowers CMS to require MA organizations to provide CMS "with such information … as the Secretary may find necessary and appropriate." *See* 42 U.S.C. § 1395w–27. Pursuant to that authority, CMS has codified Part C Reporting Requirements in § 422.516(a), which provide that "[e]ach MA organization must have an effective procedure to

[8] *See, e.g.*, U.S. Dep't of Health & Human Services Office of Inspector General, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, Report No. OEI-09-18-00260 (Apr. 2022).

develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires" information regarding the following:

- The cost of its operations
- The procedures related to and utilization of its services and items
- The availability, accessibility, and acceptability of its services
- To the extent practical, developments in the health status of its enrollees
- Information demonstrating that the MA organization has a fiscally sound operation
- Other matters that CMS may require.

In the proposed PRA, CMS proposes to add certain data elements that would provide key data to CMS on the utilization of benefits, enhance audit activities to ensure plans are operating in accordance with CMS guidelines, and ensure appropriate access to covered services and benefits.

The FHA supports the data elements proposed by CMS. In addition to the data elements proposed, the FHA urges CMS to consider additional data elements that would allow CMS to better understand and monitor plan behavior for compliance with federal law.

A. Initial Determinations (Coverage Decisions)

The FHA supports the proposed data elements for Initial Determinations of coverage decisions. In particular, the FHA supports the inclusion of the date the request was received, the disposition, the date of decision notification, the decision/dismissal rationale, reviewer qualifications, and whether a third-party vendor participated in any capacity in the determination's review or decision-making.

In addition to these data elements, we urge CMS to require MA organizations to report on the following:

- The hour the request was made and the hour the MA organization rendered a decision on the request
- A data field to define the service/coverage the provider requested (e.g., inpatient stay)

- A data field to indicate if the approved service was different from what the provider requested (e.g., the provider requested inpatient admission, but the MA organization approved only for observation)
    - Despite CMS-4201-F making clear that the two-midnight rule applies to MA organizations, MA organizations continue to violate this rule by approving only observation even when the two-midnight benchmark is clearly met. Additionally, MA organizations continue to deny certain medically necessary post-acute services ordered by physicians and, instead, approve lower levels of service. Adding this data field will provide critical information to CMS as part of its oversight of MA organizations.
- If the MA organization indicates that internal plan coverage criteria were applied, the plan should be required to identify the coverage criteria by name (e.g., MCG or Interqual).
- If the MA organization indicates that a third-party vendor participated in the decision-making, the plan should be required to identify the vendor by name.

B. Initial Determinations (Payment)

The FHA also supports the proposed data elements for Initial Determinations of payment. In particular, the FHA supports the inclusion of the date of service, the date the claim was received, the date of decision, the date the claim was paid, whether the claim was a clean claim, the decision/dismissal rationale, whether internal coverage criteria were applied, and whether a third-party vendor participated in any capacity in the determination's review or decision-making.

In addition to these data elements, we urge CMS to require MA organizations to report on the following:

- If the MA organization indicates that internal plan coverage criteria was applied, the plan should be required to identify the coverage criteria by name.
- If the MA organization indicates that a third-party vendor participated in the decision-making, the plan should be required to identify the vendor by name.

We also urge CMS to define what is meant by a clean claim so that there is no confusion or inconsistency.

C. Reconsiderations (Coverage Decisions)

The FHA supports the proposed data elements for Reconsiderations of coverage decision. In addition to the proposed data elements, we urge CMS to require MA organizations to report on the following:

- In addition to indicating whether the request was reviewed by a physician, the plan should be required to identify the specialty of that physician. One way of doing this would be to require MA organizations to provide the NPI of the reviewing physician.
- If the MA organization indicates that a third-party vendor participated in the decision-making, the plan should be required to identify the vendor by name.

III. CONCLUSION

The FHA thanks CMS for the opportunity to provide these comments. If you have any questions, please do not hesitate to contact Kristen Dobson, the FHA's General Counsel and Vice President of Regulatory Affairs, at kristend@fha.org.

Sincerely,

Mary C. Mayhew
President and CEO
Florida Hospital Association