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Humana

June 30, 2025

William N. Parham, III
Director, Division of Information Collections and Regulatory Impacts
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Service Level Data Collection for Initial Determinations and Appeals (CMS-10905, OMB:0938-New)

Dear Mr. Parham:

This letter is in response to the Centers for Medicare and Medicaid Services (CMS) agency information collection notice "Service Level Data Collection for Initial Determinations and Appeals (CMS–10905, OMB:0938-New)" as issued on May 30, 2025.

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. Humana currently serves approximately 5.9 million beneficiaries enrolled in our Medicare Advantage (MA) plans and 2.9 million beneficiaries enrolled in our Medicare Part D Prescription Drug Plans (PDPs). As one of the nation's top contractors for MA, we are distinguished by our long-standing, comprehensive commitment to Medicare beneficiaries across the United States. These beneficiaries – a large proportion of whom depend upon the MA program as their safety net – receive integrated, coordinated, quality, and affordable care through our plans. Our perspective is further shaped by the comprehensive medical coverage we provide for Medicaid beneficiaries in seven states.

Overview

CMS proposed updates to the Part C and D Reporting Requirements (§§ 422.516(a) and 423.514(a)) specifically related to the data collected on all plan activities regarding adjudicating requests for coverage and plan procedures related to making service utilization decisions.

> **Humana Comment:** While Humana appreciates CMS's efforts to be responsive to stakeholder comments by providing updates to the PRA documents between the 60-day and 30-day comment opportunities, the agency made significant changes to these reporting requirements that plans need more time to consider and evaluate. The nuances requested with proposed data technical specifications require more in depth consideration and as such, Humana recommends that CMS issue another PRA notice on the UM Audit Protocol Data Request to allow plans

sufficient time to analyze the protocols and the changes made here to provide meaningful comments to inform this program moving forward.

Additionally, Humana requests that CMS confirm the following are excluded from the reporting: eligibility denials and invalid billing code denials. If they are to be included, it will significantly increase the volume of the universes and be administratively burdensome. Humana requests CMS add additional clarification to what is excluded in each universe.

Technical Specifications

CMS states: "MA organizations must submit all required data at the contract number/PBP level, (e.g., plan 001 for contract H0000)."

Humana Comment: Humana requests clarification on whether a plan is expected to submit one unique text file for each contract or for each contract/PBP combination. It will be an administrative burden to move to reporting at the PBP level from a file creation perspective and may decrease the value of understanding contract level data. Additionally, CMS can filter contract level data by PBPs so it will not decrease CMS's ability to view PBP level data.

CMS states that "if an organization determination includes more than one service, include all the decision's multiple line items as separate entries. Each entry will have the same organization determination number."

Humana Comment: This proposal departs from historical Part C reporting and other CMS reporting requirements, such as the CMS program audit protocols, which have historically required data at the authorization or claim "header" level. While authorizations and claims often represent a single service request, broader requests containing multiple services or codes are not uncommon. Moving to service-level reporting introduces additional complexity and would necessitate further analysis and potential updates to systems and operational processes for organization determinations.

Moving to a more granular level of reporting would yield a significant increase in data volume that would not represent the true volume of authorizations or claims received and processed by plans. For example, for CMS Organization Determination Appeals & Grievances audit protocols, a larger plan like Humana may contain on million authorizations in one month alone, with approximately three million authorizations per quarter. Moving to a service-level data collection would result in bifurcation of many authorizations and is estimated to increase that quarterly volume by sixfold.

Organization determinations are classified by service primarily at the header level to support existing reporting requirements and provider practices. Typically, both authorization requests and claims are submitted as distinct requests for an entire episode of care. For example, an office visit with an additional in-office procedure. Bifurcating requests by service could have the potential to produce skewed or misrepresented trends instead of evaluating determinations in the entire context of the request. Accordingly, more granular accounting would be needed to accommodate this proposed change.

Finally, service-level granularity may pose inconsistencies in overall reporting from plan to plan due to differences in how service is defined and tracked within internal systems. As such,

obtaining a view of data across the industry may not yield the results CMS is after or may result in a skewed perception of trends. Further, significant variance could result in substantial changes to tracking and would be duplicative, unnecessary, and add administrative burden to what plans already report today for CMS Program Audits.

Due to the complexity this proposal creates and its departure from existing protocols, we urge CMS to delay implementation of this change and issue another PRA notice on the UN Audit Protocol Data Request, so that plans have the opportunity to provide further feedback.

Initial Coverage Determinations Data Element I

This field collects information on the diagnosis codes submitted with determination request.

Humana Comment: The request to include diagnosis codes departs from any other CMS reporting and the approach may not provide CMS with the desired information. One of the reasons for this is because diagnosis codes are not always accurate upon submission and more importantly, for authorizations, they are not directly tied to nor implicitly drive the condition of coverage or approval. Instead, plan operational processes rely on a full review of applicable clinical information where the member's clinical condition is appropriately documented. Decisions on requests are based on this information in clinical records and not diagnosis codes entered in the system. To provide a level of accuracy which drives meaning for reporting, operational processes would need to be updated – creating significant additional administrative burden to the plan for operational processes and oversight.

That said, we do see the value of requesting this information for payment determinations as payment/billing requirements are often driven by the presence of certain diagnosis codes. Therefore, if CMS includes this field in the final publication, Humana recommends that they limit the requirement to payment determination reporting.

Initial Coverage Determinations Data Element J

This field collects information on whether a service required prior authorization.

Humana Comment: Humana disagrees with the current proposal for requiring this data element for both authorizations and payment determinations.

Humana accepts and processes all organization determinations, regardless of whether they require prior authorization. As the majority of the authorizations requested also require prior authorization, Humana does not see the added value in requiring inclusion of this data element in the proposed reporting.

As stated above, authorization requests and claims are submitted as distinct requests for an entire episode of care. Bifurcating requests by service could have the potential to produce skewed or misrepresented trends instead of evaluating determinations in the entire context of the request. This is especially true when it comes to looking at items and services, that while separate and distinct, may be ancillary to another item or service on the same authorization and accordingly are requested together. For example, a prior authorization request for abdominal surgery may include a variety of potential approaches to cover the unknown of how surgery will progress. Those approaches can include both codes that require prior authorization and others

that do not. Therefore, Humana is unclear on the value of that data given the initial request was processed as a distinct unit.

Also, per 42 CFR 438.210(f) all plans are required to publish prior authorization metrics and the list of services that require prior authorization beginning 1/1/2026. As such, any additional information within the context of this reporting would be duplicative and an administrative burden.

Further, as stated previously, given the lack of clarity, it is reasonable to expect that there will be inconsistencies in overall reporting from plan to plan due to differences in how authorization requirements and services are tracked within internal systems. As such, obtaining a view of data across the industry may not yield the results CMS is after or result in skewed perception of trends.

Initial Coverage Determinations Data Element P
In this field, plans report information on the decision rationale.

Humana Comment: The proposed reporting technical specifications indicate that plans are to select a rationale for partially favorable and adverse decisions but does not indicate how this field should be populated for fully favorable or dismissed decisions. Humana requests clarification to indicate whether a blank field or response of 'N/A' is most appropriate for fully favorable or dismissed decisions.

Initial Coverage Determinations Data Element Q
This field requires plans to report data on the dismissal rationale, if applicable.

Humana Comment: The proposed reporting technical specifications indicate that plans should select a rationale for dismissed decisions but does not indicate how this field should be populated for fully favorable, partially favorable, and adverse decisions. Humana requests clarification to indicate whether a blank field or response of 'N/A' is most appropriate for fully favorable, partially favorable and adverse decisions. .

Initial Payment Decisions Data Element F
This field requires plans to submit data on the item, service, or Part B drug code.

Humana Comment: The proposed reporting technical specifications indicate that plans are to enter the CPT, HCPCS, DRG, or J code associated with the item, service, or Part B drug. Humana requests clarification to indicate whether a blank field or response of 'N/A' is most appropriate when this information was not provided by the entity requesting the payment decision.

Initial Payment Decisions Data Element G
This field requires plans to submit the "name of the item/service/Part B drug if there's no associated code entered in element G."

Humana Comment: We request that CMS update the technical specifications to address that Data Element G should be require plans to enter the names of the item/service/Part B drug if there is no associated code entered in data element F.

Initial Payment Decisions Data Element H
This submission field requires plans the diagnosis codes submitted with the coverage request.

> **Humana Comment:** The technical specifications propose to require plans to enter the diagnosis code submitted with the request (e.g., ICD-10, HIPPS codes) as a comma separated list. Humana requests clarification on whether a plan should submit a blank field or 'N/A' in cases where this information has not been provided.

Initial Payment Decisions Data Element I
This field requires plans to submit a service location where the item, service, or Part B drug was provided.

> **Humana Comment:** Humana requests clarification on whether a plan should submit a blank field or 'N/A' in cases where the zip code of the location where the item, service, or Part B drug was not provided.

Initial Payment Decisions Data Element M
This submission field requires plans to indicate the service provider's NPI.

> **Humana Comment:** Humana requests clarification on whether a plan should submit a blank field or 'N/A' in cases where the service provider's NPI is not known or provided.

Initial Payment Decisions Data Element S
This submission field requires plans to submit a dismissal rationale for payment decisions.

> **Humana Comment:** As proposed, the technical specifications require plans to select the rationale for dismissed payment decisions but does not indicate how this field should be populated for fully favorable, partially favorable, or adverse decisions. We request clarification on whether a plan should submit a blank field or 'N/A' in cases where a payment decision is fully favorable, partially favorable, or adverse.

Initial Payment Decisions Data Element T
This field requires plans to submit the decision rationale for partially favorable and adverse decisions.

> **Humana Comment:** The proposed technical specifications do not indicate how plans should populate this field for fully favorable or dismissed decisions. Humana requests clarification on whether a plan should submit a blank field or 'N/A' in cases where the payment decision is fully favorable or dismissed.

Initial Payment Decisions Data Element U
This field requires plans to submit whether the reviewer is a Physician or other qualified healthcare professional.

> **Humana Comment**: Unlike the Initial Coverage Determination table, there is no qualifier to include this field only "if the MA organization is expected to issue a partially or fully adverse medical necessity decision based on the initial review of the request." Humana believes this field should only be populated when the determination is based on medical necessity rationale.

Additionally, we request clarification on whether plans are to populate N/A for any claim adjudication that is not related to medical necessity.

Initial Payment Decisions Data Element X

The submission for this field states that "if element V is yes, provide OD number for associated prior approval request."

Humana Comment: Humana suggests that CMS provide an update to the technical specifications to indicate that plans should provide the OD number for the associated approval request when the answer to element W is yes. As currently constructed, element V is on the application of internal coverage criteria, not on prior approval.

Additionally, we request clarification on whether a plan should submit a blank field or 'N/A' in cases where the answer to the data field in element W is 'no.'

Initial Payment Decisions Data Element Y

This field asks plans to submit data when the answer to data element V is yes.

Humana Comment: Similar to our above comment on data element X, Humana requests that CMS provide an update to the technical specifications to indicate that plans should provide an answer in this field to whether prior authorization was a required condition for coverage in data element W, not V as is currently drafted in the technical specifications.

Further, we request clarification on whether a plan should submit a blank field or 'N/A' in cases where the answer to data element W is 'no.'

Reconsiderations Data Element L

Plans are required to submit a dismissal rationale in this data field.

Humana Comment: The technical specifications as proposed do not indicate how plans should populate this field for fully favorable, partially favorable, or adverse decisions. Humana requests clarification on whether a plan should submit a blank field or 'N/A' in these cases.

Reconsiderations Data Element M

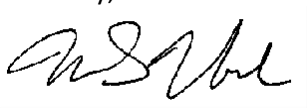
This field requires plans to select a rationale for partially favorable or adverse decisions.

Humana Comment: Humana requests clarification on whether a plan should submit a blank field or 'N/A' in cases where the reconsideration is fully favorable or dismissed.

We hope that you consider our comments as constructive feedback aimed at ensuring that together we continue to advance our shared goals of improving the delivery of coverage and services in a sustainable, affordable manner to beneficiaries, focused on improving their total health care experience.

If you have any questions, please do not hesitate to reach out to me at mhoak@humana.com and 571-466-6673.

Sincerely,



Michael Hoak
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