American Hospital Association™
Advancing Health in America

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June 30, 2025

OMB Desk Officer
Office of Information and Regulatory Affairs
Office of Management and Budget
Washington, DC 20503

Re: Service Level Data Collection for Initial Determinations and Appeals Information Collection Request under the Paperwork Reduction Act (CMS-10905)

Dear OMB Desk Officer:

On behalf of our nearly 5,000 member hospitals, health systems, and other health care organizations and our clinician partners — including more than 270,000 affiliated physicians, two million nurses and other care givers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) information collection request, "Service Level Data Collection for Initial Determinations and Appeals" published in the Federal Register on May 30, 2025.

The AHA supports CMS finalizing the data collection and commends the agency for collecting comprehensive, granular data on initial health plan determinations and reconsiderations of coverage and payment decisions. The AHA has raised concerns that certain commercial Medicare Advantage (MA) plan practices, such as excessive prior authorization, inadequate transparency and documentation in denial rationales, and the inappropriate involvement of non-specialist reviewers in clinical determinations, may result in dangerous delays or denials of medically necessary services for patients and drive up administrative costs in the health care system. The proposed data collection will enhance the agency's ability to oversee the behavior of Medicare Advantage Organizations (MAOs) and is critical for holding MAOs accountable for complying with federal requirements outlined in statute and regulations.

The following comments reflect the Paperwork Reduction Act (PRA) supporting materials and the Draft Technical Specifications for Service Level Data Collection for Initial Determinations and Appeals released by CMS on June 9, 2025.

Quarterly Data Collection

CMS proposes to collect service-level data from MAOs quarterly. AHA supports CMS' decision to require quarterly collection of the service-level data, as proposed. The timeframe for data collection supports the need for timely oversight, allowing CMS to detect trends (including seasonal and cyclical patterns in denials and appeals), monitor compliance, and respond promptly to issues that may impact beneficiary access to timely and appropriate care.

Requests for Expedited Processing

CMS proposes to collect information on whether an MA plan downgraded a request for an expedited coverage determination and processed the request within the standard timeframe.[1] We recommend that CMS consider requiring MA plans that downgrade requests for expedited processing to specify their rationale for the downgrade. This is especially important given that under existing regulations at 42 CFR § 422.570(c)(2)(ii), when a request for expedited processing is submitted by a physician who indicates that applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, the MA plan does not have the discretion to downgrade the request. Requiring MA plans to specify their rationale will improve transparency and deter inappropriate downgrading of expedited requests.

Reviewer Qualifications

If an MAO expects to issue a partially or fully adverse medical necessity decision based on the initial review of the request, CMS proposes that MAOs provide the reviewer's qualifications by specifying either "P for Physician" or "O for Other Appropriate Healthcare Professional" without collecting further information about the reviewer's qualifications.[2]

AHA supports these steps and recommends that CMS require additional data elements on reviewer qualifications, including the reviewer's name, provider identification number, area of specialty, clinical background, specific certifications, and prior work experience. Hospitals and health systems frequently report that health plan reviewers without applicable expertise in the requested service discipline are issuing denials for medically necessary patient care. Under 42 CFR § 422.566(d), organization determinations "must be reviewed by a physician or other appropriate health care professional with expertise in the field of medicine or health care that is appropriate for the service as issue, including knowledge of Medicare coverage criteria." While current regulations do not require the reviewing physician or other health care professional to be of the same specialty or subspecialty as the treating physician or other health provider, more information is needed to properly assess whether the provider or other health provider meets the regulatory standard.

Application of Internal Plan Coverage Criteria

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[1] Data Element L: Was the expedited processing request downgraded?
[2] Data Element R: Reviewer Qualifications

CMS proposes to collect information on the use of internal plan coverage criteria by having MA plans specify a simple yes or no response.[3] While the AHA fully supports collecting this information to indicate whether internal plan coverage criteria were applied in a determination, we recommend CMS expand the data collection to include data elements that would allow for a more complete evaluation of whether internal coverage criteria were used appropriately in compliance with 42 CFR § 422.101(b)(6). Specifically, we recommend that CMS consider information identifying the clinical source or guideline relied upon when internal coverage criteria were applied, whether or not the criteria were publicly available at the time of the decision, and a brief rationale explaining: 1) how the internal criteria were necessary to supplement incomplete Medicare coverage rules, and 2) how their application was expected to provide clinical benefit that outweighs potential harm. These data would help CMS ensure that internal criteria are used only in the limited circumstances allowed by regulation and in a transparent, evidence-based manner that supports access to care.

Two-Midnight Benchmark Compliance

The calendar year 2024 final rule requires MA plans to adhere to the two-midnight benchmark, referring to the inpatient admission criteria for Traditional Medicare in 42 CFR § 412.3, used by Medicare to determine whether inpatient hospital care is medically necessary.[4,5] We recommend that CMS consider requiring MA plans to submit service-level data to ensure compliance with the Two-Midnight Rule and prevent the improper denial of inpatient coverage. Despite CMS' clarification that MA plans must follow Traditional Medicare's coverage criteria, including the Two-Midnight Rule, hospitals continue to report that some MA plans apply more restrictive criteria to override physician judgment and deny inpatient claims that extend over two midnights, without sufficient explanation as to why the admitting physician's expectation that care would span over two midnights was incorrect or unreasonable. Collecting data on inpatient coverage decisions, including whether the stay met the two-midnight benchmark criteria and the rationale for any denial, would help CMS ensure that MA plans do not apply more restrictive coverage criteria than Traditional Medicare.

Use of Artificial Intelligence

While we recognize that the proposed data collection does not include data elements related to the use of artificial intelligence (AI), we encourage CMS to consider including such data elements. As MAOs increasingly adopt AI tools to support utilization management, claims adjudication, and prior authorization determinations, it will be important for CMS to have visibility into how these technologies are used and their impact

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[3] Data Element S: Were internal plan coverage criteria applied?
[4] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, 88 Fed, Reg. 22120, 22191 (April 12, 2023).
[5] CMS further clarified that MA plans must comply with the two-midnight benchmark when making coverage decisions about inpatient stays in its guidance titled FAQs Related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule CMS-4201-F (Feb. 6, 2024). Available at https://www.cms.gov/files/document/hpms-memo-faq-coverage-criteria-and-utilization-management-020604pdf.pdf.

on beneficiary access to care.[6] Collecting information on whether AI tools were involved in initial determinations or appeals, along with safeguards in place to ensure appropriate clinical oversight, would enable CMS to better monitor emerging risks and ensure that automated processes comply with existing regulations and clinical standards.[7]

Availability of the Data

We recommend that CMS make the data publicly available. Increased transparency would enhance accountability and allow beneficiaries and providers to make more informed decisions about MA participation. Public reporting of data, such as denial rates, use of internal coverage criteria and appeals outcomes, would align with broader federal goals of promoting transparency and could serve as a valuable tool for identifying patterns of concern.

In conclusion, we support the proposed data collection and urge the Office of Management and Budget to approve the information collection request without delay. Finalizing the data collection will enable CMS to better evaluate MA plan performance, safeguard beneficiaries, and promote transparency in the administration of benefits under the MA program. Thank you for your consideration of our comments. If you have any further questions, please feel free to contact Noah Isserman, AHA director of health insurance and coverage policy, at nisserman@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

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[6] Wall Street Journal, UnitedHealth Now Has 1,000 AI Use Cases, Including in Claims (May 5, 2025), https://www.wsj.com/articles/unitedhealth-now-has-1-000-ai-use-cases-including-in-claims-f3387ca3.

[7] CMS clarified when MAOs may use AI to make coverage decisions under rules for clinical coverage criteria. See Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F), CMS, Feb. 6, 2024, available at https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-2-february-5-9.