Providence Health Plan | Providence Health Assurance
P.O. Box 4327
Portland, OR 97208-4327
ProvidenceHealthPlan.com

June 30, 2025 Submitted via www.reginfo.gov

Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 314-G
Washington, D.C. 20201

Re: CMS-2744 and CMS-10905, Draft Technical Specifications for Service Level Data Collection for Initial Determinations and Appeals

Dear Administrator Oz,

Providence Health Assurance appreciates the opportunity to review and provide comment on Draft Technical Specification for Service Level Data Collection for Initial Determinations and Appeals, which was published in the Federal Register on May 30, 2025 for a 30-day comment period.

In this letter, PHP comments on proposals impacting Dual Eligible Special Needs Plans (D-SNPs). PHP's comments on this aspect of the proposed rule are unique to the Coordinated Care Organization (CCO), rather than Managed Care Organization (MCO), structure in Oregon. Regarding other aspects of the proposed rule, PHP supports the comment letters submitted by the Alliance of Community Health Plans (ACHP) and AHIP. In this comment letter, PHP provides: background on the organization and our relationship with HealthShare, a Coordinated Care Organization in Oregon; support for CMS' proposed amendment to the definition of a HIDE SNP, and a request for clarification regarding application of the "one D-SNP" policy to HIDE SNPs within a Coordinated Care Organization.

Organization. Providence Health Assurance and Providence Health Plan offers medical insurance plans in Oregon, Washington, and California for more than 600,000 members through Medicare Advantage, Medicaid, individual, commercial group, and self-funded plans. In Oregon, PHP also operates Medicaid and Dual Eligible Special Needs (D-SNP) plans.

PHP is part of Providence health system, a faith-based, not-for-profit network of hospitals, health plans, physicians, clinics, home health, and affiliated services operating across seven states: Oregon, Washington, California, Alaska, Montana, New Mexico, and Texas. Our diverse family of organizations employ 120,000 people who serve in 52 hospitals, and include more than 900 clinics, a health plan with over 600,000 beneficiaries, senior services, home health, hospice, PACE, housing, and many other health and educational services. Driven by a belief that

health is a human right, we are committed to understanding and responding to the needs of the many communities we serve, and to providing high-quality, equitable health care for all.

Comment.

I. Minimize Industry Burden and Expense by Streamlining New Reporting Requirements.

CMS has proposed substantial reporting in the Draft Technical Specification for Service Level Data Collection for Initial Determinations and Appeals. However, roughly 80% of the reporting proposed is already incorporated in the ODAG Report and Data Validation reporting. As such, we recommend that CMS eliminate proposed reporting that would be redundant with existing requirements. Any new reporting should be a separate report filed in conjunction with the ODAG Table 1 reporting.

II. Provide the Industry Sufficient Time to Alter System Configuration

CMS has not yet proposed a date for the new reporting to begin. We recommend that the new reporting begin mid-2027, with 2027 Q1 data being the first data to be relevant for the new reporting. We make this recommendation in order to ease financial burdens on small, community health plans, like ours, where we have limited internal resources and have to rely on expensive external vendors for configuration changes that need to be done without sufficient lead time. One year's notice is critical for our health plan to rely on in-house resources to build new changes into our systems.

III. Provide Clarity to Ensure Consistent Data from the Industry

A. CMS has proposed that the decision rationale be coded with one of eleven different code options for the rationale. However, there are situations were two or more of the eleven codes are appropriate. There are also situations where none of the 11 specified codes are appropriate. As such, we recommend that CMS allow for multiple codes. We further recommend that CMS create an "Other" category where health plans may specify unique rationale.
B. CMS indicates that health plans must designate where a third party vendor "in any capacity" participated in the review or decision making. This request is distinct from existing reporting that requires health plans to indicate when a third party vendor was responsible for the prior authorization review and determination. We recommend that CMS maintain the current inquiry and add an inquiry for situations when the third party vendor completes some but not all of the review and/or determination. But amending the question in this way, the data set will be more meaningful along side the existing reporting.

C. CMS proposals regarding reporting on the prior authorization data vary between documents in the proposal. One document asks for the date of decision. A different document asks for the data of notification. We recommend that CMS clarify which date it wants from health plans.
D. CMS has proposed that health plans indicate whether prior authorization was "required." We ask that CMS clarify whether "required" incorporates prior authorization done in accordance with CMS Chapter 13, wherein a health plan conducts a prior authorization only upon a provider request, even when the health plan does not otherwise require prior authorization.

Conclusion. PHP appreciates the opportunity to provide information and recommendations regarding the application of these proposals to our prior authorization reporting. For more information, please contact Tara Harrison, Government Affairs Direction at Tara.Harrison@Providence.org.

Sincerely,

Tara Harrison