Kaiser Permanente Comments on
Agency Information Collection Activities: Proposed Collection; Comment Request

Attention: Document Identifier/OMB Control Number: CMS-10905
(OMB control number: 0938-NEW)

June 30, 2025

Submitted electronically via reginfo.gov

Kaiser Permanente appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) intention to collect information from the public with respect to the Medicare Part C Service Level Determinations and Appeals published in the Federal Register (90 FR 23054) on May 30, 2025.

Kaiser Permanente offers the following recommendations and requests for clarification on the proposed data collection:

Reporting Requirements & Technical Specifications Clarifications

We appreciate that a Technical Specification document was made available separately to better assess the required data element fields and descriptions. After reviewing both the Reporting Requirements and Technical Specifications, we seek further guidance on and recommend changes to the following:

Section 1. Service Level Data for all Initial Determinations

Subsection #1: Initial Determinations (coverage decision)

- **E. Requesting Party** – Align this data element with existing ODAG audit protocols that require the following values: E: Enrollee, ER: Enrollee Representative, CP: Contracted Provider and NCP: Non Contracted Provider.

- **F. Provider NPI** – Include a "not applicable" (NA) option for requests submitted by enrollees or their representative.

- **G. Item/Service/Part B Drug Code** – Add the option for NA to allow for pre-service requests.

- **H. Item/Service/Part B Drug Description** – Add the option for NA when there is nothing to report for data element G, in other instances (to be specified) when data element H does not need to be completed, or when data element G has been completed.

- **I. Diagnosis Code –** These codes might not be available for some member-initiated pre-service requests. For these instances, NA should be allowed.

- **K. Was this a concurrent review decision?** – This data element was found in the Reporting Requirements but not in the Technical Specifications. Please advise if this is a required field.

- **M. Was expedited processing requested? (Reporting Requirements)** – This data element is listed in the Reporting Requirements, however, in the Technical Specifications the data element is listed as "L". These data element names and descriptions should align.

- **O. Date of Decision Notification (Reporting Requirements**) – This data element is listed in the Reporting Requirements, however, in the Technical Specifications the data element is listed as "N". These data element names and descriptions should align. In addition, consistent with the CMS protocols, we recommend this data element be the date of notification to the enrollee.

- **Q. Dismissal Rationale/R. Decision Rationale/S. Reviewer Qualifications** – In the instances where data element P is "Disposition is Fully Favorable", add an option for NA as data elements Q, R and S would not apply.

- **R. Decision Rationale**
  - Please clarify, for approved decisions, whether NA or option 04 (not applicable to the subsection) is the appropriate entry.
  - If option 02 (coverage excluded) is selected, there is no applicable value in data element S (Reviewer Qualifications) for non-medical staff. Please clarify whether a plan administrative staff member would be considered an Other Appropriate Healthcare Professional for a benefit determination for the purposes of this reporting.

- **S. Reviewer Qualifications** – To better align with CMS program audit protocols, we recommend this field be streamlined to focus on the qualifications of the reviewer making a medical necessity denial decision. Otherwise, we request further clarification of CMS' expectations of "expected" adverse medical necessity decisions.

- **T. Internal Coverage Criteria** – This data field is not currently available in any kind of reportable database and will need to collected manually in our current state. To provide the requested information quarterly and in the specified format through an automated process would require extensive, multiple system upgrades and enhancements. For large organizations such as ours without a centralized Utilization Management function, this manual effort would require similar but separate tasks across multiple departments.

Subsection #2 Initial Determinations (payments)

- **C. Plan Benefit Package (PBP) –** Please clarify whether the PBP/coverage should be based on the Date of Service (DOS) of the claim.

- **G. Item/Service/Part B Drug Code Description** – Add the option for NA when there is nothing to report for data element F, in other instances (to be specified) when data element H does not need to be completed, or when data element F has been completed.

- **L. Date of Service (Technical Specifications**) – This data element is missing from the Reporting Requirements, however, in the Technical Specifications the data element is listed as L "Date of Service" and it requests the Date of Service End. These data element names and descriptions should align.

- **O. Date Claim was Paid** – Please clarify whether the date reported for this data element should be the same date as what plans are currently reporting for Program Audit and Part C reporting (i.e., the date the check/payment entered the USPS mainstream).

- **F. Item/Service/Part B Drug Code; H. Diagnosis Code; and Q. Disposition** – We strongly recommend that CMS only require data be provided at the whole claim level (vs. line level), similar to annual Part C reporting and Program Audit data. Requiring plans to submit data at the claim line level will vastly increase the size of the data files because each individual claim can contain several claim lines. Additionally, plans would require additional guidance on assigning a Disposition at the claim line level because Disposition is relative to the entire whole claim. For example, the Disposition of a whole claim containing two claim lines would be considered Partially Favorable if one of the claim lines was approved while the other claim line was denied, but if reporting at the claim line level, it would not be accurate to state that each claim line was Partially Favorable.

- **L. Provider NPI** – Include an NA option for enrollee or enrollee rep. submitted requests or providers that do not have an NPI.

<u>Section 2. Service Level Data for all Appeals</u>

Subsection #2 Reconsiderations (coverage decision)

- **L. Dismissal Rationale/M. Decision Rationale/N. Was the initial organization determination request denied for lack of medical necessity? –** Add the option NA for instances where data element K is "Disposition is Fully Favorable".

- **M. Decision Rationale** – Add the option NA, or provide guidance on leaving the data element blank, when data element K (Disposition) is "Dismissal".

First Tier, Downstream, and Related Entities – Please clarify whether FDRs are in scope for this data collection. If they are in scope, consistent with the ODAG audit protocols, we recommend adding a field to enter the name of the FDR that processed the request.

Did a third-party vendor participate, in any capacity, in the determination review or decision-making? – We recommend that CMS provide examples of the type of third-party vendors they want plans to report either yes or no for this data element. In current state, this data element is unclear and vague.

Alignment with Existing CMS Reporting Requirements and Audit Protocols:

In an effort to reduce the burden on plans, we recommend aligning with the ODAG Program Audit protocols for consistency and removing any variation when same or similar data is requested. For example, data element E (Requesting Party) is the same as data element V in the ODAG audit protocols. However, in the ODAG protocols the values of the data element are specified as E, ER, CP or NCP whereas this data element specifies the values as 01, 02, 03, or 04.

Effective Date:

Should CMS proceed with finalizing its proposal to collect this data for plan year 2026, it is critical that the agency distribute the finalized Reporting Requirements and Technical Specifications by the end of Q3 2025. Providing plans sufficient lead time will support more accurate implementation and data reporting since plans will need to make significant changes to administrative processes, programming and technology infrastructure for their systems.