June 27, 2025

Mr. William N. Parham, III
Director, Division of Information Collections and Regulatory Affairs
Office of Strategic Operations and Regulatory Affairs
Office of Management and Budget

Re: Service Level Data Collection for Initial Determinations and Appeals, CMS-10905
(OMB Control Number: 0938-new)

Submitted electronically

Dear Director Parham,

Collectively, our post-acute care provider associations acting in coalition offer our strong support for finalizing the data collection initiative, CMS-10905. We represent skilled nursing facilities, home health agencies, inpatient rehabilitation hospitals and units, long-term acute care hospitals, and other providers across the United States who provide Medicare Parts A and B services.

As key stakeholders in Medicare Advantage (MA), we have long advocated for the collection of more data on prior authorization, payment decisions, and outcomes at the service level. We agree that this data collection will not only improve our understanding MA enrollee access to Medicare benefits and patterns of utilization but also provide essential information for CMS oversight and enforcement activities. In other words, we believe this data collection initiative will help us continue to improve timely access to medically necessary Medicare services, as well as facilitate important MA oversight on the part of CMS.

Additionally, we are pleased that so many of our previous comments on this data collection were carefully considered and addressed in the final version. The key questions to be answered in items J, K, M, T and U for initial coverage determinations will shed light on how these elements are working and what impact things like third-party participation has on these key plan decisions and patient access to care, and the frequency with which internal coverage criteria are used by the plans. Element K will

delineate concurrent review (CR) requests from prior authorizations (PA). This data point has been lacking. These CR requests add considerable administrative burden to skilled nursing facilities and home health agencies due to their frequency and the short duration of services approved related to each request.

We also would like to call out a few items that we hope OMB and CMS will give further consideration as this data collection initiative moves toward implementation.

1. **Clean Claims**

   As noted above, we strongly support CMS's intent to collect more granular data on claim processing and denials. However, item P under Initial Determinations (payment) is subject to impactful ambiguity: the definition and application of "clean claims."

   While CMS has established a statutory definition of a clean claim—defined in 42 CFR § 447.45(b) as a claim that can be processed without obtaining additional information from the provider or a third party—many MA plans apply their own interpretations that go beyond this standard. For example, some plans reject, or delay claims not because of missing or inaccurate data, but because information is not placed in the exact field or format they require—even when the data is present and correct. This practice creates unnecessary administrative burden, processing delays and confusion for providers.

   Additionally, some MA plans use proprietary edits or internal rules that flag claims as "not clean" for reasons that are not transparent to providers—or even to CMS. These opaque processes make it difficult for providers to understand the true reason for a denial or delay, and they undermine the goals of consistency and accountability.

   For the purposes of this data collection initiative, CMS should clarify that for item P under Initial Determinations (payment) MA plans must abide by the CMS definition of "clean claim" instead of internal definitions in its response and require plans to provide standardized, detailed explanations when a claim is deemed "not clean." This should include:

   - The specific data elements or formatting issues that triggered the rejection.
   - A clear path for providers to correct and resubmit claims.

2. **Annual Reporting on Data Collected**

   In the interest of MA program transparency, we continue to press CMS to publish the information collected under this initiative for public consumption so stakeholders can also track plan progress and analyze plan trends regarding coverage decisions and payments. It would be a lost opportunity if this data was not shared with stakeholders and consumers in an easily digestible way to help them understand and compare their MA plan options across plans and with traditional Medicare. While not within the scope of this data collection proposal, we recommend CMS publish the data annually in one or more of the following ways: 1) a single report that compares plans across metrics; 2) publish key data points by service category (e.g. post-acute care) on Medicare plan finder to assist consumer decision making; and 3) incorporate key metrics in the MA Star Rating program as part of beneficiary experience domain. We would also like this data to be available for research purposes similar to other Part C and D data.

3. **Date of Implementation**

   Finally, we did not see a proposed year for when the data collection initiative would begin. We support and encourage CMS to require plans begin reporting this data as of January 1, 2026.

We appreciate your consideration and please contact Nicole Fallon at nfallon@leadingage.org if you wish to discuss anything in this letter further with our post-acute care coalition partners.

Sincerely,

Nicole O. Fallon, on behalf of the above listed organizations
Vice President, Integrated Services and Managed Care
LeadingAge