AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

January 5, 2024

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4205-P
P.O. Box 8013
Baltimore, MD 21244-8013

Delivered Electronically

Re: AMRPA Comments on Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program Proposed Rule (CMS-4205-P)

Dear Administrator Brooks-LaSure:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) *Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program* proposed rule. AMRPA is the national trade association representing more than 700 inpatient rehabilitation hospitals and units (referred to by Medicare as Inpatient Rehabilitation Facilities, or IRFs). Our members focus on the care and functional recovery of some of the most vulnerable Medicare beneficiaries – such as traumatic brain injury, stroke, and spinal cord injury patients. Our member hospitals help patients maximize their health, functional ability, independence, and participation in their communities, so they are able to return to home, work, or an active retirement.

IRFs play a unique and critical role in providing hospital-level medical and rehabilitation care to beneficiaries in Traditional Medicare and those enrolled in Medicare Advantage (MA) plans. Unfortunately, many individuals face significantly reduced access to inpatient rehabilitation care in the latter program, and we urge CMS to ensure that all beneficiaries maintain appropriate access to medically necessary covered benefits regardless of their form of Medicare coverage. A brief summary of our recommendations for the CY 2025 MA rule follows, with additional details provided below.

- CMS should require plans to report robust prior authorization and utilization management metrics, including denials and approvals disaggregated by appeals level, on a service- and setting-specific level, across the MA program as well as in the proposed health equity analyses.
- CMS should make this plan-reported data publicly and easily accessible for current and future enrollees as well as other stakeholders.

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- CMS should expand its definition of "enrollees with disabilities" to include the full population of MA beneficiaries with disabilities for the purpose of health equity analyses.
- CMS should establish a unified portal where stakeholders can view all MA plans' health equity analyses and require certain standardized reporting to improve stakeholders' ability to compare health equity impacts across MA plans.
- CMS should enhance independence and enforcement policies applicable to Utilization Management Committees and require each Committee to represent specific experience in rehabilitation medicine.
- CMS should finalize its proposed revisions to the MA appeals process for non-hospital services and extend the same protections to hospital services so that MA beneficiaries have the same access to fast-track appeals as Fee-for-Service (FFS) beneficiaries.

I. Health Equity Analyses of Prior Authorization Policies

In last year's final MA policy rule[1], CMS instituted a new requirement that MA plans establish Utilization Management Committees (UMCs) to ensure that each plan's utilization management policies are consistent with traditional Medicare coverage. Beginning on January 1, 2024, an MA plan may not use utilization management policies for basic or supplemental benefits, including prior authorization requirements, unless those policies have been reviewed and approved by the UMC. AMRPA supported the intention of these committees, but encouraged CMS to strengthen the applicable requirements and institute external enforcement measures to ensure that these committees meaningfully address the problems CMS intended to target.

In this year's proposed rule, CMS proposes to require that UMCs conduct an annual health equity analysis, specific to each plan's use of prior authorization. Specifically, these committees would be required to examine the impact of prior authorization across the plan for enrollees with disabilities, as well as enrollees who are dually eligible for Medicare and Medicaid or receive a low-income subsidy. These analyses would compare prior authorization metrics for enrollees with and without these "social risk factors" over the prior year, aggregated for all items and services, and would be posted publicly on each plan's website. Each UMC would also be required to have at least one committee member with "expertise" in health equity. CMS seeks comment on potential expansion of this proposal, including other populations to include in the analyses and any specific items or services that CMS should consider disaggregating.

AMRPA Recommendations

A. Require Disaggregated Prior Authorization Metrics by Service and Setting

We urge CMS to ensure that information on payer practices, in the health equity analyses and beyond, is reported on a disaggregated, individual service level, as well as by setting of care. While reporting aggregated categories of data on prior authorization may be a step in the right

[1] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 88 Fed. Reg. 22120 (April 12, 2023).

direction, this information will be too broad to be meaningful for patients, providers, and stakeholders. Prior authorization and other utilization management practices impose a severe burden on access to care across many types of services, but the impact on patients varies significantly depending on the actual service being provided. Furthermore, past federal oversight reports have found that certain services – including inpatient rehabilitation – are particularly vulnerable to inappropriate denials, making it all the more important for potential enrollees to be able to see how plans cover and provide access to these types of services.[2]

Further, CMS should require plans to report variances in prior authorization rates for admissions to certain settings of care, especially post-acute care. For example, numerous reports, including Medicare Payment Advisory Commission (MedPAC) analysis, recent Office of Inspector General (OIG) reports, and AMRPA's own member survey have highlighted the clear and highly concerning differences in patient access to inpatient rehabilitation hospitals across payers. It is imperative that enrollees, caregivers, and oversight entities have access to more specific information regarding the types of items and services for which plans may be unfairly restricting access or issuing erroneous prior authorization determinations that are ultimately overturned. Requiring payers to stratify this data by service would be a simple and meaningful step towards improving the transparency of payer practices and the usability of this data for patients.

B. Revise Proposed "Disability" Definition to Include All Beneficiaries with Disabilities are in Health Equity Analyses

We appreciate CMS' heightened commitment to advancing health equity for people with disabilities and support the inclusion of beneficiaries with disabilities as a specific social risk factor population for the purposes of the annual health equity analyses. However, we note that CMS proposes to identify disability status according to the variable original reason for entitlement code (OREC) for Medicare. This will include only beneficiaries under the age of 65 who qualified for Medicare coverage originally due to their disability and will exclude any other disabled beneficiaries who have Medicare coverage for another reason (including any beneficiary who acquired their disability after age 65). The focus on identifying disproportionate impacts of prior authorization policies on people with disabilities is admirable, but this narrow definition unfortunately misses the mark on appropriately identifying the correct population.

We urge CMS to expand the definition of disability for purposes of the health equity analyses (and other agency health equity efforts) to accurately account for the proportion of Medicare beneficiaries who have a disability. AMRPA and many of our stakeholder partners have long called on CMS to appropriately recognize the population of under-65, disabled beneficiaries in CMS policies, but we also note that many senior beneficiaries have disabilities as well. In order to make these health equity analyses adequately representative of prior authorization's impacts on beneficiaries with disabilities, the whole relevant population must be included.

[2] Department of Health and Human Services (HHS) Office of Inspector General (OIG), *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns about Beneficiary Access to Medically Necessary Care* (April 27, 2022) (https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp).

We also note with appreciation that other facets of the Administration have recently increased focus on the disability lens in health equity discussions. In particular, we commend the recent decision to designate people with disabilities as a health disparity population by the National Institute on Minority Health and Health Disparities (NIMHD). We urge CMS to consider working with other agencies as necessary to develop an appropriate lens for identifying MA beneficiaries with disabilities for the purpose of MA plan requirements and other equity-focused programs.

C. Expand Requirements to Ensure Robust Public Access and Utility of Health Equity Analyses

We urge CMS to strengthen its proposed requirements regarding the public accessibility of the proposed health equity analyses. Specifically, in addition to requiring plans to make the analyses available on their own websites "without barriers," we recommend that CMS establish a unified portal where members of the public can access all analyses for MA plans from a single, centralized location (similar to the Care Compare website and/or other CMS public-facing pages). We also recommend that CMS' forthcoming guidance on the formatting of these analyses (mentioned in the proposed rule) include certain standardized formats and data that each plan must report in the same or similar manners, to allow for easier comparison between plans. Given the importance of this information on enrollees' Medicare coverage decisions, we urge CMS to make this data as useable and accessible as feasible.

D. Additional Recommendations

In addition, we reiterate many of the same recommendations AMRPA submitted in response to CMS' original proposal regarding UMCs[3]. AMRPA continues to urge CMS to develop much stronger enforcement mechanisms to ensure that MA plans' prior authorization policies and practices comply with traditional Medicare coverage requirements, and with the numerous new requirements instituted in the 2024 final rule. Specific to the use of UMCs, we believe that these Committees should be required to review policies on an ongoing basis, and to specifically feature at least one practicing physician member with expertise in rehabilitation medicine. Given recent findings suggesting that rehabilitation services in inpatient rehabilitation hospitals and other post-acute care settings continue to be subject to high rates of improper prior authorization denials[4], we believe it is critical to ensure that UMCs directly represent the perspective of rehabilitation medicine when reviewing UM policies. We believe this UMC-specific requirement would be complementary to the plan reviewer-facing provisions in the Contract Year 2024 MA rulemaking, in which CMS asserted the importance that any plan reviewer "have knowledge and experience relevant to the requested services to reasonably determine when a requested service is reasonable, necessary and covered." Finally, we urge CMS to raise the requirements for independent members on UMCs, including at least a plurality, if not a majority, of independent

[3] AMRPA's full comments on the 2024 Proposed Rule can be found here.

[4] Department of Health and Human Services (HHS) Office of Inspector General (OIG), *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns about Beneficiary Access to Medically Necessary Care* (April 27, 2022) (https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp).

members to ensure that the Committee functions separately from the financial incentives of the plan itself.

II. Medicare Advantage Plan Reporting Requirements

CMS proposes minor revisions to its current regulatory language governing the types of information that MA plans are required to report to the agency. Currently, CMS is authorized to collect all information that is necessary "to administer and evaluate" the MA program, and the agency requires MA plans to "develop, compile, evaluate, and report to CMS, to its enrollees, and the general public… statistics and other information." The agency proposes to revise this language to remove the reference to "statistics" and only reference "information."

While this change is relatively insubstantial, it appears that CMS is contemplating more significant revisions to the data it collects from MA plans. Notably, the agency indicates that future changes could be made outside of the formal rulemaking process, instead through updating or issuing a new Information Collection Request (ICR) to plans. CMS specifically notes in the preamble that the agency could require "service level data for all initial coverage decisions and plan level appeals, such as decision rationales for items, services, or diagnosis codes to have better line of sight on utilization management and prior authorization practices." However, CMS does not specify exactly what additional data collection it is considering, beyond a few potential examples, nor any timeline for when CMS might institute new reporting requirements on plans.

AMRPA Recommendations

AMRPA strongly supports CMS efforts to expand data collection requirements for MA plans and urges the agency to specify and finalize new requirements as soon as possible. AMRPA has long advocated for CMS to collect, *and publicly report*, much more robust data from MA plans on their use of prior authorization and other utilization management techniques. We believe such transparency is critical to ensuring that current and future enrollees (and providers) have more detailed information on payers' utilization of prior authorization, determination timeframes, denial rates, and overturn rates. Further, given the current lack of insight into plan practices by CMS itself, and the range of new requirements instituted for MA plans in the 2024 final rule, we believe it will be difficult, if not impossible, for CMS to appropriately oversee and enforce compliance with new mandates on plans without requiring more detailed data to be reported on a regular basis. We recognize and appreciate CMS' planned and ongoing efforts to expand MA program audits in 2024 to ensure compliance with the new 2024 requirements and believe additional data collection will be critical to the success of agency oversight.

We also recognize that the proposed "electronic prior authorization" rule[5] initially issued in December 2022 is still pending finalization. While AMPRA submitted detailed comments[6] on that proposal in March 2023, we recognize that the pending final rule may include additional requirements regarding reported data. Regardless of the vehicle for additional reporting requirements (in the 2025 MA final rule, the final electronic prior authorization rule, or a future information collection request), we firmly believe that additional data reporting is an essential aspect of any MA oversight plan.

As previously noted, AMRPA urges CMS to require plans to report on service-level and setting-specific metrics for prior authorization, not only in the health equity analyses, but on a consistent basis. We also reiterate our call for CMS to report overturn rates by the level of appeal to demonstrate how often patients prevailed against coverage denials, particularly when they were able to attain an independent level of review.

To maximize the utility of such data, we urge CMS to ensure that data reported by payers is made public in a consistent, coherent, and accessible manner. For example, plan denial and overturn rates, disaggregated by setting and service, could be publicly posted on a consumer-facing site, similar to the way consumers can use Care Compare in making their decisions regarding IRF care and other services. CMS should also incorporate the data into quality reporting programs, such as the MA Star Ratings program, to ensure that payers are immediately accountable for their performance metrics. We note that the Partnership for Quality Measure (PQM) is considering a new measure tracking overturned determinations at the initial appeals level as part of the 2023 Measures Under Consideration (MUC) list and encourage CMS to continue expanding transparency on plans' coverage determinations through all relevant avenues, including quality reporting.

III. Medicare Advantage Beneficiary Appeal Rights

CMS proposes to align certain requirements regarding the timeline for appeal rights between MA and FFS Medicare. Currently, when either an FFS or MA beneficiary receives a Notice of Medicare Non-Coverage (NOMNC) for non-hospital provider services (including those provided in a Skilled Nursing facility, home health, or Comprehensive Outpatient Rehabilitation Facility), they also receive information on how to "fast-track" an appeal to the independent review entity (IRE). Typically, the deadline for a fast-track appeal is noon on the first day after the NOMNC is delivered. If an FFS beneficiary misses this deadline and submits an "untimely" fast-track appeal request, the IRE must still accept the request and conduct the fast-track appeal, but the timelines for the IRE to turn around a decision do not apply. Instead, the IRE must simply make a determination "as soon as possible."

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[5] Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program, 87 Fed. Reg. 76,238 (Dec. 13, 2022).

[6] AMRPA's full comments on the proposed electronic prior authorization rule can be found here.

However, if an MA beneficiary misses the deadline for a fast-track appeal, they are not able to submit a later appeal to the IRE; instead, their only recourse is to request an expedited reconsideration from the MA plan itself. Additionally, under the MA regulations, if a beneficiary leaves the provider or discontinues services on or before the proposed termination date, they lose their right to seek a fast-track appeal even if they later submit such a request within the regulatory deadline. In this rule, CMS proposes to modify the MA criteria to match those in FFS, allowing MA beneficiaries access to fast-track appeals even if they submit an untimely request. CMS would also remove the language requiring beneficiaries to give up their fast-track appeal rights if they voluntarily discontinue services before the termination date.

AMRPA Recommendations

While the proposed rule only addresses appeal rights for termination of non-hospital services, a similar discrepancy exists in appeal rights when a beneficiary's inpatient hospital care is being terminated. For beneficiaries in the FFS program who miss the deadline for expedited IRE review, they can still request expedited review by the IRE at any time during the hospitalization, or within 30 calendar days after discharge (or at any time at all, "for good cause"). For MA beneficiaries, they can only request expedited reconsideration by the MA plan if they miss the initial deadline for a fast-track IRE review.

Given CMS' apparent interest in standardizing MA beneficiaries' appeal rights with those in the FFS program, we urge CMS to make the same revisions to appeal rights for hospital services. Specifically, the regulations in 42 C.F.R. § 422.622(a)(5) should be modified to match those in 42 C.F.R. § 405.1206(b)(5) and (6). CMS should clarify in the final rule that the intent of these changes is to afford both FFS and MA beneficiaries the same fast-track appeal rights when services in an inpatient hospital are being terminated. If CMS chooses to retain any substantive differences in these appeal rights between the FFS and MA program, these should be clearly delineated and explained so that beneficiaries, plans, and providers understand the intent behind any disparities. We also note that plans will have to revise the language in the standard notice of discharge appeal rights that are provided to beneficiaries and encourage CMS to quickly update the standardized notice that CMS offers in conjunction with the final rule.

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AMRPA greatly appreciates CMS' continued efforts to reform the use of prior authorization and other barriers to access in the MA program. We look forward to continuing our collaboration with CMS to ensure that all Medicare beneficiaries have timely access to the care they need, particularly with respect to medically necessary inpatient rehabilitation services. Should you have any questions or wish to discuss our comments further, please contact Kate Beller, AMRPA Executive Vice President for Policy Development and Government Relations, at KBeller@amrpa.org and Joe Nahra, Director of Government Relations and Regulatory Policy, at JNahra@amrpa.org.

Sincerely,

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