AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Submitted Electronically via HELPGOP_AIComments@help.senate.gov

September 22, 2023

The Honorable Bill Cassidy, M.D.
Ranking Member, Committee on Health, Education, Labor, and Pensions
U.S. Senate
455 Dirksen Senate Office Building
Washington, DC 20002

RE: AMRPA Feedback on Use of Artificial Intelligence for Health Care Administration and Coverage

Dear Ranking Member Cassidy:

On behalf of the members of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to provide our feedback and recommendations regarding potential legislation governing the use of Artificial Intelligence (AI) in health care. We thank the Senate Health, Education, Labor, and Pensions (HELP) Committee for its focus and attention to this critical issue.

AMRPA is the national trade association representing more than 700 freestanding inpatient rehabilitation hospitals and rehabilitation units within acute care hospitals. Our hospitals and units focus on the care and functional recovery of some of the most vulnerable patients – such as traumatic brain injury, stroke, and spinal cord injury patients. For those served in our member hospitals, timely access to medically necessary care is paramount, yet too often medical rehabilitation patients face undue barriers posed by overreliance on algorithms and rigid technological systems instead of the clinical judgment of a treating physician and rehabilitation team. Our comments focus on the implications of AI for exacerbating these barriers and reducing patient access to needed care.

AMRPA and our members have long sought reforms to health plans' use of prior authorization and other utilization management techniques because of the direct and adverse impact these practices often have on some of the nation's most severely ill and disabled patients. Especially in the rehabilitation medicine context, timely and appropriate care transitions from an acute care hospital can dramatically improve a patient's functional recovery and quality of life. In recent years, our concerns have focused on health plans' reliance on clinical algorithms, proprietary guidelines, and other strict criteria that go beyond the coverage regulations applicable to such

Anthony Cuzzola · Chair, AMRPA Board of Directors
Vice President/Administrator, JFK Johnson Rehabilitation Institute, Hackensack Meridian Health
529 14th Street NW, Suite 1280, Washington, DC 20045 · Phone: 202-591-2469 · Fax: 202-591-2445

plans, including those participating in Medicare Advantage (MA), the Affordable Care Act exchanges, and private payers.[1]

The core issue with these criteria arises when patients are reduced to a set of rigid "checkboxes" relating to their demographics, diagnoses, etc., and when decisions to approve or deny coverage is determined without consideration of the holistic evaluations and judgment of a physician or other clinician who is actually treating the individual. Unfortunately, our member hospitals are increasingly finding that AI tools and algorithms are simply offering a new barrier to accessing medically necessary care and reducing the role of provider recommendations in the health care system.

AMRPA recognizes that AI and other emerging technologies provide some benefits in the health care setting, particularly in the realm of advancing administrative efficiency. As the Committee recognizes, the extensive and growing administrative burden on physicians, non-physician practitioners, and other employees in nearly all health care settings is a serious concern, reducing time spent with patients, accelerating burnout, and reducing efficiency. Alleviating such burdensome, time-intensive, and often duplicative administrative activities has long been a key goal for AMRPA, and we welcome the role AI may play in reducing some of this workload on both the provider and payer sides. When health care providers can spend less time on administrative tasks and more time caring for patients, everyone benefits.

However, as the Committee explores potential legislation governing the use of AI in health care settings, we urge careful consideration of the negative impacts expanded reliance on AI may have on access to care. This is particularly the case in a field such as inpatient rehabilitation, where physicians are required under Medicare regulations to actively review and document their concurrence with initial admission assessments. This specialized process for IRF admissions requires that deference be given to the treating physician's determination during any type of review and makes it all the more important that AI and other tools only be used to support (rather than supplant) these physician-driven assessments. As we outline below, AMRPA strongly recommends the Committee adopt several critical guardrails to ensure that AI in health care does not prohibit patients from receiving the treatments and services they need in a timely fashion.

Key Considerations for Health Care AI

First, AI, "decision support algorithms," and other similar tools, regardless of the specific terminology used to describe them, must not serve as a replacement for the judgment of experienced and qualified clinicians. AMRPA has long held concerns that health plans are currently substituting the judgment of internal plan reviewers, who more frequently than not have little to no experience in the relevant clinical field, with the medical recommendations of specialty-trained physicians who are directly involved in caring for a given patient. Even in these situations, plans are at least able to offer a "peer-to-peer" discussion between plan reviewers and

[1] For a more detailed explanation of AMRPA's concerns with prior authorization and Medicare Advantage, please see our comments on the CY 2024 MA proposed (now final) rule and the still-pending electronic prior authorization proposed rule.

the ordering physician, though these discussions are not always available and may frequently still result in a rubber-stamp affirmation of an initial care denial.

However, these issues will take on an entirely new dimension if care and coverage decisions are made not by a human with whom a physician can have the opportunity to educate and discuss a patient's specific needs, but by an automated system powered by AI. For federal programs like MA, there are already requirements in place that care decisions must include individualized assessment of specific patient characteristics, but these must be strengthened and expanded across payers to ensure that human clinicians have meaningful involvement with and oversight of claim reviews.

Second, we sincerely believe that AI tools should not be used to deny access to care, at least when medical necessity is challenged. The Committee appropriately addresses the value that AI can provide in advancing administrative efficiency (such as enabling "instant claims approval"). AI and related systems are well-positioned to address claims for routinely approved, simple, and common procedures and diagnostic tests, where payer systems simply need to quickly confirm basic criteria, proper coding, etc. In more complex cases, though, such as inpatient rehabilitation or other post-acute care admissions, medical necessity is determined by a comprehensive review of a wide range of factors relating to the patient's condition and individualized characteristics. Determining, for example, the proper setting of care and specific rehabilitative needs for an individual who has experienced a traumatic brain injury, a stroke, a spinal cord injury, or who has a complex neurological condition like multiple sclerosis, is not a simple question – certainly, not one that can be reduced to a few black-and-white criteria. In these situations, it is paramount that any care denials be evaluated and directed not by an algorithm, but by a human reviewer with the requisite experience and training in the relevant field.

Finally, if and when AI tools are adopted to support (but not replace) clinical decision-making, a legal and regulatory framework must ensure that these tools *only* provide guidance and recommendations to human clinicians who make the final judgment regarding coverage of a given claim. AMRPA continues to hear reports from the field that AI algorithms, similar to the experience with "proprietary guidelines," may purport to only offer aggregate analysis and recommendations based on large data sets rather than individualized patient assessments. In practice, such tools serve as binding requirements that staff at payers follow precisely, with little or no opportunity for reviewers to consider specific relevant circumstances.

The Committee's white paper referenced one such (damning) example.[2] Employees at a major provider of algorithmic "support," reported that their own clinical review decisions, which they are employed by payers to provide, were being consistently overridden by the predictive algorithm. According to these reports, even clinicians' (both those employed by the treating facility and those employed by the payer) vehement disagreements based on patients' specific needs were not sufficient to skew from the treatment denials predicted by the algorithm. As AI-powered algorithms like these continue to expand their utilization in the health care setting, it is

[2] Casey Ross and Bob Herman, STAT News, *How UnitedHealth's Acquisition of a Popular Medicare Advantage Algorithm Sparked Internal Dissent over Denied Care* (July 11, 2023).

absolutely critical that restrictions be in place to ensure that they only provide guidance and not be allowed to provide the final decision on whether patients can access the care they need.

Regulatory Efforts in Medicare Advantage

As the Committee is well aware, some regulators have begun to tackle the issue of AI and algorithm use in health care, most recently in the MA program. The recently finalized 2024 MA rule[3], which goes into effect on January 1, 2024, attempts to rein in some of the use of AI, algorithms, and proprietary guidelines by Medicare Advantage Organizations. Among other new provisions, the rule will require that plans disclose their use of external coverage criteria, including AI and decision support algorithms, in a publicly accessible manner. In the same rule, the Centers for Medicare & Medicaid Services (CMS) strengthened existing requirements in the MA program that determinations regarding the medical necessity of treatment must be "based on the circumstances of the specific individual… as opposed to using an algorithm or software that doesn't account for an individual's circumstances." The rule also clarifies that medical necessity denials 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 at issue.

We believe a key element of this rule, and one that could be further strengthened by additional regulatory or legislative action, is to ensure transparency about the use of AI tools. Stakeholders should know when AI is being used to make care decisions, the basis for the AI decision-making, as well as data on the number of denials or approvals that tie to any AI tool. Furthermore, such data should not be aggregated but should be specific to different care settings and specialties. This will help assess if there are negative impacts on patient access to care and the health care system.

AMRPA has strongly supported these reforms in the MA program and continues to advocate for additional refinements to ensure that they meaningfully address problematic payer behavior. Of course, these regulations will only have the desired impact if they are appropriately monitored and enforced. We believe these new requirements are an essential starting point in constraining the use of AI and algorithms to protect those beneficiaries in the MA program. We encourage the Committee to consider how similar protections can be expanded beyond the MA program and built upon within the Committee's jurisdiction.

Interaction with Other Committees and Policymakers

We recognize that the dynamics governing the use of AI in health care cross over the jurisdictions of multiple Congressional committees and federal agencies. As noted above, CMS has already begun addressing AI issues in the MA program, though much more work is required to ensure that patient access to care is not compromised. Developing a meaningful AI framework that allows these technologies to achieve real benefits for consumers while minimizing threats to

[3] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications, 87 Fed. Reg. 79,452, 79,501 (Dec. 27, 2022).

safety and access will require cooperation across the federal government. As the HELP Committee continues to explore possibilities for legislation in this area, we urge you to coordinate closely with your colleagues in Congress and the Administration to create a robust, patient-centered AI policy.

***

AMRPA thanks the Committee for taking this step to solicit opinions from the field and stands ready to provide additional information and assistance however we can. We greatly appreciate the Committee's time and attention to our feedback and look forward to working with you and your colleagues to ensure that technological advancements do not hinder patient access to medically necessary care. If you have any questions, please contact Kate Beller, AMRPA Executive Vice President for Policy Development and Government Relations, at kbeller@amrpa.org.

Sincerely,

Anthony Cuzzola
Chair, AMRPA Board of Directors
VP/Administrator, JFK Johnson Rehabilitation Institute, Hackensack Meridian Health