AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

May 29, 2024

The Honorable Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4207-NC
P.O. 8013
Baltimore, MD 21244-8013

Delivered Electronically

Re: AMRPA Comments on Request for Information on Medicare Advantage Data

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) *Request for Information on Medicare Advantage Data*, published in the Federal Register on January 30, 2024. 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 medical care and functional recovery of some of the most vulnerable Medicare beneficiaries – such as the 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. Meaningfully increasing transparency within the MA program regarding access to care and utilization management is a key priority for AMRPA and our member hospitals, and we urge CMS to take timely action to ensure that patients, providers, and policymakers have the data and information they need to address these concerns for MA beneficiaries, as well as ensure that beneficiaries can make informed decisions as to their Medicare coverage options.

We applaud CMS for its responsiveness to AMRPA's and other stakeholders' long-held concerns regarding MA plan practices, particularly with regards to reforms finalized in recent years. However, it is critical that additional steps be taken to ensure that plans comply with these requirements and to allow stakeholders to better understand their impact and what still needs to

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be addressed in future rulemaking, enforcement, and potential legislation. Advancing data transparency in MA is an essential first step towards achieving these goals.

AMRPA's specific recommendations regarding MA transparency are as follows:

- **CMS must mandate that MA plans report, *at a setting- and service-specific level*, information regarding prior authorization practices, approvals, and denials (including more specific denial reasons).**
- **CMS should require plans to report denial overturn rates, disaggregated by service type and level of appeal.**
- **CMS should institute standardized formatting requirements for plan-reported data and incorporate plan-reported data into quality measurement programs for plans.**
- **CMS must institute data reporting requirements for MA plans that will indicate compliance (or lack thereof) with new program rules implemented in CY 2024.**

I. Expanding on the Electronic Prior Authorization Final Rule

In early 2024, CMS issued a final rule on *Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations* and other federal health programs (the "electronic prior authorization" final rule).[1] This rule included important new requirements applicable to MA plans regarding transparency on prior authorization metrics, including: a list of all items and services that require prior authorization; the percentage of standard and expedited prior authorization requests that were approved, denied, and approved after appeal, the percentage of requests for which the review timeframe was extended and then approved, and the average and median time elapsed between submission and requests and the determination by payer. All of these metrics will be required to be reported on an annual basis, beginning in 2026. Notably, however, CMS only finalized a requirement for these metrics to be reported at *the plan level, aggregated for all items and services*.

AMRPA, along with many of our partners representing post-acute patients and providers, supported these provisions in the rule, but urged CMS to expand these requirements to make the data more meaningful and actionable. This is particularly important in light of the fact that certain services have been found to be particularly vulnerable to inappropriate denials and coverage restrictions by the Department of Health and Human Services' Office of Inspector General (HHS OIG) [2] and other oversight entities. By collecting only aggregated prior

[1] 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, 89 Fed. Reg. 8,758 (Feb. 2, 2024)

[2] HHS OIG, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns about Beneficiary Access to Medically Necessary Care* (Apr. 2022) (https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf) (finding that IRF services are among the "most prominent" of the service types that MA plans denied despite meeting Medicare coverage rules).

authorization data, however, CMS will not be able to meaningfully identify and correct these problematic plan behaviors. **AMRPA therefore continues to recommend that payers be required to report information on prior authorization disaggregated by the types and services and items at issue, as well as by setting.** We believe that this is perhaps the single most impactful change that CMS can make to MA data and transparency regulations and would help ensure that current and future enrollees (as well as providers) have more detailed information on payers' utilization of prior authorization, the determination timeframes, denial rates, and overturn rates.

While in the final rule, CMS indicated concerns that more discrete data requirements could be "overwhelming" for patients and lead to data overload, we urge CMS to reconsider this position and recognize the urgent need for meaningful transparency regarding plan prior authorization practices, particularly for IRF coverage. As evidenced by a range of sources, including the Medicare Payment Advisory Commission (MedPAC)[3], the HHS Office of Inspector General (OIG)[4], and AMRPA's own member survey conducted in 2021[5], there are clear and highly concerning differences in patient access to IRF services across payers. These unfair restrictions surrounding IRF services and other post-acute care (PAC) services are likely a significant reason that MA enrollees are much more likely to exit the MA program and enroll in Traditional Medicare or another payer following major illness or injury (when such restrictions directly impact the enrollee).[6] Furthermore, the lack of such data on MA plan practices hinders the ability of government oversight entities to analyze the true impact of prior authorization in MA and make recommendations to promote beneficiary access to care and decrease health care costs.[7]

AMRPA believes it is therefore imperative that enrollees, caregivers, and oversight entities have more specific information regarding the types of items and services for which payers may be unfairly restricting access or issuing erroneous prior authorization determinations that are

[3] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, 272 (Mar. 2017) (finding that MA enrollees receive one-third the access to IRF care that is afforded to Traditional Medicare beneficiaries).

[4] HHS OIG, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns about Beneficiary Access to Medically Necessary Care* (Apr. 2022).

[5] AMRPA, *Access to Inpatient Rehabilitation for Medicare Advantage Beneficiaries: An Examination of Prior Authorization Practices* (Mar. 2022), https://amrpa.org/Advocacy-News/Medicare-Advantage-Prior-Authorization-Survey (finding that beneficiaries enrolled in MA plans face high denial rates for IRF services, endure long average wait times for decisions, and are approved for IRF care at disproportionately low rates).

[6] Government Accountability Office, *Medicare Advantage: Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending* (June 2021). https://www.gao.gov/assets/gao-21-482.pdf. (finding that stakeholders reported disenrolling from MA because of "potential limitations accessing specialized care," among other factors).

[7] *See, e.g.*, Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, 359 (Mar. 2024): "The Commission finds that plan-submitted data about beneficiaries' health care encounters are incomplete… Without adequate information, policymakers cannot fully understand enrollees' use of services, which limits policymakers' ability to oversee the program." *See also* Medicare Payment Advisory Commission, Nov. 2, 2023 Public Meeting (presentation by Ledia Tabor, MedPAC staff): "MA organizations do not report determinations by service type or specialty, so the program does not know how prior authorization requests, denials, and approvals vary across services and across MA contracts." https://www.medpac.gov/wp-content/uploads/2023/03/November-2023-meeting-transcript-SEC.pdf

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 useability of this data for patients. At minimum, such disaggregation should be applied to each of the new metrics that plans will be required to report beginning in 2026, under the electronic prior authorization final rule.

There are also additional refinements to the electronic prior authorization final rule requirements that we recommend CMS implement. First and foremost, we urge CMS to be more specific about how plans must report their prior authorization overturn rates. Federal and independent analyses have consistently demonstrated that while only a small portion of prior authorization denials are overturned, the vast majority end up fully or partially overturned in favor of the patient.[8] **We therefore urge CMS to require plans to report overturn rates, by the level of appeal and disaggregated by setting and service, in order to demonstrate how often patients prevailed**. We also encourage CMS to publicly report overturn rates at the second level of appeal (overseen by the Independent Review Entity or IRE), as AMRPA and other organizations have serious concerns about whether the IRE is meaningfully assessing plans' denials for IRF stays or simply "rubberstamping" the plan's initial determination.[9]

AMRPA also urges CMS to ensure that the data reported by payers is easily searchable by enrollees and reported in a consistent and coherent way. Allowing plans to determine where they post their data and the individualized format they use will make it exceedingly difficult for enrollees to find and compare payers with respect to their prior authorization practices. We are also concerned that this data collection will not be tied to any sort of quality program, creating concerns that plans will not have any incentive to change their practices aside from reporting data as required. We recommend that CMS consider using this payer-reported data in the same way it uses data reported by providers for quality improvement and patient education. **For example, plan denial and overturn rates, specified by setting, could be publicly posted on a consumer-facing site**, similar to the way consumers can use Care Compare in making decisions about IRF care and other services. **CMS should also incorporate this data into quality reporting programs, such as Star Ratings in the MA program, to ensure that payers are immediately accountable for their performance metrics**.

We believe these refinements are critical to ensuring that the transparency provisions in the electronic prior authorization final rule have the intended impact on patients, providers, and health plans.

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[8] *See, e.g.*, HHS OIG, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials* (Sept. 2018), https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf (finding that from 2014-2016, MA plans overturned 75% of their own denials, but only 1% of denials were appealed); Kaiser Family Foundation, *Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021* (Feb. 2, 2023), https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/ (finding that just 11% of prior authorization denials were appealed in 2021, but 82% of appeals resulted in full or partial overturns).

[9] Notably, an examination of the Medicare Parts C & D IRE Decision Database demonstrates that between January 1, 2020 and May 10, 2024, the IRE completed nearly 52,000 reconsideration determinations of IRF referrals. Of those, only 780 (1.5%) had a favorable (to the appealing party) or partially favorable decision. That the IRE affirms more than 98% of MA plan determinations raises significant questions as to the independence of this body.

II. Enforcing Compliance with the 2024 Medicare Advantage Final Rule

AMRPA greatly appreciates CMS' important steps towards reining in MA plan practices in the Contract Year (CY) 2024 MA final rule.[10] Many of the provisions in this final rule were directly responsive to long-held concerns and recommendations from AMRPA and many of our partner organizations representing patients and providers, and we thank the agency for their attention and action. Among other provisions, this final rule required plans to adhere to new requirements regarding the qualifications and experience of plan reviewers issuing denials based on medical necessity; instituted new limits on re-authorizations for already approved "courses of treatment," restricted the use of proprietary guidelines or other internal coverage criteria; and reaffirmed the requirement that MA plans comply with all Traditional Medicare statutes, regulations, and other applicable coverage requirements.

While these provisions addressed serious flaws in the existing MA program, many IRFs and other post-acute care providers have reported little, if any, changes in plan behavior since these requirements went into effect on January 1, 2024. AMRPA consistently receives reports from member hospitals of denials that appear to directly contradict explicit requirements, such as denial letters explicitly citing proprietary guidelines as the reason for denial (including Milliman Care Guidelines/MCG, InterQual, or unspecified "internal criteria")[11], as well as denials offering statements such as, "You could receive treatment at a lower level of care," "the care you require can be rendered in an alternate setting," and "needs could be met at a lower level," without any additional finding that the IRF admission otherwise did not meet the fully established coverage criteria under Traditional Medicare.[12] This indicates that many patients may be denied access to an appropriate level of care for their condition (as determined by their treating physician and clinical team), and such diversions to less intensive settings are not adequately represented in the data currently available.

Regarding reviewer qualifications, hospitals continue to report instances where the clinician making the denial (and overriding the clinical judgment of the rehabilitation physician actually treating a given enrollee) have experience or specialties far outside the realm of rehabilitation, including pediatric gastroenterology, family medicine, anesthesiology, and others.[13] We have

[10] 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. 22,120 (April 12, 2023).

[11] Explicitly prohibited under 42 C.F.R. § 422.101(b), (c), and § 422.566(d).

[12] This "less intensive setting" standard comes directly from a rescinded ruling, HCFA Ruling 85-2, which CMS withdrew in 2010 and replaced with the updated IRF coverage regulations at 42 C.F.R. § 412.622. The current coverage criteria established by Medicare for the IRF benefit does not include any standard for a denial based on the fact that a patient could receive care in a less intensive setting, if the beneficiary otherwise meets all coverage criteria established in regulation.

[13] 42 C.F.R. § 422.566(d) requires that an MA plan's determination 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 services at issue." In cases involving IRF services, MA plans are required to appoint an appropriate health care professional "with expertise" in both the field of inpatient rehabilitative care and in the Medicare coverage criteria for inpatient rehabilitative care, with CMS specifically stating that a reviewer "would need to have the background

also received reports that plans are newly refusing to provide any information on the clinician making a denial, even if the clinician is actively engaged in a peer to peer discussion with the treating rehabilitation physician. These reports are entirely new since the regulations specifying a reviewer qualification standard went into effect.

Unfortunately, hardly any of the provisions in the 2024 MA final rule included new mandated reporting by plans, enhanced monitoring by CMS, or any new penalties for non-compliance. While CMS has announced that the agency plans to focus its standard annual plan audits on these new rules, thus far it appears that many plans have simply chosen not to comply with the new requirements and continue to skirt agency rules. Therefore, we urge CMS to carefully consider MA data and transparency requirements for plans that would indicate compliance (or lack thereof) with these new provisions in the MA regulations, in order to allow beneficiaries, providers, CMS, and other oversight entities to more effectively monitor plan behavior.

In particular, we urge CMS to consider the following:

- Require plans to report on settings to which beneficiaries are diverted upon an initial denial of admission to an IRF or other inpatient setting.
- Require plans to report on the qualifications and experience of clinicians when issuing denials of care based on medical necessity.
- Require plans to affirmatively report to CMS, for publication in a centralized location, information on any internal or proprietary guidelines used for coverage determinations.
- Require plans to report to CMS use of algorithms or artificial intelligence in coverage decisions.
- Enhance requirements for plans to provide detailed denial reasons, including specifications regarding what evidence is lacking to approve or continue a course of treatment and specific rationale(s) for not covering a given service.

Reporting this information in a publicly accessible manner could significantly impact compliance with these regulations, in accordance with CMS' intention in promulgating the final rule. Such measures could help to identify areas where additional guidance may be needed or enforcement is warranted (e.g., a new penalty structure for non-compliance), as well as highlight issues for future regulation and/or legislative action.

III. Additional Reforms are Needed to Protect Patient Access in Medicare Advantage

While AMRPA recognizes that this Request for Information is focused on data and transparency in Medicare Advantage, we continue to stress the need for additional substantive reforms within the program, in order to build on CMS' action thus far to protect beneficiaries' access to care. We have detailed many of these recommendations in prior comments to CMS (in particular our

and knowledge to determine that the enrollee's medical condition requires intensive rehabilitation, continued medical supervision, and coordinated care."

comments on the proposed Contract Years 2024 and 2025 MA policy rules, as well as the proposed electronic prior authorization rule), but reiterate several key recommendations below.

- ***Accelerated Timeframe for Prior Authorization Determinations****:* Given the well-documented issues surrounding care delays and recovery time lost by patients while they await prior authorization determinations in the acute care hospital, we urge CMS to *reduce* the timeframe for payers to respond to expedited authorization requests (such as admission to an IRF). While the final electronic prior authorization rule standardized the timeframes across payers, the rule maintained the current 72-hour timeframe that applies to the MA program. This will not alter payer behavior and will continue to result in unnecessary short-term acute care hospital days, or worse, force patients into less appropriate, lower-intensity settings that are able to quickly accept patients and free up acute care beds – even if and when the higher intensity setting is the most clinically appropriate destination for a given patient. AMRPA strongly recommends that CMS enforce a 24-hour turnaround time for expedited and emergent prior authorization requests, and clarify that such timeframe applies across weekends and holidays.
- ***Conditional Approvals for Inpatient Admissions****:* In recent years, AMRPA members have reported that MA plans have begun putting additional roadblocks in place even when approving IRF admissions. Hospitals report that in some cases, MA plans will approve an IRF admission only on the condition that the MA plan will not approve a subsequent admission to a skilled nursing facility (SNF). While IRFs have a very high rate of discharge to the community, they cannot guarantee that a given patient will not need subsequent sub-acute care, particularly given the long-term and complex care needs of most patients requiring IRF care in the first place. Such conditions represent clear violations of the Medicare coverage rules, which entitle MA beneficiaries to SNF care when an individualized determination of medical necessity is made and the beneficiary qualifies for SNF coverage. CMS should work to ensure that no such "conditions" are placed on an authorization for IRF or other admission when the Traditional Medicare coverage criteria are met.
- ***Network Adequacy****:* AMRPA has also consistently raised concerns that MA plans may limit access to IRF care by keeping their provider networks narrow and inadequate to meet beneficiary demand. AMRPA members report that numerous MA plans across the nation do not maintain adequate agreements with all types of PAC providers, due in part to the fact that there are no network adequacy requirements to include IRFs and certain other types of PAC providers in MA plan networks. Without changes to the network adequacy requirements to include IRFs as a specified provider type, MA plans will continue to limit the placement of patients from acute care hospitals into the most appropriate PAC setting, even if the plan would approve the medical necessity of such an admission. CMS should revise the MA network adequacy requirements to include IRFs and other critical providers alongside the currently listed facility types used to assess adequacy of a plan's network for each service area.

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AMRPA greatly appreciates CMS' continued attention to the need for reforms to 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 President, at KBeller@amrpa.org and Joe Nahra, Director of Government Relations and Regulatory Policy, at JNahra@amrpa.org.

Sincerely,

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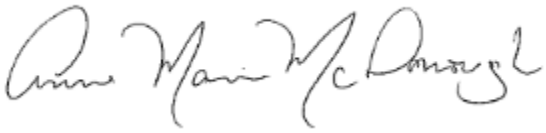
Vice President and Chief Operations Officer – Madonna Rehabilitation Hospitals



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