



April 6, 2020

SUBMITTED ELECTRONICALLY

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-4190-P, Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, Proposed Rule, 86 Fed. Reg. 9002 (February 18, 2020).

Dear Administrator Verma,

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we are submitting this letter in response to the Medicare Advantage (MA) Part C Proposed Rule for plan year 2021 and 2022 by the Centers for Medicare and Medicaid Services (CMS). Our comments focus on CMS' proposals pertaining to Medicare Advantage appeals regulations, network adequacy requirements, MA Star Ratings, as well as AMRPA's ongoing and pressing concerns about practices of MA organizations that restrict access to needed care, resulting in potential patient harm and increased cost to the Medicare program.

AMRPA is the national voluntary trade association representing more than 650 inpatient rehabilitation hospitals and units (referred to by Medicare as "IRFs" but abbreviated herein as "IRH/Us"), which play an important role in the continuum of post-acute care (PAC). Most patients treated in an IRH/U are admitted directly from a stay in an acute-care hospital due to a serious accident or medical event. IRH/U patients commonly have conditions such as stroke, spinal cord injury, amputation, major multiple trauma, brain injury, neurological disorders, and other morbidities that have resulted in serious functional deficits and the need for continuing medical supervision.

IRH/Us provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from care provided in non-hospital PAC settings.¹ Patients in an IRH/U are closely supervised by a physician, who also oversees patients' overall rehabilitation treatment, which must include a minimum of 15 hours per week of intensive therapy services.² Rehabilitation

¹ See DOBSON DAVANZO & ASSOCIATES, ASSESSMENT OF PATIENT OUTCOMES OF REHABILITATIVE CARE PROVIDED IN INPATIENT REHABILITATION FACILITIES (IRFs) AND AFTER DISCHARGE (July 2014).

² See 42 C.F.R. § 412.622.

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physicians practicing in IRH/Us oversee an interdisciplinary approach to care, which helps patients maximize their health, functional ability, independence, and participation in society so they are able to return to home, work, or an active retirement. Admission and treatment in an IRH/U is a Medicare covered benefit, and Medicare regulations are clear that MA plans must provide “all Medicare-covered services.”³ Further, MA plans must comply with all Medicare coverage regulations and manuals.⁴

I. Background on MA Plans Tactics for Post-Acute Care Admissions

Despite the life-changing (and cost-saving) benefits offered by IRH/Us, MA plans routinely and inappropriately deny and delay access to IRH/Us for patients in need of these services, usually through utilization of a prior authorization process. AMRPA hospitals report a high rate of initial denials from MA plans. Many providers report that they are able to secure admission for MA beneficiaries only after a long and resource intensive appeal, if at all. Hospitals also experience extensive delays in receiving responses from MA plans on prior authorization determinations, particularly when such determinations are needed over a weekend or holiday. These delays can have catastrophic effects on the outcomes and recovery for patients needing inpatient rehabilitation, and are inconsistent with the 24/7 operation of hospitals and the needs of these patients.

Most typically, a patient seeking admission to an IRH/U is awaiting discharge at an acute-care hospital. When clinicians screen acute-care Medicare patients for post-acute placement, they must follow very specific Medicare guidelines to determine whether the patient is appropriate for an IRH/U.⁵ When screening indicates the patient is appropriate for IRH/U care, at least one physician with specialized training and experience in rehabilitation must concur, but in actuality there are usually multiple physicians involved and in agreement about the referral. This mandated Medicare pre-admission process already amounts to a self-administered prior authorization process which – in contrast to the process used by MA plans – is administered by clinicians who are appropriately trained in rehabilitation medicine and have actually evaluated the patient in question.

The first flaw in the MA prior authorization process is that plans take up to 72 hours – which does not include weekends – to make an initial organization determination. This is wholly unacceptable and, practically speaking, means that a patient ready for discharge on Thursday may be required to remain in the acute-care hospital *five additional days* before a determination is made on Tuesday, without running afoul of Medicare rules. Not only does this delay subject the patient to additional risks, such as hospital-acquired infections, and force them to incur additional

³ *Id.* § 412.604.

⁴ *Id.* §§ 422.10(c) & 422.101(b).

⁵ 42 C.F.R. § 412.622(a). Among other requirements, to be covered in an IRH/U, the patient must need an interdisciplinary approach to care and be stable enough at admission to participate in intensive rehabilitation. There must also be a “reasonable expectation” that the patient will need multidisciplinary therapy, intensive rehabilitation, and supervision by a rehabilitation physician. The requirement for multidisciplinary therapy must include physical or occupational therapy. Intensive rehabilitation is defined as three hours per day, five days per week (or 15 hours per week). The therapy must be reasonably likely to result in measurable, practical improvement to the patient’s functional capacity or adaptation to impairments. The rehabilitation physician must see the patient at least three times per week.

costs while waiting in the acute-care hospital, the delay in receiving therapeutic intervention at the IRH/U often has meaningful negative and lasting impacts on the patient’s recovery and overall outcomes.

Once an initial determination has been reached, the frustrations for patients and providers usually continue because a very high rate of requests for IRH/U admission are initially denied. Denials are largely due to the fact that MA plans utilize proprietary decision tools such as Milliman and InterQual – guidelines that reportedly conflict with Medicare IRH/U coverage criteria in spite of the aforementioned requirements that MA enrollees receive the same benefits as those in the traditional program. Plans’ use of these decision tools seem to drive admissions to lower-acuity settings, such as skilled nursing facilities and homecare, regardless of a patient’s appropriateness for inpatient rehabilitation. Most importantly, these proprietary guidelines do not follow Medicare coverage guidelines, representing a violation of the MA enrollees’ right to the same benefits covered under traditional Medicare.⁶

Further, MA plans will often offer a “peer-to-peer” physician discussion before issuing the final organization determination. Providers are constantly disappointed by the lack of relevant experience offered by the MA plan physician reviewer, as well as the burden with participating in these calls. Providers report that normally the Medical Director or other MA physician representative discussing the case with the provider has no experience with PAC or rehabilitation. This is in stark contrast to the Medicare requirements imposed on IRFs, which require a specially trained rehabilitation physician or medical director to approve admissions.

Beyond the lack of specialized training, MA physician reviewers often have little understanding of the Medicare coverage criteria for PAC, and sometimes cite erroneous standards for IRH/U admissions. Further, the MA plans usually offer limited windows for the peer-to-peer, with little advance notice, requiring physicians to rearrange their care for patients at the last minute to participate in a call that is rarely fruitful due to the aforementioned defects. Despite the 24/7 operation and treatment of patients in hospitals, the peer-to-peers are offered only during typical business hours Monday through Friday.

As CMS knows, beneficiaries are also entitled to an appeal of the initial organization determination. However, providers and enrollees are equally stymied by these appeals because they contain most of the same shortcomings as the initial determinations. It is important to contextualize that once the initial determination has been made, the patient in question has been waiting in an acute-care hospital ready for discharge for three to five days. The MA plan then usually takes up to another 72 hours to render a reconsideration decision. This means the patient and hospitals are faced with the choice of accepting the MA plan’s lower level of care against physician advice, or unnecessarily holding the patient for *another three days* in the acute-care hospital. This is simply an untenable position that puts the MA organization’s interests before that of the patient. Similarly, hospitals report that just like the initial determination, the MA representatives conducting the reconsideration requests often lack training or experience in PAC, and render affirmations of the initial decision based on faulty coverage and medical premises.

⁶ *Id.* § 422.101(b).

Technically speaking, MA enrollees are entitled to additional levels of review beyond the reconsideration stage. However, due to the unacceptable delays in receiving earlier decisions from MA plans, it is practically impossible for a patient who has been waiting for discharge for a week or more to remain in the acute-care hospital to pursue further levels of appeal. The interests all parties dictate that the patient will at least initially need to move to a lower level of care, where they may or may not have the resources to continue to appeal their case. This is especially unfortunate since CMS' current review of appeals via the MA Star Ratings program only examines appeal outcomes at the third level of appeal, when it is already too late, and which leads to an inaccurate picture of access to care.

Not all plans in all regions operate using the same tactics. For example, a member recently provided AMRPA with a detailed accounting of their experiences with MA plans over the course of the past year. In this providers' case, one major MA plan in their region has denied 100 percent of its prior authorization requests for admission to an IRH/U. Astonishingly, 100 percent of this provider's appeals to that MA plan have been overturned by the plan at reconsideration. The plan essentially seems to be trying to run out the clock on the provider and patient, hoping they will accept a lower level of care.

Unfortunately, this life-threatening issue for beneficiaries has amounted to what could be called an "invisible problem." Throughout the prolonged process of seeking admission to an IRH/U, the beneficiaries themselves often have little understanding of the distinctions between the different levels of PAC, let alone a grasp of their rights as an MA enrollee. Patients who are denied entry to an IRH/U may never be informed or understand that they had a right to appeal and that a higher level of care is a covered benefit under Medicare.

In addition to the aforementioned practices, hospitals have noted a number of other abuses by MA plans in recent years. These include informing beneficiaries that the IRH/U is not a covered benefit, that they are not entitled to appeal the initial determination or reconsideration, and denying IRH/U physicians' ability to participate in the peer-to-peer or reconsideration because they "lack standing" in the case. In addition, for those few MA enrollees who do get admitted to IRH/Us, MA plans are putting up roadblocks to discharge the patient from the IRH/U, possibly in an attempt to frustrate the hospital and discourage future admissions.

In all, current MA's approach to prior authorization is not patient-centered, often does not follow Medicare's own requirements, and fails to ensure that treating clinicians have the ability to help their patients receive the care they need.

II. Dismissal and Withdrawal of Medicare Part C Organization Determination and Reconsideration, p. 9,069

For the reasons outlined above, AMRPA has serious concerns about how Part C Organization Determinations and Reconsiderations are handled. In addition to addressing CMS' specific proposals, AMRPA will also provide additional recommendations consistent with CMS' request for comment in the proposed rule on whether "additional beneficiary protections need to be addressed."⁷

A. Proposed Regulations for Dismissal of a Part C Organization Determination and Reconsideration, 9,069

CMS proposes to codify its rules for when an MA plan can dismiss an expedited organizational determination (EOD). CMS proposes that an MA plan may properly dismiss an MA EOD if "the individual or entity making the request is not permitted to request an organization determination under § 422.566(c)." The referenced regulation, 42 C.F.R. § 422.566(c) states that the enrollee (including his or her representative), or a physician (regardless of whether the physician is affiliated with the MA organization), can request an EOD.

AMRPA finds that this proposed regulatory language is insufficiently vague and should be amended to avoid beneficiaries being denied a fair EOD. As previously noted, hospitals often are told by MA plans that a rehabilitation physician seeking to admit a patient to an IRH/U cannot participate in EOD discussions with MA plans. Instead, MA plans say, only the attending physician of record can participate in the EOD. However, these rehabilitation physicians that are precluded from participating are the same rehabilitation physicians required to perform the *de facto* prior authorization process required by Medicare.

Denying the rehabilitation physician the ability to participate in the EOD is harmful for several reasons. First, the attending physician often relies on the rehabilitation physician's advice to determine the patient's proper PAC placement. Second, the rehabilitation physician is most familiar with the service that will be provided at the IRH/U, and how the patient's medical and functional needs do or do not align with IRH/U service. Therefore, **CMS should clarify in its regulatory text that any physician familiar with the patient's care needs, like a rehabilitation physician from an IRH/U, is considered a proper party to request a EOD under § 422.566(c). In addition, CMS should specify that these physicians are fully entitled to participate in any peer-to-peer discussions or other aspects of the EOD.**

Similar to its proposal for EOD, CMS proposed to codify when an MA plan may dismiss a request for expedited reconsideration (ER) of an MA plan EOD. CMS proposes that an MA plan may dismiss the request for ER when "the person or entity requesting an expedited reconsideration is not a proper party under paragraph (a) of this section." The paragraph (a) referenced states that the enrollee (including his or her representative), or a physician (regardless of whether the physician is affiliated with the MA organization), can request an ER. Due to the same concerns articulated regarding CMS' proposal for EOD, CMS should

⁷ Proposed Rule, p. 9,072.

further clarify and amend its regulatory text. This clarification should ensure that physicians with knowledge of a patient's care needs should be deemed a proper party and able to fully participate in requests for ER. This will ensure beneficiaries are not denied the ability to have a specialized physician represent their needs to the MA plan.

For the third level of appeal, Reconsideration by an Independent Review Entity (IRE), CMS also proposes to codify when the IRE can dismiss a request for reconsideration. CMS proposed regulatory text says that the MA plan may dismiss the request if "the person or entity requesting a reconsideration is not a proper party under § 422.578(c)." Confusingly, 42 C.F.R. § 422.578(c) does not appear to exist. There is a § 422.578, but it has no subparagraphs. CMS should issue a clarification of what it intended concerning this proposed regulation. However, regardless of what CMS intended, the agency should ensure its regulatory text is amended and clarified to ensure that any physician familiar with the patient's care needs are fully able to request and participate in Reconsiderations to IRE. As stated earlier, this will safeguard patient's ability to have the proper medical expertise represent their interests to the IRE.

Finally, these proposed regulations have highlighted the confusing differences in terminology between the initial levels of appeal for Fee-for-service and MA organization appeals. AMRPA recommends CMS align the two appeal terminologies to avoid provider confusion and burden. For example, the initial level of appeal should have the same name for both programs, rather than redetermination for Fee-for-service and reconsideration for MA appeals.

Recommendations:

- 1. CMS should amend its regulatory text to ensure that any physician with knowledge of a beneficiary's care needs is considered a proper party and able to fully participate in expedited organization determinations, expedited reconsiderations, and reconsiderations to an Independent Review Entity.**
- 2. AMRPA recommends CMS revise its appeals terminology to align Medicare Fee-for-Service and Medicare Advantage appeals.**

B. Additional Beneficiary Protections That Need to be Addressed, p. 9,071-9,072

CMS concluded this section of the proposed rule by requesting information on additional beneficiary protections that need to be addressed by the agency. As AMRPA expressed in the introduction to this letter, MA plans currently engage in harmful practices *vis a vis* prior authorization that results in adverse outcomes for patients and wasteful spending for the Medicare program. To address this, CMS should substantially amend its current regulations and enhance its oversight to address these practices.

As an overarching matter, in instances when a physician (or multiple physicians, which is often the case for a referral to an IRH/U) have deemed an admission to a hospital or facility medically necessary, and that admission is a Medicare covered benefit, MA plans should not be permitted to override this decision. Even if an MA plan deploys the requisite medical expertise in a timely fashion for these decisions, the MA plan physicians cannot be deemed to

be in any better position than the treating physician or physicians with an IRH/U who have actually evaluated the patient, to make this decision. The only additional perspective an MA plan reviewer brings to this decision is a financial incentive to choose the less costly course of treatment. **Therefore, prior authorization should be eliminated for hospital admissions ordered by an appropriate physician.**

If CMS chooses to continue to permit MA plans to utilize prior authorization, the practices of MA plans need to be drastically altered through amended regulations and enhanced oversight. First, when MA plans are choosing to interject in the practice of medicine, their operations should match that of the providers. In the case of hospitals, this means operating 24/7, and available to address needs of patients in minutes, not days. **Therefore, when a patient is currently admitted to a hospital, and/or is seeking admission to a hospital, MA plans requiring prior authorization should be required to respond to a prior authorization request in no more than 6 hours.**

Requiring decisions within this timeframe will ensure patients can continue their course of treatment without undue delay, which will provide for both better outcomes and prevent any wasted resources. CMS should amend regulations requiring EODs to be made within this 6 hour timeframe, and if no response is received, the EOD is deemed favorable to the patient. If MA plans offer “peer-to-peer” discussions before rendering an EOD, the MA plan must ensure this discussion can take place within this timeframe.

CMS should require an even more expedited timeline for reconsiderations of an EOD. Given the fragile nature of patients seeking admission to a facility, it would be inappropriate to allow for another 6 hours for each level of appeal. **Therefore, MA plans should be required to issue its reconsideration determination within 3 hours of notification of a request for a reconsideration, and IREs should likewise be required to issue a decision within 3 hours of notification of a request for a reconsideration of the MA plan’s reconsideration determination.** It is both medically appropriate and consistent with hospital level of care ensure that in no instance should it take more than 12 hours for a MA beneficiary in need of admission to a facility to have an appropriate placement.

In addition to ensuring the timeliness of decisions, CMS needs to amend its regulations and oversight to ensure that the decisions rendered on prior authorization requests are sound. The prior authorization decisions of MA plans should be based upon two things: 1) the medical judgement of physician with specialized training and experience in treating patients similarly situated to the beneficiary in question; and 2) application of this medical expertise to the applicable Medicare coverage criteria. Unfortunately, many plans either utilize decision tools that do not align with Medicare coverage guidelines to make placement decisions. To ensure MA plans base decisions upon these two factors, **CMS needs to amend regulations to curtail the use of proprietary guidelines that are not tailored to strictly match Medicare coverage guidelines. CMS can accomplish this by revising its regulations to require MA plans to make public its tools as well as to submit them to CMS before they are utilized.**

Further, **CMS should require that only physicians with appropriate expertise make decisions on prior authorizations pertaining to admissions. This is particularly needed in instances when an unfavorable decision would be overriding a practicing physician’s judgement** who has seen and evaluated the beneficiary in question. For IRH/U admissions, this should be a physician that meets Medicare’s definition of a rehabilitation physician, which is CMS’ requirement for overseeing admission decisions to IRH/Us.⁸ Likewise, the same level of expertise must be required of MA plans for each level of appeal, as well as for peer-to-peer discussions.

CMS should additionally amend regulations to hold MA plans accountable to the accuracy of its decisions. As previously stated, many MA plans reverse themselves on reconsideration at a very high rate. Even though a favorable decision is ultimately reached, this still means acute-care patient has spent extra days in the hospital, and the provider has spent time and resources on appeals. Further, when a favorable decision is not reached on initial reconsideration, it is difficult for a hospital or beneficiary to continue appeals to additional levels, given the acute nature of the patient. **Therefore, CMS should enhance its regulations to require MA plans maintain a sufficiently high level of accuracy at all levels of determination, not just the third level of appeal.**

AMRPA further recommends CMS engage in several oversight activities and enact penalties to ensure the accuracy of MA plan determinations. First, CMS should audit plans to ensure all decisions are made within the 6 or 3 hour timeframe. Next, the agency should audit plan decisions using independent physicians who are actively practicing in their field to review MA plan determinations at all levels. When plans have accuracy rates below 95%, the plans should be subject to financial penalties, and plans with lasting deficiencies should no longer be permitted to participate in the MA program. Further, it should be telling to CMS if practicing physicians are regularly disagreeing with MA plan decisions, and find these decisions harmful enough to their patients to take up valuable time and resources to contest those findings. Therefore, simply having high rates of appeal by physicians should subject MA plans to penalties.

In addition to accuracy, there should be accountability for long-term cost for MA plans. MA plans may have a financial incentive to deny admission to an IRH/U when the alternative PAC placement is less expensive in the short-term. However, when patients receive more intensive rehabilitation in an IRH/U, their improved functional status can lead to less resource use in the long-term.⁹ While it might seem as though the per-capita relationship between the CMS and MA plan already incentivizes cost control, that line of thinking misses several nuances, particularly when looking at the longer-term picture. Data suggests that high-cost patients

⁸ 42 CFR § 412.622(c) (CMS defines a rehabilitation physician as a physician that an IRH/U determines has specialized training and experience in inpatient rehabilitation. Medicare regulations require the physician to concur with a pre-admission screening and oversee the patient’s care in an IRH/U).

⁹ See DOBSON DAVANZO & ASSOCIATES, ASSESSMENT OF PATIENT OUTCOMES OF REHABILITATIVE CARE PROVIDED IN INPATIENT REHABILITATION FACILITIES (IRFs) AND AFTER DISCHARGE (July 2014).

leave MA plans and enroll in traditional Medicare at a substantial rate.^{10,11} In addition, studies show IRH/Us actually extend life expectancy relative to lower intensity settings.¹²

Armed with this information, an MA plan can save money in the short-term by denying more intensive post-acute care, and not be on the hook for the higher-long term cost for many of those patients in light of the rate in which these patients leave their plans as well as their shorter life expectancy. **Accordingly, CMS should track and rate MA plans on cost-measures such as Medicare Spending Per Beneficiary, and that tracking should extend well beyond the plan year to incorporate rolling updates of beneficiaries who were once or are still are enrolled in the MA plan.** Holding MA plans accountable for long-term costs will incentivize plans taking the best action for the patient in the long-term and focus less on short-term financial implications.

AMRPA appreciates the value that MA plans add to the Medicare program. The innovative care and payment models developed by MA organizations have led to meaningful reforms to the health care system nationwide. We realize that many of these recommendations could add cost to MA operations. Nonetheless, these reforms are necessary to restore the MA program to the patient-centered mission it was founded on. AMRPA reminds CMS that MA plans are free to not use prior authorization tactics if these new requirements prove too burdensome. However, CMS should not put cost considerations of MA organizations above beneficiaries' best interests, and these reforms will undoubtedly ensure beneficiaries receive the care they need and deserve.

Recommendations:

- 1. Prior authorization should not be required by MA plans for hospital admissions ordered by an appropriate physician.**
- 2. When a patient is admitted to a hospital, and/or is seeking admission to an IRH/U, MA plans should be required to respond to prior authorization requests in no more than 6 hours. For appeals of these decisions, MA plans should be required to issue decisions within 3 hours of receiving the appeal.**
- 3. CMS should amend its regulations to curtail the use of proprietary guidelines that are not tailored to strictly match Medicare coverage guidelines.**
- 4. CMS should require that only physicians with appropriate expertise make decisions on prior authorizations pertaining to facility admissions, particularly in instances when an unfavorable decision would be overriding a practicing physician's judgement.**
- 5. AMRPA recommends CMS enhance its regulations to require MA plans maintain a sufficiently high level of accuracy at all levels of determination, not just the third level of appeal.**

¹⁰ E.g., Momotazur Rahman et al., *High-Cost Patients Had Substantial Rates of Leaving Medicare Advantage and Joining Traditional Medicare*, 34(10) HEALTH AFF. 1675, 1679-80 (Oct. 2015).

¹¹ Government Accountability Office, *CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight*, GAO-17-393 (April, 2017).

¹² *Momotazur Rahman et al.*

- 6. CMS should track and rate MA plans on cost-measures such as Medicare Spending Per Beneficiary, and that tracking should extend well beyond the plan year to incorporate rolling updates of beneficiaries who were once or are still are enrolled in the MA plan.**

III. Proposed Network Adequacy Requirements, p. 9,092

CMS is proposing to codify several network adequacy requirements for MA plans. These proposed requirements include the types of providers that will be evaluated, and the minimum time and distance requirements for these provider types. CMS proposes several types of facility types that must be available in an MA plan network. This includes acute inpatient hospitals, cardiac surgery programs, intensive care units, and skilled nursing facilities (SNFs). However, CMS does not include IRH/Us on the list. This is a critical omission that needs to be corrected.

As previously stated, IRH/Us play a critical role in the PAC continuum. IRH/Us are the only hospital-level PAC setting required to provide close medical supervision and an intensive rehabilitation therapy program. For the nearly 400,000 Medicare beneficiaries that receive care in an IRH/U each year, having access to these services meant the ability to maximize their functional recovery following a serious injury or illness. For many patients, the high level of PAC services, both in terms of intensity and expertise, cannot be matched at a SNF or in a home-based course of treatment. If CMS fails to include IRH/Us in their list of required facilities, it will not only deny MA beneficiaries their rights to all Medicare covered benefits, but also preclude many from making a full recovery.

AMRPA insists that CMS include IRH/Us in its list of facilities subject to network adequacy reviews. This is consistent with CMS' own regulations pertaining to guaranteed access to all covered Medicare services. In addition, and as CMS knows, acute care hospitals are under no obligation to have an IRU, and many do not have one. Therefore, CMS cannot consider IRH/Us to be part of its acute inpatient hospital network adequacy requirements.

Recommendation:

- 1. Consistent with its own coverage requirements, CMS must include IRH/Us in the list of providers subject to network adequacy reviews.**

IV. Proposed Changes to MA Star Ratings, p. 9,043

CMS proposes several changes to the MA Star Ratings program, including changing the weight of patient experience and access measures. These rating categories currently receive a weight of 1.5, and CMS proposes to increase them to a weight of 4. While AMRPA agrees access to care and patient experience are very important, we also think the measures CMS uses for these categories are fundamentally flawed.

For patient experience measures, CMS uses beneficiary survey questions on topics such as ease of seeing specialists, ratings of health care quality, ratings of coordination of care, and several others. In theory, these could be helpful measures. However, given the opaque nature in which MA plans operate, as well as the tactics described herein that plans use to deny or delay care, it is

our hospitals' perception that most MA beneficiaries are unaware the extent to which they are or are not receiving the proper benefits.

As we described in the above section of this letter, denials of prior authorizations and unfavorable appeals often are an “invisible problem,” with beneficiaries unaware a higher or different setting of care was available to them. **Therefore, we do not think that giving a higher weight to these distorted measures is prudent. Instead of increasing the weight of these measures, CMS should take steps to incorporate more provider feedback into the MA ratings.** This should include surveys of providers on how efficiently and accurately MA plans make organizational determinations and appeals. Providers should also be able to give feedback on the expertise of MA plans in making clinical decisions, such as the ones made for prior authorization for admission to a facility.

Further, increasing the weight of the access measures will also not be as effective as CMS hopes it will be due to the fundamental flaws in these measures. Currently, CMS uses appeal measures such as percentage of the plan's appeals that were timely processed, and percentage of times the IRE agreed with the plan's appeal decision. As AMRPA has stated, the primary concern with plans is not that they do not issue decisions within 72 hours, but rather that the decisions they reach within that timeframe are unsound, and the 72 hour timeframe is far too long for many patients. In addition, as we described earlier, in many cases the patient is unable to continue pursuing appeals to additional levels, such as to the IRE. Even when the patient can appeal to the IRE, by then they have waited more than a week, and often times the IRE demonstrates the same lack of medical expertise or misunderstanding of coverage guidelines that the MA plan shows.

Therefore, rather than increasing the weight of these measures, CMS should provide for much more meaningful measures. These should include measures such as independent audits of the MA plans initial determinations, the frequency with which physicians appeal MA plans initial determinations, the timeliness of initial determinations (using a much shorter standard than 72 hours), and other measures that will capture the patient and provider experience much more accurately.

Recommendations:

- 1. Given that access concerns are often invisible to MA beneficiaries, CMS should not drastically reweight the patient experience measures for MA plans.**
- 2. CMS should add additional measures to the MA Star Rating Program that more accurately evaluate access to care. These include measures on how quickly MA plans respond to prior authorization requests, the level of medical expertise deployed by the MA plan in conducting reviews, the accuracy of plans' initial determinations, and the number of appeals made to the MA plan by physicians.**

V. Proposed MA Call Center Requirements, 9,115

CMS proposes to codify its requirements for MA plan requirements to have a call center available for beneficiaries. Currently, CMS only requires the call center be available during regular business hours. CMS proposes that the new regulations will require a call center be available from

8:00am-8:00pm local time. AMRPA recommends CMS enhance these requirements and add additional specificity.

As AMRPA has repeated, medical care, particularly in hospitals, does not stop on the weekends. Therefore, CMS should specify that these call centers need to be operated 7 days per week, every day of the year. Some of the most vulnerable MA beneficiaries, such as those admitted or seeking admission to a facility, often times are doing so on a weekend. These beneficiaries should have full access to real time information from their plan while this is happening. **Therefore, these call centers must be operated every day of the year. In addition, these call centers need to be available 24 hours per day, at least for certain inquiries, such as coverage of hospital admissions.**

Recommendation:

- 1. CMS should require call centers to be operated 24 hours per day, 365 days per year for critical information such as coverage for hospital admissions.**

AMRPA is committed to continuing to work with CMS to enhance oversight of MA plans and ensure access to critical services for Medicare beneficiaries. If you have any questions about AMRPA's recommendations, please contact AMRPA's Director of Government Relations and Regulatory Counsel, Jonathan Gold, JD, at jgold@amrpa.org or 202-860-1004.

Sincerely,



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Chair, AMRPA Board of Directors
President and Medical Director, Mount Sinai Rehabilitation Hospital