AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Submitted Electronically

October 8, 2024

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Division of Regulations Development
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-10905

Re: Agency Information Collection Activities; Proposed Collection; Comment Request – Service Level Data Collection for Initial Determinations and Appeals (CMS-10905)

Dear Administrator Brooks-LaSure:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we write to offer our comments on the Centers for Medicare & Medicaid Services' (CMS) proposed Information Collection Request on Service Level Data Collection for Initial Determinations and Appeals (CMS-10905), published in the *Federal Register* on August 9, 2024. AMRPA is the national trade association representing nearly 800 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals, referred to as inpatient rehabilitation facilities (IRFs). Our members focus on the medical 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 (Fee-for-Service) Medicare and those enrolled in Medicare Advantage (MA) plans. Unfortunately, many individuals face significantly reduced access to inpatient rehabilitation care in the latter program[1], and we have long urged CMS to ensure that all beneficiaries maintain appropriate access to medically necessary covered benefits regardless of their chosen form of Medicare coverage. Meaningfully increasing transparency within the MA program regarding access to care and utilization management has been a key priority for AMRPA and our member hospitals in recent years. We appreciate CMS' focus on advancing data collection so that patients, providers, and policymakers have the information they need to

[1] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy 298 (March 2017) (finding that MA beneficiaries have one-third the access to IRF care than Traditional Medicare beneficiaries).

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address concerns with MA program practices and so that beneficiaries can make fully informed decisions as to their Medicare coverage options.

I. CMS Proposed Information Collection

Under this proposed Information Collection Request (ICR), CMS seeks to expand the reporting requirements for organizations sponsoring or offering Medicare Advantage health plans ("MA organizations") regarding their use of prior authorization and related utilization management procedures. Specifically, the agency seeks to institute a new quarterly reporting requirement under which MA organizations must report a series of data elements on each initial determination of coverage, including, among others:

- The requested service code(s) and name of the associated service(s),
- The diagnosis code(s) submitted with the request for service(s),
- Whether the determination was processed as a standard or expedited request,
- Whether the provider was contracted with the MA organization (i.e., "in-network" or not),
- The plan's decision on the request (approved or denied),
- The "decision rationale," and
- Whether internal plan criteria were applied.

Plans would also be required to submit data on each appeal (plan reconsideration) that can be connected to the initial determination, including the approval/denial, the processing priority (standard or expedited), the decision rationale upon reconsideration, and the "reviewer qualifications."

CMS had previously indicated the agency was considering expanding data reporting requirements for MA organizations through the Paperwork Reduction Act (PRA) process in the MA final rule for Contract Year 2025.[2] In doing so, the agency cited the importance of CMS better understanding the circumstances in which plans choose whether to pay for a service or item and supporting the agency's critical role in overseeing MA organizations to ensure that enrollees have continued access to care. In this proposed notice, the agency further explains that the proposed ICR would "provide key data on the utilization of benefits, enhance audit activities to ensure plans are operating in accordance with CMS guidelines, and ensure appropriate access to covered services and benefits."[3] In our previous comments on the 2025 proposed rule, AMRPA strongly supported these goals, and we continue to do so. **We urge CMS to finalize these and other associated information collections to expand transparency regarding MA organizations' coverage determinations and offer more detailed comments below**.

[2] Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024-Remaining Provisions and Contract Year 2025 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 (PACE), 89 Fed. Reg. 30,448 (Apr. 23, 2024).

[3] Supporting Statement – Part A, Service Level Data Collection for Initial Determinations and Appeals (CMS-10905, OMB-New), Centers for Medicare & Medicaid Services (Aug. 9, 2024). https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing/cms-10905

II. Importance of Service-Level Data Collection

As the burden of prior authorization by MA organizations has grown in recent years, especially with regards to inpatient rehabilitation admissions, AMRPA and many other allied organizations have long called for greater transparency regarding plans' use of these practices and their impact on patient access to care. We appreciate CMS' recent flurry of activity in this area, including the 2024[4] and 2025 MA final rules and the "electronic prior authorization" final rule issued in early 2024,[5] but have raised concerns that certain new requirements have either not gone far enough, or have yet to be sufficiently enforced. AMRPA believes that the proposed service-level data collection contained in this ICR will meaningfully advance both goals.

As we have noted previously to CMS, including in our comments on the electronic prior authorization proposed rule submitted in March 2023 and our response to CMS' January 2024 *Request for Information on MA Data*, the prior authorization transparency metrics currently set to go into effect in 2026 are only mandated at the plan level, aggregated for all items and services. Despite findings that certain services (such as inpatient rehabilitation admissions) have been particularly vulnerable to inappropriate denials and coverage restrictions[6], collecting only aggregate data covering vast swaths of services threatens to limit the utility of any prior authorization data and threatens to obscure any problematic trends for specific services or types of care that CMS must address. By collecting service-specific prior authorization data for each determination that an MA organization makes, CMS will be able to better identify any access concerns and determine whether certain services are denied at an inappropriately high rate (which would be consistent with the reported trends across the post-acute care industry, especially from IRFs).

Furthermore, we appreciate that CMS specifically proposes to collect this data not only on initial determinations, but the first level of appeals as well (i.e., the plan reconsideration process). Independent data analyses have demonstrated that while relatively few MA beneficiaries facing care denials go through the appeals process, the vast majority of those who do appeal are able to get denials overturned, even though the reconsideration process simply involves the same MA organization reviewing the same patient information available at the initial determination stage. Specifically, a recent *KFF* analysis found that from 2019-2022, more than 80% of reconsiderations were fully or partially favorable towards the beneficiary, with those proportions

[4] 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).

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

[6] *See, e.g.*, 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).

actually increasing in 2022 (the most recent year for which public data was available).[7] We believe such high reconsideration rates indicate serious problems with the level of care and attention that MA organizations use in making initial determinations, and question whether some plans utilize initial denials as a "matter of course" or a tactic to delay and deny care for patients who clearly demonstrate medical need. Collecting robust, service-level data on initial determinations and reconsiderations will allow CMS (and, hopefully, the public and other stakeholders) to better understand these practices and determine what additional policy levers are necessary to ensure MA beneficiaries receive the care to which they are entitled under the Medicare program. We urge CMS to finalize this proposal and quickly begin collecting this information from MA organizations in calendar year 2025.

III. Specific Data Elements Included in CMS' Proposal

Generally, AMRPA supports the proposed data elements for collection from MA organizations. However, we believe that additional detail should be provided to ensure that the data accurately meets the standard the agency is expecting and provides meaningful information for the end user of such data.

Processing Priority (Elements I-I and II-E)

We support the inclusion of this data element, as collection will provide insight as to any trends that may be identified with the outcomes of determinations based on whether a request is processed as standard or expedited. However, we encourage CMS to also collect information on whether an MA organization accepted or denied a requesting provider's stated processing priority. Under the MA regulations for expediting organization determinations[8] and reconsideration requests[9], when a request for an expedited determination is made or supported by a physician, the MA organization "*must provide an expedited determination* if the physician indicates that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee *or the enrollee's ability to regain maximum function*" (emphasis added). Given the serious injuries, illnesses, or disabilities often preceding inpatient rehabilitation stays, and the importance of timely access to rehabilitation for maximizing functional gains, many requests for prior authorization of IRF admission (and subsequent appeals) are submitted as expedited requests, with the sufficient physician support and justification.

However, in recent months, AMRPA members have increasingly reported that MA organizations are denying such requests for expedited determinations, without any clinical justification, and automatically transferring these requests to be treated as standard determinations. This only leads to additional delays for beneficiaries in need of timely rehabilitation care, especially if the standard determination still results in an initial denial that must be appealed. Collecting

[7] Jeannie Fuglesten Biniek, Nolan Sroczynski, and Tricia Neuman, *Use of Prior Authorization in Medicare Advantage Exceeded 46 Million Requests in 2022* (KFF, Aug. 8, 2024). https://www.kff.org/medicare/issue-brief/use-of-prior-authorization-in-medicare-advantage-exceeded-46-million-requests-in-2022/.
[8] 42 C.F.R. § 422.570(c)(2).
[9] 42 C.F.R. § 422.584(c)(2).

information directly from MA organizations on how frequently they utilize these tactics and requiring plans to report a rationale for such denial, would help shine a light on whether certain services or settings face a disproportionate rate of processing priority denials. We urge CMS to add to the proposed collection to better capture this information.

Decision Rationale (Elements I-P and II-F)

CMS proposes to collect the "decision rationale" for both initial determinations and plan reconsiderations. However, this data element is not further defined, and CMS indicates in the supporting statement that the agency is specifically soliciting feedback on "how health plans can most efficiently provide information to CMS on their decision rationales."[10] Currently, MA organizations are required to "state the specific reasons for the denial" when the organization denies a service or item and communicate this to the beneficiary in writing.[11] However, providers and patients have long reported that the denial notices provided by MA organizations do not reasonably inform the beneficiary of the specific reasons for denial and often vaguely cite large swaths of regulation or include boilerplate language that does not indicate any individualized assessment of the patient's medical and functional needs. Especially for inpatient rehabilitation care, for which the coverage guidelines in Medicare statute and regulations are robust and explicitly stated, such ambiguous decision rationales are insufficient and only lead to additional confusion and delays while patients and providers attempt to address any perceived deficiencies through the appeals process.

While we recognize that changes to the existing beneficiary notification process may be outside the scope of this ICR, we urge CMS to carefully consider whether the current regulations are sufficient and more clearly define what level of detail is needed for plans to fulfill their substantive requirements with respect to decision rationales, whether the recipient is CMS, the patient, or the provider.

Reviewer Qualifications (Element II-G)

CMS proposes to collect "reviewer qualifications" when a plan makes a determination at the reconsideration level. Under the 2024 MA final rule, when an MA organization expects to issue an adverse medical necessity decision on a prior authorization request, the decision 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."[12] CMS explicitly discussed the application of this requirement to inpatient rehabilitation admissions in the preamble to the final rule, stating that "the plan reviewer reviewing a request for IRF care would need to have the background and knowledge to determine that the enrollee's medical condition requires intensive rehabilitation, continued medical supervision, and coordinated care. Accurately assessing the enrollee's diagnosis, conditions, and functional status requires clinical

[10] Supporting Statement – Part A, Service Level Data Collection for Initial Determinations and Appeals (CMS-10905, OMB-New), Centers for Medicare & Medicaid Services (Aug. 9, 2024). https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing/cms-10905.
[11] 42 C.F.R. § 422.568(e)(2).
[12] 42 C.F.R. § 422.566(d).

expertise… and could be made, for example, by a physical medicine and rehabilitation doctor, a neurosurgeon, a physical therapist, or a rehabilitation nurse."[13]

Since this rule has gone into effect, however, AMRPA members have consistently reported that denials are issued without appearing to meet this standard. For example, some MA organization reviewers denying IRF admissions have reported specialties wholly unrelated to rehabilitation, without any attempt to justify their relevant expertise, including physicians specializing in plastic surgery, anesthesiology, internal medicine, family medicine, and pediatric gastroenterology. Even more concerning, plans have lately appeared to change their processes to conceal the qualifications of their reviewers, with increasing numbers of IRFs now reporting that reviewing clinicians are refusing to provide information on their specialty, expertise, or credentials at all. Some hospitals have even reported that MA organization representatives have communicated that their legal compliance departments have made it a policy not to provide any information on the reviewing clinicians, even their names.

We believe these trends underscore just how critical it is that CMS finalize this data collection so that the agency can appropriately carry out its oversight and enforcement responsibilities over plan compliance. Providing additional clarity regarding the definition of the data element (i.e., specialty of reviewing clinician, relevant certification(s), and/or detailing any additional training that would satisfy the current regulatory standard) would help ensure that the data is appropriately informative and meets CMS' own needs for auditing and enforcement purposes. Additionally, we believe it is appropriate to collect this information at the initial determination level as well, if the initial determination resulted in a full or partial denial (i.e., if Element I-M is completed as "denied").

IV. Public Reporting of Newly Collected Data

Finally, AMRPA wishes to reiterate its previous comments regarding the importance of making relevant MA data *publicly available* and easily accessible for all stakeholders. CMS should consider all opportunities to report the data collected from payers in an easily searchable, consistent, and coherent manner. As stated earlier, the current regulatory requirements for public transparency around prior authorization will only apply to plan-wide metrics; CMS should take the opportunity presented by this ICR to expand this to service-specific data. This should include plans' performance at the reconsideration level; understanding how frequently a plan reverses its initial decision on a request for authorization is an important metric for consumers to understand what to expect from their health plan choices.

Furthermore, the data should be aggregated at a central, CMS-supported, consumer-facing site, similar to the way consumers can use Care Compare in making decisions about health care providers. By stripping out identifying data elements (e.g., provider NPI, enrollee MBI, date of service, etc.), CMS should still easily be able to present the de-identified data and allow members of the public to review plans' own performance and consider whether any trends in

[13] 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, 22,220 (April 12, 2023).

their coverage determinations should impact beneficiaries' decision-making regarding their health plan options. Additionally, CMS should incorporate the data newly collected from plans into quality reporting programs, such as MA Organization Star Ratings, to ensure that payers are held accountable for their performance.

Finally, if and when CMS finalizes such public reporting, we urge the agency to consider incorporating plan-level performance at the Independent Review Entity (IRE) level of appeal as well. While de-identified information on IRE determinations is currently made available through the Medicare Part C & D Appeals Decision Search tool, this data is not linked to the MA organization initially offering the denial. Stakeholders including AMRPA have recently raised concerns that the IRE all too frequently may be "rubber stamping" denials by plans, with only 1.5% of IRF denials being overturned by the IRE between the beginning of 2020 and the first quarter of 2024.[14] Enhancing transparency into the results of this level of appeal, and tying performance back to individual MA organizations, would further bolster the ability of consumers to fully understand the potential impacts of their health care choices.

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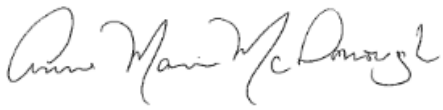
AMRPA appreciates the opportunity to comment on this ICR and we look forward to the finalized proposal. AMRPA and our members remain committed to working with CMS to ensure that the Medicare Advantage program and all payers maintain robust and appropriate access to medically necessary covered benefits for enrollees. If you have any questions regarding our comments, please contact Joe Nahra, AMRPA Director of Government Relations & Regulatory Policy, at (202) 207-1123 or by email at jnahra@amrpa.org.

Sincerely,

Chris Lee, MSPT, FACHE
Chair, AMRPA Board of Directors
Vice President and Chief Operations Officer – Madonna Rehabilitation Hospitals



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[14] Piper, Jermaine and Lane Koenig, "Medicare Advantage Prior Authorization Denials for Post-Acute Care Are Rarely Overturned," *KNG Health Consulting* (June 11, 2024). https://www.knghealth.com/medicare-advantage-prior-authorization-denials-for-post-acute-care-are-rarely-overturned/ (Finding that between January 1, 2020 and March 31, 2024, Medicare's IRE reviewed 48,938 appeals of IRF admission denials by MA organizations, and only overturned 764, while upholding more than 48,000 denials).