AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Submitted Electronically

January 27, 2025

The Honorable Jeff Wu (Acting Administrator)
The Honorable Cheri Rice (Acting Director, Center for Medicare)

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4208-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare and Medicaid Programs; Contract Year 2026 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 (CMS 4208-P; RIN: 0938-AV40)

Dear Acting Administrator Wu and Acting Director Rice:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) *Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program* proposed rule.[1] AMRPA is the national trade association representing more than 800 inpatient rehabilitation hospitals and units (referred to by Medicare as Inpatient Rehabilitation Facilities, or IRFs). Our members focus on the care and functional recovery of some of the most vulnerable Medicare beneficiaries – such as traumatic brain injury, stroke, and spinal cord injury patients. Our member hospitals help patients maximize their health, functional ability, independence, and participation in their communities, so they are able to return to home, work, or an active retirement.

IRFs play a unique and critical role in providing hospital-level medical and rehabilitation care to beneficiaries in Traditional Medicare and those enrolled in Medicare Advantage (MA) plans. It is vital that both patient populations have equivalent access to medically necessary inpatient rehabilitation services. Unfortunately, many MA enrollees face significantly reduced access to inpatient rehabilitation care, a trend which has been consistently validated by the Medicare Payment Advisory Commission (MedPAC) as well as our internal data collection efforts from AMRPA members.

[1] Medicare and Medicaid Programs; Contract Year 2026 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, 89 Fed. Reg. 99,340 (proposed Dec. 10, 2024).

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We applaud the agency for its recent efforts spanning administrations to reform prior authorization and other utilization management techniques used by MA plans. We believe that CMS should take further efforts to enforce these regulatory requirements and continue pressing forward with additional reforms to protect MA enrollees' access to inpatient rehabilitation hospital services. We urge CMS to ensure that all beneficiaries have appropriate access to medically necessary covered benefits regardless of their form of Medicare coverage. A brief summary of our recommendations for the Calendar Year (CY) 2026 MA rule follows, with additional details provided below.

- CMS should finalize its proposed clarifications around the use of internal coverage criteria but should prioritize meaningful enforcement of these and other existing Medicare rules and requirements surrounding plan coverage decisions.
- CMS should finalize its proposals to enhance the public availability of internal coverage criteria used by MA plans, and should further implement a centralized, CMS-hosted repository to make plan-reported criteria easily accessible for current and future enrollees as well as other stakeholders.
- CMS should finalize its proposal to require reporting of prior authorization metrics disaggregated by item and service through the annual health equity analyses published by each MA organization.
- CMS should finalize its proposed guardrails for artificial intelligence and continue a robust monitoring and oversight process for plan use of related systems in administering MA benefits.
- CMS should expand the mandatory network adequacy standards to include inpatient rehabilitation hospitals and units as a listed provider type, along with other settings of post-acute care.
- CMS should finalize its proposals to strengthen MA enrollee and provider notification and appeal rights.
- CMS should finalize its proposed limitation on reopening a favorable determination related to an inpatient hospital admission, and CMS should consider imposing similar limitations on reopening a favorable determination specifically concerning inpatient rehabilitation care.

I. Enhancing Rules on Internal Coverage Criteria

As finalized in the CY 2024 MA final rule[2] and enhanced in the CY 2025 final rule[3], CMS has instituted prohibitions on the denial of coverage of items or services based on internal or proprietary clinical criteria for benefits covered by traditional Medicare, for which the benefit is "fully established." These changes were directly responsive to AMRPA's and many others'

[2] 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).
[3] 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, 89 Fed. Reg. 30,448 (April 23, 2024).

concerns about the proliferation of proprietary guidelines used to deny access to IRF and other types of medically necessary care. Traditional Medicare standards for determining the medical necessity of admissions to inpatient rehabilitation hospitals are extraordinarily detailed in both statute and regulation. The IRF coverage criteria, specified in 42 C.F.R. § 412.622(c), constitute fully established coverage criteria under the definition advanced by CMS. In fact, the regulations finalized with the 2024 MA final rule explicitly affirm that MA plans must abide by the traditional Medicare coverage criteria specific to IRFs.[4]

Despite this clear statement from the agency, our members continue to report that MA plans often rely on internal coverage criteria to deny authorization and coverage of IRF admissions. These reports persisted throughout 2024, with little reported change in frequency, well after the new CMS prohibitions on such criteria went into effect. In many cases, members reported that plans appear to use these criteria to suggest that certain diagnoses categorically do not qualify for acute inpatient rehabilitation services, which is directly in conflict with the Medicare IRF coverage criteria. The fact that MA plans not only continue to rely on now-prohibited internal criteria to make medical necessity decisions for IRF care, but that these guidelines clearly impose additional barriers to care that would otherwise be covered in traditional Medicare, is highly concerning, and flies in the face of CMS' intended outcome of these new rules. We believe it is critical not only that the agency finalize its new proposals included in this rule, but that CMS prioritize and expand enforcement of these rules to ensure that MA beneficiaries are not denied care to which they are entitled under the Medicare program.

Clarifications on Internal Coverage Criteria Requirements

CMS proposes several "clarifications" to the existing regulatory language surrounding internal coverage criteria, including that internal coverage criteria cannot be used to add new, unrelated coverage criteria for an item or service with already existing coverage policies; finalizing a new definition of internal coverage criteria; and revising the specifications as to when external criteria may be justified.[5] We further appreciate the clarification that plans' obligations regarding the use of internal coverage criteria still apply when such criteria are incorporated or synthesized into algorithms, automated systems, or other workflows.

AMRPA supports the finalization of these policies; however, we question whether reports of widespread plan non-compliance are truly due to "common misunderstandings," as indicated in the proposed rule, or whether there is simply a lack of a meaningful effort to comply with the

[4] 42 C.F.R. § 422.101(b)(2): "[Each MA organization must comply with] General coverage and benefit conditions included in Traditional Medicare laws, unless superseded by laws applicable to MA plans. This includes criteria for determining whether an item or service is a benefit available under Traditional Medicare. For example, this includes payment criteria for inpatient admissions at 42 CFR 412.3, services and procedures that the Secretary designates as requiring inpatient care at 42 CFR 419.22(n), and requirements for payment of Skilled Nursing Facility (SNF) care, Home Health Services under 42 CFR part 409, ***and Inpatient Rehabilitation Facilities (IRF) at 42 CFR 412.622(a)(3).***" (emphasis added).

[5] CMS proposes to define "internal coverage criteria" as "any policies, measures, tools, or guidelines, whether developed by an MA organization or a third party, that are not expressly stated in applicable statutes, regulations, NCDs, LCDs, or CMS manuals and are adopted or relied upon by an MA organization for purposes of making a medical necessity determination." Proposed 42 C.F.R. 422.101(b)(6)(iii).

new requirements. Therefore, we continue to urge CMS to prioritize robust enforcement of Medicare rules and requirements in the realm of plan coverage decisions.

Availability and Accessibility of External Criteria

In addition to the existing requirements around when internal coverage criteria are appropriate to be used, CMS has previously codified requirements that any internal coverage criteria used by MA plans be made "publicly accessible." As CMS recognizes in this proposed rule; however, "the average person faces difficulty accessing an MA organization's website for the purpose of determining whether or not the MA plan applies internal coverage criteria to the particular Medicare item or service." As such, the agency proposes new requirements intended to make these criteria more understandable, readable, and easier to locate, including identifying and labeling each criterion individually, rather than intertwining them with applicable Medicare coverage criteria; requiring each MA organization to display on its website a list of all covered items and services for which internal criteria are used, which must be displayed prominently on the website and link directly to the full criteria; and mandating that such criteria be made accessible "without barriers," such as requiring creation of a user account or submitting personal identifying information.

AMRPA strongly supports each of these proposals and urges CMS to finalize and enforce these provisions. We have previously noted our concerns that some plans may technically comply with the letter of the regulation as currently codified but make it exceedingly difficult to determine where and how to access such criteria. CMS also references that the agency is considering an annual reporting requirement to the agency from MA organizations of information regarding internal criteria through the Paperwork Reduction Act process; we refer the agency to our previous comments on the proposed Medicare Part C Utilization Management Annual Data Submission proposal we submitted in November 2024.[6] CMS recently issued a final notice and comment period relating to this proposed Information Collection Request; if the agency considers additional revisions to the plan reporting requirements, we believe our past comments highlight the most important themes to maximize benefit to the program. As CMS implements this reporting coming into the agency, we continue to encourage CMS to similarly make this information available to the general public through a centralized CMS repository, which would further the goal of making relevant MA data publicly available and easily accessible for all stakeholders.

II. Enhancing Annual Analyses of Utilization Management Policies

In the CY 2024 final rule, CMS instituted a requirement that MA plans establish Utilization Management Committee (UMCs) to ensure that each plan's utilization management policies are consistent with traditional Medicare coverage requirements and other CMS specifications. As part of the following year's final rule, CMS required that UMCs conduct an annual health equity analysis, specific to each plan's use of prior authorization. As part of these analyses, plans are required to examine the impact of prior authorization across the plan for enrollees with

[6] Available at https://amrpa.org/wp-content/uploads/2024/11/AMRPA-Comments-on-CMS-ICR_Internal-Criteria-and-Audit-Protocol_FINAL.pdf.

disabilities, as well as those with other "social risk factors," and report certain prior authorization metrics for those with and without these factors over the prior year, aggregated for all items and services. At the time, AMRPA supported CMS' efforts to mandate additional disability-focused review by these UMCs, but urged CMS to expand on the reporting requirements to ensure that the data provided was meaningful and actionable for beneficiaries, providers, and all other stakeholders seeking to better understand the impact of plan prior authorization practices.

Now, we are pleased that CMS has heeded these calls, explicitly recognizing comments from AMRPA and other stakeholders seeking additional granularity in this data and proposes further revisions to this charge for MA plan UMCs. CMS proposes to require that each of the following mandated metrics in the UMC health equity analysis be disaggregated or reported by each covered item and service.

We strongly support the finalization of these requirements, for the same reasons laid out in our comments on the CY 2025 proposed rule.[7] We believe that disaggregated, individual service-level data on prior authorization is essential to truly understand the impact of payer practices on beneficiaries. Prior authorization and other utilization management techniques impose a severe burden on access to care across many types of services, but the impact on patients varies significantly depending on the actual service being provided. Furthermore, past federal oversight reports have found that certain services – such as inpatient hospital rehabilitation – are particularly vulnerable to inappropriate denials, making it all the more important for current and future enrollees to be able to see clearly how plans cover and provide access to these types of services.[8]

CMS solicits comment on potential "alternative" ways to group items and services for the purpose of reporting these metrics; we continue to believe that item- and service-level disaggregation is the most appropriate way for plans to fully report on the impact of their prior authorization policies. However, if CMS does intend to adopt an alternative method, it is critical that, *at minimum*, the metrics are broken out by setting of care (e.g., so that authorizations of admissions to inpatient rehabilitation hospitals, acute care hospitals, skilled nursing facilities, etc. are clearly delineated). In addition to frequent and widespread AMRPA member reports of patterns of denials for admissions to such settings, the aforementioned OIG report clearly indicates that special attention must be paid to the impact of prior authorization on access to IRFs and other post-acute care settings.

CMS also proposes to require that MA plans provide an executive summary of the results of their analyses, to ensure that the public and plan enrollees can navigate and understand the data more fully. We support the intent of this proposal and recognize that many, if not most, individual enrollees may be unlikely to review the entirety of an annual health equity analysis when making

[7] Available at https://amrpa.org/wp-content/uploads/2024/09/AMRPA-Comments-on-2025-MA-Proposed-Rule.pdf.
[8] *See, e.g.,* Department of Health and Human Services (HHS) Office of Inspector General (OIG), *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns about Beneficiary Access to Medically Necessary Care* (April 27, 2022) (https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/).

their plan enrollment elections. However, we urge CMS not to let the executive summary subsume the requirement to report and provide the full data otherwise included in this proposed rule. We have previously expressed to CMS our concerns that reporting only aggregate, plan-wide data (whether through the health equity analyses or the separate prior authorization transparency metrics set to go into effect in 2026) could obscure any problematic trends for specific services or types of care. We hold similar concerns about any executive summary that a plan might produce if not accompanied by a comprehensive report. While we recognize that CMS proposes a requirement that the executive summary language "is not misleading or misrepresentative of the findings of the analysis," we are concerned that this proposal may be too vague to effectively enforce compliance. We believe that beneficiaries and the organizations that serve them will derive more benefit from the full dataset itself, rather than a plan-drafted summary.

Finally, CMS solicits comment on "how the data produced by the analysis could be formatted to ensure consistency and uniformity across MA plans, and to ensure usability by enrollees and the public." We continue to recommend that CMS establish a unified portal where members of the public can access all analyses for MA plans from a single, centralized location (similar to the Care Compare website and/or other CMS public-facing pages). We further recommend that CMS issue guidance for MA plans detailing specific standardized formats and specifying the data that each plan must report in the same or similar manner, to allow for easier comparison between plans. We note that in the preamble of the final rule for CY 2025, CMS indicated its intention to issue "operational guidance for the format of the report," though we are unaware of such guidance being issued. Releasing such guidance in a timely fashion would help ensure that the health equity analyses are as useable and manageable as possible for beneficiaries and other stakeholders seeking to fully understand the information provided.

III. Guardrails for Artificial Intelligence

In recognition of the increasing utilization of, and concerns about, artificial intelligence (AI) and other automated systems by MA plans and across the health care industry, CMS proposes a set of new "guardrails" for the use of AI in MA. These are intended to "make clear that MA organizations must provide all enrollees, without exception, equitable access to services, including when MA organizations use AI or other automated systems to aid their decision-making."[9] These guardrails include codifying a new definition of "automated system" in the MA regulations, as well as "patient care decision support tool." [10, 11] CMS clarifies that the use of these tools does not in any way absolve MA organizations from their obligations to ensure

[9] 89 Fed. Reg. 99,397.

[10] CMS proposes to define "automated system" as "any system, software, or process that uses computation as whole or part of a system to determine outcomes, make or aid decisions, inform policy implementation, collect data or observations, or otherwise interact with individuals or communities or both. Automated systems include, but are not limited to, systems derived from machine learning, statistics, or other data processing or artificial intelligence techniques, and exclude passive computing infrastructure." 89 Fed. Reg. 99398.

[11] CMS proposes to define "patient care decision support tool" as "any automated or non-automated tool, mechanism, method, technology, or combination thereof used by an MA organization to support clinical decision-making in its health programs or activities." *Id.*

compliance with all existing Medicare policies, even if or when the tools are operated by a "First Tier, Downstream, or Related Entity."

We appreciate and support CMS' proposals and attention to these issues, and we expect this will not be the last regulatory change necessary to address the impact of AI in the MA program. CMS does note in the proposed rule that the agency has a "well-established, robust, and successful process for ensuring organizations that offer MA plans are complying with [CMS'] regulations and program guidance;" we encourage the agency to continue enhancing its oversight and enforcement efforts focused on plan use of AI and automated systems. The recently finalized information collection for the MA Utilization Management and Audit Protocol, as well as the proposed clarifications around internal coverage criteria, should assist in this work.[12] As a global recommendation, the more that the agency can provide transparency into these oversight efforts, especially the results of plan audits, the more effective we believe the agency will be in identifying and correcting any trends in plan behavior that may run contrary to the program requirements and goals.

IV. Medicare Advantage Network Adequacy

CMS proposes to revise certain definitions and exception requests in the network adequacy standards to which MA plans must adhere. These standards are intended to ensure that MA organizations fulfill their charge to provide access to appropriate providers for medically necessary treatment and services, including by maintaining an adequate contracted provider network. CMS does not, however, propose to revise the provider type list for which each plan must specifically meet mandated standards.

As in prior years, AMRPA strongly urges CMS to enhance network adequacy requirements and ensure meaningful access to necessary care by adding inpatient rehabilitation facilities to the network adequacy list at 42 C.F.R. § 422.116. In our members' experience, many MA plans limit access to IRF care by keeping their IRF provider network narrow and inadequate to meet beneficiary demand. AMRPA members report that numerous MA plans nationwide do not maintain a sufficient number of agreements with all types of post-acute care providers (particularly IRFs) due in part to the fact that there are no network adequacy requirements for MA plans to include IRFs in their networks. The omission of IRFs on the network adequacy list also may render beneficiaries unaware of their option to be discharged from an acute care hospital to an IRF level of care when they otherwise qualify for admission under the coverage criteria.

We note that, in September of 2024, former CMS Administrator Brooks-LaSure received a bipartisan letter from more than 50 Members of Congress seeking regulatory action to remedy this network adequacy issue. We also note the widespread support this provision has in the rehabilitation, disability, clinical, and consumer communities. We had hoped that the agency would address this matter in this year's proposed rule. We believe this is a critical change that would meaningfully impact patients' ability to access the care they need, in the most appropriate

[12] Medicare Part C Utilization Management Annual Data Submission and Audit Protocol Data Request (CMS-10913); ICR Reference No. 202412-0938-017.

setting for their condition, regardless of their source of Medicare coverage. Therefore, we urge CMS to require MA plans to include IRFs in their networks.

V. Enrollee Protections in Inpatient Settings

In this proposed rule, CMS sets forth four important proposals designed to enhance MA enrollee and provider protections. We strongly support each of these proposals, as they are directly responsive to MA plan practices our members have reported that run contrary to the intent of current program regulations and significantly challenge providers' ability to offer timely and medically necessary care.

First, CMS is proposing to clarify that, based on an MA plan's determination *on a request for payment*, if an enrollee has no further liability to pay for services that were furnished by an MA plan, a determination regarding these services is not subject to appeal. This would require a submission of a claim or other request for payment from a contracted provider or enrollee. Current MA regulations state that if an enrollee has no further liability to pay for services that were furnished by a MA plan, a determination regarding these services is not subject to appeal. Historically, CMS has interpreted this appeal limitation to apply to payment determinations, not coverage decisions. However, certain MA plans have improperly applied this limitation to certain coverage decisions, presumably in an attempt to circumvent appeal rights.

AMRPA applauds the agency for proposing to protect appeal rights by clarifying the application of the appeal limitation set forth at 42 C.F.R. § 422.562(c)(2). We are seriously concerned by the reports from our members of MA plans using such practices to deny care and avoid accountability; these practices must be addressed. AMRPA agrees with CMS that this proposal, if finalized, would properly reestablish CMS's original intent to exclude only contracted provider payment appeals from the appeals process when the enrollee no longer has any interest in the dispute, because the enrollee has received the services in question and has no further liability to pay for those services. We fully support this proposed clarification to existing regulations to better improve transparency and oversight over MA plans' practices to evade appeals.

Second, CMS is proposing to modify the definition of an organization determination to clarify that a coverage decision made by an MA plan contemporaneously to when an enrollee is receiving such services, including level of care decisions (such as inpatient or outpatient coverage), is an "organization determination" subject to appeal. CMS notes in the proposed rule that it has identified circumstances where some MA plans have misinterpreted the existing organization determination provisions to *exclude* decisions that rescind a previously authorized inpatient admission, deny coverage for inpatient services, or downgrade an enrollee's hospital coverage from inpatient to observation status when the decision is made concurrently to the enrollee receiving such services. These types of decisions are often referred to as "concurrent review decisions." Some MA plans have inappropriately asserted that these concurrent reviews fall outside the definition of an "organization determination" because the timing of the decision is during an ongoing course of treatment. CMS is proposing to clarify that concurrent review decisions are, in fact, organization determinations that trigger timely notice and applicable appeal rights.

AMRPA supports CMS's proposal to modify the definition of an organization determination to clarify appeal rights. We believe that this proposal will enhance compliance with the applicable organization determination notice and appeal right requirements. It is extremely troubling that MA plans are misconstruing existing law to circumvent fundamental notice and appeal right requirements. AMRPA members take pride in providing timely access to medically necessary inpatient hospital rehabilitation services. Given the clinical importance of beginning intensive rehabilitation as soon as possible following an injury, illness, disability, or chronic condition, some IRFs may admit certain patients shortly following the individualized determination by a rehabilitation physician that they meet the Medicare criteria for IRF benefits, while simultaneously seeking prior authorization from the relevant MA plan. This is especially important given the delay tactics frequently employed by MA plans that often result in patients languishing in acute care settings without being able to receive rehabilitation care while awaiting a plan determination. Such admissions necessarily require the admitting IRF to undertake some risk of plan non-payment; these hospitals make these decisions with full consideration of this risk in furtherance of their ultimate goal of ensuring patients receive the care they need, when they need it, to maximize their health, function, and independence.

Our members have reported that certain MA plans have sought to take advantage of IRFs providing prompt access to care as justification for terminating provider and enrollee appeal rights. The admission of a patient to an IRF prior to a MA coverage determination is not a waiver of provider or enrollee appeal rights. As the data shows, the vast majority of MA denials that are appealed get overturned, and patients who are admitted to IRFs pending authorization must still maintain full access to the appeals pathway.[13] MA plans should be prohibited from abusing the concurrent review process to circumvent notice and appeal rights. Further, we reject MA plans' claim that concurrent review decisions are "contractual denials" that are ineligible for review under the administrative appeals process.

Third, CMS is proposing to require MA plans to notify an enrollee's physician or provider of an organization determination or integrated organization determination on a request for an item or service. Under the proposal, if the MA plan fails to provide the enrollee, physician, or provider with timely notice of an organization determination, this failure will constitute an appealable adverse organization determination. AMRPA supports CMS's proposal to strengthen notification requirements. We agree with the agency that providers are often in the best position to explain and, if appropriate, respond to an MA organization decision on behalf of an enrollee. Strengthening notification requirements will help improve the appeals process and reduce delays in access to care. It will also close another avenue by which MA plans use delay tactics to circumvent appeal rights.

[13] 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/issuebrief/use-of-priorauthorization-in-medicare-advantage-exceeded-46-million-requests-in-2022/.

Lastly, CMS is proposing to amend the reopening rules to curtail a MA plan's authority to reopen and modify an approved authorization for an inpatient hospital admission. This proposal focuses on inpatient acute care hospital admissions. Under Medicare, in general, an inpatient hospital admission will be covered if the admitting physician expects the patient to require hospital care that crosses two midnights. An admission determination is based on physician's knowledge *at the time of admission*. This is referred to as the "Two-Midnight Rule."

Under existing regulations, an MA plan may reopen and revise an organization determination or reconsidered determination that is otherwise final and binding if there is "good cause," which may be established when there is new and material evidence that was not available or known at the time of the determination. CMS is aware of instances where MA plans are reopening a prior authorization decision on an inpatient admission during the receipt of services or after services have been rendered based on "new and material evidence." This practice, however, is inappropriate because the Two-Midnight Rule is based on the clinical information known by the physician *at the time of admission* as well as the documented medical record at that time.

Therefore, with respect to an MA plan-approved inpatient hospital admission under the Two-Midnight Rule, CMS is proposing that any additional clinical information obtained after the initial organization determination cannot be used as "new and material evidence" to establish good cause for reopening the determination. AMRPA supports the agency's proposed limitation on reopening a determination related to an approved inpatient hospital admission. We also believe that CMS should impose similar limitations on reopening a favorable determination for inpatient rehabilitation care. Although coverage of inpatient hospital rehabilitation care is not governed by the Two-Midnight Rule, coverage of such care is based on a reasonable expectation that the patient meets certain requirements *at the time of the patient's admission to the IRF*.

Specifically, under 42 C.F.R. § 412.622(a)(3), in order for an IRF claim to be considered reasonable and necessary, "there must be a reasonable expectation that the patient meets all of the following requirements at the time of the patient's admission to the IRF:"

- The patient requires active and ongoing multidisciplinary therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy). One of the therapies must be physical therapy or occupational therapy.
- The patient generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program.
- The patient must be stable enough at admission to participate in intensive rehabilitation.
- The patient requires rehabilitation physician supervision.

Because IRF coverage is determined "at the time of the patient's admission," CMS places "more weight on the rehabilitation physician's decision to admit the patient to the IRF."[14] For this reason, CMS should establish limitations on when an MA plan may reopen a favorable

[14] Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2010, 74 Fed. Reg. 39,762, 39,791 (Aug. 7, 2009).

determination with respect to IRF care based on "new and material evidence" obtained after the initial organization determination (i.e., the IRF admission decision).

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AMRPA greatly appreciates CMS' continued efforts to reform the use of prior authorization and other barriers to access in the MA program. We look forward to continuing our collaboration with CMS to ensure that all Medicare beneficiaries have timely access to the care they need, particularly with respect to medically necessary inpatient hospital 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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