March 7, 2022

ELECTRONIC SUBMISSION VIA www.regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs Proposed Rule (CMS-4192-P; RIN: 0938-AU30)

Dear Administrator Brooks-LaSure:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed Medicare Advantage (MA) and Medicare Part D rule for Contract Year 2023.[1] We offer our recommendations and comments below regarding various provisions in the proposed rule impacting beneficiaries in need of medical rehabilitation care, primarily addressing MA plans.

CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain their maximum level of health and independent function. CPR is comprised of organizations that represent patients – as well as the providers who serve them – who are frequently inappropriately denied access to rehabilitative care in a variety of settings.

This response to the proposed rule focuses on the Request for Information regarding prior authorization for post-acute care services and network adequacy requirements for MA plans.

I. Request for Information: Prior Authorization for Hospital Transfers to Post-Acute Care Settings During a Public Health Emergency

Overuse and Misuse of Prior Authorization

We greatly appreciate the opportunity to provide comment on the impact of MA plans' use of prior authorization for post-acute care services. The overutilization of prior authorization has become one of the most impactful negative pressures on access to medically necessary care in

[1] Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs Proposed Rule, 87 Fed. Reg. 1842 (Jan. 12, 2022).

the post-acute care and rehabilitation benefit, preventing beneficiaries in the MA program from receiving the treatment they need in order to regain and/or maintain their health and function following injury, illness, disability, or chronic condition. Many plans utilize prior authorization processes for items and services that are, in the end, routinely approved. Additionally, the use of prior authorization to approve care including rehabilitation services and devices, transplantation, non-elective surgeries, and cancer care is especially hard to justify, given that these and many similar medical services are unlikely to be over-utilized and often need to be provided in a timely manner in order to maximize their medical efficacy.

In these cases and others, prior authorization often serves as an unnecessary delay for beneficiaries seeking medically necessary care, and often results in no cost savings to the plan. The impact of prior authorization and other utilization management techniques employed by MA plans is stark; for example, data demonstrates that MA beneficiaries have only one-third the access to inpatient rehabilitation facilities (IRFs) that traditional Medicare beneficiaries have,[2] despite the fact that MA beneficiaries are supposed to have access to the same benefits under the fee-for-service program. Especially during the COVID-19 public health emergency, this means that patients in need of high-intensity, coordinated, interdisciplinary medical rehabilitation are either being diverted to less appropriate settings or left to languish in acute care hospitals, occupying beds that have been sorely needed to treat COVID-19 and other emergent patients.

Many MA plans seem to rely on initial denials of prior authorization as a method to delay care even if they expect to eventually approve a given service that is medically necessary for the patient. The Department of Health and Human Services' Office of Inspector General (OIG) found that when beneficiaries and providers appealed initial denials, MA plans overturned their own denials 75% of the time.[3] This means that MA plans routinely shift the burden onto patients and providers to appeal initial denials of care that are routinely approved when appealed. Unfortunately, the appeals process is cumbersome, time-intensive, and subject to significant delay due to a backlog of cases. Thus, beneficiaries and providers who do not press forward with the appeals process lose access to needed care. In this instance, initial denials serve as permanent denials of medically necessary care. As stated in the OIG report, "The high number of overturned denials raises concerns that some Medicare Advantage beneficiaries and providers were initially denied services and payments that should have been provided."

CPR has long called on CMS to increase oversight of the use of prior authorization plans. Such oversight should include stronger directives to MA plans to limit the use of prior authorization to situations where fraud and abuse has been demonstrated or where significant spikes in claims are occurring for no particular reason. CMS should also review the list of services that each MA plan subjects to prior authorization and ensure that MA beneficiaries are provided with comprehensive information disclosing the use of prior authorization in their plan and how to

[2] Medicare Payment Advisory Commission, Report to The Congress: Medicare Payment Policy 298 (Mar. 2017). (Finding that MA beneficiaries are admitted to IRH/Us at a rate nearly three times less than traditional Medicare beneficiaries).

[3] U.S. Department of Health and Human Services, Office of Inspector General. Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials; Report (OEI-09-16-00410) (Sept. 2018).

timely appeal denials of care. We urge CMS to address the widespread problems with prior authorization holistically, and not exclusively as a problem unique to the PHE. With nearly one half of Medicare beneficiaries covered under the MA program, it is past time for CMS to ensure that MA beneficiaries are able to receive the care to which they are entitled from the plans that purport to serve their health care needs.

Proprietary Guidelines and Other Barriers to Access

CPR has called on CMS to address the significant barriers under MA plans to patients accessing medically necessary post-acute rehabilitative care. As outlined above, prior authorization is a major driver of these barriers, and as referenced in the RFI, the use of proprietary guidelines is another (both of which often work hand in hand). In CPR members' experience many MA plans do not appropriately use Medicare post-acute care coverage criteria when determining when to authorize and cover services in the PAC benefit. Instead, these plans apply private, proprietary decision support tools, including those offered by companies such as Milliman Care Guidelines and InterQual, to make their decisions as to which rehabilitation setting is covered for each patient. This tends to systematically divert Medicare beneficiaries to less intensive rehabilitation settings than they are entitled to under the Medicare program, potentially risking the health and functional potential of MA beneficiaries.

In this way, patients are often denied access to clinically appropriate post-acute care services and are inappropriately diverted to less intensive levels of rehabilitation care and medical management. This is not a new problem, but has been significantly exacerbated during the PHE, where timely access to care and the availability of acute care inpatient beds has become even more critical. CMS should instruct MA plans to cease using these proprietary, non-Medicare guidelines to determine PAC coverage and, instead, rely on the same coverage requirements applicable to Medicare beneficiaries under the traditional Medicare program.

Failing to ensure a "level playing field" between the MA program and traditional Medicare – a requirement that is clearly stated in the Medicare regulations – creates an inequitable system and places burdensome restraints on beneficiaries' ability to access the rehabilitation care they need when they need it. As a first step, CMS should require MA plans to disclose to the public the guidelines that they actually use to assess the medical necessity of post-acute care, or, for that matter, all Medicare services.

When Medicare beneficiaries are injured, become seriously ill, or require surgery, they often require rehabilitation to regain functional losses. The acute hospital care is often just the first step toward recovery and returning to a normal life. Patients frequently require a course of post-acute, hospital-based rehabilitation that is intensive, coordinated, and provided by a multidisciplinary team led by a rehabilitation physician. Other settings of rehabilitation care are available for patients who do not require a hospital level of care, such as skilled nursing facilities, outpatient therapy programs, home health care, and other, more specialized settings for individuals with brain or spinal cord injuries that Medicare does not typically cover.

For example, a patient who sustains a stroke may be left with permanent neurological deficits but may also need to overcome or adapt to physical or cognitive impairments. An amputee must heal

from a traumatic injury while being fitted and learning to ambulate with a prosthetic limb. A patient confined to a hospital bed for a significant period of time during a serious illness, especially individuals who have been placed on a ventilator due to COVID-19, will lose muscle mass and may have difficulty walking, breathing, and/or performing basic self-care tasks upon recovery.

CMS has developed detailed coverage regulations for post-acute care, covering both traditional Medicare and Medicare Advantage beneficiaries. Medicare regulations are clear that Part C plans must provide all Medicare-covered services.[4] These covered services include "all services that are covered by Part A," which are "basic benefits" available to Part C enrollees.[5] Part C plans must comply with all Medicare coverage regulations and manuals.[6] Medicare manuals are equally plain. The Medicare Managed Care Manual ("MMCM") states that a Part C "plan must provide enrollees in that plan with all Original Medicare-covered services."[7] The MMCM instructs that "[i]f the item or service is covered by Original Medicare under Part A or Part B, including Part B prescription drugs, then it must be offered."[8] For many MA beneficiaries, these requirements do not comport with the reality of their coverage.

CMS has repeatedly declined to adopt any guidelines other than its own coverage criteria. However, MA plans routinely utilize Milliman Care Guidelines, InterQual, and other guidelines to deny coverage for PAC services without applying traditional Medicare coverage rules. Reports from the field suggest that this problem is growing in severity year over year, despite the temporary relaxation of some utilization management policies during the early stages of the current PHE, which only occurred at CMS' behest. As we have consistently reported to CMS in the past, the undersigned members of CPR have severe concerns that MA plans are overriding the clinical judgment of treating physicians and the rehabilitation team and using proprietary guidelines to effectively ignore Medicare coverage regulations, which constitute impermissible "rules of thumb" that may not be used to deny coverage.[9]

The most vulnerable beneficiaries are at risk of being denied access to rehabilitation services that meet their medical and functional needs without even knowing that these decisions are being made behind the scenes, based on non-Medicare guidelines, even when they would otherwise qualify for coverage under Medicare coverage rules. This of course impacts patients who already have fewer financial resources to draw upon, less access to the appeals system, and who face pre-existing disparities in their health care access. This flies in the face of the Administration's focus on advancing health care equity. Particularly given the steady growth in managed care, with the MA program now covering almost 50% of all Medicare beneficiaries,[10] it is crucial that the MA program be administered in a way that protects the rights of beneficiaries and guarantees access to medically necessary care.

---

[4] 42 C.F.R. § 422.101.
[5] Id. § 422.101(a).
[6] Id. § 422.101(b).
[7] MMCM, ch. 4 § 10.2. This manual provision describes four exceptions, which are not applicable here.
[8] MMCM, ch. 4 § 10.3.
[9] See MBPM, ch. 1, § 110.2.2; Hooper v. Sullivan, No. H-80-99 (PCD), 1989 WL 107497 (D. Conn. July 20, 1989).
[10] Medicare Payment Advisory Commission, Health Care Spending and the Medicare Program 123 (July 2021).

We urge CMS to revise future Medicare rulemaking to include explicit instructions to MA plans to cease using Milliman Care Guidelines, InterQual, or similar guidelines to determine coverage of inpatient hospital rehabilitation and other services, reduce the misuse and overreliance on prior authorization, and, instead, rely on the same coverage requirements applicable to Medicare beneficiaries under the traditional Medicare program, as the regulations require.

II. Network Adequacy Requirements for Medicare Advantage Plans

We appreciate and support the proposed revisions to the timeline for reviewing network adequacy submissions, including the emphasis on network adequacy review as part of the MA application process for new and expanding service areas. These steps will meaningfully improve access to care for beneficiaries and help ensure that services – including the full complement of medical rehabilitation services – are available in all geographic areas without undue burden on patients to access convenient care.

We also take this opportunity to offer additional recommendations for the existing network adequacy standards for MA plans, which are necessary to ensure meaningful network adequacy for beneficiaries. The adequacy of a plan's provider network can impact the level of access to benefits for enrollees. For MA enrollees to benefit from appropriate rehabilitation, CPR believes that MA plans must adhere to patient-friendly network adequacy standards that provide ample access to the full complement of rehabilitation and habilitation service and device providers, professionals, and facilities that provide both primary and specialty care. These services should be provided based on the individual's needs, prescribed in consultation with an appropriately credentialed clinician, and based on the assessment of an interdisciplinary rehabilitation team and resulting plan of care.

Facility Types for Network Adequacy Reviews

In previous years' MA/Part D rules, CMS codified the list of provider and facility specialty types subject to network adequacy reviews. CMS does *not* currently include post-acute rehabilitation programs, such inpatient rehabilitation hospitals and units (IRFs), comprehensive outpatient rehabilitation facilities (CORFs), or long-term acute care hospitals (LTCHs) in the list of facility specialty types evaluated during these reviews. These are critical settings of care for patients in need of rehabilitation services and devices and their omission in network adequacy reviews is glaring. This is illustrated by the fact that CMS includes IRFs and CORFs as a covered benefit under traditional Medicare, and hundreds of thousands of Medicare enrollees benefit from treatment from these providers on an annual basis. **CPR strongly urges CMS to include IRFs, CORFs, and LTCHs as part of the agency's network adequacy review process for MA plans**.

Ensuring the availability of a wide range of rehabilitation provider types will help ensure that enrollees have timely access to the appropriate intensity and scope of needed rehabilitation services. For instance, too often enrollees across the country may be diverted into nursing homes rather than IRFs because their health plans do not contract with a sufficient number of rehabilitation providers. Too often, enrollees with brain injuries, spinal cord injuries, those who

have sustained strokes, and others with a variety of complex but common conditions do not receive the intensive, longer-term services they need because health plans do not contract with specialized brain injury treatment programs. Further, inadequate specialty networks exacerbate health equity issues for patients who are already facing disparities in access to health care.

Time and Distance Standards

CMS also uses maximum time and distance standards for the providers and facility specialty types subject to network adequacy standards. Network adequacy standards should ensure that people with injuries, illnesses, disabilities, and chronic or complex conditions are not burdened by significant traveling distances in order to receive covered services under the plan and should recognize that many people with disabilities lack transportation options.

Telehealth Credit

CMS allows MA organizations to receive a "credit" towards the percentage of enrolled beneficiaries residing within the applicable time and distance to meet network adequacy standards, if the MA organization contracts with telehealth providers for certain specialties.

CPR appreciates that the rapid expansion of telehealth during the COVID-19 pandemic has allowed many beneficiaries, whether covered through the exchanges, Medicare, Medicaid, or other payers, to safely access medically necessary health care while protecting themselves from threat of infection with COVID-19. Further, the ability to receive medical services, including medical rehabilitation, virtually has provided tremendous benefit to many people with disabilities beyond abiding by social distancing protocols, including easing the complications associated with planning, transportation, and accessibility of in-person visits and the potential to cut down on distractions and hurdles associated with receiving care in an unfamiliar environment. We also note that the proliferation of telehealth may allow patients to receive more stable, continuing access to therapy and other important services. **We support increased access to care through the use of telehealth, as long as it does not come at the expense of providing face-to-face health care services when in-person services are necessary, preferred by the patient, or would enhance the quality of care to people with disabilities.**

It is critical that expansion of telehealth services, and policies encouraging such expansion, does not limit patients' access to in-person care, especially when the services needed by the patient are more effectively and efficiently provided in-person. Beneficiaries with illnesses, injuries, disabilities, and chronic conditions often need the highest levels of medical care in order to maintain, regain, and/or improve their health and function. It is crucial that beneficiaries receiving rehabilitation care are able to access the most appropriate care in the most appropriate settings.

People with disabilities should have access to disability-specific specialists and services, in settings that are physically accessible, and with a choice of providers – primary, specialty, and subspecialty. CPR believes that the adequacy of a plan's provider network dictates the level of access to benefits otherwise covered under the health plan. If a plan covers a benefit but limits the number of providers or specialists under that plan, coverage will be curtailed through a lack

of access to providers with sufficient expertise to treat the patient. In light of these concerns, CMS must ensure robust network adequacy standards that fully protect access to both in-person and virtual care – and these standards should be strictly enforced. It is essential that all Medicare beneficiaries have access to affordable and meaningful coverage of rehabilitative services and devices to which they are entitled.

****

We greatly appreciate your consideration of our comments on the 2023 MA/Part D proposed rule. Should you have any further questions, please contact Peter Thomas and Joe Nahra, coordinators for CPR, by e-mailing Peter.Thomas@PowersLaw.com and Joseph.Nahra@PowersLaw.com or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
ALS Association
American Academy of Physical Medicine & Rehabilitation
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Heart Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Spinal Injury Association
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Brain Injury Association of America*
Center for Medicare Advocacy*
Christopher & Dana Reeve Foundation*
Disability Rights Education and Defense Fund
Falling Forward Foundation*
Lakeshore Foundation
The Michael J. Fox Foundation for Parkinson's Research
National Association for the Advancement of Orthotics and Prosthetics
National Association of Social Workers (NASW)
National Association of State Head Injury Administrators
National Multiple Sclerosis Society*
Rehabilitation Engineering and Assistive Technology Society of North America
Spina Bifida Association
United Cerebral Palsy
United Spinal Association*

**** CPR Steering Committee Member***