



January 5, 2024

SUBMITTED ELECTRONICALLY VIA www.regulations.gov

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

Re: Contract Year 2025 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs Proposed Rule (CMS-4205-P)

Dear Administrator Brooks-LaSure:

The undersigned members of the Coalition to Preserve Rehabilitation (“CPR”) appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services’ (“CMS”) *Contract Year 2025 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs* (“proposed rule”). CPR is a coalition of more than 50 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 clinicians who serve them – who are often tasked with navigating the complex discrepancies between Traditional Medicare and Medicare Advantage (“MA”), and we appreciate CMS’s goal of streamlining and aligning the two aspects of the program where appropriate.

This proposed rule builds on the substantial changes implemented in last year’s *Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program* (“CY24 Rule”) finalized in April 2023, major new portions of which went into full effect on January 1, 2024. CPR enthusiastically applauds CMS for finalizing those regulations addressing serious beneficiary and provider concerns with utilization management tools, particularly prior authorization, and establishing new policies limiting an MA organization’s ability to deny or limit coverage of basic benefits as covered under Traditional Medicare.

Our comments to the FY 2025 proposed rule focus on the sections of the draft regulation relating to improvements of utilization management tools employed by MA organizations and enhancements to enrollees’ right to appeal an MA organization’s decision to terminate coverage

for non-hospital provider services. We thank CMS for its careful attention to expanding health equity for MA beneficiaries, particularly for individuals with disabilities and chronic conditions.

I. Improvements to Utilization Management Policies

Under the proposed rule, all MA Utilization Management (“UM”) Committees would be required to include a member with expertise in health equity beginning January 1, 2025. That health equity expertise could include educational degrees or credentials with an emphasis on health equity; experience conducting studies identifying disparities among different population groups; experience leading organization-wide policies, programs, or services to achieve health equity; or experience leading advocacy efforts to achieve health equity.

The UM Committee would be required to conduct an annual health equity analysis of the use of prior authorization and its impact on enrollees with one or more social risk factors at the plan level. Those risk factors would include receipt of the low-income subsidy, being dually eligible for Medicare and Medicaid, or having a disability. The analysis must use prior authorization metrics from the prior contract year to conduct the analysis. This analysis would be publicly available on the MA organization’s website in an easily accessible manner to the public. The member of the UM Committee with health equity expertise must approve the final version of this analysis before posting it on the website.

CPR supports these proposals to increase health equity and transparency in MA plans with the ultimate goal of increased access to covered items and services for individuals with disabilities and chronic conditions. In analyses of MA plans’ use of prior authorization, government and private organizations have found serious misuse and abuse of this utilization management technique, in particular, how frequently MA plans are requiring and denying prior authorization requests and shifting the burden on vulnerable beneficiaries to appeal these denials. The misuse of prior authorization by MA plans to deny basic benefits is still a serious concern, particularly for vulnerable MA enrollees.

The populations our members represent frequently need assistive devices and technologies, including durable medical equipment (“DME”), orthotics, prosthetics, and other assistive devices and technologies, to meet their medical and functional needs. MA plans utilize prior authorization, proprietary and internal guidelines, and other coverage policies to restrict access to these items for individuals with medical and functional needs. These new requirements would increase public oversight of prior authorization policies employed by MA organizations. We support the increased focus on health equity to ensure that all MA enrollees, regardless of their disability, injury, illness, chronic condition, or other needs are able to access the medical services and devices to which they are entitled under the Medicare benefit.

CPR supports the inclusion of a person with health equity expertise on the UM Committee, and we highly encourage CMS to prioritize broad expertise in health equity including expertise in health equity for individuals with disabilities. People with disabilities are the largest and most diverse underserved community in the United States. They experience health disparities separately and in intersection with other groups

experiencing health disparities, such as race/ethnicity, sex and gender, and socioeconomic status. The National Institutes of Health recently designated people with disabilities as a distinct health disparity population, recognizing that people with disabilities often experience a wide and varying range of health conditions leading to poorer health and shorter lifespans. Discrimination on the basis of disability contributes to inequality, exclusionary structures and policies, and programs that inhibit access to comprehensive health care resulting in poorer health outcomes for the disability population. Considering the important work of the UM Committee to review all utilization management policies implemented by MA plans, CPR strongly believes that the health equity expert should understand the disability population and the challenges people with disabilities face in accessing health care.

CPR encourages CMS to strengthen the health equity analysis by requiring more granular data of prior authorizations, particularly at the provider setting and for access to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (“DMEPOS”) from MA plans. We support more publicly available data focused on approvals/denials of services or devices for enrollees with disabilities in order to hold MA plans responsible for discriminatory policies; however, the proposed analysis would consist of prior authorization metrics aggregated for all items and services which would not provide enough detail for true accountability. CPR is concerned that prior authorization denials in the post-acute care sector (e.g., inpatient rehabilitation hospitals and units (“IRF”), skilled nursing facilities (“SNF”), and home health care (“HHC”)) are more common than in other settings, as has been recognized in the 2022 Office of the Inspector General report. These disparities in approvals would be concealed in an aggregated data reporting requirement.¹

Post-acute care is essential for people with disabilities, illnesses, injuries, and chronic conditions to receive medical rehabilitation services, and the well-documented denials of care for this at-risk population demands further examination. In addition to provider setting data, CMS could improve health equity for beneficiaries by requiring analysis at the level of items and services, particularly examining beneficiary access to DMEPOS instead of aggregating for all items and services. Moreover, requesting data that extends back over several contract years for these areas of care that are particularly needed by people with disabilities and chronic conditions will further illuminate longstanding discriminatory patterns of denials of care. Only with this level of specificity will patients and providers be able to assess which items are routinely denied, appealed, and overturned in favor of patients and providers.

CPR encourages CMS to strengthen the proposed rule’s health equity analysis by defining disability to encompass a more representative population. According to the proposed rule, disability status would be determined using the variable original reason for entitlement code (“OREC”) for Medicare, utilizing information from the Social Security Administration and Railroad Retirement Board record system to align these data. CPR would like to expand the definition of disability used in the analysis. We are concerned that

¹ U.S. Department of Health and Human Services, Office of Inspector General. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care; Report (OEI-09-18-00260) (Apr. 2022).

the current definition of disability would include only people under the age of 65 who qualify for Medicare coverage due to having a long-term disability and being unable to work. We understand that CMS selected these social risk factors to use consistent metrics, and this definition of disability will be used for the health equity index. However, this definition likely misses the main Medicare Advantage population, people over 65 with or without a disabling condition. It is critical to capture a broader MA disability population for this provision to achieve its promise.

Finally, enrollees and beneficiaries must be able to understand this information in order to act upon it. Therefore, CPR recommends requiring MA organizations to present the health equity analyses in a format that is easily accessible and readable for all enrollees, particularly individuals with disabilities and individuals with limited or low health and data literacy.

II. Enhancing MA Appeal Rights for Non-Hospital Services

To strengthen protections for MA enrollees, CMS is proposing to modify existing regulations regarding fast-track appeals and the termination dates for non-hospital provider services to align MA with traditional Medicare regulations and procedures. The proposed rule would align MA regulations regarding fast-track appeals with Traditional Medicare regulations, extending the same rights to MA enrollees that exist for Medicare beneficiaries. The proposed rule would require the Quality Improvement Organization (“QIO”) to review untimely fast-track appeals of an MA plan’s decision to terminate services in home health, comprehensive outpatient rehabilitation facilities (“CORF”), or SNF. The proposed rule would also eliminate the provision requiring the forfeiture of an MA enrollee’s right to appeal a termination of services decision if they leave the facility or discontinue services before the termination date listed on the Notice of Medicare Non-coverage (“NOMNC”).

CPR fully supports these proposed revisions to current policy and encourages CMS to extend these same beneficiary protections to IRFs and Long-Term Acute Care Hospitals (LTACHs). **CPR supports the expansion of benefits for MA beneficiaries and encourages alignment wherever possible between the rights and benefits of MA beneficiaries and those beneficiaries under Traditional Medicare, including extending fast-track appeal rights to MA beneficiaries for termination of services at inpatient rehabilitation hospitals and long-term acute care hospitals, where people with often severe injuries, illnesses and disabilities acquire their rehabilitative care.**

CPR requests that CMS ensure in the final rule that the proposed revisions are carefully worded so as to be clear about: 1) what happens when the fast-track deadline is exceeded and 2) the intention to have MA and Traditional Medicare be exactly the same (or, if distinctions remain, to be very transparent and clear about those differences). In fact, the Traditional Medicare regulations are not currently very clear on what happens if the fast-track deadline is exceeded for these services and could use clarification; currently, the NOMNC merely instructs the beneficiary to contact the Quality Improvement Organization (QIO) to explore their options.

III. Extended Timeframes for Filing an Appeal in MA and Part D.

The proposed rule would extend the 60-calendar day filing timeframe to include 5 additional days as proof of receipt of the written determination notice. This 5-day grace period to accommodate the physical mailing of claim appeals is consistent with the timeframes under the Traditional Medicare program. The proposed rule would also clarify that an enrollee also has a 60-calendar day timeframe with 5 additional days to file expedited appeal requests, expedited organizational determinations, and coverage determinations. **CPR supports this proposal to align MA and Part D plan policies with Traditional Medicare and expand beneficiary rights to appeals.**

IV. Required Notification of Unused Supplemental Benefits at Midyear

Beginning on January 1, 2026, the proposed rule would require MA plans to send a mid-year notification, no sooner than June 30 and no later than July 31, to all beneficiaries with information on any unused supplemental benefits.

CPR supports this requirement for MA plans to alert enrollees of their unused supplemental benefits to educate enrollees on these benefits and encourage their usage before the plan year expires. Studies have shown that many beneficiaries are not utilizing their supplemental benefits to the extent they could. Rather than issuing notice of unused supplemental benefits at midyear, CPR recommends that MA plans should do this on a quarterly basis to increase usage of these benefits. In the past decade, some MA plans have offered more supplemental benefits that are broader in scope and variety, many of which are not utilized by enrollees. Supplemental benefits are underutilized to the detriment of beneficiaries. We believe this provision—as with others in the proposed rule—will ensure higher quality MA plans.

V. Network Adequacy

In the proposed rule, CMS includes proposals to update network adequacy standards for MA plans, largely focused on behavioral health. In previous years, CMS has also revised the time and distance standards as well as the list of provider and facility specialty types subject to network adequacy reviews. CMS does not currently include post-acute care rehabilitation programs, including IRFs, CORFs, and long-term acute care hospitals (“LTCH”), on 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, CORFs, and LTCHs as a covered benefit under Traditional Medicare, and hundreds of thousands of Medicare enrollees benefit from treatment offered by 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.**

We greatly appreciate your consideration of our comments on the *Contract Year 2025 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs* proposed rule. Should you have any further questions regarding this information, please contact Peter Thomas or Michael Barnett, coordinators for CPR, by e-mailing Peter.Thomas@PowersLaw.com or Michael.Barnett@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES

ADVION

Allies for Independence

ALS Association

American Academy of Physical Medicine and Rehabilitation

American Association on Health and Disability

American Congress of Rehabilitation Medicine

American Medical Rehabilitation Providers Association

American Music Therapy Association

American Occupational Therapy Association

American Spinal Injury Association

American Therapeutic Recreation 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 (DREDF)

Epilepsy Foundation

Falling Forward Foundation*

Lakeshore Foundation

Michael J. Fox Foundation for Parkinson's Research

National Association for the Advancement of Orthotics and Prosthetics

National Association of Rehabilitation Providers and Agencies

National Association of Social Workers (NASW)

National Multiple Sclerosis Society

RESNA

Spina Bifida Association

Uniform Data System for Medical Rehabilitation/Netsmart

United Spinal Association*

****Member of the CPR Coalition Steering Committee***