October 8, 2024

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: CPR Comments on Service Level Data Collection for Medicare Advantage Plans (CMS-10905)(OMB Control Number: 0938-New)

Dear Administrator Brooks-LaSure:

The undersigned members of the Coalition to Preserve Rehabilitation ("CPR") appreciate the opportunity to submit these comments to the Centers for Medicare and Medicaid Services ("CMS") in response to its intent to collect service level data on Medicare Advantage ("MA") determinations and appeals.[1] CPR members commend CMS for taking the necessary steps to monitor MA plan compliance with Medicare requirements and enhance transparency in the MA program. We firmly believe that the collection of more detailed service line data is fundamental to the program's overall success and the ability of CMS to ensure that MA beneficiaries receive the vital services to which they are entitled under the Medicare program. We offer the following recommendations to assist MA plans in identifying areas of improvement and ensure that MA plans are held accountable for misusing—or even abusing—utilization management tools.

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, including inpatient rehabilitation hospitals and units.

Benefits of Collecting Setting-Specific Data

CPR fully supports the collection of service line data under MA plans. We believe that the collection of this more granular level of data will not only assist in painting a more

[1] Agency Information Collection Activities: Proposed Collection; Comment Request, CMS-10905- Service Level Data Collection for Initial Determinations and Appeals, 89 Fed. Reg. 65,359 (Aug. 9, 2024).

comprehensive picture of how the MA program is operating, but also lead to more targeted improvements, informed decision-making, and equitable care delivery, ultimately enhancing the overall quality and efficiency of the program in the future. More specifically, the collection of setting-specific data would enable a granular assessment of performance across different care settings, particularly in outpatient rehabilitation centers and the post-acute care settings, which include inpatient rehabilitation facilities ("IRFs"), skilled nursing facilities ("SNFs"), home health agencies, and hospice care. CPR believes that this level of specificity would allow for more precise measurement of coverage denials and appeals within each service line, leading to more targeted quality improvement initiatives to ensure that enrollees are receiving the medically necessary care they need.

The collection of more detailed service line data would greatly assist CMS in revealing disparities in access to and quality of care among different settings. By identifying gaps in service delivery and outcomes across service lines, MA plans would thereby be able to develop targeted interventions, instead of one-size-fits all approaches, to address these disparities and improve equity in healthcare access and quality. CPR believes that service line data is also critical for strategic planning and policy development. The collection of setting-specific data would provide insights into service utilization trends, identify emerging needs, and support the creation of policies that address specific challenges within different service lines. This data-driven approach would ensure that policies are relevant and effective in improving access to quality care across various specialties.

Comprehensive service line data would also enhance transparency and accountability by providing a clear view of how different service lines perform. This transparency would help CMS better understand the quality of care being provided in each setting, thereby holding MA plans more accountable for their performance. Accurate service line data would also support effective resource allocation by identifying which areas require more support or investment. This information would help MA plans allocate resources efficiently, ensuring that high-need service lines receive appropriate funding and support to enhance care delivery and patient outcomes.

Prior Authorization

CPR commends CMS for its recent regulatory action to reign in the overreaches of MA organizations that employ utilization management tools that inappropriately delay and deny care to beneficiaries, such as prior authorization. The Contract Year 2024 and 2025 MA final rules established guardrails for MA plans to prevent beneficiaries from severe barriers to access to post-acute care, whether due to restrictive coverage policies, improper use of prior authorization, or other utilization management techniques and administrative burdens.[2] The recently finalized

[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." *Federal Register* 88:70 (April 12. 2023) at 22120 et seq.; "Medicare Program; 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." *Federal Register* 89:79 (April 23, 2024) at 30448.

Advancing Interoperability and Improving Prior Authorization Processes rule builds on those new patient protections and addresses key issues with prior authorization including requiring written reasons for denials, shortening timeframes for decisions of appeals, and requiring greater transparency from payers.[3]

Prior authorization continues to be a serious impediment to care for beneficiaries with disabilities and individuals seeking medical rehabilitative care. CPR members, both beneficiaries and providers, continue to experience problems with prior authorization denials and hurdles in MA plans despite the new patient protections that took effect January 1, 2024. CPR encourages CMS to continue to enforce the new regulations and audit plans to ensure that beneficiaries are able to see the full impact of these new regulations in practice.

In addition to enforcement by CMS, CPR supports increased transparency from MA plans about their use of prior authorization and metrics on denials and approvals. As established in the Advancing Interoperability and Improving Prior Authorization Processes final rule, beginning in 2026, MA plans will be required to publicly report certain prior authorization metrics annually by posting them on the plan website. CMS also established in the Contract 2025 final rule that MA plans will 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.

CPR continues to support these new transparency regulations and we strongly encourage CMS to require the collection of service line level data to help assess both inpatient hospital rehabilitation and Durable Medical Equipment, Prosthetics, Orthotics and Supplies ("DMEPOS") from MA plans. More granular data for SNFs, home health agencies, physician offices, outpatient therapy services, and other sites of care would also be helpful. Instead of receiving and analyzing MA data in the aggregate, CMS would be able to view a much more site-specific picture resulting in their ability to better compare multiple payers' prior authorization metrics at the service line level. Only with this more granular level of specificity will CMS be able to assess which services are routinely denied, appealed, and overturned in favor of patients and providers, leading to reforms to accelerate access to appropriate, timely, and necessary care.

CPR is concerned that prior authorization denials in several post-acute care settings are more common than in other settings, as has been recognized in a 2022 OIG report, and that these disparities in approvals are largely concealed with the current aggregated data reporting requirement.[4] 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,

[3] "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." *Federal Register* 89:27 (February 8, 2024) at 8758 et seq.

[4] 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).

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 will further illuminate longstanding discriminatory patterns of care denials. Only with this level of specificity will CMS be able to assess which items are routinely denied, appealed, and overturned in favor of patients and providers.

Reviewer Qualifications

CPR advocates for the collection of data on reviewer qualifications when making an initial medical necessity determination. Under current regulations, if a MA plan intends to issue a partial or fully adverse medical necessity decision based on the initial review, the determination 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, including knowledge of Medicare coverage criteria, before the MA organization issues the organization determination decision."[5] Accordingly, CPR urges CMS to mandate the reporting of this required and specific clinical background information to ensure that Medicare Advantage plans are hiring clinically appropriate health care professionals to do this important work.

Network Adequacy

In recent years, CMS has updated 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, however, does not currently include post-acute rehabilitation programs, including IRFs, comprehensive outpatient rehabilitation facilities ("CORFs"), and 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 underscored 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 and to provide that information to MA enrollees in an easily accessible format.

In addition to requiring MA plans to offer access to post-acute rehabilitation and reviewing the plans for adequate networks, CPR believes that MA plans should provide more information to beneficiaries about their provider networks through provider directories available on publicly accessible websites. Provider networks are a critical component of Medicare Advantage plans, directly impacting beneficiaries' access to care. Insufficient networks can limit provider choice and accessibility, particularly in rural and underserved areas. However, there is insufficient publicly available data on the composition and adequacy of provider networks within MA plans.

[5] 42 C.F.R. § 422.566(d)

Enhanced transparency in provider network data will enable beneficiaries to make informed choices regarding their healthcare plans and ensure MA plans maintain networks that meet the healthcare needs of their enrollees. CPR recommends that CMS enhance transparency for beneficiaries by requiring MA plans to report data on geographic distribution and network sufficiency of all critical services, including post-acute rehabilitation, to meet the needs of enrollees, particularly in rural and underserved areas. It would also be helpful to beneficiaries considering the choice between Traditional Medicare or an MA plan to see comparative metrics on provider access in their geographic area. This geographic data is increasingly important as healthcare providers and hospitals drop MA plans due to excessive prior authorization denials, low payment rates, and for other reasons.

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We greatly appreciate your consideration of our comments. Should you have any further questions regarding this information, please contact Peter Thomas and Michael Barnett, CPR co-coordinators, by e-mailing Peter.Thomas@PowersLaw.com and Michael.Barnett@PowersLaw.com or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
ADVION (formerly National Association for the Support of Long Term Care)
ALS Association
American Academy of Physical Medicine & Rehabilitation
American Association on Health and Disability
American Music Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Spinal Injury Association (ASIA)
American Therapeutic Recreation Association
Amputee Coalition
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Brain Injury Association of America*
Clinician Task Force
Disability Rights Education and Defense Fund (DREDF)
Epilepsy Foundation of America
Falling Forward Foundation*
Lakeshore Foundation
Muscular Dystrophy Association
National Association for the Advancement of Orthotics and Prosthetics
National Association of Rehabilitation Providers and Agencies
National Association of Social Workers (NASW)

National Disability Rights Network (NDRN)
RESNA
Spina Bifida Association

**** Indicates CPR Steering Committee Member***