November 12, 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: CPR Comments in Response to Proposed Data Collection on Proprietary Guidelines and Medicare Advantage Plan Audit Protocol (CMS-10913; OMB Control Number 0938-New)

Dear Administrator Brooks-LaSure:

The undersigned members of the Coalition to Preserve Rehabilitation ("CPR") appreciate the opportunity to submit comments in response to the Centers for Medicare & Medicaid Services' ("CMS") *Proposed Data Collection on Proprietary Guidelines and Medicare Advantage ("MA") Plan Audit Protocol.*

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.

Our comments focus on needed improvements to utilization management policies, the need for service-line level data collection, and network adequacy requirements. 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

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 post-acute care, whether due to restrictive coverage policies, improper use of prior authorization, or other utilization management techniques and administrative burdens.[1] The Advancing Interoperability and Improving Prior Authorization Processes final 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.[2]

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 and obtain meaningful access to the Medicare benefits to which they are entitled.

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.

CMS should make the findings from this annual review easily understandable and easily accessible to the general public. Far too often, CMS will make data publicly available, but then make it difficult for the average enrollee, yet alone someone with a physical, mental or cognitive disability, to access it. **CPR encourages CMS to provide a step-by-step checklist that provides detailed instructions for how to access this information. CMS should also review the number of steps required to access this information and streamline those steps as much as possible to make it easier on the general public to get the information they need to make informed decisions.**

CPR continues to support these new transparency regulations and we strongly encourage CMS to not only enforce these regulations, but require the collection of service line level data to help

[1] "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.

[2] "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.

assess both inpatient hospital rehabilitation ("IRF") and Durable Medical Equipment, Prosthetics, Orthotics and Supplies ("DMEPOS") from MA plans. More granular data for long term acute care hospitals ("LTACHs"), skilled nursing facilities ("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 of the services various MA plans provide, 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.[3] 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 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.

II. 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 LTACHs 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.

[3] 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).

In addition to requiring MA plans to offer greater 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.

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 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
ALS Association
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
Association of Academic Physiatrists
Brain Injury Association of America*
Center for Medicare Advocacy*
Christopher & Dana Reeve Foundation*
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
United Cerebral Palsy
United Spinal Association*

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