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NARA
The National Association of Rehabilitation Providers and Agencies

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Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4212-P
PO Box 8013
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Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program [CMS-4212-P]

Dear Dr. Mehmet Oz,

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 90,000 physical therapists (PT), occupational therapists (OT), and speech language pathologists (SLP) through our member organizations who provide therapy across the United States to Medicare beneficiaries. They provide therapy in all settings across the continuum such as outpatient clinics, skilled nursing facilities (SNFs), assisted living facilities (ALFs), retirement communities, hospital inpatient and outpatient, and in the beneficiary's home. As a member-driven organization, NARA promotes best practice and business success of physical therapy, occupational therapy, and speech-language pathology providers through education, support, and advocacy. NARA's membership demographics give us a unique insight into payment and quality programs of the Centers for Medicare and Medicaid Services ("CMS") as they frequently interface directly with Medicare Advantage organizations and plans for Medicare beneficiaries and can offer insight to the impact of Medicare Advantage ("MA") plans on impact to patient care.

We appreciate CMS's continued efforts to refine Medicare Advantage (MA) and Part D policy to improve quality, transparency, and beneficiary protection, and we urge CMS to explicitly consider the impact of these changes on access to medically necessary physical therapy, occupational therapy, and speech-language pathology services. As rehabilitation providers, our members see first-hand how MA plan design, network adequacy standards, prior authorization requirements, and supplemental benefits policies directly affect patients' functional outcomes, safety, and ability to live independently in the community. We appreciate the opportunity to provide the followings comments in response to the Contract Year ("CY") 2027 MA and Medicare Part D Prescription Drug Benefit Programs Proposed Rule ("proposed rule").

**Star Ratings and Outcomes Alignment**

We support CMS's continued direction to align quality measurement and Star Ratings with outcomes that matter to beneficiaries. CMS should expand and refine outcome domains that directly reflect functional improvement, safety, and independence core goals for beneficiaries receiving physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP). We further recommend CMS aligning Star Ratings incentives with Make America Healthy Again (MAHA) priorities by strengthening prevention-focused measures that reduce falls risk, improve mobility and physical activity, and align nutrition management across the continuum of care

CMS can strengthen functional-status measurement to reflect improvement not only assessment by:

- Moving beyond "assessment completed" and prioritize measures that capture functional change over time (improvement and/or meaningful maintenance), with appropriate risk adjustment
- Ensuring measurement includes participation in daily activities (self-care, instrumental ADLs, community mobility), not only clinical status.

CMS can elevate falls prevention to an outcomes-driven incentive by:

- Retaining and enhancing falls-related measures, but structure Stars to reward demonstrable reduction in falls-related harm and sustained prevention efforts, not solely screening/documentation.
- Incentivizing MA plans to invest in evidence-based falls prevention (strength/balance training, mobility programs, home safety interventions) delivered by PT, OT, and ST and interdisciplinary teams.
- Promoting cross-setting continuity (home, outpatient, post-acute, and community-based programs) to prevent functional decline at transitions of care.

We recommend CMS keep pain as an outcome domain but shift focus to pain interference and function by:

- Not removing pain from Stars without a clinically meaningful replacement.
- Replacing "pain assessment" process measures with outcome-oriented pain measures that reflect pain interference with function, activity, sleep, and participation domains directly affected by effective conservative care.

CMS can reinforce mobility and physical activity as core outcomes to align with MAHA prevention goals by:

- Refining physical activity-related measures so they reward meaningful mobility and activity gains appropriate to baseline status, rather than "asked/recorded" processes.

- Incentivizing plan investment in PT/OT-led interventions that improve strength, endurance, gait, and conditioning, reducing downstream ED visits and avoidable hospital utilization.

Additionally, we recommend CMS add nutrition management as a prevention pathway continuum of care to align with MAHA by:

- Establishing a nutrition screening-and-intervention pathway for older adults and high-risk populations (screening plus documented intervention/referral).
- Encouraging cross-setting nutrition supports that address frailty, sarcopenia, wound healing, diabetes prevention or management, and recovery coordinated with rehabilitation goals to improve function and safety.

Functional status, falls risk, pain interference, and participation are among the most meaningful beneficiary-centered outcomes. These domains are also highly actionable through evidence-based PT, OT, and SLP interventions. By structuring Star Ratings and related reporting to reward outcomes and sustained prevention, CMS can better align MA plan incentives with beneficiary independence, reduced avoidable utilization, and MAHA priorities that emphasize upstream prevention (falls reduction, physical activity, and nutrition).

**Depression Screening and Follow-Up (DSF)**

Depression screening and timely follow-up are particularly important for older adults and individuals with disability, where untreated depression is strongly associated with reduced treatment adherence, slower functional recovery, and avoidable utilization. NARA supports CMS's proposal to add a Depression Screening and Follow-Up measure to explainable, beneficiary-relevant outcomes and to address persistent behavioral health gaps for Medicare Advantage beneficiaries.

NARA urges CMS to recognize that rehabilitation clinicians are often among the most frequent points of contact during an episode of care. CMS should encourage MA plans to incorporate PT, OT, and SLP more formally into DSF operational workflows, including:

- Team-based screening workflows where PT, OT, and SLP can help administer or trigger standardized screening (as permitted by state scope and plan protocols), document symptoms that interfere with rehabilitation participation, and activate the plan's follow-up pathway.
- Clear escalation pathways after a positive screen (warm handoffs, care coordination, and defined follow-up accountability) consistent with DSF's expectation for follow-up care within a defined timeframe.

This approach will improve DSF performance while advancing whole-person care by addressing depression as a direct barrier to functional progress.

NARA strongly recommends that CMS operationalize DSF through coordinated, team-based care models, not by imposing new, duplicative documentation tools or standalone screening requirements on therapy providers. DSF should be implemented in a way that:

- Leverages existing clinical documentation and data exchange (plan care management platforms, EHR integration, standardized instruments already used by clinicians), and
- Avoids requiring therapy providers to build parallel reporting processes that do not improve clinical care.

Depression screening and symptom assessment are already captured in skilled nursing through the Minimum Data Set (MDS) Section D (Mood), which includes PHQ-based approaches within the RAI/MDS framework. NARA recommends CMS explicitly permit MA plans to use MDS-derived mood/depression information (where applicable and available to the plan) as an acceptable data source to document that standardized screening occurred during a SNF stay reducing redundant screening and supporting continuum of care.

NARA also notes a material operational barrier: in many markets, referral sources and appointment availability for behavioral health follow-up are limited, which can hinder DSF performance and more importantly delay care for beneficiaries who screen positive. To ensure DSF drives meaningful clinical improvement (rather than measure "failures" caused by access constraints), CMS should encourage MA plans to expand timely follow-up options, including:

- Increased behavioral health network capacity and timely access standards,
- Tele-behavioral health and collaborative care models, and
- Care management resources that support follow-up completion within DSF timeframes.

NARA supports DSF and recommends CMS implement the measure through coordinated, interdisciplinary workflows that integrate PT, OT, and SLP as high-frequency touchpoints, leverage existing data sources such as SNF MDS where appropriate, and avoid new, duplicative administrative burden on therapy providers while concurrently strengthening MA plan capacity for timely mental health follow-up.

**D-SNP Continuity of Care (Proposed 120-Day Continuity Standard)**

NARA supports CMS's proposal to replace the "substantially similar network" requirement for passive enrollment between integrated D-SNPs with a minimum 120-day continuity of care standard tied to the existing "active course of treatment" protections at 42 CFR § 422.112(b)(8)(i)(B). This is a meaningful beneficiary protection, particularly for dually eligible individuals who face elevated risks when care relationships are disrupted. For beneficiaries receiving ongoing PT, OT, and/or SLP, abrupt changes in MA plan enrollment or network status can disrupt time-sensitive treatment, reverse functional gains, and increase downstream costs and risk, including falls, ED utilization, avoidable hospitalizations, and

institutionalization. Continuity is especially important when therapy is supporting recovery after hospitalization, managing progressive conditions, preventing falls, or maintaining function to avoid decline.

NARA urges CMS to explicitly clarify in regulation and/or final guidance that the 120-day continuity of care protections apply to:

- Ongoing rehabilitation episodes of care, including an established PT, OT, and SLP plan of care and scheduled therapy services; and
- The beneficiary's existing therapy clinicians and therapy locations, allowing the beneficiary to continue with their current therapists for the full continuity period, subject to medical necessity and consistent with the plan of care.

CMS has proposed that receiving integrated D-SNPs must provide continuity of care for at least 120 days and that this continuity should comply with § 422.112(b)(8)(i)(B) (with the longer 120-day minimum). NARA recommends CMS make clear that, for therapy, "continuity of care" includes continuity of the therapeutic relationship (therapist and clinic/home-based provider) and not merely coverage of a service category. To ensure the policy functions as intended, CMS should clarify that during the 120-day continuity period:

- MA plans may not disrupt or require reauthorization that delays or interrupts therapy that is part of an established, documented plan of care consistent with the active course of treatment protections referenced in the proposal.
- Beneficiaries may continue receiving therapy from the existing provider even if out-of-network, for the duration of the continuity period, when the therapy is part of the active plan of care and medically necessary (consistent with the continuity framework CMS is applying).
- Plans should not impose new administrative hurdles (e.g., new evaluations solely for coverage purposes) that functionally delay care transitions and undermine continuity.

NARA supports the proposed 120-day continuity of care standard for passive enrollment among integrated D-SNPs and respectfully requests CMS explicitly confirm that these protections apply to ongoing PT, OT and SLP episodes of care and established therapy plans of care, allowing beneficiaries to remain with their existing therapists for the full continuity period, subject to medical necessity.

**Network adequacy & the proposed "pattern of care" exception**

NARA appreciates CMS's willingness to reconsider aspects of the Medicare Advantage (MA) network adequacy framework, including its request for public input on streamlining network reviews and exception processes and the example of creating a separate "pattern of care" exception under 42 CFR § 422.116(f)(1). However, we have significant concerns about the proposed "pattern of care" exception to time-and-distance standards.

If not tightly defined, transparently reported, and actively monitored, a pattern-of-care exception could make it easier for MA plans to justify narrow rehabilitation networks, particularly in rural and underserved areas, resulting in longer beneficiary travel times, longer wait lists, and reduced access to medically necessary PT, OT, and SLP services. CMS's current time-and-distance framework exists to protect beneficiary access across provider types, and any exception must be structured to avoid becoming a pathway to systematic under-networking.

CMS should define "pattern of care" using objective access and utilization indicators, not historical claims patterns alone. CMS's own example contemplates an exception when an organization believes its contracted network is "consistent with or better than Original Medicare pattern of care." To operationalize this in a beneficiary-protective way, CMS should require that any pattern-of-care request be supported by data on:

- Travel time and distance (by county type and beneficiary distribution)
- Wait times and appointment availability for new and established patients
- Out-of-network utilization and involuntary out-of-network leakage (including continuity of care situations)
- Provider-to-enrollee ratios and evidence of capacity (not just signed contracts)

Plans seeking a pattern-of-care exception should be required to submit standardized, transparent data specific to rehabilitation access and outcomes. At a minimum, CMS should require reporting (or targeted audit submission) tied to:

- Falls and falls-related injury indicators (where claims-based proxies are feasible)
- Post-acute readmissions and ED utilization associated with mobility decline and preventable complications
- Functional decline risk signals (as feasible through existing assessment/quality pathways)

This approach aligns network adequacy with real beneficiary outcomes and reduces the likelihood that exception approvals unintentionally create access deserts.

CMS should explicitly include therapy networks (PT, OT, and SLP ) in targeted oversight when evaluating network adequacy exceptions, recognizing rehabilitation's central role in preventing institutionalization and maintaining independence. CMS is requesting feedback on the "timing and frequency" of network reviews and exceptions. NARA recommends CMS implement:

- Focused audits of therapy access in areas approved for exceptions
- Beneficiary access monitoring (including complaints/grievances related to access delays)
- Corrective action triggers when exception areas show persistent out-of-network use, excessive wait times, or declining access

NARA supports reducing unnecessary administrative burden, but "streamlining" should not dilute Medicare's longstanding coverage standards for reasonable and necessary care. CMS has recently emphasized that MA plans must follow Traditional Medicare coverage requirements, including applicable NCDs/LCDs and general coverage and benefit conditions; internal criteria are limited and must comply with regulatory safeguards. Any network adequacy policy changes particularly exception pathways must not function as an indirect mechanism to restrict access to covered, medically necessary PT, OT, and SLP services.

NARA members report persistent access barriers even when community demand is clear:

- Patient wait lists exist, yet MA plans often decline to credential additional therapy providers.
- Credentialing timelines frequently run 90–120 days, which is not operationally comparable to traditional Medicare participation; these delays can interrupt episodes of care.
- When providers do get approval after waiting months the effective date is not consistently retroactive, leaving providers and beneficiaries exposed to disruption.

NARA urges CMS to clarify and strengthen oversight by:

- Requiring MA plans to demonstrate timely credentialing and contracting processes as part of access compliance (including benchmarks for provider onboarding in high-demand areas).
- Conducting targeted reviews when there is evidence of wait lists, high out-of-network utilization, or repeated access complaints for therapy services especially in counties where an exception is granted.
- Requiring plans to adopt temporary access solutions (e.g., single-case agreements or continuity arrangements) during credentialing backlogs to prevent care interruptions.

NARA appreciates CMS's engagement on network adequacy reform and urges CMS to ensure that any "pattern of care" exception is narrowly defined, data-driven, and subject to robust oversight particularly for PT, OT, and SLP networks so that exceptions do not become a mechanism to normalize inadequate access in rural and underserved areas. CMS should pair any exception policy with stronger transparency, measurable access standards (travel time, wait time, appointment availability), and concrete oversight of credentialing and network expansion to protect beneficiary access to medically necessary rehabilitation services.

**Mid-Year Supplemental Benefit Notices: Maintain Beneficiary Awareness and Point-of-Care Access**

NARA recognizes CMS's goal of reducing administrative burden by rescinding the Mid-Year Supplemental Benefits Notice requirement. CMS notes the notice was intended to address

beneficiary awareness and utilization of supplemental benefits funded through rebate dollars, but proposes rescission based on updated utilization data, concerns about burden (particularly for smaller plans), and duplication with existing Evidence of Coverage (EOC) disclosures. We also note CMS previously delayed enforcement for the 2026 plan year and estimates rescission would avoid printing/mailing and system-update costs.

However, NARA is concerned that beneficiaries still underutilize rehabilitation-adjacent supplemental benefits that can materially improve function and prevent avoidable utilization of higher cost services via fitness/physical activity programs, home safety assessments and modifications, caregiver supports, and post-discharge home visits often due to lack of awareness or difficulty navigating plan processes. This concern is especially relevant given CMS's long-standing recognition that many supplemental benefits are intended to prevent illness/injury, ameliorate functional impact, and reduce avoidable emergency and health care utilization. We would like to point out that these supplemental benefits are frequently marketed as plan differentiators to attract enrollment; if CMS permits MA organizations to apply rebate dollars toward these offerings, beneficiary-facing communication and usability should be treated as a core consumer protection objective not merely a marketing function.

If CMS eliminates the mid-year notice requirement, NARA urges CMS to require (or at minimum strongly encourage, with audit-ready expectations) that MA plans implement point-of-care visibility tools, so supplemental benefits are transparent and actionable at the time of clinical need. Specifically, CMS should require/encourage MA plans to:

1. Provide provider-facing visibility into supplemental benefits through plan portals and/or interoperable data exchange, including:
    - Real-time display of a beneficiary's available supplemental benefits (eligibility, remaining units/visits, authorization requirements, and contact/referral pathways).
    - Portal flags or EHR-integrated indicators visible to treating clinicians particularly PT, OT, and SLP when a supplemental benefit is clinically relevant (e.g., falls risk, post-discharge transition, deconditioning).
2. Operationalize "activation pathways," not just disclosure, including:
    - A standardized, low-friction workflow for referrals and scheduling (including electronic submission and tracking), and
    - Clear turnaround times for approvals when prior authorization is required.

When therapists can see a patient's available supplemental benefits, they can help patients activate those benefits at the right time supporting adherence, improving functional outcomes, and reducing downstream utilization.

NARA also encourages CMS to align supplemental benefit transparency with MAHA's prevention priorities, including interventions that promote physical activity and good nutrition and support functional independence. Supplemental benefits that enable safe mobility (home safety supports, falls-prevention supports, exercise/fitness programs) and healthy lifestyle behaviors are directly consistent with this prevention-forward direction and should be made easier, not harder for beneficiaries to understand and use.

NARA understands CMS's desire to reduce administrative burden by rescinding the mid-year notice requirement. If CMS finalizes this change, CMS should pair it with a beneficiary-protective standard for supplemental benefit transparency and point-of-care accessibility, including provider-facing visibility (portal/EHR flags), real-time eligibility details, and streamlined activation pathways particularly for rehab-adjacent benefits that support prevention, physical activity, home safety, and functional independence.

**Marketing & Third-Party Marketing Organization (TPMO)**
NARA supports CMSs continued tightening of Medicare Advantage (MA) marketing requirements and TPMO oversight, including clearer disclaimers, stronger accountability for marketing conduct, and safeguards against beneficiary confusion and steering. These protections are essential to ensure beneficiaries can make informed enrollment decisions based on access to needed care not just premiums, supplemental benefits, or prescription drug coverage.

NARA continues to be concerned that many beneficiaries are unaware that their preferred rehabilitation providers are out of network or that PT, OT, and SLP services are subject to restrictive prior authorization until after an acute event, surgical procedure, or significant functional decline. At that point, plan switching options may be limited and delays in medically necessary rehabilitation can lead to worsened outcomes, including functional regression, increased falls risk, and avoidable emergency department use.

CMS should explicitly require that MA marketing and enrollment materials (including TPMO scripts and web-based enrollment pathways) present clear, prominent, standardized information about:

1. Provider network access
    - Whether a beneficiary's selected/commonly used PT, OT, and SLP providers are in-network (not buried in directories that are difficult to navigate or frequently outdated).
    - A plain-language explanation that provider participation can vary by location and facility-based/outpatient setting.
2. Key utilization management rules that materially affect access
    - Prominent disclosure of prior authorization requirements for PT, OT, and SLP and other post-acute services when applicable.

    - Clear description of common restrictions that affect rehabilitation access (e.g., visit thresholds, reauthorization cadence, step requirements), in consumer-friendly terms.
3. Cost-sharing clarity for beneficiaries transitioning from Traditional Medicare with Medigap
    - For beneficiaries moving from Traditional Medicare with a supplemental plan, MA materials should clearly explain that they may newly face deductibles, copayments, or coinsurance for services that were previously low-cost or predictable under Medigap coverage.
    - Disclosures should be presented as "real-life examples" for common episodes (e.g., post-surgical outpatient therapy, home health, SNF stay), not only in a summary table.

Post-acute and rehabilitation services are critical to recovery and independence; thus NARA encourages CMS to pilot or require standardized marketing disclosures that specifically highlight coverage and rules for:

- Skilled nursing facility (SNF) care
- Home health services
- Outpatient therapy (PT, OT, and SLP )
- Tele-rehabilitation where offered

These disclosures should focus on the information beneficiaries most need to avoid surprises: network access, prior authorization, typical cost-sharing, and how to initiate services quickly after hospitalization.

NARA recommends CMS require MA plans to provide timely notification when:

- A beneficiary's preferred provider (or a provider the beneficiary has utilized within a defined lookback period) leaves the network, or
- Benefit access rules change in ways likely to impact rehabilitation access (e.g., new prior authorization requirements or more restrictive utilization policies).

This should be operationalized as a consumer protection supporting continuity of care and informed decision-making rather than relying on beneficiaries to discover changes during an episode of care.

NARA urges CMS to pair any expanded marketing/disclosure requirements with meaningful oversight, including:

- TPMO monitoring and auditing of scripts, call recordings, and digital marketing flows for network/access disclosures (not just premiums and drugs)
- Review of provider directory accuracy and timeliness, with corrective action triggers
- Complaint tracking specific to "surprise" out-of-network findings, prior authorization barriers, and post-acute access delays

NARA supports CMS's ongoing efforts to strengthen MA marketing and TPMO rules. CMS should ensure beneficiaries receive clear, prominent, standardized disclosures about provider networks, prior authorization for PT, OT, and SLP , and post-acute coverage details, along with transparent cost-sharing information especially for individuals transitioning from Traditional Medicare with supplemental coverage. Robust CMS oversight is necessary to ensure these disclosures are accurate, timely, and meaningful so beneficiaries can make informed plan choices and maintain uninterrupted access to medically necessary rehabilitation services.

**RFI on Risk Adjustment and Quality Bonus Payment Redesign**

NARA appreciates CMS's solicitation of stakeholder input through the RFI focused on potential changes to Medicare Advantage (MA) risk adjustment and Quality Bonus Payments as part of the Contract Year 2027 MA/Part D proposed rule. We support efforts that improve payment accuracy, strengthen competition, and better align plan incentives with outcomes that matter to beneficiaries.

*1) Risk adjustment should better recognize functional impairment, frailty, and high-rehabilitation-need clinical profiles.*

Current MA risk adjustment methodologies often under-recognize functional impairment, frailty, and chronic musculoskeletal and neurologic conditions factors that are strongly associated with utilization needs and outcomes, and that commonly drive substantial PT, OT, and SLP care. When these factors are not adequately captured, plans may face a financial disincentive to enroll and retain beneficiaries with higher rehabilitation needs and may underinvest in services that prevent decline and avoidable utilization.

NARA urges CMS to explore policy options that better account for these drivers, including:

- Incorporating more function- and frailty-relevant indicators into risk adjustment in a manner that is clinically grounded, auditable, and resistant to manipulation, so that payments better match true beneficiary needs while minimizing incentives for coding-driven revenue.
- Evaluating how functional impairment and frailty signals captured across Medicare settings can be used to improve prediction (for example, leveraging standardized assessment domains where already collected, rather than creating new, duplicative documentation burdens).
- Recognizing chronic musculoskeletal and neurologic conditions that are prevalent among MA beneficiaries and are associated with functional limitations, fall risk, and post-acute utilization particularly where rehabilitation is the primary modality to maintain independence and prevent institutionalization.

*2) QBP redesign should elevate functional outcomes, falls prevention, safe transitions, and home/community participation*.

In any redesign of QBP, NARA urges CMS to shift emphasis toward beneficiary-centered outcome measures especially those that reflect functional recovery and independence rather than administrative process measures. CMS has already signaled interest in modernizing MA incentives and improving transparency and quality through this RFI. Specifically, NARA recommends CMS elevate and/or test measures that reflect:

- Functional outcomes and meaningful participation in daily life (mobility, self-care, and home/community participation)
- Falls risk reduction and falls-related harm
- Safe transitions of care (including post-acute coordination and avoidance of preventable readmissions and ED utilization)

CMS should also explicitly recognize the contribution of PT, OT, and SLP in achieving these outcomes both through direct clinical impact (mobility, balance, ADLs, swallow/safety, cognition/communication) and through care coordination that supports adherence, safety, and prevention.

*3) Align risk adjustment and QBP incentives with MAHA prevention priorities and whole-person outcomes*.

NARA encourages CMS to align any risk adjustment and QBP redesign with MAHA's prevention-forward direction, including increased focus on physical activity and nutrition interventions that prevent disease progression and functional decline. CMS has articulated this orientation through Innovation Center strategy priorities and the MAHA ELEVATE model focus on interventions incorporating nutrition and/or physical activity.

Rehabilitation is central to MAHA-aligned outcomes because PT, OT, AND SLP :

- Translate physical activity goals into safe, individualized plans for older adults and people with chronic conditions;
- Address barriers to adherence (pain, fear of falling, mobility limitations, cognitive/communication issues);
- Reduce downstream preventable utilization by improving function and safety in the home and community.

Accordingly, QBP redesign should reward plans that invest in evidence-based prevention strategies falls prevention, mobility restoration, safe activity progression, and coordinated nutrition supports because these are high-impact levers for independence and total cost of care.

NARA supports CMS's RFI and urges CMS to (1) modernize risk adjustment so functional impairment, frailty, and high-rehabilitation-need profiles are more accurately captured; and (2) redesign QBP to elevate functional outcomes, falls, safe transitions, and home/community participation explicitly recognizing PT, OT, and SLP as essential contributors to these outcomes and to MAHA-aligned prevention priorities.

**Support e-authorization efficiency, with enforceable AI safeguards**

NARA supports efforts to reduce friction in prior authorization (PA) through electronic and interoperable processes that can accelerate approvals and improve beneficiary experience when implemented appropriately. CMS's interoperability and PA initiatives are directionally aligned with improving transparency and efficiency in PA workflows.

At the same time, NARA urges CMS to apply clear guardrails when Medicare Advantage (MA) plans use artificial intelligence (AI), algorithms, or automated decision-support tools in PA determinations particularly for post-acute and rehabilitation services where delays or denials can rapidly lead to functional decline.

*1) Require protections against bias and disparate impact*

AI-enabled PA systems must be designed and monitored to ensure they do not embed bias or systematically disadvantage beneficiaries with higher rehabilitation needs, including individuals with functional impairment, frailty, disability, neurologic conditions, or chronic musculoskeletal conditions. NARA urges CMS to require plans to implement algorithm governance that includes:

- Routine testing for disparate impact across protected and high-risk populations;
- Ongoing monitoring for inappropriate denials that correlate with disability, age, dual status, or clinical complexity; and
- Corrective action when algorithmic outputs produce patterns inconsistent with Medicare coverage and medical necessity standards.

*2) Ensure denials are transparent, explainable, and grounded in Medicare coverage rules and evidence*

NARA requests CMS require that when AI is used in PA, plans must provide clear, beneficiary- and provider-facing explanations for any denial, including the clinical rationale and the evidence-based standard applied. This should align with CMS requirements that MA PA policies be used to confirm diagnoses/medical criteria and ensure services are medically necessary not to impose non-Medicare clinical thresholds through opaque internal logic. In addition, denials should clearly identify:

- The specific clinical criteria used (and its relationship to Medicare coverage rules);
- What documentation is missing (if applicable), using plain-language specificity; and
- How the provider can submit additional information or request peer-to-peer review.

*3) Maintain meaningful human review and accountability*
AI tools should support administrative efficiency but not replace clinical judgment. NARA urges CMS to require that:

- A qualified clinician remains accountable for PA determinations, particularly adverse decisions; and
- Plans maintain auditable documentation that a clinician meaningfully reviewed the case, rather than relying on automated outputs as a default.

These safeguards are consistent with concerns raised by federal oversight bodies regarding inappropriate MA denials that met Medicare coverage rules and created barriers to medically necessary care.

NARA supports efficient, electronic PA processes that reduce burden and improve timeliness. However, as MA plans adopt AI-enabled utilization management, CMS must ensure these tools do not introduce bias, obscure decision logic, or facilitate denials that are inconsistent with Medicare coverage standards. CMS should require transparency, evidence-based rationale for denials, and robust oversight including monitoring for disparate impact and accountability for human clinical review to protect beneficiary access to medically necessary PT, OT, and SLP and other time-sensitive services.

**Prior Authorization Portals Must Allow Full Diagnosis Coding to Support Accurate Medical Necessity Review**
NARA supports CMS's continued efforts to modernize and streamline prior authorization (PA) through electronic processes. However, as MA plans increasingly rely on online PA portals and automated decision-support tools to adjudicate therapy requests, CMS should ensure these systems capture sufficient clinical information to support accurate, individualized medical necessity determinations. NARA members report that some MA plan online PA systems limit the number of diagnosis codes to only one code that can be entered for a request. The practice of limiting diagnosis code entry fails to reflect the reality that many Medicare beneficiaries are older adults, dually eligible individuals, or are recovering from acute events with multiple comorbidities that directly affect therapy complexity, duration, safety risk, and the total number of visits needed.

When only a subset of diagnoses can be submitted, the PA record may omit material factors such as neurologic conditions, cardiopulmonary limitations, cognitive impairment, fall risk, frailty, pain conditions, or other chronic diseases that influence functional prognosis and treatment planning. This creates a distorted clinical picture and increases the likelihood of inappropriate denials or under-authorizations.

Moreover, when plans use algorithms to recommend visit counts or apply automated thresholds, incomplete diagnostic inputs can cause the algorithm to undervalue patient

acuity and complexity, resulting in authorizations that do not match the beneficiary's clinical needs and may delay recovery or contribute to functional decline.

NARA urges CMS to require that any MA plan utilizing online/electronic PA portals must:

1. Allow submission of all clinically relevant ICD-10 diagnosis codes associated with the request, without arbitrary numeric limits that prevent full representation of comorbidities and complexity.
2. Ensure the portal supports accurate linkage between diagnoses, functional limitations, and requested services (e.g., therapy frequency/duration), so medical necessity determinations can be patient-specific rather than template-driven.
3. If plans use algorithms or automated decision-support, require those tools to be based on complete clinical inputs, and ensure plans do not deny or limit services due to data omissions created by the plan's own system constraints.

CMS should also require plans to clearly disclose, in provider-facing materials, what clinical data elements are considered in PA determinations and to ensure any automated recommendations or denials are accompanied by an evidence-based rationale that reflects the beneficiary's full clinical profile. To support accurate medical necessity determinations and prevent avoidable delays in care, NARA urges CMS to require MA plans that use online/electronic prior authorization workflows to accept all relevant diagnosis codes. Limiting diagnosis codes does not present an accurate picture of a beneficiary's health status and can lead to inappropriate algorithm-driven visit limitations when material clinical information is excluded by design.

**MA Plans Create Administrative Burden for Unnecessary Paperwork**

NARA is concerned that many Medicare Advantage plans create unnecessary administrative burden by requiring providers to complete duplicative, plan-specific forms regarding patient status, progress, and continued need even though the treating clinician's daily treatment notes and progress reports already contain the same clinical information and are the standard documentation used to support medical necessity and ongoing care. This redundant paperwork diverts clinician time from patient care and can delay timely access to medically necessary PT, OT, and SLP services. CMS should require MA plans to accept and utilize existing therapy documentation (daily notes, progress notes, plan of care updates) as sufficient support for prior authorization, continued authorization, and medical necessity determinations, rather than imposing additional, proprietary paperwork requirements, absent a clear, narrowly defined justification.

**Streamline Prior Authorization Methods**

NARA notes that providers must navigate a patchwork of Medicare Advantage prior authorization submission pathways phone, fax, multiple electronic portals, and varying plan-specific instructions often differing by plan type (local vs. out-of-state), network status (in-network vs. out-of-network), service setting, and even by product line within the same

parent organization. These inconsistencies create avoidable administrative burden, increase the risk of misrouted submissions, and contribute to delays when requirements or submission addresses change without timely updates. CMS should require greater standardization and streamlining across MA plans, including clear, consistently maintained submission points, uniform intake requirements, and timely communication of any process changes, so providers can submit once through predictable channels and beneficiaries can receive medically necessary PT, OT, and SLP services without delay.

**Contract Rates Materially Below MPFS**

NARA is concerned that Medicare Advantage reimbursement for PT, OT, and SLP services is frequently not aligned with Traditional Medicare payment in ways that create access risks for beneficiaries. In many markets, MA contracted rates are materially below Medicare Physician Fee Schedule benchmarks and are further undermined by additional administrative friction (e.g., prior authorization, delayed credentialing, and claim edits), making it difficult for providers to sustainably participate in MA networks. When reimbursement does not reasonably reflect the cost of delivering medically necessary care particularly for complex, high-acuity beneficiaries plans effectively shift costs to providers, narrow networks, and increase wait times, which can delay recovery and contribute to avoidable utilization (falls, ED visits, and hospitalizations). CMS should strengthen oversight to ensure MA payment practices and contracting structures support meaningful network participation and timely access to covered rehabilitation services, consistent with Medicare's beneficiary access and network adequacy expectations.

NARA is also concerned that certain MA plan per diem payment methodologies in post-acute settings are not aligned with Traditional Medicare's case-mix criteria and, in practice, may fail to account for the full clinical complexity of beneficiaries. Under Traditional Medicare, payment systems are designed to reflect patient acuity using a comprehensive set of clinical factors and comorbidities. By contrast, NARA members report that some MA plans determine per diem rates using only a subset of the available case-mix inputs, which can materially understate severity and undervalue the resources required to safely treat high-need beneficiaries. For example, providers report that one MA has applied only a portion of the scoring methodology rather than the full set of criteria used under Traditional Medicare, resulting in rates that do not reflect total comorbidity burden.

CMS should require MA plans to provide greater transparency and standardization for per diem methodologies, including (1) clear disclosure of which clinical factors and comorbidities are included/excluded in rate setting, (2) assurance that payment reflects the complete beneficiary profile, not partial scoring approaches, and (3) an efficient process to correct or appeal rates when additional comorbidities or complications materially affect expected resource use.

In closing, NARA respectfully urges CMS to ensure that the final CY 2027 Medicare Advantage rule advances beneficiary access and outcomes by preserving and strengthening continuity of care and meaningful network adequacy for therapy services; aligning Star Ratings and Quality Bonus Payments with functional and safety outcomes where rehabilitation plays a central role; and ensuring that any deregulatory steps do not unintentionally narrow networks or weaken transparency around access to PT, OT, and SLP. NARA also encourages CMS to engage rehabilitation stakeholders in ongoing rulemaking, operational guidance, and measure development so that these policy changes translate into measurable, real-world improvements in access, quality, and patient function.

We thank you for the opportunity to provide comments related to this proposed rule. Should you have any questions concerning these comments, please contact Christie Covington, NARA Executive Director at christie.covington@naranet.org.

Respectfully submitted,

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