



August 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Medicare Program; Request for Information on Medicare Advantage program [Docket CMS-4203-NC]

Dear Administrator Brooks-LaSure:

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 80,000 physical therapists, occupational therapists, and speech language pathologists 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, 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 the impact of the Medicare Advantage programs on providers as well as beneficiaries and access to care with these programs. We appreciate the opportunity to provide the following comments related to the above request of information.

Advance Health Equity

To advance health equity, NARA recommends that CMS provide clear guidance to all Medicare Advantage (MA) plans regarding the definition of skilled criteria and coverage to ensure all beneficiaries receive the medically necessary care they are entitled to in a timely manner. Our members have expressed that there is a significant lack of understanding on how skilled criteria and coverage is determined. Skilled criteria and coverage for traditional Medicare beneficiaries is clearly defined in the Medicare Benefits Policy Manual Chapter 8 and, the CMS Long-Term Care Facility Resident Assessment Instrument (RAI) manual (specific to Part A) and the Medicare Benefit Policy Manual Chapter 15 (specific to Part B) and staff are trained on these requirements. Our members have indicated that MA plans do not follow the same criteria and coverage and do not provide their guidelines for providers to understand and follow. NARA would like to see CMS require MA plans to be transparent in their coverage criteria and guidelines to both beneficiaries and providers. NARA supports additional oversight by CMS including audits of MA plans skilled criteria determinations, denials of provider payments, and disenrollment of beneficiaries. NARA

applauds CMS in their initiated efforts in analyzing MA beneficiary's disenrollment in the last year of life following the guidance put forth by the GAO's recommendation, but would like for that timeline to be expanded to include disenrollment by beneficiaries in rural and underserved areas.

NARA recommends CMS provide clear guidance for all MA plans to report rehospitalizations to assist with monitoring health equity and compare this important measure across both Fee-For-Service (FFS) and MA plans.

Expand Access: Coverage and Care

Plan Information and Selection by Beneficiaries

Medicare beneficiaries need the following information in order to make an informed and unbiased decision about the election of a MA plan over traditional Medicare:

- Plan premium
- Beneficiary responsibility for in network and out of network services including but not limited to co-pays, co-insurances, and deductibles
- Requirements for accessing out of network benefits
- List of in network providers
- Procedure for a beneficiary to request a provider to be granted in network status (when payors close networks)
- Detailed benefits, including any limitations (i.e. covered length of stay for skilled nursing facility, how many outpatient therapy services are covered by discipline)
- Benefits requiring prior authorization
- Requirements for prior authorization by setting/service (i.e. skilled nursing facility, home health, outpatient therapy services)
- Expected length of prior authorization process
- How to appeal denied prior authorizations
- What to do when services have been denied post approval of services
- Comparison to traditional Medicare coverage

The above information should be included in marketing materials, provided upon enrollment and easily accessible throughout the enrolled period. Providers should also be able to access specifics about a beneficiary's coverage when verifying benefits prior to providing services; this would assist in providing Good Faith Estimates to beneficiaries when required. Currently, some of this information is vague, one of our members shared the following example: when verifying benefits for physical therapy of a beneficiary with Anthem MA in Virginia online verification via Availity (the plans preferred method of verification) it states "may require prior authorization" for an out of network provider; the information should clearly state if it is required or not and how the beneficiary or the provider is able to submit a prior authorization request and what information is required for that request.

Additionally, NARA recommends that CMS further strengthen consumer protections regarding plan marketing. Members have expressed concern that beneficiaries opting for a MA plan do not have a clear understanding of the benefits in detail and do not understand the difference

between an MA plan and traditional Medicare. Our members have witnessed beneficiaries that elect a MA plan and believe they have traditional Medicare as their primary insurance, and the MA plan is the secondary, quickly become frustrated to learn they have a patient financial responsibility because the MA plan is primary.

Access becomes an issue when MA plans have closed networks, as our members have reported about Aetna and Humana, in multiple states with significant rural areas such as North Dakota, South Dakota, Illinois and Indiana. CMS should require a payer offering a MA plan to accept all providers who request to join their network to ensure that all Medicare beneficiaries receive access to the care they need including in rural and underserved areas.

Prior Authorizations/Denials/Appeals

As providers, it is not uncommon to interact with a dozen or more MA plans. Every plan requires different information, provided on different time intervals, and submitted via different methods (i.e., fax, electronic upload). NARA highly recommends that CMS provide consistent guidelines that can be used for all MA plans prior authorization processes. Additionally, there needs to be transparency on the appeals process for the provider and the patient. Standardization of the appeals process would mitigate the increased burden providers are experiencing, requiring additional work beyond a script from the referring physician who has already determined the skilled need. The April 2022 OIG report (<https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>) found that MA had denied both prior authorization and payment requests that met Medicare coverage rules. Furthermore, they found that the MA plans were using clinical criteria not contained in Medicare coverage rules; were requesting unnecessary documentation; and making manual review and system errors. Currently, naviHealth requires their own form be used for ongoing SNF authorizations that cannot include the GG scale, so someone has to RE-WRITE the information from the electronic medical record (EMR) onto another form AND crosswalk the GG scale to theirs and then submit. Kaiser requires the use of the FIM and subsequently requires certification of all clinicians, which is an added cost/burden. These are just a couple of examples from our members.

Our members have shared the following examples of prior authorization denials as well as billing denials that met medical necessity and billing criteria consistent with traditional Medicare coverage rules:

- Physician referred patient to physical therapy with an aggressive frequency and duration due to patient comorbidities. The plan was specifically laid out by the physician and included 20 visits of 6 weeks. Upon submission of patient evaluation with physician signed prescription and plan, BCBS Regence prior authorization reviewer approved 8 of the 20 visits stating the patient should be discharged about the 6th visit with a home exercise program. When this was appealed, they agreed to provide an additional 6 visits but would not approve the additional 6 visits without a referral to Maximus for further review.
- A patient who was skilled in a facility in September 2021 who had pre-authorization and weekly reauthorizations received a denial in May 2022 for post-payment review of overpayment stating the facility had 30 days to provide supporting documentation to support the HIPPS billed; however, documentation was submitted with the request for

authorization and with each reauthorization as well as a previous request for full medical record documentation.

- Aetna only allows 1 evals X 180 days this is not consistent with Medicare coverage and definitely limits access to care. Our members have reported that they will pay for treatment; just not the eval.
- Some markets are being flooded with requests for additional documentation finding that various departments within the MA plans are unclear that a facility met the criteria for payment following the prior authorization and claims are denied requiring providers to spend excessive hours on multiple calls to rectify this situation. In some cases, members have reporting having to submit documentation multiple times to support services billed that had previously been reviewed for prior authorization to rectify the situation.
- Multiple members have reported that MA plans are requiring prior authorizations with clinicals but then when the claim is sent in the full medical record/documentation is required. This leads to the question-If services are approved throughout the course of treatment, then one would assume that the claim should proceed normally.
- Inaccurate interpretation of the RAI manual:
 - Humana is denying skilled days in a skilled nursing facility for inaccurate interpretation of the RAI manual coding guidelines.
 - For example, our members have reported that are receiving denials for not signing off the MDS in Section Z for GG on day 3. This was confirmed by CMS as not accurate.
 - Another GG denial example is requesting written proof that the coding of GG was collaborative. The rep told our member that she is looking for notation of a meeting that occurred – this is not specified in the RAI Manual or in the MA regs.
 - Additionally, the reviewers are not recognizing that single room isolation can occur only one day in the lookback.
- Humana is targeting providers/regions with overwhelming denials burden.
 - A member has reported that Humana appears to be processing ADRs with initial documentation sent from the hospital for prior authorization rather than reviewing documentation received from the skilled nursing facility. This allegation is based on the skilled nursing facility receiving denials from Humana due to documentation for ADRs when the skilled nursing facility never responded to a Humana ADR with documentation.
- UHC is requiring that every claim billed have the medical records also be submitted for processing of payment.
- Requests for prior authorizations taking excessive time to process leading to delays in beneficiaries receiving the timely medical care they need.
- Centene requests medical records for every claim billed with 59 modifiers.
- Humana has sent ADR requests to one member resulting in full payment of claim. Following that full payment, Humana sent a denial for specific lines due to “unbundling” requesting return of payment.
- CarePlus requires medical records for any part B claim before considering reimbursement.
- Incorrect application of NCCI edits:

- Humana and Aeta for example do not apply NCCI edits consistent with the CMS' application thereof, resulting in thousands of line-item denials every month.
- The burden on providers to appeal each and every line-item denial with evidence of the appropriate application of NCCI edits per CMS guidelines is extensive, requiring excessive time and effort. Smaller providers simply write these amounts off, losing thousands of dollars each year because the labor, time, and effort to fight these payors via an odious appeals process is just too costly, particularly during the past couple of years as healthcare providers battle a pandemic and unprecedented staffing shortages.
- A member reported that they reached out to Aetna last year on behalf of their contract therapy organization and their many clients, to address this issue directly with them. After numerous emails and several phone calls they finally acknowledged that the edits were being incorrectly applied and that their software would be updated in August to correct the problem. This however did not occur and numerous attempts to reach out to them to find out why were blatantly ignored.
 - An example of this is the edit for CPT code 97535 when billed with 97530. In January 2022 NCCI edit tables were updated, as they are quarterly, and this edit was deleted, meaning that 97535 no longer required a modifier 59 when billed on the same day as 97530, however, both above referenced Medicare Advantage Organizations (MAO), and others, continue to require the modifier and will deny services if it is not present on the claim.
 - Another example from Humana- Humana states that the codes noted below can't be billed on the same date. States they are required to be bundled and will only pay one of them (this is not in line with Medicare billing guidelines):
 - 97542 and 97530
 - 97150 and 97530
 - 97150, 97116 and 97530
- Providers are required to update their software to align with CMS NCCI edits quarterly, to ensure billing is accurate and modifiers are appropriately applied. Medicare Advantage Organizations generally state on their websites, in their provider manuals and coverage determinations that they follow Medicare guidelines. Clearly, with regards to these edits, they do not. They also do not publish whether they intend to follow the quarterly CMS updates or not, so providers are left in the dark as to whether their software should be updated for MAO's or not. The inconsistent application of NCCI edits doesn't end there. Some MAO's have determined, contrary to CMS Medicare coverage and medical necessity guidelines, that certain codes may not be billed together, regardless of whether the modifier is present or not, also resulting in line item denials that must be appealed in order to get paid for services provided to beneficiaries in good faith. These codes are not part of CMS' MUE (Medically Unlikely Edits). Nowhere are these coding guidelines published, so providers have no way of knowing how to set up their billing software or train their staff to accommodate these arbitrary

coding anomalies that seem to have no grounding in CMS regulations or evidence-based medical practice.

- Appeals Process:
 - Processes inconsistent with CMS
 - Timelines inconsistent with CMS
 - Appeal levels inconsistent with CMS
 - No way to get an ALJ hearing
 - Terminology inconsistent with CMS
 - Waiver of liability requirements

NARA recognizes that traditional Medicare does not require prior authorization for services. However, Medicare has successfully utilized post payment audits to recover reimbursement that did not meet the definition of skilled criteria. Further, we recognize that the purpose of the MA plans is to reduce fraud and save Medicare dollars; however, when medically necessary services are denied or delayed for a Medicare beneficiary with an MA plan there is a higher potential of rehospitalization or more catastrophic injury leading to higher costs and burden of care on the system. Thus, the recommendation for a heavy increase of oversight for prior authorizations, streamlined and consistent authorization processes, and transparency of how the MA plan is applying Medicare coverage rules is necessary. Additionally, NARA recommends that CMS increase its oversight of MA plans to provide consistency with skilled criteria, billing and coding guidelines as well as the appeals process to align with Medicare guidelines.

CMS guidance is not clear regarding MA plans ability to deny authorization based on internal clinical criteria that go beyond Medicare coverage rules. We are asking for clarification from CMS if they confirm that the MA enrollees understand and receive full disclosure re: the benefits for various levels of care? For example, when a beneficiary has very complex medical needs vs a beneficiary who requires minimal services in a SNF. Our members have reported that from their experience with MA plans, the skilled services approved and length of interventions are not consistent with traditional Medicare allowances. Furthermore, they have observed that cases with complex medical barriers are not always afforded the care necessary to achieve medical stability per Medicare guidelines.

NARA is recommending that CMS require MA plans to be transparent with their denials. Thus, requiring them to publish the percentage of claims they deny initially and the percentage of claims they pay in full for both Medicare Part A and B services.

Drive Innovation to Promote Person-Centered Care

CMS should address the concerns brought forth by MedPAC on June 28, 2022 in their testimony on Improving the Medicare Advantage Program (https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Mathews_OI_2022.06.28_updated.pdf?emci=4f2a4714-2622-ed11-bd6e-281878b83d8a&emdi=2e3fe7b4-3722-ed11-bd6e-281878b83d8a&ceid=10555624). MedPAC pointed out that Medicare pays more for MA beneficiaries than it would if they were

under traditional FFS. This is a concern to NARA as the MA plans payments and fee schedules are lower than the Medicare allowable. NARA agrees with MedPAC that the current policies for MA plans need to be restructured to drive innovation and promote person-centered care. One recommendation is to implement a Payer incentive for outcomes similar to shared savings program. NARA recommends that CMS work with MA plans to establish person-centered measures that make sense for the beneficiary population. For example, one member shared with us that a MA plan has a person-centered measure for tying shoes-how is this applicable to the geriatric population. Medicare is already utilizing Section GG scoring for Medicare beneficiaries, is it possible for CMS to streamline this for MA plans as well?

MA Star Rating

It is imperative that there be transparency for all stakeholders in the MA star rating system. The current system ties MA star rating to a bonus structure and the current 5-star rating is not an indicator of high quality of care. MA plans lack the standardized data reporting that Medicare has and therefore, NARA recommends a re-vamp of the MA star rating system to have consistency with Medicare's care compare. The current star rating system is hard to find for both providers as well as beneficiaries and is difficult to understand. Therefore, this data is unable to assist beneficiaries in their decision to elect a MA plan over traditional Medicare.

Payment of Service Delivery Models

There needs to be full transparency as to the coverage/criteria rules MA plans are following. This includes clear communication with all stakeholders, including provider, patient and the referral sources. Additionally, the MA plan needs to share their policies regarding cutting of skilled services. MA plans should be responsible for the communication of the ending of services, not the provider as it is the plans decision. When we as providers have to deliver this message, it has a negative impact on the provider/beneficiary relationship sometimes resulting in a negative hit in their provider rating.

NARA recommends that there be incentives for providers to perform and allow for full transparency of the data. Providers who are caring for the MA patient need to have voice in the patients' medical care being provided. Providers are advocates for our patients and we need to be allowed to be a part of the process for the patients in our care.

Support Affordability and Sustainability

MA Payment/Risk Adjustment

It is imperative that CMS increase its oversight of MA plans and their policies. Although, CMS does not have the authority to regulate the MA reimbursement rates it can, however, provide guidance and require transparency to move MA policies to be in line with Medicare guidelines. MA plans should no longer be given the freedom to pick and choose what policies they wish to follow.

Providers continue to struggle with the ongoing Public Health Emergency, staffing challenges and reimbursement challenges. It is imperative that given all these challenges that MA plans and

providers be able to work together as the number of MA beneficiaries continues to grow. It is unsustainable for providers to continue to operate with increased administrative burden for prior authorizations and ongoing denials and appeals while receiving a lower per diem rate than a traditional Medicare patient. One member shared with us that in one of their facilities they have a full-time business office manager that spends on average 16-24 hours a week on MA authorizations, appeals and denials.

NARA recommends considering a payment system based upon shared risk to address SDOH. The current system is broken and needs to be re-vamped. The issue currently is SNF and HHAs HCC scoring is done by the hospital record and PDPM and PDGM (which do not take SDOH into consideration) coding is done at the agency and facility level via the MDS and OASIS. In order to fix this issue, we need a calibration of risk adjustment scoring based on past and current medical conditions from multiple providers. In addition, having a consistent HCC scoring methodology across all payors and platforms will allow for consistency and increased accuracy with scoring. We have found that the current levels of care for some MA plans are basic and do not take risk or SDOH into consideration at all especially in the areas of discharge planning or a lack of discharge plans.

Engage Partners

NARA appreciates the opportunity to provide this feedback and would welcome a conversation with CMS and other professional organizations to further discuss a better path forward. In addition, NARA recommends that CMS establish a Technical Expert Panel (TEP) that includes a variety of MA stakeholders to address the OIG, beneficiary and stakeholder concerns.

We thank you for the opportunity to provide comments related to this request for information. Should you have any questions concerning these comments, please contact Christie Sheets, NARA Executive Director at christie.sheets@naranet.org.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Kelly Cooney". The signature is fluid and cursive, with the first name "Kelly" and last name "Cooney" clearly distinguishable.

Kelly Cooney, M.A., CCC-SLP, CHC
President

National Association of Rehabilitation Providers and Agencies