DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

November 22, 2024

The Honorable Beth Van Duyne
U.S. House of Representatives
Washington, DC 20515

Dear Representative Van Duyne:

Thank you for your recent letter and suggestion to include inpatient rehabilitation facilities (IRFs) in Medicare Advantage (MA) network adequacy standards. I appreciate hearing from you about this important issue as the Centers for Medicare & Medicaid Services (CMS) continues its work to improve the MA program and ensure enrollee access to care.

MA organizations must provide enrollees with access to all medically necessary Medicare Part A and Part B benefits available under Traditional Medicare (with some limited exceptions), as provided in accordance with section 1852(a)(1) of the Social Security Act. Our rules at 42 C.F.R. 422.112(a)(1)(i) require that all MA organizations offering coordinated care plans maintain and monitor a network of contracted providers that is sufficient to provide adequate access to covered services to meet the needs of their enrollees. MA organizations must contract with the appropriate providers and facilities to provide adequate access to services for enrollees in the plan. This means that enrollees are entitled to medically necessary care, including IRF care, regardless of whether network adequacy criteria are set for a specific specialty or facility type.

Regarding network adequacy requirements, regulations at 42 C.F.R. 422.116(b) include a list of both provider and facility-specialty types to which the network adequacy standards under MA applies. IRFs are not currently included in this list. In May 2020, CMS issued the Contract Year 2021 MA and Part D final rule (85 FR 33796), which finalized network adequacy rules for MA plans and established the regulations at 42 C.F.R. 422.116(b). This final rule also included a discussion in response to comments suggesting that CMS add additional providers to the list of facility specialty types for which CMS set these network adequacy standards. As discussed in the final rule, CMS identified which providers and facility specialty types are critical and necessary to evaluate separately based on a review of Medicare Fee-for-Service (FFS) utilization patterns, utilization of provider/facility specialty types in Medicare FFS, specialties in other managed care programs, and the clinical needs of Medicare beneficiaries (85 FR 33858). CMS would need to go through notice-and-comment rulemaking to add any provider and facility-specialty types, including IRFs, to the list of provider and facility-specialty types under 42 C.F.R. 422.116.

Your letter also asks about utilization and prior authorization with respect to IRF care. CMS currently collects data through a variety of sources (including Part C reporting requirements, program audits, independent review entity decisions, encounter data, and individual provider

complaints) to evaluate utilization trends, service requests and appeals decisions, and to ensure that MA plans are complying with CMS requirements. On January 25, 2024, CMS issued a Request for Information (RFI) to solicit information from the public on how best to enhance MA data capabilities and increase public transparency.[1] In this RFI, CMS requested comments on all aspects of data related to the MA program—both data not currently collected, as well as data currently collected. We were especially interested in: data-related recommendations related to beneficiary access to care, including provider directories and networks; prior authorization and utilization management, including denials of care and beneficiary experience with appeals processes, as well as use and reliance on algorithms; cost and utilization of different supplemental benefits; all aspects of MA marketing and consumer decision-making; care quality and outcomes, including value-based care arrangements and health equity; healthy competition in the market, including the impact of mergers and acquisitions, high levels of enrollment concentration, and the effects of vertical integration; data topics related to MA prescription drug plans; and special populations, such as individuals dually eligible for Medicare and Medicaid, individuals with end stage renal disease, and other enrollees with complex conditions. Comments received on the MA Data RFI will be used to strengthen CMS's data capabilities and MA transparency efforts.

Regarding prior authorization, CMS issued the CMS Interoperability and Prior Authorization final rule (89 FR 8758), which appeared in the *Federal Register* on February 8, 2024.[2] In the CMS Interoperability and Prior Authorization final rule, CMS finalized new requirements for MA organizations regarding prior authorization, including requiring MA organizations and other impacted payers to annually publicly report certain prior authorization metrics. The rule also finalized requirements for MA organizations and other affected payers to provide a specific reason for denied prior authorization decisions to the provider, as well as to the enrollee, among other new prior authorization policies. Additionally, on April 5, 2023, CMS issued the Contract Year 2024 MA and Part D final rule (88 FR 22120)[3], which, among other things, clarified clinical criteria guidelines to ensure that people with MA receive access to the same medically necessary care they would receive in Traditional Medicare. Specifically, CMS clarified rules related to acceptable coverage criteria for basic benefits by clarifying that MA plans must comply with national coverage determinations, local coverage determinations applicable to the MA plan's service area, and general coverage and benefit conditions included in Traditional Medicare statutes and regulations.

[1] Available at: https://www.federalregister.gov/public-inspection/2024-01832/request-for-information-medicare-advantage-data.
[2] Available at: https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability.
[3] Available at: https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program.

Thank you again for your letter. We appreciate your feedback on the requirements applicable to network adequacy, and we will take it into consideration in future policy development. If you have additional thoughts or questions, please have your staff contact the CMS Office of Legislation.

Sincerely,

Chiquita Brooks-LaSure

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