AMRPA
AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

November 30, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-2020-0093 (CY 2022 Medicare Advantage and Part D Advance Notice Parts I and II)

Dear Administrator Verma:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we are submitting this letter regarding the proposed updates to the Medicare Advantage (MA) Part C and Part D program through the calendar year (CY) 2022 Advance Notice released by the Centers for Medicare and Medicaid Services (CMS). AMRPA is the national voluntary trade association representing more than 650 inpatient rehabilitation hospitals and units (referred to by Medicare as inpatient rehabilitation facilities, or IRFs). IRFs provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from care provided in non-hospital post-acute care (PAC) settings – one of the many reasons that patient access to IRF services in the Medicare program is a top policy priority for AMRPA member hospitals.

AMRPA and its member hospitals very much appreciate all of the efforts CMS has made to support providers during the COVID-19 public health emergency (PHE). Through many of the IRF-specific regulatory flexibilities granted by CMS, IRFs have emerged as front-line providers during this PHE, treating seriously afflicted and recovering COVID-19 patients, and also taking on acute-care surge patients in communities that have exceeded acute-care hospital bed capacity. In particular, CMS' recommendation that MA plans waive prior authorization in the early months of the PHE led to a near-universal suspension of these policies, which facilitated patient access to the safe and effective hospital-level care offered by IRFs at one of the most critical times of the pandemic.

This temporary waiver period affirmed many of the concerns that AMRPA has raised in prior comments regarding the use of prior authorization in the MA program. As AMRPA has reiterated in response to prior years' Advance Notices, prior authorization practices severely restrict access to needed IRF care, and place serious strain on hospital resources and staff. These issues were exacerbated in the early stages of the COVID-19 PHE until the plan waivers facilitated much-needed relief to acute-hospitals, IRFs, and most critically, patients and their families. Now that MA plans have generally reinstated these policies, AMRPA members are once again reporting issues tied to prior authorization in discharges from acute-care hospitals and admissions to IRFs, which is typing up valuable resources that are needed to meet the needs of surges of COVID-19 and other patients throughout the country.

In the short term, AMRPA strongly urges CMS to use its discretionary authority and require MA plans to waive prior authorization policies for the duration of the PHE. The strains on acute-care

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hospitals and the need for hospital-level post-acute care by many COVID-19 survivors are even more heightened now than during the earlier prior authorization waiver period. For reference, we have attached a dataset showing the clear benefits tied to earlier prior authorization waivers during the PHE, as patients were able to access safe and effective IRF care in a more timely way without any evidence that such waivers led to unnecessary, lower acuity, or inappropriate IRF admissions (please see Appendix A). We also provide a high-level analysis of data collected during 2020 that demonstrates the benefits that accrued to patients during the prior authorization waiver period, supporting the need for immediate action on this issue.

In the longer term, AMRPA reiterates many of our previous recommendations aimed at addressing some of the specific issues with prior authorization practices that are facilitating delayed admission decisions and unfair denials. Even before the PHE, these practices were creating serious administrative burdens for our hospitals and adversely affecting patient care and recovery. With the myriad of new challenges facing hospitals – ranging from staff shortages to PPE access – the burdens created by prior authorization are simply untenable. The second section of our letter outlines the specific steps we urge CMS to take to ensure that prior authorization policies

Our specific recommendations follow:

I. Medicare Advantage Prior Authorization is Particularly Problematic During the PHE

As discussed above, MA prior authorization is a deeply troubling problem that diverts provider resources away from patient care and inhibits beneficiaries' access to important treatment. While prior authorization is concerning during ordinary times, it is particularly problematic during the ongoing COVID-19 pandemic – at a time when providers and resources are increasingly stretched thin. As acute-care hospitals are faced with limited beds and staffing shortages, it is inappropriate to prolong acute-care stays when the patient is ready for discharge to an IRF, or to require providers to rearrange their schedules and divert their attention from patient care to a prior authorization request or appeal.

In an indirect concession of these facts, many MA plans voluntarily suspended prior authorization for short periods during the early phases of the PHE. However, most plans have since reinstituted the policies – despite significant and widespread surges of cases across the country - and in doing so are subjecting beneficiaries, acute-care hospitals, and the Medicare program once again to unnecessary risk and unjustified expense.

a. Temporary Relaxation of Medicare Advantage Prior Authorization Did Not Lead to Inappropriate IRF Admissions

MedPAC data shows that under typical circumstances, MA beneficiaries make up only 1 out of 5 Medicare beneficiaries in IRFs, despite representing approximately 1 in 3 of total Medicare beneficiaries.[1] An analysis conducted by AMRPA and utilizing data from eRehabData®, demonstrated that during the period in which MA plans suspended prior authorization during 2020, MA enrollees were admitted to IRFs at a rate proportionate to FFS beneficiaries. Specifically, in Q2 2020, FFS beneficiaries represented 69.54 percent of IRF admissions and MA enrollees represented 30.46 percent.

[1] E.g., MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 298 (Mar. 2017) (finding that 2015 Medicare admissions to IRH/Us were 10.3 for every 1,000 FFS patients compared to 3.7 for every 1,000 MA patients).

This change in admissions patterns was clearly the result of the aforementioned temporary suspension of prior authorization requirements in the early phases of the PHE. Importantly, this change in trends was not due to COVID-19 patients, as COVID-19 patients only made up a small portion of IRF admissions during the time period. In addition, the age, average length of stay (ALOS), and case mix index (CMI) for MA admissions was comparable to time periods prior to the PHE and Rehabilitation Impairment Categories (RICs) for MA enrollees were more consistent with typically admitted FFS beneficiaries. As MA plans have reinstituted prior authorization policies, MA admissions to IRFs have one again dropped to disproportionate rates. In Q3 2020, FFS beneficiaries rebounded to 76.45 percent of IRF admissions while MA enrollee admissions to IRFs dropped to 23.55 percent.

It is clear from this analysis that prior authorization requirements do not prevent inappropriate admissions to IRFs – a claim proponents assert. Instead, the requirements simply create a barrier to care for beneficiaries and lead to excess spending within the Medicare program.

b. Recommendations for Current and Future PHEs

AMRPA appreciates CMS' guidance that encouraged MA plans to waive prior authorization in the early phases of the PHE. However, AMRPA asks that CMS go further and use its discretionary authority to fully suspend prior authorization practices for the duration of the PHE. This is especially necessary in light of the outsized number of COVID-19 patients who are in need of intensive rehabilitation services – which is regularly the focus of prior authorization denials, and the widespread surge in COVID-19 cases across the nation.

Given the number of plans that have reinstituted their prior authorization policies, it is critical that CMS take timely action in this area. Doing this will ensure patients continue to move to appropriate settings of care as rapidly as possible, maximizing hospital beds, staffing and other resources. Further, AMRPA urges CMS to institute a policy prohibiting the use of prior authorization by MA plans during any future PHE.

II. Overarching Recommendations for the Medicare Advantage Program

IRFs are unique in the post-acute care continuum by offering hospital-level, specialized care for Medicare beneficiaries. Patients in an IRF are closely supervised by a physician, who also oversees patients' overall rehabilitation treatment, which includes multi-disciplinary, intensive therapy services.[2] Further, IRFs are now also playing an even more critical and unique role as they provide highly specialized and comprehensive rehabilitation care for COVID-19 survivors.

In addition, IRFs already conduct a rigorous screening process for all patients prior to admission. Medicare regulations require that IRFs perform a pre-admission screening, and that a specialized physician approve of all admissions.[3] Despite these procedures, as well as the life-changing (and cost-saving) benefits offered by IRFs, MA plans use prior authorization tactics to inappropriately deny patients access, ultimately precluding them from returning to their full potential.

[2] 42 C.F.R § 412.622.
[3] *Id.*

AMRPA believes the PHE has demonstrated the clear need for many of the broader recommendations we have made in prior comment letters pertaining to prior authorization. These recommendations are generally focused on facilitating more timely, better informed, and transparent admission determinations, which will help ensure MA beneficiaries are able to access the PAC services they need going forward. In summary, our key recommendations include:

- MA plan medical reviewers used in making IRF admission determinations must have relevant experience and expertise in medical rehabilitation.
- MA plan medical reviewers must communicate with all clinicians involved in the discharge planning process.
- MA plans must provide determinations and redeterminations within 24 hours, 7 days/week, including holidays.
- MA plans must provide more transparency into the prior authorization process by submitting any proprietary decision tools to HHS for review, and HHS in turn should prohibit the use of any guidelines that do not comport with Medicare coverage requirements.
- MA plans must ensure enrollees are fully informed about Medicare coverage rules, their redetermination and appeal rights, along with information about resources to navigate the process.

a. Qualified Clinicians Must be Involved in the Medical Review Process

As a result of CMS regulations, IRFs are required to employ a rehabilitation physician with specialized training in pre-admission review to determine the appropriateness of a patient's admission to an IRF, consistent with Medicare regulations.[4] In contrast, managed care organizations often employ reviewers who lack relevant clinical experience to advise on referrals for inpatient rehabilitation. Based on AMRPA members' experiences, it is rare for a MA plan's medical reviewer to have any expertise or even baseline knowledge in medical rehabilitation, and thus most reviewers are often unable to understand the patient's rehabilitation needs.

Our members also report that a substantial number of MA plans will only correspond with the referring physician from the acute-care setting, who may be less qualified to make a determination related to medical rehabilitation, and also often refuse to correspond with the medical director of the referred-to setting, such as an IRF. This is a particularly troublesome practice at a time when acute-care hospitals are faced with significant and more immediate patient care demands due to the PHE. To ensure patients are entitled to informed medical review, MA plans should be required to elevate an appeal to a clinician with relevant expertise within a reasonable amount of time. Further, CMS should direct MA plans to correspond with any clinician involved in the discharge planning process when making referral determinations and redeterminations.

b. Medicare Advantage Prior Authorization Should Not Create Unnecessary Delays

IRFs, like all hospitals, are 24/7 operations, providing acute-level care 365 days per year. Despite this, AMRPA members report extensive delays in receiving responses from MA plans on prior authorization determinations, particularly when such determinations are needed over a weekend or holiday. It often takes up to 3 business days for providers to receive a response for a request to admit a patient to an IRF. If the request is made while approaching a weekend or holiday, the request is further delayed. This means patients can often unnecessarily spend 3-5 additional days

[4] 42 C.F.R. § 412.622(a)(4)(i).

in an acute-care hospital waiting for a MA plan decision. Not only do these delays impede the beneficiary's recovery, but it also costs acute-care hospitals and Medicare unnecessary dollars.

Once the initial decision is reached, many providers must then appeal the initial decision due to the high number of erroneous initial denials. MA plans offer limited timeframes for these appeals that require physicians and/or other hospital personnel to rearrange their schedules to meet the demands of the MA plan's review requests, which often leads to the MA plan continuing to override the medical judgements of the treating clinicians. The end result of current MA practices is that patients spend an unnecessary amount of additional days in the acute-care hospital, and the acute-care hospital and IRF devotes unconscionable resources to accomplish admission of a fully appropriate patient. This is all the more problematic during the COVID-19 pandemic, as providers need to be able to focus their full attention on caring for patients and mitigating the effects of the coronavirus, and acute-care hospitals are facing profound limitations in regards to bed availability and staffing.

CMS must ensure beneficiaries are not unnecessarily delayed in their treatment by enforcing existing timelines, and should work with plans to further expedite their processes to enable timely appeals. At a minimum, MA plans should be able to review and process post-acute care prior authorizations and redeterminations seven days a week and should never take more than 24 hours to respond. In addition to ensuring technical conformance with regulations, CMS must also do more to also ensure that hospitalized patients actually receive decisions that are timely enough to impact their future trajectory of care. Without this assurance, appeal rights are hollow.

c. Proprietary Guidelines Do Not Comply with Medicare Coverage Requirements and Lead to Decreased Access

Admission and treatment in an IRF is a Medicare covered benefit, and Medicare regulations are clear that MA plans must provide "all Medicare-covered services."[5] Further, MA plans must comply with all Medicare coverage regulations and manuals.[6] Instead of following these Medicare IRF coverage criteria, many MA plans often inappropriately deny access to IRFs for patients in need of these services through the application of private decision tools, such as Milliman and InterQual, to make coverage decisions that override clinical decision-making, both prospectively and retrospectively.

These proprietary guidelines do not appear to mirror Medicare coverage but are nevertheless being used to deny patients access to medically necessary and clinically appropriate medical rehabilitation services. MA plans often refuse to share their placement assessments with providers, caregivers or others on the basis that the underlying decision tool is proprietary. AMRPA has sought to understand the Milliman product and through small-sample modeling it has become clear that virtually no patients are recommended for placement in the IRF setting, including those recovering from major strokes with paralysis and other debilitating injury and illness.

This is particularly concerning in light of the COVID-19 pandemic, in which many recovering COVID-19 survivors are critically in need of the intensive rehabilitation services offered by

[5] Id. § 412.604.
[6] Id. §§ 422.10(c) & 422.101(b).

IRFs, in which this novel disease may not be accounted for in these previously developed placement tools.

To avoid such blatant disregard for Medicare requirements, especially at such an unprecedented time for the healthcare system, AMRPA requests that CMS instruct MA plans to (1) submit any proprietary guidelines used by the plans, and (2) ensure that such guidelines are consistent with CMS' coverage regulations governing IRFs.

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AMRPA appreciates the opportunity to comment on the Medicare Part C program. We look forward to continued engagement with CMS, and we hope that our comments will help to guide the agency's future work. If you have any questions about AMRPA's recommendations, please contact Kate Beller, J.D., AMRPA Executive Vice President for Government Relations and Policy Development (kbeller@amrpa.org / 202-207-1132).

Sincerely,

Anthony Cuzzola
Chairman, Board of Directors, American Medical Rehabilitation Providers Association (AMRPA)

Appendix A

Comparison of Traditional Medicare and Medicare Advantage Discharges Before and During the COVID-19 Public Health Emergency

Key Points:

- Due to suspension of prior authorization in Q2 2020 by most Medicare Advantage (MA) plans, beneficiaries were able to be admitted to IRFs at a rate proportionate to their Part A Medicare beneficiary counterparts. This change was not driven primarily by COVID-19 patients, which made up a small proportion of IRF admissions.
- Further, the age, CMI and ALOS of MA admissions remained consistent with pre-Public Health Emergency (PHE) levels during this time period. In addition, the distribution of MA beneficiaries by Rehabilitation Impairment Categories (RICs) more closely matched the distribution of Part A Medicare beneficiaries. **This data refutes assertions that prior authorization policies prevent unnecessary, lower acuity, or inappropriate IRF admissions.**
- 76.2% of MA patients admitted to IRFs in Q2 2020 were discharged to community, demonstrating the excellent clinical outcomes delivered by the IRFs. According to the most recent MedPAC data, only 41% of SNF patients were discharged to home.
- In short, the different cost structure of IRFs is directly tied the capability and capacity of IRFs to deliver high-quality and high-intensity care (both during and after a PHE) that other PAC settings cannot do as well or as safely. Allowing admission decisions to be based on cost rather than outcomes, appropriateness of the setting, and likelihood of the patient being discharged home runs counter to patient interests.
- As MA plans reinstate prior authorization policies, AMRPA urges CMS to assess how these prior authorization policies adversely impact patient access to IRFs, particularly as the PHE continues to impact acute hospital capacity across the country. If such policies are allowed to remain in place without commonsense reforms – such as prohibiting proprietary guidelines that run afoul of Medicare coverage guidelines - AMRPA remains highly concerned about MA patient access to medically necessary IRF care.
- AMRPA's primary recommendations related to MA prior authorization reform remain the same as before the PHE, but these changes are now all the more critical in light of post-acute care providers' (PACs') response to COVID-19. AMRPA therefore urges CMS <u>to act within its authority to take the following actions as soon as practical</u>:
    - Prior authorization determinations – both initial determinations and any appeal of such determination – must each be completed in a 6-hour timeframe in order to avoid unnecessary delays in the acute-hospital setting. The current timeframes (generally 72 hours) often result in patients being discharged to a less appropriate setting to alleviate hospital capacity issues (this issue has been exacerbated during the COVID-19 PHE).
    - Require MA plans to respond to prior authorization requests over the weekends and on holidays, consistent with the "24/7" operation of the hospitals subject to these policies.
    - MA plans must submit guidelines or algorithms used as part of their PAC admission determinations to HHS.

- Any guidelines submitted by MA plans that are inconsistent with Medicare coverage rules must be prohibited.

Data Background:

- In 2019, and consistent with previous years, MA beneficiaries represented only 1 in 5 Medicare IRF Admissions (20.1%: 79.9%), despite representing approximately 1 in 3 Medicare beneficiaries in total.
- Hospitals consistently report that MA plans engage in an overly restrictive prior authorization process that often denies MA beneficiaries access to medically necessary IRF care.
- Beginning in March 2020, many MA plans voluntarily suspended prior authorization in response to the COVID-19 public health emergency (PHE), which is largely attributable to CMS' guidance encouraging plans to take such action. Utilizing real time data on IRF admissions from eRehabData®, pre-PHE admissions (Q4 2019) were able to be compared to Q2 (April-June) of 2020 as well as two months of Q3 2020.
- Although the PHE is still in effect, MA plans have largely re-implemented prior authorization policies; this immediately resulted in decreased access to IRFs for Medicare MA patients in Q3 2020.

FINDINGS: ADMISSIONS, COVID-19 PATIENTS, CMI, AGE & AVERAGE LENGTH OF STAY (ALOS)

Comparison of Medicare and MA Patients' Use of IRF services						
	Q4 2019		Q2 2020		Q3 2020	
	Part A Medicare Patients	MA Patients	Part A Medicare Patients	MA Patients	Part A Medicare Patients	MA Patients
FFS vs. MA Admissions	79.93%	20.07%	69.54%	30.46%	76.45%	23.55%
COVID-19 Patients	0%	0%	4.45%	8.47%	4.68%	7.05%
Case Mix Index	1.42	1.54	1.50	1.53	1.49	1.57
Average Age	78.12	73.21	74.76	74.19	74.32	72.44
Average Length Of Stay	11.91	14.26	12.39	13.06	13.02	14.67

Source: eRehabData®

- During Q2 of 2020, MA beneficiary admissions to IRFs increased to the volumes proportionate with the overall MA and traditional Medicare beneficiary population. However, 8.47% of the MA beneficiaries were COVID-19 patients. In Q3 to date, this percentage has decreased to 7.05%.
- Part A COVID-19 beneficiaries were 4.45% and 4.68% of IRF admissions in Q2 and Q3 respectively.

- This suggests that MA plans favor COVID-19 patients for IRF admission while denying authorization to other beneficiaries.
- Further, the MA population admitted during the PHE was not materially different from those that were admitted prior to the PHE in terms of age, case mix index (CMI) and ALOS.

FINDINGS: CMI BY RIC GROUP

CMI of Medicare patients and MA patients by RIC group						
RIC group	Q4 2019		Q2 2020		Q3 2020	
	Part A Medicare Patients	MA Patients	Part A Medicare Patients	MA Patients	Part A Medicare Patients	MA Patients
1 Stroke	1.66	1.67	1.73	1.74	1.74	1.74
2 Brain Injury	1.42	1.50	1.48	1.49	1.49	1.51
3 Spinal Cord Injury	1.66	1.75	1.80	1.86	1.75	1.80
4 Orthopedic	1.30	1.34	1.40	1.39	1.37	1.37
5 Neurological	1.42	1.49	1.53	1.50	1.49	1.55
6 General Rehab/Medical	1.28	1.29	1.34	1.33	1.33	1.36

- The MA population admitted to IRFs across Rehabilitation Impairment Groups (RICs) (except Brain Injury) were of a higher acuity than the Medicare Part A prior to the PHE. These data are consistent with a prior authorization process which creates a barrier to access to IRFs for MA beneficiaries.

FINDINGS: COMMUNITY DISCHARGE RATES IN FFS AND MA

Percentage of Medicare Patients (Part A or MCO) Community Discharge from IRF						
	Q4 2019		Q2 2020		Q3 2020	
Discharge Setting	Part A Medicare Patients	MA Patients	Part A Medicare Patients	MA Patients	Part A Medicare Patients	MA Patients
Community	78.57%	74.92%	77.29%	77.29%	74.15%	71.83%

Source: eRehabData®

- IRFs delivered superior clinical outcomes for all Medicare patients (Part A and MA) with very high percentages of discharge to community.
- Community Discharge includes patients with IRF-PAI codes 01—Home; 04—Intermediate Care; 06—Home under care of organized home health service organization; or 50—Hospice (Home).

FINDINGS: FFS VS. MA PATIENTS PER RIC GROUP

Percentage of Medicare Patients and MA Patients with RIC group						
	Q4 2019		Q2 2020		Q3 2020	
RIC group	Part A Medicare Patients	MA Patients	Part A Medicare Patients	MA Patients	Part A Medicare Patients	MA Patients
1 Stroke	67.41%	32.59%	61.98%	38.02%	64.45%	35.55%
2 Brain Injury	78.28%	21.72%	72.14%	27.86%	74.57%	25.43%
3 Spinal Cord Injury	74.75%	25.25%	64.58%	35.42%	72.92%	27.08%
4 Orthopedic	86.62%	13.38%	72.40%	27.60%	82.58%	17.42%
5 Neurological	86.53%	13.47%	75.04%	24.96%	82.22%	17.78%
6 General	86.68%	13.32%	71.74%	28.26%	81.64%	18.36%

Source: eRehabData®

- The ratio of beneficiaries covered in MA versus part A is 1 in 3 or 33.3% to 66.6%. Without a prejudiced admission policy, the ratio of Medicare patients admitted to IRF should also be 1 in 3 or 33.3% MA to 66.6% Part A. The above charts show that, while Stroke matches the expected ratio, other groups approached the correct ratio only in Q2 while prior authorization was suspended and illustrate the typical discriminatory practices in the time periods before and after.
- The data also suggest medically appropriate MA patients in the diagnostic groups Brain Injury, and Spinal Cord, but particularly Orthopedic, Neurological and General Rehabilitation were inappropriately denied admittance to the IRF.