AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

March 13, 2023

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–0057–P
P.O. Box 8013
Baltimore, MD 21244-8013

Delivered Electronically

Re: Response to the Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program, 87 Fed. Reg. 76238 (December 13, 2022)

Dear Administrator Brooks-LaSure:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to offer our comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule that seeks to modernize prior authorization processes for certain payers (hereinafter referred to as "the Proposed Rule"). AMRPA has long advocated for wide-ranging improvements to the types of prior authorization practices and other utilization management techniques used by payers, particularly Medicare Advantage (MA) plans, and we greatly appreciate CMS' heightened interest in these issues in recent months.

By way of background, AMRPA is the national trade association representing more than 700 inpatient rehabilitation hospitals and units (referred to by CMS as Inpatient Rehabilitation Facilities, or IRFs). IRFs play a unique and critical role in providing hospital-level rehabilitation care to beneficiaries requiring ongoing and intensive care following acute care hospitalization, such as patients recovering from stroke, traumatic brain injury, and traumatic spinal cord injury, among other serious conditions. Given the complexity of patients requiring inpatient rehabilitation and the well-evidenced connection between the onset of an intensive therapy program and patient outcomes, it is imperative that all payers facilitate timely access to medically necessary inpatient rehabilitation. We therefore strongly support recent regulatory efforts to address some of the major barriers that MA plans and other payers are using to restrict admissions for medically necessary IRF care, and our comprehensive comments on CMS' recent proposed rule specific to prior authorization in the Medicare Advantage program is included in Appendix I.

With respect to the Proposed Rule, AMRPA appreciates CMS' stated interest in "streamlining processes related to prior authorization," "shortening the timeframe for certain payers to respond to prior authorization requests," and "establishing policies to make the prior authorization process more efficient and transparent." AMRPA shares these goals and stands ready to work with CMS to identify policy reforms that can help achieve these outcomes across payers. We are concerned, however, that the current proposal does not go far enough to meaningfully address problematic payer behavior with respect to decision timeframes and care delays, nor would it enable patients and providers to determine how often payers fail to furnish statutorily covered benefits (such as IRF services) on a setting-specific basis – information that we believe is imperative as patients choose between plans and programs.

In light of our shared prior authorization reform goals and the additional steps necessary to improve the way that payers utilize prior authorization specific to IRF services, AMRPA offers the following recommendations:

- **Accelerated Timeframe for Prior Authorization Determinations:** Given the well-documented issues surrounding care delays and recovery time lost by patients while they await prior authorization determinations in the acute-care hospital, we urge CMS to *reduce* the current timeframe for payers to respond to expedited authorization requests (such as post-acute care authorizations). Maintaining the current 72-hour timeframe as it applies in the MA program will not alter payer behavior and will therefore continue to result in unnecessary short-term acute care hospital (STACH) days, or worse, force patients into less appropriate, lower-intensity settings due to the multi-day wait for authorizations. **AMRPA therefore recommends that CMS reduce the timeframe for expedited requests from 72 hours to 24 hours, and clarify that the 24-hour timeframe applies across weekends and holidays**.

- **Making Reported Data More Useable for Patients and Providers:** While the Proposed Rule laudably looks to improve transparency surrounding prior authorization practices, the current proposal would require payers to post data on metrics such as approvals, denials, and timeframes on an aggregate level (covering all services and items covered by the payer). AMRPA is concerned that this structure would not provide stakeholders with information on services that are particularly vulnerable to erroneous denials or problematic authorization timeframes, such as inpatient rehabilitation.[1] **We therefore recommend that this type of data be posted on a service-specific basis and published in a way that is easily accessible to and understood by enrollees**.

- **Improved Timeline for Key Reforms:** As CMS recognizes in several segments of the Proposed Rule, prior authorization reforms are necessary to reduce care delays and improve patient outcomes. These are critical, time-sensitive goals, and we therefore urge CMS to accelerate the proposed 2026 implementation date for many of its proposals. We note that CMS proposed a host of reforms (such as enhanced reviewer qualification standards and improved adherence to Medicare coverage criteria) for MA plans in Contract Year 2024,

[1] See, e.g., the Medicare Payment Advisory Commission (MedPAC) March 2017 Report to Congress, finding that MA beneficiaries are able to utilize IRF services at one-third the level of traditional Medicare beneficiaries. MedPAC Report to The Congress: Medicare Payment Policy, pg. 298 (Mar. 2017).

and that such a timeframe should be the target for all prior authorization refinements. **Even if certain technological advancements contemplated in this rule are not feasible in a one-year timeframe, CMS should look to implement as many complementary reforms in a one-year period as possible to address the concerningly high rate of inappropriate prior authorization denials and avoidable care delays**.[2]

We appreciate CMS' consideration of these proposal refinements, and we provide additional supporting detail and specific implementation recommendations below.

I. CMS Must Adopt a 24-Hour Response Deadline for IRF Admissions and Other Time-Sensitive Admission Determinations

Proposed Rule Provisions: Under the Proposed Rule, impacted payers would need to implement new technological standards for their prior authorization processes, such as creating an automated process for providers to determine whether prior authorization is required for a service, providing timely updates on the payer's determination, and requiring the payer to transmit specific reasons for the denial of a prior authorization request. AMRPA strongly supports these efforts and believes these are commonsense ways to modernize payer practices and facilitate the exchange of much-needed data to patients' care teams. This is particularly important given the impact of effective payer-provider communications on timely and appropriate post-acute care placements.

One of the most important features of the proposed "streamlined" prior authorization process centers on the timeframe in which payers must render prior authorization determinations. With the exclusion of certain payers, most federal payers (including MA plans) would need to send prior authorization decisions within 7 days for standard requests and within 72-hours (3 days) for expedited requests. For MA plans, this proposal would shorten the response timeframe for standard requests from 14 days to 7 days, but maintains the existing timeframe for expedited requests. CMS seeks comment on alternative timeframes with shorter turnaround times, noting the potential merits of requiring 5 days for standard requests and 48-hours (2 days) for expedited requests. Consistent with current policy, CMS is not proposing that these timeframes would take into account weekends and holidays (which, in practice, can add several more days to a payer's determination timeframe and corresponding patient care delays). In nearly all circumstances, IRF admissions are currently categorized as decisions requiring an "expedited" request.

AMRPA Response: AMRPA has long been concerned that the 72-hour timeframe for expedited requests is unworkable for patients requiring inpatient rehabilitation, and this substandard requirement has led to persistent and widespread abuses by payers. Because the 72-hour timeframe does not include weekends, AMRPA members consistently report that payers (particularly MA plans) purposely time their prior authorization determination clock to start on Friday afternoons, essentially creating a 5-day timeframe for their decision. Members also report that plans use stall tactics to delay their determination timeframe (such as requiring daily therapy

[2] See, e.g., HHS Office of Inspector General Report, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care* (April 2022), finding that MA plans denied nearly 15% of prior authorization requests that in fact met Medicare coverage rules, and that IRF services were cited as a service vulnerable to such denials.

notes) rather than relying on the rehabilitation physician's clinical judgment. These practices lead to either wasted STACH days in which the patient is delaying their intensive rehabilitation program (impeding their ultimate recovery), or they must simply be moved to a less appropriate setting if the STACH is unable to wait for the payer's determination.

The detrimental impacts of the current 72-hour standard for patients needing IRF care was starkly illustrated in AMRPA's 2021 member survey.[3] Based on the results of the survey (representing over 12,000 prior authorization requests for IRF services in August 2021), roughly 85% of IRFs waited more than 2 days on average for all requests.[4] In practice, this amounted to patients spending nearly 31,000 days in a STACH waiting for a determination, and approximately 14,000 STACH wait days were accumulated for requests that were approved without dispute.[5] As CMS is aware, any delay in beginning rehabilitation treatment can have dramatic and negative effects on patients' recovery, functionality, and quality of life. Furthermore, the total wait time attributable to prior authorization responses also creates special costs and burdens to the IRFs and acute hospitals, as our members need to hold a bed open in anticipation of eventually receiving the patient and inpatient hospitals must keep ready to discharge patients at their hospitals. These delays effectively limit the number of beds available and reduce overall care access for some of the most vulnerable patients in the healthcare system.[6]

While AMRPA recognizes that CMS' proposed timeframes may be appropriate for other services or items, special consideration must be made when a prior authorization determination affects a patient needing continuous hospital-level care. **AMRPA therefore urges the agency to adopt a 24-hour standard for truly "urgent" determinations, such as those involving an IRF admission.** By maintaining the current 72-hour standard, the Proposed Rule would not meaningfully address any of the critical patient care and safety issues revealed by the AMRPA member survey, as well as the anecdotes that AMRPA members consistently share with our association from the field in real time. In addition to adopting a 24-hour response requirement for IRF requests, **CMS should also mandate that payers respond to requests over the weekend and holidays** to ensure urgent patient needs are timely met. AMRPA notes that the *Improving Seniors Timely Access to Care Act* – a bill that received tremendous bipartisan support in the 117th Congress – also included a 24-hour timeframe for urgent prior authorization requests, and we strongly recommend that CMS adopt the same standard to ensure that urgent care needs are met.

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[3] Data were submitted by 102 respondents who provided information about a total of 475 RHUs, representing approximately 40% of the RHUs nationwide. The responses included IRFs from 47 states and Puerto Rico. Data on 12,157 PA requests for the month of August 2021 were included in the survey

[4] AMRPA Member Survey: *Access to Inpatient Rehabilitation for Medicare Advantage Beneficiaries: An Examination of Prior Authorization Practices* (Aug. 2021); available here.

[5] Id.

[6] Our data showed that the vast majority of IRFs (84%) around the country **wait two days or more**, on average, for an initial determination. Once a Reconsideration (the first level of appeal) is filed, it takes up to **another three days** for that decision to be issued. This means that it can take **six days or longer** from when the initial request is filed for a Reconsideration to be issued. Since more than 50% of patients are initially denied access, the lack of timely and meaningful recourse impacts the majority of patients that have been deemed in need of inpatient rehabilitation care by their treating physician.

In summary, AMRPA recommends the following specific changes with respect to prior authorization determination timeframes:

- CMS should reduce the timeframe for expedited prior authorization determinations from 72-hours to 24-hours and clarify that all admissions involving hospital-level care (such as IRF admissions) always qualify for the expedited timeframe.

- The new 24-hour standard for admissions involving hospital-level care (such as IRF admissions) should not include any exceptions for weekends and holidays, which would appropriately mirror the 24/7 operations of hospitals and patient needs.

II. CMS Should Consider Ways to Make the Transparency Requirements More Useable by Patients & Other Stakeholders

Proposed Rule Provisions: Under the Proposed Rule, impacted payers would need to publicly report aggregated metrics on the payer's website or via a publicly accessible hyperlink, such that different organizations' data may be found across multiple types of websites. The proposed reporting would be administered on an organizational level – meaning at the state level for Medicaid and CHIP fee-for-service payers, the plan level for Medicaid and CHIP managed care, the issuer level for the federal exchange issuers, and at the organizational level (rather than contract level) for MA plans.

CMS proposes a number of datapoints to be reported across payers, and proposes that this data be reported at the aggregate level (such that the data would reflect all items and services covered by the payer). The specific data points that would need to be reported include:

- A list of all items and services that require prior authorization;
- The percentage of standard prior authorization requests that were approved, aggregated for all items and services;
- The percentage of standard prior authorization requests that were denied, aggregated for all items and services;
- The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services;
- The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services;
- The percentage of expedited prior authorization requests that were approved, aggregated for all items and services;
- The percentage of expedited prior authorization requests that were denied, aggregated for all items and services;
- The average and median time that elapsed between the submission of a request and a determination by the payer, plan, or issuer, for standard prior authorization, aggregated for all items and services; and

- The average and median time that elapsed between the submission of a request and a decision by the payer, plan, or issuer, for expedited prior authorization, aggregated for all items and services.

The Proposed Rule does not mandate a standardized reporting format, and only goes as far as to "encourage" payers to consider readability and accessibility when posting the required data. While CMS states that this reporting is meant to give patients and providers a "better understanding of a payer's prior authorization review and approval process," the lack of a consistent reporting format could result in significant differences in the useability of the data posted across payers. Lastly, CMS is not currently proposing to tie the payer's performance metrics to any sort of quality program (e.g., the Star Ratings program in MA), though the Proposed Rule notes that the data may be used for the purposes of quality star ratings and similar programs in future rulemaking.

AMRPA Response: AMRPA has consistently advocated for more transparency regarding the way that payers use prior authorization and the accuracy and outcomes of their determinations. In concept, we believe that the proposal is an important step towards ensuring that current and future enrollees (as well as providers) have more detailed information on payers' utilization of prior authorization, the determination timeframes, denial rates, and overturn rates. However, we believe certain key refinements must be implemented in order for this data collection to provide meaningful information to enrollees when comparing and selecting payers.

First, **AMRPA recommends that payers be required to report the aforementioned information *by the types of services and items at issue on a setting-specific basis***. As evidenced by a range of sources – including MedPAC's analysis and AMRPA's member survey – there are clear and highly concerning differences in patient access to IRF services across payers. These unfair restrictions surrounding IRF services and other post-acute (PAC) care are likely a significant reason that MA enrollees are much more likely to exit the MA program and enroll in Traditional Medicare or another payer following major illness or injury (when such restrictions directly impact the enrollee).[7] AMRPA believes it is therefore imperative that enrollees, caregivers, and oversight entities have more specific information regarding the types of items and services for which payers may be unfairly restricting access or issuing erroneous prior authorization determinations that are ultimately overturned. Requiring payers to stratify this data by service would be a simple and meaningful step towards improving the transparency of payer practices and the useability of this data for patients.

AMRPA also encourages CMS to consider whether other datapoints may be helpful to collect as part of this transparency effort. For example, in the recent Contract Year 2024 Medicare Advantage proposed rule, CMS proposes to bolster qualification standards for any entity reviewing medical necessity in the MA program. CMS could improve its oversight of this potential new rule by requiring plans to report the qualifications of its review team (organized by service type). In addition, we urge CMS to be more specific about how plans must report their

[7] GAO Report; Medicare Advantage: Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending (June 2021). Available here: https://www.gao.gov/assets/gao-21-482.pdf (finding that stakeholders reported disenrolling from MA because of "potential limitations accessing specialized care," among other factors).

prior authorization overturn rates. A recent Kaiser Family Foundation study found that while only 11% of prior authorization denials were appealed, the *vast majority* (82%) were fully or partially overturned in favor of the patient upon reconsideration.[8] **We therefore urge CMS to report overturn rates by the level of appeal to demonstrate how often patients prevailed, particularly when they were able to attain an independent level of review.**

AMRPA would also like to reiterate points raised in our Contract Year 2024 MA comment letter (included as Appendix I) related to transparency surrounding proprietary guidelines. While AMRPA believes these guidelines should rarely, if ever, be permitted in the context of statutorily covered services such as IRF services, it is imperative that plans publicly post such guidelines in such circumstances. As CMS moves to require payers to post the type of information covered in the current proposed rule, we encourage CMS to consider whether this reporting could also include when payers utilize internal guidelines and the content of such guidelines.

Finally, **AMRPA urges CMS to ensure that the data reported by payers is easily searchable by enrollees and reported in a consistent and coherent way.** Allowing plans to determine where they post their data and the format that they use will make it exceedingly difficult for enrollees to find and compare payers with respect to their prior authorization practices. We are also concerned that this data collection will not be tied to any sort of quality program, creating concerns that plans will not have any incentive to change their practices aside from collecting data. As an alternative, CMS could use this payer-reported data in the same way it uses data reported by providers for quality improvement and patient education. For example, **plan denial and overturn rates, specified by setting, could be publicly posted on a consumer-facing site**, similar to the way consumers can use Care Compare in making their decisions regarding IRF care and other services. **CMS should also incorporate the data into quality reporting programs, such as Star Ratings in the MA program, to ensure that payers are immediately accountable for their performance metrics.**

In summary, AMRPA recommends the following specific changes with respect to CMS' prior authorization transparency provisions:

- CMS should require payers to post prior authorization utilization, approval, denial, and overturn data on a setting-specific basis to enable patients and providers to understand key metrics based on specific items and services.
- CMS should require payers to report other key metrics that are particularly useful to current and future enrollees, such as payers' appeal performance and the qualifications of those charged with making prior authorization determinations.
- Data should be reported in a uniform and easily searchable way that allows patients, families, providers, and other stakeholders to access and compare payer data.
- As CMS implements new types of public reporting for plans, CMS should consider expanding these requirements to include the proprietary guidelines and other internal guidelines used by MA plans and other payers.

[8] Kaiser Family Foundation; Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021 (February 2, 2023). Available here: https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/

- The data reported by payers should be directly tied to quality reporting programs such that payers are immediately accountable for their performance metrics.

III. CMS Should Expedite Implementation of Key Provisions to Protect Patient Access & Promote Transparency Across the Healthcare System

Proposed Rule Provisions: While CMS provides a few different implementation dates across proposals, some of the most important elements – including the prior authorization decision timeframes and reporting requirements – would not take effect until 2026. This provides a notably long implementation timeline of over three years. In addition, the Proposed Rule allows certain payers (e.g., state Medicaid, CHIP FFS programs, and qualified health plans on the federal exchanges) to seek an extension of the proposed implementation deadlines, or an exemption from certain proposed requirements. In the event of litigation or a change in Administration, or other delays, this timeframe could be pushed out even longer, despite the clear need for timely and comprehensive reform efforts.

AMRPA Response: AMRPA urges CMS to accelerate the implementation of numerous prior authorization reforms to the maximum extent possible. In response to the Contract Year 2024 MA proposed rule, AMRPA members submitted examples of egregious plan behavior that show the compelling need for immediate remedies. Waiting 3+ years to implement changes will only exacerbate the negative impact on patient care, the costs tied to unnecessary STACH wait times, and the incredible burdens created for patients, caregivers, and providers under the current prior authorization processes. While we commend CMS for recognizing that these practices need to be modernized, a long implementation period for reforms that are already long overdue does not serve the best interests of patients.

Importantly, many of the technology changes outlined in this rule are not new but simply add on to existing plan requirements. Specifically, plans should already have in place many of the application program interface (API) functionality and would merely update or add-on to these existing tools. Similarly, standards for electronic prior authorization have undergone robust testing and piloting, as opposed to requiring development. Given these facts, as well as the substantial notice provided in past rules and legislative efforts, plans should not require a three-year period to improve care for providers and patients.

AMRPA strongly supported the one-year timeframe for many of the prior authorization-related proposals contained in the Contract Year 2024 MA proposed rule. However, we note that a number of commenters (almost all MA plans) pushed for a longer implementation time – and in many cases cited this proposed rule as the rationale for such timeframe. With these practices directly impacting patient access to IRF services and other covered services on a day-to-day basis, we believe it is critical that CMS look to the most expedited timeframe possible. We therefore ask CMS to adopt a 2024 start date for any protections that can be feasibly implemented in that time.

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AMRPA greatly appreciates CMS' efforts to address longstanding issues tied to prior authorization across payers. While this Proposed Rule represents an important step forward, we urge CMS to finalize proposals with the recommendations offered above as soon as possible. We share CMS' goals of modernizing prior authorization practices and making such processes

more transparent for enrollees, and we believe the agency should work with stakeholders to accomplish these goals in an accelerated timeframe.

AMRPA is dedicated to protecting patient access to medically necessary rehabilitation, and we look forward to continuing our collaboration with CMS to eliminate unnecessary barriers to care such as those identified in the proposed rule. Should you have any questions or wish to discuss our comments further, please contact Kate Beller at KBeller@ampra.org.

Sincerely,

Anthony Cuzzola
Chair, AMRPA Board of Directors
VP/Administrator, JFK Johnson Rehabilitation Institute, Hackensack Meridian Health

Anne Marie McDonough
Chair, AMRPA Denials Management Committee
Senior Director of Rehabilitation Medicine, Staten Island University Hospital Northwell Health

Attached:

Attachment 1: AMRPA Comments on Contract Year 2024 Medicare Advantage Proposed Rule & Proposed Prior Authorization Reforms (CMS–4201–P)

Attachment 2: AMRPA Prior Authorization Survey Data