AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

March 7, 2022

The Honorable Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4192-P
P.O. Box 8013
Baltimore, MD 21244-8013

Delivered Electronically

Re: *Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Prior Authorization Request for Information; 87 Fed. Reg. 1842; (Jan. 12, 2022).*

Dear Administrator Brooks-LaSure:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we submit this letter in response to the *Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs* proposed rule. AMRPA is the national voluntary trade association representing more than 700 inpatient rehabilitation hospitals and units (referred to by Medicare as Inpatient Rehabilitation Facilities, or IRFs). IRFs play a unique role in providing hospital-level medical and rehabilitation care to Medicare beneficiaries. Our comments focus on CMS' *Request for Information on Prior Authorization for Hospital Transfers to Post-Acute Care Settings During a Public Health Emergency*. AMRPA is pleased to see CMS is addressing prior authorization (PA) because the Association has serious concerns about the adverse impact of these policies on hospitalized patients, both now while the public health emergency (PHE) is in place and also under more normal circumstances. We particularly appreciate the RFI's focus on some of the specific issues raised by AMRPA in previous correspondence.

AMRPA's concerns regarding PA practices pre-dates the PHE. Many of the harmful consequences of MA plans' PA conduct have continued during the pandemic, especially in more recent months. To help CMS identify appropriate policies to correct these issues, both within and outside of the PHE, we offer the following: (1) background on the essential role IRFs have played during the pandemic; (2) data we have collected during the PHE to show the actual waste and harm PA practices have caused; (3) explanations of the improper practices MA plans use to delay and deny IRF admissions, both before and during the COVID-19 PHE; and (4) AMRPA's recommendations to improve the health equity of patients who need rehabilitation hospital care while simultaneously reducing waste.

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As explained in more detail in this letter, IRFs have seen MA plans routinely and consistently divert beneficiaries away from IRFs to other inappropriate settings of care through use of improper PA tactics such as: reliance on unqualified reviewers; using flawed proprietary guidelines that conflict with Medicare overage rules; using delays in responding to transfer authorization requests to pressure hospitals and patients into using improper substitutes for IRF care; not providing real-time and responsive recourse to appeal adverse decisions; and several others. AMRPA's newly released study shows that MA plans routinely delay determinations for IRF admissions, harming beneficiaries and wasting substantial hospital resources. These practices, and the corresponding adverse impact on patient care and outcomes, warrant a multi-faceted response from policymakers.

AMRPA recommends the following:

- **CMS should seek and utilize the authority to suspend the use of prior authorization during future public health emergencies.**
- **CMS should impose a shorter, more clinically appropriate decision response requirements for patients who need to be transferred to an IRF.**
- **CMS should utilize its oversight authority to collect data on plan performance and enforce such timelines.**
- **CMS should ensure that PA determinations are only made by qualified personnel with training and experience that meets CMS standards.**
- **CMS should ban the use of proprietary guidelines that conflict with Medicare coverage rules.**

We appreciate your consideration and look forward to working with you to inform sound policy reforms moving forward.

I. IRFs and Post-Acute Care During the COVID-19 Pandemic

IRFs play a crucial role in the continuum of post-acute care (PAC). Most patients treated in an IRF are admitted directly from a stay in an acute-care hospital due to a serious accident or medical event. IRF patients commonly have conditions such as stroke, spinal cord injury, amputation, major multiple trauma, brain injury, neurological disorders, and other morbidities that have resulted in serious functional deficits and the need for continuing medical supervision. IRFs also have rehabilitated thousands of COVID-19 patients who have been seriously debilitated by this novel disease.

IRFs provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from care provided in non-hospital PAC settings. Patients in an IRF are closely supervised by a physician, who also oversees patients' overall rehabilitation treatment, which must include a minimum of 15 hours per week of intensive therapy services, as well as around-the-clock, specialized nursing care.[1] The rehabilitation physicians charged with overseeing all patient care in IRFs are required to meet specialized requirements for a rehabilitation physician,

[1] *See* 42 C.F.R § 412.622.

ensuring patients can progress through recovery with maximum efficiency and safety.[2] This level of care is critical for debilitated patients who are stable enough to be discharged from the acute-care hospital to begin intensive rehabilitation, but are at risk for medical complications without continued close medical management.

Since the start of the COVID-19 pandemic, IRFs' role has expanded as they have provided critical hospital capacity to additional types of patients to alleviate the burden on their communities' acute-care hospitals. A recent report authored by ATI Advisory detailed the way in which IRFs provided critical services throughout the various stages of pandemic across the nation, and enabled their communities to ensure proper care for all who needed it.[3] Key to enabling such a response, CMS used its authority to waive the traditional coverage criteria during the PHE.[4] Due to the sophisticated capabilities of IRFs, the field was also uniquely positioned to lead the way in caring for recovering COVID-19 patients who faced myriad functional challenges and medical complications. Using their specialized experience and expertise, thousands of COVID-19 patients were able to continue their road to recovery through an IRF stay. Many IRFs also continue to oversee the recovery of COVID-19 patients with long-term, chronic symptoms by establishing "long-COVID" clinics to apply their rehabilitative expertise to these complex conditions.

Unfortunately, during the course of the pandemic MA beneficiaries have faced the same systematic barriers to IRF care as prior to the PHE. As a result, these beneficiaries were faced with suboptimal functional recovery, a higher chance of re-admission to acute-care hospitals, and several other harmful consequences.

II. The Impact of PA on IRF Admissions and Patient Care Delays During the COVID-19 Public Health Emergency

AMRPA is able to provide several insightful data sets to CMS regarding improper MA PA practices during the COVID-19 PHE. The first data set is the result of a nationwide data collection effort conducted by AMRPA during the pandemic. The second set of data is an analysis of data from the early stages of the pandemic, compared to pre-pandemic data.

A. Delays and Denials During the COVID-19 Public Health Emergency

In August 2021, during a surge in COVID-19 cases nationwide due to the Delta variant, AMRPA collected data on the outcomes of MA PA requests for IRF admissions. A total of 475 IRFs—approximately 40% of all IRFs nationwide—submitted data on 12,157 requests for the survey month, representing IRFs from 47 states, plus the District of Columbia and Puerto Rico. A comprehensive summary of the data is included in a report attached as Appendix A to this document. Overall, this information strongly supports AMRPA's contentions that access

[2] *Id.*

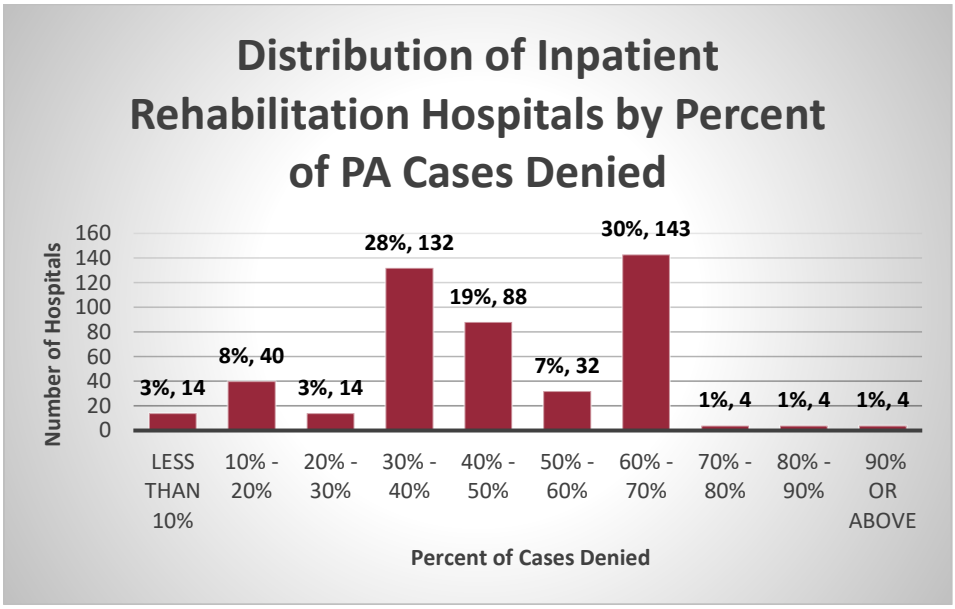
[3] *Role of Inpatient Rehabilitation Hospitals During the COVID-19 Pandemic*; ATI Advisory (December 2021) (https://amrpa.org/Portals/0/ROLE%20OF%20IRHS%20DURING%20COVID.pdf?ver=2021-12-14-090229-847).

[4] Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program; 85 Fed. Reg. 27,550 (May 8, 2020).

to IRFs is systematically and inappropriately limited by MA PA practices, which result in patient harm through tactical delays and denials, as well as significant costs to hospitals and the Medicare program.

Prior Authorization Requests for Admission to IRFs (August 2021)	
Percent of Initial Requests Denied	**53.32%**
Average Wait Time for Denied Requests	**2.59 Days**
Average Wait Time for Approved Requests	**2.49 Days**
Total Wait Days	**30,926**

As shown above, MA plans overruled rehabilitation physicians in more than half of cases. In addition, hospitalized patients waited two and half days or longer, on average, to receive a determination from an MA plan. This resulted in nearly 31,000 days waiting for determinations in just one month.



The results regarding denials and delays were nearly uniform across the country. As shown above, 87% of hospitals reported that at least 30% of its initial requests were denied. With respect to patient care delays, 84% of hospitals said they waited 2 days or longer for requests that were denied, and 57% said they waited 2 days or longer for approved requests.

These findings demonstrate the incredible strain that PA puts on hospitals and the Medicare program, as well as the denial of needed care for MA beneficiaries. At a time when hospitals were operating at emergency status, this survey captured **30,926 unnecessary hospital days** due to waits caused by PA. Remarkably, hospitals reported **14,152 days** spent waiting just for cases that were approved, demonstrating that even when MA plans allow access to IRFs, the PA process consumes valuable hospital resources and unnecessarily delays needed care.

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

These findings on the denials and delays during later stages of the pandemic are all the more concerning in light of the critical role that IRFs played in the initial COVID-19 surges, and MA plans' reliance on IRFs during that time to care for some of the most acute patients in need of hospitalization. As AMRPA has previously shared with CMS, the data collected during the early COVID-19 surges, when MA plans voluntarily waived their PA policies, statistically affirms the inappropriate denial of access for MA beneficiaries.

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%
Case Mix Index	1.42	1.54	1.50	1.53	1.49	1.57
Discharge to Community	78.58%	74.92%	77.29%	77.29%	74.15%	71.83%

Source: eRehabData®

In 2019, and consistent with previous years, MA beneficiaries represented only 20% of Medicare IRF admissions, despite representing approximately 36% of Medicare beneficiaries in total. When MA plans voluntarily suspended PA in response to the early stages of the COVID-19 PHE (Q2 2020), MA beneficiary admissions to IRFs increased to volumes much more proportionate with the overall split between MA and traditional Medicare enrollment. At the same time, IRFs continued to treat patients at high acuity levels, countering the notion that PA is needed as a form of utilization control to screen out inappropriate patients. Despite CMS' own recommendations to MA plans, MA plans largely re-implemented and maintained their PA policies beginning in Q3 2020, and admission for MA beneficiaries dropped to pre-PHE levels.

To further illustrate the harm done by prior authorization, the chart below demonstrates that the shift in admission patterns when PA was waived was similar across all Rehabilitation Impairment Groups (RICs). Prior to the PHE, all MA admissions under all RICs were

disproportionately low relative to MA enrollment. During the waiver of PA, the proportion of MA admissions for every RIC rose consistently and substantially, allowing MA admission to be more consistent with Medicare enrollment. Once PA requirements began to be reimplemented, MA admission again fell to disproportionately low levels.

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 Rehab/Medical	86.68%	13.32%	71.74%	28.26%	81.64%	18.36%

Source: eRehabData®

Changes in admission trends during the period PA was waived shows how PA denies beneficiaries needed care. While PA practices are often framed as preventing unnecessary or excess service utilization, IRF admissions in the MA program were more evenly aligned with FFS admissions (relative to enrollment), rather than resulting in a spike of unnecessary care. Further, average patient acuity was higher during the period where PA was generally waived, showing that IRFs continued to serve those patients most appropriate for intensive post-acute care. In conjunction, this demonstrates that PA is a blunt instrument designed to limit utilization, rather than ensure proper patient placement.

Unfortunately, given that MA plans were not *required* to continue to relax or restrict PA policies for the duration of the PHE, PA became a serious access issue after Q2 2020. As later variants continued to stretch hospital capacity limits, the issues with these practices were amplified to the detriment of acute-care hospitals, patients, and IRF providers.

III. Systemic Shortcomings of Prior Authorization in the Medicare Advantage Program

AMRPA has raised serious concerns about the use of PA in the MA program long before the COVID-19 PHE. In particular, AMRPA has posited that the current process utilized by MA plans is harmful for hospitalized patients, and that serious reforms are needed to ensure MA plans meet the needs of beneficiaries. In addition, PA results in huge financial waste for beneficiaries, hospitals and Medicare. The concerns AMRPA has raised fall into a few categories, and can be broadly described as 1) Accuracy, 2) Timeliness and 3) Accountability.

A. Accuracy: Determinations by MA Plans Run Contrary to Best Medical Practices and Medicare Coverage Rules

As supported by the data in Section II, MA plans deny PA requests for admission to an IRF at a very high rate, often utilizing unqualified reviewers and inappropriate admission criteria. This high denial rate is despite the fact that CMS requires that IRFs utilize a specialized physician to screen and certify all IRF admissions as medically necessary and meeting the Medicare coverage criteria.[5] When the high denial rate is considered in this context, the disconnect between the recommendations of practicing rehabilitation physicians and the lack of access provided by MA plans is striking. This divide supports AMRPA's contention that MA plans fail to utilize appropriately qualified reviewers and rely on erroneous standards for making determinations about IRF admissions.

In the experience of AMRPA hospitals and physicians, MA plans rarely utilize clinicians with experience in rehabilitation care. Sometimes, after a tentative denial, an MA plan will offer a "peer-to-peer" discussion between the MA reviewer and a rehabilitation physician. Physicians report that its typical for the MA physician to be trained in a completely unrelated specialty, with little understanding of rehabilitation medicine or the Medicare criteria for IRF admission. Sometimes the reviewer lacks an understanding the differences between IRFs and other post-acute settings. Even with the opportunity to try to educate the MA reviewer, these experiences typically result in a rubber-stamp affirmation of the denial.

Through interactions with MA plans, it has also become apparent to hospitals that MA plans rely on decision making tools in the form of an algorithm of similar method that steers almost all patients away from IRFs to less-intensive settings of care. Hospitals report that when they press MA reviewers on the rationale for a denial, they are often told the decision is based on the use of InterQual or Milliman Care Guidelines (MCG). Based on our members' experience, these criteria appear grossly inconsistent with and more restrictive than Medicare coverage rules, which state that MA beneficiaries are entitled to the same core benefits according to the same criteria as traditional Medicare beneficiaries.[6] These guidelines have not been made available to providers because these companies sell them to MA plans, making them proprietary and protected from scrutiny, nor do providers have an understanding of whether and how these guidelines are reviewed or approved by CMS. The lack of transparency surrounding these guidelines is significantly concerning since they play such a critical role in determining the access to care for seriously ill or injured MA beneficiaries.

[5] 42 C.F.R. § 412.29(d).
[6] *Id*. § 412.604. Id. §§ 422.10(c) & 422.101(b).

More recently, MA plans have also begun putting additional roadblocks in place when tentatively approving IRF admissions. Hospitals report that MA plans will approve an IRF admission on the condition that the MA plan will not approve a subsequent admission to a SNF. While IRFs have a very high rate of discharge to the community, they cannot guarantee all patients will not need subsequent sub-acute care. In any event, such a condition is a flagrant violation of the Medicare coverage rules, which entitles MA beneficiaries to SNF care when appropriate.

Accurate PAC determinations are also challenged by issues caused by inadequate network coverage of IRFs in MA plans. AMRPA members report that numerous MA plans across the nation to do not maintain adequate agreements with all types of post-acute care providers, due in part to the fact that there are no network adequacy requirements for MA plans to include IRFs in their network. Without changes to network adequacy requirements to include IRFs and certain other types of PAC providers in MA plan networks, MA plans lack the ability to place patients from acute care hospitals in the most appropriate setting. AMRPA is increasingly concerned that these shortcomings are driving placement decisions that run counter to patients' best interests and Medicare coverage rules.

The result of the inaccurate determinations made by MA plans is that tens of thousands of MA beneficiaries are denied access to medically necessary IRF services, almost all of whom would have been admitted and treated had they been enrolled in traditional Medicare. This is a discriminatory practice that denies needed care and pushes patients with intensive post-acute care needs out of the MA program. Unfortunately, as described below, there is little meaningful recourse available to these beneficiaries for these erroneous determinations.

B. Timeliness: Harmful Delays in Care Result from Prior Authorization

As mentioned previously, a very high percentage of patients seeking admission to an IRF are first hospitalized at an acute-care hospital. When a patient sufficiently stabilizes for discharge, care needs and financial considerations ensure both acute-care hospitals and IRFs move as quickly as possible to determine the discharge destination and initiate a transfer. As CMS is aware, time is of the essence when it comes to maximizing functional recovery from stroke, traumatic brain injury, spinal cord injury, amputation, and other conditions experienced by Medicare beneficiaries. Further, unnecessary days in an acute-care hospital are administratively and clinically taxing for hospitals and their patients.

Despite the multi-faceted need to move hospitalized patients through the continuum of care as efficiently as possible, and regulations requiring determinations "as expeditiously as the enrollee's health condition requires," MA plans' use of PA results in patients spending unnecessary days in the acute-care hospital as a matter of standard practice.[7] As shown in the data presented in Section II., it is typical for IRFs to wait 2-3 days for a determination from an MA plan as to whether a patient may be approved for admission. When taken as a whole, this amounts to hundreds of thousands of days spent waiting for determinations from MA plans.

[7] 42 C.F.R. § 422.572(a)(1).

AMRPA has also found that PA practices are not consistent across the post-acute continuum. Specifically, hospitals can often secure an authorization for less-intensive settings of care such as SNF or HHA much more quickly than it can secure an authorization for IRFs. This leads to hospitals pushing patients to skilled nursing facilities (SNFs) or home health agencies (HHAs), or patients choosing these quicker discharge options, rather than waiting for the determination for IRF admission from the MA plan and going to the appropriate care setting that meets their individual needs. In addition, during the COVID-19 PHE, many hospitals reported PA was entirely waived by MA plans for SNFs and HHAs, while remaining in place for IRFs. Therefore, acute-care hospitals with minimal capacity due to the pandemic were forced to decide between discharging the current patient to a suboptimal destination, or turning away additional patients in need of care, all due to the delay in the PA determinations for IRF decisions.

The delays encountered by MA beneficiaries are detrimental to patient outcomes, cost the Medicare program and its patients additional money, and hamper hospitals' ability to maximize capacity during emergencies. More importantly, MA beneficiaries in need of immediate therapeutic interventions in order to maximize their functional recovery risk suffering irreparable harm from delays in initiating this care.

C. Accountability: Lack of Meaningful Appeals and Oversight Allows Inappropriate Denials of Care

There is currently a lack of meaningful recourse for inappropriate actions by MA plans. Currently, it appears CMS does not provide any oversight or require any transparency regarding MA determinations at the initial level of review. This lack of oversight and transparency is troubling since, as explained further below, the subsequent appeal options are not feasible or practical for hospitalized patients and their providers.

Once an initial denial has been issued by an MA plan and an appeal is filed, it takes another 2-3 days for a Reconsideration to be issued by the MA plan. This means that it can take 6 days or longer from when the initial request is filed (depending on how long the appeal took to file) for a review of the initial decision by an MA plan to be issued. To put this in context, the average IRF length of stay for Medicare beneficiaries is only 12.6 days. Therefore, in the time it takes to receive a Reconsideration, a patient could be well on their way to discharge home, rather than costing Medicare, hospitals, and patients additional dollars waiting for a determination. The week following patient stabilization in an acute-care hospital is also a critical timeframe to initiate therapeutic interventions, and delays in initiation can have long-lasting and permanent effects.

After 5 or 6 days, even if a denial is reversed under Reconsideration, it is unlikely the patient will still be admitted to an IRF. This is because acute-care hospitals are understandingly hard-pressed to allow a patient to stay any longer than is necessary, let alone nearly a week or more. This is especially true during the COVID-19 PHE. Therefore, once the Reconsideration is issued, the patient has likely already been discharged to another post-acute setting. Patients and providers are hesitant to undergo yet another transfer while the patient is recovering from a serious injury or illness. This is exacerbated by the fact the patient's condition may have

changed in that critical week, and a full re-evaluation of the patient would be needed. The end result is that even if the MA plan eventually overturns its own initial determination, it has essentially run out the clock and will not need to pay for IRF care, and faces no repercussions for inappropriately (now by its own admission) denying access for this care.

CMS does not appear to track data on initial MA determinations or subsequent Reconsiderations. The only apparent oversight of MA plan determinations seems to be in the MA Star Rating program, where plans are rated on how quickly they forward denial affirmations to the Independent Review Entity (IRE) and how often the IRE overturns the MA plan determination. However, this oversight is entirely inadequate, as it would take 9 days or more to receive a determination from an IRE, which is long past the practical window to admit a patient to an IRF.

The data available from the IRE supports the failure of MA plans to address the needs of hospitalized patients in need of post-acute care. In the most recent available IRE data, only 2,357 IRF appeals were submitted during the third quarter of 2021. A rough extrapolation of the data presented in Section II points to this being approximately 5 percent of the total initially *denied* IRF requests in a calendar quarter. Denied reconsiderations are automatically forwarded to the IRE. This means that very few initial IRF denials are ever appealed due to the impractical timeline, MA plans reverse themselves at a very high rate on Reconsideration (thereby avoiding the claim being forwarded to the IRE), or some combination thereof. Under either or both scenarios, there is again little to no accountability or oversight as to the accuracy or timeliness of MA determinations since so few initial denials are ever independently reviewed, and there is no data available on these initial determinations.

The complex nature of Medicare coverage rules and varying sites of post-acute care also make it difficult for a patient to challenge their placement. It should not be expected that an MA beneficiary would necessarily understand the differences in levels of care between an IRF and a SNF, or what site of care would be most appropriate for their clinical circumstances. This is especially true for many IRF patients who have just undergone a serious medical event, many of whom may face cognitive deficits (which the IRF would seek to address). Therefore, from a beneficiary perspective, the issue of PA often amounts to an invisible problem, only truly understood by the providers seeking to achieve the best possible outcomes for their patients.

Due to the current lack of oversight and accountability, MA plans are able to essentially run out the clock on many beneficiaries by waiting 2-3 days to issue an initial determination. Beneficiaries and providers that have not been successfully dissuaded with the initial delay can be further discouraged by the 2-3 delay in subsequent appeals. This, combined with lack of data collection or accountability for these initial determinations, means that patient choice can be limited without any meaningful recourse.

The data and experiences provided by AMRPA demonstrates that there are both patient access concerns as well as unnecessary costs due to the current PA practices used by MA plans. Specifically, abusive MA tactics costs tens of thousands of unnecessary acute-care hospital days every month due to PA requirements. This cost is immediately borne by hospitals and

beneficiaries; however, the Medicare Trust Fund is also impacted. As cost-reports are filed, lengths of stay for patients are artificially increased. This results in increased payments to hospitals for these additional days, as well as increased payments to MA plans for covering the cost of these payments to hospitals.

When patients are denied access to the IRF, increased costs are also borne by Medicare in the form of increased care needs of beneficiaries. IRFs are extremely effective and efficient in returning patients to the community through intensive rehabilitation. IRFs discharge to community rate is significantly higher than SNFs, despite the length of stay for IRFs being less than half that of SNFs. In addition, the rehospitalization rate for IRFs 7.8%, compared to 13.7% for SNFs.[8] Therefore, when MA plans push patients towards a SNF, they could be costing Medicare more money in the form of rehospitalizations and longer lengths of stay. This is not to say that a SNF is not an appropriate care site for many recovering beneficiaries (evidenced by the many patients evaluated by rehabilitation physicians and determined to be optimally placed in a setting other than an IRF). Rather, when the clinicians in an IRF evaluate and have confidence that their hospital can rehabilitate a patient under the current Medicare guidelines, it should be seen as the most sound fiscal choice (for the Medicare program) and clinically (for the patient).

IV. Recommendations to Ensure Proper and Timely Post-Acute Care Treatment and to Avoid Costly and Harmful Delays and Denials

Under typical circumstances, the prior authorizations and utilization review practices of MA plans are harmful and wasteful. In the context of the PHE, the use of PA created a bottleneck in the efforts to move patients as efficiently as possible through the continuum of care, denying hospitals and providers the ability to maximize their care capabilities. AMRPA recommends that CMS take steps to enhance the accuracy and timeliness of PA determinations, as well as add additional accountability for initial determinations in the MA program. As a key first step, CMS should seek and use authority to suspend the use of PA by MA plans during future PHEs. AMRPA stands ready to work with policymakers to implement the nuances of this policy change, such as whether prior authorization should be immediately suspended when hospital capacity reaches a certain threshold at the national, regional, and /or local level. Such action would be invaluable in its ability to ensure that provider capacity is maximized, provider burden is minimized, and patients receive care as quickly as possible during future PHEs.

More broadly, to ensure proper determinations by MA plans and protect patient access to a covered benefit, CMS should modify its rules and enhance oversight of the process that is used by MA plans. First and foremost, it should be required that any denial of care be approved by specialist physician in the field of the care being sought. In the context of IRFs, this means that a physician must meet the qualifications of a rehabilitation physician found in the regulations. Since CMS requires this type of specialized physician to approve all IRF admissions, it cannot be expected that a physician of *lesser* qualifications would issue a more qualified determination.

[8] March 2021 Report to the Congress: Medicare Payment Policy; Medicare Payment Advisory Commission (March 15, 2021). (https://www.medpac.gov/document/march-2021-report-to-the-congress-medicare-payment-policy/).

To further ensure the accuracy of determinations, CMS should also require that all determinations are made on the basis of Medicare coverage criteria, and not the MA plans' differing criteria. Ideally, CMS should review and approve all guidelines that plans may rely on to reach determinations to ensure its consistency with the Medicare regulations. If MA plans are unwilling to disclose such criteria for approval, there should be limitations on its use, and instead should rely mainly on the Medicare criteria for reaching admission and medical necessity determinations.

With regards to timeliness, CMS should either modify its rules or enhance its enforcement regarding the timelines for providing PA determinations. A hospitalized patient should not have to wait more than 24 hours for a determination from an MA plan, whether the patient is being assessed on a weekday, a weekend, or a holiday. This could be accomplished by a revision to the current regulations, or by clarifying that the current language requiring determinations "as expeditiously as the enrollee's health condition requires," demands hospitalized patients receive more immediate determinations from MA plans. Similar enhancements must be made to the timelines for Reconsiderations and further appeals of determinations. As explained earlier, waiting days for appeal determinations is not an option for hospitalized patients, and allows MA plans to inappropriately deny care without any recourse.

When it comes to demanding accuracy and timeliness of MA determinations, simply modifying the rules or clarifying interpretations is not enough. After all, CMS already technically requires adherence to Medicare coverage guidelines and timeframes that match the beneficiary's health needs. CMS should therefore also greatly enhance its oversight and the accountability of MA plans, consistent with past Government Accountability Office findings.[9] MA plans should be required to disclose the rate at which it approves and denies requests, the qualification of the reviewers and the criteria used to reach these decisions, the time it takes to render every decision, and data on the outcomes of its beneficiaries. CMS should use this data to closely examine and audit plans for compliance with all of these rules.

Summary of Recommendations:

- **CMS should obtain authority to waive PA during future PHEs to avoid costly care delays and maximize provider capacity.**
- **CMS must ensure all denials of access to care are reviewed by appropriate specialists that meet any CMS criteria for specialized care.**
- **MA plans must be required to make PA determinations according to Medicare coverage criteria, and any proprietary guidelines utilized by MA plans should be banned unless certified as compliant.**
- **CMS must enhance its rules and enforcement for the timeliness of PA determinations for hospitalized patients to ensure MA beneficiaries are not harmed by care delays.**
- **CMS should enhance its oversight of MA plan actions to ensure proper accountability for PA determinations at the initial levels.**

[9] GAO Report; Medicare Advantage: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight (April 2017). Available here: https://www.gao.gov/assets/gao-17-393.pdf.

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AMRPA greatly appreciates CMS' efforts to support providers during the PHE, and we believe that the current COVID-19 PHE can help inform policy changes that can meaningfully improve care access and outcomes for all patients moving forward. We look forward to continuing our collaboration with CMS to ensure all Medicare beneficiaries have access to the most appropriate care. Should you have any questions or wish to discuss AMRPA's comments, please contact Jonathan Gold at jgold@amrpa.org

Sincerely,

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

Attached: Report on Prior Authorization Requests During the COVID-19 Public Health Emergency

Appendix A

Access to Inpatient Rehabilitation for Medicare Advantage Beneficiaries: An Examination of Prior Authorization Practices

Abstract:

The use of prior authorization (PA) by Medicare Advantage (MA) plans is a pressing concern among rehabilitation providers. A nationwide survey of rehabilitation hospitals and units (RHUs) was conducted to determine how frequently PA was used to deny admission to an RHU, how timely those decisions were rendered, and the resulting consequences for patients. The survey, which tracked data for one month (August 2021), found that MA plans overrule rehabilitation physician judgement at a rate of 53%. In addition, patients wait on average more than two and half days for a determination. This resulted in more than 30,000 days waiting for determinations during the single survey month. Since the vast majority of patients being referred to an RHU are hospitalized in an acute hospital, enormous cost and burden results from the use of PA. In addition, seriously impaired MA beneficiaries may be harmed by denials and delays in access to care.

Introduction and Background

Medicare Advantage (MA) plans offer various premium and cost-sharing arrangements that differ from traditional Medicare (TM), as well as health and wellness benefits not offered to beneficiaries enrolled in TM. In addition to financial flexibilities, MA plans are permitted to employ various utilization management strategies not regularly used in TM, including requiring prior authorization (PA) of an item or service as a condition of payment. When PA is required by MA plans, the plan must pre-approve the service, or payment will not be made to the provider. While the use of PA to manage benefits is permitted, MA plans are nonetheless obligated by law to provide all of the benefits offered in TM.[i]

The number of beneficiaries who have chosen to enroll in MA plans has grown at an accelerated pace in recent years. Of the approximately 64 million Medicare beneficiaries, an estimated 28 million now receive their Medicare benefits through private insurers that have contracted with CMS to offer MA plans.[ii]

As enrollment in MA has grown, providers have reported that PA determinations and subsequent denials have increased and often do not follow appropriate evidence-based guidelines.[iii] In addition, physicians report the PA process often delays care and has a negative impact on clinical outcomes.[iv] Concerns have also been raised about the lack of accountability for the use of PA by MA plans. These concerns are due to high overturn rates of denials and due to insufficient publicly reported data. [v]

In the context of rehabilitation hospitals and units (RHUs), PA delays the discharge of patients from an acute hospital, and denies or delays access to needed therapeutic interventions. RHUs (referred to by Medicare as Inpatient Rehabilitation Facilities or IRFs) provide specialized physician-directed care that includes close medical management and an intensive program of rehabilitation. The goals of care in a RHU include continuing medical management of the patient's underlying health problems and improving the patient's functional capacity so that the patient can return to the community. The vast majority of patients referred for admission to an RHU are in an acute hospital due to serious illness or injury.

The Medicare coverage criteria stipulate that a RHU stay is eligible for payment if the patient would practically benefit from and tolerate intensive, multi-disciplinary therapy and requires ongoing supervision by a rehabilitation physician.[vi] The Medicare rules also require that a rehabilitation physician approve each patient for admission. Due to the stringent Medicare rules and the intensity of services offered, RHUs treat more seriously ill and functionally impaired patients than lower intensity post-acute care settings.

Medicare does not have regulatory requirements for PA response times that are specific to hospitalized patients. This has increasingly become a concern since many providers have reported exacerbation of the process burden and high rates of denials for PA requests for admissions. In addition, there is essentially no publicly available data to determine the consequences of PA requirements at the initial determination level or at the initial appeal level. Medicare and its contractors do report the outcomes of the second level of appeal (formally referred to as "Reconsideration by an Independent Review Entity"). However, this level of appeal is rarely utilized for patients seeking admission to an RHU given the lengthy and time-consuming process, which is impractical for patients in need of immediate care decisions.

Given the lack of available data on PA practices and outcomes, the American Medical Rehabilitation Providers Association (AMRPA) conducted a survey of RHUs across the nation to gain more quantitative and qualitative information, including the pervasiveness of PA use as a benefits management practice, frequency of denials, and associated delays in care.

Survey Objectives

The goals of this survey were to determine how common denials of authorization for RHU care are, how timely those determinations are made, and what the consequences of those determinations may be.

Design

RHUs were solicited to participate prospectively in a data collection effort for the month of August 2021. The survey was publicized through trade association and professional

channels to the RHU community, including disclosure of the specific questions that would be included on the survey and a spreadsheet form that could be used to capture the PA activity as it occurred. Participants submitted their data via an online portal.

The survey consisted of nine questions, shown below in Table 1.

Table 1: Survey Questions
S1. How many Medicare Advantage patients did you request prior authorization to admit for rehabilitation hospital care?
S2. How many of those requests were ultimately approved?
S3. For those cases that were approved, how long did it take on average for the MA plan to grant authorization from the time of initial request (in days and including weekends)?
S4. How many of your requests were ultimately denied?
S5. In those denied cases from question #4, how long did it take on average for the MA plan to issue its *initial* formal denial from the time of the initial request (in days and including weekends)?
S6. In how many cases, whether ultimately approved or denied, did the hospital, physician, patient (or family) need to engage in extra effort to try to obtain authorization for admission? This could include requests from the plan for additional documentation, needing to conduct a peer-to-peer discussion, filing a formal appeal, or any other steps that were taken beyond the initial request for authorization.
S7. Of those requests requiring additional engagement from hospital, patient or family (per question #6), how many were ultimately granted authorization?
S8. In your experience, what do you think has most common reason Medicare Advantage plans use to deny an authorization request? Please only select one answer. a. Patient does not meet Medicare criteria for IRF admission. b. Patient could be treated at lower level of care/intensity. c. Patient does not meet medical necessity criteria (generally). d. Patient does not require physician supervision. e. Patient does not require multiple therapy disciplines and/or intensive therapy. f. Patient cannot tolerate multiple therapy disciplines and/or intensive therapy.
S9. Was prior authorization waived during the month of August by plans or your state due to COVID-19 or for any other reasons? Note: Any patients admitted under these circumstances without a prior authorization request being made should not be included in your survey results. a. Yes b. No

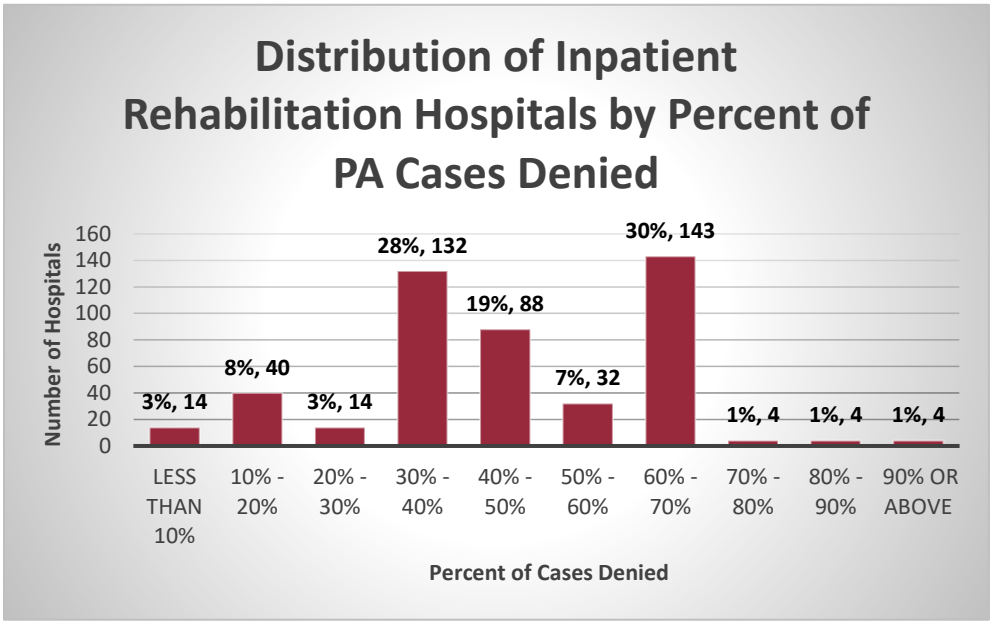
Participants

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

Results

Of the 12,157 PA requests reported for the month, 6,482 of those requests were initially denied by the MA plan (53.32% of all requests). 84% of respondents reported that 30-70% of initial requests were denied during the survey month. **Figure 1** shows the distribution of denial frequency cited by RHUs.

Figure 1. Distribution of Hospitals by denials



Wait times of greater than 2 days for requests were typical for the vast majority of respondents, with 84% of respondents waiting more than 2 days on average for all requests. The average wait time for the initially approved requests was 2.49 days. The average wait time for the initially denied requests was 2.59 days.

The wait times were very consistent across all IRFs. 84% of RHUs also reported an average wait time of 2.1 days or greater for denied requests. For approved requests, the majority (56%) had wait periods over two days. **Figure 2** shows the distribution of wait time for a negative response. **Figure 3** shows delays experienced when an initial favorable response was received.

Figure 2. Distribution of Hospitals by wait time for negative response

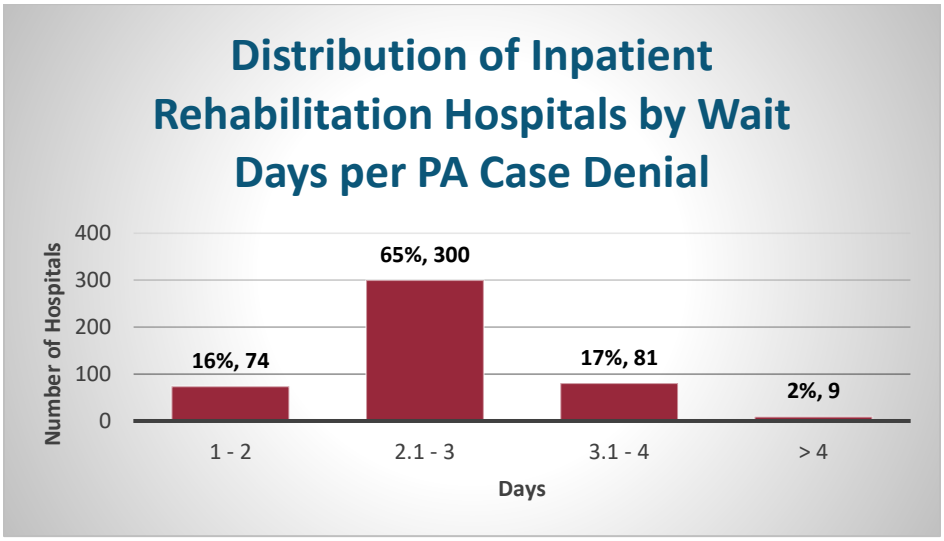
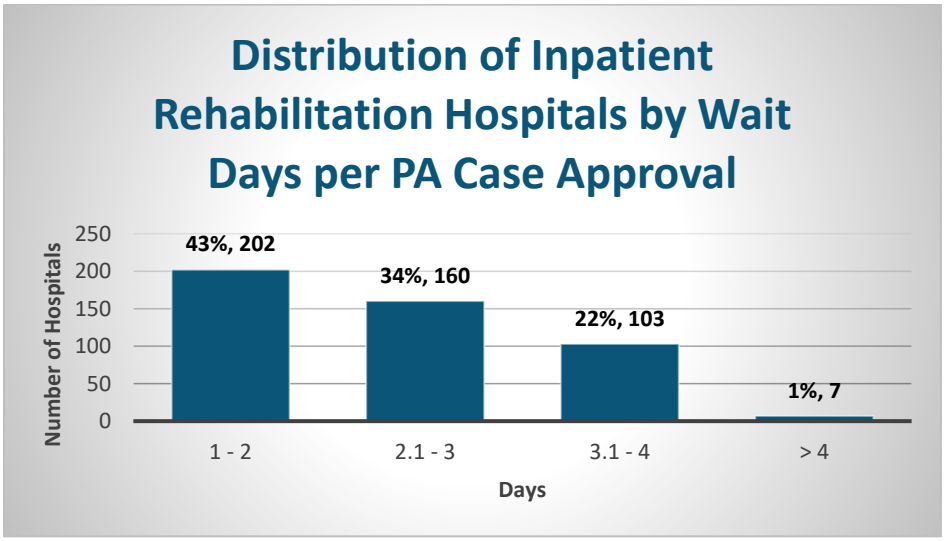


Figure 3. Distribution of Hospitals by wait time for favorable response



A total of 14,152 acute hospital days were spent waiting for requests that were ultimately approved, and 16,774 acute hospital days were spent waiting for denied requests, totaling 30,926 total acute hospital days spent waiting for a determination.

Respondents provided information regarding any additional effort required to seek authorization for 4,823 requests. 35.39% of these requests required additional effort on behalf of the hospital, physician, patient or family. For requests that required this additional effort, 28.94% were approved for admission as part of the initial request.

The most commonly provided reason for a denial cited by RHUs was that the patient "could be treated at a lower level of care/intensity." The next most common reason was that the patient "does not meet medical necessity criteria." Some respondents indicated multiple rationales for denying payment so the total of reasons reported exceeds 100%. Finally, 29% (136) of respondents indicated that PA was waived at some point during the survey month by plans or regulators due to the COVID-19 pandemic.

Discussion

PA is being commonly used to deny patient access to RHU care. These determinations are difficult to challenge, since subsequent appeals take additional days, and the patient typically must be transferred more promptly than that. The data presented here shows that even when a MA plan agrees with the request, there are substantial delays in communicating that decision. With these delays and denials, there is an associated risk that patients may be harmed.[viii]

The high frequency of denials suggests that there is a striking disagreement between the medical decisions of practicing rehabilitation physicians and the judgments being rendered by MA plans. Since rehabilitation physicians determined that each of these referred patients required RHU admission, the widespread denials by MA plans calls into question what criteria and expertise plans utilized to render decisions.

Although MA plans are not required to disclose the specific expertise and guidelines they use to reach determinations, respondents reported the primary reason cited for a denied request was that the patient "could be treated at a lower intensity setting of care." This is disconcerting because Medicare has stated that this shall not be a basis for denying RHU coverage, yet denials for this reason appears to be a common practice by MA plans.[ix] Whether a patient could be treated elsewhere is *not* one of the Medicare criteria used by physicians to determine whether the patient is appropriate for inpatient rehabilitation admission. Instead, that determination is made based on whether the patient meets the enumerated Medicare standards, referenced above. This finding is consistent with other surveys that have found that plans utilize improper medical guidelines for PA requests.[x]

If any of the denied patients been enrolled in TM, they likely would have been admitted to the RHU without delay. Instead, because the beneficiary chose to enroll in MA, and due to the opaque review process and criteria utilized by MA plans, the patients were denied access to the RHU.

Medicare regulations require MA plans to issue determinations "as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request."[xi] This survey shows that MA plans consistently *do not* issue determinations as expeditiously as the beneficiary's condition requires, since such a response would be made within minutes to hours, not days. It is likely that in many cases, PA unduly delays the initiation of needed therapeutic interventions and hampers patients' recovery. This

finding is again consistent with other surveys that indicate PA detrimentally impacts clinical outcomes for patients.[xii]

The data presented here represent only one month of activity during the COVID-19 Pandemic and National Public Health Emergency. Since the vast majority of patients seeking admission to an RHU are hospitalized in an acute hospital, each day of delay in transfer represents increased risk and cost. Since MA plans typically pay for hospital admissions on a prospective basis, the immediate additional cost is borne by the hospital.[xiii] As these additional lengths of stay are captured through Medicare's tracking of resource utilization, payments may be increased due to extended length of stay for these patients, costing Medicare additional unnecessary dollars.

Conclusions

MA plans' use of the PA process to delay and deny patient transfers of from acute hospitals to RHUs is a widespread and common problem that can harm patients. PA processes increase administrative burden, delay necessary care, and increase waste and cost to the health care system.

There is an urgent need to eliminate these unnecessary delays in providing care to patients and mitigate denials based on opaque and inconsistent criteria. These needs can be addressed by regulatory and contractual changes to the MA plan operational requirements, and by ensuring that qualified clinicians are making proper and timely determinations about RHU referrals.

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[i] 42 C.F.R. § 422.101.

[ii] Bob Herman, *Medicare Advantage enrollment soars almost 9%, Axios* (Jan. 18, 2022), https://www.axios.com/medicare-advantage-enrollment-2022-soars-055b6d7d-d2c7-4e69-9eba-420c0ee4ef6e.html.

[iii] American Medical Association, 2020 AMA Prior Authorization (PA) Physician Survey, (April, 2021) https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf & https://www.ama-assn.org/system/files/2021-05/prior-authorization-reform-progress-update.pdf.

[iv] American Medical Association, 2021 AMA Prior Authorization (PA) Physician Survey, (February, 2022) https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

[v] HHS Office of Inspector General (OIG), Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials (Sept. 25, 2018) (https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp).

[vi] 42 C.F.R. 412.622.
[vii] CMS Inpatient Rehabilitation Facility Data, General Information Data Set (December 2021), https://data.cms.gov/provider-data/topics/inpatient-rehabilitation-facilities.
[viii] Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge; Dobson & Davanzo (July 2014) (https://amrpa.org/Portals/0/Dobson%20DaVanzo%20Final%20Report%20-%20Patient%20Outcomes%20of%20IRF%20v_%20SNF%20-%207_10_14%20redated.pdf)
[ix] CMS IRF PPS Coverage Requirements Nov. 12, 2009 National Provider Conference Call ("Notice that nowhere on the slide and nowhere in this presentation are we going to talk about whether the patient could have been treated in a skilled nursing facility or another setting of care. Under the new requirements, a patient meeting all of their required criteria for admission to an IRF would be appropriate for IRF care whether or not he or she could have been treated in a skilled nursing facility.") (Available for download: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage).
[x] American Medical Association, 2020 AMA Prior Authorization (PA) Physician Survey, (April, 2021) https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf & https://www.ama-assn.org/system/files/2021-05/prior-authorization-reform-progress-update.pdf.
[xi] 42 C.F.R. § 422.572(a).
[xii] American Medical Association, 2020 AMA Prior Authorization (PA) Physician Survey, (April, 2021) https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf & https://www.ama-assn.org/system/files/2021-05/prior-authorization-reform-progress-update.pdf.
[xiii] Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices, Robert A. Berenson, Jonathan H. Sunshine, David Helms, and Emily Lawton, Health Affairs 2015 34:8, 1289-1295 (https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1427).