AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

February 13, 2023

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–4201–P
P.O. Box 8013
Baltimore, MD 21244-8013

Delivered Electronically

Re: Response to the Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program Proposed Rule (CMS–4201–P); 87 Fed. Reg. 79452 (December 27, 2022)

Dear Administrator Brooks-LaSure:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we submit this letter in response to the Centers for Medicare & Medicaid Services' (CMS) *Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program Proposed Rule* (CMS–4201–P) (the Proposed Rule). AMRPA is the national 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 and critical role in providing hospital-level medical and rehabilitation care to beneficiaries in traditional Medicare and enrolled in Medicare Advantage (MA) plans. We strongly support many of the proposals included in the Proposed Rule, particularly concerning reforms focused on MA plans' prior authorization (PA) and other utilization management practices. For all the reasons outlined below, we urge you to finalize many of the proposed changes for the upcoming MA contract year and consider enhancing several proposals focused on implementation, compliance, and enforcement of the new regulations.

Reform of PA practices is at the top of AMRPA's advocacy agenda because of the direct and adverse impact PA practices often have on some of Medicare's most severely ill and injured beneficiaries, including those living with disabilities. PA reform is particularly important in the rehabilitation medicine context when timely and appropriate care transitions can dramatically improve a patient's functional recovery and quality of life. Given the significant growth of the MA program in recent years and increasing scrutiny of plan behavior by government oversight entities, timely and effective policy changes to MA plans' PA practices are critical to correct serious and concerning care access and equity issues. Reforming MA plans' PA practices is particularly imperative in advancing health equity, as research shows that minority and low-income beneficiaries enroll in MA plans at a significantly higher rate, and these beneficiaries face larger knowledge gaps and higher disenrollment rates.

As we detailed in our response to CMS's Request for Information (RFI) on MA in August 2022 (also attached), IRFs have seen MA plans routinely and consistently divert beneficiaries away from

IRFs to other, inappropriate and less-intensive care settings by misusing PA and other utilization management tactics, such as: using unqualified reviewers; applying flawed or unsupported proprietary guidelines that conflict with traditional Medicare coverage rules; employing delay tactics that pressure hospitals and patients into choosing inappropriate substitutes for IRF care; and obfuscating the reasons for a denial to make it more difficult for providers to respond or pursue an appeal, among numerous other tactics.

In addition to these problematic practices routinely described by our members, our own survey data (provided as an attachment) demonstrates that beneficiaries enrolled in MA plans face high denial rates for IRF services, endure long average wait times for decisions (even when admissions are approved by the plan), and are approved for IRF-level care at disproportionately low rates.[1] Collectively, these findings demonstrate that MA beneficiaries are simply not receiving the same post-acute care (PAC) benefits as their traditional Medicare peers, and to which MA beneficiaries are entitled, due in large part to MA plans' PA practices. MedPAC has made similar findings, stating that MA enrollees receive one third the access to IRF care than traditional Medicare beneficiaries.[2]

We applaud CMS for listening to provider-stakeholders and for proposing several PA policy reforms that would improve MA beneficiaries' care access and health outcomes. AMRPA and many disability and consumer organizations have been advocating for these reforms for many years, and we are grateful CMS has finally recognized the need for more MA accountability and transparency in their coverage decisions. For rehabilitation patients, these reforms are critically needed to improve transparency and ensure fairness in their covered benefits so that they have the same PAC access as their traditional Medicare beneficiary peers. For physicians and other IRF clinicians, these reforms would significantly reduce administrative burden and better protect the treating providers' discretion in the context of patient care and PAC placement. These reforms can also benefit MA plans by standardizing and streamlining processes and ensuring uniformity across different plans. While this Proposed Rule represents a critical first step, there is important work still to be done to further improve PA practices, and we look forward to continuing to collaborate with you and your staff. Below, we offer our specific responses to key PA proposals included in the Proposed Rule, including:

- AMRPA strongly supports the proposed prohibition on the use of internal, proprietary guidelines to inform coverage determinations. In the circumstances in which MA plans would be permitted to establish their own coverage criteria (i.e., when no relevant traditional Medicare coverage criteria exist), we strongly believe that CMS should open those guidelines to public comment to enable providers and other stakeholders to contest inappropriate coverage conditions. CMS should also audit or review and approve those guidelines to ensure that MA plans are not applying overly restrictive or medically irrelevant criteria.

[1] As detailed in our attached analysis, our data showed that **MA plans denied 53% of all initial requests for admission**. When the high denial rate is considered in proper context – as an overruling of a practicing physician's medical judgment in treating a severely and acutely ill recovering patient – this denial rate is extremely concerning and has direct, detrimental impacts on patient outcomes.

[2] Medicare Payment Advisory Commission, Report to The Congress: Medicare Payment Policy 298 (Mar. 2017).

- AMRPA strongly supports proposals that prohibit MA plans from denying care, or steering care to a less-intensive care setting, based on the plan's suggestion that care could be provided in another setting.

- AMRPA strongly agrees with proposals that require MA plans to conduct an individualized assessment for coverage decisions, and we believe that plans should be required to communicate clearly how they have relied upon the proposed factors (including medical history, physician recommendations, and clinical notes) in making their determinations. We recommend that CMS continue to work with stakeholders to standardize the language that MA plans use in their denial explanations and to regulate MA plans' use of arbitrary patient update requests.

- AMRPA strongly supports programs that would reduce provider burden, but we note that implementing gold-carding programs in a way that benefits good actors and streamlines the process for providers may be difficult in practice. We are happy to discuss our experiences, and the potential problems, with gold-carding programs in more detail as CMS continues to develop policy in this area.

- AMRPA strongly believes that the current, and proposed, 72-hour response timeline is simply too long for patients in need of rehabilitation care to wait for plan approval. For IRF care, we strongly recommend that CMS require MA plans to respond, including over the weekend, to requests **within 24 hours**.

- AMRPA strongly agrees with reforms that ensure continuous coverage for the duration of the patient's ordered treatment plan, without requiring additional plan approvals or placing additional burden on providers. CMS should consider the entire PAC spectrum when implementing these reforms. For example, CMS should clearly prohibit MA plan practices that condition IRF admission approval on the patient being ineligible for a subsequent SNF admission.

- While AMRPA believes that the proposed changes to reviewer qualifications are improvements over the current standards, we strongly believe that requests for IRF services require the MA plan reviewer to have knowledge of the relevant specialty. Given the unique complexities of IRF care, CMS should establish a higher threshold for denial of IRF services when the MA plan reviewer is not a physician with rehabilitation medicine knowledge.

- While we support requiring MA plans to establish a Utilization Management Committee, we believe that CMS must create and employ stronger enforcement mechanisms – including auditing processes, transparent reporting processes, and penalties for non-compliance – to ensure that plans' policies and practices comply with traditional Medicare coverage decisions and guidelines.

- AMRPA applauds CMS's efforts to incorporate health equity measures into MA plan Star Ratings. We believe that achieving the Administration's health equity goals requires that MA beneficiaries receive the PAC benefits to which they are entitled. To enhance the visibility and useability of Star Ratings for patients and their families, we strongly believe that quality measures should more transparently capture and report key metrics related to the plan's PA practices.

A. Revising Standards for Coverage

Prohibition on the Use of Proprietary Guidelines. The Proposed Rule reiterates the existing policy that MA plans generally must follow traditional Medicare-published coverage standards when making medical necessity determinations. CMS also proposes a specific prohibition on denying coverage of items or services based on internal, proprietary, or external clinical criteria not found in traditional Medicare coverage policies. CMS also proposes that MA plans may develop internal clinical coverage criteria *only* when no applicable Medicare statute, regulation, National Coverage Determination, or Local Coverage Determination establishes that an item or service must be covered. In these circumstances, the MA plans' internal clinical coverage criteria must be based on current evidence in widely used treatment guidelines or clinical literature that is made publicly available. CMS notes that this information should include a summary of the evidence relied upon for medical necessity determinations, a list of sources of such evidence, and an explanation of the rationale that supports the adoption of the coverage criteria. CMS does not propose that MA plans be required to provide an opportunity for public comment on such coverage criteria.

Response: The problematic use of internal proprietary guidelines to deny care or divert care to less-intensive care settings has become increasingly recognized and acknowledged. In April 2022, a report by the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) raised serious concerns that MA plans routinely deny care requests that meet traditional Medicare coverage criteria and specifically highlighted the PAC setting as prone to such improper tactics. In effect, MA beneficiaries were consistently being denied care that was available to their traditional Medicare peers, based on plan criteria. Our members' experiences also demonstrate that MA plans commonly rely on proprietary decision-making tools – such as InterQual or Milliman Care Guidelines – that steer patients away from IRFs. These criteria appear grossly inconsistent with, and more restrictive than, traditional Medicare coverage rules. The lack of transparency in these guidelines (exacerbated by the lack of opportunity for public review and comment) has created broad access issues for rehabilitation patients.

Given the concerning access issues such proprietary guidelines have presented, AMRPA strongly supports the proposed prohibition on MA plans' use of internal, proprietary guidelines to inform coverage determinations. We generally agree with the safeguards that CMS proposes in which MA plans would be permitted to establish their own criteria (i.e., when no relevant traditional Medicare coverage criteria exist). However, with respect to IRF care specifically, traditional Medicare standards for admission and medical necessity of such care are extraordinarily detailed. There is no reason MA plans should need additional internal criteria to assess coverage of IRF care. With respect to other Medicare services and devices, we believe that additional protections should be included to ensure that MA plan guidelines adhere to widely used treatment guidelines and/or current evidence in the relevant clinical literature. We recommend that CMS open these guidelines to public comment to enable providers and other stakeholders to contest inappropriate coverage conditions and offer evidence to rebut the data put forward by MA plans. As part of this process, CMS should audit or review and approve the guidelines to ensure that MA plans are not applying overly restrictive or medically irrelevant criteria.

We also strongly support CMS's proposal to revise 42 C.F.R. § 422.101(b) to specifically incorporate the coverage criteria for IRF benefits codified under the Prospective Payment for

Rehabilitation Hospitals and Rehabilitation Units at "42 CFR 412.622(3)." This proposal clarifies that IRF services must be included within an MA plan's scope of benefits offered to its enrollees and that MA plans cannot deny those benefits to an enrollee if he or she *satisfies the coverage criteria for IRF benefits under the Medicare fee-for-service program*. CMS may, therefore, wish to consider clarifying the text to be finalized in the pending final rule by modifying "42 CFR 412.622(3)" to "42 CFR 622(a)(3)" so that a complete citation of the IRF coverage criteria regulations comprising paragraph (3) appears in the final regulatory text for the proposed 42 C.F.R. § 422.101(b).

Prohibition on Diverting Patients to Other Settings. In preamble language, CMS also discusses that MA plans may only deny a request for Medicare-covered PAC services ordered for a particular setting when the MA plan determines that the traditional Medicare coverage criteria for those services cannot be satisfied in that setting. In other words, MA plans cannot deny PAC services ordered for a particular care setting because those services *could* be provided in an alternative setting – thus preventing MA plans from diverting patients to a less-intensive care setting unless the patient does not meet traditional Medicare-established criteria for the ordered care setting. The Proposed Rule provides a Skilled Nursing Facility (SNF) example: "[i]f an MA patient is being discharged from an acute care hospital and the attending physician orders post-acute care at a SNF because the patient requires skilled nursing care on a daily basis in an institutional setting, the MA organization cannot deny coverage for the SNF care and redirect the patient to home health care services unless the patient does not meet the coverage criteria required for SNF care..." (87 Fed. Reg. 79502; emphasis added).

Response: IRFs play a unique and crucial role in the PAC continuum. IRFs treat some of Medicare's most seriously disabled and vulnerable beneficiaries, providing services that cannot be adequately substituted. IRF patients commonly have conditions such as stroke, spinal cord injury, amputation, major multiple trauma, brain injury, neurological disorders, and other injuries that have resulted in serious functional deficits and the need for continuing medical supervision. Intensive rehabilitation with highly trained therapists, 24-hour nursing care, close medical supervision, and the other benefits of a hospital setting allow our patients to recover in ways not otherwise possible, and in many instances, not otherwise safe.

Unfortunately, our members have often experienced coverage denials for our MA patients based on the plan's determination that care "could" be provided in another care setting (typically a "less intensive" one) - a rationale that CMS has asserted is not appropriate for coverage denial.[3] These denials contradict the medical expertise and recommendations of the ordering physician and often do not provide additional reasons for the denial aside from the perfunctory statement that an alternative care setting would suffice. Data show that more than 10 percent of MA denials for patients who are pre-screened for IRF care result in care provided at lower-acuity settings.[4]

Importantly, during the early stages of the COVID-19 pandemic, our members reported that MA plans routinely waived PA requirements. As demonstrated from the data reported by our members

[3] Centers for Medicare & Medicaid Services, Inpatient Rehabilitation Facility Coverage Requirements Conference Call (November 12, 2009). Available for download: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.

[4] eRehabData® Comparison of Medicare and MA Patients' Use of IRF Services (as presented at the October 2022 AMRPA Fall Conference; please also see Attachment 1).

during this period, IRFs not only treated higher volumes of high acuity patients when PA was waived but also delivered the same high return-to-community rates. In fact, when PA was broadly waived across the MA program, the proportion of MA and traditional Medicare beneficiaries treated in IRFs almost precisely aligned with utilization projections based on enrollment in the respective programs.[5] These statistics clearly demonstrate the unfair access restrictions that PA created for MA beneficiaries prior to the PHE and affirm the clear value that IRFs can provide to higher numbers of MA beneficiaries when admission decisions are not hampered by PA practices.

We strongly support proposals that limit MA plans' PA processes to confirming diagnoses and that prohibit MA plans from denying care – or steering care to a less intensive care setting – based on the plans' unsupported and impermissible assertion that care could be provided in another setting. Given IRFs' unique capabilities, which cannot be appropriately provided in another care setting, AMRPA strongly supports reforms that prevent MA plans from diverting MA beneficiaries to other care settings based on cost rather than clinical considerations.

Codifying Individualized Coverage Decisions. The Proposed Rule would codify the existing policy that MA plans must provide individualized coverage decisions. The Proposed Rule states that MA plan decisions should consider the enrollee's medical history, physician recommendations, and clinical notes in making medical necessity determinations. CMS also proposes that the MA plan's Medical Directors be involved in ensuring the clinical accuracy of medical necessity decisions, where appropriate. The Proposed Rule would also codify existing guidance that, when an enrollee or provider requests a pre-service determination and the plan approves, the plan cannot later deny coverage or payment based on medical necessity (unless for good cause, e.g., fraud).

Response: In our members' experience, MA plans often apply overly restrictive criteria, and appear to screen patients based on certain conditions. Such condition-based screening violates the requirement that patients be individually assessed, and these screening practices should be prohibited. The Medicare coverage requirements for IRF care (found at 42 C.F.R. 412 § 622(a)(3)) purposefully rely heavily on the judgment of a rehabilitation physician and are based on an intensive review of the individual patient's functional status, therapy needs, and stability. AMRPA members consistently report, however, that plans use criteria that appear completely misaligned with this regulatory language (for example, inappropriately denying coverage for patients with conditions not covered by the 60% rule – which is a classification rule used to determine whether a particular hospital qualifies as an IRF, rather than a patient-facing coverage criteria). It is imperative that MA plans' coverage policies and criteria precisely align with the letter and intent of the traditional Medicare program. We strongly agree with proposals that require MA plans to conduct an individualized assessment for coverage decisions, and we believe that plans should be required to communicate clearly how they have relied upon the factors that CMS has proposed (including medical history, physician recommendations, and clinical notes) in making their determinations in a clear and specific manner.

In many cases, our members have received denial explanations that do not reflect an individualized analysis: plans often use a single sentence to deny coverage, or plans simply state that the patient does not meet medical necessity criteria and then essentially copy the entire Medicare manual to

[5] Id.

support that conclusion. Currently, MA plans can easily game the system by including virtually no information or by inundating providers with information, putting the burden squarely on providers during the first round of review. When plans are permitted to refer to one-size-fits-all statements, or list essentially every available reason (including technical reasons) for a denial, it is impossible for providers to meaningfully respond. It has been our experience that MA plans commonly use this tactic to "run out the clock," forcing acute care hospitals to search for other care settings to discharge patients. If providers are unable to timely address denials because plans do not provide specific and individualized reasons for their decisions based on the factors that CMS has outlined, MA beneficiaries will continue to receive sub-optimal care. We recommend that CMS continue to work with stakeholders to standardize the language that MA plans use in their denial explanations, including specific reasons for the denial and demonstration that the MA plan has considered the required factors in reaching its determination.

Our members also frequently experience another delay tactic: MA plans often arbitrarily request patient updates with the knowledge that the provider will likely be too busy to respond immediately to the update request. MA plans then refuse to process requests until the provider submits the update. In these cases, the plan already has the expert medical opinion of the ordering physician in hand and intentionally puts the onus of continually justifying that opinion on the physician. These update requests impose an additional, arbitrary layer in the coverage determination process, overburdening physicians and harming patients while offering no real informational benefit. Given the common use of this tactic, we recommend that CMS also work with stakeholders to regulate MA plans' use of arbitrary patient update requests to avoid care delays and unnecessary costs to the Medicare program.

Gold-carding Programs. Some payers implement "gold-carding" programs that reduce PA requirements for certain providers that have demonstrated consistent adherence to submission requirements and appropriate utilization of items or services. The Proposed Rule encourages, but would not require, MA plans to adopt gold-carding programs that relax PA requirements for contracted providers that have demonstrated compliance with plan policies and procedures. This encouragement is not included in the proposed regulatory text, and CMS seeks comment on potentially establishing a requirement that plans implement gold-carding programs. CMS also states that the agency would consider including a gold-carding measure as a factor in quality ratings for MA plans as a way for plans to raise their scores.

Response: We strongly support programs that would reduce provider burden throughout the PA process. However, we note that implementing gold-carding programs in a way that benefits good actors and streamlines the process for providers may be difficult in practice, and we outline some potential pitfalls here for CMS's consideration. At a base level, because initial approvals are so difficult to obtain, it would be difficult for providers to demonstrate that they meet the plan's criteria more often than not (such that the provider would qualify for the gold-card program). Additionally, PA criteria vary from plan to plan, and providers must tailor each submission request to the particular plan's idiosyncrasies – making it difficult for providers to comply in the first place and making it even more difficult to demonstrate consistent compliance over time.

Because the deck is already stacked so severely against providers being able to demonstrate compliance with plan policies and appropriate utilization, we fear that very few providers would

actually benefit from gold-carding programs, especially in the rehabilitation and PAC context where initial denials are relatively high. Instead, plans could simply use the existence of their gold-carding program to boost their Star Ratings and reputation without actually having to meaningfully alter their current processes. Additionally, plans could simply change their submission criteria (including technical criteria) to make it more difficult for providers to qualify for the gold-carding program if plan administrators feel that the programs are not working in the plan's favor.

Instead of measuring compliance at the initial request stage, one potential metric that could be used to qualify providers for a gold-card program is the provider's success rate on appeal, including beyond the initial internal plan redetermination process. When providers are consistently successful on appealed determinations, this signals that the providers are appropriately utilizing services and providing appropriate documentation to support their requests. These providers should have a significantly reduced submission burden and reduced stringency of review of their requests. We also recognize there may be some logistical complications with this proposal, especially given the time required for appeals. We would be happy to discuss our experiences with gold-carding programs, and the potential problems with these programs, with you and your staff in more detail as CMS continues to develop policies in this area.

Response Timelines. While we realize that standardized response timelines for coverage requests are addressed in a separate, related proposed rule,[6] we would like to take the opportunity in this response to emphasize that the timeliness of MA plans' responses is especially critical in the IRF context. For our patients, any delay in beginning rehabilitation treatment can have dramatic and negative effects on their recovery, functionality, and quality of life. Response delays are not only detrimental to patients' health, but delays can also be extremely costly to the health care system and the Medicare program. Delays can result in patients languishing in acute care hospital beds for several additional days, which is costly to the referring hospital and to patients, who must pay related deductibles and co-payments. Delays are also costly to IRF facilities that need to hold a bed open in anticipation of eventually receiving the patient, reducing the number of beds available and reducing overall care access.[7]

Finally, delays in access to IRF care often translate into outright denials as acute care hospitals have no choice but to move patients ready for discharge to a post-acute care setting that accepts the patient, regardless of whether the patient is best served in that setting. The current 72-hour timeline (which would be unchanged in a separate prior authorization rulemaking currently subject to comment) is simply too long for patients in need of rehabilitation care, or any patient in an acute care hospital, to wait for PAC approval. For IRF care, MA plans must respond to coverage determination requests **within 24 hours** to ensure that precious and crucial patient recovery time is not lost.

[6] 87 Fed. Reg. 76238, 76293-94 (December 13, 2022).

[7] 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.

Additionally, MA plans are currently not required to respond to requests over the weekend and often take advantage of the weekend to delay decisions and force hospitals to seek care in alternative, less-intensive settings. In contrast, traditional Medicare contractors do respond to requests over the weekend. As a result, traditional Medicare beneficiaries can be placed in the appropriate PAC setting in a timely manner, but MA beneficiaries must wait for longer periods to receive their care. If an MA beneficiary's request is submitted on a Friday, for example, they could end up waiting in the hospital for five days before receiving a response because the MA plan refuses to be available to respond to requests over the weekend. Shutting down operations during the weekend results in subpar care for MA beneficiaries relative to their traditional Medicare beneficiary peers. Hospitals continue to operate during the weekend, and patients continue to need intensive rehabilitation care during the weekend. MA plans must be responsive to those needs. In addition to a 24-hour response requirement for IRF requests, CMS should also mandate that MA plans respond to requests over the weekend to ensure timely care determinations and transitions for MA beneficiaries.

In exigent circumstances, a patient may need to be moved urgently into IRF care before the facility has received approval from the MA plan. In these cases, the plan will often refuse to cover the initial days of care provided, which occur before the plan officially approves the care, especially when the patient was transitioned into IRF care over the weekend. In some cases, the plan will simply issue an administrative denial based on the fact that the patient was admitted without prior authorization. Plans' reluctance to retroactively approve care disincentivizes IRFs from admitting these patients, who are critically in need of intensive rehabilitation care, without first obtaining authorization from the plan. As a result, some of the most vulnerable, fragile, and critically ill MA beneficiaries do not immediately receive the care they need, and IRFs that do decide to provide care for those patients risk reimbursement for these urgent and important services. In addition to a 24-hour response requirement, including weekend responses, CMS should also consider establishing requirements for retroactive approval when a beneficiary has been urgently moved into IRF care before approval can be obtained.

B. Continuity of Care and Conditions Placed on Care Approval

Restricting Termination of Coverage and Conditional Coverage. The Proposed Rule specifically solicits feedback on situations in which an MA plan terminates a beneficiary's PAC coverage before the individual is healthy enough to return to home or the MA plan terminates coverage after a favorable appeal to a Quality Improvement Organization (QIO) to continue coverage. To avoid repetitive PA requests for continuing coverage, CMS proposes that an approval granted through PA processes be valid for the duration of the approved course of treatment. The Proposed Rule also addresses situations in which beneficiaries switch MA plans. In these cases, for beneficiaries undergoing an active course of treatment, the Proposed Rule would require a minimum 90-day transition period and would require that the PA approval remain valid for the beneficiary's full course of treatment.

Response: Termination of Coverage. AMRPA strongly agrees with PA reforms that ensure MA beneficiaries receive continuous coverage for the duration of their ordered treatment plan, without requiring additional PA request approvals or placing additional burden on providers. We also strongly support the transition period when MA beneficiaries switch plans and the requirement

that PA approvals remain valid for the full course of treatment in those circumstances. In our members' experience, MA plans routinely seek to terminate treatment early and place additional burdens on providers to continue to prove that the beneficiary still requires care in an IRF setting. Our members also report consistently having to engage in peer-to-peer reviews with MA plans to ensure that MA beneficiaries can move to an IRF setting. As the acute care hospital is also typically involved in these peer-to-peer reviews, IRF physicians must rely on a willing partner, whose participation in the process is outside IRF physicians' control, to ensure that patients have access to appropriate care.

These additional MA plan-imposed requirements place a heavy and unnecessary burden on providers and may discourage choosing the level of care that is most appropriate and instead encourages choosing a level of post-acute care that imposes less burdensome hurdles during the admission process. Our members also report that MA plans will often attempt to "drop" their IRF patients at the end of the year when the beneficiary's plan contract is up for renewal. Interruptions in coverage can be extremely detrimental to our patient population, and responsible care transitions are imperative for patient safety and quality of care. We strongly support reforms that reduce the burdens placed on providers, patients, and patients' families to ensure that patients receive their full benefits throughout the course of their ordered treatment plan.

Conditions on Coverage. To ensure that MA beneficiaries receive necessary and appropriate care across the PAC continuum, AMRPA also recommends that CMS address situations in which MA plans make IRF approvals conditional on the patient not receiving subsequent SNF or other PAC coverage. Our members 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 that all patients will not need subsequent post-acute care, particularly given the long-term and complex care needs of most patients requiring IRF care. The conditions that MA plans attach to IRF approval are a flagrant violation of traditional Medicare coverage rules, which entitle MA beneficiaries to SNF care when an individualized determination of medical necessity is made and the beneficiary qualifies for SNF coverage.

As a result of these MA plan-imposed conditions, our members are essentially forced to implement additional internal rules that apply only to MA beneficiaries, such as determining that a patient will likely have a successful discharge to community. These conditions effectively restrict access to care for MA beneficiaries in a way that does not apply to traditional Medicare beneficiaries. Accordingly, AMRPA requests that CMS consider the entire PAC spectrum when ensuring that MA beneficiaries' continuity of care is protected. This requires, for example, clear prohibitions on MA plan practices that prohibit the use of SNF care following an IRF admission and other MA plan actions that fail to reflect the progressive levels of recovery required by certain patients.

Inadequate Networks. To ensure that MA beneficiaries have meaningful access to care across the PAC continuum, AMRPA also recommends that CMS address PAC inadequacies in MA plan networks. In our members' experience, MA plans tend to limit access to IRF care by keeping their IRF provider network narrow and inadequate to meet beneficiary demand. AMRPA members report that numerous MA plans, nationwide, do not maintain a sufficient number of agreements with all types of PAC providers (particularly IRFs) due in part to the fact that there are no network adequacy requirements for MA plans to include IRFs. Our members also report that, many times,

patients will be discharged with home health, but the home health agencies with which the MA plans contract are extremely short-staffed and cannot meet patient demand. As a result, the MA plan informs the patient that they can either receive care in an outpatient setting or they can wait until the home health agency has the capacity to provide the care. MA plans' continued contracting with short-staffed agencies is an unacceptable practice that ultimately denies MA beneficiaries access to care that they are entitled to receive.

Without changes to network adequacy requirements to include IRFs and certain other types of PAC providers, MA plans will continue to place patients in inappropriate care settings. We are increasingly concerned that MA plan network inadequacies are driving patient placement decisions that run counter to patients' best interests and Medicare coverage rules. AMRPA supports the Proposed Rule's improvement of network adequacy standards for behavioral health services, and we urge similar action be taken for IRF coverage. CMS may also consider other changes in the future to better facilitate safe care transitions from a PAC setting to the home environment, such as commencing IRF and home health agency coverage at the same time to ensure the continuity of care that the Medicare program seeks to deliver.

C. Medical Necessity Reviewer Qualifications

CMS proposes to revise PA reviewer standards to require that the reviewing physician (or another appropriate health professional) conducting medical necessity reviews for MA plans have "expertise in the field of medicine that is appropriate for the item or service being requested" before the plan can issue an adverse decision. The current standard only requires the health professional to have "sufficient medical expertise," without linking the required experience to the item or service at issue. However, CMS does not propose to require that the reviewing physician (or another appropriate health professional) have the same medical specialty or subspecialty as the ordering physician.

Response: As we have described, there are several ways in which MA beneficiaries are inappropriately directed away from IRF care, raising serious access and equity concerns. In our members' experience, MA plans rarely use clinicians who have experience in rehabilitation care to review requests for rehabilitation services. Our hospitals and physicians report that it is typical for the MA-reviewing physician to be trained in a completely unrelated specialty, with little understanding of rehabilitation medicine or of the Medicare criteria for IRF admissions. Sometimes the MA reviewer lacks an understanding of the differences between IRFs and other PAC settings, while clearly utilizing guidelines provided by the MA plan to divert patients to less-intensive settings. In some cases, after issuing a tentative denial, the MA plan will offer a "peer-to-peer" discussion between the MA reviewer and the ordering physician. Even when our members have the opportunity to educate the MA reviewer during these "peer-to-peer" discussions on the necessity of IRF care for the patient, these peer-to-peer conferences typically, and frustratingly, result in a rubber-stamp affirmation of the initial denial.

While we support the new proposed language as an improvement upon the current reviewer qualifications standard, we strongly believe that the review of requests for IRF services requires the MA plan reviewer to have knowledge of the relevant specialty. If the reviewer falls short of those qualifications, it is our view that the reviewer simply cannot have the expertise and experience to appropriately evaluate and overrule the referring physician's care recommendation.

If the plan is unable to have that type of clinician review the requests, the plan should defer to the expert medical opinion of the referring specialist and not issue a denial unless it can provide a substantial showing that the treating practitioner's decision should be overruled. Given the unique complexities of the patient in the IRF context, we recommend that CMS employ such a standard.[8] In other words, there should be a higher threshold for denial when the reviewer is not a physician with specialized training and experience in medical rehabilitation - the same standard CMS requires of admitting IRF physicians. Additionally, CMS should consider requiring plans to document the reviewer's qualifications in the determination materials.

D. Utilization Management Committee and Compliance Mechanisms

In the Proposed Rule, CMS proposes that MA plans establish a Utilization Management Committee (Committee), similar to a Pharmacy and Therapeutics Committee, to ensure that the plan's utilization management policies are consistent with traditional Medicare coverage decisions and guidelines. This Committee would be led by the plan's Medical Director and would meet at least annually. A majority of the Committee's membership would be required to be practicing physicians; the Committee must include at least one practicing physician who is independent and free of conflict relative to the MA plan; the Committee must include at least one practicing physician who is an expert regarding the care of elderly or disabled individuals; and the Committee must include members representing various clinical specialties. Under the Proposed Rule, starting January 1, 2024, an MA plan may not use utilization or management policies for basic or supplemental benefits unless reviewed and approved by the Committee.

Response: While we support requiring MA plans to establish and use a Utilization Management Committee, we believe that CMS must create and employ much stronger enforcement mechanisms to ensure that MA plans' PA policies and practices comply with traditional Medicare coverage decisions and guidelines. In our members' experience, MA plans do not adhere to current program guidelines, and the only recourse available to providers is to appeal the plan's decision. Appealing a decision is a resource-intensive and time-consuming process for providers and patients and their families. Given our current experience with MA plans not adhering to existing guidance, we are not optimistic that plans will adhere to reformed policies. Although an internal oversight Committee could help ensure that plans are using PA processes appropriately, we do not believe that internal enforcement mechanisms will be sufficient on their own to ensure plan accountability.

We strongly support the deadline requiring plans to have approved utilization policies in place by January 1, 2024. If plans are unable to have their utilization policies reviewed and approved by that deadline, plans should not be able to use those policies in practice. Additionally, we believe that the Committee should be required to review policies on an ongoing basis, or at least more often than annually. Although the Committee members would be required to include a practicing physician with expertise in care for elderly or disabled individuals, we recommend that the Committee be required specifically to have a practicing physician member with expertise in rehabilitation medicine. We believe this is especially appropriate given the importance of

[8] We note that in traditional Medicare, under 42 C.F.R. § 412.622(a)(4), a rehabilitation physician must concur with the findings of the required pre-admission screening of a potential IRF patient – to highlight that, in traditional Medicare, only a rehabilitation physician is recognized as having the appropriate level of knowledge and experience to make the ultimate decision regarding an IRF admission.

rehabilitation care services, and the significant and validated concerns about plans' restrictive practices regarding rehabilitation care access, to the MA beneficiary population. The Committee should also be comprised of network physicians who have experience with, and would have to engage directly with, the plan's approved PA policies. Further, although the Committee would be required to have at least one independent member, we believe this will be insufficient to ensure disinterested oversight. We strongly recommend that the Committee have a plurality, if not a majority, of independent members to ensure that the Committee functions separately from the plan.

We strongly recommend that CMS develop a more robust enforcement plan, including auditing processes, transparent reporting processes, and penalties for non-compliance, to ensure that MA plans comply with the important PA policy reforms included in the Proposed Rule. MA plans should be publicly accountable for their PA policies and practices, and key PA metrics should be able to be easily measured across plans so beneficiaries have a better understanding of their access to PAC care under the plan's policies. At a minimum, such reporting should include the number or percentage of denials, the reason(s) for denials, and the turnaround time to respond to requests for care approval. We are happy to continue to work with CMS to develop more robust enforcement mechanisms to ensure plan accountability.

E. Marketing Practices

The Proposed Rule includes new marketing requirements and protections to ensure that MA and Part D beneficiaries, and people shopping for Medicare coverage, are not potentially misled by plan marketing tactics and to ensure that they have accurate and necessary information to make coverage choices that best meet their needs. Recent Congressional and press attention has focused on problematic MA marketing practices, including a Senate Finance Committee report that detailed deceptive marketing practices by MA plans and urged CMS to take action to protect Medicare beneficiaries. In the Proposed Rule, CMS proposes over twenty distinct changes to the MA and Part D marketing regulations, with many of these proposals focusing on marketing activity conducted by Third Party Marketing Organizations (TPMOs) and entities operating on behalf of more than one MA organization (MAO)/Part D sponsor. These proposals include greater transparency around TPMOs, strengthening the role of plans in monitoring agents, brokers, and TPMOs, prohibiting misleading uses of the Medicare name and related logos or information, regulating the use of superlatives, and requiring agents to explain the effect of a beneficiary's enrollment choice on their current coverage whenever the beneficiary makes an enrollment decision.

Response: We strongly support reforms that prohibit the use of misleading information and deceptive marketing practices, and we encourage CMS to develop robust enforcement mechanisms around these new marketing restrictions as well. In our members' experience, patients do not understand the difference between traditional Medicare and MA plan benefits, including the differences in access to PAC benefits. In fact, research shows a growing knowledge gap among Medicare beneficiaries regarding their PAC benefits, which is more prominent among less wealthy and minority beneficiaries.[9] Beneficiaries typically do not understand the choice they are making

[9] Ankuda CK, Moreno J, McKendrick K, Aldridge MD. *Trends in Older Adults' Knowledge of Medicare Advantage Benefits, 2010 to 2016*. J Am Geriatr Soc. 2020 Oct; 68(10):2343-2347. doi: 10.1111/jgs.16656. Epub 2020 Jun 20. PMID: 32562568; PMCID: PMC8049536.

when they select into an MA plan. In many cases, they believe they are simply getting *additional* benefits on top of their traditional Medicare coverage and do not understand that they would have to give up some freedom of provider choice and would be subject to the MA plan networks. Beneficiaries need more accurate information to be made available to them, especially information that makes the differences between MA plan coverage and traditional Medicare coverage more apparent.

F. Star Quality Rating System Measures and Advancing Health Equity

CMS proposes several changes to the MA Star Ratings program, including several proposals aimed at advancing health equity. Specifically, beginning with the 2027 Star Ratings, CMS proposes to implement a health equity index (HEI) to reward plans that obtain a high measure-level score for a subset of beneficiaries with specified social risk factors, including for dually eligible beneficiaries, beneficiaries who receive low-income subsidies, and beneficiaries with a disability. CMS also proposes to specify that the existing requirement to provide culturally competent care includes underserved groups beyond linguistically and culturally diverse populations, to include people with disabilities, diverse sexual orientations, and those who live in rural and other underserved areas. To facilitate beneficiary access to culturally competent care, CMS proposes to codify existing best practices for provider directories to require that MA plans include each provider's cultural and linguistic capabilities in their provider directories. The Proposed Rule would also require MA plans to incorporate activities that reduce health disparities – including improving communication, developing and using linguistically and culturally appropriate materials, and hiring bilingual staff – into the plan's Quality Improvement program.

Response: We applaud CMS's efforts to incorporate health equity measures into MA plans' Star Ratings. We strongly believe that quality measures should also more transparently measure and report key metrics related to the plan's PA practices. As noted, beneficiaries who enroll in MA plans are disproportionately lower-income and from minority populations compared to their traditional Medicare beneficiary peers. As a result, MA plans' practices that restrict access to care for these beneficiaries have a direct and negative impact on the agency's health equity goals. MA plans' approach to PAC placements has a significantly negative impact on some of the most debilitated Medicare beneficiaries, as these patients are most often denied proper placement due to the complexity and cost of their PAC needs. Many of these more severely impacted patients have a disabling condition, which results in inequitable access for this protected group. We strongly believe that achieving health equity goals requires that MA beneficiaries receive the PAC benefits to which they are entitled. We urge CMS to consider future policy changes to enhance the visibility and useability of Star Ratings for patients and their families. 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.

***

AMRPA greatly appreciates CMS's efforts to reform PA practices and to improve the MA program. These reforms are an important step in the right direction, and work must still be done to ensure that MA beneficiaries receive the high-quality care to which they are entitled. Given the identified impacts on patients, we urge CMS to finalize proposals with the recommendations offered above as soon as possible. While MA plans may feel this is a large change in existing

policy, we argue that many of these policies should already be in place and should not require additional delay. Furthermore, we believe plans may benefit from these reforms as they provide greater consistency across payers and create a more even playing field.

We look forward to continuing our collaboration with CMS to ensure that all Medicare beneficiaries have timely access to the care they need, particularly with respect to medically necessary inpatient rehabilitation services. 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, North Shore/Staten Island University Hospital

Attached:

Attachment 1: eRehabData® Analysis re: Medicare Advantage & Fee-for-Service Admission, Denial, and Related Data

Attachment 2: AMRPA Response to CMS RFI on Health Equity & Access Issues in the Medicare Advantage Program

Attachment 3: AMRPA Prior Authorization Survey Data

Attachment 1: eRehabData® Analysis re: Medicare Advantage & Fee-for-Service Admission, Denial, and Related Data

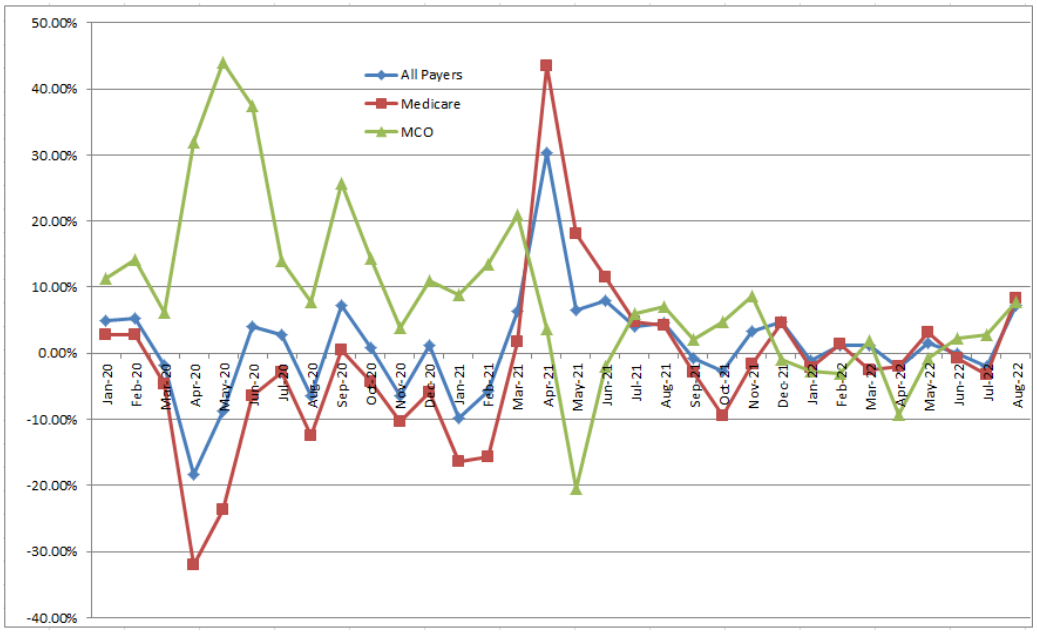
Medicare Advantage: Pre-Admission Screened, But Denied IRF Admission Reasons

	2017	2018	2019	2020*
Admitted to Other IRF	4.35%	4.88%	4.84%	5.65%
Admitted to Other Level of Care (not IRF or SNF)	2.70%	2.16%	2.06%	2.25%
Admitted to SNF	9.24%	10.81%	9.47%	10.02%
Does Not Meet Medically Necessary Criteria	5.88%	5.86%	7.24%	6.25%
Expired	0.03%	1%	1%	0.91%
Insurance Denied	34.50%	32.87%	25.43%	21.31%
Insurance Out of Network	4.32%	3.75%	3.47%	4.97%
No 40% Bed Available	0.56%	0.31%	0.22%	0.22%
No Bed Available	1.65%	1.31%	1.75%	4.00%
No Reliable Discharge Plan	1.85%	1.38%	1.78%	1.83%
Other	5.45%	4.52%	11.18%	12.15%
Patient/Family Refused	7.83%	5.17%	4.71%	4.85%
Physician Refused	0.93%	0.70%	0.81%	0.73%
Too Functional	9.13%	7.22%	7.98%	6.72%
Too Impaired	10.27%	9.87%	10.69%	9.89%
Unable to Accommodate Special Medical Needs	1.02%	1.15%	1.26%	1.25%
Went Home	0.29%	7%	6%	7.01%

*YTD 9/30/20

More than 10 percent of MA denials for patients who are pre-screened for IRF care result in care provided at lower-acuity settings, with roughly 10 percent of those patients being admitted to SNFs.

Change in Discharge Volume from Prior Year eRehabData® Inpatient Rehabilitation Facilities



Medicare Advantage beneficiary access to IRFs increased dramatically when MA plans generally waived prior authorization during the early COVID-19 surges.

AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

August 31, 2022

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–4203–NC
P.O. Box 8013
Baltimore, MD 21244-8013

Delivered Electronically

Re: *Medicare Program; Request for Information on Medicare Advantage; CMS–4203–NC; 87 Fed. Reg. 46,918 (August 1, 2022)*

Dear Administrator Brooks-LaSure:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we submit this letter in response to the *Request for Information on Medicare Advantage* published in the Federal Register on August 1, 2022. 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 directly respond to CMS' questions posed in Section B ("Expand Access: Coverage and Care"), specifically question numbers 13 and 14 regarding utilization management techniques, including prior authorization.** However, given how these utilization management techniques directly relate to health equity concerns, CMS will also find our comments relevant to the questions posed in Section A ("Advance Health Equity").

AMRPA is pleased to see CMS' continued interest in addressing prior authorization (PA) practices through prior stakeholder outreach and requests for information (RFI). Prior authorization reform is at the top of AMRPA's advocacy agenda due to the direct and adverse impact these practices impart on some of Medicare's most severely ill and injured beneficiaries, including those living with disabilities. Given the significant growth of the Medicare Advantage (MA) program in recent years – and particularly the fact that over half of Medicare beneficiaries may be enrolled in MA plans as soon as 2023 – timely and effective policy changes are critical to avoid serious access and equity issues. This is particularly true since research has shown that minority and less affluent beneficiaries are enrolling in MA at a higher rate, and that these beneficiaries face larger knowledge gaps and disenrollment rates than other beneficiaries due to access issues.

As explained in more detail in Section I of 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 or unsupported proprietary guidelines that conflict with Medicare coverage rules; using delay tactics to pressure hospitals and patients into using inappropriate substitutes for IRF care; and not providing real-time and

responsive recourse to appeal adverse decisions, among numerous other tactics. In addition to hearing about these issues from our members on a routine basis, AMRPA recently engaged in a data collection effort which resulted in staggering findings about access to care for MA beneficiaries. These findings are detailed throughout this letter, including a dedicated analytical summary in Appendix I. Section II of this letter outlines AMRPA's specific recommendations to CMS to meaningfully improve patient access and care delays, including:

- **CMS must prohibit MA plans from utilizing proprietary guidelines that conflict with Medicare coverage rules, as this can place undue burden and access restrictions on particularly vulnerable beneficiaries**
- **CMS must ensure that determinations and appeals are made in a timely manner to afford meaningful review and oversight of plan behavior**
- **CMS must require transparency regarding the methods and outcomes of prior authorization determinations and appeals**
- **CMS must require that all MA denials of hospital admissions be approved by practicing and qualified physicians**
- **CMS must seek authority to require MA plans to fully waive prior authorization requirements as necessary during national or local Public Health Emergencies and other extenuating circumstances**

I. MA Plans Use Prior Authorization to Divert Hospitalized Patients to Inappropriate Post-Acute Care Placements

IRFs play a unique and crucial role in the continuum of post-acute care (PAC), which is why Medicare recognizes IRF care as a distinct covered benefit. IRFs treat some of Medicare's most seriously disabled and vulnerable beneficiaries, offering a service that cannot be adequately substituted with alternative PAC placement for select patient populations. The vast majority of patients treated in an IRF are admitted directly from an acute-care hospital due to a serious injury, illness, 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. The unique combination of intensive rehabilitation with highly trained therapists, 24-hour nursing care, close medical supervision, and the other benefits of a hospital setting allow patients to recover in ways not otherwise possible.

The COVID-19 Public Health Emergency (PHE) has highlighted the unique capabilities of IRFs. A recent report authored by ATI Advisory detailed the ways in which IRFs provided critical services throughout the various stages of the pandemic across the nation, and enabled their communities to ensure proper care for all who needed it.[1] Due to their sophisticated capabilities, IRFs were able to

[1] *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).

provide expanded hospital capacity for acute-care hospitals, and to lead the way in caring for recovering COVID-19 patients who faced myriad functional challenges and medical complications.

In recognition of IRFs' unique role in the PAC continuum and critical role during the PHE, CMS urged MA plans to waive PA numerous times during the pandemic. As a compelling testament to the clear value of and need for robust patient access to IRFs, our members reported that MA plans routinely waived PA through the most critical early stages of the PHE. As detailed in our appendix, IRFs not only treated higher volumes of high acuity patients when PA was waived, but also delivered the same high return-to-community rates. These statistics clearly demonstrate the unfair access restrictions that PA created prior to the PHE and affirm the clear value that IRFs can provide to higher numbers of MA beneficiaries if admission decisions were not hampered by PA practices.

Unfortunately, MA plans restored their utilization of PA practices soon after the first COVID surges. Despite the fact that traditional Medicare patients are routinely referred and admitted to IRFs with positive outcomes, MA beneficiaries once again face systemic and harmful barriers to accessing needed IRF care due to MA plan practices. This restricted access for MA beneficiaries, which is supported by the data presented in our appendix, cannot be explained by differences in beneficiary population or proper care utilization review. Rather, it is apparent that certain MA plans inappropriately divert patients to less resource intensive settings, due to short term financial incentives, by conducting improper claim reviews.

The approach taken by MA plans to PAC placements has a significantly negative impact on some of the most debilitated Medicare beneficiaries, as these patients are most often denied proper placement due to the complexity and cost of their PAC needs. Many of these more severely impacted patients have a disabling condition, which results in inequitable access for this protected group. Unfortunately, due to the complex nature of Medicare benefits, it is very difficult for prospective enrollees to understand these differences before deciding whether to enroll in an MA plan or traditional Medicare. In fact, research shows a growing knowledge gap among Medicare beneficiaries regarding their PAC benefits, which is more prominent among less wealthy and minority beneficiaries.[2]

In addition to the overall growth in MA, enrollment growth among black and other minority populations has outpaced other groups.[3] As a consequence, the troublesome PA practices have an increasingly large impact on minority groups. This may help explain why research has also shown that rates of disenrollment from MA plans among ethnic and minority beneficiaries are higher than the general population.[4] It is therefore critical that CMS address these barriers for MA beneficiaries, as PA reform will advance CMS' stated mission to "eliminat[e] avoidable differences in health outcomes experienced

[2] Ankuda CK, Moreno J, McKendrick K, Aldridge MD. *Trends in Older Adults' Knowledge of Medicare Advantage Benefits, 2010 to 2016*. J Am Geriatr Soc. 2020 Oct;68(10):2343-2347. doi: 10.1111/jgs.16656. Epub 2020 Jun 20. PMID: 32562568; PMCID: PMC8049536.
[3] *Growth In Medicare Advantage Greatest Among Black And Hispanic Enrollees*, David J. Meyers, Vincent Mor, Momotazur Rahman, and Amal N. Trivedi, Health Affairs 2021 40:6, 945-950.
[4] Martino SC, Mathews M, Damberg CL, Mallett JS, Orr N, Ng JH, Agniel D, Tamayo L, Elliott MN. *Rates of Disenrollment From Medicare Advantage Plans Are Higher for Racial/Ethnic Minority Beneficiaries*. Med Care. 2021 Sep 1;59(9):778-784. doi: 10.1097/MLR.0000000000001574. PMID: 34054025.

by people who are disadvantaged or underserved, and provid[e] the care and support that our enrollees need to thrive."

The most critical issues created by PA practices for IRF patients are as follows:

A. MA Plans Make Prior Authorization Determinations That Contradict Medicare Rules and Best Medical Practices

MA plans typically deny PA requests for admission to an IRF at a very high rate, often utilizing unqualified reviewers and inappropriate admission criteria. These high denial rates occur 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] As detailed in the appendix to this letter, AMRPA's data showed that **MA plans denied 53% of all initial requests for admission.** When the high denial rate is considered in proper context – as an overruling of a practicing physician treating a severely and acutely ill recovering patient – it is extremely concerning and has direct, detrimental impacts on patient outcomes.

There are several ways in which MA beneficiaries are inappropriately directed away from IRF care that raise serious access and equity concerns. First, it is the consistent experience of AMRPA hospitals and physicians that MA plans rarely utilize clinicians who have experience in rehabilitation care to review cases. 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 it is 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 admissions. Sometimes the MA reviewer lacks an understanding of the differences between IRFs and other PAC settings, but these reviewers clearly utilize guidelines provided by the MA plan to divert patients to less-intensive settings. Even with the opportunity to educate the MA reviewer, these "peer-to-peer" 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 proprietary decision-making tools that steer 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 require MA beneficiaries to be provided with 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. Furthermore, providers do not understand 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 access to care for seriously ill and injured MA beneficiaries. In fact, a 2022

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

Department of Health and Human Services (HHS) Office of Inspector General (OIG) report found that "many" of the MA prior authorization denials that it reviewed were denied because plans "appl[ied] … clinical criteria that were not required by Medicare,"[7] showing the highly concerning and widespread nature of this problem.

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 skilled nursing facility (SNF). While IRFs have a very high rate of discharge to the community, they cannot guarantee that all patients will not need subsequent sub-acute care – particularly given the long-term and complex care needs of most patients requiring IRF care in the first place. In any event, such a condition is a flagrant violation of the Medicare coverage rules, which entitles MA beneficiaries to SNF care when an individualized determination of medical necessity is made and the beneficiary qualifies for SNF coverage.

MA plans also tend to limit access to IRF care by keeping their IRF provider network narrow and inadequate to meet beneficiary demand for IRF care. AMRPA members report that numerous MA plans across the nation do not maintain adequate agreements with all types of PAC 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 will continue to lack the ability to place patients from acute care hospitals into the most appropriate PAC setting. AMRPA is increasingly concerned that these shortcomings are driving placement decisions that run counter to patients' best interests and Medicare coverage rules.

B. MA Beneficiaries Face Harmful Delays in Receiving Care Due to 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, acute-care hospitals and IRFs move as quickly as possible to determine the appropriateness for IRF admission and begin care in an IRF. As CMS is aware, timely initiation of care is critical when it comes to maximizing functional recovery from stroke, traumatic brain injury, spinal cord injury, amputation, and other conditions experienced by Medicare beneficiaries needing IRF services. Despite the Medicare requirement that all patients be screened and approved for IRF admission by a specialized rehabilitation physician, traditional Medicare patients are often beginning their IRF course of treatment within 24 hours of the referral.

In stark contrast, MA beneficiaries seeking IRF admission, including the vast majority who are hospitalized, wait days and sometimes weeks for approval to begin IRF care (at which point many are diverted elsewhere due to such delays). The data provided by AMRPA in the appendix affirms the staggering delays caused by these issues. This data shows that **MA beneficiaries wait, on**

[7] Department of Health and Human Services (HHS) Office of Inspector General (OIG), *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns about Beneficiary Access to Medically Necessary Care* (April 27, 2022) (https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp).

average, more than two and half days (while hospitalized) to receive a determination from an MA plan. To emphasize the overall impact of these delays, AMRPA found that patients incurred 30,000 days waiting for PA determinations during the month of August 2021 alone. This included more than 14,000 days for patients who were admitted through the initial determination. Therefore, even when appropriate coverage determinations are made, the process is still harmful to beneficiaries due to delays in receiving needed interventions.

Despite the need for prompt intervention and regulations requiring the determination be rendered "as expeditiously as the enrollee's health condition requires," it is a matter of standard practice for MA beneficiaries to spend unnecessary days in the hospital to their detriment.[8] One AMRPA member reports waiting up to seven days on average to receive an "expedited" review from a particular plan, which is egregious considering an expedited review must be offered when the patient's "life, health, or ability to regain maximum function [is] in serious jeopardy."[9] These practices, of course, also add cost to the Medicare program as patients incur inpatient hospitalization costs while awaiting their medically necessary rehabilitation care.

C. There is a Lack of Meaningful Appeal Options and Oversight of MA Plan Determinations

While there are appeal rights for both MA beneficiaries and providers to challenge denials of care, the current rules do not afford meaningful recourse for patients seeking admission to IRFs. This is particularly concerning given the OIG's finding that IRF services are among the "most prominent" of the service types that MA plans denied despite meeting Medicare coverage rules.[10] As mentioned earlier, our data shows the vast majority of IRFs (84%) around the country wait two days or more, on average, for an initial determination. Once a Reconsideration (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 (depending on how long the appeal took to file) for a Reconsideration to be issued.

To put this in context, the average IRF length of stay for Medicare beneficiaries is approximately 13 days. Therefore, in the time it takes to receive a Reconsideration, a patient could have been well on her way to discharge to home, rather than missing out on rehabilitation care and costing Medicare, hospitals, and patients additional dollars in the acute-care hospital. In addition, a Reconsideration is not even an independent review of the request. Such a review only occurs at the second level of appeal, which will take nine days or more to complete. Since more than 50% of all patients are initially denied access, the lack of meaningful recourse impacts the majority of patients that have been deemed to need inpatient rehabilitation by their treating providers.

Even if a patient receives a favorable Reconsideration, it is still unlikely that the patient will be admitted to an IRF. This is because acute-care hospitals are understandably hard-pressed to allow a patient to stay even a day longer than is necessary, let alone nearly a week or more, and the patient

[8] 42 C.F.R. § 422.572(a)(1).
[9] 42 C.F.R. § 412.622(a).
[10] HHS OIG, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns about Beneficiary Access to Medically Necessary Care* (April 27, 2022) (https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp).

is often discharged to a sub-optimal PAC location. The end result is that even if the MA plan overturns its initial determination, the plan has still essentially "run out the clock" – meaning that it will not need to provide the IRF care for the patient, and faces no repercussions for employing these restrictive tactics. This highlights the glaring gap in oversight and accountability for MA plan determinations.

Without CMS oversight and transparency, there is little meaningful protection offered to prospective IRF patients given these lax authorization timeframes. Transparency regarding MA determinations appears to be at the third level of determination, where CMS tracks the rate at which an Independent Review Entity (IRE) overturns the MA plan determinations. However, as explained earlier, this oversight is entirely inadequate, as it would take nine 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 complex nature of Medicare coverage rules and varying PAC sites 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 experience cognitive deficits (which the IRF would seek to address). Further, as mentioned previously, this difficulty in navigating Medicare benefits disproportionately impacts minority and less wealthy beneficiaries. Therefore, from a beneficiary perspective, and especially for minority and other vulnerable groups, the issue of PA is often an invisible problem, only truly understood by the providers seeking to achieve the best possible outcomes for their patients.

A recent high-profile PA denial that was reported by *the New York Times*[11] demonstrates the enormous challenges and inequities created by the current PA process. A patient who indisputably required inpatient rehabilitation was repeatedly denied admission by his plan in March 2022 on grounds that did not comport with Medicare coverage criteria. Only due to extraordinary circumstances – having a family that was able to incur the costs of inpatient rehabilitation out-of-pocket and that had existing familiarity with the Medicare appeals system and a willingness to endure *months* of appeal procedures – was the plan's decision fully and favorably overturned in favor of the patient. Even in this case, the plan's decision was overturned over five months after the initial denial. While the ultimate decision was an important win for the patient, the vast majority of Medicare beneficiaries cannot devote the kind of time and resources required to challenge a plan. AMRPA therefore urges CMS to make serious reforms to ensure the appeals process is equitable and accessible to all beneficiaries – especially those who are most vulnerable.

In sum, the result of the inaccurate determinations made by MA plans, and the challenges posed by the appeals system, 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. Further, the delays encountered by MA beneficiaries are detrimental to patient outcomes, cost the Medicare program and its patients additional money, and hamper hospitals' ability

[11] Abelson, Reed. *Medicare Advantage Plans Often Deny Needed Care, Federal Report Finds.* New York Times, April 28, 2022.

to maximize capacity during emergencies. More importantly, MA beneficiaries in need of immediate therapeutic interventions in order to maximize their functional recovery risk are suffering irreparable harm from delays in initiating this care.

This is a discriminatory practice that denies needed care and pushes patients with PAC needs out of the MA program, consistent with the Government Accountability Office's (GAO) recent finding that "beneficiaries in poorer health … may be relatively more inclined to disenroll to join FFS, because of potential issues affecting their access to care or the quality of their care."[12] These and other reports clearly show the disparate impact of PA practices on vulnerable beneficiaries and the compelling need for policy reforms as part of the Administration's health equity initiatives. Our specific recommendations for protecting access to medically necessary inpatient rehabilitation for this population is outlined in the next section.

II. Recommendations to Protect Beneficiary Access to Medically Necessary Inpatient Rehabilitation Care

CMS must take several steps to ensure MA beneficiaries are not inappropriately denied access to intensive post-acute care, particularly IRF services. This includes ensuring that all requests for PA receive timely, careful review in accordance with Medicare guidelines; guaranteeing access to timely and independent appeals of all determinations; offering proper oversight of all MA plan determinations and public transparency of the outcomes of these determinations; seeking authority to mandate suspension of PA during future PHEs and other extenuating circumstances; and ensuring that prospective MA beneficiaries fully understand the difference in utilization review practices between MA plans and traditional Medicare.

A. CMS must prohibit MA plans from utilizing proprietary guidelines that conflict with Medicare coverage rules

The common practice of MA plans basing determinations on guidelines that run contrary to Medicare coverage rules represents a blatant violation of MA beneficiary rights. The HHS OIG has confirmed hospitals' experiences that this is an ongoing practice that violates Medicare standards.[13] It is therefore critical that MA plans do not rely on coverage guidelines that do not precisely mirror Medicare rules – especially clinical guidelines that are proprietary in nature, shielded from transparency, and not based on credible clinical evidence. MA plans should be required to fully disclose any utilization review support tools before they are used so that CMS can ensure consistency with Medicare coverage rules as written and in application.

B. CMS must ensure that determinations and appeals are made in a timely manner to afford meaningful review and oversight of plan behavior

[12] Government Accountability Office, *Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending* (June 2021) (https://www.gao.gov/assets/gao-21-482.pdf).
[13] HHS OIG, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care* (April 2022) (https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf).

CMS must either clarify or modify its rules to ensure beneficiaries are not harmed by waiting multiple days for initial determinations and appeals. Hospitals operate 24 hours a day, 365 days per year to meet the needs of their patients. It is never appropriate for a hospitalized patient to have to wait more than 24 hours for a determination, regardless of whether it is weekday, a weekend, or a holiday. CMS should therefore either modify its regulations, or clarify that the current language requiring determinations be made "as expeditiously as the enrollee's health condition requires" demands that hospitalized patients receive more immediate determinations from MA plans. Similar changes must be made to the timelines for Reconsiderations and subsequent appeals. As explained earlier, waiting days for appeal determinations is not a practical option for hospitalized patients and allows MA plans to inappropriately deny care without any recourse.

C. CMS must require transparency regarding the methods and outcomes of prior authorization determinations and appeals

There is presently no data provided by CMS or MA plans regarding initial PA determinations made by MA plans. This data is essential to program oversight as well as to Medicare beneficiaries considering enrollment in an MA plan. As stated earlier, the currently presented data for IRE reviews at the third level of determination is not meaningful for hospitalized patients in need of intensive post-acute care. Therefore, CMS should require public disclosure of MA plan PA policies and outcomes of determinations. This includes disclosure of the types of guidelines and expertise used for these determinations, as well as a breakdown of request outcomes by type of service requested. This data will provide meaningful insight to both CMS and beneficiaries as they consider their enrollment options and weigh how such decisions may impact their access to services.

D. CMS must require that all MA denials of IRF admissions be approved by practicing and qualified physicians

As stated earlier, CMS requires a practicing and specialized rehabilitation physician to approve all admissions to IRFs. An MA plan should not be permitted to allow a lesser qualified clinician to overrule the judgment of these physicians. Ensuring that a competent physician reviews all unfavorable determinations will help ensure patients are not inappropriately diverted away from medically necessary inpatient rehabilitation care.

E. CMS must seek authority to fully waive prior authorization requirements as necessary during national or local Public Health Emergencies and other extenuating circumstances

It has become apparent that PA can be particularly harmful during PHEs and other circumstances in which the health care system, particularly hospitals, are facing capacity issues. AMRPA heard from numerous members across the country during nation-wide and local surges that hospitals were hamstrung in their efforts to utilize beds for more acute COVID-19 patients due to the PA practices that restricted other patients (who still required hospital-level care) from accessing IRFs. While AMRPA greatly appreciated CMS' repeated recommendations that plans waive PA during

different stages of the pandemic, CMS' lack of authority to *require* these waivers was an impediment to many communities' recovery efforts – particularly when plans prematurely reinstated PA practices during subsequent surges.

As demonstrated by the data collected by AMRPA, there are potentially upwards of a million unnecessary days being spent by patients in acute-care hospitals waiting for IRF admissions each year. While this should be remedied under usual circumstances, it is especially important that this not occur when the health care system is in crisis. While the COVID-19 PHE is one example of a crisis, other circumstances may also warrant the suspension of PA at a national or local level.

As HHS and other policymakers shape future pandemic preparedness policies based on lessons learned from the COVID-19 PHE, the ability for CMS to require the restriction of PA practices in future emergencies is essential. We therefore urge CMS to seek authority to mandate MA plans to forgo PA requirements during PHEs and other circumstances when beneficiaries might be facing care rationing, or other declared emergencies.

In closing, we note that many of these recommendations are consistent with the recommendations of the HHS OIG, which stated that CMS should issue new guidance on the appropriate use of clinical criteria in medical necessity reviews, should update its audit protocols to address the issues identified in the OIG's reports, and should direct MA plans to take additional steps to identify and address vulnerabilities that can lead to manual review and system errors. AMRPA was pleased to see that CMS agreed with all of these recommendations from the HHS OIG, and we urge CMS to take timely action to implement these and other reforms in the near future.

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AMRPA greatly appreciates CMS' efforts to improve the MA program. We look forward to continuing our collaboration with CMS to ensure that 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 or Kate Beller at KBeller@ampra.org.

Sincerely,

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

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

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Appendix 1: Access to Inpatient Rehabilitation for Medicare Advantage Beneficiaries: An Examination of Prior Authorization Practices

Background: AMRPA has long demonstrated the impact of PA through patient experiences and examples of provider burden. In 2021, CMS asked whether AMRPA could work to "quantify" the impacts of these practices with hard data on delays and other adverse outcomes. As a result, AMRPA embarked on an effort to collect data on the outcomes of MA plan PA requests for IRF admissions nationwide in August 2021. As part of this effort, a total of 475 IRFs from 47 states, plus the District of Columbia and Puerto Rico – approximately 40% of all IRFs nationwide – submitted data on the outcomes for 12,157 requests for the survey month. The results demonstrate numerous failures in the current PA process used by MA plans.

Results: Overall, the data confirmed the observations of AMRPA members regarding PA practices. First, the data showed that MA plans overrule the judgment of treating, specialized rehabilitation physicians at a very high rate. Overall, *more than 53% of all initial requests for an IRF admission were denied*, resulting in 6,482 patients being diverted to less-intensive settings during the course of just one month. The high rate of denial was very consistent across providers, with 87% of all hospitals having at least 30% of their requests denied during the month. Given the rigorous screening performed by IRFs prior to making a request for admission, these results are driven in large part by the use of unqualified reviewers and reliance on inappropriate guidelines, as well as the lack of practical appeal options.

PA 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**

In addition to the high rate of denial, the survey data confirmed that MA beneficiaries spend an astounding number of unnecessary days in the acute-care hospital waiting for PA determinations. The average wait time for all determinations was more than two and a half days. This experience was also consistent among providers across the country, with 84% of IRFs reporting that the average response time was two days or greater. Even among patients that MA plans approved upon the initial request, there was *a total of more than 14,000 days spent waiting for PA determinations during the month.* Therefore, even when appropriate determinations are made, the process is still harmful to beneficiaries due to delays in receiving needed interventions, and the process is still costly to Medicare and providers.

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In addition to the continued restrictions on IRF access due to PA, AMRPA has also been able to collect data on the outcomes of waiver of PA requirements. AMRPA did this by analyzing data from the early months of the COVID-19 PHE, when MA plans voluntarily waived their PA policies. The findings statistically affirm the inappropriate denial of IRF 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 historical figures, MA beneficiaries represented only 20% of Medicare IRF admissions despite representing approximately 36% of Medicare beneficiaries in total. When MA plans temporarily suspended PA in response to the early stages of the COVID-19 PHE (Q2 2020), MA beneficiary admissions to IRFs increased to more proportionate volumes. Despite the increased admissions, the medical and functional profiles of patients remained remarkably similar. In other words, IRFs were treating more of the same types of patients, dispelling any notion that the PA process was properly screening out inappropriate referrals. Unfortunately, despite CMS' own recommendations, MA plans largely re-implemented and maintained their PA policies in Q3 2020, and IRF admission for MA beneficiaries dropped to levels consistent with historical levels.

Beyond data from the field, independent audits of MA plan practices have confirmed the inappropriate use of PA. In 2018, the HHS OIG reviewed MA determinations and appeals data.[14] It found that MA plans overturned 75% of their own denials. However, it also found that only about 1% of denials were ever appealed by beneficiaries or providers. This data is consistent with AMRPA's assertion that the current structure and timeline of MA determinations and appeals render little meaningful recourse for beneficiaries, especially those most in need of timely care. Building on its prior findings, the HHS OIG issued a second report this year that examined the PA determinations of MA plans.[15] In this report, the

[14] Department of Health and Human Services (HHS) Office of Inspector General (OIG), *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials* (September 2018) (https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf.)
[15] Department of Health and Human Services (HHS) Office of Inspector General (OIG), *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care* (April 2022) (https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf).

OIG found that IRF services were among the "most prominent" of the service types that MA plans denied despite meeting Medicare coverage rules. In this report, the OIG provided several specific examples of MA beneficiaries being denied IRF care inappropriately, all of which are typical of denials occurring on an everyday basis at IRFs throughout the country.

The data available from the Independent Review Entity (IRE), which is the second level of appeal for MA determinations, supports the finding that there is inadequate opportunity for appeal of plan decisions. In the most recent available IRE data, only 2,799 IRF appeals were submitted during the first quarter of 2022.[16] A rough extrapolation points to this being approximately 5% of the total initially *denied* IRF requests in a calendar quarter. Since 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.

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[16] Part C Reconsideration Appeals Data – Q2 2022 (http://www.medicareappeal.com/researchersdata).

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AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

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 judgment 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.[1]

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.[2]

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.[3] In addition, physicians report the PA process often delays care and has a negative impact on clinical outcomes.[4] 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.[5]

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.[6] 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 was the 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

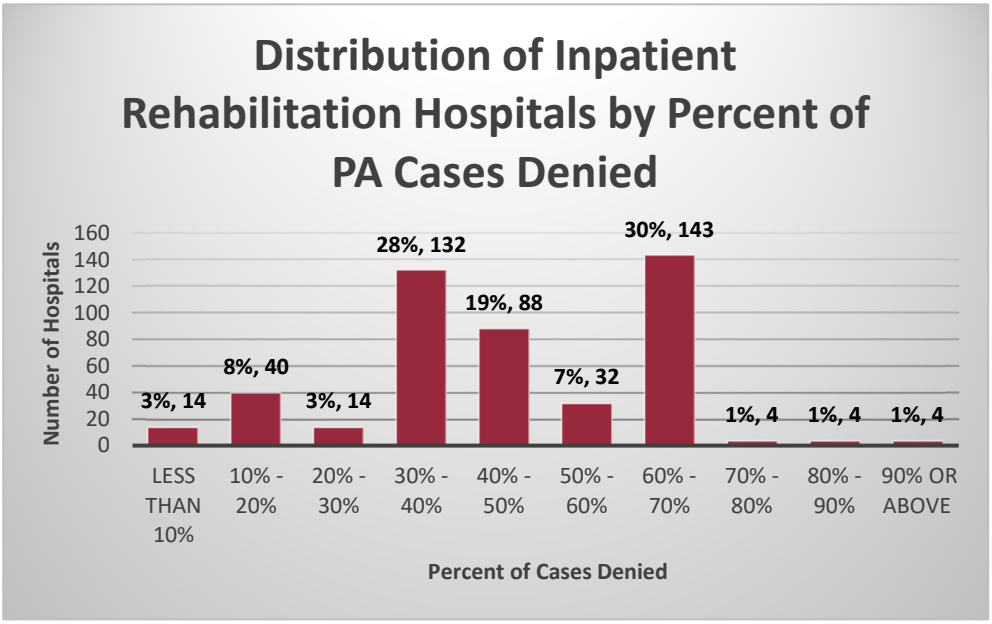
Participants

Data were submitted by 102 respondents who provided information about a total of 475 RHUs, representing approximately 40% of the RHUs nationwide.[7] 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

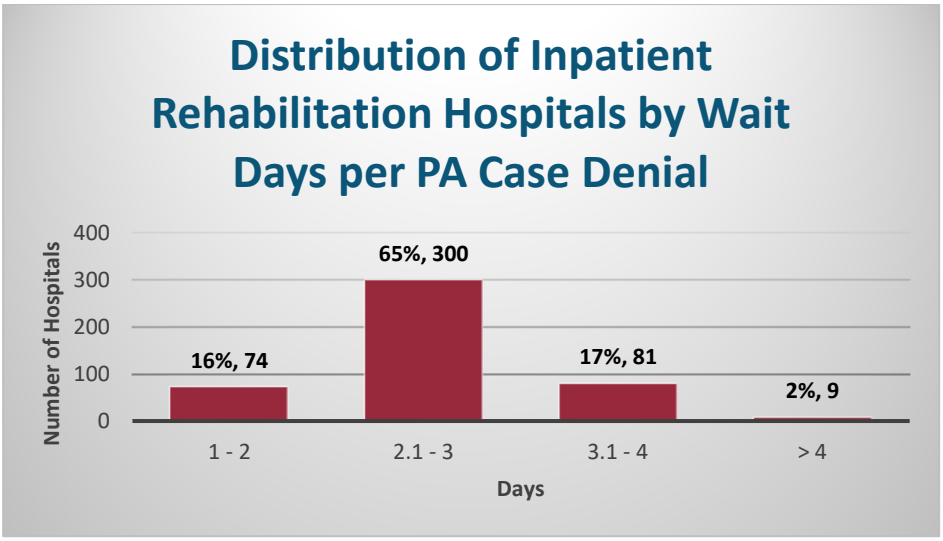
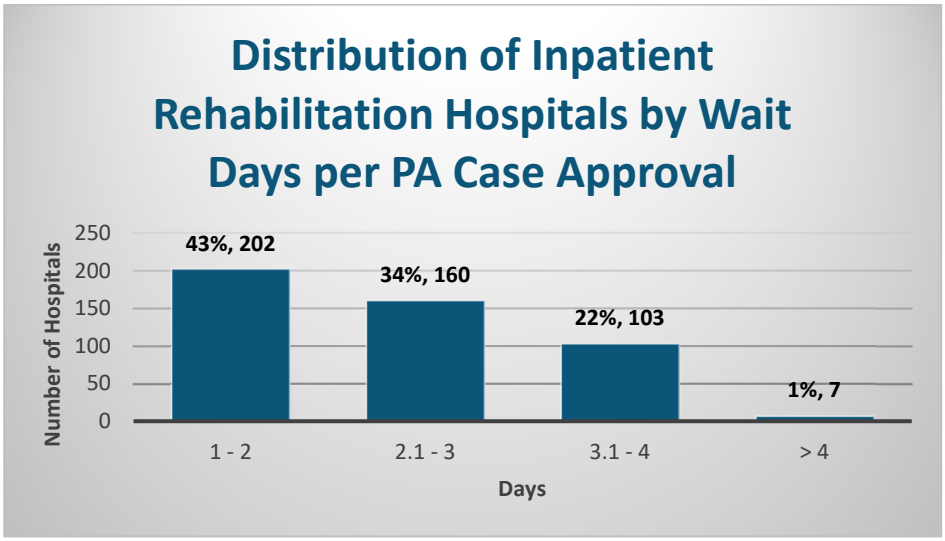


Figure 3. Distribution of Hospitals by wait time for favorable response



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.[8]

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.[9] 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.[10]

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."[11] 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.[12]

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.[13] 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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9. [9] 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).
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