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.

***

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

Anthony Cuzzola · Chair, AMRPA Board of Directors
Vice President/Administrator, JFK Johnson Rehabilitation Institute
529 14th Street NW, Suite 1280, Washington, DC 20045 · Phone: 202-591-2469 · Fax: 202-591-2445

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.

Anthony Cuzzola · Chair, AMRPA Board of Directors
Vice President/Administrator, JFK Johnson Rehabilitation Institute
529 14th Street NW, Suite 1280, Washington, DC 20045 · Phone: 202-591-2469 · Fax: 202-591-2445

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.

***

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

Anthony Cuzzola · Chair, AMRPA Board of Directors
Vice President/Administrator, JFK Johnson Rehabilitation Institute
529 14th Street NW, Suite 1280, Washington, DC 20045 · Phone: 202-591-2469 · Fax: 202-591-2445