



March 6, 2020

SUBMITTED ELECTRONICALLY

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

**Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2021
for Medicare Advantage (MA) Capitation Rates and Part C and Part D
Payment Policies –Part II**

Dear Administrator Verma,

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we are submitting this letter regarding the proposed updates to the Medicare Advantage (MA) Part C program through the 2021 Advance Notice released by the Centers for Medicare and Medicaid Services (CMS). Our comments focus on CMS' request for comment on implementing prior authorization-related measures in the MA Star Ratings Program as well as AMRPA's ongoing and pressing concerns about practices of MA organizations that restrict access to needed care, resulting in patient harm and increased cost to the Medicare program.

AMRPA is the national voluntary trade association representing more than 650 inpatient rehabilitation hospitals and units (IRH/Us). Most patients treated in an IRH/U are admitted directly following a stay in an acute-care hospital due to a serious accident or medical event. IRH/U patients commonly have conditions such as stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, brain injury, neurological disorders, and other morbidities that have resulted in serious functional deficits.

IRH/Us provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from care provided in non-hospital post-acute care (PAC) settings. Patients in an IRH/U are closely supervised by a physician, who also oversees patients' overall rehabilitation treatment, which must include a minimum of 15 hours per week of intensive therapy services.¹ Rehabilitation physicians practicing in IRH/Us oversee an interdisciplinary approach to care, which helps patients maximize their health, functional ability, independence, and participation in society so they are able to return to home, work, or an active retirement. Despite the life-changing (and cost-saving) benefits offered by IRH/Us, MA plans use prior authorization tactics to deny patients access, ultimately precluding them from returning to their full potential.

¹ 42 C.F.R § 412.622.

Admission and treatment in an IRH/U is a Medicare covered benefit, and Medicare regulations are clear that MA plans must provide “all Medicare-covered services.”² Further, MA plans must comply with all Medicare coverage regulations and manuals.³ As this letter will detail further, MA plans routinely and inappropriately deny and delay access to IRH/Us for patients in need of these services, usually through utilization of a prior authorization process. Supporting this conclusion, the Medicare Payment Advisory Commission (MedPAC) has repeatedly found that MA enrollees are admitted to IRH/Us at approximately one-third the rate of Medicare fee-for-service beneficiaries.⁴

Unfortunately, this life-threatening issue for beneficiaries has amounted to what could be called an “invisible problem.” Throughout the prolonged process of seeking admission to an IRH/U, the beneficiaries themselves often have little understanding of the distinctions of post-acute sites of care, let alone a grasp of their rights as an MA enrollee. Patients who are denied entry to an IRH/U may never be informed or understand that they had a right to appeal and that a higher level of care is a covered benefit under Medicare. Beyond transparency issues, AMRPA members also report extensive delays in receiving responses from MA plans on prior authorization determinations, particularly when such determinations are needed over a weekend or holiday. These delays can have catastrophic effects on the outcomes and recovery for patients needing inpatient rehabilitation.

For these reasons, AMRPA is pleased to see that CMS is seeking ways to hold MA plans accountable for prior authorization practices through the MA Star Ratings program. The remainder of this letter will summarize providers’ and patients’ troubling experiences with MA plans pertaining to discharges from acute-care hospitals to PAC settings. Based on these experiences, AMRPA is providing CMS with recommendations for the approaches it should take to incorporate prior authorization measures in the MA Star Ratings program. Specifically, AMRPA recommends:

- 1. MA plans should be required to track and report the time it takes for the plan to make an initial organizational decision. MA plans that make decisions in 12 hours or less should receive the highest Star Ratings score.**
- 2. CMS should incorporate avoidable hospital days into the MA Star Rating program to incentivize rapid determinations for hospitalized patients.**
- 3. CMS should audit plans’ initial determinations to determine whether the plan is relying on Medicare coverage guidelines and whether it utilized reviewers with relevant medical expertise. The findings of these audits should be scored and incorporated into the MA Star Ratings system.**

² *Id.* § 412.604.

³ *Id.* §§ 422.10(c) & 422.101(b).

⁴ *E.g.*, MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 298 (Mar. 2017) (finding that 2015 Medicare admissions to IRH/Us were 10.3 for every 1,000 FFS patients compared to 3.7 for every 1,000 MA patients).

4. **CMS should score MA plans based on the number of times physicians appeal its initial determinations. The more often practicing physicians disagree with plans' determinations, the lower the MA plans' MA Star Rating should be.**
5. **CMS should incorporate provider surveys into the MA Star Ratings. Providers should be surveyed on whether the MA plan made decisions in an appropriate timeframe, whether the plan had 24/7 availability of medical personnel, whether the MA plan made decisions in accordance with sound medical judgement and Medicare coverage rules, and whether the MA plan employs personnel who have appropriate qualifications.**
6. **CMS should hold MA plans accountable for long-term cost and incorporate this into the Star Ratings. This should include tracking utilization by patients beyond just the plan year and even for patients who have left the plan.**

In making its recommendations, AMRPA offers an overarching point that there are serious and fundamental flaws in the rules and oversight for how MA plans handle admissions to PAC settings. Adding measures to evaluate MA quality as it pertains to prior authorization will provide at best modest relief from the current access challenges facing MA enrollees and improve plans' compliance with the rules that exist today. Most importantly and as a general principle, however, AMRPA does not think it is appropriate that MA plans be allowed to utilize prior authorization at all when multiple treating and consulting physicians have attested to the appropriateness for a hospital admission, which is the case for most MA enrollees seeking admission to an IRH/U. In addition, the current regulatory timeframes – allowing 72 hours or more for a prior authorization decision and appeal – is wholly inconsistent with the 24/7 operation of hospitals and the intensive level of care needed for most IRH/U patients. AMRPA urges adoption of timeframes that better reflect the urgency of these PAC placement decisions for beneficiaries, as this type of action will provide more meaningful relief to patients facing access issues caused by current prior authorization practices.

Therefore, while some additional MA Star Ratings measures pertaining to prior authorization may provide some incremental improvement in the MA program, in no way will this adequately address the underlying defects in the MA program that routinely lead to Medicare beneficiaries being denied access to essential post-acute care. We welcome the opportunity to further engage with CMS on this overarching programmatic issue.

MA Plans Tactics for Post-Acute Care Admissions

Most typically, a patient seeking admission to an IRH/U is awaiting discharge at an acute-care hospital. When clinicians screen acute-care Medicare patients for post-acute placement, they must follow very specific Medicare guidelines to determine whether the patient is appropriate for an IRH/U.⁵ When screening indicates the patient is appropriate for IRH/U care, at least one

⁵ 42 C.F.R. § 412.622(a). Among other requirements, to be covered in an IRH/U, the patient must need an interdisciplinary approach to care and be stable enough at admission to participate in intensive rehabilitation. There must also be a “reasonable expectation” that the patient will need multidisciplinary therapy, intensive rehabilitation, and supervision by a rehabilitation physician. The requirement for multidisciplinary therapy must include physical or occupational therapy. Intensive rehabilitation is defined as three hours per day, five days per week (or 15 hours

physician with specialized training and experience in rehabilitation must concur, but in actuality there are usually multiple physicians involved and in agreement about the referral. This mandated Medicare process already amounts to a self-administered prior authorization process which – in contrast to the process used by MA plans – is administered by clinicians who are appropriately trained and have actually seen the patient in question.

The first defect in the MA prior authorization process is that plans take up to 72 hours – which does not include weekends – to make an initial organization determination. This is wholly unacceptable and, practically speaking, means that a patient ready for discharge on Thursday may be required to remain in the acute-care hospital *five additional days* before a determination is made on Tuesday, without running afoul of Medicare rules. Not only does this delay subject the patient to additional risks, such as for hospital-acquired infections, and force them to incur additional costs while waiting in the acute-care hospital, the delay in receiving therapeutic intervention at the IRH/U often has meaningful negative and lasting impacts on the patient’s recovery and overall outcomes.

Even once an initial determination has been reached, the frustrations for patients and providers usually continue because a very high rate of requests for IRH/U admission are initially denied. This is largely due to the fact that MA plans utilize proprietary decision tools such as Milliman and InterQual – guidelines that reportedly conflict with Medicare IRH/U coverage criteria in spite of the aforementioned requirements that MA enrollees receive the same benefits as those in the FFS program. Plans’ use of these decision tools seem to drive admissions to lower-acuity settings, such as nursing homes and homecare, regardless of a patient’s appropriateness for inpatient rehabilitation. Most importantly, these proprietary guidelines do not follow Medicare coverage guidelines, representing a violation of the MA enrollees’ right to the same benefits covered under traditional Medicare.⁶

Further, MA plans will often offer a “peer-to-peer” physician discussion before issuing the final organization determination. Providers are constantly disappointed by the lack of relevant experience offered by the MA plan physician reviewer, as well as the burden with participating in these calls. Providers report that normally the Medical Director or other MA physician representative discussing the case with the provider has no experience with PAC or rehabilitation. Beyond the lack of specialized training, physician reviewers often have little understanding of the Medicare coverage criteria for PAC, and sometimes cite erroneous standards for IRH/U admissions. Further, the MA plans usually offer limited windows for the peer-to-peer, with little advance notice, requiring physicians to rearrange their care for patients at the last minute to participate in a call that is rarely fruitful due to the aforementioned defects. Despite the 24/7 operation and treatment of patients in hospitals, the peer-to-peers are offered only during business hours.

per week). The therapy must be reasonably likely to result in measurable, practical improvement to the patient’s functional capacity or adaptation to impairments. The rehabilitation physician must see the patient at least three times per week. Medicare coverage may not be denied based on treatment norms or rote “rules of thumb.”

⁶ *Id.* § 422.101(b).

As CMS knows, beneficiaries are also entitled to an appeal of the initial organization determination. However, providers and enrollees are equally stymied by these appeals because they contain most of the same shortcomings as the initial determinations. It is important to contextualize that once the initial determination has been made, the patient in question has been waiting in an acute-care hospital for three to five days. The MA plan then usually takes up to another 72 hours to render a reconsideration decision. This means the patient and hospitals are faced with the choice of accepting the MA plan's lower level of care against physician advice, or unnecessarily holding the patient for *another three days* in the acute-care hospital. This is simply an untenable position that puts the MA organization's interests before that of the patient. Similarly, hospitals report that just like the initial determination, the MA representative conducting the reconsideration requests often lack training or experience in PAC, and render affirmations of the initial decision based on faulty coverage and medical premises.

Technically speaking, MA enrollees are entitled to additional levels of review beyond the reconsideration stage. However, due to the unacceptable delays in receiving decisions from MA plans, it is practically impossible for a patient who has been waiting for discharge for a week or more to remain in the acute-care hospital to pursue further levels of appeal. The interests of the patient dictate that the patient will at least initially need to move to a lower level of care, where they may or may not have the resources to continue to appeal their case. Even if a favorable decision can be reached at the second level of appeal, it is often no longer in the best interest of the patient to once again disrupt their recovery with a transfer to the IRH/U from the lower acuity setting.

In addition to the aforementioned practices, hospitals have noted a number of other abuses by MA plans in recent years. These include informing beneficiaries that the IRH/U is not a covered benefit, that they are not entitled to appeal the initial determination or reconsideration, and denying IRH/U physicians ability to participate in the peer-to-peer or reconsideration because they "lack standing" in the case. In addition, for those few MA enrollees who do get admitted to IRH/Us, MA plans are putting up roadblocks to discharge of the patient from the IRH/U, possibly in an attempt to frustrate the hospital and discourage future admissions.

In all, current MA approach to prior authorization is completely devoid of practices that are patient-centered or ensure the treating clinicians have the ability to help their patients receive the care they need. Incentivizing MA plans to improve their performance relative to current regulations could be a positive first step toward more comprehensive reform of the managed care prior authorization process.

MA Star Rating Measures to Provide Accountability for Prior Authorization Practices

The overarching principle that should guide CMS' approach to oversight of MA plans is to ensure that patients are receiving the right care at the right time and in the right setting. This means that CMS should measure two overall categories of prior authorization performance: 1) timeliness and 2) accuracy. Therefore, while patient feedback should remain an important component of MA Star Ratings, provider feedback on MA plans should also be included to a greater degree than currently exists, along with independent reviews conducted by CMS.

Accountability for Timeliness

As discussed earlier, a patient in an acute-care hospital should not be waiting more than a few hours for a decision on their discharge disposition. Currently, Star Ratings account only for timely appeals. For many patients seeking PAC placement, by the time they have reached the appeal stage, it is already too late for clinically appropriate PAC placement. Therefore, MA plans should be incentivized to provide the *initial* authorization determinations as timely as possible, especially for vulnerable hospitalized patients.

To accomplish this, MA plans should be required to track and report the time it takes for a decision to be made on a prior authorization request for a patient in an acute-care setting. The scoring of this measure should tier median response times, so that MA plans that typically provide responses in under 12 hours (while factoring in all clinical/environmental patient needs) receive the highest score, those that typically respond within 24 hours receive the second highest score, and plans with response times typically longer than 24 hours receive the lowest rating.

CMS should also hold MA plans accountable by tracking the number of avoidable days their beneficiaries spend in acute-care hospitals. Avoidable days metrics are already tracked by hospitals and CMS, and if incorporated into MA Star Ratings, would encourage MA plans to move as quickly as possible to discharge the patient to the appropriate site of care. CMS should use an objective scoring mechanism to provide MA plans with the lowest number of avoidable days the highest Star Rating score, and those with a high number of avoidable days should receive a significant reduction in their Star Ratings.

Recommendations:

- 1. MA plans should be required to track and report the time it takes for the plan to make an initial organizational decision. MA plans that make decisions in 12 hours or less should receive the highest Star Ratings score.**
- 2. CMS should incorporate avoidable hospital days into the MA Star Rating program to incentivize rapid determinations for hospitalized patients.**

Accountability for Accuracy

It is self-evident that timeliness is only one aspect of a properly conducted authorization request. It is equally imperative, if not more so, that an MA plan have a process in place that reaches the appropriate clinical decision about the patient's admission. While that decision is always best left to the treating or consulting physician, when MA plans nonetheless choose to second-guess physician decisions, they should be incentivized to ensure they have an efficient way to employ the requisite expertise to review the case. Currently, MA Star Ratings only account for accuracy of appeals. As stated earlier, some patients are unable to remain in the acute-care hospital and appeal their case, and even if they do, they've been harmed by having to do so. Therefore, it is important that CMS also account for accuracy of *initial* determinations, and not appeals alone.

First and foremost, the MA plan should be asked to demonstrate its initial decisions are reached in accordance with Medicare coverage guidelines. CMS should audit plans' initial determinations, separate and apart from the current independent review entity processes, to

determine whether the plan is relying on Medicare coverage guidelines and whether it utilized reviewers with relevant medical expertise. Plans that rely on inappropriate proprietary guidelines that do not conform with Medicare rules, or do not have properly trained reviewers, should receive the lowest score in this rating. Plans that rely on Medicare coverage guidelines, but inappropriately deny care nonetheless, or do not have properly qualified personnel, should also receive a subpar score. The audits should be able to objectively verify that the plan consistently made decisions using highly qualified staff who conform to the Medicare coverage guidelines in order for the plan to receive an above average score. Independent practicing physicians assigned to cases within their field of expertise should conduct these audits.

Another way that CMS could evaluate MA plans' prior authorization processes is to track the total number of appeals initiated by physicians, regardless of outcome. It is unsurprising that an MA plan often affirms its initial determination at reconsideration, even though the plan is required to use different personnel for the appeal. Moreover, for the aforementioned reasons, many acute-care patient cases cannot proceed to the second level of appeal. Therefore, an effective way to track the accuracy of MA plans' determinations would be to evaluate how often a treating physician disagrees with plans' initial determinations. It should be telling to CMS when specialized physicians disagree strongly enough with an MA plan to pursue an appeal for a patient. It can be reasonably concluded that MA plans with higher rates of appeals from physicians are doing a poor job of making proper initial decisions for patients.

Beyond patient experience and CMS audits, the MA Star Ratings should also take into account providers' perspective on plans. After all, it is the providers who are the specialists treating the patient and in the best position to judge the appropriateness of MA plans' decisions. CMS should develop a survey of providers that takes into account several aspects of MA plan performance. The areas surveyed should include whether the MA plan made decisions in a timeframe consistent with the patient's medical condition, whether the MA plan had 24/7 availability of medical personnel to match the operations of hospitals, whether the MA plan made decisions in accordance with sound medical judgement and Medicare coverage rules, and whether the MA plan employs personnel who have appropriate qualifications. All of these are important factors that not only affect MA enrollees' access to appropriate care, but would also be difficult for a consumer to discern. Therefore, it is imperative that CMS incorporate this provider perspective into the Star Ratings.

Long-term cost is another way to hold MA plans accountable through the Star Ratings program. MA plans may have a financial incentive to deny admission to an IRH/U when the alternative post-acute placement is less expensive in the short-term. However, when patients receive more intensive rehabilitation in an IRH/U, their improved functional status can lead to less resource use in the long-term.⁷ This is why CMS needs to add incentives for MA plans to control long-term costs. While it might seem as though the per-capita relationship between the CMS and MA plan already incentivizes cost control, that line of thinking misses several nuances, particularly when looking at the longer-term picture.

⁷ See DOBSON DAVANZO & ASSOCIATES, ASSESSMENT OF PATIENT OUTCOMES OF REHABILITATIVE CARE PROVIDED IN INPATIENT REHABILITATION FACILITIES (IRFs) AND AFTER DISCHARGE (July 2014).

First, data suggests that high-cost patients leave MA plans and enroll in traditional Medicare at a substantial rate.^{8,9} In addition, studies show IRH/Us actually extend life expectancy relative to lower intensity settings.¹⁰ Armed with this information, an MA plan can save money in the short-term by denying more intensive post-acute care, and not be on the hook for the higher-long term cost for many of those patients in light of the rate in which these patients leave their plans as well as their shorter life expectancy. Accordingly, CMS should track and rate MA plans on cost-measures such as Medicare Spend Per Beneficiary, and that tracking should extend well beyond the plan year to incorporate rolling updates of beneficiaries who were once or are still are enrolled in the MA plan. Holding MA plans accountable for long-term costs will incentivize plans taking the best action for the patient in the long-term and focus less on short-term financial implications.

Finally, CMS requests information about how it could evaluate MA plans on how well the plan operates automated or electronic prior authorization. AMRPA considers it highly important that plans continue to make transferring medical information and other communications as seamless as possible. For many providers, electronic prior authorization offers a convenient and time-saving option for communication with the MA plan. However, due to the wide range of electronic health record systems and interoperability issues that still exist in the field, MA plans should also provide alternative options for communicating with hospitals. AMRPA recommends that CMS incorporate a question in its provider survey that invites feedback on the availability of electronic and other convenient means to communicate with the MA plan. This would ensure that MA plans are not incentivized to use only one method, but rather to make it as easy as possible for providers to transmit information.

As far as automation goes, AMRPA has serious concerns about any sort of automated process that does not incorporate expert medical review. The disposition to PAC can often be medically complex and nuanced. AMRPA has explained to CMS how certain decision-making tools currently in use lead to improper placements. Any sort of automation that an MA plan is permitted to operate should be thoroughly vetted by CMS and strictly adhere to Medicare coverage guidelines. Given the current concerns with automation, we do not recommend CMS implement any measures on automation at this time, and instead focus on aligning MA plans' decisions with Medicare coverage criteria.

Recommendations:

- 1. CMS should audit plans' initial determinations to determine whether the plan is relying on Medicare coverage guidelines and whether it utilized reviewers with adequate medical expertise. The findings of these audits should be scored and incorporated into the MA Star Ratings system.**

⁸ E.g., Momotazur Rahman et al., *High-Cost Patients Had Substantial Rates of Leaving Medicare Advantage and Joining Traditional Medicare*, 34(10) HEALTH AFF. 1675, 1679-80 (Oct. 2015).

⁹ Government Accountability Office, *CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight*, GAO-17-393 (April, 2017).

¹⁰ *Momotazur Rahman et al.*

2. **CMS should score MA plans based on the number of times physicians appeal its initial determinations. The more often practicing physicians disagree with plans' determinations, the lower the MA plans' score should be.**
3. **CMS should incorporate provider surveys into the MA Star Ratings. Providers should be surveyed on whether the MA plan made decisions in an appropriate timeframe, whether the plan had 24/7 availability of medical personnel, whether the MA plan made decisions in accordance with sound medical judgement and Medicare coverage rules, and whether the MA plan employs personnel who have appropriate qualifications.**
4. **CMS should hold MA plans accountable for long-term cost and incorporate this into the Star Ratings. This should include tracking utilization by patients beyond just the plan year and even for patients who have left the plan.**

AMRPA is committed to continuing to work with CMS to enhance oversight of MA plans and ensure access to critical services for Medicare beneficiaries. If you have any questions about AMRPA's recommendations, please contact AMRPA's Director of Government Relations and Regulatory Counsel, Jonathan Gold, JD at jgold@amrpa.org or 202-860-1004.

Sincerely,



Robert Krug, MD,
Board Chair, AMRPA
President and Executive Medical Director, Mount Sinai Rehabilitation Hospital