AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

March 3, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

Submitted Electronically

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Administrator Brooks-LaSure:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we submit this letter in response to the proposed updates to the Medicare Part C (Medicare Advantage (MA)) program in the CY 2023 Advance Notice released on February 2, 2022 by the Centers for Medicare and Medicaid Services (CMS). Our response focuses on CMS' solicitation of feedback related to health equity, as well as AMRPA's long-standing concerns related to MA prior authorization practices. In their current form, these practices are restricting access to medically necessary care for some of the nation's most vulnerable patients and are contrary to the Administration's goals of attaining health equity across federal programs.

AMRPA is the national voluntary trade association representing over 700 inpatient rehabilitation hospitals and units (referred to as inpatient rehabilitation facilities (IRFs) by policymakers). The patients admitted to an IRF have serious, disabling conditions such as stroke, amputation, spinal cord injury, traumatic brain injury, poly-trauma, neurologic illnesses and other conditions that can result in significant functional impairments. We applaud the Biden Administration's focus on reducing health disparities and inequities, including the concentrated efforts to achieve inclusive healthcare for people with disabilities.[1]

IRFs – which are fully licensed hospitals – provide a unique level of medical and rehabilitation interdisciplinary care that improves health and function including to many of our country's disabled patients. This sets IRFs apart from the other post-acute care (PAC) settings and provides highly valued care to beneficiaries and their families, and a high value proposition to the

[1] Fact sheet: Biden-Harris administration ... - The White House. (n.d.). Retrieved March 3, 2022, from https://www.whitehouse.gov/wp-content/uploads/2021/05/White-House-Disability-Policy-Fact-Sheet.pdf

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Medicare program.[2] Unfortunately, many MA plans utilize burdensome and discriminating prior authorization practices that divert IRF patients to less appropriate PAC settings. These MA plans appear to prioritize short-term fiscal benefits over the medical needs of their members.

MA organizations (MAOs) are required to provide all Medicare-covered services and comply with all Medicare coverage regulations and manuals.[3] [4] As AMRPA has asserted in prior comment letters, MA plans routinely deny and delay access to hospital-level rehabilitative care for enrollees. This jeopardizes the vulnerable patients IRFs are intended to serve and adversely impacts a patient's potential recovery. For these reasons, AMRPA urges CMS to take steps to reign in and hold MAOs accountable for their inappropriate use of prior authorization for IRF admissions. Constraining these improper actions that impact Medicare patients' access should be a central part of CMS's efforts to improve health equity in the Medicare program.

Referrals for IRF admissions generally occur due to ongoing medical care needs that follow an acute-care hospital stay, many of these are for patients with disabilities. Expert clinicians in IRFs work with these acute-care hospitals, to understand the medical status and needs of their patients to decide if an admission to the IRF is appropriate. They also assess the patient's compatibility with the IRF coverage criteria outlined in Medicare regulations to determine if a patient is appropriate for IRF care. When a patient has been successfully screened for admission to an IRF, a rehabilitation physician reviews the recommendation and makes the final decision to admit the patient.[5] This process amounts to a thorough review and assessment process conducted by physicians trained in rehabilitation. Despite this, MAOs routinely deny authorizing these proposed admissions, utilizing criteria that subvert expert medical judgment and the appropriate Medicare coverage criteria. These improper denials of payment place additional stress and burden on patients, families, hospitals, and the broader system, resulting in delays of care, improper care, and substantial waste of medical dollars.

Currently, MA prior authorization processes may take up to 72 hours – not including weekends – to make an initial organization determination. As a result, patients, many of whom are disabled and seeking equitable care, ready for discharge on a Thursday could remain in an acute-care hospital for five unnecessary days before an MA determination is even rendered. This delay results in wasteful and avoidable costs to the Medicare program, but more importantly, inhibits patients' timely and equitable access to necessary rehabilitative care. Those delays may have lasting adverse impact on the patient's timely recovery and restoration of function. Many patients

[2] Davanzo, D., El-Gamil, A., Li, J. W., & Manolov, N. (2014). Assessment of Patient Outcomes of rehabilitative care provided in inpatient rehabilitation facilities and after discharge.
[3] Id. § 412.604.
[4] Id. §§ 422.10(c) & 422.101(b).
[5] 42 C.F.R. § 412.622(a). Among other requirements, to be covered in an IRF, 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 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."

who are initially denied coverage for an IRF admission are diverted into less appropriate settings because they are unable to endure this staggering delay between referral and final authorization.

These are just some of the practices used by MA plans that create serious access and care quality threats for disabled patients. Studies have shown that MA enrollees return to Medicare fee-for-service (FFS) enrollment at a higher rate than FFS beneficiaries shift to MA. For patients who utilized hospital, PAC or long-term care (LTC), rates of shifting from FFS to MA are significantly lower than for beneficiaries who did not utilize those services. These findings suggest that MA plan benefits are not sufficiently meeting the needs of patients with higher care needs,[6] and that patients are being forced to change their Medicare enrollment (a significant undertaking) to access IRF care and other services *to which they are equally entitled under both programs*. Park et al. found that high-cost/need patients were the most likely beneficiary population to switch from MA to FFS, and that enrollees who required the use of PAC or hospitalization, those with poorer self-reported health, and those with lower satisfaction of their access to care were more likely to switch out of MA to FFS.[7]

Even the U.S. Government Accountability Office (GAO) has raised concern about the rate of MA disenrollment. In an April 2017 report, the GAO recommended that CMS utilize disenrollment and beneficiary health status data to improve MA oversight after finding that MA enrollees in poor health were 47% more likely to disenroll from MA compared to enrollees in better health.[8] As HHS noted in response to its report, the Department recognizes the importance of using plan oversight and "other mechanisms to ensure that MA plans are meeting all regulatory requirements, including ensuring MA enrollees are provided **equal access to health care services regardless of health status."**[9] AMRPA's analysis of its own data show a clear disparity in rates of IRF access among MA and FFS enrollees.[10] It is clear that MA plans are routinely restricting access to rehabilitative care for people who have many healthcare disparities. We therefore urge HHS to use its oversight authority to address the issues identified by the GAO, as well as protect equitable access to IRF care for beneficiaries.

In closing, AMRPA applauds CMS' assertion in this year's Advance Notice that it seeks to "[drive] value in the Medicare program to make sure that the Medicare dollar is spent effectively and efficiently on programmatic changes that will close health equity gaps." With that in mind,

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[6] 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).

[7] Park, S., Meyers, D. J., & Langellier, B. A. (2021). Rural Enrollees In Medicare Advantage Have Substantial Rates Of Switching To Traditional Medicare: Study examines the rates at which Medicare beneficiaries in rural areas switch between Medicare Advantage plans and traditional Medicare. *Health Affairs*, *40*(3), 469-477.

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

[9] Id. (Emphasis added).

[10] An analysis conducted by AMRPA and utilizing data from eRehabData®, demonstrated that during the period in which MA plans suspended prior authorization during 2020, MA enrollees were admitted to IRFs at a rate proportionate to FFS beneficiaries. Specifically, in Q2 2020, FFS beneficiaries represented 69.54 percent of IRF admissions and MA enrollees represented 30.46 percent. In Q3 2020, FFS beneficiaries rebounded to 76.45 percent of IRF admissions while MA enrollee admissions to IRFs dropped to 23.55 percent as prior authorization requirements were reinstated.

AMRPA urges CMS take definitive action against improper MA prior authorization practices and ensure that patients in need have timely access to IRF care.

AMRPA has previously shared with CMS[11] commonsense recommendations that we believe will help the agency address these critical access issues and help achieve its stated health equity goals. These recommendations are summarized below:

- MA plan medical reviewers used in making IRF coverage determinations must have relevant experience and expertise in medical rehabilitation.
- MA plan medical reviewers must communicate with any clinicians involved in the discharge planning process.
- MA plans must make determinations and redeterminations within 24 hours of request, 7 days/week, including holidays.
- MA plans must provide more transparency into their prior authorization processes by submitting any proprietary decision tools to HHS for review, and HHS in turn should prohibit the use of any guidelines that are not consistent with Medicare coverage requirements.
- MA plans must ensure enrollees are fully informed about Medicare coverage rules, their redetermination and appeal rights, along with information about resources to navigate the process.

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AMRPA is grateful for the opportunity to submit these comments related to the Medicare Part C program. We look forward to continued engagement with CMS. If you have any questions related to AMRPA's recommendations, please contact Kate Beller, J.D., AMRPA's Executive Vice President for Government Relations and Policy Development (kbeller@amrpa.org / (202) 207-1132).

Sincerely,

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

[11] AMRPA Comment Letter re: CMS-2020-0093 (CY 2022 Medicare Advantage and Part D Advance Notice Parts I and II)