AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Statement for the Record
from the

# American Medical Rehabilitation Providers Association (AMRPA)

## Homeland Security & Governmental Affairs Committee
## Permanent Subcommittee on Investigations
## United States Senate

Hearing on:

Examining Health Care Denials and Delays in Medicare Advantage

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On behalf of the members of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to provide a written statement for the record of the Subcommittee's recent hearing, "Examining Health Care Denials and Delays in Medicare Advantage." We thank the Subcommittee for its time and attention to these important issues and encourage the Subcommittee to continue this focus on ensuring that Medicare Advantage (MA) beneficiaries can access medically necessary care without delays and other barriers.

AMRPA is the national trade association representing more than 700 freestanding inpatient rehabilitation hospitals and units, referred to in the Medicare program as "inpatient rehabilitation facilities" (IRFs). Our hospitals and units focus on the care and functional recovery of some of the most vulnerable Medicare beneficiaries – such as traumatic brain injury, stroke, and spinal cord injury patients. The vast majority of our members are Medicare participating providers and according to the Medicare Payment Advisory Commission (MedPAC), IRFs served 335,000 Medicare beneficiaries with more than 379,000 IRF stays in 2021.[1]

Reform of prior authorization practices and other utilization management techniques employed by MA plans has long been at the top of AMRPA's advocacy agenda because of the direct and adverse impact these practices often have on some of Medicare's most severely ill and injured beneficiaries, including those living with disabilities. Prior authorization reform is particularly important in the rehabilitation medicine context when timely and appropriate care transitions from the acute care hospital can dramatically improve a patient's functional recovery and quality of life. While there has been significant growth in the MA program in recent years – with more than half of all beneficiaries now enrolled in MA plans[2] – there has also been increasing scrutiny of plan behavior by federal oversight entities.[3] The confluence of program growth and problematic plan behavior makes timely and effective policy changes to MA plans' prior authorization and denial practices all the more critical to correct serious and concerning care access and equity issues. Reforming MA plans' 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 disenrollment rates.

Our statement focuses on four key issues:

(1) the impact of prior authorization and other MA plan practices on beneficiary access to care in the inpatient rehabilitation facility benefit,
(2) AMRPA's support for recent and pending policy reforms to MA plan practices,

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[1] Medicare Payment Advisory Commission (MedPAC), *MedPac March 2023 Report to the Congress: Medicare Payment Policy* (March 15, 2023) (https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf)

[2] Centers for Medicare and Medicaid Services (CMS), *Medicare Monthly Enrollment* (May 2023) (https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment)

[3] See, e.g., 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.asp).

(3) further areas for Congressional and regulatory engagement, and
(4) additional detail and context regarding the discussion of the IRF benefit during the Subcommittee's recent hearing.

## I. Impact of Prior Authorization and MA Plan Practices on IRF Beneficiary Access

AMRPA members across the country report that MA plans routinely and consistently divert beneficiaries away from IRFs to less intensive settings of care through the misuse or abuse of prior authorization and other utilization management practices. Some of these specific tactics include using flawed or unsupported proprietary guidelines that conflict with Medicare coverage rules, reliance on unqualified reviewers to overturn the clinical judgment of treating physicians and specialized rehabilitation providers who make up the rehabilitation team, 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. As the Subcommittee heard from the hearing witnesses, the impact of inappropriate delays and denials of IRF admissions that result from the misuse and abuse of prior authorization have a direct negative impact on beneficiaries' long-term health, function, and ability to maximize their recovery.

AMRPA recently embarked on an effort to collect data on the outcomes of MA plan prior authorization requests for IRF admissions nationwide in August 2021. A total of 475 IRFs from 47 states, as well as the District of Columbia and Puerto Rico, submitted data on the outcomes of 12,157 requests for the survey month. Overall, the data confirmed the observations of AMRPA members regarding prior authorization practices. More than 53% of all initial requests for an IRF admission were denied, resulting in nearly 6,500 patients being diverted to less-intensive settings of care during 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. Each of these denials represents the overruling of a practicing physician treating a severely and acutely ill recovering patient.

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 prior authorization determinations, with a 2.5+ day average wait time for all determinations. MA plans often claim that prior authorization is used as a utilization management tool to mitigate unnecessary costs; however, this fails to account for the expense of prolonged inpatient stays that may create greater costs to patients and the Medicare program. Even among patients for whom MA plans approved their initial request for IRF admission, the survey data represents more than 14,000 days in the aggregate spent waiting for a determination during a single month. These unnecessary delays result in additional acute care hospitalization expenses while restricting acute care hospitals from filling their beds with other patients with pressing care needs. We once again note that for patients in need of the intensive, medically managed course of rehabilitation provided in IRFs, every day spent waiting in an acute care bed without receiving rehabilitation care can limit their ability to recover and achieve their maximum level of health and function. The findings of AMRPA's survey are summarized in Appendix 1 and detailed in full in Appendix 2.

We also appreciate the Subcommittee's attention to the results of the Department of Health and Human Services (HHS) Office of Inspector General's (OIG) 2018 and 2022 report confirming the inappropriate practices used by some MA plans. As the Subcommittee heard, the OIG found that MA plans overturned 75% of their own denials, but only about 1% of denials were ever appealed by beneficiaries and providers.[4] More recently, the OIG found that IRF services were among the "most prominent" of the service types that MA plans denied despite meeting Medicare coverage rules.[5] These findings, and similar findings raised by other provider and stakeholder organizations, highlight another concerning issue that AMRPA has raised with CMS and others multiple times. While some beneficiaries may eventually be able to garner a victory on appeal in cases where their services had been inappropriately denied by MA plans, this path is by no means assured, even when the plans are denying claims that meet the Medicare coverage criteria. As the Subcommittee heard in Ms. Bent's all-too-familiar testimony, the appeals process is lengthy, costly, and comes at a time when patients are at their most vulnerable; many, if not most, patients simply do not have the resources to be able to pursue an appeal even when their physician and other providers can confidently assert that their care *should* be covered. Stricter oversight by both Congress and the Administration, in concert with rehabilitation stakeholders, is the only way to ensure that MA beneficiaries are not blocked from accessing the care they need.

AMRPA is pleased to learn of the Subcommittee's outreach to the largest MA plans to learn more about how decisions are made to deny access to care, and we look forward to additional information being released by the Subcommittee regarding its findings.

## II. Recent Regulatory Reforms Show Promise, but Enforcement is Critical to Ensure Compliance

As noted throughout the recent hearing, the Centers for Medicare & Medicaid Services (CMS) recently finalized one rule focused on restricting certain MA plan practices regarding prior authorization and other barriers to care (the "2024 MA rule")[6], and is reviewing a second proposed rule focused on streamlining and standardizing the use of prior authorization by MA plans and other payers (the "electronic prior authorization rule").[7] AMRPA has strongly supported both of these rules and advocated for additional refinements to ensure that they

[4] Department of Health and Human Services (HHS) Office of Inspector General (OIG), *Medicare Advantage Appeal Outcomes and Findings Raise Concerns About Service and Payment Denials* (September 2018) (https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf).

[5] 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).

[6] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 88 Fed. Reg. 22,120 (April 12, 2023).

[7] Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program, 87 Fed. Reg. 76,238 (Dec. 13, 2022).

meaningfully address problematic payer behavior. In particular, we continue to seek an expansion of the electronic prior authorization proposed rule to require MA plans return decisions for expedited and urgent requests (such as post-acute care authorizations) within 24 hours (instead of the proposed 72-hour timeframe), and a commitment from CMS to publicly report data on prior authorization practices on a service-specific basis and in a way that is easily accessible to and understood by enrollees.

We are pleased to see that a number of Subcommittee members have signed a pending letter to CMS calling for these specific reforms to be included in the final rule. Our detailed comments on the 2024 MA rule can be found here and our comments on the electronic prior authorization rule can be found here.

However, as Chairman Blumenthal stated during the hearing, these regulations (both those that are finalized for MA Contract Year 2024 and those that are pending in the electronic prior authorization final rule) will only have the desired impact if they are appropriately enforced. While we are heartened that CMS has heard the calls from patients and providers to rein in these types of plan behavior, we will be monitoring closely to understand how plans are complying with these new and newly codified requirements and work to ensure that CMS is appropriately overseeing the implementation of these rules when they go into effect. This is particularly important because AMRPA members continue to report that MA plans are currently using these tactics that will presumably be barred beginning in Contract Year 2024.

Given the Subcommittee's investigatory and oversight functions, we believe that it may be relevant to follow up with CMS after implementation of the rules to ensure plans are complying with the letter and intent of the regulatory reforms. We would be happy to provide the Subcommittee with any additional information and data from our members as well as to highlight how CMS is working to ensure better oversight. AMRPA has recommended that CMS develop a robust enforcement plan, including auditing processes, transparent reporting processes, and penalties for non-compliance, to ensure that MA plans comply with the new and important reforms outlined in these rules. MA plans should be publicly accountable for their policies and practices, and key metrics should be able to be easily measured across plans so beneficiaries have a better understanding of their access to post-acute care under the plan's policies when making enrollment decisions. At a minimum, such reporting should include the number or percentage of denials, the reason(s) for each denial, and the turnaround time to respond to requests for care approval. Such public reporting will also allow Congress to fulfill its oversight role of CMS' management of the MA program, and better understand whether and how additional action may be necessary to ensure that MA patients can access medically necessary care to which they are legally entitled.

## III. Discussion of IRF Coverage Requirements and IRF Payment System

AMRPA appreciates the Subcommittee's focus on the IRF benefit, given the previously cited findings that IRF services are among the most prominent service types denied by MA plans despite meeting Medicare coverage rules. We would like to offer additional details and context on some of the IRF-specific payment and coverage rules referenced during the hearing; though

these issues are largely *not* directly related to the MA policies within the Subcommittee's focus, we want to ensure that Members of the Subcommittee fully understand how these issues interact with the field's concerns about unnecessary delays and denials of medically necessary IRF care.

We recognize the Subcommittee's attention to the costs incurred by the Medicare program, and the need to ensure that Medicare dollars are spent on high-value care. We share the concern from several witnesses that some of the MA plan practices discussed during the hearing may be incentivized by the cost structure of the MA program, which offers higher profit per patient when care is denied or patients are diverted to lower-cost settings. This is because MA plans are paid a capitated monthly amount for each patient, thereby creating a financial incentive to care for the patient most efficiently. We also note that some analyses have suggested that reining in the use of prior authorization and other utilization management techniques by MA plans could result in higher expenditures by the Medicare program in the short term. However, as noted in the OIG report (detailed further below), a significant portion of MA denials are for care that met the Medicare Fee-for-Service criteria, i.e., should have been covered by the MA plans (which must provide, at minimum, the same level of coverage offered in Fee-for-Service or "Traditional" Medicare). Therefore, AMRPA firmly believes that such inappropriate denials are not reasonable cost-cutting measures but instead are limitations on medically necessary care to which MA beneficiaries are entitled.

Further, the care provided in IRFs is critical to the long-term health and function of beneficiaries who have sustained severe injuries and illnesses that necessitate intensive inpatient hospital rehabilitation. By receiving a full course of medically necessary, intensive therapy in an IRF, patients are able to maximize their recovery, often reducing or eliminating the need for longer-term (and costly) medical care after discharge. For example, a study on the long-term clinical outcomes of clinically similar patients treated in IRFs and SNFs found that patients treated in the IRF setting were able to return to the home setting earlier while experiencing fewer emergency room visits and hospital readmissions over the two-year study period.[8] In contrast, when patients who need IRF care are instead diverted to lower-intensity settings, or face significant delays in beginning IRF care while languishing in an acute care hospital, they may achieve lesser outcomes, face a greater threat of readmissions, and/or need ongoing medical care and support – all of which result in excess costs to the Medicare bottom line over the long term. AMRPA firmly believes that ensuring patient access to the right medically necessary care, at the right time, in the right setting, as determined by the patient's specific care needs, is the best way to achieve better patient outcomes and protect the fiscal health of the Medicare program.

## *IRF Services in OIG Report*

AMRPA continues to strongly back the findings and recommendations in the OIG's recent report regarding delays and denials that some patients face in their MA plans. As referenced previously, the OIG specifically identified inpatient rehabilitation as a service that its reviewers believe is inappropriately restricted by MA plans. The OIG found that 13 percent (1,631 denials) of the

[8] Dobson DaVanzo & Associates, *Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge* (June 2014).

more than 12,000 denials in the week-long sample met Medicare coverage rules, and thus likely would have been approved in the Fee-for-Service program. Within these more than 1,500 instances of inappropriate denials, the OIG report highlighted approximately 30 specific examples: four of these involved denials of IRF admissions.

In each of these examples, the OIG found that MA plans determined the request for IRF admission did not meet the Medicare coverage criteria, though the OIG's physician panel found otherwise. These cases follow common patterns that frequently inhibit patient access to IRF care. In one example, the MA plan determined that a lower level of care (such as a skilled nursing facility or home health care) was sufficient and thus denied the IRF admission, while the OIG reviewers found that the patient's condition was in fact severe enough to necessitate the medical supervision and management that occurs in an IRF. This trend was specifically referenced in the 2024 MA proposed rule preamble, which clarified that MA plans cannot deny a request for otherwise covered post-acute care services in a particular setting just because the patient might be able to also receive care in a less-intensive setting.[9] Other denials included inappropriate determinations that patients did not meet the Medicare medical necessity criteria for IRF admission.

The report also noted that at the time of the OIG's data request, three out of four of these inappropriate denials had not been reversed, though the report does not confirm whether or not those three cases had been appealed. We again emphasize that no matter how egregious any given denial of care may seem to both patient and provider, the appeals process is difficult and burdensome for even the most well-resourced patients. Ms. Bent also noted that even successfully reversing a denial does not mean that a given beneficiary can stop worrying about their coverage and does not protect the patient from receiving subsequent denials. A robust appeals process allows some beneficiaries the ability to challenge care denials but cannot substitute for further action to rein in these practices.

## *CMS Rules for Classification of IRFs*

As referenced in the written testimony from the Subcommittee's witnesses, IRFs must comply with specific criteria to maintain their classification as IRFs and receive Medicare payment under the IRF Prospective Payment System (PPS), as opposed to the traditional acute care hospital payment system (IPPS). IRFs must meet all criteria to be classified as an inpatient hospital under Medicare regulations and meet the so-called "60 Percent Rule." This requires that at least 60% of all patients admitted to an IRF for treatment must have a diagnosis of one or more of 13 specified conditions listed in 42 C.F.R. § 412.29(b)(2). These conditions include stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, certain neurological conditions, burns, certain severe arthritis conditions, and bilateral hip or knee replacements when the patient has a body mass index equal to or greater than 50 or is age 85 or older. The other 40% (or less) of an IRF's patients may qualify for coverage with a wide variety

[9] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications, 87 Fed. Reg. 79,452, 79,501 (Dec. 27, 2022).

of other debilitating conditions. IRFs are evaluated on an annual basis to determine whether they have met or exceeded the 60 Percent Rule in order to maintain their exclusion from the IPPS.

It is important to note that the 60 Percent Rule is purely used to determine, in the aggregate, whether a freestanding rehabilitation hospital or unit can maintain its designation and payment under the IRF PPS and is *not* used to determine whether individual patients qualify for admission to IRFs. IRF admission decisions are driven on an individual basis by a detailed set of Medicare coverage rules, laid out separately in 42 C.F.R. § 412.622. These extensive coverage requirements involve an individualized assessment of each potential IRF patient, not based on their single diagnosis code, but on a comprehensive evaluation of the patient's needs and prospective outlook in response to treatment. Patients who are appropriate for IRF care have conditions that are serious enough to require intensive, interdisciplinary treatment, in a hospital setting, with significant medical management and oversight. If a patient does not meet the full slate of coverage criteria in the clinical judgment of the rehabilitation physician, they will not be approved for an IRF admission. In fact, our members consistently report that a high percentage of patients referred to IRFs are determined *by the IRF clinical team* to not meet these very stringent criteria.

There are a number of highly complex patient populations that benefit from receiving IRF care that fall outside the conditions covered in the 60 Percent Rule. These conditions, including cardiac, oncology, and pulmonology (among others), are clearly suitable for intensive rehabilitation, as these patients require multi-disciplinary medical teams and close medical supervision by a full-time physician. Any insinuation that these patient populations should not be treated in an IRF due to the fact that they fall outside of those conditions listed in the 60% rule is a misunderstanding of the highly complex and diverse IRF patient population and fails to recognize changes in care delivery since the 60% rule was first implemented in 1984 (then referred to as the 75% rule). AMRPA would therefore strongly counter any suggestion that MA plans should use the conditions cited in the 60 Percent Rule to enforce a higher standard of access to IRF admissions, as such policy would impede access for patients who clearly benefit from IRF services and violate the existing coverage rules.

We share the Subcommittee's particular concern about MA plans' reliance on algorithms, proprietary guidelines, and other strict criteria that are not found in the Medicare coverage regulations, to restrict access to care against the decisions of treating doctors and other clinicians. Along similar lines, allowing MA plans to utilize the 60 Percent Rule as a de facto coverage restriction would not only go beyond the scope of MA plans' authority but would serve as exactly the type of "checkbox" restrictions that eliminate the role of physician judgment in an IRF admission. Such policy would also fail to reflect advances in medicine and technology that have made intensive rehabilitation an integral part of the recovery for an increasingly broad range of patients[10] – which in turn demonstrates the ongoing need for patient-centered and physician-led admission decision-making.

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[10] As an example, due to treatment advances and improved outcomes, the American College of Surgeon's Commission on Cancer now requires that rehabilitation services be included in order to certify a cancer program.

We appreciate the Subcommittee's time and attention to these critical issues and look forward to working with you and your colleagues to advance health care policy reforms that ensure patients are able to access the care they need. If you have any questions, please contact Kate Beller, AMRPA Executive Vice President for Policy Development and Government Relations, at kbeller@amrpa.org.

Sincerely,

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## Appendix 1: Access to Inpatient Rehabilitation for Medicare Advantage Beneficiaries: An Examination of Prior Authorization Practices (Executive Summary)

**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.

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.[11] 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

[11] 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 Denial*s (September 2018) (https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf.)

examined the PA determinations of MA plans.[12] In this report, the 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.[13] 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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[12] 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).
[13] Part C Reconsideration Appeals Data – Q2 2022 (http://www.medicareappeal.com/researchersdata).

# Appendix 2: Access to Inpatient Rehabilitation for Medicare Advantage Beneficiaries: An Examination of Prior Authorization Practices (Full Survey Results)

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

### Abstract

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

### Introduction and Background

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

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

As enrollment in MA has grown, providers have reported that PA determinations and subsequent denials have increased and often do not follow appropriate evidence-based guidelines.[iii] In addition, physicians report the PA process often delays care and has a negative impact on clinical outcomes.[iv] Concerns have also been raised about the lack

of accountability for the use of PA by MA plans. These concerns are due to high overturn rates of denials and due to insufficient publicly reported data. [v]

In the context of rehabilitation hospitals and units (RHUs), PA delays the discharge of patients from an acute hospital and denies or delays access to needed therapeutic interventions. RHUs (referred to by Medicare as Inpatient Rehabilitation Facilities or IRFs) provide specialized physician-directed care that includes close medical management and an intensive program of rehabilitation. The goals of care in an 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 an RHU stay is eligible for payment if the patient would practically benefit from and tolerate intensive, multi-disciplinary therapy and requires ongoing supervision by a rehabilitation physician.[vi] The Medicare rules also require that a rehabilitation physician approve each patient for admission. Due to the stringent Medicare rules and the intensity of services offered, RHUs treat more seriously ill and functionally impaired patients than lower intensity post-acute care settings.

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

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

## Survey Objectives

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

## Design

RHUs were solicited to participate prospectively in a data collection effort for the month of August 2021. The survey was publicized through trade association and professional channels to the RHU community, including disclosure of the specific questions that would be included on the survey and a spreadsheet form that could be used to capture the PA activity as it occurred. Participants submitted their data via an online portal.

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

| Table 1: Survey Questions |
|---|
| S1. How many Medicare Advantage patients did you request prior authorization to admit for rehabilitation hospital care? |
| S2. How many of those requests were ultimately approved? |
| S3. For those cases that were approved, how long did it take on average for the MA plan to grant authorization from the time of initial request (in days and including weekends)? |
| S4. How many of your requests were ultimately denied? |
| S5. In those denied cases from question #4, how long did it take on average for the MA plan to issue its *initial* formal denial from the time of the initial request (in days and including weekends)? |
| S6. In how many cases, whether ultimately approved or denied, did the hospital, physician, patient (or family) need to engage in extra effort to try to obtain authorization for admission? This could include requests from the plan for additional documentation, needing to conduct a peer-to-peer discussion, filing a formal appeal, or any other steps that were taken beyond the initial request for authorization. |
| S7. Of those requests requiring additional engagement from hospital, patient, or family (per question #6), how many were ultimately granted authorization? |
| S8. In your experience, what do you think has most common reason Medicare Advantage plans use to deny an authorization request? Please only select one answer.<br>a. Patient does not meet Medicare criteria for IRF admission.<br>b. Patient could be treated at lower level of care/intensity.<br>c. Patient does not meet medical necessity criteria (generally).<br>d. Patient does not require physician supervision.<br>e. Patient does not require multiple therapy disciplines and/or intensive therapy.<br>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.<br>a. Yes<br>b. No |

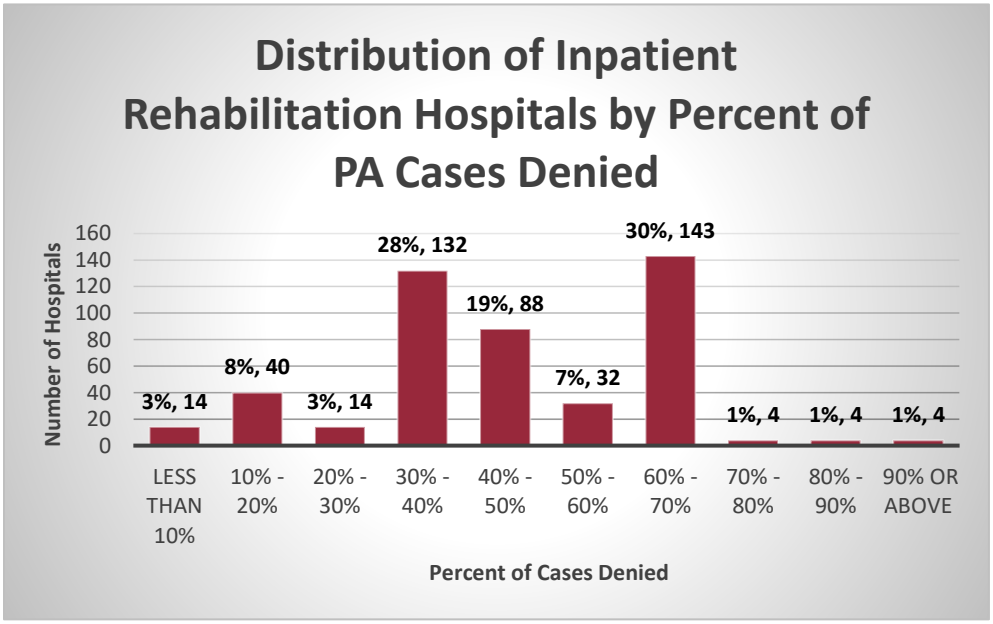
## Participants

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

## Results

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

*Figure 1. Distribution of Hospitals by denials*




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

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

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

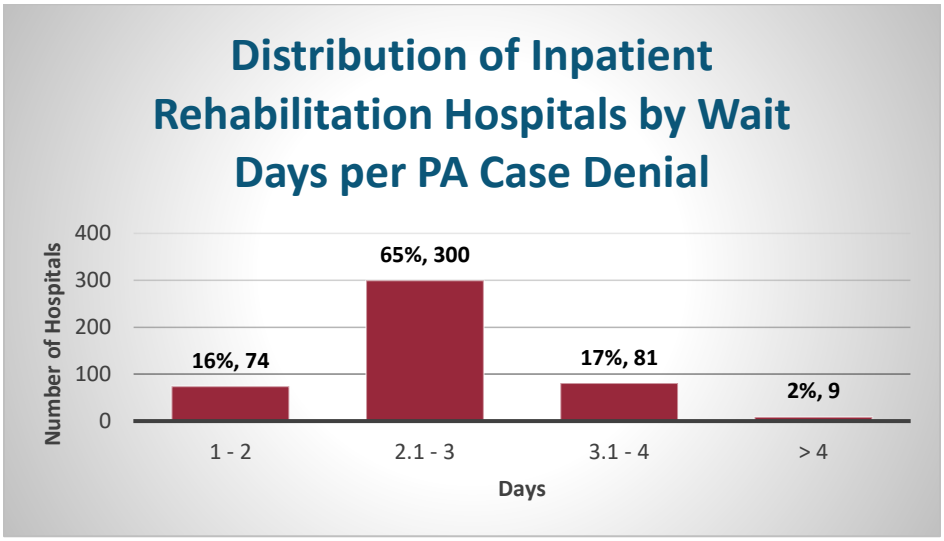
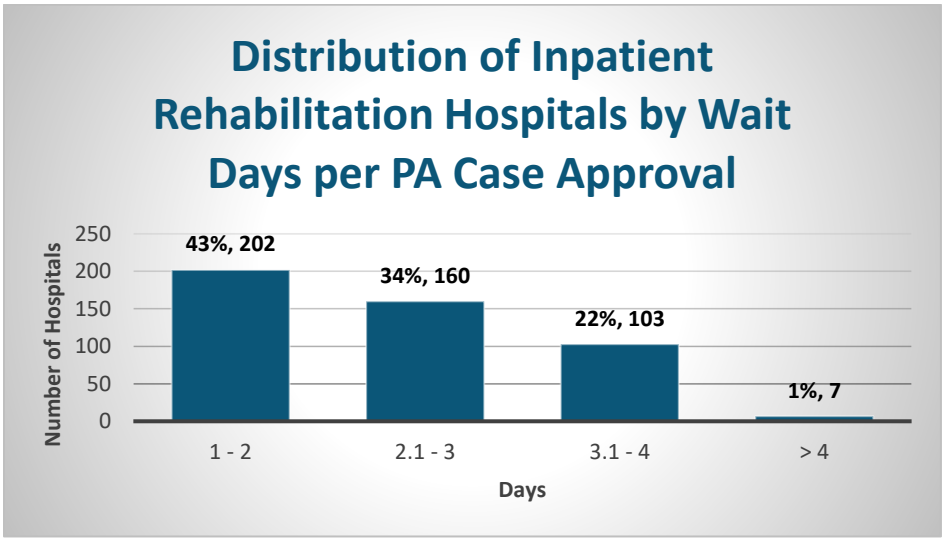



*Figure 3. Distribution of Hospitals by wait time for favorable response*




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

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

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

## Discussion

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

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

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

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

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

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

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

## Conclusions

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

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

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## References


[i] 42 C.F.R. § 422.101.

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

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

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

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

[vi] 42 C.F.R. 412.622.

[vii] CMS Inpatient Rehabilitation Facility Data, General Information Data Set (December 2021), https://data.cms.gov/provider-data/topics/inpatient-rehabilitation-facilities.

[viii] Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge; Dobson & Davanzo (July 2014) (https://amrpa.org/Portals/0/Dobson%20DaVanzo%20Final%20Report%20-%20Patient%20Outcomes%20of%20IRF%20v_%20SNF%20-%207_10_14%20redated.pdf)

[ix] CMS IRF PPS Coverage Requirements Nov. 12, 2009 National Provider Conference Call ("Notice that nowhere on the slide and nowhere in this presentation are we going to talk about whether the patient could have been treated in a skilled nursing facility or another setting of care. Under the new requirements, a patient meeting all of their required criteria for admission to an IRF would be appropriate for IRF care whether or not he or she could have been treated in a skilled nursing facility.") (Available for download: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage).

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

[xi] 42 C.F.R. § 422.572(a).

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

[xiii] Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices, Robert A. Berenson, Jonathan H. Sunshine, David Helms, and Emily Lawton, Health Affairs 2015 34:8, 1289-1295 (https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1427).