



AMRPA Statement re: Fiscal Year 2021 HHS Budget Proposal

The American Medical Rehabilitation Providers Association (AMRPA) has serious concerns about the proposal in the President’s Fiscal Year (FY) 2021 Budget that would expand the use of prior authorization in the Medicare fee-for-service (FFS) program. AMRPA members report that prior authorization – which is currently utilized by plans in the Medicare Advantage program – has directly resulted in inappropriate care delays and denials of care. The impact of prior authorization is particularly harmful for inpatient rehabilitation patients, given their complex medical and therapy needs and the effect of care delays on their outcomes and recovery. The prior authorization process also deflects valuable hospital resources to administrative red-tape that drives up costs, which stands in direct conflict to the Administration’s *Patients over Paperwork* initiative. In addition, the premise of this proposal, that rehabilitation hospitals and units are prone to improper payments and that prior authorization would address this, is based on a small sample of audits, the results of which are not reflective of the field as a whole.

Post-acute care (PAC) patients, such as those seeking care in an inpatient rehabilitation hospital or unit (referred to by Medicare as “IRFs”), are usually concluding an acute-care hospital stay and have an immediate need for continuing rehabilitation and close medical supervision. When a patient’s physician and the IRF clinicians agree that a patient is in need of intensive rehabilitation at an IRF, admission should not be delayed or overruled by a Medicare contractor that does not have the training or expertise to determine the appropriate PAC placement. Even in the increasingly rare instance when a prior authorization results in a favorable IRF admission decision, the initiation of therapeutic interventions is still delayed and patients are forced to spend unnecessary extra time in an acute-care hospital, increasing their risk of infection and complicating their recovery.

A recent Journal of the American Medical Association (JAMA) article found that the “financial toll, emotional distress, and psychological effects [of prior authorization] on patients can be substantial and recourse can be limited.”¹ Due to findings such as these and the overwhelming consensus about the detrimental nature of current prior authorization practices among medical professionals, AMRPA calls on Congress to refrain from taking any action to expand prior authorization and instead focus on efforts to address current problems with this practice in the Medicare Advantage program – such as passing H.R. 3107, the *Improving Seniors’ Timely Access to Care Act of 2019*. This bill – with nearly 180 bipartisan cosponsors and the endorsement of nearly 400 medical professional and patient associations - would take important first steps to reform some of the most egregious uses of prior authorization by Medicare Advantage plans, such as the lack of qualifications of reviewers and the absence of transparency regarding plans’ prior authorization appeal and overturn rates.

¹ Gaines ME, Auleta AD, Berwick DM. Changing the Game of Prior Authorization: The Patient Perspective. JAMA. Published online February 03, 2020. doi:10.1001/jama.2020.0070.



AMRPA remains ready to continue to work with the Trump Administration and Congress to improve post-acute placement and admission processes to ensure that patients receive the appropriate services for their specific clinical needs. However, implementing a flawed and harmful managed care tool in the traditional Medicare program is not in the interest of patients, providers, or the Medicare program. Therefore, AMRPA urges Congress not to adopt the Administration's proposal and focus its efforts instead on passing the bipartisan and patient-centered legislation, H.R. 3107.

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