



November 20, 2019

The Honorable Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, Southwest  
Washington, D.C. 20201

***Delivered Electronically***

***RE: CMS Request for Information re: Future of Program Integrity & Request for Information re: Advanced Technology in Program Integrity***

Dear Administrator Verma:

The American Medical Rehabilitation Providers Association (AMRPA) appreciates the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services' (CMS) Requests for Information (RFIs) regarding ways to modernize program integrity in the Medicare program. AMRPA applauds CMS' efforts to work collaboratively with stakeholders to "identify new tools, strategies, and other innovative approaches to minimize improper payments and reduce provider and supplier burden." We have major concerns, however, about the agency's interest in looking to the Medicare Advantage (MA) program to help "inform" potential reforms in the fee-for-service (FFS) Medicare program – particularly with respect to claim review practices and prior authorization policies. AMRPA members find that certain tools used by MA plans have resulted in harmful care delays and denials for inpatient rehabilitation services, and we therefore call on CMS to address these practices in MA rather than expand such harmful policies to the FFS program. Our concerns and recommendations on these and other issues are provided in greater detail below.

AMRPA is the national trade association representing more than 650 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals (collectively referred to as inpatient rehabilitation facilities (IRFs, hereinafter referred to as IRH/Us) by the Centers for Medicare and Medicaid Services (CMS)), outpatient rehabilitation service providers, long-term care hospitals (LTCHs), and several skilled nursing facilities (SNFs). The vast majority of our members are Medicare participating providers. In 2017, IRH/Us served 340,000 Medicare beneficiaries with more than 380,000 IRH/U stays.<sup>1</sup> AMRPA members help their patients maximize their health, functional ability, independence, and participation in society so they are able to return to home, work, or an active retirement.

Our comments below are focused on three major issues included in the RFI: (1) the potential expansion of prior authorization in the FFS Medicare program; (2) addressing current program integrity issues in the Medicare Advantage program; and (3) ways to improve the accuracy of IRH/U audits while reducing provider burdens. AMRPA stands ready to work with CMS to identify

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<sup>1</sup> Medicare Payment Advisory Commission (MedPAC), "Chapter 10: Inpatient Rehabilitation Facility Services," Report to the Congress: Medicare Payment Policy, March 2019.

reforms in these areas that can effectively improve claim reviews and curb improper payments, while also reducing significant provider burdens currently facing IRH/Us.

## **I. Applying Prior Authorization in FFS Will Lead to Inappropriate and Harmful Care Delays & Denials**

AMRPA is highly concerned by provisions in the RFIs that indicate CMS' interest in "learning from the forward-thinking [program integrity] tools" utilized by MA plans and considering how to incorporate such tools in the FFS program – including prior authorization. Specifically, the RFI poses a number of implementation-related questions focused on prior authorization in FFS Medicare, such as (1) whether prior authorization can be used in a way that protects "complete access to medically reasonable and necessary covered services for beneficiaries;" (2) whether clinical decision support tools can play an appropriate role in prior authorization; and (3) if CMS can apply prior authorization in FFS without adding to provider and beneficiary burden. AMRPA asserts that the answer to all these questions is a resounding "no," based on the current regulatory landscape facing our industry and the adverse impact that such policies currently impart on inpatient rehabilitation access in the MA program.

As an initial matter, prior authorization policies are particularly misplaced when applied to IRH/Us. Before a beneficiary can ever be admitted to an IRH/U, Medicare regulations require a qualified physician to evaluate the patient against objective pre-admission criteria. Among other requirements, the beneficiary must be able to tolerate and benefit from intensive therapy, at least three hours per day, with extensive documentation to confirm this. Due to the rigor of existing IRH/U admission criteria, our members report that they decline admission for a substantial portion of patients referred to their hospital – essentially creating a "de facto" prior authorization policy that is based on the physician's clinical judgment and tailored to specific patient needs.

With respect to whether prior authorization policies can "protect complete access" to necessary services for beneficiaries, the experience of IRH/U beneficiaries in the MA program shows that these policies produce the opposite result. Our members report that, based on their direct experience with prior authorization practices in MA, these policies lead to improper denials, referrals to inappropriate care settings, and lengthy delays in care that cause irreversible clinical harm. MA plans take one to three business days to respond to a prior authorization request for IRH/U admission, and even longer when accounting for weekends. These initial requests are denied at a very high rate, and then the hospital must engage in the days-long appeals process. All the while, the patient's acute stay has been unnecessarily extended up to a week, and the patient is without the comprehensive rehabilitation services needed. Often times, acute-care hospitals are left with no practical choice but to discharge the patient to a lesser-intensity setting of care, and by the time a favorable appeal determination is reached, it can be a difficult decision whether to move the patient yet again. Even in the increasingly rare cases when an MA patient is successfully admitted to an IRH/U, the administrative burden and resources expended are taxing and detract from care.

Supporting the stark lack of access for MA beneficiaries needing inpatient rehabilitation, CMS data demonstrates that MA enrollees are admitted to IRH/Us at one-third the rate of FFS beneficiaries - due largely to prior authorization policies that drive patients to lower-acuity settings.<sup>2</sup> Expanding

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<sup>2</sup> Medicare Payment Advisory Commission (MedPAC), "Chapter 10: Inpatient Rehabilitation Facility Services," Report to the Congress: Medicare Payment Policy, March 2017.

prior authorization to the FFS program would therefore devastate access to IRH/U services throughout the entire Medicare program. To further illustrate these access issues, AMRPA notes that there is strong bipartisan agreement in Congress to reform components of the prior authorization policies that have unfairly impeded access to reasonable and necessary covered services for MA beneficiaries. Specifically, the House Appropriations Committee's FY 2019 Report cautions against the use of prior authorization to inappropriately delay needed care and directs CMS to issue guidance to restrict these practices.<sup>3</sup> In addition, 132 bipartisan members of the House have sponsored legislation that would fundamentally overhaul the way MA plans administer prior authorization.<sup>4</sup>

AMRPA similarly opposes the use of the currently marketed, proprietary clinical decision tools in the FFS program, based again on our members' experience in the MA program. Many MA plans use clinical decision support tools – specifically proprietary guidelines (such as Milliman and InterQual) – that result in MA beneficiaries being denied services they are entitled to receive under Medicare statute. For example, while Medicare regulations clearly require MA plans to provide “all Medicare-covered services,”<sup>5</sup> plans often apply these guidelines to make coverage decisions that run afoul of Medicare coverage rules and improperly deny coverage of inpatient rehabilitation. These guidelines also often contradict well-established standards and best practices in rehabilitation medicine, such as the American Heart Association and American Stroke Association's guidelines for stroke recovery.<sup>6</sup>

The net effect of these practices is to divert many enrollees who qualify for inpatient hospital rehabilitation to less appropriate, lower-acuity settings, such as nursing homes and homecare – inevitably decreasing their prospects for optimal recovery. AMRPA is alarmed, therefore, that CMS expresses interest in the RFI as to how MA plans use prior authorization “to closely monitor whether claims meet payer guidelines,” as such guidelines often work to deny beneficiaries access to covered and clinically necessary services. Therefore, rather than looking to *expand* the use of such clinical support tools, AMRPA urges CMS to reexamine the use of all proprietary guidelines used by MA plans and prohibit their usage when they run afoul of Medicare coverage criteria.

Finally, AMRPA underscores the administrative and financial burdens that prior authorization creates for providers, particularly the way that such policies are currently structured in the MA program. MA plans' prior authorization policies often require providers to submit extensive documentation and spend time challenging inaccurate reviews of IRH/U prior authorization requests, diverting time and resources away from patient care (as more fully detailed in the next section). This is especially true for treating physicians, who must rearrange their schedules to participate in “peer-to-peer” discussions at the convenience of the MA plan.<sup>7</sup> Introducing prior authorization and clinical decision support tools into

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<sup>3</sup> H.R. REP. NO. 116-62, at 139 (2019).

<sup>4</sup> H.R. 3107, 116th Cong. (2019).

<sup>5</sup> 42 C.F.R. § 422.101(b)(2).

<sup>6</sup> “In-patient rehab recommended over nursing homes for stroke rehab,” American Heart Association/American Stroke Association Scientific Statement, May 4, 2016, *available at* <http://newsroom.heart.org/news/in-patient-rehabrecommended-over-nursing-homes-for-stroke-rehab>. See also AHA/ASA, GUIDELINES FOR ADULT STROKE REHABILITATION AND RECOVERY: A GUIDELINE FOR HEALTHCARE PROFESSIONALS FROM THE AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION (2016), *available at* <http://stroke.ahajournals.org>.

<sup>7</sup> IRH/Us find the term “peer-to-peer,” as used in the context of prior authorizations for admissions, to be a misnomer. Hospitals rarely find that the MA plan is utilizing a physician trained in rehabilitation medicine to make prior authorization admissions determinations. This situation is exacerbated by the fact that sometimes rehabilitation physicians at the IRH/U do not have standing to participate in peer-to-peer discussions while the patient is in an acute care setting.

FFS would add harmful new administrative and financial burdens for providers of FFS patients, in contrast to the stated burden reduction goals of this Administration. AMRPA remains eager to work with CMS to identify new tools and technologies that could improve pre- and post-payment claim reviews, but we staunchly oppose using prior authorization as a means of improving program integrity in the FFS program.

## **II. Addressing Program Integrity Issues in the Medicare Advantage Program**

As outlined in the preceding section, AMRPA believes that any expansion of prior authorization policies poses a serious threat to beneficiary access to timely and clinically-appropriate services, particularly IRH/U services. As an equally important policy issue, AMRPA also calls on CMS to focus its immediate attention on curbing the abusive and burdensome prior authorization policies that currently operate in the MA program. One of the major issues that providers face with respect to prior authorization is the variance in prior authorization requirements and processes among plans, which in turn create significant confusion for both providers and their patients. Therefore, in response to CMS' request for the "specific changes [it] should consider as part of its program integrity strategy in the MA program," AMRPA urges CMS to consider the following measures:

- Establishing a clear and uniform process for providers to submit prior authorization requests, such as through an electronic medium that facilitates faster and more easily reviewable determinations
- Requiring plans to ensure that the contractors reviewing prior authorization requests have appropriate clinical background and experience on the claims at issue. This is particularly important for inpatient rehabilitation-related claims, given the intricacy of IRH/U admission criteria and the medically complex nature of IRH/U patients
- Mandating that prior authorization policies be consistent with Medicare coverage criteria and clinical guidelines. This would prohibit, for example, the use of proprietary guidelines that contravene established clinical guidelines for stroke patients and often attempt to place stroke patients in a lower-acuity setting rather than an IRH/U
- Creating new requirements to ensure plans have staff available 24 hours, 7 days a week to respond to prior authorization requests, given the need for immediate review of IRH/U admission requests and other treatment decisions in the PAC setting
- Requiring plans to establish clinically appropriate and targeted documentation requests. This would curb the current practice of MA plans delaying prior authorization determinations via requests for excessive documentation that often have limited relevance to the PAC placement decision at issue

These reforms would significantly enhance the administration of MA program and the patient experience of care. Collectively, these reforms would significantly reduce administrative burden for providers and better ensure that patients are receiving timely access to clinically appropriate services – directly in line with CMS' goals outlined in this RFI. AMRPA stands ready to work with CMS to help implement these types of reforms to improve program integrity in the MA program, including the identification of appropriate timeframes for PAC-related prior authorization determinations.

### **III. Reforms to Improve Inpatient Rehabilitation-Focused Audits**

In addition to addressing the aforementioned pre-payment issues involving inpatient rehabilitation services, AMRPA calls on CMS to improve its program integrity oversight through key changes to the way its auditors intersect with IRH/Us. There are numerous entities that audit IRH/U claims – including Medicare Administrative Contractors (MACs), Supplemental Medical Review Contractors (SMRCs), Recovery Audit Contractors (RACs), the Comprehensive Error Rate Testing Contractor (CERT), and the Office of Inspector General (OIG) – and all of these entities interpret IRH/U coverage criteria differently, often producing time-intensive and inaccurate audit results. In addition to the time spent on the audits themselves, hospitals spend countless hours appealing denials, which are overturned at a very high rate. AMRPA supports needed reforms to improve audit practices, reduce provider burdens, and produce audit results that are more educational and instructive for both providers and the Medicare program.

AMRPA has long supported establishing a standing Medical Rehabilitation Advisory Board to ensure that Medicare medical necessity standards and enforcement reflects the real-world practice of rehabilitation medicine. This Advisory Board could advise CMS and its audit contractors on ways to accurately review medical necessity determinations as applied to IRH/U services, given the aforementioned complexity of both the IRH/U compliance criteria and IRH/U patient mix. Such an Advisory Board would interface with both providers and auditors to ensure that all parties maintain parallel medical necessity expectations. This effort would significantly improve IRH/U audits and significantly reduce the burdens currently created by the different audit contractor reviews and processes.

Furthermore, to advance CMS' goals of improving provider education, CMS should require auditors to make their instructions and guidelines available for public feedback and discussion. Doing so would help make audits more educational and less punitive, and potentially result in fewer appeals. Relatedly, in the case of denials, CMS auditors should be required to explain how and why specific facts led to the conclusion that the patient did not meet the coverage criteria. This would help the provider refine its admission and documentation practices to address deficiencies that are clearly identified and explained by the auditor and understood by the provider. More detailed denials would also help educate providers and reduce the occurrence of similar errors in future audits.

Lastly, and consistent with our recommendations related to prior authorization, AMRPA urges CMS to require auditors to have appropriate training and experience in the context of their claims reviews. Currently, contractors often use non-physicians, or physicians who do not meet Medicare's qualifications of a rehabilitation physician, to make medical necessity determinations of IRH/U services. To improve the accuracy of IRH/U reviews and significantly cut down on appeals, CMS should require that only a physician who meets the Medicare requirements of a qualified rehabilitation physician, with current experience in IRH/U practice, review and approve all denials issued on the basis of medical necessity.

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AMRPA appreciates the opportunity to participate in CMS' important efforts to improve program integrity in the Medicare program. We are eager to provide any technical assistance or further information on our recommendations and look forward to continuing to collaborate on ways to improve IRH/U claim reviews and protecting patient access to vital inpatient rehabilitation services. If you have any questions, please do not hesitate to reach out to Kate Beller, AMRPA Executive Vice President for Policy Development and Government Relations (202-207-1132, [kbeller@amrpa.org](mailto:kbeller@amrpa.org)) or Jonathan Gold, Director of Government Relations & Regulatory Counsel (202-860-1004, [jgold@amrpa.org](mailto:jgold@amrpa.org)).

Sincerely,

A handwritten signature in blue ink, appearing to read "Richard Kathrins", with a stylized flourish at the end.

Richard Kathrins, PhD

Chair, AMRPA Board of Directors

President & Chief Executive Officer, Bacharach Institute for Rehabilitation