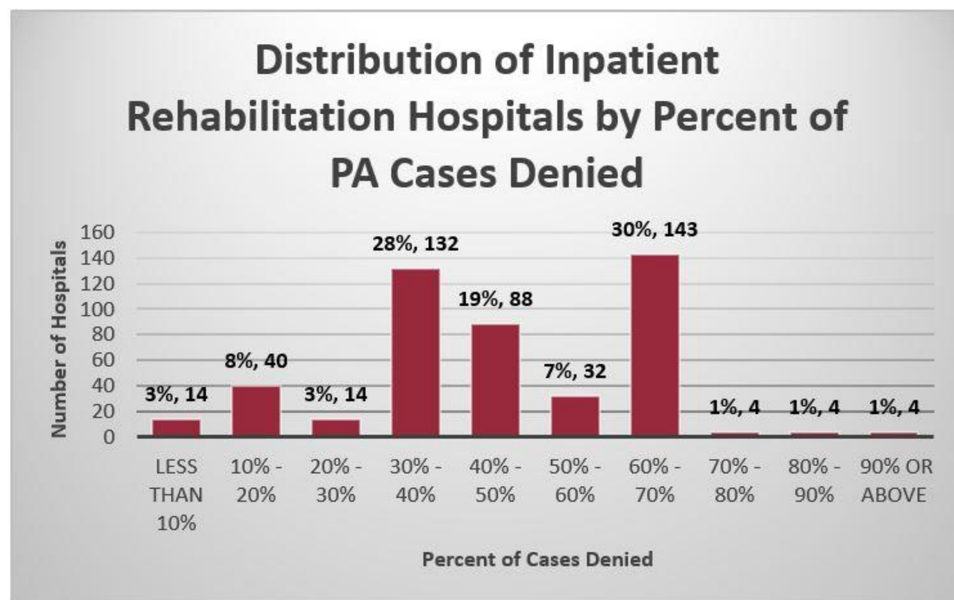
AMRPA 2024 Prior Authorization Survey

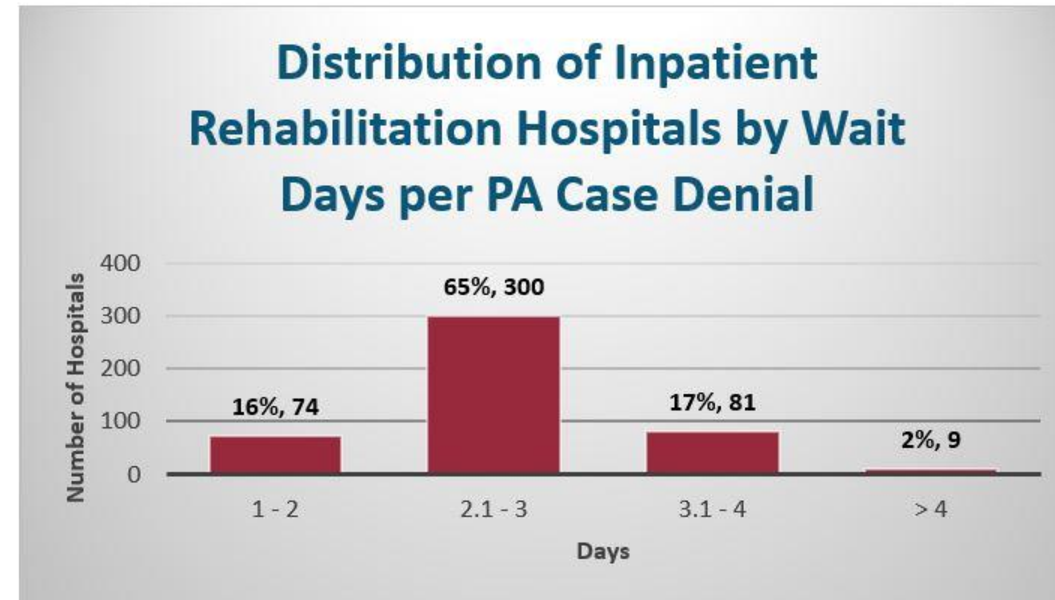
Why Conduct the Survey?

- Prior Authorization in Medicare Advantage (MA) continues to be the largest barrier to patient access to inpatient rehabilitation care that our members report.
- Advocating for Prior Authorization reform remains one of AMRPA's top policy priorities for 2024.
- Recent regulatory reforms have opened the door to Prior Authorization fixes, but more work still remains to have a meaningful impact on patients and providers.
- Policymakers have specifically requested more robust data from the field in the absence of comprehensive reporting requirements instituted by CMS.

2021 Survey

- Available at: https://amrpa.org/Advocacy-News/Medicare-Advantage-Prior-Authorization-Survey
- 475 IRFs represented – let's beat that record!
- Covered more than 30,000 waiting days in one month alone.





2024 Survey Goals & Format

Goal: Collect meaningful, actionable data on the impact of Medicare Advantage plan denials of prior authorization for inpatient rehabilitation admissions.

Format: Excel spreadsheet with monthly tabs for summary information collected by MA plan. (OPTIONAL tracking tool for individual claims – not for submission to AMRPA).

Collection Period: July 1-31 and August 1-31, 2024

Deadlines for Data Submission: August 10 (for July data) and September 10 (for August data)

Survey Data Elements

- Medicare Advantage Plan Name
- Network Status (is your hospital in-network with this plan?)
- Referrals Requesting Prior Authorization
- Referrals Initially Denied
- Average Days to Decision
- Level 1 Appeals
- Level 1 Denials
- Total MA Admissions
- Top Reason for Denial

How Do Hospitals Track this Information?

- AMRPA is collecting summary monthly data for July & August 2024.
- Hospitals should use our Survey Tool to report monthly data for each MA plan they serve (i.e., total prior auth requests for Humana, United, Aetna, etc.)
- AMRPA has an **Optional** "Claim Log" tab on the survey tool, for those hospitals who want to use the same tool to track each admission and then summarize by month for reporting.
    - Use of the Claim Log is optional – hospitals can use whatever method is preferred to track each claim and AMRPA is <u>**not**</u> seeking information on individual admissions.

AMRPA AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Medicare Advantage Prior Authorization Tracking Tool

Despite playing a critical role in the care continuum, Medicare Advantage (MA) plans inappropriately restrict access to inpatient rehabilitation hospitals and units (IRFs) and other settings of post-acute care. As a result, Medicare beneficiaries in MA are deprived of the opportunity to access the same services that are covered under traditional Medicare (TM). Prior research has shown that MA enrollees are less likely to use institutional post-acute care (PAC) than TM beneficiaries, raising concern that this difference in institutional PAC use may reflect barriers in access to PAC faced by MA beneficiaries.

Over the years, AMRPA and other PAC organizations have shared critical feedback with CMS on MA's prior authorization process and have documented prior authorization denials that have resulted in the inability of Medicare beneficiaries to access medically necessary and appropriate IRF care. On April 5, 2023, the Centers for Medicare & Medicaid Services (CMS) issued its Contract Year 2024 Policy and Technical Changes to the Medicare Advantage (MA) and Medicare Prescription Drug Benefit Programs Final Rule (CMS-4201-F). This rule took significant steps towards ensuring timely access to care.

Effective January 1, 2024, the agency implemented this final rule which amended regulatory language and clarified that MA plans are required to comply with general coverage and benefit conditions included in TM statutes, including specific references to the availability of IRF admissions. CMS further clarified that under the rule, the prior authorization processes can only be used to confirm the presence of diagnoses or other medical criteria that is the basis for coverage of a certain item or service or ensure an item or service is medically necessary.

AMRPA invites you to participate in this initiative to track MA prior authorization denials. We will not attribute the information to your IRF(s). We ask that you report aggregated MA data by month in the appropriate tab.

AMRPA is working in conjunction with other PAC organizations to collect data on the impact of this new rule on access to post-acute care. Your answers will help AMRPA assess the extent to which IRFs have benefited from the passage of CMS-4201-F and be shared with policymakers to advocate for Medicare Advantage beneficiaries' access to IRF care.

AMRPA AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Guidance on Completing the MA Prior Authorization Tool

Overview of Medicare Advantage Plan Prior Authorization Appeals Process

Most Medicare Advantage (MA) plans require post-acute care (PAC) services to be authorized prior to the service being provided, including for IRF admissions. The Centers for Medicare & Medicaid Services (CMS) provides an appeal process for MA enrollees and their providers to challenge denial of services decisions. The appeal process consists of the following steps:

(1) Initial Determination – Request Prior Authorization for Patients
(2) Peer-to-Peer Conversation (Optional) (Part of the Initial Determination)
(3) Level 1 Appeal – Request Reconsideration by the MA plan
(4) Peer-to-Peer Conversation (Optional)
(5) Level 2 Appeal – External Review by the Independent Review Entity (IRE). This appeal is automatic; the MA plan must transmit the entire case to the IRE within 24 hours of an MA plan upholding its denial during the Level 1 Appeal process.

This data tool collects information on MA prior authorization denials. It focuses on capturing information on initial determinations and level 1 appeals.

Step 1. Initial Determination

First, an MA plan will make an organization determination ("initial determination") to either allow or deny services at an inpatient rehabilitation hospital or unit ("IRF") after submission of a request for prior authorization for the plan member (beneficiary). The plan member, their representative, or the physician can request the initial determination. If the initial determination decision is a denial, the MA plan must submit in writing to the plan member the reasons for the denial and information on how to appeal the denial. After the initial determination decision to deny has occurred, a plan member and/or the attending or treating physician can appeal the decision. The physician who would be treating the patient at the IRF ("treating physician") may appeal the decision with permission from the patient and should consult with the physician treating the patient at the short-term acute care hospital (STACH ["attending physician"]) before contacting the MA plan.
During the initial determination phase of the appeal process, you will record the following information to include in the monthly report:

Medicare Advantage Plan Name	The **name of the MA plan** you contacted for prior authorization (i.e., United Healthcare, Aetna, etc.)
In-Network?	Whether the reporting facility is "**in-network**" with the given MA plan (Yes or No).
Referrals Requesting Prior Authorization	The **total number of initial prior authorization requests** submitted to this MA plan for the given month.
Referrals Initially Denied	The **total number of initial prior authorization requests denied** by the MA plan at the initial determination phase in the month. MA plans are required to send a written notice of the decision to enrollees by mail. This notice may be referred to as the Notice of Denial of Medical Coverage (NDMC) or the Integrated Denial Notice (IDN).
Referrals Initially Approved	This number is calculated **automatically** by subtracting the number of initial denials from the total number of initial requests submitted.
Average Days to Decision	The **average** number of days it takes for this plan to return an initial decision, whether an approval or denial. If you are using the claim log to track individual claims, please tally the total number of days to decision across all the patients for a given plan and divide by the number of patients.

Step 2. Peer-to-Peer Conversation (Optional)

Please provide some basic information about your submission and identify a point of contact for AMRPA if there are questions or follow-up is needed.

Field	Response
Hospital/Health System Name:	
State (if submitting on behalf of multiple locations, please enter "System")	
Unit or Freestanding (if submitting on behalf of multiple locations, please enter "System")	
Facility Count (How many IRFs are represented in this submission):	
Bed Count (how many IRF beds are represented in this submission):	
Contact Name for Survey	
Contact Email for Survey	

Note: we strongly urge all survey respondents to report information on a facility basis, that is, on behalf of each individual hospital, not an entire system or network. However, if you are not able to provide facility-level data, we are still accepting aggregated data covering multiple facilities and ask that you provide the total number of facilities included as well as the total bed count represented in your submission.

Please Note: This Claim Log is for **internal tracking purposes only. AMRPA is asking all respondents to aggregate information at the **plan level** for purposes of reporting back to AMRPA. If you utilize the Claim Log, please make sure to avoid disclosing any identifiable patient information.

Case ID	Medicare Advantage Plan (Name)	In-Network?	Days to Initial Decision	Status of Initial Prior Authorization Request	Level 1 Appeal Decision (if applicabl	Admitted/Not Admitted	Reason for Denial (if applicable)	Notes
1245 (Example)	United Healthcare	Yes	3	Approved/Denied	Approved/Denied/NA	Admitted/Not Admitted	Medical Necessity - Does Not Require Physician Supervision	(EXAMPLE)

AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

WWW.AMRPA.ORG

Medicare Advantage Plan (Name)	In-Network?	Referrals Requesting Prior Authorization	Referrals Initially Denied	Referrals Initially Approved*	Average Days to Decision	Level 1 Appeals	Level 1 Appeals Denied	Denials Overturned on Level 1 Appeal*	Total Referrals Approved*	Admissions	Top Reason for Denial
*Fields that are highlighted grey are automatically calculated, and do not require input.											
Responses covering July 1-31, 2024 are due back to AMRPA by August 10, 2024. Please submit all survey information and questions to jnahra@amrpa.org.											
United Healthcare (EXAMPLE)	Yes	100	85	15	2.4	70	40	30	45	40	Insufficient Documentation - Plan of Care
				0				0	0		
				0				0	0		
				0				0	0		
				0				0	0		
				0				0	0		
				0				0	0		
				0				0	0		
				0				0	0		
				0				0	0		
				0				0	0		
				0				0	0		
				0				0	0		
				0				0	0		
				0				0	0		
				0				0	0		
				0				0	0		

Next Steps

1. Please complete the short "pre-registration" survey to let us know you are participating.
   PRE-REGISTRATION SURVEY: https://forms.office.com/r/bxvjVHXtkU
2. Review the survey tool and prepare to track each data element for July & August 2024.
3. Calculate the aggregate data for each month and report it in the survey tool (use the July 2024 or August 2024 tab).
4. Send the monthly report back to AMRPA by the 10th on the following month (August 10 for July data; Sept. 10 for August data).
5. AMRPA will analyze the data and publish a full report in Fall 2024.

Frequently Asked Questions

- **Will my hospital be identified in the survey results?**
  All information submitted to AMRPA will be kept confidential, and results will only be published at an aggregate, de-identified level. A confidentiality agreement may be executed upon request further outlining this approach.
- **Can I provide information at a system-level?**
  When possible, we encourage members to submit information at the individual hospital/facility level to allow for greater understanding of any geographic variation, but system-wide information will also be accepted.
- **When will results be available?**
  AMRPA staff will analyze all data once collected and prepare results for publication in Fall 2024.
- **Should I submit information on IRE or ALJ appeals?**
  For this survey, we are only collecting information on initial requests and Level 1 appeals (plan reconsideration). If you have any notable experiences with Level 2 or higher appeals to share, please contact Joe Nahra, jnahra@amrpa.org.

Questions?

- For all information about the 2024 Survey, visit https://amrpa.org/Prior-Auth-Survey-2024

- Contact Joe Nahra (jnahra@amrpa.org) with any and all questions.