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September 17, 2024

The Honorable Christi A. Grimm
Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Advantage Organizations' Use of Prior Authorization for Post-Acute Care (Report Number OEI 09-24-00330)

Dear Inspector General Grimm:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations and our clinician partners — including more than 270,000 affiliated physicians, two million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) applauds the U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) for your recently announced review of Medicare Advantage Organizations' Use of Prior Authorization for Post-Acute Care.

The AHA continues to be concerned about the policies and practices of certain Medicare Advantage Organizations (MAOs) that impede patient access to care and circumvent rules designed to ensure access and coverage parity between Medicare Advantage (MA) and Traditional Medicare. Hospitals and health systems continue to experience inappropriate denials and delays in care for MA beneficiaries consistent with the concerns raised by prior HHS OIG work that found MAOs sometimes denied prior authorization requests for post-acute care after a qualifying hospital stay even though the requests met Medicare coverage rules. As indicated by the mounting evidence of inappropriate insurer denials and delays of post-acute care services, further scrutiny of these practices is warranted. The AHA strongly supports investigation into and greater oversight of MAO practices, particularly as they pertain to access to post-acute care services.

In the following sections, we describe the experience of referring hospitals and post-acute care providers with problematic MAO practices that inappropriately limit access to Medicare-covered post-acute care services and/or fail to comply with federal rules. **As described below, these practices have, in some cases, caused direct and**

irreversible harm to patients, stymieing their recovery from serious illness or injury and hindering restoration of their functional capabilities. These abusive practices further strain health care delivery system resources and capacity at referring general acute-care hospitals by imposing days- or weeks-long delays in the necessary authorizations to transition patients to the next site of care, while sometimes precluding patient access to post-acute care sites altogether. **We hope the experiences of patients, hospitals and health systems shared in this letter will inform your examination of MAO use of prior authorization for post-acute care services. We also hope it will spur greater action to curb practices that harm Medicare beneficiaries and unnecessarily delay timely access to care.** On behalf of our members, we would be pleased to serve as a resource for any additional data, examples or information that would be helpful as you conduct your inquiry into this important topic.

We also want to acknowledge not all MA plans are the same; many have active partnerships with providers in service of their shared patients/members and consistently act in good faith to follow the rules. To this end, we believe that enforcement actions should be targeted to MA plans that have a history of suspected or actual violations or whose performance metrics related to appeals, grievances and denials could be indicative of a broader problem warranting investigation. Every effort should be made in carrying out enforcement activities to ensure that undue burden is not placed upon MA plans that consistently act in good faith and adhere to federal rules.

Background

After a stay in an acute-care hospital, many patients require institutional post-acute care, which is provided by inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), skilled-nursing facilities (SNFs), home health agencies (HHAs) and hospices. The most acute and debilitated patients are often referred for hospital-level post-acute care at IRFs and LTCHs. While MAOs can permissibly require prior authorization for admissions to IRFs and LTCHs, they cannot decline to cover them. These services are, as you know, a covered benefit under Medicare Part A, therefore, they also must be covered for MA beneficiaries.[1] In addition, and consistent with guidance from the Centers for Medicare & Medicaid Services (CMS), MAOs also must apply the same coverage criteria as Traditional Medicare when evaluating eligibility for IRF and LTCH services.[2] In other words, MAOs may not apply more restrictive criteria than Traditional Medicare applies for the use of institutional post-acute care services, which are basic benefits under Medicare.

The AHA has engaged extensively with CMS and other federal policymakers regarding concerns about access to care for MA beneficiaries, including inappropriate denials of

[1] 42 C.F.R. § 422.100.
[2] 42 C.F.R. § 422.101(b)(2).

coverage and payment for medical care that do not comply with these federal standards. These challenges have been particularly pronounced in post-acute care, where some plans routinely apply more restrictive policies than Traditional Medicare, limiting access to Medicare-covered services and ignoring the clearly defined coverage requirements for basic benefits. In response to these widespread concerns and the findings of prior HHS OIG reports, CMS finalized a ground-breaking rule last year that took important steps toward addressing these issues, including better alignment of MA with Traditional Medicare, clarification of the coverage criteria that may be applied to post-acute care services, and limitations on the use of prior authorization for such requests, among other provisions. **However, despite these important developments, hospitals and health systems report little to no change in MAO practices concerning post-acute care authorizations. Indeed, MA beneficiaries continue to face persistent delays and denials of medically appropriate post-acute services.**

For example, hospitals and health systems report that certain MAOs continue to ignore Medicare coverage criteria in favor of their own when responding to prior authorization requests. Many also continue to issue denial notices providing general conclusions that care is unnecessary or does not meet Medicare criteria without any explanation or information on how the criteria were applied to the patient's individual circumstances. In addition, some MAOs continue to utilize clinician reviewers for prior authorization requests whose expertise does not comply with CMS' requirement that reviewers have relevant training and expertise in the requested service and sufficient knowledge of the beneficiary's condition to make an appropriate determination. **These practices demonstrate a flagrant disregard not only for Medicare rules and regulations but also for the health and well-being of MA beneficiaries.**

Certain MAOs Routinely Deny Access to Medically Appropriate Post-Acute Care

IRFs and LTCHs work closely with acute-care hospital partners to properly screen and determine appropriate discharge locations for patients, including ensuring patients meet Medicare criteria for the requested post-acute care. Despite this careful coordination and assessment of patients' medical needs, MAOs regularly overrule the judgment of treating providers when reviewing requests for admission to IRFs and LTCHs and either deny authorization for post-acute care altogether or attempt to transition patients to lower-than-prescribed levels of care. For example, one large post-acute provider that operates both IRFs and LTCHs found that only approximately 29% of MA beneficiaries referred to IRFs and 39% of MA beneficiaries referred to LTCHs have been admitted to date in 2024. In contrast, the admission rates for Traditional Medicare beneficiaries referred to these providers were more than double for IRFs and over 20% higher for LTCHs.

Improper delays and denials of post-acute care can have catastrophic real-world impacts on patients and their families. One such example shared by an AHA member involved an 81-year-old MA beneficiary who was admitted to an acute-care hospital for possible heart failure. The patient, who became dependent on a ventilator, remained in

that hospital for 38 days while the facility and the patient's family sought admission to an LTCH — a Medicare-covered benefit. The MAO denied LTCH admission, citing (erroneously) that the patient would not need an extended stay and had tolerated some degree of ventilation weaning in the acute-care hospital. After appeals also were denied, the patient was eventually discharged to a SNF. Within 24 hours of discharge, the patient was readmitted to the acute-care hospital in acute respiratory failure and shock.

In another such example, a hospitalized patient who had a below-the-knee amputation due to complications of a diabetic infection and sepsis was denied admission to an IRF. The MAO insisted the patient go to a SNF instead. This occurred even though the SNF itself expressed concern about its ability to manage the complexity of this particular patient. And, indeed, the patient was harmed as a result of this denial — while in the SNF, the patient's wound ruptured and the patient became septic again, requiring readmission to the acute-care hospital in critical condition. Further, despite the role of the MAO's own decision in the patient's ultimate readmission, the acute-care hospital was not reimbursed for the second admission according to the MAO's readmission policy, which also is more restrictive than Medicare. Unfortunately, examples like these are an everyday occurrence for many MAO beneficiaries and their providers.

The available data further bolsters these anecdotal reports of MAOs inappropriately restricting patient admissions to IRFs and LTCHs. First, there are a number of analyses, including a chapter in the Medicare Payment Advisory Commission's March 2024 report to Congress, highlighting that MA beneficiaries utilize institutional post-acute care at a markedly lower rate than Traditional Medicare beneficiaries.[3,4] Second, one large provider of IRF services reports that they continue to see approximately a quarter of all requests for IRF admissions denied by MAOs, even though each of these patients is thoroughly screened for compliance with the CMS IRF criteria and coverage rules. In addition, a large LTCH provider reports that more than 20% of their requests for MAO authorization have been denied to date in 2024.

MAOs Fail to Issue Complete Denial Notices and Continue to Apply Impermissible Internal Coverage Criteria

Although MAOs frequently deny authorization for a beneficiary's IRF or LTCH care, MAOs often fail to provide proper or complete rationales for these denials, directly contravening CMS transparency requirements. Some MAOs continue to cite proprietary guidelines or internal coverage criteria that contradict CMS coverage rules, which are explicitly barred by CMS. Others cite failure to meet standards for admission criteria that

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[3] Medicare Payment Advisory Commission, March 2024 Report to Congress, Chapter 9, pg. 264. https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch9_sec.pdf.
[4] Bentley, F. 2017. Medicare Advantage patients less likely to use post-acute care. Washington, DC: Avalere Health. https://avalere.com/press-releases/medicare-advantage-patients-less-likely-touse-post-acute-care.

are simply not Medicare criteria as the reason for denial; for example, claiming that a patient must have an expected length of stay of more than 25 days to be admitted to an LTCH. In some cases, MAOs provide general conclusions or statements that the post-acute care services recommended by the treating physician are not medically necessary but provide no rationale or explanation to support that determination.

Our members have cited denial letters that state that the patient “does not meet IRF Medicare coverage criteria” or that “the patient does not require 3-hours of therapy per day.” In the latter example, the MAO failed to explain that conclusion, how the relevant criteria are applied to the individual patient’s circumstances, or why it disagrees with the treating clinicians’ attestation regarding the need for such a regimen.

Importantly, CMS rules require transparency in internal coverage criteria and adherence to Medicare guidelines. This transparency cannot meaningfully be achieved if plans can just state the care is not medically necessary and cite the Medicare manual without analysis or justification. In addition to violating CMS rules, the absence of a full and complete denial notice with a rationale prevents providers or patients from understanding what information is needed to request reconsideration or appeal an adverse determination.

Blocking or Delaying Access to Post-Acute Care Financially Benefits the MAO, Creating Perverse Incentives

Although blocking or delaying access to post-acute care can harm patients, it can financially benefit MAOs. MAOs can reduce payment obligations and increase profit when they steer patients to less intensive care settings than needed, keep patients in the referring hospital longer than necessary, or block access to institutional post-acute care sites altogether to avoid separate additional payments to a post-acute care facility.

In some cases, it appears to be a deliberate strategy of certain MAOs to steer beneficiaries to a lower level of care than the patient’s condition requires (e.g., a SNF instead of an IRF) because the MAO can pay less for a lower acuity level of care. This occurs even when the MAO’s effort to steer the patient to a different setting directly contradicts the independent medical judgment of the treating physician regarding the level of care required to effectively manage the patient’s condition.

Similarly, many denial letters for IRF and LTCH services indicate the MAO’s preference for the patient to stay in the general acute-care hospital until the patient is ready to go home or to a lower level of care that costs the plan less. Although care at an acute care hospital is more costly than a sub-acute level of care, the plan will have already paid the referring hospital a flat rate for care and would prefer to use the hospital to delay or avoid the patient’s discharge to the next site of care, which would require a separate, additional reimbursement. For example, one MAO denial letter for admission to an LTCH summarized the care the patient will need upon leaving the hospital, including infection-fighting medication, dialysis and wound care for a bone infection, and simply

told the patient, “When you are ready to leave the hospital you can receive this care in another setting.” In other words, the plan was indicating that the patient would stay in the acute care hospital — not moved to a long-term care hospital — until hospital services were no longer required. Keeping patients in the hospital longer than medically necessary to delay or avoid discharge to another setting is a direct violation of CMS rules. In addition, if the patient meets Medicare criteria for LTCH admission, as the hospital strongly believed was the case for this patient, the plan is prohibited from this type of steering to other lower-cost or lower-acuity settings that it prefers.

In another similar example, an MA plan denied LTCH services for a patient on a ventilator following multiple strokes with the justification that “your needs are currently being met in the acute care hospital setting (ACH). ACHs and LTCHs are licensed to provide the same level of care. There is no advantage in transferring you from the current ACH to a LTCH.” These denials are wholly inconsistent with Medicare criteria for admission to an LTCH and deny patients access to a basic Medicare benefit. **It is inappropriate for MAOs to override the treating physicians’ judgment of the beneficiary’s required care simply because they financially benefit from doing so. Such behavior is an egregious violation of federal rules and public trust. MAOs must be held accountable.**

Delays are still pronounced even for patients who ultimately can secure authorization for admission to IRFs or LTCHs. AHA analysis of Medicare claims data indicates that the length of stay (LOS) in the referring hospital is typically longer for MA beneficiaries than for Traditional Medicare beneficiaries discharged to a post-acute setting. For example, in the first three quarters of 2019, the LOS in the referring hospital was 35% longer for MA beneficiaries being discharged to an LTCH compared to Traditional Medicare beneficiaries; 27% longer for MA beneficiaries being discharged to an IRF; and 14% longer for MA beneficiaries being discharged to a SNF.[5] **This also suggests that the more costly or intensive the recommended post-acute setting, the longer the MAO forces the patient to wait in the acute care hospital to be transferred, presumably in the hope of delaying or avoiding the need for additional payment in another setting of care**.

MAO Clinician Reviewers Do Not Have Required Expertise and Medical Training in the Service Being Requested

Despite recent CMS rulemaking efforts to address this MAO behavior, many MAOs continue to use medical reviewers for prior authorization requests who lack the required medical training and expertise in the service being requested. Further, medical reviewers frequently lack the necessary knowledge of the beneficiary’s condition and circumstances to make an informed determination. Indeed, hospitals and health systems report that peer-to-peer discussions among physicians often reveal that the

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[5] AHA analysis of fiscal year 2019 and 2020 Medicare Provider Analysis and Review (MedPAR) files.

health plan clinician overseeing the review frequently has little or no training in post-acute care or rehabilitation. This is problematic because understanding the specific differences in each post-acute setting is critical to reviewing the appropriateness of a particular admission and the level of care required for that individual patient's circumstances. For example, a clinician who is unfamiliar with the multiple disciplines involved in caring for complex rehabilitation patients in an IRF setting would not be able to properly determine whether the patient meets the Medicare coverage requirement pertaining to interdisciplinary care needs. Similarly, a reviewer who is not experienced in caring for ventilator-dependent patients would not be able to properly evaluate the appropriateness and necessity of LTCH-level care for patients in need of ventilation.

Furthermore, peer-to-peer discussions frequently reveal a lack of knowledge of the specifics of the beneficiary's condition and are devoid of any analysis of how the criteria are applied to the patient's individual circumstances. Members report that in some cases, it seems as if the health plan reviewer has not even reviewed the patient's medical record before opining on — and often overruling — the treating physician's recommendation about the patient's care. **This is another violation of CMS rules, which require a medical reviewer to have both adequate training and experience in the relevant area of medicine, and an adequate understanding of the patient's condition, to reach an appropriate determination.[6]**

Finally, AHA is concerned that many MAO clinicians do not sign their name or credentials on denial letters. This makes it almost impossible to challenge or enforce existing requirements that health plan clinician reviewers have necessary clinical expertise in the service being requested to make an appropriate medical necessity determination. In many cases, the identity of the MAO representative who reviewed or signed off on an adverse determination is often a mystery to the patient or provider. This obfuscation tactic makes it nearly impossible to determine whether in the absence of a CMS audit MAOs are complying with the above provisions. In the interest of broader transparency, and to ensure compliance with an important provision designed to safeguard patients from under-qualified reviewers overruling their treating physician, we recommend that MAO clinician reviewers be required to sign their name, provide their medical credentials and areas of expertise, and attest that they have the relevant medical training and expertise to appropriately make a medical necessity determination on the case they are reviewing. We also encourage the HHS OIG to further examine MAO compliance with existing regulations governing the expertise of prior authorization reviewers and to identify any other possible solutions to increase adherence and transparency in the qualifications of MAO medical reviewers.

Denials of Access to Post-Acute Care Negatively Impact Patients and Disrupt the Health Care Continuum

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[6] 42 C.F.R §§ 422.566(d) and 422.629(k)(3)

The delay and denial of appropriate post-acute care can have profound and permanent impacts, particularly for seriously debilitated patients, like those that IRFs and LTCHs specialize in treating. These specialized hospitals provide a wide array of clinical services supporting returning patients to their everyday lives with the maximum possible function after a serious incident or illness. When a patient's treating physician or care team determines that an IRF or LTCH stay is needed, it is because these settings offer the patient the best opportunity for optimal recovery. In the case of IRFs, intensive rehabilitation with close medical supervision and 24-hour nursing care allows for a more complete recovery for a subset of patients needing an intensive and medically supervised course of rehabilitation. LTCHs can be critical to recovery for patients as well; many ventilator-dependent patients may experience serious complications or fail to fully wean off the ventilator if they remain in the acute-care hospital or are discharged to another setting that is inappropriate for their complex care needs.

The process to appeal an adverse determination — even if ultimately successful — can generate delays that impact patient care. To start, an initial prior authorization approval — for the lucky minority of MA beneficiaries who receive first-pass authorization — can take at least 72 hours in the best-case scenario. Due to the high rate of denials, however, many beneficiaries will wait an additional 72 hours or more — sometimes weeks — for the peer-to-peer and appeals processes to occur. By comparison, Traditional Medicare beneficiaries are often referred for IRF or LTCH services and discharged to those sites of care within 24 hours of the initial request. The additional wait time for MA beneficiaries leaves them stuck in settings that are not equipped to care for their unique rehabilitative needs and considerably delays their course of treatment.

This can be a material detriment to patients' long-term outcomes and chance at rehabilitation or recovery. Often patients who are denied admission to a post-acute facility must remain in the acute-care hospital (even when they are medically ready for discharge and have other unmet rehabilitative care needs), or temporarily go to a different site of care to continue appealing to the plan for authorization to go the correct site of care. This process can involve multiple unnecessary medical transports for the patient and tremendous stress for them and their families, while also wreaking havoc on the hospital discharge planning process. Indeed, it is not unusual for exhausted patients to drop their appeals due to frustration with the process and unwillingness to undergo another facility transfer. Sometimes patients choose simply to accept a lower-than-prescribed level of care to initiate the next steps in their rehabilitation to the extent possible. Patients on ventilators often need families and other loved ones to battle on their behalf to get them to a site of care that can safely care for their complex medical needs. Certain MAOs take advantage of the limited bandwidth of such patients and their families in these stressful situations, simply wearing them down until they essentially have no choice but to accept the care the MAOs are willing to cover.

Perhaps most notable and troubling, MAOs ultimately (after extended appeals processes and delays) overturn the vast majority of these denials, a further indication

that they were inappropriate at the outset. For example, one large national LTCH provider found from January through April 2024, it appealed 241 denied LTCH authorizations. Of those, the plan overturned 182, or 76%, of its own denials. Unfortunately, these late-stage authorizations cannot always correct the harm to the patient or the delays in their rehabilitation resulting from the erroneous denial. In some cases, the patient will miss their opportunity to receive medically necessary post-acute care services that should have been covered by Medicare.

These roadblocks to post-acute care access also disrupt the broader health care delivery system by consuming resources needed to care for other patients. As described above, the authorization and appeal process will sometimes leave patients who are medically ready for discharge waiting at acute-care hospitals for weeks until a discharge destination can be found or until the plan overturns the denial. This, in turn, limits the capacity of acute-care hospitals and, at times, compromises the availability of beds and resources for their communities.

Network Adequacy Standards Also Limit Access to Post-Acute Care

While we recognize the scope of HHS-OIG's investigation relates to prior authorization, we wish to raise a related barrier for your consideration that precludes MA beneficiaries from accessing Medicare-covered benefits and hope this may be a subject of interest for policymakers and oversight agencies. CMS has explicitly stated that MAOs must cover appropriate post-acute services when Medicare coverage requirements are met. It logically follows that MAOs should be required to include these provider types in their networks to ensure that meaningful access exists, but many have avoided doing so. There are no specific requirements under the current MA network adequacy rules to include IRFs and LTCHs in provider networks. This is a perceived loophole that some MAOs are utilizing to impede patient access to covered services. Inadequate post-acute provider networks present challenges for patients referred for this specialized care not provided by the referring hospital. For example, we routinely hear from post-acute providers that MAOs will refuse to contract with IRFs in a given market. In one such case, an MAO reported that it does not believe it needs IRFs in the network. In others, MAOs have reported that MA enrollees' rehabilitation needs are met by non-IRF (i.e., SNF) providers in the plan's network. In fact, one state with high MA penetration has *zero* in-network IRFs for most of its counties.

We have urged CMS to prescriptively include IRFs and LTCHs in MAO network adequacy requirements, a necessary step to achieve the desired parity between access to services in Traditional Medicare and MA.

Conclusion

Despite recent rulemaking to better align MA with Traditional Medicare, certain MAOs continue to commit blatant and widespread violations of federal rules with respect to post-acute care authorizations, forcing MA beneficiaries and providers to contend with

these challenges and barriers. The AHA applauds the HHS OIG's examination of MAO prior authorization use for post-acute care services, and the agency's broader work plan designed to improve access to care for managed care enrollees. We urge the HHS OIG to thoroughly investigate prior authorization processes, timeliness and outcomes as part of its planned report, including reviews of the medical necessity criteria used by MAOs, the rationales provided for denials, and the qualifications of health plan clinician reviewers. We also encourage the HHS OIG to examine the adequacy and transparency of data collection and reporting efforts related to MAO use of prior authorization and to issue recommendations for better oversight of these processes.

In addition, while the scope of this inquiry is limited to MA, we observe that many of the same challenges exist for post-acute care prior authorization use by Medicaid managed care plans. Accordingly, we recommend that the HHS OIG similarly explore this topic in future work and identify opportunities to improve access to appropriate post-acute care services in the Medicaid program.

The AHA is pleased to be a resource on these issues and would welcome the opportunity to provide any additional information that would be helpful in your study and examination of this important topic. Please feel free to contact me if you have any questions, or have a member of your team contact Michelle Kielty Millerick, AHA's director of health insurance coverage policy, at mmillerick@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President
Government Relations and Public Policy