



Some Health Plans Unduly Restrict Patient Access to IRF & LTCH Care

In early 2022, the Biden Administration requested information from healthcare providers to gauge to what extent Medicare Advantage (MA) plans may be restricting patient access to Medicare benefits. Hospital trade associations submitted statements documenting how MA plans often limit access to some Medicare benefits – including patient care in Inpatient Rehabilitation Hospitals (IRFs) and Long-term Care Hospitals (LTCHs).

According to documents filed with CMS, there is an increasing body of evidence showing the stark disparities in access to and use of IRF and LTCH services for MA patients, as compared to patients who receive their benefits through the Original Medicare Fee-For-Service (FFS) program. For example:

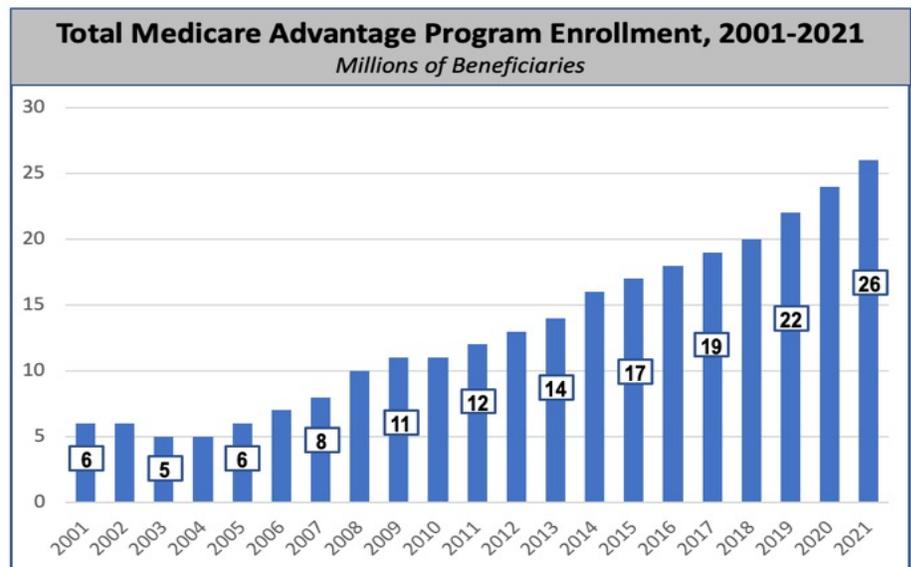
- MedPAC has reported that in 2014 beneficiaries in the FFS program were **2.75 times more likely** than MA enrollees to be admitted to an inpatient rehabilitation

hospital.¹ By 2019, MedPAC reports the disparity had grown even wider – with FFS patients **4.4 times more likely** to be admitted to a rehabilitation hospital.²

- Similarly, the National Association of Long-term Care Hospitals has found that in 2015 MA beneficiaries were **56% less likely** to be admitted

to an LTCH, relative to FFS program beneficiaries.³

Because enrollment in the Medicare Advantage program is growing rapidly each year, this is an issue of significant concern. The Congressional Budget Office (CBO) estimates that, for the first time ever, MA plans will soon enroll more than 50% of Medicare beneficiaries.



KEY FACTS

- Today **47%** of eligible Medicare beneficiaries are enrolled in an MA plan — this is up from <20% in 2000.
- **By 2024, a majority** of eligible beneficiaries are expected to access their benefits through an MA plan.
- **Nearly 5M (19%)** of MA plan enrollees are enrolled through a union or other retiree group MA plan.

Source: CMS, Kaiser Family Foundation (KFF), Congressional Budget Office (CBO)

¹ MedPAC, March 2016 Report to the Congress: Medicare Payment Policy, Ch. 9, pg. 248.

² MedPAC, March 2021 Report to the Congress: Medicare Payment Policy, Ch. 9, pg. 264.

³ National Association of Long-term Care Hospitals Policy Brief, Medicare Advantage Limits Use of Long-term Care Hospitals; Users Have Significantly Higher Severity than in Traditional Medicare, February 2021.





Several policies are used by MA plans to limit patient access to post-acute care services

Several policy and operational factors impact MA program enrollees' access to post-acute care (PAC) services. With the majority of Medicare beneficiaries set to receive care through an MA plan in the coming years the program runs the risk of devolving into two separate benefit structures — with beneficiaries having different levels of access to certain kinds of care. To avoid this outcome, these are some of the key issues policymakers will need to consider to ensure appropriate access to PAC care in the future.

POLICY	WHAT IT IS?	WHY IS IT IMPORTANT?
Network Adequacy Regulations	These rules stipulate what kinds of providers (and how many) MA plans must include in their networks	Current CMS regulations don't require MA plans to include certain providers – including long-term care and inpatient rehabilitation hospitals
Prior Authorization (PA) and Other Utilization Management Rules	These rules, developed by the MA plans themselves, often require pre-approval by the plan for certain care — including transfers to PAC hospitals	The rules and procedures often vary between MA plans, and delays in reviewing PA requests often delay care or act to discourage use of some services
Medical Necessity Review Protocols	These are the standards and procedures a plan uses to determine if a patient or physician's request for services is "medical necessity"	Currently there is little to no transparency about how MA plans conduct these reviews, and many plans use their own proprietary processes. This has led to concerns that some plans' standards differ with Medicare program rules, and that some reviewers are not clinically qualified to review requests.
Reviews and Appeals Regulations	These regulatory requirements stipulate timelines for reviewing PA denials and related appeals	Currently, there is ambiguity about which requests must be expedited, and time frames for review are often too long — often resulting in a de facto denial of care



CMS Seeks Information on MA Coverage Restrictions

In March, the Centers for Medicare and Medicaid Services (CMS) solicited public comment on MA plans use of prior authorization and other utilization management policies during the COVID-19 public health emergency (PHE). Many key stakeholders, including the American Hospital Association (AHA) and the American Medical Rehabilitation Providers Association (AMRPA), took this opportunity to comment on recent trends impacting beneficiary access to post-acute care services, especially post-acute hospital care.

Some of the key points included:

- MA plans use of prior authorization to deny beneficiary access to IRF and LTCH care eased up slightly during the first year of the PHE, but has been quickly reimposed. MA plans are now **denying PA requests for PAC hospital care at rates higher than before the pandemic.**
- The AHA reported that LTCH denial rates have increased significantly, with one MA plan increasing its denial rate by 13% between 2018 and 2022 for one of its hospital members.
- Similarly, AMRPA reported that more than 53% of initial physician requests for inpatient rehabilitation care for patients enrolled in an MA plan were denied in August of 2021.
- There is great variation in PA denial rates of physician requests for PAC hospital care among MA plans — underscoring the sense that plans are using very **different medical review criteria** when evaluating requests for PAC hospital care.
- The rate at which patients use IRF and LTCH care continues to vary significantly between the Medicare fee-for-service program and the MA program. The patients admitted to IRFs and LTCHs from MA plans are sicker on average than the patients that come from Medicare fee-for-service. This suggests that many MA patients who could benefit from IRF/LTCH care are being denied access.
- Delays and the extended time taken to review PA requests for PAC hospital care is not insignificant and in many cases can act as a de facto denial of care. The AHA reported that during the pandemic **the average wait time for an MA plan's review of a PA request exceeded 3 days – and was often longer** if initiated over a weekend or if the MA plan requested additional clinical documentation as part of its review.
- This coincides with the AHA's finding that most pre-transfer **hospital stays for MA patients who are transferred to a post-acute hospital are much longer** (up to 35% for LTCH patients) than those for FFS patients – suggesting delays in the approval of transfer requests may be a contributing factor.

Sources:

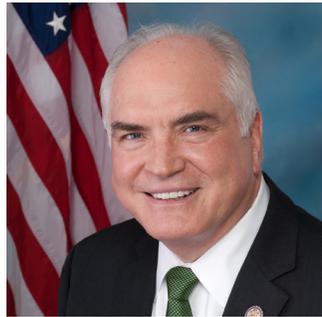
American Hospital Association, *Comment Letter regarding CMS-4192-P, Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Program*, March 7, 2022.

American Medical Rehabilitation Providers Association, *Comment Letter regarding Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Prior Authorization Request for Information; 87 Fed. Reg. 1842; (Jan. 12, 2022), March 7, 2022.*

RELATED LEGISLATION: Improving Senior's Access to Timely Care Act



Rep. Suzan DelBene (D-WA)



Rep. Mike Kelly (R-PA)

Members of Congress are beginning to take notice of how some MA plans make it difficult for Medicare patients to access care. Reps. Suzan DelBene (D-WA), Mike Kelly (R-PA), Ami Bera, MD (D-CA), and Larry Bucshon, MD (R-IN) have introduced **The Improving Seniors' Access to Timely Care Act** (HR 3173). This bill has been cosponsored by 276 House members (63% of House members) from both sides of the political aisle. This is a rare and impressive testament to the importance of the issue. A companion bill was introduced in the Senate (S 3018) by Sens. Roger Marshall, MD (R-KS), Krysten Sinema (D-AZ) and John Thune (R-SD).

The bills are mostly focused on prior authorization and would:

- Require MA plans to establish electronic PA processing capabilities;
- Streamline prior authorization for services routinely approved by MA plans;
- Increase transparency around how MA plans use prior authorization and related medical review criteria; and
- Ensure prior authorization requests are reviewed by qualified medical personnel.

TIMELINE

1965 — Medicare signed into law by President Johnson

1972 — Congress passes President Nixon's proposal to use California-style managed care in Medicare

1982 — Congress passes "TEFRA," which creates a full-risk operating model for Medicare HMOs

1997 — Congress passes the Balanced Budget Act, redesigning Medicare managed care, creating a separate statute ("Part C") and a new name "Medicare+Choice"

2003 — Congress passes the Medicare Modernization Act (MMA), improving HMO rates – and renames program to "Medicare Advantage." At time of passage, Medicare HMO enrollment is only **13%** of beneficiaries

2010 — Congress passes President Obama's Affordable Care Act (ACA) which creates new regional rate adjustments. Medicare HMO enrollment rises to **24%** of beneficiaries.

2024 — Medicare HMO enrollment expected to reach more than **50%** of Medicare beneficiaries and **46%** of all Medicare spending

WASHINGTON STAFF

CHAIR, **BILL WALTERS**

Select Medical, Washington Office
WeWalters@SelectMedical.com

EXECUTIVE DIRECTOR, **KATHY ANDERSON**

Kathy.Anderson@Recovery-Care.org

CREATIVE DIRECTOR, **REBEKKAH JOHNSON**

Rebekkah.Johnson@Recovery-Care.org

DIRECTOR OF GOVERNMENT AFFAIRS, **ERICA WILDBERGER**

Erica.Wildberger@Recovery-Care.org



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