American Academy of Physical Medicine and Rehabilitation

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REMOVE BARRIERS TO PATIENT-CENTERED CARE

Reforming the Use of Prior Authorization in Medicare Advantage

Prior authorization of health care services is routinely overused by Medicare Advantage ("MA") plans, according to the HHS Office of Inspector General. In addition, providers in inpatient rehabilitation hospitals and units ("IRFs") report that an inordinate number of prior authorization requests for IRF care are initially denied by MA plans. Unnecessary use of prior authorization places an untenable burden on physicians and creates significant barriers to patients in accessing rehabilitation care. Data from the Medicare Payment Advisory Commission ("MedPAC") demonstrate that MA beneficiaries receive one third the access to IRFs that traditional Medicare beneficiaries receive. The MA program served more than 22 million beneficiaries in 2019, comprising 34 percent of the total Medicare population, according to MedPAC.

AAPM&R urges Congress to pass H.R. 3107, the *Improving Seniors' Timely Access to Care Act of 2019* to protect patient access to care and reduce physician burden.

This bipartisan legislation (with more than 260 cosponsors in the House) would help protect patients from unnecessary delays by reforming prior authorization in the MA program. The bill would streamline and standardize prior authorization in many situations and provide much-needed transparency for Medicare rehabilitation patients. As more enrollees, especially seniors and individuals with disabilities and chronic conditions, choose the MA program for their health insurance needs, it is crucial that prior authorization not function as a barrier to accessing medically necessary care. AAPM&R is strongly in favor of passing H.R. 3107 as a first step in streamlining the prior authorization process and increasing transparency in the MA program.

Enhancing the "Three- Hour Rule"

The Centers for Medicare and Medicaid Services ("CMS") uses an *intensity of therapy* requirement to determine, in part, which Medicare beneficiaries qualify for treatment in an IRF. The "three-hour rule" requires the patient to participate in, and benefit from, at least three hours of rehabilitation therapy per day, five days per week. In 2010, CMS revised the IRF regulations and narrowed the three-hour rule so that only ***physical therapy, occupational therapy, speech therapy,*** and/or ***orthotics and prosthetics*** are countable toward the three-hour rule. Other skilled therapies including recreational therapy, psychological services, respiratory therapy, and neuropsychological services are no longer counted, limiting their availability in many rehabilitation hospitals.

AAPM&R urges Congress to pass the *Access to Inpatient Rehabilitation Therapy Act*, soon to be introduced in the 117th Congress, to restore physician judgment to IRF care and ensure that patients are able to access the rehabilitation services they need.

This bill would maintain the explicit focus on the four therapies listed above, while adding flexibility for the physician and rehabilitation team to determine the appropriate mix of skilled services to provide a more tailored treatment plan to meet individual patient needs.

AAPM&R asks Congress to enact the Improving Seniors' Timely Access to Care Act (H.R. 3107) and to cosponsor the Access to Inpatient Rehabilitation Therapy Act in the 117th Congress to help ensure IRF patients can access the medically appropriate care they need.

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