November 4, 2024

Kathryn Coleman Director, Medicare Drug and Health Plan Contract Administration Group Centers for Medicare & Medicaid Services U.S. Department of Health and Human Services 4700 Security Boulevard Baltimore, MD 21207

Dear Ms. Coleman:

On behalf of the more than 500,000 rehabilitation providers and post-acute care facilities our organizations represent, we respectfully request a meeting to clarify the use of prior authorization by Medicare Advantage plans. In September, UnitedHealthcare (UHC) imposed 100% prior authorization to all Medicare Advantage plans it administers for chiropractic treatment, physical and occupational therapy, and speech-language pathology services. We seek clarity on this use of prior authorization given recent rules to curtail the use of this practice by these plans. In addition, the implementation, operational, and access challenges associated with the process may require a reconsideration of whether this process should be at a minimum paused and even fully rescinded.

Our organizations met with UHC officials in October 2024, but many of the details they shared about the rationale for implementing prior authorization and the process fail to address the concerns we raised. We believe meeting with CMS staff will help ensure the process is being implemented appropriately.

## **UHC Prior Authorization Process**

The UHC prior authorization process was launched on September 1, 2024, with only 30 days' notice to clinicians, facilities, and UHC members. The process allows a chiropractor, physical or occupational therapist, or speech-language pathologist to conduct an initial evaluation. However, for treatment services outlined in the patient's plan of care to be covered, the clinician or facility must submit a request form along with associated medical record documentation and the number of visits being requested via an online portal established by UHC. This process applies to all claims filed after September 1, 2024—even for patients who initiated therapy prior to this date.

Our members have reported that the UHC submission portal has been down on numerous occasions, requiring them to fax in their documentation. While UHC reports an average response time of four business days, we have received reports that clinicians and their patients are waiting an average of eight to ten business days for a response. For some patients with multiple comorbidities or chronic conditions, delays of up to two weeks are significant.

Anecdotally, our providers report that eight visits are approved regardless of the patient's diagnosis or other factors, such as social determinants of health, which should be considered in determining medical necessity. Based on final rules issued in the last

two years, our understanding is prior authorization determinations must be individualized to the patient. If most patients are approved for eight visits at a time, it calls into question whether these determinations are individualized. As we enter the third month of this requirement, our members report the amount of visits approved per request continues to shrink, and in some cases as few as one or two visits are approved at a time.

In addition, therapy services are often provided multiple times a week, depending on the patient's needs, and so it is possible a clinician or facility would have to submit additional prior authorization requests approximately every two weeks until the patient has met the goals established in the plan of care. This is a sizeable administrative burden for therapists and their employers.

UHC stated in our October meeting that approximately 86% of requests are approved or partially approved. It also stated that most of the remaining requests are eventually approved or partially approved upon resubmission or appeal with less than 1% ultimately denied. Given the high "success" rate of clinicians in submitting these requests, it calls into question whether the administrative burden is justified.

UHC also conveyed in an update posted on October 18 that treatment could begin on the same day as evaluation "if [providers] wish to do so" as authorizations, when issued, are retroactive to the date of the evaluation. However, UHC is also giving a time period in which the visits can be used. For example, a provider submits a request for prior authorization to UHC and ten days later it approves six visits retroactive to the day it was requested, but there are only four days left to use the visits. The therapist then has to try to provide six visits in four days, which is not generally aligned with the plan of care or appropriate based on the patient's clinical presentation. It also may not work for the patient's schedule to try to schedule so many visits in the limited time period. The therapist could provide therapy right after the evaluation, but there is no guarantee that UHC will approve and pay for those visits.

## Federal Government Has Found Prior Authorization Is an Ineffective Utilization Management Technique

In 2022, the U.S. Department of Health and Human Services Office of Inspector General (OIG) issued a report raising serious concerns regarding the use of prior authorization by Medicare Advantage plans. In the report, the OIG noted that nearly 10% of prior authorization denials were ultimately overturned in favor of the clinician or patient on appeal. Further, the report found that 13% of prior authorization denials were issued even though the requests met Medicare coverage rules and 18% of denied requests met both the Medicare and Medicare Advantage plan's coverage rules. The use of prior authorization by these plans establishes an inequity in Medicare coverage for beneficiaries based on whether they are covered under an Advantage plan or traditional Medicare. It is very concerning that nearly one-fifth of these denials are in violation of the plan's own coverage guidelines.<sup>1, 2</sup>

In addition, Congress is considering legislation to address the use of prior authorization by Medicare Advantage plans. Our organizations strongly support these efforts as reflected in S. 4532/H.R. 8702, the Improving Seniors' Timely Access to Care Act of 2024. The concerns this legislation is seeking to address were underscored in a report issued by the Senate Permanent Subcommittee on Investigations issued this month. Of the three Medicare Advantage plan providers reviewed in the report, the use of prior authorization by UHC was perhaps the most alarming. Specifically, from 2019 to 2021, the use of prior authorization by UHC for post-acute care determinations more than doubled from 10.9% to 22.7%. The report reinforces the OIG findings that a small number of adverse determinations are appealed—only 10%—but when those appeals are filed, they are often found in favor of the patient.

In our meeting with UHC, it claimed that the new prior authorization policy for outpatient therapy services was the result of recent increases in the number of beneficiaries receiving outpatient therapy and increases in the duration of their care. Both the OIG and the Subcommittee reports raised concerns that Medicare Advantage plans were rejecting coverage for post-acute care stays that met Medicare coverage rules in favor of less costly care. By shifting beneficiaries from post-acute care to outpatient care, it is reasonable to assume that a higher number of beneficiaries, with more acute illnesses, would now be receiving outpatient therapy services. In other words, any increase in utilization could conceivably be explained by a shifting of patients from one practice setting to another as a result of prior authorization denials. However, instead of working with providers to ensure their networks had the capacity to meet the increased demand for these outpatient services, UHC used this increase as its reason to implement a prior authorization policy that essentially dictates the number of therapy visits a beneficiary can receive.

The impact on access to care is also detailed in the report. A survey conducted by the American Medical Association found that 19% of health systems who responded had left one or more Medicare Advantage plan networks and 61% were considering leaving these networks. These findings are reinforced by a survey of members of the American Speech-Language-Hearing Association that found nearly 53% of respondents were sinking under the burden of prior authorization requirements—in addition to significant payment cuts across payers—leading them to stop seeing patients covered under Medicare and commercial plans (7% and 19%, respectively) or restrict the number of patients they accept when they are covered by Medicare or commercial plans (15% and 13%, respectively).

The report also indicates health plans are using artificial intelligence to facilitate the prior authorization process, another fact that should give policymakers pause when overseeing the use of prior authorization by these plans. The findings of this report call into serious question the rationale and appropriateness of prior authorization in general but more specifically by UHC. As such, we urge you to, at a minimum, pause this process. However, the findings are so egregious that we strongly encourage you to require UHC to end the use of prior authorization immediately.

Based on Congress' interest in this issue and the OIG's findings, CMS has issued multiple final rules in the last two years designed to rein in the inappropriate use of prior authorization by Medicare Advantage plans. While we appreciate the work done to date and that these rules do not fully prohibit the use of prior authorization, we remain concerned that prior authorization continues to demonstrate that its only impact is delays in care and increased burden for clinicians and their patients. It is not an effective mechanism for controlling improper payments, as demonstrated by UHC's own findings that most requests are ultimately approved.

Thank you for reviewing these concerns. Our organizations would welcome an opportunity to better understand how the rules finalized in recent years effectively control the use of prior authorization. We also would appreciate an opportunity to determine whether UHC's prior authorization process conforms to the rules, should be rescinded or, at a minimum, paused until these concerns are addressed.

Sincerely,

American Occupational Therapy Association American Physical Therapy Association American Speech-Language-Hearing Association American Chiropractic Association ADVION National Association of Rehabilitation Providers and Agencies

<sup>1</sup> U.S. Department of Health and Human Services Office of Inspector General. (2022, April 27). *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*. <u>https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/</u> <sup>2</sup> UnitedHealthcare. (2024, October 18). *Medicare Advantage: Prior authorization resources for outpatient therapy and chiropractic services*. <u>https://www.uhcprovider.com/en/resource-library/news/2024/med-adv-pa-resources-outpatient-therapy-chiropractic.html</u>