DRAFT

March 5, 2018

VIA ELECTRONIC MAIL

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: **2019 Medicare Advantage and Part D Advance Notice Parts I and II and Draft Call Letter: Ensuring Access to Medical Rehabilitation Services**

Dear Administrator Verma:

The undersigned members of the Coalition to Preserve Rehabilitation ("CPR") write with respect to the proposed updates to the Medicare Advantage ("MA") and Part D programs through the 2019 Advance Notice and Draft Call Letter released by the Centers for Medicare and Medicaid Services ("CMS"). This letter primarily addresses MA plans.

CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function. CPR is comprised of organizations that represent patients who are frequently inappropriately denied access to rehabilitative care in a variety of settings. This response to the Draft Call Letter focuses on patient access to inpatient hospital rehabilitation under the Medicare Advantage program. We also address the proposal on health-related supplemental benefits which will promote independent living.

Improper Use of Non-Medicare Guidelines by Medicare Part C Plans

We request that CMS instruct Medicare Advantage ("MA" or "Part C") plans to apply CMS's coverage regulations governing inpatient rehabilitation hospitals and units ("IRFs"). As CPR has commented in response to prior call letters, there are significant barriers under MA plans to patients accessing the post-acute, rehabilitative care they need. In our experience, many Part C plans do not use Medicare IRF coverage criteria when determining coverage for IRF care. Instead, these plans improperly apply private, proprietary decision support tools, including Milliman and InterQual guidelines ("non-Medicare guidelines"), to make their decisions as to which rehabilitation setting is covered for each patient. This diverts Medicare beneficiaries to less intensive rehabilitation settings

than they are entitled to under the Medicare program, potentially risking the health and functional potential of Medicare beneficiaries.

In this way, patients are often denied access to clinically appropriate inpatient hospital rehabilitation services and are inappropriately diverted to less intense levels of rehabilitative care and medical management. CMS should instruct Part C plans to cease using Milliman and InterQual guidelines to determine IRF coverage and, instead, rely on the same coverage requirements applicable to Medicare beneficiaries under the fee-for-service program.

When Medicare beneficiaries are injured, become seriously ill, or require surgery, they often require rehabilitation to regain functional losses. The acute hospital care is often just the first step toward recovery and returning to a normal life. Patients frequently require a course of post-acute, hospital-based rehabilitation that is intensive, coordinated, and provided by a multidisciplinary team led by a rehabilitation physician. Other settings of rehabilitation are available for patients who do not require a hospital level of care, such as skilled nursing facilities, outpatient therapy programs, home care and other settings.

For example, a patient who sustains a stroke may be left with permanent neurological damage and need to overcome or adapt to physical or cognitive impairments. An amputee must heal from a traumatic injury while being fitted and learning to ambulate with a prosthetic limb. A patient confined to a hospital bed for a significant period of time during a serious illness will lose muscle mass and may have difficulty walking or performing basic self-care tasks. IRFs strive to improve the quality of life of patients recovering from surgical procedures, strokes, spinal cord injuries, brain injuries, amputations, hip fractures, and many other conditions that decrease a person's ability to function, live independently, and perform common daily activities, such as walking, using a wheelchair, bathing, or eating.

CMS has developed detailed coverage regulations for Medicare IRF coverage.[1] The same coverage rules apply to both Part A fee-for-service and Part C Medicare Advantage beneficiaries. Medicare regulations are clear that Part C plans must provide "all Medicare-covered services."[2] These covered services include "all services that are covered by Part A," which are "basic benefits" available to Part C enrollees.[3] Part C plans must comply with all Medicare coverage regulations and manuals.[4] Medicare manuals are equally plain. The Medicare Managed Care Manual ("MMCM") states that a Part C "plan must provide enrollees in that plan with all Original Medicare-covered services."[5] The MMCM instructs that "[i]f the item or service is covered by Original Medicare under Part A or Part B,

[1] See 42 C.F.R. § 412.622(a). Among other requirements, to be covered in an IRF, the patient must need an interdisciplinary approach to care, be stable enough at admission to participate in intensive rehabilitation, and there must be a "reasonable expectation" that the patient will need multidisciplinary therapy, intensive rehabilitation, and supervision by a rehabilitation physician. The requirement for multidisciplinary therapy must include physical or occupational therapy. Intensive rehabilitation is defined as three hours per day, five days per week (or 15 hours per week). The therapy must be reasonably likely to result in measurable, practical improvement to the patient's functional capacity or adaptation to impairments. The rehabilitation physician must see the patient at least three times per week. Medicare coverage may not be denied based on treatment norms or rote "rules of thumb."

[2] 42 C.F.R. § 422.10(c).

[3] *Id.* § 422.101(a).

[4] *Id.* § 422.101(b).

[5] MMCM, ch. 4 § 10.2. This manual provision describes four exceptions, which are not applicable here.

including Part B prescription drugs, then it must be offered."[6] Therefore, Part C plans must determine IRF coverage using the Part A regulations at 42 C.F.R. § 412.622 and MBPM chapter 1.

The Milliman Care Guidelines ("MCG") are a proprietary decision support tool that includes inpatient admission guidelines. InterQual is also proprietary and includes clinical care guidelines. InterQual includes criteria for assessing the level of care, including acute rehabilitation. CMS has not adopted either set of guidelines, and they are not referenced in any Medicare IRF regulations or manuals. Indeed, CMS has repeatedly declined to adopt Milliman, InterQual, or any guidelines other than its own coverage criteria.

In a 2001 Federal Register preamble, a commenter criticized a CMS coverage regulation as *inconsistent* with InterQual, and CMS declined to defer to InterQual.[7] In 2004, CMS expressly refused to adopt InterQual criteria for IRF coverage, stating that the criteria "are proprietary."[8] In 2007, CMS described InterQual criteria as mere "guidelines."[9] In 2010, a commenter requested that CMS remove certain procedures from the "inpatient only list" because Milliman Care Guidelines designated the procedures safe in an outpatient setting, but CMS refused, stating "we remain convinced that these procedures could be safely performed only in the inpatient setting."[10]

Despite this consistent and very clear guidance from CMS, rehabilitation hospitals and units, as well as physicians who practice in these settings report that a number of Medicare Part C plans routinely deny IRF coverage based on Milliman or InterQual guidelines without applying Medicare IRF coverage rules. We are hearing that this problem has grown severe in the recent past. Our beneficiary and clinical member organizations inform us that a growing number of Medicare managed care cases are being diverted from an IRF level of care based on guidelines that have not been sanctioned or adopted by the Medicare program (e.g., Milliman, InterQual). This is why it is unsurprising that in its March 2017 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) once again found that MA enrollees were admitted to IRFs at approximately one-third the rate of Medicare fee-for-service beneficiaries in 2015.[11]

The undersigned members of CPR are concerned that some Medicare Advantage plans may be overriding the clinical judgment of treating physicians and the rehabilitation team, and seem to be ignoring Medicare coverage regulations. Part C plans must approve IRF admissions if there is a "reasonable expectation" that the patient will need multidisciplinary therapy, intensive rehabilitation, and supervision by a rehabilitation physician."[12] Part C plans may not use proprietary decision support algorithms to deny IRF coverage to Medicare beneficiaries with no regard to binding Medicare regulations. Such algorithms are impermissible "rules of thumb" that may not be used to deny IRF coverage.[13]

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[6] MMCM, ch. 4 § 10.3.
[7] 66 Fed. Reg. 59,880 (Nov. 20, 2001).
[8] 69 Fed. Reg. 23,5761 (May 7, 2004).
[9] 72 Fed. Reg. 4,885 (Feb. 1, 2007).
[10] 75 Fed. Reg. 71,800, 71,996 (Nov. 24, 2010).
[11] MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 298 (Mar. 2017) (finding that 2015 Medicare admissions to IRFs were 10.3 for every 1,000 FFS patients compared to 3.7 for every 1,000 MA patients).
[12] 42 C.F.R. § 412.622(a)(3), (a)(5).
[13] *See* MBPM, ch. 1, § 110.2.2; *Hooper v. Sullivan*, No. H-80-99 (PCD), 1989 WL 107497 (D. Conn. July 20, 1989).

The use of non-Medicare guidelines by some Part C plans jeopardizes the health of Medicare beneficiaries. Beneficiaries are put in the position of contesting the Part C plan's coverage denial, potentially delaying the needed rehabilitation to which they are entitled. Many beneficiaries are not aware that they can contest the Part C plan's initial determination to deny IRF care, and they may lack the family support necessary to appeal.

The most vulnerable beneficiaries are at risk of being denied access to rehabilitation services that meet their medical and functional needs without even knowing that these decisions are being made behind the scenes, based on non-Medicare guidelines, even when they would otherwise quality for coverage under Medicare coverage rules. Particularly given the steady growth in managed care, with the MA program now covering one-third of all Medicare beneficiaries,[14] it is crucial that the MA program be administered in a way that protects the rights of beneficiaries and guarantees access to medically necessary care.

We therefore urge CMS to revise its Call Letter to include explicit instructions to Part C, Medicare Advantage plans to cease using Milliman, InterQual, or similar guidelines to determine coverage of inpatient hospital rehabilitation and, instead, rely on the same coverage requirements applicable to Medicare beneficiaries under the Part A fee-for-service program.

Disclosure to Patients of Network IRFs in Post-Discharge Plans

We urge the Secretary to exercise his authority to require the identification of network IRFs within a reasonable geographic area during the acute care hospital discharge planning process. Under 42 U.S.C. § 1395x(ee), the Secretary has considerable discretion in determining which post-hospital services and facilities must be included in a hospital discharge plan. Under 42.C.F.R. § 482.43, hospitals must arrange for the initial implementation of a patient's discharge plan. Under current regulations, once a discharge planning evaluation has determined that home health or post-hospital extended care services are required, a hospital must provide the patient with a list of home health agencies (HHAs) or skill nursing facilities (SNFs) available under their MA plan.

Hospitals are not obligated to list available inpatient rehabilitation hospitals or units in a patient's discharge plan and, therefore, many MA beneficiaries have no idea of the choices they have to select an IRF, assuming them qualify for coverage. Patients should know all IRF options available to them in their geographic area as part of the discharge planning process—just as they are informed about SNFs and HHAs. The lack of inclusion of IRFs in the discharge plan constrains patient choice due to lack of knowledge. Of course, it goes without saying that in order for this to be effective, MA plans must include IRFs within their networks, in order to ensure that patients receive the appropriate level of post-acute care following illness or injury.

Health-Related Supplemental Benefits

We support CMS's proposed interpretation of "primarily health related" supplemental benefits to include a broader range of benefits, including "daily maintenance" items. Supplemental benefits that include coverage of items and devices such as wheelchair ramps, fall prevention devices, and other assistive devices and modifications may be crucial for individuals in the rehabilitation stage or individuals living with mobility impairments and other disabilities. These types of health-related

[14] Gretchen Jacobson et al., *Medicare Advantage 2017 Spotlight: Enrollment Market Update*, THE HENRY J. KAISER FAMILY FOUNDATION, Jun. 6, 2017, *available at* https://www.kff.org/medicare/issue-brief/medicare-advantage

interventions are critical to limiting the incidence of injuries or unnecessary health conditions, reducing avoidable emergency and health care utilization. Access to these benefits also enables Medicare enrollees to live as independently as possible, as long as possible, in their homes and communities. We also emphasize that these benefits must be available in a nondiscriminatory manner. Higher cost enrollees should not be excluded from tailored benefits in favor of healthier populations.

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Thank you for your consideration of our views. For more information, please contact Peter Thomas, coordinator for CPR by e-mailing Peter.Thomas@PowersLaw.com or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation
Academy of Spinal Cord Injury Professionals
ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association of People with Disabilities
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Dance Therapy Association
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Association of University Centers on Disabilities
Brain Injury Association of America
Christopher and Dana Reeve Foundation
Clinician Task Force
Disability Rights Education and Defense Fund
Falling Forward Foundation
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Association of State Head Injury Administrators
National Multiple Sclerosis Society
National Rehabilitation Association
Rehabilitation Engineering and Assistive Technology Society of North America
United Spinal Association