Key 2019 Policy Priorities

Inpatient rehabilitation hospitals and units (IRFs) provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from care provided in non-hospital post-acute settings. AMRPA members help patients maximize their health, functional skills, independence, and participation in society so they can return to home, work, or an active retirement. Policymakers should work to protect access to medically necessary IRF care and advance evidence-based post-acute care reforms.

Protect Access To Medically Appropriate IRF Care

- **Align Medicare IRF Coverage Criteria Across Part A and MA.** Some Medicare Advantage (MA) plans apply private, proprietary coverage guidelines that are often misaligned with Medicare criteria and evidence-based practices. This practice diverts patients from inpatient rehabilitation settings to clinically inappropriate settings that decrease their prospects for recovery.

  *AMRPA urges Congress to direct CMS to implement beneficiary protections and provide information to Congress regarding MA denials, appeals, and rehospitalizations of post-acute care patients.*

- **Oppose Reimbursement Cuts.** Medicare spending on IRFs is a tiny fraction of Medicare spending and is not a cost driver. Total spending on IRFs has been relatively flat since 2004, even as spending on other post-acute care providers has increased.\(^2\) MedPAC indicates that IRFs have a lower rate of potentially avoidable readmissions compared to other PAC providers.\(^2\)

  *AMRPA urges Congress to oppose any cuts to IRF Medicare reimbursement.*

- **Support Medicare Audit Reforms.** Auditors’ different interpretations of IRF coverage criteria render good-faith compliance efforts by IRFs unpredictable and exceedingly resource-intensive. Medicare auditors do not make consistent decisions regarding the medical necessity of clinically complex services.

  *AMRPA urges Congress to collaborate with IRFs to develop audit reforms that would improve audit practices, bridge the understanding gap between auditors and providers, and ensure auditor decisions are more closely aligned with the real-world practice of rehabilitation medicine.*

  *AMRPA urges Congress to oppose any proposals requiring prior authorizations for IRF stays.*

Advance Evidence-Based Post-Acute Care Payment Reforms

- **Require CMS to Pilot Test Any Alternative PAC Payment Models and Technical Prototypes Before Submitting Recommendations to Congress.** PAC payment reforms should be informed by the implementation of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, which standardizes patient assessment, outcomes and resource use data across different PAC providers as a precursor to evidence-based payment reforms. The IMPACT Act requires CMS to submit to Congress recommendations and a PAC payment prototype.

  *AMRPA urges Congress to require CMS to pilot test any alternative PAC payment model prototypes before the Agency submits its recommendations and final prototype to Congress.*

---

\(^1\) MedPAC March 2018 Report to Congress.

\(^2\) Id.
The Need for Regulatory Modernization and Provider Parity

The American Medical Rehabilitation Providers Association’s (AMRPA’s) members provide rehabilitation services across multiple health care settings, including inpatient rehabilitation hospitals and units (referred to as IRFs). Our members are committed to helping patients maximize their health, functional skills, independence, and participation in society so they can return to home, work, or an active retirement. The ability of IRFs to deliver patients the care they need depends on the ability to modernize outdated policies, align them with scientific evidence, and ensure greater parity among post-acute care providers.

- **Update outdated regulatory requirements to put patients back at the center of their care:**
  - **The 60% Rule**: The Medicare rule requiring that 60% of IRF cases come from one of 13 diagnoses is based on clinical data that are more than three decades old. Not only does this rule needlessly discriminate against patients who could clearly benefit from intensive care in an IRF, but it is not reflective of contemporary medicine which can now help patients rehabilitate following major organ transplantation, cancer, cardiac, pulmonary events, and other diagnoses excluded from the so-called CMS-13. To preserve appropriate patient access to care, **Congress should repeal the 60% Rule or direct CMS to update the list of qualifying conditions and provide needed flexibility** when demonstrating compliance.
  
  - **“3-Hour Rule”**: IRFs’ intensity of therapy requirement is being rigidly interpreted by Medicare contractors and auditors in a way that harms patients. They often deny whole claims if a patient received fewer than 3 hours of therapy on any single day, even for valid documented clinical reasons, and even though total therapy hours exceed 3 hours per day. Consistent with written regulations, Congress should direct CMS to abide by an approach that evaluates therapy over a longer duration (e.g., 15 hours per week) as well as expand the types of therapy that satisfy the intensity requirement, including neuropsychology, therapeutic recreation, respiratory, and cognitive therapy, among others.

- **Ensure regulatory regimes provide parity across like situations and providers:**
  - **LTCH and IRF Parity**: Due to a rule change in 2019, long-term care hospitals (LTCHs) can now host inpatient rehabilitation units, but IRFs cannot host LTCH units. CMS’ decision to create this disparity affords new business opportunities and other efficiencies for LTCHs unavailable to IRFs. **To ensure this realignment of post-acute care sites of service occurs in a rational, evidence-based, and patient-centric way, Congress and CMS should review the impact of this one-sided change**. CMS could correct this disparity any number of ways, including establishing LTCH units, allowing IRFs to host LTCHs without burdensome co-location restrictions, test integrated models, or other approaches.

  - **New Unity Parity**: Due to arbitrary CMS policies, if a new rehabilitation unit opens after the first day of a cost reporting period, the unit is paid as an acute care hospital for the remainder of the year. By contrast, freestanding IRFs can open on at any time and are immediately paid under the IRF PPS. This draconian policy can make launching a rehabilitation unit incredibly risky and highly punitive if there are even the slightest delays. **Congress should ensure “new unit parity” by directing CMS to pay all IRFs as IRFs from day one.**

AMRPA supports congressional efforts to modernize the Medicare program and ensure it continues to meet the needs of a growing and changing population. **Regulatory modernization to ensure equal access, adherence to evidence, and parity among providers are imperatives.**
Rehabilitation is Not a Medicare Cost Driver

Medical rehabilitation improves patient outcomes and reduces costs by maximizing patient health, preventing subsequent medical complications and readmissions, improving functional skills, restoring independence and allowing patients to return to their homes and families. It represents a tiny fraction of Medicare spending. Of the $672 billion in total Medicare spending in 2016, Medicare spent $7.7 billion on inpatient rehabilitation hospitals and units (IRFs). This represents approximately 1.1 percent of total Medicare spending and 4.2 percent of the $183 billion spent on inpatient care.¹

Rehabilitation Hospital Spending Makes Up a Small Percentage of Total Post-Acute Care Spending

Even within the post-acute care sector, spending on IRFs makes up a small fraction of total costs. In a sector with four major sites of rehabilitative care, IRF expenditures made up just 12.8 percent of total post-acute care spending in 2016.²

¹ AMRPA calculation based on MedPAC March 2018 Report to Congress.
² Id.
Rehabilitation Hospital Spending Has Remained Relatively Flat Since 2004, While Spending on Other Post-Acute Care Providers Has Soared

Total Medicare spending on IRFs has been relatively flat since 2004, even as spending on other post-acute care providers has increased rapidly. According to the Medicare Payment Advisory Commission (MedPAC), Medicare spending on IRFs was $7.7 billion in 2016, up by just 20.3 percent over a 12-year period. By contrast, during that same period, Medicare spending on nursing home care, home health, and long-term care hospitals (LTCHs) increased by 65.3, 56, and 41.6 percent, respectively.3

The Supply of Rehabilitation Hospitals and Units Has Decreased Since 2004

Since 2004, the total number of IRFs has shrunk representing a 12.7 percent decrease. During this same period, the number of home health agencies increased by 66 percent and skilled nursing facilities (SNFs) increased by 2.3 percent.4 In the past five years, the growth in the number of IRFs has been almost inconsequential (0.4 percent) compared to the longer term decline.

---

3 MedPAC March 2018 Report to Congress.
Medicare Advantage Practices are Improperly Restricting Access to Medically Necessary Rehabilitative Care

Medicare Advantage (MA) plans are denying their enrollees access to medically necessary post-acute care, particularly inpatient rehabilitation hospital (IRF) services, by:

- Using proprietary guidelines in place of Medicare coverage criteria to determine medical necessity;
- Misinforming patients about their post-acute care options at discharge;
- Wrongly denying IRF admissions by denying preauthorization requests and putting up roadblocks to challenge the decision; and
- Retroactively denying payment for arbitrary or technical issues after care has been furnished.

As a result of these tactics, MA plan enrollees have far less access to Medicare-covered services than fee-for-service (FFS) beneficiaries and are being wrongfully denied this medically necessary rehabilitative care.

MA Beneficiaries Are Entitled to Inpatient Rehabilitation

MA beneficiaries are legally entitled to the same benefits available under Medicare FFS. Medicare regulations stipulate the MA plans:

- Must comply with FFS coverage guidelines and national and local coverage determinations subject to limited exceptions; and
- May not design benefits to discriminate against beneficiaries or discourage enrollment by particular subsets of the Medicare population.

MA Plans Are Nevertheless Improperly Restricting Access to IRFs

Rather than abiding by binding Medicare coverage criteria, MA plans are using proprietary placement guidelines to justify denying patients’ access to IRFs, and divert them to lower intensity settings, such as a skilled nursing facilities (SNFs). These guidelines contradict well-established best practices in medicine and national expert guidance, such as the American Heart Association and American Stroke Association’s (AHA/ASA) guidelines for stroke recovery. AHA/ASA “strongly recommends that stroke patients be treated at an in-patient rehabilitation facility rather than a skilled nursing facility.”

MedPAC has confirmed that MA enrollees are admitted to IRFs at a rate nearly three times less than FFS beneficiaries. Surveys indicate that as many as 80 percent of patients referred to IRFs are denied access by their MA plans. Some MA plans operate with SNFs as the only option available to their enrollees.

MA Plans Circumvent Beneficiary Protections to Deny Access

MA plans have created processes to make gaining access difficult or impossible and employ a variety of other tactics to deny hospitalized patients access. Based on our members’ experiences, these include:

- Slow-walking admissions by taking days to process preauthorization requests, and declining to accept patients or handle appeals late on Fridays, over the weekend, and on holidays, thereby running the clock on hospitalized patients who need timely placement decisions.
- Refusing to communicate with IRFs’ medical directors to whom patients are referred, and will only correspond with the referring physician from the acute care hospital, who may not be available during the limited window during which discharge decisions must be made.
- Categorically denying access because the diagnosis does not fall into one of thirteen diagnosis categories (“CMS-13”), which fundamentally misconstrues the 60 percent criterion used to classify IRFs as a de facto medical necessity guideline.
Relying on individuals with little to no experience or knowledge of medical rehabilitation to review preauthorization requests and appeals of coverage denials.

Denying a referral to an IRF but refusing to provide a written copy of the denial notice, thereby foreclosing the possibility of a successful appeal.

Even when MA enrollees succeed in gaining access to an IRF, denials often follow preauthorization with continued authorizations throughout the patient’s stay and following discharge from the IRF, including for years following discharge. The combined effect of the high rate of denial and other obstacles is that acute care providers have become less willing to assist MA-enrolled inpatients in obtaining the requisite approvals, especially when it threatens to prolong the acute care stay. Instead, discharge staff make referrals to settings that they know will not be challenged by the MA plan, such as nursing homes. This directly and negatively impacts access and ultimately long-term health outcomes for these patients.

**MA Plans Lack Accountability for Patient Outcomes**

Patients’ long-term survival and outcomes have been shown to vary significantly by post-acute setting, hence the AHA/ASA recommendation. Since these quality indicators do not impact MA plans’ payment, managed care decision-making often ignores what is in the long-term interest of the patient.

**Federal Action Is Needed**

Without any repercussions for violating Medicare beneficiaries’ legal rights, there is no downside for MA plans to continue to disregard the law. AMRPA recommends:

1. Obligatory disclosure of coverage rules so all Medicare beneficiaries receive adequate information about post-acute care options prior to discharge from an acute care hospital;
2. Prohibitions on the use of proprietary decision tools unless they are shown to be consistent with Medicare coverage policy;
3. Procedural safeguards to speed determinations and appeals and provide MA enrollees with a meaningful and timely opportunity to appeal improper coverage denials; and
4. Auditing MA plan performance to ensure equal access to medical rehabilitation across MA and FFS.

Congress and CMS must ensure that MA Plans follow the law with regard to beneficiary access to appropriate medical rehabilitation including hospital-level care.

---

2. 42 C.F.R. §422.101(b)(2).
3. See id. § 422.100(f)(1)-(3).
5. 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).
6. Although AMRPA’s survey is qualitative, it reflects respondents representing 46 inpatient rehabilitation hospitals and units from all regions of the country.