March 23, 2018

The Honorable Bill Cassidy
U.S. Senate
Washington, D.C. 20510

The Honorable Thomas Carper
U.S. Senate
Washington, D.C. 20510

The Honorable Michael Bennet
U.S. Senate
Washington, D.C. 20510

The Honorable Todd Young
U.S. Senate
Washington, D.C. 20510

The Honorable Chuck Grassley
U.S. Senate
Washington, D.C. 20510

The Honorable Claire McCaskill
U.S. Senate
Washington, D.C. 20510

Dear Senators Cassidy, Bennet, Grassley, Carper, Young and McCaskill:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we commend you for your bipartisan effort to increase health care price and information transparency. AMRPA shares your goal of increased transparency and greatly appreciates your solicitation of recommendations for ways to empower patients and caregivers to decide what medical care best fits their needs.

AMRPA is the national voluntary trade association representing more than 600 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, and outpatient rehabilitation service providers (collectively referred to as inpatient rehabilitation facilities, or IRFs). Our members provide medical rehabilitation services in an array of health care settings, working to maximize patients' health and functional skills so they can live as independently as possible by returning home, resuming work or pursuing an active retirement. In the IRF setting, AMRPA members provide intensive, comprehensive, hospital-based, rehabilitation therapy programs coupled with complex medical management of the patient. IRFs provide a multitude of therapy services including physical and occupational therapy, speech language pathology, and prosthetic/orthotic services.

Summary of Comments

AMRPA is pleased to provide our recommendations for delivering health care in a more transparent manner that seeks to empower patients, and improve the quality of care while lowering overall costs. Our comments focus on improving access in Medicare Advantage (MA) plans to increase consumer transparency and access to clinically appropriate medical rehabilitation services at the point of service.

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Given that the MA program now covers one-third of all Medicare beneficiaries,[1] it is increasingly important that the program be administered in a way that protects beneficiaries' legal rights and guarantees their access to medically necessary care.

AMRPA asks that the following proposals be considered for inclusion in any legislation drafted as a result of this emerging transparency initiative:

- Requiring disclosure of Medicare post-acute care coverage rules so beneficiaries receive adequate information about potential options upon admission to, and especially at discharge from, a short-term acute care hospital;
- Restricting the use of proprietary decision tools unless they are shown to be fully consistent with Medicare coverage policy and clinical decision-making;
- Requiring reporting of utilization, denial, and overturn rates for enrollee utilization of post-acute care;
- Auditing MA plan performance to ensure equal access to inpatient hospital rehabilitation across MA and fee-for-service Medicare beneficiaries, including by ensuring that IRFs are included in plans' provider lists for determining network adequacy; and
- Requiring that CMS develop better transparency means related to value of care and total episode of care comparative pricing information.

Background: MA Enrollees' Challenges Accessing Clinically Appropriate Care

AMRPA remains concerned that an increasing number of MA plans are circumventing Medicare coverage rules to deny beneficiaries access to medically necessary inpatient rehabilitation care. In fact, in its March 2017 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) found that MA enrollees were admitted to IRFs at approximately one-third the rate of Medicare fee-for-service beneficiaries in 2015.[2] Ultimately, these coverage denials can be distilled down to a lack of transparency for the MA enrollee. Either their legal entitlement to inpatient rehabilitation care is withheld, and in many cases materially misrepresented, or they are allowed to be admitted to an IRF only to find out after discharge that the MA plan subsequently determined there was insufficient evidence of medical necessity. It is in this latter instance of retroactive denial, that the cost of post-acute care is hidden from the patient at the point of care.

Due to the uniquely intensive medical and rehabilitation services provided in an IRF, Medicare utilizes rigorous screening criteria and other regulatory requirements to ensure that each and every patient admitted to an IRF belongs there. CMS has developed detailed coverage regulations for Medicare IRF coverage.[3] These coverage rules also apply to both Part A fee-for-service and Part C MA beneficiaries.

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[1] 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-2017-spotlight-enrollment-market-update/.

[2] 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).

[3] 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 and be stable enough at admission to participate in intensive rehabilitation. There must also be a

Medicare regulations are clear that MA plans must provide "all Medicare-covered services."[4] These covered services include "all services that are covered by Part A," which are the "basic benefits" available to MA enrollees.[5] MA plans must comply with all Medicare coverage regulations and manuals.[6] Medicare manuals are equally clear that an MA plan "must provide enrollees in that plan with all Original Medicare-covered services."[7] The relevant manual instructs that "[i]f the item or service is covered by Original Medicare under Part A or Part B, including Part B prescription drugs, then it must be offered."[8] Therefore, MA plans must determine IRF coverage using the Part A regulations at 42 C.F.R. § 412.622 and other applicable guidance.

Rather than following these Medicare IRF coverage criteria, many MA plans improperly apply private decision tools, such as Milliman and InterQual, to make coverage decisions that override clinical decision-making, both prospectively and retrospectively. These proprietary guidelines do not mirror Medicare coverage guidelines but are nevertheless being used to deny patients access to medically necessary and clinically appropriate medical rehabilitation services. Moreover, MA plans often obfuscate their reasoning, refusing to share their placement assessments with providers, caregivers or others on the basis that the underlying decision tool is proprietary. This posture places patients in an unwinnable Catch-22 situation and flaunts one of the underlying premises for having uniform and transparent Medicare coverage policies that are available to all beneficiaries.

Consequently, many beneficiaries who qualify for inpatient hospital rehabilitation are diverted to less appropriate, lower-acuity settings, such as nursing homes and homecare, inevitably decreasing their prospects for full recovery. In doing so, MA plans fail to disclose the long-term costs associated with receiving inadequate post-acute care in the wrong setting – both in terms of diminished functional gain, lost productivity, and greater health care costs in the form of increased readmissions and emergency room visits, and more days in long-term care.[9]

Disregard for MA Enrollee Appeal Rights

Hospitalized MA enrollees are often precluded from exercising fundamental appeal rights in seeking clinically appropriate post-acute care. In many cases, enrollees are completely unaware of their rights to the same benefits as those enrolled in traditional Medicare, as well as their right to appeal a denial of a preauthorization for services in a particular setting. The most vulnerable beneficiaries are often at the greatest risk of being denied access to medically necessary rehabilitation services without knowledge

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"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."

[4] 42 C.F.R. § 422.10(c).

[5] *Id.* § 422.101(a).

[6] *Id.* § 422.101(b).

[7] Medicare Managed Care Manual, ch. 4 § 10.2.

[8] *Id*. § 10.3.

[9] DOBSON DAVANZO & ASSOCIATES, ASSESSMENT OF PATIENT OUTCOMES OF REHABILITATIVE CARE PROVIDED IN INPATIENT REHABILITATION FACILITIES (IRFS) AND AFTER DISCHARGE (July 2014).

of the decisions being made behind the scenes, and may lack the social or financial supports necessary to appeal without guidance.

The operating procedures of MA plans erect numerous barriers, bureaucratic processes and delays, as well as unreasonable paperwork demands which restrict access to higher-acuity post-acute care settings, such as IRFs, and limit opportunities for timely redeterminations. MA plans frequently deny a referral to an IRF but decline to provide a copy of the denial notice to the patient or caregiver, thereby hindering the possibility of a successful appeal. Based on AMRPA members' experiences, it is rare for an MA plan's medical reviewer to have any expertise or even baseline knowledge in medical rehabilitation, and thus most reviewers are often unable to understand the patient's rehabilitation needs. In contrast, IRFs are required to have a rehabilitation physician with specialized training in preadmission review to determine the appropriateness of a patient's admission to an IRF, consistent with Medicare regulations.[10] The aggregate effect of the high rate of initial denials and delays in preadmission determinations is that patients are stuck in the acute care setting for longer periods of time that are clinically appropriate, thereby exposing patients to increased health risks while imposing additional costs on the health care system.

Inadequate MA Data Impedes both Price and Information Transparency

While existing Medicare data demonstrate that MA enrollees utilize post-acute care settings, such as IRFs, at a rate nearly one-third of those enrolled in the traditional fee-for-service program, empirical data underlying this disparity remains scarce.[11] This has prompted increased calls for increased MA data transparency from medical experts pointing to the valuable insights into health care utilization, quality and cost that have been obtained from the availability of traditional fee-for-service Medicare data. For example, CMS' former Chief Data Officer, Niall Brennan, recently noted that releasing MA claims data is long overdue, and that the availability of MA data constitutes a key component to continuing "recent advances made in transparency and open government."[12]

At a minimum, CMS should promptly institute reporting requirements for MA plans to begin recording this baseline data in uniform data sets and be required to report this information to CMS on a quarterly basis. Just as fee-for-service Medicare comparative information is now publicly available; the public should also be given timely access to summary MA data, as well as full data sets for appropriate purposes.

Moreover, CMS must gain a better understanding of the long-term cost and quality implications of this disparity in the utilization of post-acute care. In particular, the agency should work with plans to capture longer-term outcomes data based on an episode that extends two years beyond the initial acute care hospitalization. The most robust study on this topic, performed by Dobson, DaVanzo & Associates, found that Medicare beneficiaries admitted to IRFs for their immediate post-acute care had significantly better outcomes across a range of quality indicators compared to highly matched

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[10] 42 C.F.R. § 412.622(a)(4)(i).

[11] MEDPAC, *supra* note 2, at 248.

[12] Niall Brennan et al., *Time to Release Medicare Advantage Claims Data*, JAMA, Mar. 13, 2018, at 975.

beneficiaries who received their immediate post-acute care in a skilled nursing facility (SNF). Over the two-year study period, on average IRF patients:

- Returned home from their initial stay two weeks earlier;
- Remained home nearly two months longer;
- Experienced fewer emergency visits;
- Stayed alive nearly two months longer; and,
- Had an eight percent lower all-cause mortality.[13]

According to these findings, modestly higher spending on immediate post-acute care in the IRF setting was generally offset over the course of the two year period.[14] Given the stark disparity in days in the community, IRFs are likely the more economical option if other payors—such as Medicaid—are taken into account. The availability of this information would empower consumers, reduce costs, increase quality and improve the system. Ultimately, clarifying Medicare rules for access to post-acute care is in everyone's interest, including health care providers, MA plans, and patients, as well as the Medicare program itself.

Unit Pricing and the Total Episode of Care

In the post-acute sector, there are substantive differences between different sites of service. Further, significant differences exist in unit pricing (e.g., the per diem payment model used in SNFs versus the discharge-based approach of the IRF prospective payment system (PPS)). The disparate payment systems today incentivize providers to discharge as early as possible from a setting with a discharge-based payment system to a setting with a per diem based payment system, and encourage inefficient use of each level of care.

Alternative payment models (APMs) may offer some potential to realign incentives, but early experience suggests APM participants could also be incentivized to discharge to per-diem based providers in the expectation of shorter length of stay (LOS). Regardless, it is important that Congress and CMS grapple with the value proposition that is obscured today because of these fundamental disparities across siloed payment systems. It is simply not good enough to talk about price transparency alone; rather there needs to be transparency around cost, quality and value across the total episode of care.

The Need for Greater Price Flexibility

As we move toward episodic payment structures and proceed from testing to implementing promising APMs, providers with a discharge-based payment are disadvantaged. Medicare reimbursement for IRF services is incredibly rigid, with a fixed per-discharge payment based largely on factors outside of the IRF's control (e.g., principal diagnosis in the preceding hospitalization). In contrast, other post-acute care providers such as SNFs and home health agencies (HHAs) have a greater degree of control over their Medicare charges, namely through decreasing lengths of stay under the per diem system.

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[13] *See* DOBSON DAVANZO & ASSOCIATES, ASSESSMENT OF PATIENT OUTCOMES OF REHABILITATIVE CARE PROVIDED IN INPATIENT REHABILITATION FACILITIES (IRFS) AND AFTER DISCHARGE (July 2014).

[14] *Id*.

To facilitate greater price transparency and ultimately innovate care delivery, IRFs should be able to be responsive to such consumer-directed approaches and not be constrained by an inelastic Medicare fee structure, at least within the context of APMs. An increasing number of these models hold provider entities, such as acute care hospitals and/or networks of downstream providers, responsible for post-acute spending. These models encourage post-acute care providers like IRFs to produce high-quality outcomes at a reduced cost. However, since Medicare rules do not allow IRFs to "charge less" in this context, existing bundling programs typically incentivize bundle-holders to steer patients away from receiving inpatient medical rehabilitation, even when it is imperative to their recovery. This runs counter to efforts to enhance transparency at the point of care, undermines patient-centric decision-making, and also runs afoul of Medicare rules. For IRFs to be able to compete alongside other providers in these APMs, willing participants must be permitted to charge a reduced amount, a per diem payment, or offer a discount from the IRF PPS rate. Despite waiving a myriad of other fundamental rules for APM participants, CMS has to date been unwilling to consider pricing flexibility; thus Congressional action is needed. Pricing flexibility, along with commensurate relief from the effects of regulations and policies that were designed around traditional prospective payment rates in the era of model testing will not only enhance transparency to patients, but will bring down the cost of care.

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Once again, AMRPA greatly appreciates the opportunity to provide comments regarding your initiative to increase transparency in the health care system. If you have any questions regarding our concerns, please contact Carolyn Zollar at (202) 223-1920 or czollar@amrpa.org, or Martha Kendrick at (202) 887-4215 or mkendrick@akingump.com.

Sincerely,

Richard Kathrins, PhD
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