AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

March 1, 2019

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

Re: **CMS-2018-0154 (2020 Medicare Advantage and Part D Advance Notice Part II and Draft Call Letter).**

Dear Administrator Verma:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), I am submitting this letter regarding the proposed updates to the Medicare Advantage (MA) and Part D programs through the 2020 Advance Notice and Draft Call Letter released by the Centers for Medicare and Medicaid Services (CMS).[1] Our comments focus on concerns regarding MA enrollee access to medical rehabilitation services, particularly access to inpatient rehabilitation hospitals and units.

AMRPA members provide rehabilitation services across the spectrum of health care settings including inpatient rehabilitation hospitals and units (referred to by Medicare as inpatient rehabilitation facilities, or IRFs), hospital outpatient departments, and settings independent of the hospital, such as comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, skilled nursing facilities (SNFs) and long term care hospitals (LTCHs). AMRPA members help patients maximize their health, functional skills, and independence, so they can participate in society by returning to home, work, or an active retirement. As part of furnishing care in the IRF setting, AMRPA members provide intensive, comprehensive, hospital-based, rehabilitation therapy programs coupled with complex medical management of the patient. Some of the therapy services provided include physical and occupational therapy, speech language pathology, and prosthetic/orthotic services, to name a few.

Summary of Comments

AMRPA appreciates CMS' efforts to administer the MA program in a transparent manner that affords stakeholders the opportunity to provide comments. With steady growth in managed care, the MA program now covers one-third of all Medicare beneficiaries.[2] It continues to be

[1] Centers for Medicare and Medicaid Services, 2020 Medicare Advantage and Part D Advance Notice Part II and Draft Call Letter (Jan. 2019) [hereinafter "Draft Call Letter"].

[2] Gretchen Jacobson et al., *Medicare Advantage 2018 Data Spotlight: First Look*, THE HENRY J. KAISER FAMILY FOUNDATION, Oct. 13, 2017, *available at* https://www.kff.org/medicare/issue-brief/medicare-advantage-2018-data-

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important that the MA program be administered in a way that protects beneficiaries' legal rights and guarantees their access to medically necessary health care.

MA plan enrollees are routinely denied access to post-acute care benefits to which they are entitled. CMS' urgent attention to this matter is therefore required. AMRPA recommends and requests CMS action to address barriers to access as outlined below:

- Require 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;
- Restrict the use of proprietary decision tools, which are inconsistent with Medicare coverage policy and clinical decision-making;
- Ensure MA plan enrollees are reasonably able to appeal improper coverage denials;
- Require reporting of utilization, denial, and overturn rates for enrollee utilization of post-acute care; and
- Audit MA plan performance to ensure comparable access to inpatient hospital rehabilitation across MA and fee-for-service Medicare beneficiaries.

Background: Access Challenges

As AMRPA has commented in response to prior call letters, significant administrative hurdles are embedded in the MA program that prevent patients from accessing the post-acute care they need. We have detailed information regarding the challenges MA enrollees routinely face in trying to access medical rehabilitation in AMRPA's prior letters. We will refrain from restating the entirety of the information here, but we remain concerned—and increasingly so—that many MA plans continue to deny medically necessary inpatient rehabilitation care and are circumventing Medicare coverage rules in the process.

When Medicare beneficiaries are injured, become seriously ill, or require surgery, they often require medical rehabilitation to regain functional losses. The acute hospital stay is often just the first step toward recovery and returning to life in the community. Patients frequently require a course of hospital-based rehabilitation that is intensive, rehabilitation physician-directed and coordinated, and delivered by a multidisciplinary team.

IRFs strive to continue the healing process and deliver the medical and nursing care needed while also improving the quality of life for 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. For example, a patient who sustains a stroke may be left with permanent neurological deficits and need to overcome or adapt to physical, language and cognitive impairments. Other post-acute care settings generally provide less intensive and less coordinated rehabilitation services without the nursing care levels and hours or physician availability of IRFs.

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Due to the uniquely intensive medical and rehabilitation services provided in an IRF, Medicare has incredibly rigorous screening criteria and other regulatory requirements to ensure that each and every patient admitted to an IRF is appropriate. The agency 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 Medicare Advantage beneficiaries. 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.

However, instead of 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. The effect of this practice is to divert many enrollees who qualify for inpatient hospital rehabilitation to less appropriate, lower-acuity settings, such as nursing homes and homecare, inevitably decreasing their prospects for full recovery. Even more frustrating, AMRPA members increasingly report that MA plans inform their enrollees that IRF care is not covered under their plan. 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.[9]

To illustrate the tension between standard MA operating procedures and best clinical practices, the American Stroke Association (ASA) and American Heart Association (AHA) emphatically recommend that all stroke patients receive their immediate post-acute care in the IRF setting. The ASA/AHA guidelines are based on years of clinical analysis, including the most comprehensive independent analysis ever undertaken in the field. However, many MA enrollees who suffer strokes are denied access to inpatient rehabilitation and redirected to nursing homes

[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 "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] 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).

for their post-acute care. In one recent survey of our membership, AMRPA found that patients with a primary diagnosis of stroke constitute 30 percent of cases denied preadmission approval by MA plans. This practice directly contravenes evidence-based best practices and is purportedly based on the aforementioned decision support tools that MA plans refuse to divulge.

Further illustrating the deficiency in access to post-acute care provided by MA plans, independent researchers recently found that MA plan benefits are not designed to adequately meet enrollees' post-acute and long-term care needs, and that post-acute provider networks and cost-sharing restrict access to needed care. The study's authors identified these practices as driving a unidirectional flow of higher-cost enrollees from enrollment in MA back to traditional fee-for-service Medicare.[10]

Improper Use of Non-Medicare Guidelines

A number of problematic practices by managed care organizations are contributing to this worsening phenomenon. Based on reports from AMRPA members, the rates of preadmission denials and retroactive claims denials have steadily risen as MA plans increasingly rely on proprietary guidelines such as Milliman and InterQual guidelines, defer to medical or clinical staff who lack rehabilitation expertise, and erect other administrative barriers that make appealing initial denials untenable for hospitalized patients, their caregivers, and the acute care hospitals forced to extend their stays until discharge plans are arranged.

These proprietary guidelines do not appear to mirror Medicare coverage but are nevertheless being used to deny patients access to medically necessary and clinically appropriate medical rehabilitation services. MA plans often refuse to share their placement assessments with providers, caregivers or others on the basis that the underlying decision tool is proprietary. This posture puts patients in an unwinnable situation and flaunts one of the underlying premises for having uniform Medicare basic benefits coverage policies that are available to all. AMRPA has sought to understand the Milliman product and through small-sample modeling it has become clear that virtually no patients are recommended for placement in the IRF setting, including those recovering from major strokes with paralysis and other debilitating injury and illness. Based on this modeling, 95 percent of reviewed cases qualifying for inpatient-level rehabilitation care were directed to a lower acuity setting, such as a nursing home or homecare.

To avoid such blatant disregard for Medicare requirements, AMRPA requests that the final Call Letter instruct MA plans to apply CMS' coverage regulations governing IRFs. CMS must ensure that MA plans are not designing benefits to discriminate against beneficiaries or discourage enrollment by inhibiting access to services or steering particular subsets of Medicare beneficiaries to specific coverage options.[11] AMRPA believes that CMS should reiterate concerns that some MA plans may be disregarding anti-discrimination provisions with policies that impermissibly discourage particular services through measures such as excessive enrollee cost-sharing requirements.

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[10] Momotazur Rahman et al., *High-Cost Patients Had Substantial Rates of Leaving Medicare Advantage and Joining Traditional Medicare*, 34(10) HEALTH AFF. 1675, 1679-80 (Oct. 2015).

[11] 42 C.F.R. §422.100(f)(1)-(3).

However, AMRPA does not believe that monitoring cost-sharing practices is alone sufficient to combat discriminatory practices that both deny access and discourage enrollment among certain Medicare beneficiaries. For these reasons, **AMRPA renews our request that CMS remedy this situation in the final Call Letter by explicitly instructing MA plans to: (1) refrain from using private decision tools to override clinical decision-making and subvert Medicare beneficiaries' rights under the law; and instead (2) apply the existing Medicare coverage rules governing IRF care.**

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 the final Call Letter, CMS has an opportunity to ensure patients' basic appeal rights will be met.

MA enrollees are often completely unaware of their rights to the same benefits of 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 of the decisions being made behind the scenes, and may lack the social or financial supports necessary to appeal without guidance. Accompanying any preauthorization request, MA plans should be required to inform enrollees about their redetermination and appeal rights, including information about resources to help them navigate the process. There should also be a required disclosure of Medicare post-acute care coverage rules so Medicare beneficiaries receive adequate and explicit information about potential options upon admission to, and especially at discharge from, a short-term acute care hospital.

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. MA plans are presently required to provide these notices upon request, but in light of the obvious access problems, **CMS should instruct MA plans to provide denial information to the patient automatically, and to other health care providers whenever requested by the patient, a caregiver, or providers involved in delivering the patient's acute or planned post-acute care**. **Additionally, patients should be held harmless when plans fail to comply with notice rules and requirements.**

Further, managed care organizations often employ reviewers who lack relevant clinical experience to advise on referrals for medical rehabilitation. 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 employ 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.[12] Despite this expertise, our members report that a substantial number of MA plans will only correspond with the referring physician from the acute care setting, who may be less qualified to make this determination, and also often refuse to correspond with the medical director of the referred-to setting, such as an IRF. To ensure patients are entitled to informed medical review, MA plans should be required to elevate an appeal to a clinician with relevant expertise within a reasonable amount of time, certainly within 24 hours, regardless of the day of the week. Further, CMS should direct MA plans to correspond with any clinician involved in the discharge planning process when making referral determinations and redeterminations.

MA plans often maintain unreasonably limited hours for considering preauthorization requests and redeterminations and stretch out their review processes over several days, essentially forcing hospitalized patients to be discharged to alternative settings. Current appeal processes permit MA plans to take up to 72 hours to render an initial decision or redetermination. Moreover, AMRPA members report that if a determination period ends on a Friday, plans will often respond that no one is available to reconsider the determination until the following week. The aggregate effect of the high rate of initial denials, combined with administrative hurdles that slow the redetermination process, is that patients are stuck in the acute care setting, which is clinically inappropriate, introduces additional health risks to the patient and costs to the health care system. Additionally, MA plans often waive precertification requirements for subacute rehabilitation settings such as nursing homes. As a result, hospital personnel are pressured to discharge to these settings rather than wait days for MA plans to consider and reconsider referrals for inpatient rehabilitation. Over time, acute care providers and their discharge planning personnel become less willing to assist patients in obtaining the requisite approvals to access the appropriate level of rehabilitation care, especially when the administrative timeline needlessly prolongs the acute care stay as well as in light of increasing pressures to limit inpatient services Instead, discharge personnel increasingly make referrals only to post-acute care settings that they know will not be denied by the MA plan.

CMS should revisit these practices and use the Call Letter as an opportunity to eliminate unnecessary requirements that challenge beneficiaries' ability to appeal. The agency must ensure 24/7 access by enforcing existing timelines and should work with plans to further expedite their processes to enable timely appeals. At a minimum, MA plans should be able to review and process post-acute care preauthorizations and redeterminations seven days a week and should never take more than 24 hours to respond. To that end, we request that all hospitalized patients needing a placement/admission determination be entitled to the emergency protocols with regard to medical review.

In addition to ensuring technical conformance with regulations, CMS must also do more to also ensure that hospitalized patients actually receive decisions that are timely enough to impact their future trajectory of care. Without this assurance, appeal rights are hollow.

[12] 42 C.F.R. § 412.622(a)(4)(i).

To that end, AMRPA urges CMS take steps in the final Call Letter to ensure MA plan enrollees have a meaningful opportunity to appeal improper coverage denials. Specifically, CMS should direct MA plans to: (1) provide Medicare post-acute care coverage rules so beneficiaries receive adequate information about potential upon discharge from a short-term acute care hospital; (2) automatically provide a copy of the denial notice to the patient or caregiver; (3) inform enrollees about their redetermination and appeal rights; (4) process preauthorizations and redeterminations within 24 hours for all hospitalized patients seeking authorization for post-acute care admissions; (5) enforce these timelines on weekends and holidays; (6) consult clinicians with relevant expertise for placement decisions; (7) be willing to communicate with the medical director of the referred-to setting; (8) increase the weight of the following measures capturing access: Plan Makes Timely Decisions about Appeals and Reviewing Appeals Decisions; and (9) make plan-level appeals and grievances publicly available so that Medicare beneficiaries are able to make informed choices about plan selection during open enrollment.

Inadequate Measurement of MA Performance

There are currently insufficient incentives for MA plans to authorize referrals to inpatient medical rehabilitation settings, which can cost slightly more than non-hospital settings in the short term, but produce better outcomes and savings in the long-term. Notably, patients' long-term survival and outcomes have been shown to vary significantly by post-acute setting, hence the AHA/ASA recommendation. 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 beneficiaries who received their immediate post-acute care in a SNF.[13] According to the 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]

MA plans are not currently held accountable for many relevant quality outcomes, such discharge back to the community, or long-term health outcomes, such as days in the community, and thus systematically fail to make an investment in enrollees' long-term health. Since these quality indicators do not impact MA plans' payment, decision-making too often ignores consideration of what is best for the patient. AMRPA would like to work with CMS and other stakeholders to rectify this overarching shortcoming of the MA program.

In the meantime, we encourage CMS to enhance transparency about MA utilization of post-acute care services. While individual medical providers experience inappropriate denials of patient referrals on a daily basis, CMS appears to lack robust data on the aggregate number (and proportion) of placement decisions, including the total number of patients being referred to different post-acute care settings. We encourage CMS to enhance reporting on the total numbers (and proportion) of denials which are successfully and unsuccessfully appealed and the number of retroactive/post-payment denials and appeals. CMS should promptly institute reporting requirements for MA plans to begin recording this baseline data in uniform data sets and be

[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.*

required to report this information to CMS on a quarterly basis. The agency should make this information public on an annual basis.

Additionally, AMRPA encourages CMS to make changes in the final Call Letter to audit plan performance along additional dimensions including compliance with Medicare coverage rules and beneficiary protections. AMRPA appreciates that CMS includes several appeals measures in the Star Ratings program because these metrics are critical indicators of overall plan performance.[15] However, CMS should do more than just require MA plans to submit data on appeals, but should audit the information to ensure its accuracy and conformance with regulatory requirements.

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AMRPA appreciates the opportunity to provide comments on the Draft Call Letter and is hopeful that many of these concerns can be addressed in the final. If you have any questions regarding our comments, please contact Carolyn Zollar, J.D., AMRPA's Senior Counsel at (202) 223-1920 or czollar@amrpa.org, Kate Beller, J.D., AMRPA's Executive Vice President for Government Relations and Policy Development at (202) 223-1920 or kbeller@amrpa.org, or AMRPA's Washington Counsel Martha Kendrick, J.D., at (202) 887-4215 or mkendrick@akingump.com.

Sincerely,

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Chair, AMRPA Board of Directors
President and CEO, Bacharach Institute for Rehabilitation

[15] Draft Call Letter, at 110.