October 23, 2017

Demetrios Kouzoukas
Principal Deputy Administrator & Director of the Center for Medicare
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medical Rehabilitation Medicare Advantage (MA) Concerns/Recommendations

Dear Deputy Administrator Kouzoukas:

On behalf of American Medical Rehabilitation Providers Association (AMRPA) and the American Academy of Physical Medicine and Rehabilitation (AAPM&R), we write to provide the Centers for Medicare and Medicaid Services (CMS) with specific, actionable recommendations for strengthening the Medicare Advantage (MA) program. AMRPA's leadership greatly appreciated the opportunity to speak with you about the challenges that inpatient medical rehabilitation providers, and the patients who need our services, face within the MA program. While we commend CMS for taking needed steps to simplify the MA program, more agency action is needed to ensure MA enrollees have equal access to critically needed medical rehabilitation services as those in traditional fee-for-service Medicare.

As you know, our members provide medical rehabilitation facility and professional services across the spectrum of health care settings including freestanding inpatient rehabilitation hospitals and hospital-based units (collectively referred to by Medicare as inpatient rehabilitation facilities, or IRFs), hospital outpatient departments, comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and skilled nursing facilities (SNFs). As part of furnishing care in the IRF setting, AMRPA's members provide intensive, comprehensive, hospital-based, rehabilitation programs coupled with medical management of the patient. Specific services include physical and occupational therapy, speech language pathology, prosthetic/orthotic services, and psychological and social work services, to name a few. IRFs are part of a continuum of care, known as post-acute care, that is delivered to patients after an acute hospital care episode and which is often integral to restoring patients' physical and mental health for life in the community. 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.

AAPM&R is the national medical specialty organization representing more than 10,000 physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

Our organizations submit this letter in follow-up to your invitation to provide recommendations for the most important reforms that CMS can and should undertake to enhance MA enrollee access to medical rehabilitation.

I. Background on MA Access Challenges

To recap the discussion that you and your team had with AMRPA leadership this summer, our community is very troubled that MA plans continue to deny medically necessary inpatient rehabilitation care at staggering rates and are circumventing mandatory Medicare coverage policies and other regulations in the process. MA enrollees seeking access to medically necessary post-acute care are often faced with significant, and often insurmountable, administrative hurdles and delayed access. Instead of following binding Medicare coverage criteria, MA plans frequently apply private, proprietary decision tools to make coverage decisions that override expert clinician decisions and patients' wishes and preferences. These proprietary guidelines do not conform to Medicare coverage criteria, yet they are being used to deny patients access to medically necessary rehabilitation care. The effect of this practice is to divert many enrollees who qualify for inpatient rehabilitation to clinically inappropriate lower-acuity settings, such as nursing homes and homecare, putting them at serious risk for adverse medical events, less successful rehabilitation, and significantly reduced longevity.

Based on reports from our members, the rates of pre-authorization denials and retroactive claim denials have steadily risen as MA plans increasingly rely on these proprietary guidelines, defer to the plans' own medical or clinical staff who lack rehabilitation expertise, and erect other administrative barriers that compromise enrollee access to IRFs. Further, appealing initial denials is often untenable for patients and their caregivers. When faced with an initial denial and working on an appeal, acute care hospitals are forced to either extend the stay of the patient while appeals are being pursued, or compel patients to accept discharge to less appropriate settings against the best interest of the patient. A recent survey of AMRPA's membership found that **as many as 80 percent of qualifying referrals to IRFs are denied by MA plans**, either prospectively or retrospectively. These hospitals report that MA plans frequently inform their enrollees that IRF care is not covered under their plan.

Analysis of Medicare data has demonstrated that this issue is a worsening phenomenon. In its March 2017 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) found that in 2015, **MA enrollees were admitted to IRFs at approximately one-third the rate of Medicare fee-for-service beneficiaries**.[1] It is thus unsurprising that 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 MA back into traditional fee-for-service Medicare.[2] While Medicare beneficiaries who do not utilize post-acute care switch between traditional fee-for-service and MA at approximately the same rate, those with even modest post-acute care utilization are significantly

[1] MEDPAC, REPORT TO CONGRESS, at 248, tab. 9-6 (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, reflecting an greater wider disparity than in 2014).

[2] 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).

more likely to switch out of MA than to switch into it, and those with substantial post-acute care utilization are six times more likely to switch to traditional Medicare than into MA. These dramatic findings prompted the study authors to question whether current MA policies are designed to meet the needs of enrollees who use post-acute and long-term care.[3]

Given these concerns, AMRPA and AAPM&R are eager to work with CMS to curb the practices underlying this detrimental trend and reinstate basic protections that Medicare beneficiaries are entitled to as a matter of law.

II. Transformational Regulatory Reform

AMRPA and AAPM&R appreciate your thoughtful consideration of substantial and worsening access limitations within the MA program and request for additional information. We recommend that CMS immediately consider the following enhancements to the current beneficiary protections for enrollees of MA plans:

- Disclosure of post-acute care coverage rules so Medicare beneficiaries receive adequate information about potential options upon admission to, and especially at discharge from, a short-term acute care hospital;
- Collecting missing data underlying access challenges within MA including post-acute care referrals, denials, requests for reconsideration, and overturned decisions by site of service;
- Prohibiting the use of proprietary decision tools unless they are shown to be fully consistent with Medicare coverage policy and clinical decision-making;
- Ensure MA plan enrollees have a meaningful opportunity to appeal improper coverage denials; and
- Audit MA plan performance to ensure equal access to inpatient hospital rehabilitation across MA and fee-for-service Medicare beneficiaries.

Most of these enhancements would not require any modifications to the existing regulations and merely require CMS to advise MA plans of their obligations to enrollees under current law and direct plans to comply.

A. Collecting Needed Data

As you know, there is inadequate data about patient experiences as they seek access to post-acute care. Medicare's existing data demonstrate that MA enrollees utilize certain post-acute care settings, such as IRFs, at a rate nearly one-third of the traditional fee-for-service program.[4] However, there is limited empirical data underlying this stark disparity. For example, CMS does not capture data regarding the choices MA enrollees are provided for post-acute care. 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 denials, the total number of patients being referred to different post-acute care settings, the total numbers (and proportion) of denials which are successfully and unsuccessfully appealed, and the number of

[3] *Id*. at 1680-81.
[4] MEDPAC, *supra* note 1, at 248.

retroactive/post-payment denials and appeals, among other critical data. CMS lacks this information in the aggregate and it lacks this information on a MA plan-specific basis—or is declining to be transparent about such data—both of which are important for understanding and addressing the gross disparity in access. The agency should also have access to information about final dispositions by care setting and medical condition in order to analyze and make sense of these trends. The lack of transparency is also problematic from the beneficiaries' perspective, as well as providers. Collecting and releasing this data would be helpful in resolving these problems.

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.

In addition, 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 beneficiaries who received their immediate post-acute care in a 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 8 percent lower all-cause mortality rate.[5]

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.[6] 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.

Although MA enrollees cycle in and out of the program and between different plans each year, **CMS should gather as much longitudinal data as it can about their care episodes, including key indicators such as mortality and morbidity, emergency department visits and rehospitalizations, days in the community and days alive, among other outcomes data**. Likewise, the agency needs information about the total and categorical costs of treating these patients across these episodes. To the extent that this requires the development of new data items or reporting measures, AMRPA and AAPM&R are happy to work with CMS and other stakeholders to aid in their development. The lack of MA plan accountability for long-term health and resource

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

use outcomes is inevitably a driving force in these inefficient and shortsighted post-acute care utilization patterns.

B. Limitation on Proprietary Placement Tools

Instead of adhering to Medicare coverage criteria and guidelines, many MA plans utilize private, proprietary decision tools, such as Milliman and InterQual guidelines, to make placement decisions that override shared patient and clinician decision-making, both prospectively and retrospectively. Many MA plans will only cover services in the setting recommended by the placement guideline. This fact is problematic for a number of reasons, such as lack of transparency, inconsistency with best practices, and violation of Medicare beneficiaries' rights.

To rectify this wholly inappropriate use of proprietary guidelines, CMS should first and foremost reassert the supremacy of Medicare coverage rules over all other decision tools, especially to the extent such tools are inconsistent with both scientific evidence and applicable law. Medicare beneficiaries enrolled in MA plans are entitled by statute to the same benefits available under traditional fee-for-service Medicare.[7]

To illustrate the tension with best clinical practices, the American Stroke Association and American Heart Association emphatically recommend that all stroke patients should receive their immediate post-acute care in the IRF setting.[8] 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 are redirected to nursing homes for their post-acute care. AMRPA has sought to understand the Milliman product and through small-sample modeling it became 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. In one recent survey of its membership, AMRPA found that patients with a primary diagnosis of stroke constituted 30 percent of cases denied preadmission approval by MA plans.

For these reasons, private placement guidelines should not be used in place of existing Medicare fee-for-service coverage criteria or other CMS regulations. They could, however, be used to help inform patients' understanding of treatment options or to discuss options with hospital discharge planners provided they are fully consistent with binding Medicare policy.

To address this problem, **CMS should issue guidance reminding MA plans of their obligation to admit patients based on established Medicare fee-for-service IRF medical necessity criteria**. This statement should be included in CMS' annual and upcoming "Call Letter" to MA plans. Specifically, the letter should clarify the appropriate limited role for placement guidelines, which may not be used to supersede the clinical decision-making process between clinicians, patients and caregivers, and must not be used to subvert beneficiaries' rights under the law.

[7] 42 U.S.C. § 1395w-22(a)(1)(B)(i).

[8] American Heart Association/American Stroke Association Scientific Statement, GUIDELINES FOR ADULT STROKE REHABILITATION AND RECOVERY: A GUIDELINE FOR HEALTHCARE PROFESSIONALS FROM THE AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION (2016), *available at* http://stroke.ahajournals.org/.

Lastly, there must be substantially greater transparency around the use of screening and placement guidelines by MA plans. As previously discussed, not only do MA plans often use these decision tools as the basis for denying medically necessary post-acute care services, but they refuse to share their assessment with patients, caregivers, and clinicians. This information deficit and asymmetry results in providers and plan representatives talking past each other and hinders clinicians' efforts to help patients secure access to clinically appropriate settings. To avoid this complication, **CMS should direct MA plans to share any decision tool assessment of an individual patient with that patient, their caregivers and providers**.

C. Ensure Fair Preauthorization and Appeal Processes

As you are well aware, tremendous resources are wasted by all sides on medical reviews, especially relating to MA plans' preauthorization and the subsequent appeal process. Nowhere is this more pronounced than in the context of hospital discharges as there are multiple referral options for post-acute care and the placement criteria are highly patient-specific. With minimal effort, CMS could do a great deal to ensure patients' basic appeal rights are being satisfied.

First, MA enrollees are often unaware of both 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**.

MA plans erect numerous barriers, bureaucratic processes and delays, and unreasonable paperwork demands designed to restrict access to higher-acuity post-acute care settings, such as IRFs, and limit opportunities for timely redeterminations. Too often, MA plans deny a referral to an IRF but refuse to provide a copy of the denial notice to the patient or caregiver, thereby foreclosing 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, they should be required automatically to provide these notices to patients, not just upon request. **MA plans should be instructed 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**.

Managed care organizations often employ reviewers who lack relevant clinical experience to advise on post-acute care referrals. 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 clinical 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. AMRPA members report that a substantial number of MA plans will only correspond with the referring physician from the acute care setting, who may not be available for a variety of reasons, and refuse to correspond with the medical director of the referred-to setting, such as the IRF. To ensure patients are entitled to informed

medical review, MA plans must be able to elevate an appeal to a clinician with relevant expertise within a reasonable amount of time, and certainly within 24 hours, regardless of the day of the week or weekend. Further, **CMS should direct MA plans to correspond with any knowledgeable clinician involved in the discharge planning process when making referral determinations and redeterminations**.

MA plans often maintain unreasonably limited hours for considering preauthorizations and redeterminations and stretch out determinations over several days, essentially forcing hospitalized patients to be discharged to other settings. Current appeal processes allow MA plans to take 72 hours to render a decision or redetermination. Moreover, AMRPA members report that if a determination period ends on a Friday, plans will often respond that there is no one available to reconsider the determination until the following week. The aggregate effect of the high rate of initial denials combined with hurdles designed to slow the redetermination process is that patients are stuck in the acute care setting, which is clinically inappropriate, introduces additional risk to the patient and cost to health care providers and the system. MA plans often waive precertification requirements for subacute rehabilitation settings such as nursing homes and, 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. 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 scrutinize these practices and work with MA plans to eliminate unnecessary requirements designed to frustrate meaningful appeals. 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 recommend that **all hospitalized patients be entitled to the MA emergency protocols with regard to medical review**.

D. Auditing Plan Performance

In addition to more information on placement decisions and their potential impact on quality and cost, CMS should audit plan performance across multiple dimensions including on compliance with Medicare coverage rules and beneficiary protections like appeals.

AMRPA and AAPM&R recognize that CMS is addressing significant administrative challenges due to an overburdened audit system and we certainly would not want to exacerbate those challenges by layering a new audit program on top of a broken one. Thus, by "audit," we mean simply that **CMS should do more than require MA plans to submit data, but should verify the information submitted is accurate, ensure that reported performance is consistent with regulatory requirements, and ultimately seek to rectify any plan performance that is consistently out of compliance with official policy**.

* * *

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. All participants would benefit from regulatory simplification necessitating fewer and less complex medical reviews. More explicit directives with regard to MA plans' obligations to their enrollees on these matters would help to ensure that Medicare beneficiaries' rights are safeguarded and they have access to medically necessary care that they are entitled to as a matter of law.

Once again, AMRPA and AAPM&R greatly appreciate the opportunity to discuss these matters with you and we welcome the opportunity to collaborate further to enhance the MA program. If you have any questions regarding our shared concerns, please contact Carolyn Zollar at (202) 223-1920 or czollar@amrpa.org, or Martha Kendrick at (202) 887-4215 or mkendrick@akingump.com for AMRPA or Peter Thomas at peter.thomas@ppsv.com or 202.872.6730 for AAPM&R.

Sincerely,

Bruce M. Gans, MD
Chair, Board of Directors
American Medical Rehabilitation Providers Association
Executive Vice President and Chief Medical Officer, Kessler Institute for Rehabilitation
National Medical Director for Rehabilitation, Select Medical

Jennifer M. Zumsteg, MD, FAAPMR
Chair, Health Policy and Legislation Committee
American Academy of Physical Medicine and Rehabilitation

Cc: Seema Verma, Administrator
Cc: Carla DiBlasio, Senior Adviser for Medicare