March 4, 2016

VIA ELECTRONIC MAIL AT AdvanceNotice2017@cms.hhs.gov

Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: **Response to Medicare Advantage and Part D Advance Notice and Draft Call Letter: Ensuring Access to Medical Rehabilitation Services**

Dear Acting Administrator Slavitt:

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 2017 Advance Notice and Draft Call Letter released by the Centers for Medicare and Medicaid Services (CMS). This letter primarily addresses Medicare Advantage plans.

The Coalition to Preserve Rehabilitation (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 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.

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"). 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. ***In this way, patients are often denied access to clinically appropriate inpatient hospital rehabilitation services.*** 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.

The Milliman and InterQual guidelines do not govern Medicare IRF coverage and, yet, several Part C plans routinely deny coverage based on these non-Medicare guidelines. 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.

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, 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 level of care, including acute rehabilitation. CMS has not adopted either

[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.

[6] MMCM, ch. 4 § 10.3.

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).

The undersigned members of the Coalition to Preserve Rehabilitation 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."[11] 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.[12]

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.

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 fee-for-service program.

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[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] 42 C.F.R. § 412.622(a)(3), (a)(5).
[12] *See* MBPM, ch. 1, § 110.2.2; *Hooper v. Sullivan*, No. H-80-99 (PCD), 1989 WL 107497 (D. Conn. July 20, 1989).

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For more information, please contact the CPR Steering Committee members listed below. Thank you for considering our views.

Sincerely,

CPR Steering Committee

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Endorsing Organizations

Academy of Spinal Cord Injury Professionals
ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Heart/Stroke Association
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Therapeutic Recreation Association
Amputee Coalition
The Arc of the United States
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Association of University Centers on Disabilities
Brain Injury Association of America
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Disability Rights Education and Defense Fund
Easter Seals
Epilepsy Foundation
Falling Forward Foundation
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Association of State Head Injury Administrators
National Council for Behavioral Health
National Multiple Sclerosis Society
National Stroke Association
Paralyzed Veterans of America
Uniform Data System for Medical Rehabilitation
United Cerebral Palsy
United Spinal Association