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AGRICULTURE
Chairman, Subcommittee on Conservation and Forestry

EDUCATION & THE WORKFORCE

NATURAL RESOURCES

Congress of the United States
House of Representatives

March 4, 2016

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: **Medicare Advantage and Part D Advance Notice and Draft Call Letter**

Dear Acting Administrator Slavitt:

I 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 and managed care plans.

Prior to being elected to serve as the Member the House of Representatives from Pennsylvania's 5th Congressional District, I coordinated medical rehabilitation programs in a major hospital system in North-Central Pennsylvania and provided rehabilitation therapy to Medicare beneficiaries for a number of years. These services were provided in a variety of settings including inpatient rehabilitation hospitals and units, skilled nursing facilities, and outpatient services. This personal experience with treating the rehabilitation needs of Medicare beneficiaries, both in the fee-for-service program and under Medicare managed care, help inform this response to your draft "Call Letter."

Improper Use of Non-Medicare Guidelines by Medicare Part C Plans

I respectfully request that CMS instruct Medicare Advantage ("MA" or Part C") plans to apply CMS's coverage regulations governing inpatient rehabilitation hospitals and units ("IRFs"). It has come to my attention that many Part C plans do not use Medicare IRF coverage criteria when determining coverage for IRF care. Instead, these plans have improperly applied private, proprietary decision support tools, including Milliman and InterQual guidelines ("non-Medicare guidelines"), to make decisions as to which rehabilitation setting is covered for each patient. CMS should instruct Part C plans to cease using Milliman and InterQual guidelines to determine IRF coverage and rely upon 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. Several Part C plans routinely deny coverage based on these non-Medicare guidelines, diverting Medicare beneficiaries to less intensive rehabilitation settings than they are entitled to under the Medicare

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program, potentially risking the health and functional potential of Medicare beneficiaries and severely compromising the ability of many IRFs to provide appropriate care.

When a Medicare beneficiary is injured, becomes seriously ill, or requires surgery, 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 IRF rehabilitation. 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 both heal and learn to adapt to new circumstances, including learning how to use a prosthetic limb. A patient confined to a bed for a significant period of time during a serious illness will lose muscle mass and 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. 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.[1] CMS places "weight on the rehabilitation physician's decision to admit the patient to the IRF."[2] The interdisciplinary approach to care is demonstrated by weekly meetings of the rehabilitation team, led by the rehabilitation physician.[3] The requirement for multidisciplinary therapy must include physical or occupational therapy.[4] Intensive rehabilitation is defined as three hours per day, five days per week (or 15 hours per week).[5] The therapy must be reasonably likely to result in measurable, practical improvement to the patient's functional capacity or adaptation to impairments.[6] The rehabilitation physician must see the patient at least three times per week.[7] Medicare coverage may not be denied based on treatment norms or rote "rules of thumb."[8]

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."[9] These covered services include "all services that are covered by Part A," which are "basic benefits" available to Part C enrollees.[10] Part C plans must comply with all

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[1] 42 C.F.R. § 412.622(a)(3), (a)(5).
[2] 74 Fed. Reg. 39,762, 39,791 (Aug. 7, 2009) (final rule); 42 C.F.R. § 412.600 *et seq.*
[3] *Id.* § 412.622(a)(5).
[4] *Id.* § 412.622(a)(3)(i).
[5] *Id.* § 412.622(a)(3)(ii).
[6] *Id.*
[7] *Id.* § 412.622(a)(3)(iv).
[8] Medicare Benefit Policy Manual ("MBPM"), ch. 1, § 110.2.2; *Hooper v. Sullivan*, No. H-80-99 (PCD), 1989 WL 107497 (D. Conn. July 20, 1989).
[9] 42 C.F.R. § 422.10(c).
[10] *Id.* § 422.101(a).

Medicare coverage regulations and manuals.[11] 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."[12] 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."[13] 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.[14] InterQual is also proprietary and includes clinical care guidelines.[15] InterQual includes criteria for assessing level of care, including acute rehabilitation.[16] CMS has not adopted either set of guidelines, and they are not referenced in any Medicare IRF regulations or manuals. Indeed, CMS has repeatedly declined to adopt either Milliman or InterQual.

In a 2001 Federal Register preamble, a commenter criticized a CMS coverage regulation as *inconsistent* with InterQual, and CMS declined to defer to InterQual.[17] In 2004, CMS expressly refused to adopt InterQual criteria for IRF coverage, stating that the criteria "are proprietary and not available for our review. . . . If we were to modify our policy based on these proprietary clinical guidelines, we believe that we should review guidelines from various sources, not just the one cited by the commenter [i.e., InterQual]."[18] In 2007, CMS described InterQual criteria as mere "guidelines."[19] 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."[20]

Despite this consistent and very clear guidance from CMS, rehabilitation hospitals, units, and the 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. Apparently, this problem has grown severe in the recent past. Our members 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 (i.e., Milliman and InterQual).

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[11] *Id.* § 422.101(b).
[12] MMCM, ch. 4 § 10.2. This manual provision describes four exceptions, which are not applicable here.
[13] MMCM, ch. 4 § 10.3.
[14] MCG, "Inpatient & Surgical Care," http://www.mcg.com/content/inpatient-surgical-care.
[15] McKesson, "InterQual Evidence-based Clinical Content," http://www.mckesson.com/payers/decision-management/interqual-evidence-based-clinical-content/.
[16] McKesson, "InterQual Level of Care Criteria," http://www.mckesson.com/payers/decision-management/interqual-evidence-based-clinical-content/interqual-level-of-care-criteria/.
[17] 66 Fed. Reg. 59,880 (Nov. 20, 2001).
[18] 69 Fed. Reg. 23,5761 (May 7, 2004).
[19] 72 Fed. Reg. 4,885 (Feb. 1, 2007).
[20] 75 Fed. Reg. 71,800, 71,996 (Nov. 24, 2010).

I am concerned that some Medicare Advantage plans may be overriding the clinical judgment of treating physicians and flouting 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.[21] 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.[22]

The use of non-Medicare guidelines by 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 most harmed by the Part C plans' misuse of the non-Medicare guidelines.

I 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.

Sincerely,

Glenn 'GT' Thompson
Member of Congress

[21] 42 C.F.R. § 412.622(a)(3), (a)(5).
[22] *See* MBPM, ch. 1, § 110.2.2; *Hooper v. Sullivan*, No. H-80-99 (PCD), 1989 WL 107497 (D. Conn. July 20, 1989).