March 1, 2019

SUBMITTED ELECTRONICALLY VIA www.regulations.gov

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

Re: **Medicare Advantage and Part D Draft CY 2020 Call Letter**

Dear Administrator Verma:

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 Medicare Advantage and Part D Draft CY 2020 Call Letter released by the Centers for Medicare and Medicaid Services ("CMS"). This letter primarily addresses Medicare Advantage ("MA" or "Part C") plans.

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—as well as the clinicians who serve them—who are frequently inappropriately denied access to rehabilitative care in a variety of settings. This response to the Draft Call Letter focuses on the proposal on supplemental benefits for beneficiaries with chronic conditions, the Star Rating system, and non-opioid pain management supplemental benefits. Our response also reiterates key points we addressed in last year's draft MA Call Letter that continue to be priorities of our coalition, namely, ensuring access to care in inpatient rehabilitation hospitals and units ("IRFs") under the MA program.

Supplemental Benefits for Beneficiaries with Chronic Conditions

CPR appreciates CMS's attention to implementing non-primarily health related "special supplemental benefits for the chronically ill" under the Bipartisan Budget Act of 2018. Access to a broad range of non-primarily health related items and services, such as transportation for non-medical needs and home-delivered meals, is important for enabling MA enrollees to live as independently as possible and as long as possible in their homes and communities. Given the essential role that these items and services play in the lives of individuals with chronic conditions, CPR emphasizes that these benefits should also be covered for traditional Medicare beneficiaries. Making such benefits available to MA

plan enrollees, but not traditional Medicare beneficiaries, exacerbates an already inequitable system where there is not a level playing field between the MA program and traditional Medicare. True choice between MA and traditional Medicare dictates that benefits between these two parts of the Medicare program are comparable.

These non-primarily health related supplemental benefits should be reasonably available to all beneficiaries who meet the definition of a "chronically ill enrollee." CPR opposes any contemplated arbitrary limits on these supplemental benefits, such as dollar amounts or other limits. Such limits would restrict access to needed services without regard to their necessity or reasonable costs, thereby limiting access to these items and services in direct contravention of Congressional intent. Meanwhile, CPR supports permitting MA plans to consider factors such as financial need in determining non-primarily health related supplemental benefits for MA plan enrollees with chronic conditions, provided that such benefits must always be available in a nondiscriminatory manner.

CPR opposes granting MA plans the flexibility to determine which chronic conditions meet the statutory standard of complex chronic condition (i.e., "is life threatening or significantly limits the overall health or function of the enrollee"), as we fear that MA plans could inappropriately limit access to these benefits in contravention of Congressional intent. A uniform definition adopted by CMS for determining which chronic conditions meet the statutory standard is important to ensuring that these benefits are provided consistently and reliably across MA plans.

Finally, as discussed below, CPR strongly urges CMS to ensure that MA enrollees have access to IRF care, a covered Medicare benefit, before CMS devotes additional resources to these supplemental benefits. Many MA plans inappropriately restrict or deny access to IRF care for enrollees. In fact, 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 traditional Medicare beneficiaries in 2015.[1] At a base level and in compliance with its own regulations, CMS must ensure that MA enrollees have equal access to this covered Medicare benefit in both the MA and traditional Medicare parts of the program.

Star Rating Enhancements

CPR appreciates CMS's attention to measures relevant to individuals with disabilities and chronic conditions in its proposed changes to the Star Ratings through the addition of measures examining care transitions from an inpatient setting to the home, as well as follow-up care provided after an emergency department visit for patients with multiple chronic conditions. In future iterations of the Star Rating system, CPR recommends that CMS add measures that examine access to rehabilitation in inpatient settings (IRFs), as well as outpatient or home-based settings. We also encourage CMS to adopt measures to assess MA plan compliance with the *Jimmo v. Sebelius* settlement, which explicitly rejects an "improvement standard" and clarifies coverage for skilled services provided to Medicare beneficiaries that improve, maintain and prevent deterioration of function in skilled nursing facilities, home health agencies, and outpatient clinics.

[1] 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 traditional Medicare patients compared to 3.7 for every 1,000 MA patients).

Such measures should focus on both access to care and the functional outcomes of rehabilitation care in these post-acute care settings. The addition of such measures would be a key tool for determining the degree of access to rehabilitation care afforded to MA plan beneficiaries and holding MA plans accountable for ensuring access to these essential services.

CPR wishes to express its continued concern that audit violations will no longer directly impact MA plan Star Ratings, as determined by CMS in last year's MA Call Letter. The lack of a link between audit results and Star Ratings means that MA plans that encounter serious enforcement actions can still receive high Star Ratings and, as a result, quality bonus payments. The U.S. Department of Health and Human Services Office of Inspector General expressed concern about this lack of impact on Star Ratings in a recent report on MA appeal outcomes and audit findings.[2] Coupled with the March 2017 MedPAC report findings that MA beneficiaries have significantly less access to inpatient rehabilitation hospitals and units than traditional Medicare beneficiaries have, as well as the high rate of reversals of denied IRF claims in favor of providers through the administrative appeals process, the elimination of data involving audit findings in the Star Ratings for MA plans is particularly troubling for individuals with disabilities and chronic conditions and moves in the wrong direction. CPR encourages CMS to reinstate these measures and strengthen the Star Rating system to include these data.

Non-Opioid Pain Management Supplemental Benefits

CPR supports MA plan coverage of supplemental benefits that address medically-approved non-opioid pain management and complementary and integrative treatments. Coverage of these services and treatments, including but not limited to, peer support services, psychosocial services/cognitive behavioral therapy, non-Medicare covered chiropractic services, acupuncture, and therapeutic massage, is an important step forward in addressing both the essential need for effective pain management and the nationwide opioid addiction crisis. There is a lack of data evaluating the use of opioids for the variety of chronic pain syndromes that individuals with spinal cord injuries endure. Nevertheless, coverage of the above services should not undercut or restrict access to opioid-based pain management services when medically necessary to treat intractable or neuropathic pain, such as in individuals with spinal cord injuries, brain injuries, and other serious conditions.

Effective pain management to treat or ameliorate the impact of an injury or illness (e.g., pain, stiffness, loss of range of motion, etc.) is vitally important to individuals with disabilities and chronic conditions. CPR appreciates CMS's efforts to encourage coverage of these medically effective and widely beneficial treatments and services. To that end, it is critical that these treatments and services are covered for and widely available to traditional Medicare beneficiaries as well as MA enrollees. As stated above, making such benefits available to MA plan enrollees, but not traditional Medicare beneficiaries, exacerbates an already inequitable system where there is not a level playing field between the MA program and traditional Medicare.

Improper Use of Non-Medicare Guidelines by Medicare Advantage Plans

As reflected in CPR's comments on the CY 2019 Draft Call Letter, we reiterate our request that CMS instruct MA plans to apply CMS's coverage regulations governing IRFs under the traditional Medicare program. There are significant barriers under MA plans to patients accessing the post-acute, rehabilitative care they need. In our experience, many MA plans do not use Medicare IRF coverage

[2] U.S. Dep't of Health & Human Servs., Office of Inspector General, OEI-09-16-00410, Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials (Sept. 2018).

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. This tends to divert 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 MA beneficiaries.

In this way, patients are often denied access to clinically appropriate inpatient hospital rehabilitation services and are inappropriately diverted to less intensive levels of rehabilitative care and medical management. CMS should instruct MA 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 traditional Medicare program. As previously stated in this letter, failing to ensure a level playing field between the MA program and traditional Medicare creates an inequitable system and places burdensome restraints on beneficiaries' ability to choose the plan that is right for them.

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 functional capacity and 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.[3] The same coverage rules apply to both traditional Medicare Part A and Part C Medicare Advantage beneficiaries. Medicare regulations are clear that Part C plans must provide all Medicare-covered services.[4] These covered services include "all services that are covered by Part A," which are "basic benefits" available to Part C enrollees.[5] Part C plans must comply with all Medicare coverage regulations and manuals.[6]

[3] 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."

[4] 42 C.F.R. § 422.101.

[5] *Id.* § 422.101(a).

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."[7] 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."[8] 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 the level of care, including acute rehabilitation. 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 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.[9] In 2004, CMS expressly refused to adopt InterQual criteria for IRF coverage, stating that the criteria "are proprietary."[10] In 2007, CMS described InterQual criteria as mere "guidelines."[11] 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."[12]

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 traditional Medicare IRF coverage rules. Anecdotal evidence suggests this problem is growing in severity 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). This is why it is unsurprising that, as stated previously in this comment letter, MedPAC's March 2017 Report found that MA enrollees were admitted to IRFs at approximately one-third the rate of traditional Medicare beneficiaries in 2015.

The undersigned members of CPR are concerned that some MA 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."[13] Part C plans may not use proprietary decision support algorithms to deny IRF—or any other—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.[14]

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[6] *Id.* § 422.101(b).
[7] MMCM, ch. 4 § 10.2. This manual provision describes four exceptions, which are not applicable here.
[8] MMCM, ch. 4 § 10.3.
[9] 66 Fed. Reg. 59,880 (Nov. 20, 2001).
[10] 69 Fed. Reg. 23,5761 (May 7, 2004).
[11] 72 Fed. Reg. 4,885 (Feb. 1, 2007).
[12] 75 Fed. Reg. 71,800, 71,996 (Nov. 24, 2010).
[13] 42 C.F.R. § 412.622(a)(3), (a)(5).
[14] *See* MBPM, ch. 1, § 110.2.2; *Hooper v. Sullivan*, No. H-80-99 (PCD), 1989 WL 107497 (D. Conn. July 20, 1989).

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. Particularly given the steady growth in managed care, with the MA program now covering one-third of all Medicare beneficiaries,[15] it is crucial that the MA program be administered in a way that protects the rights of beneficiaries and guarantees access to medically necessary care.

We therefore urge CMS to revise its Call Letter to include explicit instructions to MA 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 traditional Medicare program.

Disclosure to Patients of Network IRFs in Post-Discharge Plans

We urge CMS to exercise its authority to require the identification of network IRFs within a reasonable geographic area during the acute care hospital discharge planning process. Under 42 U.S.C. § 1395x(ee), the Secretary of the Department of Health and Human Services has considerable discretion in determining which post-hospital services and facilities must be included in a hospital discharge plan. Under 42.C.F.R. § 482.43, hospitals must arrange for the initial implementation of a patient's discharge plan. Under current regulations, once a discharge planning evaluation has determined that home health or post-hospital extended care services are required, a hospital must provide the patient with a list of home health agencies (HHAs) or skilled nursing facilities (SNFs) available under their MA plan.

Inexplicably, hospitals are not obligated to list available inpatient rehabilitation hospitals or units in a patient's discharge plan and, therefore, many MA beneficiaries have no idea of the choices they have to select an IRF, assuming they qualify for coverage. MA patients should know all IRF options available to them in their geographic area as part of the discharge planning process—just as they are informed about SNFs and HHAs. The lack of inclusion of IRFs in the discharge plan constrains patient choice due to lack of knowledge. It goes without saying that in order for the discharge planning process to be effective, MA plans must include IRFs within their networks and disclose this option to patients who qualify in order to ensure that patients receive the appropriate level of post-acute care following illness or injury.

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[15] 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

Thank you for your consideration of our views. For more information, please contact Peter Thomas, coordinator of CPR by e-mailing Peter.Thomas@PowersLaw.com or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

Academy of Spinal Cord Injury Professionals
ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association of People with Disabilities
American Association on Health & Disability
American Congress of Rehabilitation Medicine
American Heart Association/American Stroke Association
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Physical Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
Association of Academic Physiatrists
Brain Injury Association of America
Center for Medicare Advocacy
Christopher & Dana Reeve Foundation
Clinician Task Force
Disability Rights Education and Defense Fund
Falling Forward Foundation
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Association of Social Workers
National Multiple Sclerosis Society
National Rehabilitation Association
RESNA
Uniform Data System for Medical Rehabilitation
United Spinal Association