

March 5, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201
CMS-2017-0163

Re: Encompass Health Comments on “Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter”

Dear Administrator Verma:

We appreciate the opportunity to provide comments on the CY 2019 Medicare Advantage (“MA”) draft call letter (CMS-2017-0163) (“the Call Letter”) from the Centers for Medicare and Medicaid Services (“CMS”). Encompass Health is one of the nation’s leading providers of post-acute services with 127 inpatient rehabilitation hospitals, 200 home health agencies, and 37 hospices, employing approximately 30,000 individuals across 36 states and Puerto Rico. In 2017, nearly 90% of our patients were Medicare beneficiaries. Our comments on the MA Call Letter focus on CMS’ intention to expand the scope of the primarily health related supplemental benefit standard and Medicare beneficiaries’ access to rehabilitation hospital services under the Medicare Advantage program.

CMS’ expanded interpretation of supplemental healthcare benefits should permit the offering of care management services for home health patients by MA plans. As discussed in greater detail below, care management services meet CMS’ expanded interpretation of supplemental healthcare benefits because these services primarily relate to the health and well-being of patients who receive them. MA enrollees receiving care management services will receive more coordinated care and achieve better healthcare outcomes within the home setting.

A. CARE MANAGEMENT SERVICES DEFINED

1. Care Management Services: Description

Care management services involve a team of clinicians that utilize innovative and value-driven patient care strategies through predictive analytics and technology in order to remotely manage patients, particularly patients whose complications place them at high-risk of emergency room utilization and/or hospitalization. The services, which are distinct from direct care services, involve creating a patient profile according to multiple clinical inputs (including diagnosis, comorbidities, medication regime, functional limitations, pain levels, additional

clinician findings, etc.) and then tracking a patient's progress against relevant physician protocols that are developed and linked to a patient's profile. Effectively triaging high-risk patients with the right level of care, at the right time, has proven to be able to play an integral part of achieving the better outcomes while lowering costs. By utilizing care management services in this way, patients can more often remain at home and become more effective at managing their individual healthcare conditions and circumstances, which translates to happier patients and lower overall healthcare expenditures.

Patient progress tracking is a central component of care management services for home health patients and is comprised of comprehensive telehealth outreach and feedback processes that provide caregivers with more complete information and insight into a patient's condition and how it changes over time. These services could, for example, be comprised of a series of manual and automated phone calls to a beneficiary from a team of experienced clinicians designed to ascertain how the patient feels throughout a care episode, or for any timeframe. Outreach to a beneficiary could vary in volume and frequency according to individualized patient findings or clinical inputs, relevant physician protocols for the underlying condition(s), or the in-home level of care and support provided. The information garnered from this outreach and feedback, paired with the in-depth profile maintained by the clinical team, generates more complete information about a patient's condition as he/she is being cared for in the home.

2. Care Management Services: Benefits

Compared to traditional in-home care, which depends primarily on the physical presence and diligence of a nurse visiting the beneficiary's home for determining changes in patient need and condition, care management services enable practitioners to frame, track, and account for changes in patient conditions on an ongoing basis while simultaneously encouraging greater patient engagement via more frequent interactions. The patient information provided to a caregiver/physician attained through comprehensive care management services enables more appropriate and patient-centered care responses from such professionals, thereby ameliorating the effects of medical complications and reducing the risk of additional emergency or healthcare utilization and corresponding costs of such utilization. And the direct nature of phone calls helps patients become more involved in their own care.

Furthermore, the telehealth processes of a care management services program can help patients become more engaged with their caregivers, which can lead to greater involvement in their overall healthcare. Care management services enable consistent and detailed data collection on care recommendations, patient reactions, and overall medical progress, thus building a valuable body of reliable knowledge to inform improvements for future care episodes and to further inform their primary care physician on how best to manage their condition(s). Tangible benefits of care management services are being achieved now by many organizations, including Encompass Health.

B. CARE MANAGEMENT MEETS THE NEW “PRIMARYLY HEALTH RELATED” STANDARDS FOR SUPPLEMENTAL HEALTH BENEFITS

The 2019 Call Letter discusses CMS’ new interpretation of supplemental healthcare benefits for MA plans and the necessary factors that would qualify such benefits as being “primarily health related.” Care management services satisfy the requirements and therefore should be eligible for offering as a supplemental health benefit via MA plans nationwide.

Specifically, in order for a supplemental benefit to be considered a healthcare benefit, it first “must focus directly on an enrollee’s healthcare needs” and also “be medically appropriate and ordered by a licensed provider as part of a care plan if not directly provided by one.”¹ Care management services are focused directly on a patient’s healthcare needs because they are crafted and customized to give a caregiving team more information about a patient’s conditions and unique characteristics, thus enabling the team to timely respond to the individual patient’s healthcare needs. Furthermore, in current practice, physicians specifically request these care management services for particular patients (primarily those at high risk of complication or readmission). Accordingly, care management services meet these threshold requirements for supplement healthcare benefits.

CMS also states that, in order for a particular item or service to be offered as a supplemental health benefit, it must also be “primarily health related.”² In order to be “primarily health related,” the item or service must “diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization.”³ Care management services meet several of these standards:

- Care management enhances treatment for medical conditions by generating better information about patient condition and increased coordination between patients and their caregivers;
- Care management gives caregivers more information about a patient’s needs, enabling more tailored care plans, such as patient-specific functional regimens or more precise medication dosages;
- Care management services, specifically the frequency with which they “touch” an in-home patient via outreach and feedback functions, can help reduce the psychological impacts dealing with a serious illness or injury in the home setting, such as loneliness and isolation;

¹ CMS, Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter 183 (Part II, released Feb. 1, 2018), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-02-01.html>.

² *Id.*

³ *Id.*

- And as noted above, when implemented in practice, care management services also result in significant reductions in healthcare utilization.

Accordingly, care management services meet the “primarily health related” standards for supplemental health benefits and should be eligible for inclusion by MA organizations in their offerings to enrollees.

C. Ensuring Rehabilitation Hospitals Services Are Accessible by MA Enrollees:

MA plans are required to submit provider lists to CMS in order to demonstrate adequate access to various types of care, including specialty care. CMS maintains standards and metrics on access that MA plans must meet. However, rehabilitation hospitals are not a provider type that is required to be included on a plan’s provider list. This causes gaps in access to rehabilitative care for MA beneficiaries enrolled in plans that do not include rehabilitation hospitals in their provider lists. We are aware of several geographic areas where we know an MA plan does not have a contracted in-network rehabilitation hospital within a reasonable time/distance. These plans often claim that “essential rehabilitation” is sufficiently provided by skilled nursing facilities (“SNFs”) and rely exclusively on SNFs to provide such care. We respectfully urge CMS to require MA plans to include rehabilitation hospitals in their provider lists as part of a plan’s access-to-care criteria.

Additionally, MA plans are inconsistent in the time it takes to approve or deny a request of coverage of rehabilitation hospital services. Many MA plans take too long to approve or deny a request for rehabilitation hospital coverage, and when a decision is made the patient has already been moved to another care setting, typically to a SNF, which may not be the appropriate care setting for the beneficiary. CMS should require MA plans to issue a precertification decision (approved or denied) within 24 hours of receipt of all necessary documentation. We respectfully urge CMS to require MA plans to issue coverage decisions for rehabilitation hospital services within 24 hours.

D. CONCLUSION

We welcome CMS’ efforts to expand the availability of supplemental healthcare benefits, by granting MA plans flexibility to offer new and innovative items and services under the supplemental benefits framework, and we respectfully urge CMS to ensure that care management services be included as part of those benefits. Care management is proven to generate improvements in the two areas CMS states as goals: enhancing beneficiary quality of life and improving outcomes. By creating more and better opportunities for information to flow between patients, caregivers, and providers, MA enrollees will see enhancements to their care coordination and care delivery, helping them reach their own personal medical goals in less time and at less cost. We also respectfully urge CMS to take responsive action on the comments above pertaining to ensuring that MA enrollees are able to consistently access rehabilitation hospital services.



Thank you for your consideration of these comments. Should you wish to follow up on any material discussed in this letter, please feel free to contact me via email at Justin.hunter@encompasshealth.com or at (202) 448-1649.

Sincerely,

A handwritten signature in blue ink that reads "Justin Hunter". The signature is fluid and cursive, with the first name "Justin" and last name "Hunter" clearly legible.

Justin Hunter
Senior Vice President
Encompass Health

A handwritten signature in blue ink that reads "A.C. Baird". The signature is more stylized and less legible than the one to its left, with the initials "A.C." and the last name "Baird" being the primary components.

Andrew Baird
Director, Government Relations
Encompass Health