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**House Committee on Energy and Commerce
Subcommittee on Health**

Keeping the Promise: Site of Service Medicare Payment Reforms

**Written Statement for the Record
Bruce M. Gans, M.D., Chair
American Medical Rehabilitation Providers Association**

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The American Medical Rehabilitation Providers Association (AMRPA) thanks the Committee on Energy and Commerce Subcommittee on Health for the opportunity to submit comments for the hearing record. Moreover, we appreciate the Subcommittee's thoughtful oversight of Medicare payment policy and examination of ways to improve the Medicare program for seniors and all taxpayers. AMRPA shares the Subcommittee's interest in addressing variation in spending, quality and margins across different sites of service. We believe that evidence-based, patient-centric changes to the delivery system and payment policies are necessary to modernize the Medicare program and ensure that patients have access to necessary and appropriate post-acute care. Forward-thinking reforms should seek to align payment with desired changes in the delivery of care and move from a provider-centric to a patient-centric payment system. We caution, however, that effective reforms must create efficiencies and drive innovation and quality care to advance the interests of beneficiaries, rather than simply cutting payments by shifting patients to seemingly less costly (in the short run) care settings. We are also cognizant of the need to analyze downstream consequences of admission and care decisions since many important markers of quality and health outcomes may not be evident within short-term episodes of care.

AMRPA is the national trade association representing inpatient rehabilitation hospitals and units (IRH/Us), outpatient rehabilitation centers, and other medical rehabilitation providers. AMRPA members provide medical rehabilitation services in a vast array of health care settings, including IRH/Us, hospital outpatient departments, and settings that are independent of the hospital, such as comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and outpatient practices in skilled nursing facilities (SNFs). While there are a number of provider types discussed in the context of post-acute care, medical rehabilitation hospitals and units are separate and distinct both in terms of quality outcomes and regulatory requirements. There is a unique population of patients who require intensive, hospital-level rehabilitative care that cannot be provided in any other setting in order to maximize their health, functional skills, and independence so they are able to return to home, work, or an active retirement.

General Principles for Post-Acute Care Reform

In order to advance post-acute care reform, AMRPA developed a set of principles for reform that will help ensure that a reformed payment and delivery system is feasible for providers and beneficial for patients. Specifically, we urge Congress to be guided by the following principles in any reforms to the post-acute care sector:

- While reforming post-acute care, Congress should take steps to reduce the need for post-acute care in the first instance. As a nation, we have a vast amount of knowledge in treating the predominant reasons that patients need post-acute care, including stroke, traumatic brain injury, spinal cord injury, congestive heart failure, chronic obstructive pulmonary disease, and serious wounds. At the same time, we know of ways to prevent them or mitigate their effects. For example, thrombolytic drugs can greatly mitigate the adverse effects of stroke if administered in a timely manner. Many brain injuries can also be prevented with appropriate protection of the head during sporting activities. Additionally, lifestyle changes such as diet, exercise, and smoking cessation also prevent the chronic conditions being seen and treated by IRH/Us. Congress should establish policies that prevent the need for acute and post-acute care as a fundamental step to reducing costs and improving outcomes.
- Qualified clinicians should determine patient care—both with respect to the type and site of care. Clinicians should be empowered to make post-acute care utilization decisions with reasonable criteria that are evidence- and consensus-based. Periodic audits could be utilized to hold physicians accountable to exercising that authority.
- Post-acute care reform should include an accurate definition of post-acute care. The current definition excludes outpatient services and is being driven by how Medicare Parts A and B are defined, not by how care is actually delivered. Post-acute care reform and reinvention will only be ultimately successful by eliminating this arbitrary divide.
- A reformed system should ensure electronic interoperability between and among different providers of care. Post-acute care providers are at the crossroads of information flowing out of the acute care hospitals, yet post-acute care providers were not included in recent health information technology (HIT) incentive programs. The absence of such funding for post-acute care providers has arguably made information sharing worse than before the incentives were provided. Post-acute care providers should be included in HIT incentives to enhance patient care safety and efficiency, and reduce costs.
- A reformed system should create a mechanism to promote frank and open discussion between acute care hospitals and post-acute care providers to identify and rectify adverse health outcomes that occur because of care transitions.
- The current post-acute care system, including provider fee schedules and coverage criteria, is long-standing. Therefore, any changes to this system will require extensive provider, professional, and patient outreach and education. As a result, implementation of a reformed system should include a sufficient transition period and resources for such education. All stakeholders, including health care professionals and patients, should be consulted in the development of a new Medicare physician payment system.
- A reformed system should include a quality measurement and reporting system for post-acute care

providers that should be based on the principles of:

- Avoiding adverse events;
 - Achieving positive health outcomes;
 - Achieving positive functional gains;
 - Providing a positive patient experience;
 - Achieving durable health and functional gains; and
 - Demonstrating efficient and cost effective use of resources.
- Payments must reflect the true cost of care and resources utilized based on the patient’s conditions. Systems that allow for a fixed number of visits or an average cost limit disproportionately penalize patients with complex disabilities such as spinal cord injuries, brain injuries, and some neurological conditions that require extended rehabilitation.
 - Provider administrative burden should be minimized whenever possible. Current regulations that inhibit the use of the most cost effective setting—such as the 3 hour rule for IRH/Us and the 25 Percent Rule for LTCHs—should be eliminated and replaced with incentives to use post-acute care settings prudently.
 - The payment eligibility criteria for post-acute care providers should be reformed based on structure, process, and outcomes for each setting, and these criteria should not be confused with defining appropriateness for a specific patient.

IMPACT Act

Recently unveiled draft legislation by the bipartisan, bicameral staff of the Senate Finance and House Ways and Means Committees reflects the understanding that payment changes cannot be meaningfully implemented without comparative data of the quality and outcomes across different sites and settings of care. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 takes a measured approach of analyzing and reporting to Congress on payment system reform.

While AMRPA has various concerns with the scope, timeline, and details of the draft IMPACT Act, the bill’s general approach has merit in first identifying the building blocks of reform. Specifically, the legislation seeks to use performance assessment as a foundation for changes to the payment system. It also recognizes that standardized data and common data tools are a requisite foundation for accurate resource use and other quality comparisons. In sum, the IMPACT Act recognizes that data systems must be overhauled before quality can be accurately assessed across care settings and thus payment and service delivery policy can be improved. AMRPA believes this systematic approach represents an affirmation that moving hastily to institute payment reforms like bundling or “site neutrality” in the absence of a complete understanding of the differences between sites of care would be detrimental to patients and the Medicare program in general.

BACPAC Act

Representative David McKinley’s Bundling and Coordinating Post-Acute Care (“BACPAC”) Act of 2014 (H.R.4673) recognizes important limitations in the current payment system, but attempts to superimpose a complex new payment model on a tenuous foundation. Although AMRPA believes that the health care system should explore ways to transition toward patient-centric, episode-based models of care, doing so should not create financial disincentives for patients to receive medically appropriate inpatient rehabilitation care.

Current Medicare payment policies are defined by “silos” of post-acute services and have substantial room for improvement with regard to efficiency and patient-centricity. AMRPA could only support a well-developed bundling proposal that is built upon an adequate foundation of data integration and based on sound evidence with fully developed quality measures and risk-adjusted payment systems. At this time, a bundled payment system that includes critical beneficiary protections does not exist and it would likely take several years to develop, adequately test, and validate.

Absent sufficient safeguards for patient access and choice, AMRPA is not able to support legislating broad bundling reforms that lock-in federal savings and defer to the Secretary of HHS to implement a skeletal bundling plan for the post-acute care sector. The potential savings to the Medicare program from prematurely implementing a bundling payment system on the current foundation are dubious and far outweighed by the unjustifiable risk to Medicare beneficiaries.

At this time, AMRPA cannot support the BACPAC Act of 2014, as drafted. At a minimum, we propose the following important revisions:

- **Bundle Coordinator:** AMRPA supports the BACPAC’s designation of a physician as the individual charged with making treatment decisions under the bundle, as well as the requirement that this physician have experience in post-acute care/rehabilitation service delivery, including the implementation of post-acute care plans.
- **Holder of the Bundle:** AMRPA opposes the proposal to permit acute care hospitals and insurance companies to serve as the “holder” of the bundled payment for the 90-day bundling period. Regardless of their ability to bear risk, this approach imposes formidable disincentives to divert patients to the least costly setting, regardless of patients’ specific clinical needs. Regardless of the structure, the bundle holder should be accountable for performance across a series of quality and outcome measures to protect against underservice.
- **Risk-Bearing Entities:** The holder of the bundle must be able to fully assume the risk of holding this bundled payment while providing services to a beneficiary over a 90-day episode of care. The legislation should require financial solvency and related standards to ensure that bundle holders have the capacity to provide consistent and reliable care, even to outlier patients. These standards should be specifically adapted to the post-acute care setting.
- **Exemption of Certain Vulnerable Patients from First Phase of Bundling:** Bundling is a concept that has not been sufficiently tested and, while AMRPA does not oppose the concept, we strongly believe that adequate safeguards must be included in any legislation to protect vulnerable Medicare beneficiaries. Among these beneficiaries are people with traumatic brain injuries, spinal cord injuries, moderate to severe strokes, multiple-limb trauma, amputations, and severe neuromuscular and musculoskeletal conditions. While these subgroups constitute a minority of Medicare beneficiaries served on an annual basis, they constitute particularly vulnerable subgroups that ought to be exempt from the initial phases of any bundled payment system, until new payment systems can demonstrate sufficient quality outcomes, risk adjustment, and patient safeguards to ensure quality care.
- **Prosthetics, Orthotics and Custom DME Should Be Exempt from the Bundle:** AMRPA believes that certain devices and related services should be exempt from the bundled payment system. For example, customized devices that are relatively expensive and intended to be used by only one person should be separately billable to Medicare Part B during the 90-day bundled period,

as well as prosthetic limbs and orthotic braces, custom mobility devices and Speech Generating Devices (“SGDs”). Under a bundled payment system, there are strong financial incentives to delay or deny access to these devices and related services until the bundle period lapses. Once this occurs, Medicare Part B would be available to cover the cost of these devices, but this delay has potentially significant negative consequences for patient outcomes, and opportunities are lost for rehabilitation and training on the use of the device or technology during the PAC stay.

- **Inclusion of Quality and Outcome Measures:** Quality measures must be mandated in any PAC bundling bill to assess whether patients have proper access to necessary care. This is one of the most critically important methods of determining whether savings are being achieved through better coordination and efficiency, or through denials and delays in services. However, uniform quality and outcome measures that cross the various PAC settings do not currently exist. The existing LTCH CARE instrument for LTACHs, the IRF-PAI for rehabilitation hospitals, the MDS 3.0 for SNFs, and the OASIS instrument for home health agencies are all appropriate measurement tools for each of these settings. But the reality is they measure different factors, are not compatible across settings, and do not take into consideration to a sufficient extent a whole series of factors that truly assess the relative success of a post-acute episode of care. Therefore, AMRPA recommends that the following measures be incorporated into the PAC system:
 - Access and Choice: Measures should include assessment of whether the patient has appropriate access to the right setting of care at the right time and whether the patient is able to exercise meaningful choice;
 - Function: Incorporate and require the use of measures and measurement tools focused on functional outcomes that include measurement of maintenance and the prevention of deterioration of function, not just improvement of function;
 - Individual Performance: Measurement tools should be linked to quality outcomes that maximize individual performance, not recovery/rehabilitation geared toward the “average” patient;
 - Quality of Life: Require the use of quality of life outcomes (measures that assess a return to life roles and activities, return to work if appropriate, reintegration in community living, level of independence, social interaction, etc.);¹ and
 - Patient Satisfaction: Measures should not be confined to provider-administered measures but should directly assess patient satisfaction and self-assessment of outcomes. CMS or MedPAC should be required to contract with a non-profit entity to conduct studies in this area and factor the results into any final PAC bundled payment system in the future.²
- **Avoid Financial Incentives to Divert Patients to Less Intensive Settings:** In order to protect against diversion of patients to less intensive, inappropriate PAC settings, we recommend that any PAC bundling legislation include instructions to the Secretary that payment penalties should be established to dissuade PAC bundle-holders from underserving patients or stinting on care.

¹ These extended functional assessment and quality of life measures are consistent with the World Health Organization’s International Classification of Functioning, Disability and Health and the measurement tool designed around the WHO-ICF known as the Activity Measure for Post-Acute Care™ (“AM-PAC”™).

² “uSPEQ” (pronounced “You Speak”) is an example of a patient satisfaction assessment tool that measures the end users experience with their post-acute care experience. The survey can be answered by the patient, family or caregiver.

AMRPA reiterates its concurrence with proponents of the IMPACT Act that introducing bundled payments in the absence of a complete quality picture, infrastructure to seamlessly coordinate services, and data that transcends individual sites of care would be premature.

Site-Neutral Payments

Although AMRPA supports consideration of payment reforms that focus on the individual patient rather than the provider or setting, leading proposals to establish “site neutral” payment rates cause far more problems than they resolve. Current proposals to equalize payments to IRH/Us and SNFs for certain conditions create financial barriers to inpatient medical rehabilitation and shifts patients to nursing homes based on their diagnoses alone, without taking into account their individual medical and functional needs. Admission decisions and treatment plans should not be based on punitive Medicare policies, but should instead center on the clinical needs of individual patients.

The concept of neutral payment presupposes that the care rendered in different settings is equivalent and thus the payment should be neutral. Not only is that premise unsubstantiated by evidence, but the regulatory framework implies the exact opposite. There are strict coverage criteria for inpatient medical rehabilitation, and IRH/Us are subject to extensive medical requirements that do not apply to other providers. The coverage criteria for IRH/Us are highly unique within post-acute care, incredibly rigorous, and include extensive documentation requirements. IRH/Us must have medical directors and nurses who specialize in rehabilitation, have 60 percent of admissions come from thirteen specific categories, and can only admit patients who require, and can tolerate, three hours of interdisciplinary therapy a day, as well as the potential to meet predetermined goals.

These criteria demonstrate the central role that rehabilitation physicians fulfill in preadmission screening, admitting the patient to the hospital, conducting a post-admission evaluation in addition to the patient history and physical examination, developing the individualized overall plan of care, leading weekly team meetings and seeing the patient for at least three face-to-face visits per week to assess and adjust the rehabilitation program. This type of intensive medical care is not appropriate for many patients and thus these requirements are not imposed for other sites of care. However, Congress should not impose site neutral payment rates without concurrently establishing site neutral regulatory standards.

CMS presently lacks the requisite data to compare the care delivered across different settings. The leading indicators, however, reveal that the care delivered in different settings is far from comparable. IRH/Us achieve superior results in a shorter amount of time compared to other sites of care. For more than a decade, Medicare patients have consistently had an average length of stay of approximately 13 days in IRH/Us compared to more than a month in even relatively efficient nursing homes. More than 80 percent of IRH/U patients achieve discharge to home after rehabilitation, compared to approximately 45 percent of SNF patients. Also, acute hospital readmission rates for SNFs far exceed rates for IRH/Us. According to MedPAC’s March 2013 Report to Congress, 19.2 percent of SNF patients were discharged to acute care and 28 percent were rehospitalized directly or within 30 days, compared to 10.3 percent of rehabilitation inpatients with 12 percent readmitted within 30 days. These aggregate figures mask that for certain conditions, such as hip replacement, the disparity in unplanned readmission and length of stay is far more extreme.

Unfortunately, CMS has never comprehensively analyzed the comparative costs of medical rehabilitation and nursing home care over an entire episode of care. Taking into account discharge to home and community and readmission costs, the reality is that medical rehabilitative care is not significantly more costly than nursing home care and may be the less costly alternative for many Medicare beneficiaries.

According to a recent longitudinal analysis by Dobson DaVanzo & Associates, patients treated in IRFs had significantly better long-term clinical outcomes than those treated in SNFs. Specifically, IRFs patients returned home from their initial stay two weeks earlier, remained home nearly two months longer, and survived nearly two months longer than clinically-comparable SNF patients.³ Congress should consider the true cost differentials and quality outcomes across an entire episode of care before enacting reforms that seek to shift patients from one care setting to another.

Without a systematic way to account for these vast disparities, AMRPA worries that site neutral payments represent a redistributive proposal under which beneficiaries will be deprived of access to medically necessary care while other providers will gain market share at the expense of clinically appropriate, hospital-level, quality care. Moreover, due to the hidden costs associated with rehabilitation in other post-acute settings, actual savings to the Medicare program will never be realized.

Bundled Payments

Through thoughtful and transparent deliberation, AMRPA believes that an approach to bundling payment could be developed that has the potential to meet the twin aims of improving quality and reducing cost. Bundling typically involves payment to one accountable entity for a predefined grouping of items and services, which may be supplied by various providers and settings, for an episode of care. It is imperative to test bundling different components of post-acute services together before moving to bundle acute care services with post-acute care services. Moreover, it is critical that any bundled payment program include incentives to provide high-quality care in the most appropriate setting to improve patient outcomes.

The primary goal of any payment reforms in the post-acute care sector should be to improve patient choice, access to services, and health outcomes. In delegating the development of a prototype for a post-acute care prospective payment system, Congress should direct CMS to avoid financial incentives that jeopardize patient choice and access or lead to inappropriate underutilization of medically necessary rehabilitation services. We will not know whether bundling payments truly has the potential to enhance care and save money until a viable bundled payment model is adequately tested within the Medicare population.

The Continuing Care Hospital

AMRPA believes that reforms with the greatest chance of long-term success do not use reimbursement to try to override clinical decision-making, but instead seek to align payment changes with efficiencies in the delivery of care. The Medicare Shared Savings Program is a salient example of effectively integrating care delivery and payment reforms. The Continuing Care Hospital (CCH) model has the potential to be another success story, moving from a provider-oriented to a patient-centered payment system and improving care coordination. Rather than relying on the outdated Post-Acute Care Payment Reform Demonstration, Congress should direct the Center for Medicare and Medicaid Innovation (CMMI) to promptly implement the CCH pilot, as currently required by statute.

The CCH model focuses admission, treatment, and payment decisions on the needs of the patient and is an amalgam of different care approaches including IRH/Us, long-term care hospitals (LTCHs), and hospital-based SNFs organized to deliver intensive rehabilitation therapy and critical medical components. Defining the episode of care as a CCH stay plus the 30 days following discharge allows CMS to begin testing a viable post-acute care bundled payment model before having to report to Congress on

³ DOBSON DAVANZO & ASSOCIATES, ASSESSMENT OF PATIENT OUTCOMES OF REHABILITATIVE CARE PROVIDED IN INPATIENT REHABILITATION FACILITIES AND AFTER DISCHARGE (unpublished manuscript, May 2014).

prospective payment and other post-acute care payment reforms. Although CMMI does not require additional legislation to launch the CCH pilot – which it is already statutorily mandated to do – Congress should ensure that implementation occurs swiftly as an important step in evaluating viable post-acute care payment reforms.

Conclusion

AMRPA supports careful consideration of new payment models, but not as a façade for cutting costs and shifting spending to other parts of the Medicare program at the expense of patients’ full recoveries from serious illness and injuries. We look forward to working with the Energy and Commerce Committee in thoroughly vetting proposals to reform the post-acute care sector and advancing proposals that take this charge seriously. We thank you once again for the opportunity to submit this statement in the Subcommittee’s record.

Sincerely,

A handwritten signature in black ink that reads "Bruce M. Gans, MD". The signature is written in a cursive style and is contained within a thin black rectangular border.

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