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## INTRODUCTION

My name is Peter Thomas and I help coordinate the CPR which is a consumer-led, national coalition of patient, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with disabilities, injuries or chronic conditions may regain and/or maintain their maximum level of health and independent function. Members of the CPR Steering Committee include the National Multiple Sclerosis Society, the Center for Medicare Advocacy, the Brain Injury Association of America, United Spinal Association, and the Christopher and Dana Reeve Foundation.

## RESPONSES TO QUESTIONS FOR THE RECORD

(ALL QUESTIONS ASKED BY CHAIRMAN PITTS)

**Q: In your testimony, you state that data collection from all Post-Acute Care reform sites is an integral step toward balanced and appropriate bundling of services in the Medicare program. I agree that data collection is important but understand that sometimes data collection from different sectors can be impeded by different industries using different proprietary tools that may not all measure the same. In your opinion, how important would the use of a standardized tool by the Medicare program be in our efforts to collect standardized data from the various Post-Acute Care settings?**

A: Creating a uniform quality assessment instrument to measure outcomes across PAC settings is a critical step in both adopting appropriate—and sufficiently granular—quality metrics to ensure PAC patients under a bundled Medicare payment system achieve good patient outcomes and risk adjusters accurately capture the unique needs of individual patients. Uniform quality and outcome measures that cross the various PAC settings do not currently exist. The existing LTACH 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 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 care episode of care.

**Q: You state in your testimony that you do not support Congressional efforts to reform Post-Acute Care at this time until data collection and quality metrics are in place to achieve good patient outcomes and until such time, would support the Secretary of Health and Human Services to implement a skeletal PAC bundling plan. What in your opinion would a "skeletal PAC bundling plan" look like?**

A: Unfortunately, this question represents a misreading of my testimony. CPR does not, in fact, support passage of any bundled payment system until such time as appropriate quality metric and risk adjusters are ready for implementation. A bundled PAC payment system that includes critical beneficiary protections does not currently exist and, we expect, will take several years to develop, adequately test, and validate. CPR has strong concerns about the development of a skeletal bundling plan prior to the development and establishment of a universal assessment instrument, beneficiary protections against stinting on care, and robust quality measures which include quality of life measures that are meaningful to individuals with disabilities and chronic conditions.

Until sufficient patient protections and a uniform assessment tool are in place, we do **not** support legislating broad PAC bundling reforms (what I referred to in previous testimony as a “skeletal PAC bundling system”) that lock-in federal savings and defer to the HHS Secretary to implement all the details of a comprehensive PAC bundling plan. It is simply too risky to Medicare beneficiaries to implement PAC bundling prematurely. In addition, there are a number of improvements we would like to suggest to improve the draft BACPAC Act of 2014, including the following:

1. **PAC Bundle Holder**: We have serious concerns with the proposal to permit acute care hospitals and insurance companies to serve as the holder of the PAC bundle for the 90-day bundling period. Regardless of their ability to assume the risk, there are strong incentives in such a model for entities with little direct knowledge of rehabilitation to divert patients to the least costly PAC setting. In the absence of robust quality metrics, the only real incentive will be to keep the patient from being readmitted to the acute care hospital which will eventually lead to financial penalties. In terms of quality of care, this is a very low bar. Current law requires the Centers for Medicare and Medicaid Services (CMS) to pilot test a concept known as the Continuing Care Hospital (CCH),<sup>1</sup> where the PAC bundle is held by a combination of post-acute care providers (i.e., LTACH, IRF and hospital-based SNF). This would, at least, place the bundle in the hands of providers who understand rehabilitation and these patients’ needs. At the very least, we would suggest the removal of insurers as being eligible to hold the bundle. This would be akin to joining a managed care plan (for purposes of PAC services) within the fee-for-service Medicare program. If beneficiaries wish to join Medicare Advantage, that option is certainly available to them, but this concept should not be permitted to apply to fee-for-service. In any event, the bundle holder **MUST**

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<sup>1</sup> Inexplicably, CMS has not yet pursued the mandated CCH pilot program.



be accountable for the achievement of quality and outcome measures to protect against underservice.

2. **Entities Able to Assume the Risk**: Any bundle holder must be truly able to assume the risk of holding this bundled payment while providing services to a beneficiary across an episode of care, whether it be 90 days or some other time period. Financial solvency and related standards should be explicitly adopted in the legislation to ensure that bundle holders have the capacity to provide consistent and reliable care, even to outlier patients. Such standards ought to be tailored to PAC/rehabilitation providers, such as the standards of the Commission on Accreditation of Rehabilitation Facilities (CARF) and other appropriate accreditors.
3. **PAC Bundle Coordinator**: The draft BACPAC bill defines a “PAC Physician” as having primary responsibility with respect to supervising the delivery of the services during the PAC episode. We support a requirement that the health care professional making treatment decisions be a clinician rather than a layperson, but the bill should require this physician to have experience in post-acute care/rehabilitation service delivery, as this is the very expertise necessary to develop and implement PAC treatment plans.
4. **Prosthetics, Orthotics and Custom DME Should Be Exempt from the Bundle**: CPR believes that certain devices and related services should be exempt from the bundled PAC payment system, just as outpatient rehabilitation therapy and other services are treated under the draft bill. For instance, 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. Prosthetic limbs and orthotic braces are critical to the health and full function of people with limb loss and other disabling conditions. Custom mobility devices<sup>2</sup> and Speech Generating Devices (SGDs) serve the individual needs of very specific patients under the Medicare program. Under a bundled payment system, there are strong financial incentives to delay or deny entirely 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 is very deleterious to patient outcomes, and opportunities are lost for rehabilitation and training on the use of the device or technology during the PAC stay.

This phenomenon was witnessed when Congress implemented prospective payment for skilled nursing facilities (“SNFs”) in 1997 and initially included orthotics and prosthetics in the SNF bundle or “PPS.”<sup>3</sup> As a result, most skilled nursing facilities began to delay and deny access to prosthetic and orthotic care until the beneficiary was discharged from the SNF and then Medicare Part B assumed the cost of O&P treatment. During this period, patients experienced inappropriate and unreasonable delays in access to O&P care that often make the difference between independent function and life in a nursing home. In

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<sup>2</sup> Custom mobility devices are often referred to as “Complex Rehabilitative Technology” or “CRT.” In fact, bipartisan legislation has been introduced in both houses of Congress to create a separate designation under the Medicare program for CRT entitled, “Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013,” H.R. 942 and S. 948

<sup>3</sup> Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4432, 111 Stat. 251, 414 –22 (1997) (codified at 42 U.S.C § 1395yy).



1999, Congress recognized this problem and exempted a large number of prosthetic limb codes from the SNF PPS consolidated billing requirement,<sup>4</sup> thereby permitting these charges to be passed through to Medicare Part B during the SNF stay.<sup>5</sup> As a result, SNF patients once again had access to prosthetic care during the course of their SNF stay. This experience should not be repeated under new bundled payment systems and, therefore, we recommend that Congress exempt prosthetics, custom orthotics, and custom durable medical equipment from any PAC bundling legislation.

**Q: CMS in recent months has taken steps to drastically alter the landscape of the Medicare Part D program by removing protections for critically ill patients as it relates to mental illness drugs and personalized drug plans. It was only bipartisan Congressional and public push back that stalled the effort this month but CMS has insisted that despite such outcry, it plans to go forward with such policies in the future. How can we ensure that CMS or HHS puts in place a system that takes into account your concerns when they have lately appeared so tone-deaf to the concerns of Medicare beneficiaries?**

A: CPR does not normally take positions on Medicare Part D policy. However, as a co-chair of the Consortium for Citizens with Disabilities' (CCD) Health Task Force, I can say that many within the disability community are extremely concerned with actions by CMS that threaten the six protected classes of drugs under Medicare. Members of CCD (a national coalition of over 100 consumer and provider disability organizations) actively oppose any action by CMS to lift these protections. One way Congress could ensure that access to Part D drugs is protected is to remove CMS' discretion to shrink or restrict which drugs are protected under this statutory protection.

**Q: Medicare is facing insolvency, which would jeopardize care for millions of seniors that depend on the program. What policies or payment reforms would you recommend Congress consider to help keep the promise to seniors by saving Medicare from insolvency?**

A: CPR supports Medicare delivery reforms that improve access to quality care for Medicare beneficiaries. Some of the recent programs which have shown that they can, when implemented appropriately, improve the quality of care and produce savings for the Medicare program by enhancing the independence of Medicare beneficiaries, improving health outcomes, preventing secondary conditions and avoiding costly institutionalizations include the Independence at Home ("IAH") program and the Programs of All-Inclusive Care for the Elderly (PACE). These programs should be expanded significantly in the future. Congress should also encourage in the strongest terms CMS to implement the Continuing Care Hospital (CCH) demonstration, which has already been authorized and which would help test post-acute care bundling reforms that could save Medicare money and improve the quality of care in the PAC realm. Congress should also encourage CMS to limit Medicare coverage for orthotic and prosthetic services to those services provided by licensed and appropriately credentialed O&P practitioners and suppliers. To achieve this, Congress should pass the Medicare

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<sup>4</sup> Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, § 103, 113 Stat. 1501A-321, 1501A-325-26 (1999) (codified at 42 U.S.C § 1395yy(e)).

<sup>5</sup> Unfortunately, Congress did not similarly exempt custom orthotics from the SNF consolidated billing requirements which has led to a serious lack of access to appropriate custom orthotic care in the SNF setting.



Orthotic and Prosthetic Improvement Act, H.R. 3112. Congress should also pass legislation that separates complex rehabilitation technology (“CRT”) from traditional durable medical equipment under Medicare. This bill is known as Ensuring Access to Complex Rehabilitation Technology Act, H.R. 942. Establishing a CRT category separate from DME would make it possible for CMS to tailor coverage policies for individuals with significant long-term disabilities and chronic conditions, ensuring access to the technology that will enhance independence, improve health outcomes and save money for Medicare in the long term by preventing secondary conditions, hospitalizations and institutionalization. Finally, Congress should continue to pass policies which shrink and ultimately eliminate the institutional bias in Medicaid which impacts not only Medicaid beneficiaries, but dual eligibles as well. Programs like the Money Follows the Person (“MFP”) program and the Rebalancing incentives program support transitioning dual eligibles out of institutions and into their homes and communities - the preferred setting of most beneficiaries and the less expensive setting most of the time.

**Q: What do you think about the possible savings to beneficiaries if Congress were to combine the A/B cost-sharing and adopt a catastrophic cap? This reform has been recommended by MedPAC, former Sen. Lieberman, and the President's Fiscal Commission.**

A: CPR has not taken a position on this proposal. In general, however, CPR opposes policies that produce savings by simply cost-shifting to Medicare beneficiaries. Proposals which shift costs to beneficiaries could very well lower utilization, but they disproportionately hurt those who have severe disabilities and chronic conditions – those who most need health care interventions and who have less alternatives to those interventions. It is possible that combining cost-sharing under Medicare Part A and B could result in cost-shifting, depending on how the policy is implemented.