WRITTEN TESTIMONY OF PETER W. THOMAS, J.D.
COALITION TO PRESERVE REHABILITATION
"KEEPING THE PROMISE: SITE OF SERVICE MEDICARE PAYMENT REFORMS"
HOUSE ENERGY & COMMERCE HEALTH SUBCOMMITTEE

On behalf of the Coalition to Preserve Rehabilitation, a consumer-led coalition of 30 rehabilitation and disability organizations, my testimony will focus on the post-acute care ("PAC") site-neutral payment proposal and broader PAC bundling reforms. CPR believes that rehabilitation is the linchpin to improving the health, function, and independence of Medicare beneficiaries and, as such, is a cost-effective service. All settings of PAC services play an important role in the treatment of Medicare beneficiaries after an injury, illness, disability, or chronic condition. But these settings are not the same in terms of patient outcomes and it is critical to preserve access to rehabilitation at varying levels of intensity and coordination.

All Medicare PAC reforms based on site-neutrality that Congress considers should, above all, preserve access to the right level of intensity of rehabilitation, in the right setting, at the right time to meet the unique individual needs of Medicare beneficiaries. CPR strongly believes that any legislative changes to the Medicare program should not have the effect of restricting access to rehabilitation provided in PAC settings. Congress should avoid proposals that will lead to a reduction in Medicare rehabilitation benefits or that erect policy barriers that affect beneficiaries by channeling them into settings of post-acute care that do not meet the beneficiaries' individual medical and rehabilitation needs, simply to save funds.

CPR opposes the site-neutral IRF-SNF proposal to equalize payments for certain conditions as it is little more than an outright financial disincentive for inpatient rehabilitation hospitals and units to accept certain Medicare patients based solely on patients' diagnoses, not based on their individual medical and functional needs. We favor well-developed bundling proposals based on sound evidence with fully developed quality measures and risk-adjusted payment systems so that savings are not achieved by stinting on patient care. Our testimony details a number of specific suggestions to improve the Bundling and Coordinating Post-Acute Care ("BACPAC") Act of 2014 in a manner that protects some of the most vulnerable Medicare beneficiaries under a bundled PAC payment system.

CPR supports the collection of uniform data across a variety of PAC settings with a major emphasis on appropriate quality standards and risk adjustment to protect patients against underservice. We support existing bipartisan efforts to develop a uniform quality assessment instrument to measure functional and quality of life outcomes across PAC settings. Improving patient outcomes should be the hallmark of any reform to the Medicare program, especially payment or delivery reforms including any site-neutral or bundled payment system that impacts some of the most vulnerable Medicare beneficiaries.

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PETER W. THOMAS, J.D.
ON BEHALF OF THE

COALITION TO PRESERVE REHABILITATION

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES

IN CONNECTION WITH ITS HEARING ON

"KEEPING THE PROMISE: SITE OF SERVICE MEDICARE PAYMENT REFORMS"

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Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee:

Thank you for the opportunity to testify on behalf of the Coalition to Preserve Rehabilitation ("CPR") on the issue of site-neutral payments under the Medicare program. I will confine my testimony to post-acute care ("PAC") services. 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 & Dana Reeve Foundation.

Like many Americans who have sustained a serious injury or illness, I know firsthand the value of rehabilitation. When I was ten years old, I was involved in a car accident and lost my legs below the knees. I spent two and half months in Craig Rehabilitation Hospital in Denver, Colorado and returned home walking on two artificial limbs. Since then, I have undergone additional surgeries, outpatient rehabilitation, and have used thirteen sets of prosthetic limbs over the past forty years. As a result of quality rehabilitation and good prosthetic care, I was able to become an attorney and advocate on behalf of people with disabilities. I would hope that every Medicare beneficiary, indeed all Americans, have the same access that I did to quality rehabilitative care when they encounter an injury, illness, disability, or chronic condition.

Long term acute care hospitals ("LTACH"), inpatient rehabilitation hospitals and units ("IRFs"), skilled nursing facilities ("SNFs"), and home health care agencies all play an important role

in the recovery and rehabilitation of Medicare beneficiaries.[1] The services provided in each of these settings cater to beneficiaries with a particular set of medical and functional needs which are rarely defined by primary diagnosis alone. All Medicare post-acute care reforms based on site-neutrality that Congress considers should, above all, preserve access to the right level of intensity of rehabilitation, in the right setting, at the right time to meet the unique individual needs of Medicare beneficiaries. This is, of course, much easier said than done. Meeting this challenge, while making Medicare post-acute care payment policy more efficient, requires serious deliberation. Uniform data needs to be collected across a variety of PAC settings with a major emphasis on appropriate quality standards and risk adjustment to protect patients against underservice. Improving patient outcomes should be the hallmark of any reform to the Medicare program, especially payment or delivery reforms including any site-neutral or bundled payment system that impacts some of the most vulnerable Medicare beneficiaries. It is one thing to maintain or improve quality outcomes while making the system more cost-efficient. It is quite another to ultimately save money in post-acute care by redesigning payment and delivery systems in a manner that does not protect against stinting on patient care and diverting beneficiaries into the least costly setting.

CPR strongly believes that any legislative changes to the Medicare program should not have the effect of restricting access to rehabilitation provided in post-acute care settings. Congress should avoid proposals that will lead to a reduction in Medicare rehabilitation benefits or that erect policy barriers that affect beneficiaries by channeling them into settings of post-acute care that do not meet the beneficiaries' individual medical and rehabilitation needs, simply to save funds. In this testimony,

[1] Although these settings are commonly referenced when discussing post-acute care policy, there are other providers in the post-acute care continuum that are critical to a well-functioning system. For instance outpatient therapy, hospice providers, durable medical equipment, prosthetics, orthotics, and supplies all contribute to the Medicare-covered set of post-acute care services. In addition, there are other specialty rehabilitation providers (whether or not Medicare covers these services) that focus on specific conditions, such as residential/transitional treatment programs for people with moderate to severe acquired brain injuries.

I will discuss rehabilitation and the Medicare beneficiary, and our specific views on "site-neutrality" and bundling proposals under the subcommittee's consideration.

Rehabilitation and the Medicare Beneficiary

Millions of individuals with injuries, illnesses, disabilities, and chronic conditions rely on the Medicare program for access to the rehabilitation services they need to improve their health, functional ability, and live as independently as possible in their homes and communities. According to the Centers for Medicare and Medicaid Services ("CMS"), more than two-thirds of Medicare beneficiaries, or approximately 21.4 million individuals, had at least two chronic conditions in 2010.[2] There are over eight million Medicare beneficiaries under the age of sixty-five who qualify for the program based on their disability status. Many people or beneficiaries with all kinds of injuries and illnesses avail themselves of both inpatient hospital and outpatient rehabilitation services at some point in their lives. For all Medicare beneficiaries, the Medicare rehabilitation benefit is a lifeline to improved health and functional status, and enhanced quality of life. And yet, growth in Medicare spending has been extremely low over the past three years: approximately 1.9 percent annually on average.

While spending has grown significantly in some post-acute settings over the past decade, Medicare spent the same amount on inpatient hospital rehabilitation in 2005 as it did in 2011, with a modest uptick in spending in more recent years, according to the CMS Office of the Actuary.[3] Timely, intensive, and coordinated rehabilitation provided in a rehabilitation hospital or unit decreases unnecessary long term dependency costs to the federal government. It also returns beneficiaries to their homes and communities, decreases the need to shift costs onto the states by relying on Medicaid

[2] *CMS Chartbook 2012: Chronic Conditions Among Medicare Beneficiaries*, CMS, 6 (2012), http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf.

[3] CMS Office of the Actuary as cited by Mark E. Miller, Ph.D., Medicare Payment Advisory Commission testimony on Medicare Post-Acute Care Reforms, June 14, 2013.

as the payer of last resort for long term nursing home care that might have been averted with early, intensive and coordinated rehabilitation. This level of care is also the linchpin to reduction of costly and unnecessary hospital readmissions for beneficiaries with a wide range of debilitating conditions.

Site-Neutral Payment Proposal

CPR is grateful that Congress, in its most recent legislation to adequately compensate physicians serving Medicare patients and extend the exceptions process to the Medicare outpatient therapy caps, chose not to adopt a major site-neutral PAC proposal that was included in the President's most recent budgets and discussed in-depth in recent MedPAC reports. CPR opposes the site-neutral IRF-SNF proposal to equalize payments for certain conditions as it is little more than an outright financial disincentive for inpatient rehabilitation hospitals and units to accept certain Medicare patients based solely on patients' diagnoses, not based on their individual medical and functional needs. Implementation of site-neutral payment for patients with hip fractures, joint replacements and other conditions such as stroke would simply eliminate access by erecting financial barriers to admit these individuals in inpatient rehabilitation hospitals and units. Admission decisions and treatment plans should not be based on arbitrary Medicare rules, but rather on the clinical needs of individual patients in terms of amount, duration, intensity, and scope of rehabilitation services.[4] Because SNFs are reimbursed on a per diem payment system and lengths of stay appear to be significantly greater in SNFs—as opposed to rehabilitation hospitals and units—there is a real question as to the cost-effectiveness of treating these patients in SNFs, particularly when patient outcomes are difficult to compare across settings. These comparisons also fail to consider the downstream costs of less-than-optimal rehabilitation/functional status of patients, resulting in unnecessarily high dependency costs

[4] For the same reason, CPR also opposes raising the 60 Percent Rule to 75 percent. This, too, is a rule that ultimately serves to bar the door to the inpatient hospital or unit based solely on the diagnosis of the patient rather than one's individual medical and functional needs.

and perhaps unnecessary institutionalization in nursing homes rather than return to the home and community setting. In addition, the site-neutral proposal is premised on the supposition that these types of patients are equally served and have the same outcomes in both IRF and SNF settings. Recent data suggest otherwise.

In preliminary study results released in March 2014 by Dobson | DaVanzo,[5] Medicare data over a two-year period demonstrated that when patients are matched on demographic and clinical characteristics, rehabilitation provided in inpatient rehabilitation hospitals leads to lower mortality, fewer readmissions and emergency room visits, and more days at home—not in a PAC institutional setting—than rehabilitation provided in SNFs for the same condition. In terms of mortality, the starkest difference between the two settings involved patients with stroke, traumatic brain injury, and amputations. This study demonstrates that care provided in IRFs and SNFs is not the same and that outcomes are, in fact, significantly different as a result of the specific type of services provided in these two different settings. The study demonstrates the enduring effects of timely, intensive and coordinated rehabilitation provided in an IRF and how these services improve not only the length of beneficiaries' lives, but the quality of their lives as well. Rather than adopting this site-neutral proposal—and other more comprehensive PAC bundling proposals—Congress chose to exercise restraint and continue deliberating on this important set of policies. CPR applauds this Congressional approach solely based on the complexity of policies under consideration and the risks to patients if the reforms are not based on uniform, validated data and conceived with beneficiary protections in mind.

<u>Bundling and Coordinating Post-Acute Care (BACPAC) Act of 2014</u>

Congressman McKinley (R-WV) has released draft legislation to bundle post-acute care under the Medicare program. Known as the Bundling and Coordinating Post-Acute Care ("BACPAC") Act

[5] Assessment of Patient Outcomes of Rehabilitation Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge, Dobson, DaVanzo and Associates, Preliminary Report (March 2014).

of 2014, the bill seeks to bundle payments for Medicare post-acute care services (including SNF and extended care services, home health, inpatient rehabilitation hospital care, long term acute hospital care, durable medical equipment, and outpatient prescription drugs). A number of exceptions to the bundle are proposed such as physician services, hospice care, outpatient hospital services, ambulance services, and outpatient therapies. The bundled payment could be held by any entity that demonstrates the financial capacity to direct Medicare beneficiaries' PAC care including acute care hospitals, insurance companies and PAC providers.

CPR recognizes that the current "silos" of post-acute care can be inefficient and can discourage episode-based care that is patient centered. We favor well-developed bundling proposals based on sound evidence with fully developed quality measures and risk-adjusted payment systems so that savings are not achieved by stinting on patient care. Unfortunately, a bundled PAC payment system that includes these critical beneficiary protections does not exist and, we expect, will take several years to develop, adequately test, and validate. This is why, with certain caveats, we support existing bipartisan efforts to develop a uniform quality assessment instrument to measure outcomes across PAC settings.[6] Doing so 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.

Until these and other patient protections are in place, we do not support legislating broad PAC bundling reforms that lock-in federal savings and defer to the Secretary of the U.S. Department of Health and Human Services ("HHS") to implement a skeletal PAC bundling plan. It is simply too risky to Medicare beneficiaries to implement PAC bundling prematurely. In addition, there are a

[6] This draft legislation is known as the "IMPACT Act," or Improving Medicare Post-Acute Care Transformation Act of 2014.

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, as long as these patients are not readmitted to the acute care hospital, which comes with financial penalties. Current law requires CMS to pilot test a concept known as the Continuing Care Hospital ("CCH"),[7] where the PAC bundle would be held by this new PAC-centered entity which would provide a combination of post-acute care services currently provided by LTACHs, IRFs, and hospital-based SNFs. Any one of these three PAC entities or a combination of them could be the bundle holder. This concept would properly place the bundle in the hands of providers who understand rehabilitation and these patients' needs. In any event, the bundle holder MUST 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 a 90-day episode of care. Financial solvency and related standards should be required by 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.

[7] Inexplicably, CMS has not yet pursued the mandated CCH pilot program.

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 person charged with making treatment decisions under the bundled payment be a health care professional rather than a layperson, and that this physician has 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[8] 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 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.

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[8] 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.

This phenomenon was witnessed when Congress implemented prospective payment for SNFs in 1997 and initially included orthotics and prosthetics in the SNF bundle or Prospective Payment System ("PPS.")[9] As a result, most SNFs 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 orthotic and prosthetic ("O&P") treatment. During this period, SNF patients experienced inappropriate and unreasonable delays in access to O&P care. Such delays and denials of O&P care often impede patients' ability to independently function or, in some cases, result in life in a nursing home. In 1999, Congress recognized this problem and exempted a large number of prosthetic limb codes from the SNF PPS consolidated billing requirement,[10] thereby permitting these charges to be passed through to Medicare Part B during the SNF stay.[11] As a result, SNF patients once again had access to prosthetic limb 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.

5. **Exemption of Certain Vulnerable Patients from First Phase of Bundling**: PAC bundling is a concept that is clearly untested at this time and, while CPR does not oppose the concept, we strongly believe that safeguards must be included in any PAC bundling legislation to protect vulnerable Medicare beneficiaries. Among these Medicare patients are people with traumatic brain injuries, spinal cord injuries, moderate to severe strokes,

[9] Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4432, 111 Stat. 251, 414 –22 (1997) (codified at 42 U.S.C § 1395yy).
[10] 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)).
[11] 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.

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 are very important and very vulnerable subgroups that, we believe, should be exempt from the first phases of any bundled payment system. While such groups of patients could be phased-in at the patient's option as bundling develops, we believe the most vulnerable patients should only be included in PAC bundling on a mandatory basis when the bundled payment systems can demonstrate sufficient quality outcomes, risk adjusters, and patient safeguards to ensure quality care.

6. **Appropriate PAC 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 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 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. For instance, before widespread PAC bundling is adopted, measures must be incorporated into the PAC system that cover the following domains:

- 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;
- 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.);[12]
- Individual Performance: Measurement tools should be linked to quality outcomes that maximize individual performance, not recovery/rehabilitation geared toward the "average" patient;
- 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; 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.[13]

7. **Create Financial Disincentives 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 HHS Secretary

[12] 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"™).
[13] "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.

that payment penalties should be established to dissuade PAC bundle-holders from underserving patients.

Thank you for the opportunity to testify on this important issue area. The CPR Coalition is ready and willing to assist this Subcommittee as it continues to consider site-neutral payments and bundling proposals under the Medicare program.