

**THE ORTHOTIC AND
PROSTHETIC ALLIANCE**

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**WRITTEN TESTIMONY OF THE
ORTHOTIC & PROSTHETIC ALLIANCE
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES
WITH RESPECT TO ITS HEARING ON
“MEDICARE POST-ACUTE CARE DELIVERY AND OPTIONS TO IMPROVE IT”
APRIL 16, 2015**

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American Academy of Orthotists and Prosthetists (AAOP)
American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Inc. (ABC)
American Orthotic & Prosthetic Association (AOPA)
Board of Certification/Accreditation, International (BOC)
National Association for the Advancement of Orthotics and Prosthetics (NAAOP)

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

Thank you for the opportunity to submit testimony for the record on behalf of the Orthotic and Prosthetic Alliance (O&P Alliance) and the Amputee Coalition in connection with your hearing entitled, “Medicare Post-Acute Care Delivery and Options to Improve It.” The O&P Alliance is a coalition of the five major national orthotic and prosthetic organizations representing over 13,000 O&P professionals and 3,575 accredited O&P clinics across the country. The Amputee Coalition is the nation’s only national consumer association solely representing the interests of individuals with limb loss, many of whom require prosthetic and orthotic care.

We have serious concerns with bundling proposals of Medicare post-acute care (PAC) services and wish to express our views on this topic. More specifically, we wish to address the Bundling and Coordinating Post-Acute Care Act of 2015 (“BACPAC” Act), H.R. 1458. We believe this legislation has been improved since it was last introduced by Congressman McKinley in the 113th Congress as H.R. 1458, and we applaud Congressman McKinley including an exemption from the post-acute care bundle in his bill for orthotics and prosthetics. However, without more reliable data that is comparable across settings of post-acute care, better quality measures, sufficient pilot testing of the concept of bundling, and other factors described below, we continue to have grave concerns with this approach to post-acute care reform and the impact it may have on Medicare beneficiaries with limb loss and orthopedic conditions who are in need of orthotic and prosthetic care.

Medicare PAC Bundling is Premature and Requires Additional Data

Above all, any PAC reform that Congress enacts should ensure that Medicare beneficiaries have continued access to the amount, duration and scope of rehabilitation services and devices they need to maximize their recovery from injury or illness. Access to timely and quality orthotic and prosthetic care is a critical element of PAC services that must be preserved in any PAC payment reform proposal. Given the untested and unproven concept of bundling and the relative lack of reliable treatment and outcomes data that cuts across all PAC settings, we believe Medicare PAC bundling is premature at this time. The O&P Alliance and the Amputee Coalition is very concerned that Congress may enact a framework of bundling that places tremendous discretion with the Secretary of Health and Human Services to make many of the difficult decisions.

We urge Congress not to take this approach. Instead, we urge Congress to refrain from PAC reforms until data can be collected and analyzed pursuant to the Improving Medicare Post-Acute Care Transformation (“IMPACT”) Act of 2014. This legislation was signed into law by the President last October and now serves as the framework for PAC data collection across all settings of post-acute care. Uniform and current data need 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. We request that Congress give the Centers for Medicare and Medicaid Services (CMS) sufficient time to collect data under the IMPACT Act’s provisions before adopting a short-term, underdeveloped, approach to bundled payments impacting the recovery and rehabilitation of some of Medicare’s most vulnerable beneficiaries.

BACPAC Act of 2015

The current version of the BACPAC Act of 2015 ([H.R. 1458](#)) has some significant improvements from the previous legislation by the same name. The legislation seeks to bundle payments for Medicare post-acute care services (including extended care services, home health, inpatient rehabilitation hospital care, long term acute hospital care, skilled nursing facility care, durable medical equipment, outpatient prescription drugs, and outpatient physical and occupational therapy services). Exceptions to the bundle include physicians' services, hospice care, outpatient hospital services, ambulance services, outpatient speech-language pathology services, and orthotics and prosthetics. 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, third-party administrators, and PAC providers. With respect to H.R. 1458, O&P Alliance and the Amputee Coalition would like to share the comments below.

- **All Prosthetics and Orthotics Should Be Exempt from the Bundle:** The O&P Alliance and the Amputee Coalition supports the exclusion from the bundle of all prosthetic limbs and orthopedic braces, as is the case under the previous and current BACPAC Act. We believe that certain devices and related services should be exempt from the bundled PAC payment system as they are critical to an individual in returning to full function and would likely be delayed or denied under a bundled payment system. Orthotics and prosthetics for individuals with limb loss and other injuries can be relatively expensive and are useful only to one person. They are not appropriate for repeated use by multiple patients, as is the case with many forms of

durable medical equipment. In order to prevent financial incentives for bundle holders to delay access to this important care, orthotics and prosthetics should be separately billable to Medicare Part B during the 90-day bundled period and, therefore, we support the exclusion of these services from the bundle in the BACPAC Act.

These devices and related services are critical to the health and full function of people with limb loss and other disabling conditions. Prosthetics and orthotics serve the individual needs of relatively few 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 prosthesis or orthosis 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 prospective payment system (“PPS”).¹ 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, Medicare patients experienced inappropriate and unreasonable delays in access to

¹ Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4432, 111 Stat. 251, 414 –22 (1997) (codified at 42 U.S.C § 1395yy).

orthotic and prosthetic care that often make the difference between independent function and 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,² thereby permitting these charges to be passed through to Medicare Part B during the SNF stay.³ 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 urge Congress to retain the exemption of all prosthetics and orthotics from any bundled PAC reform proposal, including the BACPAC Act.

- **Use of Medicare Rates for PAC Service Providers:** In BACPAC Act of 2015, bundle holders are required to pay Medicare PAC providers Medicare rates⁴ rather than negotiated rates for covered PAC services, as permitted in the previous bill, H.R. 3796. The O&P Alliance and the Amputee Coalition supports this improvement in the new version of the bill. Given the fact that the bill also allows the bundle holder to be an acute care hospital, an insurer, or a third party administrator, we have serious concerns that negotiated rates between the bundle holder and PAC providers would have led to a “race to the bottom” in terms of the quality of providers serving beneficiaries under the bundle, including O&P providers.

² 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)).

³ 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.

⁴ See BACPAC Act of 2015, page 14: “For PAC services furnished by a PAC provider and furnished with respect to a qualifying discharge, the entity shall pay the PAC provider under the PAC network agreement between the entity and the PAC provider—“(i) *with respect to such PAC services that are services for which the PAC provider would receive payment under this title without regard to this section, an amount that is not less than the amount that would otherwise be paid to such PAC provider under this title for such services...*” [Emphasis added].

The requirement to pay providers Medicare rates forces providers to compete based on quality, reputation, and high levels of service which accrue to the benefit of patients. However, given the fact that the new BACPAC Act also requires the bundled payment amount to equate to only 96% of the average cost of a given episode of care, thereby saving the government significant PAC expenditures, the O&P Alliance and the Amputee Coalition questions how the bundle holder is going to achieve these savings. If such savings are borne on the backs of Medicare beneficiaries by being denied access to appropriate O&P technology, or delayed access to O&P care altogether, then we have serious concerns with this outcome and would urge Congress to reduce the amount of mandated savings to be achieved by bundling.

- **PAC Coordinator (“PAC Bundle Holder”)**: We also have serious reservations with the proposal to permit acute care hospitals, insurance companies, and third-party administrators 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 medical rehabilitation, orthotics and prosthetics, or rehabilitation therapies, to divert patients to the least costly PAC setting and delay access to O&P care, as long as these patients are not readmitted to the acute care hospital, which comes with financial penalties. Because of these incentives, we would support the removal of insurers and third party administrators as being eligible to hold the bundle. The bundle holder must have expertise in the clinical area being administered, namely, post-acute care. That

being said, the O&P Alliance and the Amputee Coalition supports the BACPAC Act's new language suggesting that the PAC bundle holder is accountable for the achievement of quality and outcome measures to protect against underservice.⁵

- **PAC Physician:** The BACPAC Act 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, including treatment of individuals with limb loss and other neuromuscular and musculoskeletal conditions, as this is the precise expertise that is often necessary to develop and implement PAC treatment plans.
- **Exemption of Certain Vulnerable Patients from First Phase of Bundling:** PAC bundling is a concept that is clearly untested at this time and, therefore, 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 limb amputations and multi-limb trauma, brain injuries, spinal cord injuries, moderate to severe strokes, and severe neuromuscular and musculoskeletal conditions. While this is clearly a minority of Medicare beneficiaries, it is a very important subgroup 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

⁵ See BACPAC Act of 2015, pages 12-13, regarding quality assurance, PAC coordinator performance, and care coordination.

should not be included in PAC bundling on a mandatory basis unless and until the bundled payment systems can demonstrate sufficient quality outcomes, meaningful and accurate risk adjustment mechanisms, and patient safeguards to ensure high quality care.

- **Choice of Provider within Bundled Payment Systems:** Under the current Medicare fee-for-service system, patient choice of provider is a hallmark of the program and a major beneficiary protection. Providers under bundled payment systems will have access to patients that may lead to life-long patient-provider relationships that last far longer than the initial 90-day bundled period. This is critical with the provision of prosthetic and orthotic care, where an intimate professional relationship often forms between the prosthetist/orthotist and the patient. It is critical to maintain patient choice of provider and ensure that bundled payment systems have appropriate network adequacy standards to ensure this choice of provider is meaningful.
- **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. The current BACPAC Act only mentions that the PAC Coordinators have “in effect a written plan of quality assurance and improvement, and procedures implementing such plan, that meet quality standards as the

Secretary may specify.”⁶ We do not believe this language is sufficient to ensure that quality and outcomes are being accurately measured under bundled payment systems and we urge Congress to strengthen this language.

Before PAC bundling is enacted and implemented, measures must be incorporated into the PAC system address the following:

- Function: Bundled payment systems must incorporate and require the use of measures and measurement tools focused on functional outcomes, and include measurement of maintenance and the prevention of deterioration of function, not just improvement of function;
- Quality of Life: Bundled payment systems must 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.). These are the key measures to truly assess the outcomes of individuals with limb loss and other conditions requiring prosthetic and orthotic care;⁷
- 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 an independent entity to conduct studies in this area and factor the results into any final PAC bundled payment system in the future.

⁶ See BACPAC Act of 2015, page 12-13.

⁷ These extended functional assessment and quality of life measures are consistent with the World Health Organization’s International Classification of Function, Disability and Health (ICF) and the measurement tool designed around the WHO-ICF known as the AM-PAC.

The orthotic and prosthetic community understands the magnitude of the problem that our nation faces in attempting to contain federal health care spending. But we do not believe that federal savings should be achieved through what we believe to be untested and underdeveloped post-acute care reforms that do not adequately take into account long-term cost-effectiveness and maximal patient outcomes. Therefore, of greatest importance, we endorse wholeheartedly the inclusion of the exemption to keep orthotic and prosthetic services out of any bundled payment approach, in recognition of both the fact that this patient care involves establishment and patient choice of a lifetime care provider responsible for assisting and maximizing patient mobility, AND in recognition of just how important that mobility is to maintaining vitality, health and productivity of patients who unfortunately must already shoulder the very substantial burdens of limb loss or limb/mobility impairment. Bundling of PAC services should not proceed unless and until significant improvements and safeguards are in place in the BACPAC Act and any other PAC proposal. PAC reforms should be based on reliable data that cuts across all PAC settings (i.e., data from the IMPACT Act) in order to fully inform the design of bundling or any other PAC reform in a manner that does not delay or deny patients the care they need and deserve. Such post-acute care reform should incentivize good outcomes for patients, not just cost savings.

Thank you for the opportunity to submit written testimony on this important issue.