



**WRITTEN TESTIMONY 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
“MEDICARE POST ACUTE CARE DELIVERY AND OPTIONS TO IMPROVE IT”
APRIL 16, 2015**

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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 Coalition to Preserve Rehabilitation (“CPR”) in connection with your hearing entitled, “Medicare Post Acute Care Delivery and Options to Improve It.” We were fortunate to have been invited by the Subcommittee last year to testify during the hearing entitled, “Keeping the Promise: Site of Service Medicare Payment Reforms” on the issue of site-neutral payment of post-acute care (“PAC”) and included significant comments at that time on the Bundling and Coordinating Post-Acute Care Act of 2014 (“BACPAC” Act). Since then, a new version of this legislation has been introduced by Congressman McKinley, H.R. 1458, which we have analyzed and submit this statement for the written record. CPR 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 injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain their maximum level of health and independent function. Members of the CPR Steering Committee include the Center for Medicare Advocacy, the National Multiple Sclerosis Society, the Brain Injury Association of America, United Spinal Association, and the Christopher and Dana Reeve Foundation.

Medicare PAC Payment Reform Requires Serious Deliberation and Reliable Data

All Medicare post-acute care reforms that Congress considers should, first and foremost, preserve access to quality rehabilitation services provided at the appropriate level of intensity, in the right setting, and at the right time to meet the 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 and should be based on reliable data that is comparable from one PAC setting to another. 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. The Improving Medicare Post-Acute Care Transformation (“IMPACT”) Act of 2014, signed by the President into law last October, now serves that data collection purpose. We request 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 changes from the previous legislation by the same name, but the overall bill is the same. The legislation 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). Unlike its predecessor, the BACPAC Act of 2014 ([H.R. 3796](#)), the current Act includes in the bundle outpatient physical therapy services and outpatient occupational therapy services, but retains outpatient speech-language pathology services outside of the bundle. 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.

We favor systems 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 we support existing bipartisan efforts led by Rep. Martha Roby and Rep. Bill Pascrell to refrain from legislating site-neutral PAC payments or take other PAC reform actions until data is collected and analyzed under the authorities enacted in the IMPACT Act. This data can be used to develop a uniform quality assessment instrument to measure outcomes across PAC settings; such a tool would be invaluable to enacting PAC reforms that do not compromise patient care. This 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 HHS Secretary to implement broadly outlined bundling authorities. It is simply too risky to Medicare beneficiaries to implement PAC bundling prematurely. In addition, there are a number of comments we wish to make with respect to the BACPAC Act of 2015.



1. **Use of Medicare Rates for Qualifying PAC Services:** In BACPAC Act of 2015, bundle holders are required to pay Medicare PAC providers Medicare rates¹ rather than negotiated rates for covered PAC services, as permitted in the H.R. 3796. CPR 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, CPR had serious concerns that negotiated rates with PAC providers under the bundle could have led to a race to the bottom in terms of the quality of providers serving beneficiaries under the bundle. 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 to equate to 96% of the average cost of a given episode of treatment, thereby saving the government significant PAC expenditures, CPR 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 more intensive, coordinated, or advanced rehabilitative treatments, then CPR has serious concerns with this outcome.
2. **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 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 the Centers for Medicare and Medicaid Services (CMS) to pilot test a concept known as the Continuing Care Hospital (CCH),² 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 a minimum, insurers and third party administrators should not be eligible to hold the bundle. This would be akin to joining a

¹ 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].

² Inexplicably, CMS has not yet pursued the mandated CCH pilot program.



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. That being said, CPR 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.³

3. **Entities Able to Assume Risk:** Any PAC 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. While financial solvency is mentioned broadly as a requirement of the PAC bundle holder,⁴ financial solvency, transparency, appropriate governance, accountability, and related standards should be more explicitly adopted in the legislation to ensure that PAC bundle holders have the capacity to provide consistent and reliable care, even to outlier patients. Such standards are readily available and well validated through a number of accreditation organizations that specialize in quality improvement and accountability of post-acute care, such as the standards developed by the Commission on Accreditation of Rehabilitation Facilities (CARF) or other appropriate accreditors.
4. **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, as this is the very expertise necessary to develop and implement PAC treatment plans.
5. **Outpatient PT, OT, and SLT Services Should All be Exempt from the Bundle:** Outpatient physical therapy services and outpatient occupational therapy services were previously excluded from the bundle in the BACPAC Act of 2014, but are now included in the BACPAC Act of 2015. However, speech-language pathology services remain exempt from the bundled payment. We question the reason for this change in the new bill. Outpatient PT, OT, and speech-language pathology services are critical to the long term

³ See BACPAC Act of 2015, pages 12-13, regarding quality assurance, PAC coordinator performance, and care coordination.

⁴ See BACPAC Act of 2015, page 10.



outcomes of Medicare beneficiaries in need of rehabilitation following illness or injury. Including any of these services in the bundled payment will serve as a cap in services that will penalize those beneficiaries most in need of rehabilitation. We support the exclusion from the bundle of all outpatient therapy services as originally proposed in the 2014 BACPAC legislation. Medicare beneficiaries needing rehabilitation services must have access to quality therapy services at the appropriate amount, duration and scope to meet patient needs.

6. **All Prosthetics, Orthotics and Custom DME Should Be Exempt from the Bundle:**

CPR supports the exclusion from the bundle of all prosthetic limbs and orthopedic braces, as is the case under the previous and current BACPAC Act. CPR would also support a further exclusion of customized durable medical equipment, particularly mobility devices known as “complex rehabilitative technology” or “CRT”⁵ as well as Speech Generating Devices (SGD’s). CPR believes 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. All customized devices (such as prosthetics, orthotics, CRT and SGDs) 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. These devices and related services are critical to the health and full function of people with limb loss and other disabling conditions. Not all Medicare beneficiaries require prosthetics, orthotics, CRT and/or SGDs, but these devices are critical to the health and function of some patients. 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

⁵ 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.



the SNF bundle or prospective payment system (“PPS”).⁶ 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 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,⁷ thereby permitting these charges to be passed through to Medicare Part B during the SNF stay.⁸ 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 all prosthetics, custom orthotics, CRT and SGDs from any PAC bundling legislation.

7. **Exemption of Certain Vulnerable Patients from First Phase of Bundling:** PAC bundling is a concept that is clearly untested at this time, and we strongly favor fully developed quality measures and risk-adjusted payment systems so that savings are not achieved by stinting on patient care to protect vulnerable Medicare beneficiaries. Among these Medicare patients are people with brain injuries, spinal cord injuries, moderate to severe strokes, multiple-limb trauma, amputations, 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 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.
8. **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.

⁶ Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4432, 111 Stat. 251, 414 –22 (1997) (codified at 42 U.S.C § 1395yy).

⁷ 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)).

⁸ 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.



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 “ha[ve] in effect a written plan of quality assurance and improvement, and procedures implementing such plan, that meet quality standards as the Secretary may specify.”⁹ But the truth is that 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. For instance, before widespread PAC bundling is adopted, measures must be incorporated into the PAC system as follows:

- Function: 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: 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.);¹⁰
- 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

⁹ See BACPAC Act of 2015, page 12-13.

¹⁰ 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.



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.¹¹

9. **Create Financial Disincentives Preventing Clinically Inappropriate Diversion of 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 that payment penalties should be established to dissuade PAC bundle holders from underserving patients.

The disability and rehabilitation community understands the magnitude of the problem that our nation faces in attempting to contain federal health care spending. However, achieving federal savings through what we believe to be short-sighted, underdeveloped, and untested post-acute care reforms that do not adequately take into account long-term cost-effectiveness, maximal patient outcomes, and the future capacity of our rehabilitation system to continue serving our most challenging Medicare beneficiaries, is not the path to success. Therefore, bundling of payment of PAC services should not proceed without significant improvements and safeguards being added to the current BACPAC Act, and without first gathering significant data from the IMPACT Act to fully inform the design of bundling in a manner that does not stint on patient care. 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.

¹¹ “uSPEQ”® (pronounced “You Speak”) is an example of a patient satisfaction assessment tool developed by CARF, International, that measures end users’ experience with post-acute care. The survey can be answered by the patient, family or caregiver.