August 19, 2013

Honorable Max Baucus Chairman Senate Finance Committee	Honorable Orrin G. Hatch Ranking Member Senate Finance Committee
Honorable Dave Camp Chairman House Ways and Means Committee	Honorable Sander M. Levin Ranking Member House Ways and Means Committee

RE: COALITION TO PRESERVE REHABILITATION'S RESPONSE TO REQUEST FOR COMMENTS TO POST ACUTE CARE REFORM STAKEHOLDERS

Dear Committee Chairs and Ranking Members:

Millions of individuals with injuries, illnesses, disabilities and chronic conditions rely on the Medicare program to access the rehabilitation services and devices 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.[1] There are over six million Medicare beneficiaries below the age of 65 who qualify for the program based on this disability status. For these individuals, the Medicare rehabilitation benefit is a lifeline to improved health and functional status, and enhanced quality of life, but all Medicare beneficiaries are at risk of illnesses or injuries that necessitate treatment in a post acute care environment.

Your request for comments from post acute care (PAC) stakeholders dated June 19, 2013, is extraordinarily detailed and comprehensive in nature. We expect the primary PAC provider organizations will submit extensive comments. Rather than addressing each individual question within each section of your letter, the undersigned members of the Coalition to Preserve Rehabilitation offer a series of principles and recommendations that, if followed, would help protect access to critical rehabilitation care in the future.

CPR is a coalition of national consumer, 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 independent function.

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

Overall Position on Medicare Post Acute Care Reform

CPR has serious concerns with efforts to unduly focus Medicare spending reductions in settings in which post acute care is provided, particularly in inpatient rehabilitation hospitals and units (IRH/Us) as well as outpatient therapy services. Overall, Medicare spending growth has been extremely low over the past three years and the Congressional Budget Office has projected this historically low rate of growth as contributing hundreds of billions of dollars to deficit reduction. In fact, Medicare spending has increased only 1.9% annually on average for the past three year period. In addition, Medicare data establish that spending in the inpatient rehabilitation hospital setting has remained relatively flat over the past decade due in part to policy changes made by previous Congresses.

From a macro perspective, we question why Congress would seek deep Medicare spending reductions in post acute care. These settings of care are instrumental in enabling Medicare beneficiaries to reconstruct their lives after an acute illness or injury. These services promote ambulation, restoration of health and function, independent performance of daily activities, return to home and community-based settings, and return to work (if appropriate). One must look no further than the examples set by Senator Mark Kirk, Senator Tim Johnson, Congresswoman Tammy Duckworth, and Congresswoman Gabby Giffords to appreciate the importance and effectiveness of rehabilitation and, more generally, post acute care.

Effective rehabilitation decreases unnecessary dependency costs to the federal government in a variety of related programs. It decreases the need to shift costs onto the states by relying on Medicaid as the payer of last resort for unnecessary long-term nursing home care, and it is the linchpin to reduction of costly and unnecessary hospital readmissions for beneficiaries with a wide range of debilitating conditions.

For these and other reasons, we strongly believe that any changes to the Medicare program should not have the effect of impeding access to rehabilitation and other post acute care services. Congress should avoid proposals that decrease short-term healthcare expenditures by simply shifting costs to beneficiaries, states, and other provider settings. It 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 their individual rehabilitation needs in terms of amount, duration, intensity and scope of rehabilitation services.

Your request for comments from stakeholders states that Medicare's rules do not clearly delineate the types of patients[2] who are appropriate for each setting. While the decision to admit a patient to a particular PAC setting may be debatable for certain patients, there are well established processes and requirements in place for admission of patients to each post acute care setting. Admission requirements are most clearly defined for inpatient rehabilitation hospitals and units. Physicians, in conjunction with other rehabilitation professionals, make these admission decisions every day based on the individual needs of Medicare beneficiaries. The undersigned organizations generally oppose policy proposals

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[2] Choice of terminology is particularly important for purposes of care planning and care coordination when the worlds of health care providers and independent living intersect. The disability community prefers the term "person" to "patient" and the term "services and supports" to "care." The terms "patient" and "care" connote a medical model with a focus on episodes of illness, which is completely appropriate in Medicare post acute care policy, but is not generally used or is appropriate for ongoing services and supports for persons with disabilities well after an acute episode of acute and post acute care has been delivered.

based on treatment norms and financial incentives that artificially supplant the clinical judgment of treating professionals.

The concept of bundled payments in order to achieve reduced health care spending and improved patient outcomes is an unproven policy to date, but a number of pilots and demonstrations authorized under existing Medicare law are beginning to test the bundling concept. These reforms to the Medicare post acute care system ought to be given time to either achieve their promise or demonstrate their shortcomings. New delivery models that focus on persons with multiple chronic conditions are in their infancy and should be give time to demonstrate whether they have value. Some bundling proposals (i.e., the Continuing Care Hospital pilot program) have not even been pursued yet by CMS.

Before Congress legislates additional bundling requirements in the post acute care setting, these and other programs should be given an opportunity to demonstrate whether they can better align financial incentives with coordination of high quality care and prioritize care provided in the home and community while preventing unnecessary institutionalization, readmissions, and promoting person-centered care and decision making.

Principles for Preserving Access While Reforming the Post Acute Care Delivery System

Consumer, disability, rehabilitation, and clinical organizations support reforms to the PAC system provided the reforms follow several fundamental principles. These reforms must put patients first, must maintain access to rehabilitation at the appropriate level of intensity consistent with the beneficiary's needs, and must allow physicians and the rehabilitation team to provide care in the most efficient and effective post acute care provider setting. Specifically, we request that Congress adhere to the following principles as it seeks to enact post acute care reforms:

- Value of Rehabilitation: Congress must recognize that rehabilitation provided in post acute care settings is critical to reducing long term, unnecessary costs in the Medicare system. These services seek to return individuals to high levels of functioning post injury or illness. They decrease the likelihood of readmissions to the acute care hospital and limit the severity of long term disabling conditions that could result in unnecessary placement in long term care institutions, placing significant burdens on government resources. Proposals to divert Medicare's investment in post acute care to offset the cost of other policy changes (e.g., the SGR "fix") or simply to reduce the short-term federal deficit should be carefully considered and scrutinized before being adopted.

- Beneficiaries First: Any changes to Medicare's post acute care systems should focus first on what is best for beneficiaries. Achievement of long-term, good patient outcomes should be the controlling factor in any reform agenda, not short term cost reduction or increased administrative burden on providers of care.

- Clinician Recognition: The skills and services of health care professionals should be appropriately recognized and valued. Physicians, providers and other health professionals should have the discretion to deliver services that are clinically appropriate for the patient based on clinical evidence and professional judgment.

- Impact on Individuals of All Ages: Congress and the U.S. Department of Health and Human Services (HHS) should be aware that changes to the Medicare program impact not only seniors, but over 6 million beneficiaries under the age of 65. In addition, Medicare changes are often adopted by private insurers and State Medicaid programs. As a result, the committees should consider the implications of any changes to the Medicare post acute care system on both the senior and non-elderly population, especially young people in need of rehabilitation post-injury or illness.

- Transparency in Policy Making: All stakeholders, including patients, consumer and disability organizations, physicians, and rehabilitation service providers should be consulted in the development of post acute care reforms as developments occur and consensus emerges. Transparency in policy making in this area is critical to achieving effective reforms.

- Quality of Care Metrics: Reformed PAC systems should include metrics related to quality of care that are granular enough to accurately assess the impact of policy changes on patient outcomes, patient access, and patient choice, as critical components of the system. Quality measures selected for any reformed PAC system should promote positive outcomes and avoidance of adverse events and promote efficient and effective treatment. Quality measures must include analysis of the individual's quality of life, including whether the individual is able to return to his or her home and participate in community based activities.

- Vulnerable Populations: The special needs of vulnerable beneficiaries must be addressed in post acute care reform. We are specifically concerned about the unique needs of persons with disabilities, persons with multiple chronic conditions—which many rehabilitation patients have—and patients who have the potential to resume prior functions and activities if they receive appropriate rehabilitation care. Diverting these individuals to SNFs (or worse, nursing homes) when more intensive inpatient rehabilitation care is warranted, must be avoided. In fact, all nursing facility/SNF admissions and all continued stays should include assessments for appropriate and individualized services and supports so that vulnerable beneficiaries are not underserved and unnecessarily institutionalized.

- Education and Transition: Significant changes to the post acute care system will require extensive provider, professional, and beneficiary outreach and education. As a result, implementation of any new payment or delivery system should include a sufficient transition period and resources for such education.

- Arbitrary Limits: Changes to payment systems should reflect the true cost of care and resources utilized based on the patient's conditions. Systems that rely on a fixed number of visits or other arbitrary limits disproportionally penalize patients with complex conditions and disabilities such as spinal cord injuries, brain injuries, and some neurological conditions that require extended and/or intensive rehabilitation. Reformed delivery and payment systems must account for and accommodate beneficiaries who are outliers and who require greater than average health care services.

- Tests Before Full Implementation: In considering possible reforms to Medicare post acute care, we encourage the use of pilots or demonstrations prior to full implementation, and specifically encourage implementation of the Continuing Care Hospital pilot program mandated in the Affordable Care Act. Lessons learned from this pilot, as well as the

experience of Medicare SNP's (Special Needs Plans) and the PACE (Program of All Inclusive Care for the Elderly) program should be incorporated into future reform plans.

These principles will help to ensure that Medicare beneficiaries have access to high quality rehabilitation care in a variety of settings and intensities that meet their individual medical and rehabilitation care needs for years to come. The most effective cost reduction strategy for post acute care is the achievement of long-term positive patient outcomes including maximized health and function, independent living, participation in community activities and, where appropriate, return to work.

CPR Response to Specific Inpatient Rehabilitation Policy Proposals Under Consideration

With respect to some of the post acute care proposals currently being considered by the committees with Medicare jurisdiction, the Coalition to Preserve Rehabilitation has stated its concerns with respect to a variety of proposals that would severely restrict access to inpatient rehabilitation hospital and unit services for Medicare beneficiaries with injuries, illnesses, disabilities and chronic conditions. We reiterate those concerns below and ask you to not include in your legislation the following proposals.

- **Deep Cuts to Future Investments in Inpatient Rehabilitation Hospitals and Units**
  The magnitude of aggregate reductions in annual inflation updates to IRH/U care included in the President's most recent budget proposal is completely disproportional to Medicare spending increases in this setting of care. According to Medicare data, Medicare spending for IRH/Us has been relatively flat for the past ten years, in stark contrast to many other areas of both acute and post acute care spending under the program. In fact, Medicare spending on inpatient rehabilitation services accounts for only 1.2% of total Medicare spending[3] and only 11.4% of Medicare spending on post acute care services.[4] Large spending reductions in post acute care will deal a serious blow to the capacity of IRH/Us—and all post acute settings—to accommodate the needs of an aging population with disabling conditions. Inpatient hospital rehabilitation is cost-effective by maximizing the functional capacity of individuals who receive such services. The ability to leave the hospital and live as independently as possible in the home and community-based setting, as opposed to spending long periods of time in institution-based care or being readmitted to the acute care hospital, will avert the need for enormous unnecessary spending for these beneficiaries in future years.

- **Increasing the 60% Rule for Inpatient Rehabilitation Hospitals and Units**
  We oppose raising the 60% rule, which was established by Congress in 2007, up to a 75% compliance threshold, a percentage that would clearly restrict access to IRH/U services. This is an issue that was debated for several years and Congress resolved. Congress settled this debate in the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA") with the implementation of a reasonable rule that has permitted appropriate access to inpatient

[3] CMS National Health Expenditures by Type of Service and Source of Funds, CY 1960-2011, https://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage; and MedPAC March 2013 Report to Congress (Table 1).
[4] AMRPA calculation based on MedPAC March 2013 Report to Congress, MedPAC January 2013 Meeting Presentation on Home Health, and MedPAC December 2012 Meeting Presentation on Skilled Nursing Facilities.

hospital rehabilitation in the years that have followed. The data clearly establish that the 60% Rule is working in its current form. Inpatient rehabilitation has not experienced nearly the same increases in Medicare spending that other settings of post acute care have over the past several years. Raising the rule from a 60% to a 75% compliance threshold would simply take clinical decision-making out of the hands of physicians and the rehabilitation team and place those decisions in the hands of hospital administrators and, ultimately, government officials. We strongly urge you to preserve the 60% rule so as to not erect arbitrary barriers to intensive, hospital-based rehabilitative care.

- **Site-Neutral Payment Proposal**
  This proposal would reduce significantly access to inpatient hospital rehabilitation for patients with particular conditions. These conditions, depending on the severity of the patient, are treated in both IRH/Us as well as Skilled Nursing Facilities (SNFs). The fallacy behind this proposal is that similar patients achieve equal outcomes when treated in either setting and that it costs more for Medicare to treat these patients in IRH/Us. But even the study that the Medicare Payment Advisory Commission (MedPAC) cites for this proposition states that its "results are preliminary, and additional work is needed to define clinically meaningful differences in self-care and mobility functional status." (See, Research Triangle Institute Study, Vol. 4, Sec. 8, page 58.) Implementation of site-neutral payment for patients with hip fractures, joint replacements and other conditions would simply eliminate access to intensive rehabilitation programs by erecting a financial disincentive for admission of these individuals in IRH/Us. In addition, because SNFs are reimbursed on a per diem payment system and lengths of stay appear to be significantly greater than in IRH/Us for these patients, there is a real question as to the cost-effectiveness of treating these patients in SNFs, particularly when patient outcomes are examined. This appears to be another proposal to drive patients to less intensive, less appropriate rehabilitation settings, rather than the setting that best meets their rehabilitation needs. For these reasons, we request that your committees not include this proposal in any final Medicare legislation.

- **Outpatient Therapy Services**
  Although outpatient rehabilitation therapy is not one of the identified post acute care settings in your June 19th letter to stakeholder, the interplay between inpatient and outpatient rehabilitation is critical to positive patient outcomes. The Coalition to Preserve Rehabilitation must express our dismay with CMS's implementation of medical manual review under exceptions process to the Medicare outpatient therapy caps. Although consumer and disability organizations have long opposed these arbitrary caps in therapy benefits, CMS's current use of Recovery Audit Contractors (RACs) to review claims in excess of $3700 per person is highly objectionable. The use of RACs to assess whether therapy services for these beneficiaries are reasonable and necessary creates a presumption of fraud, abuse and overutilization, and creates a chilling effect on access to services above this $3700 cap.

  This cap serves to deny care to the very individuals who need it most, approximately 5% of those requiring outpatient therapy services. This policy has a disproportionate impact on people with disabilities and chronic conditions who utilize therapy services to improve, maintain and prevent deterioration of their function and health status. We ask you to (1) prevent CMS from utilizing RACs to administer the outpatient therapy benefit, (2) extend

the exceptions process for the therapy caps beyond December 2013, (3) streamline the exceptions process for those with documented disabilities and chronic conditions, and (4) consider redesigning the physical therapy, occupational therapy and speech-language pathology benefits to focus on functional outcomes rather than arbitrary caps on the benefit.

Beneficiary Protections

Given the magnitude of the impact of the reforms being contemplated for Medicare post acute care, we cannot think of a more important section of your letter on which to submit comments. Virtually all reform proposals should first be measured by the impact they are expected to have on beneficiaries. As already stated, the undersigned organizations generally oppose policy proposals based on treatment norms and financial incentives that artificially supplant the clinical judgment of treating professionals.

In terms of measuring the impact of various reforms—especially bundling proposals—on beneficiaries, existing measurement tools should be used and additional measurement tools should be developed where existing measures are not granular enough to assess changes in quality, outcomes, access, choice and other factors. Where Congress decides to move forward with reforms, it must include strong protections for beneficiaries to ensure they receive quality care at sufficient amount, duration, scope and intensity to meet their individual needs.

Congress should insist that CMS employ measurement tools to ensure that reform proposals do not achieve short term savings by shifting costs to beneficiaries, other providers, and other payers. CMS should also insist that appropriate measures are used with sufficient sensitivity to assess whether short term savings are (or are not) being achieved by stinting on care or inappropriately diverting patients to less intensive levels of care.

In addition to sufficiently sensitive measures, participation by patients in any reform initiative should be strictly voluntary, especially where new delivery or payment models are capitated or bundled. The beneficiary should have the right to opt out of these arrangements and this right should be completely transparent to the beneficiary, or his or her guardian or family members. If the beneficiary chooses to participate in a new delivery model, he or she should retain the right to choose providers within the network, assuming the patient qualifies for the level of care in which he or she desires to obtain treatment. The relationships of all participating providers must be transparent to patients and beneficiaries must retain all Medicare appeal rights they currently have regarding discharge from acute care hospitals, post-acute care placements, and other issues.

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The disability and chronic illness community understand the magnitude of the problem that our nation faces in attempting to contain federal health care spending and finally fix the Medicare physician fee schedule. However, achieving significant federal savings on the backs of people with disabilities and some of our most vulnerable Medicare beneficiaries is not the path to success.

We look forward to working with you to strengthen the Medicare program while preserving access to rehabilitation services for all Medicare beneficiaries. For more information, please contact any member of the CPR Steering Committee listed below.

Thank you for considering our views.

Sincerely,

CPR Steering Committee (with contact information)

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CPR and Other Supporting Organizations

ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association on Health and Disability
American Association of People with Disabilities
American College of Rheumatology
American Congress of Rehabilitation Medicine
American Therapeutic Recreation Association
American Medical Rehabilitation Providers Association
American Music Therapy Association
Amputee Coalition
Association of Academic Physiatrists
Association of Assistive Technology Act Programs
Association of Rehabilitation Nurses
Brain Injury Association of America
Christopher and Dana Reeve Foundation
Disability Rights Education & Defense Fund
Easter Seals
National Association for the Advancement of Orthotics and Prosthetics
National Association of Head Injury Administrators
National Multiple Sclerosis Society
National Stroke Association
Paralyzed Veterans of America
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United Spinal Association