



**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
“SETTING FISCAL PRIORITIES”
DECEMBER 9, 2014**

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Chairman Pitts, Ranking Member Pallone, 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, “Setting Fiscal Priorities.” The CPR Coalition will confine its testimony to Medicare site-neutral payment proposals involving post-acute care (PAC) services. 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.

Rehabilitation and the Medicare Beneficiary

The provision of post-acute care and rehabilitation services is a critical mission of the Medicare program and many post-acute care settings assist beneficiaries in regaining skills, functions and living as independently as possible. Long term acute care hospitals (LTACHs), 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. 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.

CPR has significant concerns with proposals that treat IRFs and SNFs as though they serve the same population, offer the same level of rehabilitation services, and produce the same outcomes. They do not. MedPAC is currently debating whether to adopt a site-neutral payment proposal between IRFs and SNFs for Medicare patients with certain orthopedic impairments and 17 other undisclosed conditions. We believe that such site-neutral payments raise alarming concerns for Medicare



beneficiaries that could have long-term implications on their ability to access the appropriate level of rehabilitative care in the right setting and at the right time post-injury or illness.

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 affects 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 fails to protect against stinting on patient care and diverting beneficiaries into the least costly setting. Because of these concerns, we strongly urge Congress not to adopt site-neutral payments between IRFs and SNFs prematurely.

Payment Reform Requires Serious Deliberation

All Medicare post-acute care reforms based on site-neutrality 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. 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 IMPACT Act, signed by the President into law this 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, blunt approach to site-neutral payment.



Site-Neutral Payment Creates Financial Disincentives for IRFs to Accept Certain Patients

CPR opposes the site-neutral IRF-SNF proposal to equalize payments for certain unspecified conditions as it is little more than an outright financial disincentive for inpatient rehabilitation hospitals and units to accept certain Medicare patients. These patients include those unfortunate enough to have primary diagnoses including hip fracture, joint replacement, and 17 other conditions that MedPAC has not disclosed to date. This proposal would use Medicare payment policy to essentially bar the door to the rehabilitation hospital based solely on patients' diagnoses, not based on their individual medical and functional needs.

Instituting site-neutral payments between IRFs and SNFs in the manner MedPAC is contemplating will likely create a strong financial disincentive for IRFs to admit certain patients. This financial disincentive will be tied entirely to the primary diagnosis assigned to the patient, without any consideration for the individual's care needs or other comorbid conditions. Such a financial disincentive may well drive IRFs to avoid admitting such patients, depriving these beneficiaries of access to the IRF level of coordinated, intensive rehabilitative care. Conversely, site-neutral payments would benefit SNFs financially.

Site-Neutral Payment Based on Diagnosis May Violate CMS Regulations and Federal Case Law

A site-neutral payment system based on diagnosis would essentially ignore the established, comprehensive, regulatory framework that was developed to determine whether a patient is eligible for care in an IRF. This set of Medicare regulations and manual instructions places a premium on an individual assessment of each patient's rehabilitative and medical needs, physician judgment, and extensive documentation to demonstrate coverage and medical necessity.

This dynamic could easily be described as the use of an impermissible "rule of thumb" for determining coverage. Medicare coverage for inpatient hospital rehabilitation must be determined on



an individual basis.¹ The Medicare program has been very clear that “rules of thumb” are not permissible bases upon which to make a determination of medical necessity and coverage of care.² In fact, the Secretary of Health and Human Services explicitly agreed that “denials of admissions, services, and/or Medicare coverage based upon numerical utilization screens, diagnostic screens, *diagnosis*, specific treatment norms, the ‘three hour rule,’ or other ‘rules of thumb’ are not appropriate.”³

Instead, medical review determinations are to be “based on reviews of individual medical records by qualified clinicians, not on the basis of diagnosis alone.”⁴ The denial of care for patients with the effected condition codes will not be carried out by Medicare contractors, but if the Medicare program makes it financially infeasible for IRFs to admit such patients, the impact will be the same. Patients may be denied care to which they are otherwise entitled based on regulatory coverage criteria that focus on a single factor: diagnosis.

SNFs and IRFs are Not Equivalent

We are extremely concerned that MedPAC seems to view rehabilitation provided in SNF and IRF settings as equivalent. Proponents of site-neutral payments assert they are appropriate because these two settings of care allegedly treat similar patients and achieve equal outcomes regardless of setting. To the contrary, the expertise, staffing, equipment and medical care in SNFs and IRFs are drastically different and we cannot understand how MedPAC does not recognize this fact. The level of medical and therapeutic care available in IRFs is far more intense, complex, and multi-disciplinary.

Furthermore, IRFs are required to provide patients with close medical supervision by a physician with specialized training in rehabilitation, a multidisciplinary, coordinated approach to

¹ Medicare Benefit Policy Manual, CMS. Pub. 100-2, ch. 1, § 110.

² *Hooper v. Sullivan*, 1989 WL 107497 (D. Conn.).

³ *Id.* (emphasis added).

⁴ 73 Fed. Reg. 46,370, 46,388 (August 8, 2008).



rehabilitation that includes 24-hour rehabilitation nursing, an intensive therapy program—widely regarded as three or more hours of skilled therapy per day—and licensure and accreditation for hospital level rehabilitation care. SNFs, on the other hand, do not require any of these staffing levels or care coordination.⁵ To treat both of these settings as essentially the same will endanger some of the most physically and medically vulnerable Medicare beneficiaries.

Cost-Effectiveness of Rehabilitation in Various Settings

Proponents of site-neutral payments argue that it costs more for Medicare to treat similar patients in IRFs than in SNFs. In fact, because SNFs are reimbursed on a per diem payment system and lengths of stay appear to be significantly greater than in IRFs for these patients, there is a real question as to the cost-effectiveness of treating these patients in SNFs. In addition, MedPAC is not measuring the cost-effectiveness of timely, coordinated and intensive inpatient hospital rehabilitation over the long term, including the impact that a lack of these services may have on Medicaid expenditures on long-term nursing home stays.

From a health care sector perspective, MedPAC's June 2014 Databook illustrates that from 2001 to 2011, home health care and SNF expenditures have contributed more to Medicare post-acute care spending than IRF spending. In 2012, Medicare post-acute care expenditures totaled only \$6.7 billion for IRFs, as compared to \$18.3 billion for home health agencies and \$28.4 billion for SNFs.⁶ MedPAC's site-neutral payment proposal appears to be another attempt to drive patients to less intensive, less appropriate rehabilitation settings, rather than the setting that best meets their rehabilitation needs.

⁵ See American Medical Rehabilitation Providers Association, <https://www.amrpa.org/newsroom/AMRPA-infographic.png>.

⁶ See Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program*, June 2014, <http://www.medpac.gov/documents/publications/jun14databookentirereport.pdf?sfvrsn=1>, page 112.



Outcomes Between IRFs and SNFs Differ Dramatically

According to a July 2014 report by Dobson | DaVanzo, 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 also 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.⁷

Recent Reports Highlight Quality Concerns in SNFs and Nursing Homes

The coalition's concerns are heightened by the steady flow of reports highlighting lapses and deficiencies in the quality of SNF and nursing home services. An HHS Office of Inspector General (OIG) report from February 2014 found that approximately 22 percent of Medicare beneficiaries faced adverse events, and another 11 percent faced temporary harm events while receiving treatment in SNFs within, on average, 15.5 days following their admission to the SNF. The report stated that 59 percent of these adverse and temporary harm events were either clearly or likely preventable. Inadequate nurse staffing was the cause of many of these adverse and temporary harm events. Over half of the

⁷See Dobson Davanzo, *Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge*, July 2014, <https://www.amrpa.org/newsroom/Dobson%20DaVanzo%20Final%20Report%20-%20Patient%20Outcomes%20of%20IRF%20v%20%20SNF%20-%207%2010%2014%20redated.pdf>. See also study highlights for amputation, traumatic brain injury, stroke, and other patients at American Medical Rehabilitation Providers Association at http://www.amrpa.org/Public/Study_Rehab_Hospitals_Yield_Better_Outcomes.aspx.



beneficiaries that had experienced harm were re-admitted to the hospital, costing Medicare an estimated \$208 million in August 2011, and equating to \$2.8 billion in FY 2011.⁸

Recent reports raise serious questions about quality and quality reporting in nursing homes. A six-part report by a local Michigan television station in November 2014 highlighted how mistakes in nursing homes caused or contributed to 112 deaths in the state in the past three years.⁹ A recent report by the Sacramento Bee in November 2014 found that nine out of ten of California's largest nursing home chains had staffing measures—such as turnover rates—that were below state averages in 2012, when most recent data was available.¹⁰

The integrity of the very method by which nursing homes report quality data is questioned by many. In October 2014, citing its earlier August 2014 publication, the *New York Times* reported that the rating system for nursing homes “relied so heavily on unverified and incomplete information that even homes with a documented history of quality problems were earning top ratings.”¹¹ Key data does not factor into the rating system, including the percentage of residents given antipsychotic drugs, the percentage of residents discharged to the home and community, and the percentage of residents readmitted to a hospital.¹² An April 2014 report by the Center for Medicare Advocacy found that the

⁸ See HHS Office of the Inspector General, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, February 2014, <http://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf>.

⁹ See Woodtv.com, *Deadly Mistakes: Inside Michigan Nursing Homes*, available at <http://woodtv.com/2014/11/10/deadly-mistakes-inside-michigan-nursing-homes/>; *Allergies Ignored; Woman Dies after Banana Dessert*,” at <http://woodtv.com/2014/11/11/allergies-ignored-woman-dies-after-banana-dessert/>; *Family Left in Dark after Nursing Home Death*, available at <http://woodtv.com/2014/11/11/family-left-in-dark-after-nursing-home-death/>; *Died in Vain; No Dignity for Alfie*,” available at <http://woodtv.com/2014/11/11/died-in-vain-no-dignity-for-alfie/>; *Nursing Home Solutions: Fines? Staffing? Culture?*, available at <http://woodtv.com/2014/11/11/nursing-home-solutions-fines-staffing-culture/>; and *Nursing Home Deaths: What Price for a Life?*, available at <http://woodtv.com/2014/11/11/nursing-home-deaths-what-price-for-a-life/>.

¹⁰ See The Sacramento Bee, *Nursing Homes Cloak Ownership for Good Reason*, November 2014, <http://www.sacbee.com/opinion/editorials/article3792498.html>, and *Unmasked: How California's Largest Nursing Home Chains Perform*, November 2014, <http://media.sacbee.com/static/sinclair/Nursing1c/index.html>.

¹¹ See The New York Times, *Medicare Revises Nursing Home Rating System*, October 2014, http://www.nytimes.com/2014/10/07/business/medicare-alters-its-nursing-home-rating-system.html?_r=0. See also The New York Times, *Medicare Star Ratings Allow Nursing Homes to Game the System*, August 2014, <http://www.nytimes.com/2014/08/25/business/medicare-star-ratings-allow-nursing-homes-to-game-the-system.html>.

¹² See The New York Times, *Medicare Revises Nursing Home Rating System*.



“star rating” system “likely reflect[s] facilities’ self-reported and unaudited [assertions] that staffing and quality measures have improved,”¹³ rather than definitely showing improved quality of care.

Finally, in November 2014, the Center for Public Integrity stated that nursing facilities report more nursing staff on Nursing Home Compare than indicated in the facilities’ Medicare cost reports.¹⁴

CPR is not making the case that all SNFs and nursing homes can be painted with the same brush, but these reports heighten our concerns with policies that potentially place vulnerable patients at risk by driving them into settings of post-acute care that may not be able to truly meet their individual needs.

Relaxing IRF Regulations in Conjunction with Site-neutral Payment will Dilute IRF Setting

In MedPAC’s November public meeting, echoing Chapter 6 of its June 2014 Report, MedPAC agreed to recommend that IRF regulations be relaxed when implementing site-neutral payments. In the words of the June 2014 Report, this would be accomplished “to level the playing field between IRFs and SNFs.”¹⁵ CPR understands how this proposal may appear reasonable and equitable to providers involved, particularly IRFs, but we believe that, ultimately, this will dilute the IRF setting. It will also blur the lines between IRFs and SNFs, and thus, undercut the crucial role of IRFs for the treatment of individuals with some of the most challenging injuries, illnesses, disabilities and chronic conditions. We do not believe that the site-neutral proposals being discussed today will be confined to

¹³ See Center for Medicare Advocacy, *The Myth of Improved Quality in Nursing Home Care: Setting the Record Straight Again*, April 2014, <http://www.medicareadvocacy.org/the-myth-of-improved-quality-in-nursing-home-care-setting-the-record-straight-again/>.

¹⁴ See The Center for Public Integrity, *Analysis Shows Widespread Discrepancies in Staffing Levels Reported by Nursing Homes*, November 2014, <http://www.publicintegrity.org/2014/11/12/16246/analysis-shows-widespread-discrepancies-staffing-levels-reported-nursing-homes>.

¹⁵ See Medicare Payment Advisory Commission, *Chapter 6: Site-neutral Payments for Select Conditions Treated in Inpatient Rehabilitation Facilities and Skilled Nursing Facilities*, June 2014, [http://www.medpac.gov/documents/reports/chapter-6-site-neutral-payments-for-select-conditions-treated-in-inpatient-rehabilitation-facilities-and-skilled-nursing-facilities-\(june-2014-report\).pdf?sfvrsn=2](http://www.medpac.gov/documents/reports/chapter-6-site-neutral-payments-for-select-conditions-treated-in-inpatient-rehabilitation-facilities-and-skilled-nursing-facilities-(june-2014-report).pdf?sfvrsn=2), pages 95 and 98.



those same conditions tomorrow. We fear that site-neutral payments will cause Medicare patients to lose access to intensive, coordinated hospital rehabilitation in years to come.

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 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, is not the path to success.

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

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Endorsing Organizations

ACCSES
American Association on Health and Disability
American Music Therapy Association
American Therapeutic Recreation Association
Amputee Coalition
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Brain Injury Association of America
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Disability Rights Education and Defense Fund
National Association for the Advancement of Orthotics & Prosthetics
National Association of State Head Injury Administrators
National Multiple Sclerosis Society
Paralyzed Veterans of America
United Spinal Association