



PROTECT REHABILITATION SERVICES CRITICAL TO MEDICARE BENEFICIARIES WITH INJURIES, ILLNESSES, DISABILITIES AND CHRONIC CONDITIONS

WRITTEN TESTIMONY ON PROPOSALS TO REFORM MEDICARE POST-ACUTE CARE BEFORE THE HOUSE WAYS AND MEANS HEALTH SUBCOMMITTEE JUNE 28, 2013

Thousands of individuals with disabilities and chronic conditions utilize Medicare to access the rehabilitation services they need to remain healthy, functional, 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 about 21.4 million individuals, had at least two chronic conditions in 2010.¹ To these individuals and others with injuries and illnesses, Medicare is a lifeline to a better quality of life through improved health and functional status.

In connection with the June 14 hearing to examine the President's and other bipartisan Medicare proposals related to post-acute care, the House Ways and Means Health Subcommittee is considering numerous changes to the Medicare program that impact people requiring varying levels of rehabilitative care in inpatient and, potentially, in outpatient settings. We hope the Subcommittee is sensitive to the importance of preserving access to high quality rehabilitation care under the Medicare program. Senator Kirk, Senator Johnson, and former Congresswoman Gabby Giffords offer compelling examples of how comprehensive rehabilitation leads to a return to health, function, and independent living.

As representatives of people with disabilities and chronic conditions and providers who serve them, the undersigned organizations of the Coalition to Preserve Rehabilitation recognize the importance of Medicare reforms that prolong and strengthen the long term viability of the program. However, we have 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 in deficit reduction. In addition, Medicare data establish that spending

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>

in the IRH/Us setting has remained relatively flat over the past decade due in part to policy changes made by previous Congresses.

As members of the Coalition to Preserve Rehabilitation (CPR), 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, decreasing benefits, or erecting 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.

A number of pilots and demonstrations authorized under existing Medicare law are already reforming the Medicare post-acute care system and these reforms ought to be given time to achieve their promise. New delivery models that focus on persons with multiple chronic conditions are in their infancy and should be given time to demonstrate their value. Bundling proposals are being pursued that have not yet had the opportunity to produce meaningful results and CMS has not even implemented some existing programmatic requirements to date (i.e., the Continuing Care Hospital pilot program). These and other programs should 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.

Inpatient Rehabilitation Hospital Proposals

With respect to some of the post-acute care proposals currently being considered by the Committee, the Coalition to Preserve Rehabilitation opposes policies that would severely restrict access to IRH/U services for Medicare beneficiaries with injuries, illnesses, disabilities and chronic conditions.

As this Subcommittee considers Medicare proposals that reduce spending to offset the cost of a fix to the physician fee schedule or otherwise reduce the overall deficit, we ask you to NOT include in your legislation the following proposals.

1. 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 expenditures in this setting of care. According to the data, Medicare expenditures for IRH/Us has been relatively flat for the past several 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 makes up only 1.2% of total Medicare spending² and only 11.4% of Medicare spending on post-acute care services.³ During the hearing, Jon Blum was specifically asked about appropriate margins and he stated that anytime margins were in the double digits the Agency felt this was problematic. Given that this double digit threshold has not been exceeded it would be inappropriate to impose

² 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).

³ 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.

market basket reductions. 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.

2. **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 has been debated for several years and that Congress has 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 been demonstrated to permit appropriate access to inpatient hospital rehabilitation in the years that have followed. The data clearly establishes that the 60% Rule is working in its current form. Inpatient rehabilitation has not experienced nearly the same increases in Medicare expenditures that other settings of post-acute care have over the past several years. Raising the rule from 60% to 75% would simply take clinical decision-making out of the hands of physicians and the rehabilitation team and place those decisions into the hands of bureaucrats. We strongly urge you to preserve the 60% rule so as to not erect arbitrary barriers to intensive, hospital-based rehabilitative care.

3. **Site-Neutral Payment Proposals**

This proposal would reduce significantly access to inpatient 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. 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. This appears to be just another proposal to drive patients to less intensive, less appropriate rehabilitation settings, rather than the setting that best meets their rehabilitation needs.

Outpatient Therapy Services

The Coalition to Preserve Rehabilitation cannot pass up the opportunity in the context of this hearing to express our dismay with CMS’s implementation of the exceptions process medical manual review 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 the Subcommittee 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.

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

We look forward to working with you to preserve the Medicare program while preserving access to rehabilitation services for all Medicare beneficiaries. Thank you for the opportunity to submit this testimony for the written record. For more information, please contact Peter Thomas at peter.thomas@ppsv.com or (202) 872-6730.

Sincerely,

American Academy of Physical Medicine and Rehabilitation
American Congress of Rehabilitation Medicine
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Brain Injury Association of America
Center for Medicare Advocacy
Christopher & Dana Reeve Foundation
Easter Seals
National Association of State Head Injury Administrators
National Association for the Advancement of Orthotics and Prosthetics
National Disability Rights Network
Paralyzed Veterans of America
The Arc of the United States
United Spinal Association