



**CONSORTIUM FOR CITIZENS  
WITH DISABILITIES**

May 15, 2009

The Honorable Max Baucus  
Chairman  
Committee on Finance  
United States Senate  
Washington, D.C. 20510

The Honorable Charles E. Grassley  
Ranking Member  
Committee on Finance  
United States Senate  
Washington, D.C. 20510

**RE: Disability Community Response to Delivery System Recommendations**

Dear Chairman Baucus and Ranking Member Grassley:

The Consortium for Citizens with Disabilities (CCD) Health Task Force is pleased to submit written comments on the Senate Finance Committee's set of recommendations regarding health care delivery system reform contained in the document, "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs" (April 29, 2009). CCD would like to be a constructive force in the health care reform debate. We greatly appreciate your efforts in moving this critical issue forward and would like to highlight our support for the recommendations on coordination of chronic conditions, and express our concerns with respect to Medicare post-acute care bundling.

CCD believes that the goal of health care reform should be to assure that all Americans, including people with disabilities and chronic conditions, have access to high quality, comprehensive, affordable health care that meets their individual needs and enables them to be healthy, functional, live as independently as possible, and participate in the community. The CCD is a coalition of national consumer, service provider, and professional organizations which advocate on behalf of persons with disabilities and chronic conditions and their families.

Persons with disabilities and chronic illnesses often have health care needs of greater amount, duration and scope than the rest of the population. Many people have multiple conditions, contributing to endless variation in the complexity and severity of individuals in need of health and long term services and supports. Health care for people with disabilities and chronic conditions includes a range of services and devices that include, as well as follow, acute care medicine. Such services are often long term and ongoing in nature and seek to maximize health

status, full function and participation in society, employment, independent living, and the pursuit of fulfilling and meaningful lives.

## 1. Coordination of Chronic Conditions

There are several provisions in the delivery system reform recommendations that CCD supports and believes will lead to better coordination, improved quality of care, and ultimately, reduced costs in treating Medicare beneficiaries with chronic conditions and disabilities. While the various approaches offered in the set of recommendations may become complex or confusing if implemented simultaneously, we generally support the recommendations to:

- Allow qualified groups of Medicare providers, such as Accountable Care Organizations, who meet quality thresholds to share in the cost-savings they achieve for Medicare.
- Establish at CMS a center to test and disseminate payment innovations for coordinating the care of chronically ill Medicare beneficiaries.
- Create a new benefit to reimburse for certain care management activities performed by non-physician professionals (such as nurse practitioners) hired or contracted by physicians.

Recommendation: Each of these provisions could significantly enhance the treatment and rehabilitation of people with disabilities and chronic conditions covered by Medicare. We encourage the Committee to ensure that these initiatives are not implemented at cross-purposes and move forward with these recommendations in this legislation.

## 2. Bundling of Post-Acute Care

CCD strongly supports national health care reform and understands that changes to entitlement programs and other reforms may be necessary to offset the cost of such a significant improvement in health care access. However, CCD has serious concerns with proposals referred to as “post-acute care (“PAC”) bundling” and urges great restraint by Congress and the Obama Administration as these proposals are considered in the future. PAC bundling would restructure the current Medicare payment system to consolidate payments for acute care hospitalization with payments to cover a 30-day period of post-acute care.

Under the proposal, this consolidated payment for each patient would be managed by the acute care hospital (although the recent Senate Finance Committee’s set of delivery system reform recommendations suggests that other entities may be the recipient of the lump sum payment). Proponents of this proposal argue that such a system would “align incentives” of health care providers and create more efficient care, but CCD believes that this system would also create strong financial disincentives to provide intensive rehabilitation in the most appropriate setting and, as a result, lead to Medicare beneficiaries being underserved. This underservice could very well result in unforeseen and unnecessary costs to Medicare and other government programs as a result of poor outcomes for patients.

Recommendation: CCD urges Congress to exercise great restraint in considering proposals to bundle post-acute care services and assign the acute care hospital as the care coordinator. If Congress PAC bundling does move forward, we urge Congress to:

- require the Centers for Medicare and Medicaid Services (CMS) to conduct rigorous demonstration projects to test PAC bundling to ensure that beneficiaries are not underserved;
- limit PAC bundling to certain acute care diagnoses that do not require extensive or complex post-acute rehabilitative care for the patient population at issue; and
- require strong consumer protections and validated measurement tools to ensure that beneficiaries with disabilities and chronic illnesses receive the intensity of rehabilitation and other PAC services they need to maximize their functional status, return to the community setting after illness or injury, and live as independently as possible;
- exempt from the bundled payment specialty, low prevalence, highly customized or relatively expensive items and treatments (e.g., limb prosthetics, custom orthotics, complex rehab mobility devices) so that hospitals do not simply delay these treatments until the 30-day post-acute care time period lapses.

The bundled PAC payment system proposed in the FY 2010 federal budget and in the Senate Finance Committee’s delivery system reform proposals involves a single payment to cover—what amounts to—the average cost to Medicare of PAC services provided in inpatient rehabilitation facilities, long-term care hospitals, skilled nursing facilities, home health care agencies, and hospital outpatient services for treatment of the same condition. Because the payment for each patient is proposed to be an average of five very different levels of intensity of care, there will be a distinct financial disincentive for the acute care hospital to refer patients to higher intensity (and, therefore, higher cost) settings of post-acute care. In this instance, the quality of care may be severely compromised, improvements in functional status during the post-acute care stay will presumably decrease, and Medicare beneficiaries will be generally less equipped to return to their homes after an illness or injury and return to their lives pre-injury or illness. This, in turn, could lead to significant costs to the government and exact an unnecessary human toll.

Such a system will also create a strong incentive a hospital to bring all settings of post-acute care under its own roof, consolidate its referral sources, and contract with the post-acute care providers that will provide the least cost to the hospital. Proponents may view this as increased “efficiency” while others see a race to the bottom in terms of quality. It is likely that hospitals will be reluctant to refer complex patients such as brain injuries, spinal cord injuries, and multiple trauma patients outside of the control of the hospital network, even though well-developed and evidence-based specialty programs unaffiliated with the hospital may be in the best interests of patients. In short, bundling will signal a return to the days of the acute medical model being used to treat people with disabilities and chronic illnesses, where hospitals were the locus of care. The CCD questions whether acute care hospitals have the expertise and interest in truly providing services other than what they do best, provide emergency and acute care medicine.

The assumption of the proposal's proponents is that the acute care hospital receiving the payment will establish a mechanism to channel cases to the appropriate PAC provider to meet the complexities of the case, thus removing that determination from the patient, patient's family, and the attending physician and other health professionals advising the patient at discharge. This elimination of physician and clinical judgment, coupled with the lack of patient choice, is a serious change in the motivation of the decision-makers as to the course of post-acute care received by the beneficiary in need of these services.

Finally, bundling will place great pressure on hospitals to omit or delay certain types of treatments that are routinely provided in the current post-acute care settings, including specialty devices such as prosthetic limbs, custom fabricated orthoses, custom rehab mobility devices and other examples. There are a number of experiences with bundled payments from which lessons can be derived, including capitated HMO payments. The transition to capitated HMOs sparked the patient rights debate of 1990's. Another example is the transition to the Skilled Nursing Facility Prospective Payment System in the late 1990's. Under this bundled payment system, access to prosthetic limbs and custom orthoses was virtually eliminated when the SNF PPS went into effect, prompting Congress to subsequently exempt the vast bulk of prosthetic device codes from that payment system. Once these prosthetic device codes were exempt from the bundled SNF rate, utilization of prosthetic limbs in the SNF setting returned to an appropriate level.

Thank you for your consideration of our views on these important issues.

Sincerely,

A handwritten signature in black ink that reads "Peter W. Thomas". The signature is written in a cursive style with a large initial "P" and "T".

Peter W. Thomas, CCD Health Task Force Co-Chair on behalf of the CCD Health Task Force

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