



PROTECT MEDICARE SERVICES AND DEVICES CRITICAL TO THE INDEPENDENCE OF PEOPLE WITH DISABILITIES AND CHRONIC CONDITIONS

Millions of individuals with injuries, illnesses, disabilities and chronic conditions utilize Medicare to access the services and devices they need to remain healthy, functional, and live independently 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 Over 8 million Medicare beneficiaries are less than 65 years old and qualify for Medicare based on their disability status. Beneficiaries who are dually eligible for both Medicare and Medicaid often have very significant medical needs and may require long term services and supports. In short, Medicare is a lifeline to individuals with injuries, illnesses, disabilities and chronic health conditions.

As part of the SGR reform effort, Congress is now considering major changes to the Medicare program to offset the cost of the physician fee schedule fix and generally reform the Medicare program. Unfortunately, many of the policies being seriously considered would have a major impact on access to quality care for some of the most vulnerable Medicare beneficiaries and dual eligibles. This position statement details the perspective of the disability community as Congress considers its Medicare reform options.

The undersigned members of the Consortium for Citizens with Disabilities (CCD) strongly believe that any changes to the Medicare program should not impede access to critical Medicare services, devices and medications. Any changes to the program should not focus on decreasing short-term healthcare expenditures by cost-shifting to beneficiaries or decreasing benefits, but rather should focus on decreasing long term—and often unnecessary—costs in the healthcare system by increasing quality and improving health outcomes.

In addition, CCD strongly supports Medicaid because of the program's track record for providing services that allow individuals with disabilities to remain independent and access cost effective healthcare services and long term services and supports. It is a critical program for people with disabilities and must not be cut to fund reform of the Medicare Sustainable Growth Rate formula.

A number of programs and demonstrations authorized under recent health care legislation are already reforming the Medicare system to reflect these laudable goals. CMS is funding several initiatives designed to improve quality of care for people who are dually eligible and over time reduce costs. Other initiatives advance reforms which focus on coordinating care for beneficiaries with multiple

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>

chronic conditions, prioritizing services and supports in home and community based settings while preventing institutionalization and promoting person-centered planning and delivery of health care. The impact of the current reforms and demonstrations must be understood before additional Medicare cuts are made. We strongly oppose arbitrary cuts to Medicare services and cost-shifting to beneficiaries which will impede access to medically necessary care for people with injuries, illnesses, disabilities and chronic conditions and exacerbate rising long-term healthcare costs.

I. **Protect Rehabilitation Services for Medicare Beneficiaries with Injuries, Illnesses, Disabilities and Chronic Conditions**

Prevent Cuts to Inpatient Rehabilitation Hospital Care

The high profile experiences of Senator Mark Kirk, Senator Tim Johnson, Representative Tammy Duckworth, Representative Jim Langevin, and Former Congresswoman Gabrielle Giffords illustrate the importance of intensive, coordinated inpatient rehabilitation hospital services. All patients should have access to such critical services to restore their health status and function after incurring an injury, illness, disability or chronic condition. We strongly oppose policies which cut funding arbitrarily for inpatient rehabilitation hospital services and which further restrict the types of patients who can gain access to those services (i.e. making access condition-based).

For instance, when someone sustains a brain injury, acute surgical care—such as that provided in a trauma center or hospital—is only the first step in recovery. Post-acute rehabilitation of sufficient scope, duration and intensity is necessary to regain lost skills and learn new compensatory strategies. This treatment may be provided in an inpatient rehabilitation hospital, another post-acute care setting, an outpatient rehabilitation clinic, a residential/transitional rehabilitation facility, or home- and community-based treatment programs. Once active treatment ends, individuals need access to ongoing management to ward off medical complications and maintain their level of function. With proper treatment, individuals who sustain even the most severe injuries can live healthy, independent and satisfying lives. This scenario is no different for Medicare beneficiaries with a wide range of injuries, illnesses, disabilities and chronic conditions.

In fact, timely, coordinated, and intensive rehabilitation can return health and function to Medicare beneficiaries in a manner that saves the federal government millions in unnecessary long term care costs. By focusing on recovery and rehabilitation, skills and functions lost to illness or injury can be restored with the goal of living as independently as possible and achieving the maximum quality of life. Proposals that seek to arbitrarily limit access to appropriate rehabilitation may achieve some short term savings but fail to consider the unnecessary long term costs that are often the result.

Access to appropriate rehabilitation should be preserved. Specific policies include:

• **Cuts to Future Investments in Inpatient Rehabilitation Hospitals and Units**

All post-acute care services comprise only 11.4 percent of Medicare spending, while total spending on inpatient rehabilitation hospitals and units is only 1.2 percent. But the amount proposed to be cut from inpatient rehab hospitals under the President's most recent budget were completely disproportional to Medicare spending increases in this setting of care. According to Medicare data, Medicare spending for inpatient rehab hospitals has been relatively flat for the past ten years—with a slight uptick in spending in recent years—in stark contrast to many other areas of both acute and post-acute care spending under the program.² Large spending reductions in post-acute care will

² CMS National Health Expenditures by Type of Service and Source of Funds, CY 1960-2011,

deal a serious blow to the capacity of inpatient rehabilitation hospitals and units to accommodate the needs of an aging population with disabling conditions.

- **Increasing the 60 Percent Rule for Inpatient Rehabilitation Hospitals and Units**
We oppose raising the 60 percent rule, which was established by Congress in 2007, up to a 75 percent compliance threshold, a percentage that would arbitrarily restrict access to intensive, coordinated rehabilitation hospital services. This is an issue that was debated for several years and that Congress resolved in the Medicare, Medicaid and SCHIP Extension Act of 2007 (“MMSEA”) by setting the threshold at 60 percent. 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 in the hands of hospital administrators and, ultimately, government officials. We strongly urge the preservation of the 60% rule so as to not erect arbitrary barriers to intensive, hospital-based rehabilitative care.
- **Site-Neutral Payment Proposal**
This proposal would equalize payment rates for certain patients who, depending on the severity of their condition, are treated in both rehab hospitals and Skilled Nursing Facilities (SNFs). 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 blatant financial disincentive for admission of these individuals in inpatient rehab hospitals and units. In addition, because SNFs are reimbursed on a per diem payment system and lengths of stay appear to be significantly greater than in rehab hospitals, 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 medical and rehabilitation needs. For these reasons, we oppose this proposal and urge Congress to reject it.
- **Implementing Post-Acute Care Bundling Prior to Evaluation of CMS and MedPAC Studies**
Bundling payment raises serious concerns regarding the quality of care that patients receive, including concerns that providers might stint on care to prevent financial losses, jeopardizing access to care. We strongly urge Congress to wait to evaluate the findings of current bundling demonstrations, pilots and research before proposing new, or expanding existing, bundling authority. CMS is currently pursuing post-acute care bundling in a variety of demos and pilots. But it has not yet pursued a statutorily required pilot on post-acute care bundling known as the “Continuing Care Hospital.”

In addition, the Medicare Payment Advisory Commission is currently researching models for post-acute care reform. Several of the bundling proposals under consideration, such as those contained in the President’s fiscal year 2014 proposed budget, include few details as to how bundling would be implemented. These models have yet to be tested and analyzed and to expand the scope of such models without this analysis has the potential to unnecessarily harm Medicare beneficiaries.

Rather than cutting funding, CCD recommends testing and implementing strategies for better care coordination within the post-acute care rehabilitation world, such as the Continuing Care Hospital demonstration authorized under the Affordable Care Act. New policies should recognize the long term value of the intensive, coordinated services provided in the inpatient hospital setting as well as other

https://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage; and MedPAC March 2013 Report to Congress (Table 1).

settings of post-acute care. The policy focus should be on care coordination that will lead to better outcomes and a reduction in unnecessary healthcare costs over the lifetime of beneficiaries.

II. Protect Medicare Outpatient Therapy Services

Caps on therapy services, especially when combined with manual medical review (MMR) of individual claims, have 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. The therapy caps have always restricted services to the beneficiaries who need them most. We call on lawmakers to ensure access for these patients in need of therapy services by addressing, permanently, the outpatient therapy caps alongside ongoing efforts in Congress to fix Medicare payment under the physician fee schedule.

We are encouraged by language advanced in the Senate that would repeal the therapy cap, sunset the problematic MMR process, bar incentive-based contractors from conducting medical reviews, and move toward a system that values improving functional outcomes over arbitrary dollar limits. As the House of Representatives continues to advance reform on a parallel track, we request that the therapy cap and other barriers to therapy services be addressed before full House consideration of its Medicare bill.

III. Oppose Reforms Which Shift Costs to Medicare/Medicaid Beneficiaries

While increasing cost-sharing onto Medicare beneficiaries may or may not reduce utilization of health services, CCD believes that shifting costs onto beneficiaries creates serious risks that patients will delay or forego needed services and treatments that will keep them healthy and ultimately reduce long term health costs. Therefore, CCD opposes the following proposals:

- **Oppose changes to Part D that Shift Costs to Medicare Beneficiaries**

We oppose a proposal to increase brand name copayments for dual eligibles with the Low-Income Subsidy (LIS), more commonly known as Extra Help, for Medicare Part D. Proposals to increase Extra Help dual eligible copayments for brand name drugs and diminish copayments for generic medications would disproportionately place an undue financial burden on low-income beneficiaries, many of whom have disabilities and chronic conditions,³ who often must take brand name prescription drugs. These higher costs are likely to diminish access and adherence among vulnerable beneficiaries. In the long run, inconsistent prescription adherence can increase health care spending due to the increased likelihood of emergency room visits, ambulance rides and hospital stays.⁴

- **Oppose Medigap Reforms That Will Shift Costs to Medicare Beneficiaries and Extend Guaranteed Issue to Medicare Beneficiaries with Disabilities and ESRD**

It is inappropriate and inefficient to increase Medicare beneficiary cost sharing in an attempt to affect provider behavior. Increasing Medigap cost-sharing only increases the likelihood that individuals with disabilities and chronic conditions will delay or forego medically necessary care because they cannot afford the additional cost. Individuals who forgo or delay necessary

³ A disproportionate share of Extra Help beneficiaries (43%) are people with disabilities who are under the age of 65. (MedPAC, "[A Data Book: Health Care Spending and the Medicare Program](#)," (June 2013))

⁴ Swartz, K. "[Cost-Sharing: Effects on Spending and Outcomes](#)" Robert Wood Johnson Foundation Research Synthesis Report No. 20 (December 2010)

care could end up in the hospital and/or acquiring secondary conditions, resulting in more expense to the Medicare program over time. Shifting the fee-for-service system to one that rewards beneficiary satisfaction and high performance outcomes is a much more effective way of decrease healthcare costs than shifting costs to beneficiaries.

Instead, Congress should focus on the only private insurance market that continues to legally discriminate against people due to their disability and end stage renal disease (ESRD) status. Congress should pass federal legislation that guarantees issue of Medigap coverage to those Medicare beneficiaries who qualify for the program due to their disability or ESRD status so that such individuals are able to obtain supplemental Medigap insurance in every state, just like the law mandates for the over-65 Medicare population.

- **Oppose Copayments for Medicare Home Health Services and Expand Delivery Reforms such as the Independence at Home Program and Care Transitions Program**

Most beneficiaries with disabilities and chronic conditions prefer to receive services in their homes and communities, rather than in institutions. Home health care can help avoid unnecessary and expensive hospitalization by providing necessary routine care that helps people maintain their function and prevent deterioration of health status. Increasing copayments for home health services could discourage beneficiaries who already have high Medicare expenses from utilizing the home health benefit. Instead of requiring copayments for home health, we recommend fully implementing and expanding, where appropriate, design reforms which focus on treating beneficiaries with costly chronic conditions in their homes and communities, thus avoiding unnecessary hospitalizations—design reforms such as the Independence at Home Program and the Care Transitions Program.

IV. **Protect Access to Assistive Devices and Technologies for People with Disabilities**

According to CMS, 15.5 million Medicare beneficiaries used durable medical equipment, orthotics, prosthetics and supplies (DMEPOS) in 2010.⁵ For individuals with disabilities and chronic conditions, access to these technologies enables them to live independently in their homes and communities while improving or maintaining their health status and avoiding harmful, painful and expensive acute care episodes and secondary conditions.

In any Medicare reform bill, we recommend that Congress:

- Ensure access to complex rehabilitation technology by including H.R. 942/S.948, the Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013; and,
- Dramatically improve the DME competitive bidding process by including H.R. 1717, the Medicare DMEPOS Market Pricing Program Act of 2013.

Complex Rehabilitation Technology (CRT) refers to medically necessary and individually configured manual and power wheelchair systems, adaptive seating systems, alternative positioning systems, and other mobility devices that require evaluation, fitting, design, adjustment and programming. CRT is designed to meet the specific and unique medical and functional needs of individuals with medical conditions that are significantly different from those experienced by the traditional senior Medicare

⁵ Statement to Congress on Tuesday, September 11, 2012 by Laurence D. Wilson, CMS Chronic Care Policy Group Director: <http://www.hhs.gov/asl/testify/2012/09/t20120911a.html>

population. This population tends to qualify for Medicare based on their disability and not their age, and consists of individuals diagnosed with long term conditions or disabilities such as cerebral palsy, muscular dystrophy, multiple sclerosis, spinal cord injury, amputation, brain injury, stroke, amyotrophic lateral sclerosis (Lou Gehrig's disease), and spina bifida.

Medicare currently does not have unique device coverage for the more complex and long-term needs of individuals with disabilities and chronic medical conditions. However, HR 942/S. 948 would ensure these individuals can access devices to remain independent in their homes and communities and avoid costly institution-based care. The bill reclassifies an already established category of DME and applies more appropriate rules to meet the needs of beneficiaries. As such, it is not expected to be a significant cost to the Medicare program.

DME Competitive Bidding: CMS continues to implement the Medicare DMEPOS competitive bidding program as beneficiaries continue to have serious concerns as to the lasting impact of this program on access, choice, and quality. CCD recommends that Congress incorporate further beneficiary safeguards into the Medicare competitive bidding program, including:

- A requirement that CMS work with independent, third party non-profit organizations familiar with consumers with disabilities and chronic illnesses who require the long term use of complex rehabilitation technology to develop, modify and implement:
 - a continuous survey of the Medicare beneficiary experience with the DMEPOS benefit, including functional outcome measures; and
 - a continuous quality control 'secret shopper' survey over time of contract suppliers.
- Provisions of H.R. 1717, the Medicare DMEPOS Market Pricing Program Act of 2013, specifically:
 - The establishment of an independent market mechanism to set DME pricing and establish binding bids from participating suppliers of durable medical equipment, supplies and related services;
 - The development of auction systems in geographic areas that are smaller and more homogeneous than bidding areas under CMS' current bidding program, facilitating improved access to devices for people with disabilities and chronic illnesses.
- A requirement that CMS reactivate and make permanent the Program Advisory and Oversight Committee (PAOC). The Medicare Modernization Act required Medicare to establish and administer a PAOC to provide advice on the development and implementation of CMS' Competitive Acquisition Program.

V. Improve Access to Community-Based Mental Health Services

We urge you to maintain in the final Medicare legislation the "Excellence in Mental Health Act" amendment offered by Senators Stabenow, Blunt, and Grassley, which authorizes a 10-state, five-year Medicaid demonstration to expand access to intensive community-based mental health services for people with severe mental illnesses. This provision takes a substantial step toward improving access to care by providing a secure source of Medicaid financing for an array of intensive community-based mental health services for persons with serious and persistent mental illnesses. The services would include targeted case management, crisis mental health services, psychiatric rehabilitation and other intensive community-based interventions for low income children and adults with severe mental disorders.

VI. “Extenders” Critical to People with Disabilities

CCD urges Congress to address the other critical programs that are usually considered when Congress addresses the Sustainable Growth Rate formula, provisions commonly known as “extenders.” These include:

- Making permanent the Qualified Individual (QI) low-income Medicare beneficiary assistance program in order to protect vulnerable Medicare beneficiaries’ economic security and access to physicians;
- Extending funding for Family-to-Family Health Information Centers (F2FHICs) through FY 2018 at \$6 million per year, and permitting grants to be awarded in US territories, to continue to assist families with children with serious health conditions and disabilities; and
- Making permanent the program that provides outreach and enrollment activities for low-income Medicare beneficiaries.

Thank you for your consideration of our views with respect to the impending Medicare legislation. For more information, please contact: Theresa Morgan, CCD Board Member and CCD Health Task Force Co-Chair at 202-466-6550 or Theresa.Morgan@ppsv.com.

Sincerely,

American Association of People with Disabilities (AAPD)

ACCSES

American Academy of Physical Medicine and Rehabilitation (AAPM&R)

American Medical Rehabilitation Providers Association (AMRPA)

American Music Therapy Association (AMTA)

American Network of Community Options and Resources (ANCOR)

American Occupational Therapy Association (AOTA)

American Therapeutic Recreation Association (ATRA)

Association of Assistive Technology Act Programs (ATAP)

Brain Injury Association of America (BIAA)

Dialysis Patient Citizens (DPC)

Disability Rights Education & Defense Fund (DREDF)

Easter Seals

Family Voices

Lupus Foundation of America

National Alliance on Mental Illness (NAMI)

National Association for the Advancement of Orthotics and Prosthetics (NAAOP)

National Association of County Behavior Health & Developmental Disability Directors (NACBHDD)

National Association of State Head Injury Administrators (NASHIA)

National Council for Behavioral Health

National Multiple Sclerosis Society (NMSS)

Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)

Paralyzed Veterans of America (PVA)

Special Needs Alliance (SNA)

The Arc of the United States

United Cerebral Palsy (UCP)

United Spinal Association