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SUBMITTED ELECTRONICALLY: [chronic\\_care@finance.senate.gov](mailto:chronic_care@finance.senate.gov)

The Honorable Orrin Hatch  
Committee on Finance  
United States Senate  
Washington, DC 20510

The Honorable Ron Wyden Chairman,  
Ranking Member, Committee on Finance  
United States Senate  
Washington, DC 20510

The Honorable Johnny Isakson  
United States Senator  
Committee on Finance  
United States Senate  
Washington, DC 20510

The Honorable Mark Warner  
United States Senator  
Committee on Finance  
United States Senate  
Washington, DC 20510

Re: Request for comments on Chronic Care Working Group's options document

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

On behalf of the Clinician Task Force (CTF), thank you for the opportunity to provide input on improving care for Medicare patients with chronic conditions, and for your long-standing commitment to addressing these critical and complex issues. The CTF is pleased to respond to the Working Group's request for feedback on policies which could improve chronic care. We share the Working Group's goals of improving the delivery of high quality care at greater value and lower cost without adding to the deficit.

The CTF is a not-for-profit nationwide group of more than 50 physical and occupational therapists, whose work involves providing wheelchair seating and mobility services to individuals with disabilities. We are the only professional clinical group dedicated to Complex Rehabilitation Technology and Seating and Wheeled Mobility service provision. Our mission is to advocate for professionally sound, clinically based public policies that ensure individuals with functional mobility impairments have appropriate access to seating, positioning and mobility products and services. The CTF works closely with other Complex Rehabilitation Technology (CRT) stakeholder groups including but not limited to the ITEM Coalition, NCART, RESNA, APTA, AOTA and United Spinal Association regarding issues that impact consumer access to appropriate quality CRT products and services.

For clarity, Complex Rehab Technology (CRT) products and associated services include medically necessary, individually configured devices that require evaluation, configuration, fitting, adjustment or programming. These products and services are designed to meet the

specific and unique medical, physical, and functional needs of an individual with a primary diagnosis resulting from a congenital disorder, progressive or degenerative neuromuscular disease, or from certain types of injury or trauma. For purposes of this document, CRT refers to individually configured manual wheelchair systems, power wheelchair systems, adaptive seating systems, alternative positioning systems and other mobility devices.

## **INTRODUCTION**

Our comments are based on our knowledge and experience working with individuals with complex functional mobility impairments many of whom are dual eligible Medicare/Medicaid beneficiaries with long term chronic needs. As the Working Group considers improving care for those with chronic conditions, it is critically important to understand and address the strong relationship between these conditions and functional impairments, which drive the need for long-term services and supports (LTSS). For the purposes of this document our comments are limited to rehabilitation/habilitation services, durable medical equipment (DME) and complex rehabilitation technologies (CRT) and related services.

We urge the Working Group to provide greater support for individuals with complex functional mobility impairments by:

1. Including in policy proposals access to appropriate rehabilitation services and CRT services and technologies
2. Incorporating accurate measures of functional status in Medicare's risk adjustment
3. Developing quality measures sensitive to the impact of rehabilitation/habilitation and CRT devices and services
4. Providing incentive and supports for telehealth and interoperability of EHRs for rehabilitation providers and CRT suppliers
5. Supporting the development and evaluation of new care models for individuals with chronic long term functional mobility impairments

These goals fit into the overarching policy objective of the Working Groups initiative. Specifically, ongoing, high-quality, coordinated rehabilitation services and LTSS can improve the overall care for this uniquely vulnerable population and at the same time lower overall cost, improve outcomes and reduce readmissions.

The Clinician Task Force (CTF) submits the following comments and recommendations to the Chronic Care Working Group:

### **1. Including in policy proposals access to appropriate rehabilitation services and CRT services and technologies**

An important but often overlooked subset of individuals with chronic conditions are eligible for Medicare due to disability not age. Many of these individuals also qualify for Medicaid resulting in dual eligibility. For example individuals with diagnoses such as: ALS, MS, MD, Progressive Muscular Atrophy, Spinal Muscular Atrophy, SCI, TBI, Post-Polio Syndrome, Cerebral Palsy, Spina Bifida, Friedreich's Ataxia, Guillian Barre, Huntington's Disease, etc. typically experience long term functional mobility impairments frequently

resulting in a permanent need for wheeled mobility. It is well documented that this relatively small population are costly and high utilizers of healthcare resources.

In establishing a person's need for CRT products and services, consideration is always given to the person's immediate and anticipated medical and functional needs. These needs include, but are not limited to, activities of daily living (ADLs), instrumental activities of daily living (IADLs), functional mobility, positioning, pressure redistribution, and communication. CRT is used to address these needs and enable the individual to accomplish these tasks safely, timely, and as independently as possible in all environments the individual is expected to encounter. CRT is essential for the health and well-being of people with disabilities who require the equipment and services and for their caregivers. The proper access to and provision of CRT products and services is critical for the independence, well-being, and ability of people with disabilities to live, attend school, work, worship and participate in their communities. Conversely, a lack of access or devices that do not provide the intended result can negatively affect a person's health and ultimately increase the cost of care.

Issues that manifest themselves in the current Fee-For-Service Medicare program and require attention and consideration in new models of care are numerous. Here are some examples:

- The Medicare program currently applies a restrictive interpretation of language in the Social Security Act regarding equipment coverage. Under this interpretation, Medicare will only pay for medical equipment that is medically necessary for use “in-the-home”. As a result, Medicare does not cover technology that is required to access the community for returning to work or school, going to the doctor or other medical services, grocery shopping or other activities associated with independent living, self-care or care of other dependents such as young children or aging parents. These activities are part of the daily lives of individuals living with disabilities on Medicare.
- Currently certain coverage policies are “diagnosis driven”, meaning that a person qualifies for the technology solely based on their medical diagnosis. Moreover, coverage policies within the Medicare program are primarily targeted at the typical Medicare beneficiary; individuals over age 65 and primarily with chronic disease. A diagnosis based policy leaves no means for functional criteria to qualify a person for appropriate and necessary CRT. While individuals may present with medical and functional needs similar to that seen with one of the diagnoses listed in the coverage policy, they are relegated to a lower level, less appropriate alternative simply because they do not have the listed diagnosis.
- For the past decade, codes under the HCPCS coding system (which is used to bill items and services) have become more generic and code descriptors like “any type” have been adopted. This causes a wide range of technology with different clinical applications and widely differing costs to be grouped into the same code. Couple this with a pricing methodology that utilizes a median price, and the result is that the more costly complex rehab technology cannot be provided at the Medicare fee schedule amount. For the individual requiring complex rehab, this results in either greater out of pocket costs to

the beneficiary, or receiving less than appropriate technology which can lead to further medical and functional complications such as pressure ulcers, orthopedic deformities, falls, and hospitalizations.

- Currently Medicare Part B does not cover the purchase of CRT in long term care facilities even when the provision of CRT would enable an individual to return to home or a community setting. The lack of this coverage prevents individuals who otherwise would have the ability to return home or to a community setting from doing so.
- Today within traditional Medicare there are concerns that access to specialty care is reduced. Due to policy development in silos within acute care, long term care and home care there exists access limitations within each of these groups to specialty services. As care coordination policies are developed incentivizing the appropriate level of care for beneficiaries living with chronic diseases it is important to ensure that individuals retain access to the specialty care that they require. For example within a HH episode of care, there exists an expectation that the HH physical therapist or occupational therapist will provide all therapy related services. Yet it is not typically this group of HH clinicians that possess the specialty knowledge, skills and experience necessary to conduct a comprehensive specialty CRT evaluation for an individual with complex seating and wheeled mobility needs as is currently required by Medicare for access to CRT.

The Working Group is urged to consider policy changes that factor in the needs of this vulnerable population. We note that the Policy Options Document makes no reference to rehabilitative services and devices. Rehabilitation is key to the ability of beneficiaries with chronic conditions to maintain their functional status and independence while managing their comorbid illnesses or conditions. Maximizing functional status and independent living for beneficiaries with chronic conditions will save Medicare significant dollars in the long term.

With an increasing focus on ACO's, medical homes, disease management and care coordination it is important to recognize access to specialty services is necessary. The Working Group is urged to consider policy provisions that enable individuals to obtain specialty care, such as CRT evaluation, at regional referral centers, model centers, specialty clinics, etc.

We request that the Working Group consider inclusion of policy proposals that advance access to appropriate rehabilitation services and devices and would be happy to further discuss such proposals with the Working Group.

## **2. Incorporating accurate measures of functional status in Medicare's risk adjustment**

Functional status reflects an individual's ability to perform activities of daily living, instrumental activities of daily living, essential roles and responsibilities (school, work, parenting, caregiver for aging parent), etc. Functional status is a better predictor of risk than presence of chronic conditions alone. This has been a critical missing variable that should be included in risk adjustment across the Medicare program, including Medicare Advantage and

new payment models. Functional status measure development and use is progressing, thanks in part to provisions in the IMPACT Act of 2014, and we encourage continued progress and prioritization of this measure at CMS and the National Quality Forum.

### **3. Development of quality measures sensitive to the impact of rehabilitation/habilitation and CRT devices and services**

Robust meaningful quality measures are essential tools to ensure that patients are receiving high-quality care. Although Medicare is increasingly using quality measures to assess providers, facilities and health plans, the program lacks sufficient measures for function, activity and participation sensitive to the impact of rehabilitation and CRT devices and services. Focus on pressure ulcers, fall prevention and safety must include specific information on the types of services and technologies being utilized. Accordingly, we urge the Working Group to encourage CMS to develop and test quality measures that incorporate items specific to rehabilitation and CRT devices and services. In particular, the agency needs measures that are applicable across sites of care and are incorporated into the larger picture of episodes of care, lifetime of care and population health. In this way data about utilization of care (LTSS e.g. caregiver assistance, transportation services, site of care, comorbidities) can be considered.

### **4. Providing incentive and supports for interoperability of EHRs and Telehealth Services for rehabilitation providers and CRT suppliers**

Telehealth services has the potential to improve access to specialty services to rural and underserved areas and should be considered across the Medicare program, including Medicare Advantage and new payment models and expanded to include additional providers such as rehabilitation and CRT professionals. The CTF supports lifting the originating site requirement entirely to enable teleconsultation regardless of beneficiary location. For rehabilitation and CRT services it is realistic to expect that one member of the CRT team (clinician or supplier) will be at the hub site and the other at the beneficiary's location. This model has been proven effective for both evaluation and fittings/deliveries to ensure that the CRT system is properly configured and outcomes are assessed.

Interoperability is critical for engagement with patients experiencing chronic conditions, and for provider consumption of patient generated health information. While we urge the Working Group to promote the ability to exchange health information confidentially and securely across healthcare systems, settings of care, vendors, certified EHRs and EHR modules and systems, and geographies; pushing data through secure messaging alone is insufficient for achieving the nation's health goals. Incentives and supports to promote interoperability amongst all chronic care stakeholders will further the Working Group's goals to enable systemic engagement with patients, care providers, medical professionals and other healthcare stakeholders.

## **5. Supporting the development and evaluation of new care models for individuals with chronic long term functional mobility impairments**

Care management initiatives have the potential to achieve meaningful improvements in quality and reductions in cost. CMS should grant flexibility to authorize non-covered Medicare benefits (such as CRT for specific functional purposes), or to substitute alternative benefits for specific sub-populations or individuals, when doing so is expected to result in better care or outcomes at a better cost, and is offered as an option to the beneficiary. Often these services can be instrumental in caring for the member at home, rather than an institution. Examples might be: seat elevation on a power wheelchair to enable independent transfers; a power wheelchair for a marginal household ambulator to enable independent community mobility for grocery shopping, pharmacy, medical appointments and to enable independence in the home and community while decreasing personal care assistance that is not otherwise covered by Medicare.

## **6. Receiving High Quality Care in the Home**

Performing medical and functional assessments in a familiar environment is sensible. Rehabilitation services in settings outside of the home do not provide opportunity to evaluate the environment, the individuals functioning in his/her home, safety, routines, etc. Furthermore providing services in the home is critical for individuals to benefit from the expertise of rehabilitation professionals knowledgeable about compensatory strategies, rehabilitation technologies (Durable Medical Equipment (DME) and Complex Rehabilitation Technologies (CRT)), environmental modifications and appropriate long term services and supports (LTSS).

The CTF supports expanding IAH programs nationwide across the Medicare program, including Medicare Advantage and other models. The addition of functional criteria as a foundation for risk scores as a way to identify complex chronic care beneficiaries eligible for inclusion is recommended.

The CTF members have the expertise needed to assist the Chronic Care Working Group in addressing issues and identifying reasonable solutions to identified problems while protecting beneficiary access to medically necessary and appropriate technologies and services. We strongly encourage the Working Group to engage stakeholders to problem solve some of these complex issues.

Thank you for your thoughtful consideration of the above comments and recommendations. The CTF is available to provide assistance and clinical input as needed.

Sincerely,



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