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THE VOICE OF BRAIN INJURY, HELP, HOPE AND HEALING

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Comments Regarding the Provisions of the House Tri-Committee Health Reform Discussion Draft Pertaining to Reform of Payment Mechanisms (Including Bundling) Under the Public Health Insurance Option and Medicare

The Brain Injury Association of America (BIAA) applauds your efforts to design health care reform that will improve the accessibility, quality, effectiveness, and efficiency of patient care. BIAA is the leading national organization representing individuals, families and professionals who are touched by life-altering, often devastating, traumatic brain injury (TBI). Together with its network of more than 40 chartered state affiliates and hundreds of local chapters and support groups across the country, the BIAA provides information, education and support to assist the 1.4 million Americans who sustain a traumatic brain injury each year.

BIAA believes that national health care reform must address the unique needs of individuals sustaining brain injury and other catastrophic injuries, illnesses, and diseases. Brain injury is the start of a lifelong disease process requiring access to a full continuum of medically necessary treatment, including rehabilitation, furnished by accredited programs in the most appropriate treatment setting as determined in accordance with the choices and aspirations of the patient and family in concert with an interdisciplinary team of qualified and specialized clinicians. Medically necessary treatment must be provided consistent with the National Institutes of Health Consensus Panel on Rehabilitation of Persons with Traumatic Brain Injury and the Traumatic Brain Injury Medical Treatment Guidelines, and other generally accepted standards of medical practice.

BIAA enthusiastically supports protections and standards for qualified health plans included in the House Discussion Draft, such as no imposition of pre-existing condition exclusions, guaranteed access to essential benefits (including rehabilitation services), guaranteed issue and renewal, adequacy of provider networks, limits on cost sharing, no annual or lifetime limits on coverage, and consumer protections.

With respect to reforms of payment mechanisms and policies under the public health insurance option and under the Medicare program, we believe that post-acute care (PAC) payment systems must facilitate, not impede improvements in functional status of individuals with brain injury and their ability to return to their homes and communities. More specifically, BIAA supports:

- The deliberative planning process envisioned by the House Discussion Draft that is guided by the stated goals to improve health outcomes, reduce health disparities, prevent or manage chronic illness or injury, and promote care that is integrated, patient centered, quality-driven, and efficient;
- Rigorous pilot testing of post-acute care bundling and other reforms, including studies that determine whether bundling should be limited to certain acute care diagnoses that are common and highly predictable and exempt from bundling other diagnoses, such as traumatic brain injury, that are of low predictability and highly complicated;
- The establishment of certain minimum requirements for any bundling proposal, such as provisions that ensure the inclusion of "any willing provider" in the bundled payment system; and
- Studies that test innovative payment methods that make payments directly to nonhospital-based treatment centers, including residential rehabilitation facilities specializing in the treatment of brain injury that have earned accreditation by the Joint Commission on Accreditation of Healthcare Facilities and/or the Commission on Accreditation of Rehabilitation Facilities.

For the reasons described below, BIAA does not support mechanisms and policies regarding the bundling of payments for post-acute care to acute care hospitals for patients with complex and highly unpredictable diagnoses and health outcomes, as is the case for individuals with brain injury and other catastrophic conditions. We believe such payment systems may impede, rather than facilitate, improvements in functional status and may facilitate premature return to homes and undue levels of preventable disability without adequate facilitation of progression through necessary step down levels of treatment.

Hospitals should be paid for what they do best, i.e., provide emergency and other medical interventions to stabilize the patient's condition and arrest disease progression in the early minutes and hours after brain injury (known as the "golden hour"). We do not support "reforms" of payment mechanisms and policies that would simply restructure the current payment systems to bundle payments for acute care hospitalization with payments to cover a specified period of post-acute care for all individuals with disabilities and chronic conditions, including individuals sustaining brain injury. With respect to Medicare, we do not support a single payment to hospitals 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.

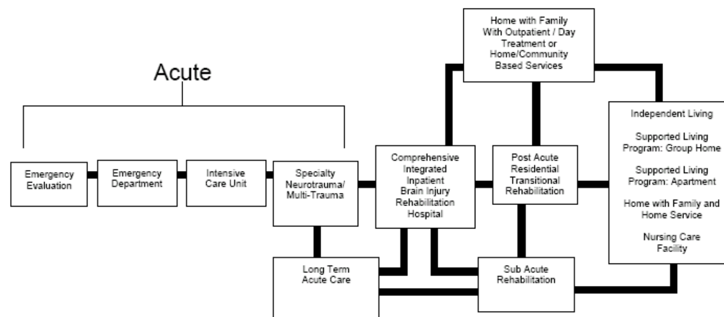
More specifically, BIAA is especially concerned about payment systems in which acute care hospitals are the locus of control as we believe that for many individuals with brain injury and other disabilities and chronic conditions bundling for post-acute care controlled by hospitals would:

- Lead to a race to the bottom in terms of quality;
- Signal a return to the days of the acute medical model being used to treat people with disabilities and chronic illnesses and injuries, where hospitals were the locus of care;
- Reduce access to both acute and post-acute care; and
- Diminish physician and clinical judgment, coupled with the lack of patient choice.

Lead to a race to the bottom in terms of quality. Inappropriate bundling would create strong financial disincentives to refer complex patients, such as those with brain injuries, outside of the control of the hospital network, even though well-developed and evidence-based specialty programs unaffiliated with the hospital would better serve these individuals. As a result patient outcomes will be compromised with less ability to return to home, work and life roles. This, in turn, could lead to significant long-term cost to the government.

Signal a return to the days of the acute medical model being used to treat people with disabilities and chronic illnesses and injuries, where hospitals were the locus of care. We have already learned that acute care hospitals do not have the expertise and interest to provide the full treatment continuum of medically necessary and appropriate services (including rehabilitation) for individuals with brain injuries and other disabilities and chronic conditions. Tremendous progress has been achieved in the last thirty years in the treatment of TBI. Thirty years ago, medical treatment was largely constrained to expensive and ineffective hospital-based treatment that averaged a 4 to 6 month length of stay (LOS), resulted in high levels of morbidity and disability, and resulted in discharge to skilled nursing facilities (SNF's), locked psychiatric facilities or to hospital beds in family homes. We now see hospital LOS for TBI has decreased to a range of 11 to 17 days nationally. Mortality and morbidity have improved vastly. An entire continuum of highly specialized, non-hospital-based treatment options (figure 1) have emerged in response to private sector demands, managed care and improvements in emergency medicine, intensive care medicine and rehabilitation medicine.

Figure 1: Continuum of Care (adapted from the Rocky Mountain Regional Brain Injury System)



The treatment options of the above continuum were developed in response to consumer-driven market forces. Access to the options along the developed treatment continuum is predicated by the patient's needs, balanced with clinical judgment and funding availability. The CDC cites a lack of consistent access to medical rehabilitation due to financial constraints imposed by insurance contracts and public funding policy. As a consequence, the high cost of disability following TBI represents an appropriate target for reduction and substantial savings via the preservation and widespread application of the existing options and flexibility of the current medical rehabilitation continuum.

PAC bundling applied to brain injury will extend the current financial disincentives for provision of the best medical treatment induced by the Prospective Payment System (PPS), furthering truncation and restriction of medical rehabilitation treatment services. The CMS quality guidelines connote return to home as the best treatment outcome. However, ***premature*** return home that disallows maximal reduction in disability and maximal improvement in independence and return to work following TBI is most probable under PAC bundling.

Therefore, design of a PAC bundling system must be sophisticated enough to deal with conditions such as TBI, where the diagnosis is non-homogenous and the clinical course is highly unpredictable. The only commonality to brain injury is that there is no commonality. Every injury presents a vastly different clinical presentation and requires highly specialized and individualized treatment planning to achieve maximized disability reduction and the best health outcome. The flexibility and efficiency of the current medical rehabilitation continuum must be preserved under health care reform.

Reduce access to both acute and post-acute care. By accepting bundled payments, hospitals will be positioned just like private insurers; that is, they will be expected to accept the risk (and reward) associated with each patient. As was demonstrated in the failings of capitation, hospitals lack actuarial knowledge and have limited financial reserves. They will be incentivized to treat patients with easier, more procedure-based care while turning away patients with complex, unpredictable care needs. Such "creaming" would lead to reduced access to care for individuals with brain injury. Further, the unpredictable nature and therefore the exceptionally high cost of treatment of major multiple trauma and traumatic brain injury will encourage hospitals to restrict emergency treatment access resulting in delayed delivery of critical medical care that has been widely demonstrated to substantially reduce morbidity and mortality as patients and their cost of care will be transferred to trauma centers.

Diminish physician and clinical judgment, coupled with the lack of patient choice. The assumption of a hospital-based bundling proposal is that the acute care hospital receiving the payment will establish a mechanism to channel cases to the appropriate post-acute provider to meet the complexities of the case. In fact, such a proposal will remove that determination from the patient, patient's family, attending physician, specialized case manager or other health professionals advising the patient at discharge. This diminution of physician and clinical judgment, coupled with lack of patient choice, seriously violates long-established principles of medical ethics and informed choice and would promote a highly questionable and undesirable change in the motivation of the decision-makers as to the course of post-acute care received by the individual in need of these services.

In sum, health care reform must address the unique health care needs of all Americans, including those experiencing catastrophic injury, illness and disease such as brain injury. Payment methods adopted by Congress must facilitate achievement of this overarching goal. Proposals that do not meet all Americans' needs, such as PAC bundling controlled by the acute care hospital, should be rejected. We are grateful that the House appears to recognize the risks inherent in PAC bundling and applaud your efforts to ensure a deliberative and evidence-based process as modifications to payment methodologies are developed. Thank you for your consideration of our views.

Sincerely,

Susan H. Connors
President/CEO