American Physical Therapy Association

The Science of Healing. The Art of Caring.

Recommendations on Reforming the Medicaid Program

Submitted to: The Medicaid Commission

Wednesday, September 6, 2006

Recommendations of the American Physical Therapy Association (APTA) Presented to the Medicaid Commission

RE: Proposed Models and Policy Recommendations for Overhauling the Medicaid Program

Introduction

APTA is very concerned with the current state of the Medicaid system. We applaud the efforts of the Medicaid Commission and the federal government to find plausible solutions to reshape the system into a more efficient and patient-centered program that will add greater benefit to the lives of millions of poor and disabled Americans. In response to mandates of the recent Deficit Reduction Act of 2005 (DRA), the Department of Health and Human Services outlined new flexibilities available to states that will help people served by Medicaid programs maintain access to affordable health care, and allow states to use innovative approaches to providing health insurance and long-term care services. In these comments, we will explore some of the current models being implemented in the States and discuss the role of physical therapy within these state plans.

Background

APTA represents more than 66,000 physical therapists, physical therapy assistants, and students of physical therapy across the country. Physical therapy is the profession devoted to restoration, maintenance, and promotion of optimal physical function. Physical therapists are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status across all ages and acuity levels. Physical therapists help patients maintain health by preventing further deterioration or future illness. Physical therapy is practiced in hospitals, outpatient clinics or offices; inpatient rehabilitation facilities; skilled nursing, extended care, sub-acute facilities; patients' homes, education or research centers, schools, and hospices.

The Medicaid program has evolved from a welfare benefit program to a complex system of care that plays three main roles: to provide health insurance to over 52 million individuals who would otherwise be uninsured (25 million of whom are children); to provide coverage of long-term care services to Medicare recipients and lower to middle income families; and to provide subsidies to safety net providers.

More than 8 million individuals with disabilities are enrolled in the Medicaid program and account for 44 percent of the total Medicaid expenditures. Of the Medicaid funds spent on behalf of individuals with disabilities, 37 percent of Medicaid dollars are spent for long-term care services.

Rehabilitation treatment is a key health service to Medicaid beneficiaries. These therapy services are provided in a variety of settings including but not limited to home care, Intermediate Care Facilities for People with Mental Retardation (ICF/MR), skilled nursing facilities and schools. Therapy helps a beneficiary gain the best possible function. Specifically, physical therapy services ensure the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health.

Medicaid has "mandatory" services that each state must offer and then each state is allowed the flexibility to cover additional "optional" services as it sees fit. Physical therapy falls into this category of "optional benefits", and is currently covered in 37 states. When covered this benefit serves the most vulnerable Medicaid populations—children and individuals with disabilities. APTA is concerned that as the Medicaid system is streamlined to become more efficient and cost-effective, optional services such as physical therapy will be marginalized.

It is our fear that beneficiaries who could greatly benefit from physical therapy will lose access to these services. Elimination of optional services, which in fact are essential services, could likely cost the state more when eliminated services translate to institutionalized care, development of more severe health outcomes, or increased visits to hospitals.

Discussion

Below, we have outlined three models that are currently being considered and implemented by states across the country. With each model, we have outlined our thoughts on the feasibility of each model and recommendations on how to strengthen these proposed models for future implementation:

Individual Responsibility for Managing Personal Healthcare

In Secretary Leavitt's "Roadmap for Medicaid" he highlighted promoting personal responsibility, independence and choice by helping individuals take control of their long-term support needs, including planning for the future and making rational, informed choices about all types of health care needs; As examples, he suggested offering a State plan benefit for self-directed personal care services without a waiver and opting to participate in the State Long-Term Care Partnership Program[1].

Several states have begun to shape their state plans with this guidance in mind and are implementing policies that emulate this general principle. For example, West Virginia is planning to phase in a redesigned form of Medicaid that requires patients to sign a "member agreement" pledging to take responsibility for their own healthcare. This includes making and keeping doctors appointments, adhering to prescribed medications,

and discretionary use of emergency care services. Penalties for breach of this agreement or refusing to sign such an agreement will be a reduction in Medicaid benefits[2].

Recommendations:

- ***Safeguarding against Unfair Penalizations of Beneficiaries.*** State plans should explicitly state that such agreements will not unfairly penalize children, adolescents, disabled or mentally impaired adults who have no legal or physical control over the administration of their healthcare.

- ***Establishing Due Process Measures.*** When entering into these agreements, patients must be adequately informed of their rights and responsibilities and measures must be put into place to ensure that beneficiaries are afforded adequate notice to respond to any state actions to reduce benefits as a result of non-compliance with the written agreement.

- ***Allowing for Economic Restraints.*** Special provisions or considerations must be given to beneficiaries who are unable to meet their responsibilities due to financial constraints (i.e. difficulty in securing transportation to medical appointments, etc.).

- ***Designing Benefit Flexibility.*** Due to the heightened responsibility being placed upon the beneficiary, the state should, in turn, give the beneficiary flexibility in designing their individual health plans based upon their personal health care needs which would include physical therapy services regardless of the traditional services covered in the state or current optional benefit classification.

Collaboration of Coverage between the State and Private Entities

Another possible model to revamp the Medicaid system is "privatization" of Medicaid. One option would be to build on public-private partnerships through premium assistance with employer coverage options. States with strong employer-based coverage may emphasize family coverage and premium assistance. States may form larger insurance pools by combining Medicaid beneficiaries with their public employees, thus spreading risk and reducing costs[1].

The purpose of this new flexibility option is to allow states to offer benchmark benefit packages that are more comparable to those in the private sector for non-disabled, non-elderly persons who are eligible for Medicaid. The benchmark approach allows flexibility to extend to four types of coverage to Medicaid beneficiaries: (1) Blue Cross/Blue Shield standard Federal Employee Health Benefits Program coverage; (2) State employee coverage; (3) coverage of the largest commercial Health Maintenance Organization (HMO) in the State; or (4) Secretary-approved coverage providing appropriate coverage for the population served[1].

Florida began to privatize part of its Medicaid program in September. The state is directing two geographical regions of Medicaid beneficiaries to choose from 19 health plans, each offering different services. Deviating from traditional reimbursement plans, Florida health officials will assess the health of every Medicaid beneficiary in the two regions and pay for a predetermined amount of care based on that assessment.[2]

Recommendations:

- ***Incorporating Prevention and Wellness Initiatives.*** Private insurers have led the way in implementing prevention/wellness programs, using health information technology, and requiring a team approach in patient care. Medicaid should not be any different from these private initiatives. Both entities aim to provide quality health care, efficiently and cost-effectively.

- ***Encouraging Multi-disciplinary Medicine.*** Medicaid must embrace and recognize the team approach to the delivery of quality health care. Physical therapists are integral members of the health care team, and states, as well as the federal government, should make every effort to make unrestricted access to physical therapy available to all Medicaid beneficiaries.

- ***Minimizing Costs to the Beneficiary.*** When collaborating with employers by offering employee coverage options, Medicaid should ensure that programs are carefully crafted in a manner that does not result in excessive premiums or other undue hardships on the employee. A majority of these individuals are already under tight budgetary constraints. They depend on Medicaid to supplement their existing medical benefits and income, and they cannot afford an increase in their current deductibles and premiums.

Disease Management and the Creation of Patient Categories

Disease management programs are an emerging strategy for states to improve care and are designed to reduce overall expenditures. These programs usually include adherence to evidence-based medical practice guidelines, providing support services to the physician in taking care of the patient, and adherence to an individual treatment plan. The "Roadmap for Medicaid"[1] gave several examples of disease management strategies that have been successful in the past. Some of the frequently used categories have been diabetes, chronic obstructive pulmonary disease (COPD), and heart failure.

Kentucky has taken this approach in its Medicaid program. The state is dividing beneficiaries into four categories depending upon their health and their age, with different benefits for each group. Under the new plan in Kentucky, most adults will face

higher co-payments for medical services. But, beneficiaries who sign up for a disease-management program eventually will be able to earn credits toward extra benefits, such as preventative care.[2]

Physical therapists are integral members of the healthcare team for the management of several chronic diseases and conditions. The physical therapist integrates five elements of management: examination, evaluation, diagnosis, prognosis, and intervention. These elements are designed for comprehensive treatment and to optimize outcomes.[3]

Recommendations:

- ***Promoting Preventative Medicine.*** The Commission should recommend that all state programs include prevention services and promote health, wellness, and fitness. Physical therapists are involved in prevention, promoting health, wellness, and fitness, and in performing screening activities. These initiatives decrease program costs by helping Medicaid patients: (1) achieve and restore optimal functional capacity; (2) minimize impairments, functional limitations and disabilities related to congenital and acquired conditions; (3) maintain health; and (4) create appropriate environmental adaptations to enhance independent function.

- ***Creating a Comprehensive Treatment Plan.*** When categorizing patients by their health status and age, states should take a comprehensive approach to treatment. All stakeholders and providers must be included in the treatment planning to ensure that the patient receives the maximum benefit of all therapies that may improve their condition. This should include preventative and rehabilitation services, as well as long-term care provisions.

- ***Encouraging Patient and Caregiver Participation.*** States should make special efforts to educate patients and caregivers on proper ways to maintain the patient's condition and healthy living. Educational outreach is one of the most important components of disease management.

Additional Proposed Policy Standards

APTA recognizes the barriers and issues that arise due to the unique structure of the Medicaid program - the collaboration between the federal government and the states. We appreciate the flexibility and advantages that this structure lends states in designing their Medicaid program to fit their citizen's needs, but we also know that the system can often become confusing and unmanageable for providers. We believe that there are several standards that should be implemented on a federal level to improve the functionality and efficiency of the program for patients and providers.

We urge the Medicaid Commission to consider the following recommendations:

- ***Standardizing Documentation Standards:*** Because of the partnership between the federal and state entities and the shared responsibilities, providers are often confused as to proper documentation standards. Unlike the clearly articulated documentation standards[1] that have been created by the Center for Medicare & Medicaid Services (CMS) for Medicare, clinical documentation guidelines for Medicaid are often confusing or non-existent. Therefore, we recommend that the Commission include in its report the implementation of uniform documentation standards for Medicaid across the board. Standardized documentation guidelines will lead to better efficiency and improved delivery of healthcare. By creating uniform clinical documentation standards, states will be able to collect the data necessary to measure quality and performance and the valuable information needed to detect fraud and abuse.

- ***Incorporating Health Information Technology:*** As the Commission continues to explore cost-savings and efficiency in the Medicaid program, the APTA commends its decision to include health information technology (health IT) in its discussions. Numerous news reports and activities in the private sector and the Administration show that significant positive changes can be achieved with the adoption of comprehensive health information technology and quality assessment in health care delivery.

  Physical therapists recognize that health care providers must ensure that their interventions contribute to the function, health, and well-being of their patients—the health consumer. To this end, the APTA supports the adoption of health information technology and the concept of pay for performance. However, it is vitally important that the adoption of health IT is approached comprehensively, including patient assessment tools, clearly identified health outcomes, interventions based on sound science and evidence, recognition that individuals with the same medical condition often present differently, and a cross-section of health care providers in health IT adoption plans. Too often discussions about health IT are centered on physicians and hospitals and the discussions are done in a vacuum with no relationship to the "end-game," which is better performance by the health care provider (pay for performance) and improved health outcomes.

  The goal for adopting health IT and pay for performance is not only ensuring efficiency in health care delivery but more importantly improving and/or

[1] As delineated in CMS Transmittal 52, June 30, 2006 (Medicare Benefits Policy Manual, Pub. 100-02)

preventing a decline in individuals' health status. Following this principle, the APTA has developed a database containing current research evidence on the effectiveness of physical therapy interventions, an electronic medical record (EMR) system, and an instrument that provides the beginning of documentation of outcomes that identify the unique contributions of the physical therapist practice.

In 2005, APTA launched *Hooked on Evidence*, an outcomes and evidence-based practice database that now contains more than 3,000 articles. With *Hooked on Evidence*, APTA provides physical therapy clinicians the learning tools they need to foster evidence-based practice in physical therapy. *Hooked on Evidence* recently added clinical scenarios that present a brief description of patients/clients who are typically seen in physical therapy practice. Plans are in place to include scenarios that describe people with knee conditions, those with impairments and functional limitations following a stroke, low back pain, shoulder conditions, joint arthroplasties and cerebral palsy.

To enhance the work of the evidence-based database, APTA has developed *CONNECT. CONNECT* is a point-of-care, computerized patient record system that will ultimately link to *Hooked on Evidence*, the national outcomes database. *CONNECT's* components include a touch screen and menu-driven documentation approach allowing access to a template, much like a paper chart template. The drop-down screens and text suggestions in the documentation software make it easy for clinicians to follow. The program is very goal-oriented, with reminders as the clinician and patient approach pre-determined deadlines for reaching stated objectives. The documentation system actually drives patient care. The EMR system will help physical therapy clinicians drive down the average visits per case and improve the physical therapy profession's position in the debate regarding pay for performance. There is also an opportunity for CONNECT to be used as a patient health record allowing for continuity of care in other health settings and with other providers.

APTA has also developed an outcome quality measurement instrument called the *Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). OPTIMAL* relies on an initial self-assessment before physical therapist interventions begin, potentially interim assessments, and another self-assessment at discharge. When coupled with the physical therapist interventions, the *OPTIMAL* instrument could assist with goal setting from the patient's perspective—making treatment more relevant and useful to the patient.

APTA believes that health information technology is critical to the future success and sustainability of health care. Therefore, the Commission's report should incorporate elements of health information technology into the long-term strategic plan for overhauling the Medicaid program.

- ***Improving Access to Durable Medical Equipment:*** For people with a variety of physical disabilities such as spinal cord injuries, traumatic brain injuries, cerebral palsy, and amputations, and who have limited financial resources, Medicaid is often their only means of accessing durable medical equipment (DME) like wheelchairs, prosthetic devices, and assistive technologies, particularly in school-based settings.

  Physical therapists provide orthotics, ambulatory aids, and mobility assistance devices to the patients they serve to help them improve their function. These items become an essential part of the treatment plan for the patients who need them. The need for DME is determined by physical therapists as an integral part of their physical therapy plan of care. The clinical judgment and expertise of the physical therapist is critical in selecting a particular DME item for the patient and is based on the therapist's evaluation of the individual patient. The physical therapist ensures that the item is appropriate to achieve the patient's functional goals, is properly sized and fitted for the patient, and that the patient and/or caregiver is educated in the proper use of the item.

  In order to ensure that Medicaid beneficiaries receive the proper DME for their condition and to maximize rehabilitation and overall function, federal and state governments must ensure that health providers such as physical therapists are at the center of decision-making and that adequate funds are appropriated for the furnishing of DME.

- ***Focusing on Long-term Care:*** Medicaid is a primary source of long-term care for the elderly and persons with disabilities. Plans to develop a long-term care strategy must include improved availability and coordination of in-home and community-based care and institutional long-term care. An additional objective is ensuring the beneficiary's access to a range of health professionals who will help with improvement and maintenance of a suitable health status and level of function. Physical therapists have extensive education and clinical experience in aging and disease processes and the conditions' impact on patients. As long-term care moves toward home and community-based care options, physical therapists also have a role. Physical therapists frequently teach self-care and home management to their patients.

- ***Targeting Case Management:*** The optional program of Targeted Case Management (TCM) within Medicaid creates a cost-saving and effective "one-stop" opportunity for Medicaid beneficiaries to gain access to needed medical, social, educational, and other services to achieve optimal functioning. Hard-to-reach populations such as rural residents, individuals with developmental and physical disabilities, children in foster care, and ethnic and racial minorities, are the very people Medicaid is meant to help. It is imperative that when evaluating

TCM that the CMS analyze the agency's oversight of the program and its implementation. Instead of a wholesale overhaul of TCM services, the states must review best practices of the program and develop adequate reporting and evaluation guidelines for states to follow.

Conclusion

As you begin to develop your December report to Congress, we ask that the Commission take a thorough evaluation of the existing Medicaid program and offer recommendations that result in comprehensive and quality care for all Medicaid beneficiaries which include protection for the integrity and essential role of physical therapists in caring for adults and children with disabilities. We applaud the Commission on its work thus far, and we hope that its efforts will result in long-lasting reform that protects both the funding and structure of the program so that it may continue to meet the vital health care needs of the Medicaid population.

APTA appreciates the opportunity to provide these comments and looks forward to working in partnership with the Commission, the Administration, and Congress in achieving these goals. Please feel free to contact Roshunda Drummond-Dye, Esq., Associate Director of Regulatory Affairs at (703) 706-8547 or at roshundadrummond-dye@apta.org, if you have any questions regarding our comments.

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[1] Department of Health and Human Services: "Roadmap for Medicaid Reform", April 3, 2006
[2] Goldstein, Amy. "States Changes Reshape Medicaid." Washington Post June 12, 2006
[3] The American Physical Therapy Association, Guide to Physical Therapy Practice. Second. Alexandria, VA: APTA, 2003.