

Principles for a Medicare Unified Post-Acute Care Payment System

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As Congress, the Centers for Medicare and Medicaid Services (CMS), and the Medicare Payment Advisory Commission (MedPAC) consider over the next few years the design and structure of a unified payment system for Medicare patients in need of post-acute care (PAC), the American Academy of Physical Medicine and Rehabilitation (AAPM&R) will assess all proposals using the following principles to guide this important set of reforms. We urge other PAC stakeholders and policy makers to adopt similar principles and adhere to them in the design and implementation of a unified PAC payment system.

1. **Meet Patient Needs:** Any PAC reform should focus primarily on meeting the post-acute care needs of Medicare beneficiaries with injuries, illnesses, disabilities, and chronic conditions, and seek to optimize measurable patient outcomes with an emphasis on health, function, independent living, quality of life, and return to life roles.ⁱ
2. **Appropriate Financial Incentives:** PAC payment levels must accurately reflect the diagnosis, severity, comorbid conditions, and other patient factors, which include social determinants of health,ⁱⁱ that dictate PAC resource use. Any PAC payment reform should not include financial incentives that compromise access to care for beneficiaries in need of post-acute care services, including the intensity, duration, and scope of medical management and medical rehabilitation services and devices.
3. **Prioritize Functional Outcomes:** Any PAC payment reform must recognize the importance of not only appropriate medical management of the patient, but also the functional status of the beneficiary; the ability to improve, maintain, or prevent deterioration of function; and the achievement of long-term, measurable functional outcomes.ⁱⁱⁱ
4. **Cognitive Status:** Any PAC payment reform should recognize the cognitive status, comorbid mental health conditions, and social determinants of health of beneficiaries and accommodate those factors into payment policies that address the mental health care and cognitive needs of beneficiaries during a PAC course of treatment.^{iv}



5. Efficiency: Any PAC reform system should streamline decision-making, limit documentation burden, eliminate unnecessary bureaucracy and government audit activity, and support efficiency without compromising patient care.^v Any PAC reform should incorporate technological advances in healthcare delivery.

6. Role of the Physiatrist: The role of Medical Director of Rehabilitation in a rehabilitation hospital should be filled only by a physiatrist, a licensed physician (M.D. or D.O.) who has completed a Physical Medicine & Rehabilitation (PM&R) residency accredited by the ACGME, the AOA, or the Royal College of Physicians and Surgeons of Canada and meets the training and experience requirements for examination by the American Board of PM&R or the American Osteopathic Board of PM&R.^{vi} Additionally, any PAC payment reform should recognize that physiatrists are best suited to fill the role of Rehabilitation Physician.

7. Physiatrist-Driven System Based on Physiatrist Expertise: Any PAC reform system should be physiatrist-driven. For patients for whom a substantial portion of their care is impacted by functional impairment, physiatrists should lead a multidisciplinary team of rehabilitation professionals to make treatment decisions, triage patients to the appropriate level of care, and determine when transfers from one level of care to another should occur.^{vii} In treating Medicare beneficiaries across the PAC continuum, any PAC reform system should grant deference to the professional expertise of the treating physiatrist based on his/her individualized patient assessment.

8. Training Opportunities: Any PAC reform must accommodate robust opportunities and experiences for physiatrist trainees across the continuum of rehabilitation care, in both inpatient and outpatient settings. This comprehensive rehabilitation educational approach will promote high-quality health and rehabilitative care well into the future.^{viii}

9. PAC Setting Flexibility: Any PAC reform must include flexibility by brick and mortar PAC providers to transfer patients easily from one level of care to another depending on the intensity of the patients' needs, reflecting the concept and ability of a "swing-bed".^{ix}

10. Data Sharing and Access to Data: Any PAC reform must ensure that patient data is transferred easily across acute to post-acute and within PAC settings such that physicians have immediate access to this data.^x
11. Demonstration Project and Phase-In Approach: Any unified PAC reform system must be tested before being widely implemented. This could occur through a sufficiently sized and geographically representative demonstration project to assess the viability of the reformed system and should be phased-in to ensure that Medicare patients and providers do not experience disruptions in access to and the quality of PAC care.^{xi}

ⁱ Currently, the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires LTCHs, IRFs, HHAs, and SNFs to report standardized patient assessment data with regard to quality measures and standardized patient assessment data elements. IMPACT Act, Pub. L. No. 113-185, § 2, 128 Stat. 1952, 1952-68; *also see* CMS, *IMPACT Act of 2014 Data Standardization & Cross Setting Measures*, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures.html> (last modified Dec. 11, 2018).

ⁱⁱ Social determinants of health (SDOH) are conditions in which people are born, grow, live, work, and age that shape their health. Examples include factors such as access to transportation, access to healthy food, neighborhood, housing security, and many others. Artiga, S and Hinton, E. *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*. (May 10, 2018), Kaiser Family Foundation. <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

ⁱⁱⁱ This principle is reflected in the inpatient rehabilitation facility-patient assessment instrument (IRF-PAI), which IRFs are required to include in the patient's medical record. 42 C.F.R. § 412.606(a); CMS, Medicare Benefit Policy Manual, Pub. 100-02, Ch. 1, § 110.1.5. The IRF-PAI contains Quality Indicators that measure, among other things, the patient's functional abilities at admission and functional discharge goals. CMS, *Final IRF-PAI Version 3.0*, 2 (Oct. 1, 2019), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Downloads/Final-IRFPAI_Version3_Eff_20191001-FY2020.pdf.

^{iv} IRFs must assess a patient's cognitive pattern as part of the IRF-PAI. CMS, *Final IRF-PAI Version 2.0*, 2 (Oct. 1, 2018), <https://www.cms.gov/medicare/medicare-fee-for-service-payment/inpatientrehabfacpps/irfpai.html>. The other settings of post-acute care similarly recognize the importance of cognitive status in their respective prospective payment systems.

^v This principle is reflected in CMS's recent efforts to identify and reform Medicare regulations that are unnecessary and excessively burdensome on health care providers and suppliers. Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction, 83 Fed. Reg. 47,686 (Sept. 20, 2018).

^{vi} Position statement on the definitions of “Rehabilitation Physician” and “Director of Rehabilitation.” Scott R. Laker et al., *American Academy of Physical Medicine and Rehabilitation Position Statement on Definitions for Rehabilitation Physician and Director of Rehabilitation in Inpatient Rehabilitation Settings*, 11:1 PM&R 1-5 (2018).

^{vii} This principle is currently reflected in the coverage criteria for IRF services. 42 C.F.R. § 412.622(a)(3)(iv), (4), (5). Specifically, in order for an IRF claim to be considered reasonable and necessary, the rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation, must concur with the patient’s preadmission screening, lead the interdisciplinary team meetings, complete the post-admission physician evaluation, and develop the patient’s individualized overall plan of care. *Id.* § 412.622(a)(3)(iv), (4), (5).

^{viii} Medicare currently provides payments to hospitals and hospital-based providers for the costs of approved residency programs in medicine, osteopathy, dentistry, and podiatry. *See* 42 C.F.R. §§ 413.76-413.83. Medicare also provides payments to hospitals for the cost of approved nursing and allied health education activities. *Id.* § 413.85.

^{ix} Under the Medicare program, rural hospitals and critical access hospitals (CAHs) may enter into a swing-bed agreement, under which the hospital can use its inpatient beds to provide either acute or post-hospital SNF care. *Id.* § 413.114; *also see* CMS, *Swing Bed Providers*, <https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/swingbed.html> (last modified Nov. 13, 2017). Currently, post-hospital SNF care furnished in rural hospitals is paid under the SNF PPS, and such care provided in CAHs is paid based on 101 percent of reasonable cost. 42 C.F.R. § 413.114(a)(2).

^x CMS has previously indicated its commitment to interoperability of health data. Jennifer Bresnick, *Verma: CMS Will “Use Every Lever” for Promoting Interoperability, Data Access*,” HEALTH IT ANALYTICS (Apr. 25, 2018), <https://healthitanalytics.com/news/verma-cms-will-use-every-lever-for-promoting-interoperability-data-access>.

^{xi} CMS conducts and sponsors various Medicare demonstration projects to measure the likely impact of new methods of coverage, service delivery, and payment. CMS, *Medicare Demonstration Projects & Evaluation Reports*, <https://www.cms.gov/medicare/demonstration-projects/demoprojectsevalrpts/index.html> (last modified July 19, 2016).