American Academy of Physical Medicine and Rehabilitation

aaPM&R

9700 W. Bryn Mawr Ave., Suite 200
Rosemont, Illinois 60018
www.aapmr.org

phone 847/737.6000
fax 847/737.6001
info@aapmr.org

August 19, 2013

The Honorable Max Baucus
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Dave Camp
Chairman
1102 Longworth House Office Building
Ways & Means Committee
Washington, D.C. 20515

The Honorable Sander Levin
Ranking Member
1106 Longworth House Office Building
Ways & Means Committee
Washington, DC 20515

Dear Chairmen Baucus and Camp & Ranking Members Hatch and Levin:

As an important member of the physician community, the American Academy of Physical Medicine and Rehabilitation (AAPM&R) appreciates the opportunity to address the questions posed in the Committees' letter dated June 19, 2013. Thank you for the invitation to assist the Committees in ensuring the sustainability of the Medicare program and in developing alternative models for healthcare delivery and reimbursement that reward high-quality, cost effective care. The Academy supports reforms to the post-acute care (PAC) system, provided that the reforms follow fundamental principles that put beneficiaries' needs first, maintain access to rehabilitation at the appropriate level of intensity consistent with the beneficiary's needs, and allow physicians and their rehabilitation teams to provide patient-centered care in the most efficient and effective setting.

The AAPM&R is the national medical society representing more than 8,000 physiatrists, physicians who are specialists in the field of physical medicine and rehabilitation (physiatry). Physiatrists treat adults and children with acute and chronic pain, persons who have experienced catastrophic events resulting in paraplegia, quadriplegia, traumatic brain injury, spinal cord injury, limb amputations, rheumatologic conditions, musculoskeletal injuries, and persons with neurologic disorders or any other disease process that results in impairment and/or disability. **Physiatrists treat patients across all PAC settings, including inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), home health (HHAs), and long term acute care hospitals (LTACHs).** With appropriate rehabilitation, many patients can regain significant function, and live independent, fulfilling lives.

Quality

The single most important priority to physiatrists is a focus on **patient outcomes and improved function across care settings and diagnostic groups.** The AAPM&R believes strongly that the biggest barrier to measuring quality of care in PAC settings is the lack of generally accepted or universally applicable outcome measures of functional status, impairment, and disability that have been nationally endorsed for quality incentive reimbursement. Because of this dearth of outcome measures, the current measures that exist within the PAC setting are not particularly relevant to rehabilitation, as they focus mainly on process rather than outcomes.

Classification systems distinguish patients according to the primary disabling diagnosis which determines the need for rehabilitation care, because, for example, therapeutic rehabilitation processes differ strikingly for those with spinal cord injury, stroke, hip fracture or frailty from the combined effects of multiple medical conditions. Outcome measures should also take into consideration the clinical complexity and management of multiple comorbidities, as well as their premorbid function. Additionally, current and future coding systems do not reflect illness severity and resultant impairment within each diagnosis code; as a result, the severity of the disease process and its effect upon functional status may not be captured if diagnosis codes alone are used in quality and performance measurement. However, the International Classification of Functioning, Disability and Health (ICF)[i] provides a framework to support the development of data items on functioning and disability and improve data reliability between administrative and population data collections. Quality outcome measures based on the framework of the ICF have the potential to be applicable across all levels of post-acute care as well. The AAPM&R recommends referring to ICF when considering new measure sets applicable to persons with multiple chronic conditions and disabilities.

Furthermore, newly developed measures should look longitudinally at beneficiaries' functional status, beyond discharge from acute hospital and PAC settings. As such, any measure sets should not conclude at discharge. As many beneficiaries will continue to require support in their communities, capturing functional status in the community may have a positive impact on patient outcomes and increase the likelihood of beneficiaries remaining at home rather than in an institutional setting.

Assessment Tools

The Academy supports the effort to create a tool that can be utilized across PAC settings and believes that any progress in this area is to be commended. However, there is insufficient information and research available regarding the CARE tool, including the specific items evaluated, comparisons of current PAC instruments (i.e., IRF-PAI MDS, OASIS) with respect to function and outcomes, and standardization and training required for certification for PAC facilities' staff.

In evaluating the information we do know about the CARE Tool, it is clear that there are improvements needed in the instrument to allow comparisons across PAC settings. The January 2012 Report to Congress[ii] prepared by CMS and entitled Post Acute Care Payment Reform Demonstration (PAC-PRD) reported that IRF admission was associated with a statistically

significant improvement in self-care function compared to SNFs. This statistically significant improvement was especially evident in the analysis of beneficiaries with nervous system conditions. The analysis also demonstrated that Home Health treatment was associated with a statistically significant improvement in self-care function compared to SNFs. There were no statistical differences regarding changes in mobility. Further study of the CARE Tool is necessary to assure that the instrument is able to identify the important functional outcome variations in self-care, mobility and other domains in patients treated in different PAC settings. It is also vital that it is validated properly and that methods are employed to ensure that it is positively influencing care delivery and outcome before wide-spread implementation occurs.

Furthermore, it is possible that the CARE Tool is not adequate in measuring the differences in the patients admitted to different PAC settings and the nuances in functional outcomes of those patients in each setting. The January 2012 CMS Report to Congress states that the tool would control for acuity measures, meaning that beneficiaries' condition severity would be leveled or explained away as if it were inconsequential to the data being collected. The Academy believes patient selection based on severity and other clinical variables is an important part of the care intervention itself. For example, a surgeon would have dismal outcome data if he or she operated on every patient seeking a consultation. Choosing which patient would benefit from surgery and avoiding surgery in patients who would not benefit from surgery, or whose risk for complications outweighs the chance of optimal recovery, is an integral and necessary part of the episode of care. The same selection process is true for rehabilitation medicine and applies to all PAC settings. Therefore, considering acuity a confounding variable and controlling for it may skew the data that the Care Tool wishes to collect and subject to comparison.

It is important that the Care Tool and any other outcome tools capture the myriad variables taken into consideration when determining the most appropriate PAC setting for a beneficiary. These include pre-hospitalization functional status, pre-hospitalization living setting (e.g., physical structure, obstacles), social support available on discharge from PAC (e.g., family, friends), clinical comorbidities, current therapy tolerance, cognitive and behavioral status, patient motivation for therapy participation, patient and/or family preference (e.g. location including proximity to home), financial resources and insurance coverage, and patient potential for functional recovery.

Value Based Purchasing

Although the Academy supports the use of value based purchasing in PAC settings, it is critical that such a policy not be implemented too quickly and that a realistic timeframe be built into any Value Based Purchasing (VBP) program implementation. The Academy believes that the issue of appropriately measuring functional status outcomes across different post-acute care settings needs to be addressed prior to implementing any VBP program. Moreover, the data derived from functional status measures only becomes meaningful when there is an acknowledgment of the distinction between functional gain, and achievement of a particular functional benchmark.

Reducing Hospital Readmissions

Acute care hospital readmissions are costly and can be prevented when the appropriate PAC setting is utilized at the right time for the right patient. Because physiatrists practice across PAC settings, the specialty is in a unique position to evaluate beneficiaries being discharged from acute hospital

stays, to follow them across care settings, and to compare care outcomes. Any changes to the current PAC delivery system should focus first on what is best for the beneficiary. The achievement of sustainable improvements in patient outcomes throughout the care continuum, for all diagnostic groups of patients with disabling conditions, will lead to a reduction in acute hospital readmissions. Furthermore, the collaboration between providers in all PAC settings to return patients to home and community living should be the chief goal of any meaningful changes in PAC delivery and reimbursement.

Cultural Shifts

One important difference between the care provided in IRFs and LTACHs, versus that in SNFs, is cultural in nature. While LTACHs and IRFs, by definition, provide intense rehabilitation to improve health and function with the goal of patients returning to home and community settings, SNFs provide care that does not always promote achievement of goals in an intensive and focused manner. The staff in SNFs may be more accustomed to a custodial care model, whereby residents may not be pushed to engage in therapy, or where there may be fewer staff to train families in order to facilitate discharge back to the community. With an aging population, there are many cases where SNF-based or custodial care is appropriate. However, for those over 65 who have the capability of independent living, and for the over six million beneficiaries under the age of 65, our country's entire PAC system needs to align both philosophically and culturally to avoid prolonged institutionalization, to keep these beneficiaries out of acute care systems, and to help beneficiaries achieve a high quality of life.

For example, in order for a patient to enter an IRF, CMS requires that the beneficiary be able to tolerate three hours of rehabilitation therapy a day (i.e., physical therapy, occupational therapy, and/or speech language pathology). If, upon discharge from an acute hospital, a beneficiary cannot tolerate three hours of therapy a day, the beneficiary is disqualified for IRF admission and may be admitted to a SNF instead. Going forward, it is critical that the PAC system avoid allowing these beneficiaries to convalesce in a SNF for long periods of time while possibly billing both Medicare and Medicaid for these stays, when more intensive rehabilitation programs would result in functional improvements that allow them to go home. Incentive structures to change the SNF clinical mind-set and care culture would likely make a difference in the ability of the entire acute care and PAC system to work in a more comprehensive and efficient manner towards not only reducing acute hospital readmissions, but allowing more beneficiaries to return home with meaningful participation in social roles in the community, exponentially raising the quality of life for beneficiaries while saving money for both Medicare and Medicaid.

Penalty Systems

The Academy believes that rehabilitation provided to the right patient in the right setting at the right time would go a long way toward preventing acute hospital readmissions and preventing inappropriately long PAC stays. However, it is critical that there be incentives for preventing these acute hospital readmissions in order to improve care across every PAC setting. Any incentive or penalty system established must take into consideration whether the clinical condition which required discharge back to the acute hospital setting was present at the time of admission to the PAC setting. If the condition was present at the time of PAC admission and persisted throughout the PAC stay, the PAC setting should not be penalized for the acute hospital readmission. Likewise,

inappropriate acute hospital discharge planning that resulted in an ill-chosen PAC setting or an acute hospital discharge that was too early should not penalize the PAC setting.

Bundled Payments

The Academy believes that, if done correctly, bundled payments could save money and promote a multidisciplinary, coordinated team approach to patient care, a model that physiatrists have already been advocating and employing for decades. However, the AAPM&R feels strongly that **acute care bundled payments should not extend to PAC settings.** If done in this manner, the acute care hospital would be incentivized to send beneficiaries to the least costly PAC setting, as opposed to the most medically appropriate or higher value setting, in order to retain more of the episode's payment. Therefore, the most appropriate bundled payment model would include two separate bundles: one starting and ending in the acute hospital setting, and a second starting and ending in PAC settings.

Site Neutral Payments

Physiatrists treat patients in many different settings of care, including IRFs, SNFs, LTACHs and HHAs. This across-setting experience is invaluable when evaluating the site-neutral payment concept. The main argument underlying this payment model is that treatment performed in the IRF setting for a given condition is similar to that performed in the SNF setting for that same condition.

First, it may be premature to implement such a payment model before cross-cutting quality and performance measures are created, reported, and then compared. It may be that these measures reflect the cultural differences in each setting, as explored earlier in this letter. If that is the case, how can the care be considered equal?

Furthermore, Medicare requirements for inpatient rehabilitation facilities (IRFs) are stringent and different from other post-acute care settings. To be classified as an IRF, the rehabilitation hospital or rehabilitation unit must have medical directors and nurses who specialize in rehabilitation, and have 60 percent of admissions drawn from just 13 specific diagnoses. IRFs can only admit patients who can tolerate three hours of therapy a day and have the potential to meet predetermined reasonable functional goals.

Because IRFs are able to deliver high quality care that enables most patients to return home quickly, the Center for Medicare Advocacy and others recognize that any cost savings per treatment episode will be minimal for these patients if they are diverted to a SNF, where the care is likely more custodial and substantially less medically intensive than that provided in an IRF. Lastly, it is also important to note that IRFs in recent years in have not seen significant cost growth, as compared to other PAC settings.

In sum, **the Academy opposes lowering payments to IRFs under any site-neutral payment policy, as it will likely force IRFs to deliver care at costs that will exceed reimbursement, or negatively impact patient access to needed IRF care by forcing facilities to decline financially unaffordable admissions.** Because of these factors, any move to implement this payment policy should be halted, or at least delayed, until quality and performance metrics can be developed, collected, and appropriately analyzed.

Beneficiary Protections

Because physiatrists treat some of the most vulnerable beneficiaries including the elderly, persons with disabilities, those having sustained catastrophic injuries and illnesses, and those with multiple chronic conditions, it is vital that any new incentive system or penalty be designed to curb unnecessary procedures and acute hospital readmissions, but not hinder access to rehabilitative care for those beneficiaries who need this type of care the most. For some beneficiaries, such as the elderly whose clinical conditions are not likely to improve, it may be inevitable that acute hospital readmissions occur no matter how excellent the care provided in the PAC setting. This and similar scenarios may cause PAC facilities to deny access to these beneficiaries for fear of financial penalty.

In order to protect these vulnerable beneficiaries, Congress could consider a program similar to that which has been proposed by CMS in the CY14 physician fee schedule rule[iii]. CMS has proposed that certain beneficiaries who have complex chronic conditions (two or more), are at risk for death or significant decline, and are expected to require care management for at least 12 months or until death, be qualified for a program in which a physician (primary care or any relevant specialist) manages care and is reimbursed appropriately based on time and care coordination efforts. Congress could develop a hybrid of this proposal that would qualify a physician or PAC setting to treat these types of patients and remain exempt from financial penalties.

In addition, the biggest threat to beneficiaries with bundled or episodic payment systems is the risk that they will be directed away from the most intensive, appropriate rehabilitation setting and toward a less expensive, less appropriate setting, simply to create short-term savings. Whether patients will have appropriate access to care or be subject to stinting on care is a critical issue that must be closely measured and assessed as payment reforms are designed and implemented. Medicare savings can best be achieved by returning beneficiaries with illnesses and injuries to health, full function, independent living, and full participation in the community.

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The American Academy of Physical Medicine and Rehabilitation thanks the Committees for the opportunity to share its thoughts on meaningful and balanced Medicare payment reforms for PAC settings. We remain committed to being part of a responsibility solution in any way we can. We hope these comments provide meaningful and thoughtful perspectives for your deliberations over possible payment reforms. If you have any questions or require more information, please contact Sarah D'Orsie, Director of Government Affairs, at sdorsie@aapmr.org, or (202) 349-4277.

Sincerely,

Alberto Esquenazi, MD
President, Board of Governors
American Academy of Physical Medicine & Rehabilitation (AAPM&R)

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[i] World Health Organization. International Classification of Functioning, Disability and Health (ICF), http://www.who.int/classifications/icf/en

[ii] Centers for Medicare and Medicaid Services (CMS). Report to Congress; Post Acute Care Payment Reform Demonstration (PAC-PRD), January 2012,

[iii] Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014, I. Complex Chronic Care Management Services, Federal Register, Volume 78, No. 139, July 19, 2013, Page 43337, http://www.gpo.gov/fdsys/pkg/FR-2013-07-19/pdf/2013-16547.pdf