American Academy of Physical Medicine and Rehabilitation

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SUBMITTED VIA ELECTRONIC COMMUNICATION

Susan Edwards
Office of Inspector General
Department of Health and Human Services
Attn: OIG—0803—N
Room 5513
Cohen Building
330 Independence Avenue SW
Washington, DC 20201

RE: OIG—0803—N, Request for Information Regarding the Anti-Kickback Statute and Beneficiary Inducements CMP

Dear Ms. Edwards:

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) appreciates this opportunity to comment on the Request for Information on evolving the rules of the Anti-Kickback statute's safe harbors to reflect changing business practices and technologies in medicine. The American Academy of Physical Medicine and Rehabilitation (AAPM&R) is the national medical specialty organization representing more than 9,000 physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

Promoting Care Coordination and Value-Based Care in Alternative payment Models

In response to the questions regarding promoting care coordination and value-based care, we assert that Physiatrists depend on working with allied health providers to treat patients effectively. As a specialty, for physiatrists to provide better value (health outcomes achieved divided by the cost of delivering these outcomes) physiatrists need to have more financial integration with our allied health providers. Stark and anti-kickback laws have prevented physicians from

owning and sometimes being a director of physical, occupational, speech therapy centers, gyms, massage parlors, and imaging centers that play a large role in an episode of care for a patient.

As we move to delivery systems that look at episodes of care and focus on high quality cost-efficient care, physicians will need to have a larger role in these services. Physiatrists who are developing physiatry medical homes or alternative payment models (APMs), such as episodes of care like oncology APMs, will plan to take on risk if they provide evidence-based care that is cost efficient. Physiatrists who plan to participate and work within these models should have a "safe harbor" exception to provide better value.

For Physiatrists, or the appropriate physician specialists, to be the leader in looking at wasteful spending in conservative management of care, they need to work with all providers to providing the right amount of care. One over utilized service is the amount of physical therapy. 2015 data shows that on average a patient will go to 10.8 sessions for an episode of back care costing $1300 dollars to the healthcare system. Using an evidence-based STarT back trial, physicians should be ordering a progressive exercise plan with two sessions at a time with home exercise programs in the intermediary. Some patients will just expire their sessions consecutively without ever progressing to more advanced exercise and a return to their pre-injury status. For physicians to make well-informed decisions about injections, imaging, and surgery referrals, physicians must be more accountable for physical therapy prescriptions.

Additionally, quality metrics measuring functional outcome are necessary to track patient care for musculoskeletal conditions. For physiatrists to track quality more efficiently, physicians and allied health providers need to have similar electronic health records, patient engagement tools, and care plans. If there are multiple different systems, it becomes extremely difficult to design episode of care models for patients being treated conservatively for musculoskeletal conditions.

In the future, if physicians will oversee an entire episode of care and will be held to financial risk, it is paramount that they have more control of financial services provided.

Beneficiary Incentives to Improve Quality of Care and Patient Engagement

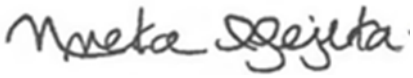
Providers and suppliers may be increasingly leveraging technology and provide technology-based incentives to improve patient adherence to treatment

recommendations, increase patient engagement etc. For example, providing a tablet or smart device for patients to track their activity and send that information directly to their providers. Such incentives may be useful to protect because the ability to have such communication keeps physicians informed on how patients are doing. In physiatry, for example, when treating a patient with back pain, it is imperative to know that the patient is exercising daily. Tracking this can keep patients from being readmitted. Offering incentives to increase the utilization of certain telehealth services, such as providing smart devices to better monitor health, could be very beneficial to patients. Additionally, access to online rehabilitation or exercise programs could be offered to appropriate patients. Both options would not only help keep patients healthy between physician visits, but also could decrease admissions and increase savings in health care.

We commend CMS for seeking ways to reduce obstacles the Anti-Kickback poses to accelerate the transformation our health care system to a value-based system that includes care coordination through HHS's Regulatory Spring to Coordinated Care.

We thank you for your consideration of these comments. If we can be of any assistance, please do not hesitate to contact Reva Singh, AAPM&R's Director of Advocacy & Government Affairs, at rsingh@aapmr.org or 847-737-6030.

Sincerely,



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