American Academy of Physical Medicine and Rehabilitation

aaPM&R

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November 21, 2013

Carol Carter, Ph.D.
Principal Policy Analyst
MedPAC
1425 Eye Street, NW, Suite 701
Washington, DC 20001

Dear Dr. Carter:

As a member of the physician community, the American Academy of Physical Medicine and Rehabilitation (AAPM&R) appreciates the opportunity to comment on the session, "Rationalizing Medicare's Payments for Post-Acute Care" held as part of the fall MedPAC meeting on November 7, 2013. The Academy supports reforms to the post-acute care (PAC) system, provided that 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 who have experienced catastrophic events resulting in paraplegia, quadriplegia, traumatic brain injury, spinal cord injury, limb amputations, rheumatologic conditions, musculoskeletal injuries, acute and chronic pain, and persons with neurologic disorders or any other disease process that results in impairment and/or disability.

Physiatrists treat beneficiaries across all PAC settings, including inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), home health agencies (HHAs), and long term acute care hospitals (LTACHs). In addition, physiatrists may act as primary care providers for the disabled and are often times best positioned to manage discharge planning from acute care to post-acute care settings. With appropriate rehabilitation, many patients can regain significant function, and live independent, fulfilling lives.

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Because physiatrists treat patients in many different settings of care, it is important to note that this cross-cutting 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 the same condition. The Academy disagrees with this argument and believes that there are important issues to consider before reaching any conclusion regarding the equality of services provided in each setting.

Specifically, it may be premature to implement such a payment model before cross-cutting quality and performance measures are created, reported, and then compared. While there is interest in the CARE tool, it is a work in progress and needs further evaluation. The Academy believes in and supports the concept of one tool that would measure functional status across settings, given that it is properly tested and validated and is updated on a continual basis. Until these conditions have been met, it is not appropriate to limit access to high quality care while testing mere theories of equality between the care provided in different settings.

An important difference between the care provided in IRFs and LTACHs, versus that in SNFs, is both cultural and structural in nature. These differences may be exposed when crosscutting quality measures are utilized and compared. For example, 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 functional 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. While in the IRF setting, Medicare requirements are such that 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.

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. The Academy does not endorse one setting over the other, it only endorses use of each facility-based care appropriately. Neither IRFs nor SNFs should be utilized inappropriately, which is why discharge planning from acute settings and additional studies based on outcomes are needed to further advance the science of placing patients in the correct setting based on their potential outcomes.

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Finally, when studying certain conditions for outcome parallels between settings, it is important to measure longitudinally. For beneficiaries who need intense rehabilitation, immediate health outcomes are equally important to long-term independence outcomes. Also, in creating a study as MedPAC has proposed to compare outcomes for specific conditions, it is critical to account for the differences between like settings. For instance, because of the well-defined criteria for being designated as an IRF, it is reasonable to assume that IRFs are more similar to each other than SNFs are to other SNFs. How will a sample be constructed for the purposes of comparing an accurate representative cross section of SNFs as a setting?

In sum, the Academy opposes moving towards a site-neutral payment policy until cross-cutting quality and performance metrics can be developed, tested, and appropriately analyzed. It is critical for patient care, and to achieve long term savings for the Medicare program to ensure that the right patient receives the right care in the appropriate setting.

The American Academy of Physical Medicine and Rehabilitation thanks MedPAC for the opportunity to share its thoughts on meaningful and balanced Medicare payment reforms. We remain committed to being part of the solution in any way we can. We hope these comments provide meaningful perspective in your deliberations over possible recommendations. 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,

Peter C. Esselman, MD
Chair, Quality, Policy, Practice, Research Committee (QPPR)
American Academy of Physical Medicine and Rehabilitation (AAPM&R)