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 847/754.4368
info@aapmr.org

Testimony of

GREGORY M. WORSOWICZ, M.D., M.B.A.

On behalf of the
American Academy of Physical Medicine and Rehabilitation
(AAPM&R)

Before the Ways and Means Health Subcommittee
Committee on Ways & Means
U.S. House of Representatives

Hearing: "The Evolution of Quality in Medicare Part A"

Wednesday, September 7, 2016
2:00 PM
1100 Longworth House Office Building
Washington, D.C.

Greg Worsowicz, M.D., M.B.A.
Business Phone : (573) 884-7418
Electronic Mail : worsowiczg@health.missouri.edu

Chairman Brady, Subcommittee Chairman Tiberi, Ranking Member McDermott, and Members of the Subcommittee:

It is a great honor to testify before the House Ways and Means Health Subcommittee today on the evolution of quality under Part A of the Medicare program. As a physician, I strive every day to find ways to improve the quality of care that I and my clinical colleagues provide to all patients. There are many strategies to achieve improvements in quality and, ultimately, better patient outcomes while providing care in the most efficient manner possible. I intend to focus my comments on payment reform measures and value based purchasing (VBP) in the post-acute care (PAC) sector, topics this subcommittee may consider in the future based on legislation already introduced to this committee.

By way of introduction, I am a board-certified physiatrist, a physician who specializes in physical medicine and rehabilitation (PM&R). I serve as Chairman and Professor of Clinical PM&R at the University of Missouri School of Medicine, the Medical Director of Rusk Rehabilitation Center, LLC, in Columbia Missouri, a joint venture between the University of Missouri and HealthSouth Corporation, and have worked in New Jersey, Florida, Texas, and Missouri in a number of health care settings including inpatient rehabilitation hospitals, skilled nursing facilities, long term acute care hospitals, and acute care hospitals. I have also served on the board of a home health agency. I am currently President of the American Academy of Physical Medicine and Rehabilitation (AAPM&R) and testify today on their behalf.

AAPM&R is a national medical society representing more than 9,000 physiatrists who adults and children with acute and chronic pain; persons who have experienced catastrophic injuries resulting in paraplegia, quadriplegia, traumatic brain injury, spinal cord injury, limb amputations, and musculoskeletal injuries; and individuals with neurologic disorders, rheumatologic conditions, or any other disease process that results in impairment and/or disability. With appropriate rehabilitation, many patients can regain significant function and live independent and fulfilling lives.

Physiatrists primarily receive their training in inpatient rehabilitation hospitals and units (IRFs) but work across the entire post-acute care continuum. They are well positioned to assess the medical and rehabilitation needs of patients in order to determine whether, and when, to send a particular patient to a long-term acute care hospital (LTACH), an IRF, a skilled nursing facility (SNF), or a home health agency (HHA) in their community. These different levels of post-acute care provide very different levels of medical and rehabilitation care. The notion that these PAC settings provide the same services, treat the same patients, and achieve the same outcomes is simply not correct and several recent studies have demonstrated this.[1]

The goal is to provide the right level of medical and rehabilitative care at the right time: to match the medical, functional, and situational circumstances of each patient with the level of rehabilitation intensity, coordination of care, and comprehensiveness that each PAC setting provides. In many instances, the decision to treat a patient in a particular PAC setting is relatively clear. In those instances, when it is not, clinical judgment plays a major role in the selection of the appropriate PAC setting based on the patient's medical and functional needs, and taking into account the totality of the patient's situation, including the potential to live independently, with or without family and other support systems.

---

[1] Buntin MB, et al. Med Care.2010; 48(9): 776-784 (Retrospective review of 287,115 Medicare patients; IRF patients have lower mortality, greater return to community); Wang H, et al. PMR 2011;3(8): 686-694 2011 (Retrospective review of 33,000 patients under Kaiser system; IRF patients had lower mortality than SNF); Deutsch A., Arch Phys Med Rehabil. 2013; 94(4): 630-632. (Retrospective review of 58,724 patients (pre-PPS – 1997); IRF patients with higher FIM motor scores and more community discharges).

For instance, in my practice, I routinely treat Medicare patients who have experienced a stroke, an injury to the brain resulting from restricted blood flow. Patients with stroke present with a wide variety of medical and functional needs, from limb paralysis or weakness, to difficulty with speech, to complications with vision, balance, cognitive function, coordination and other physical impairments. Occasionally, the decision to admit the patient to either an IRF or a SNF is not clear. Ultimately, the physician and the rehabilitation team must make a decision based on an assessment of the patient and the medical record, the patient's acuity, the assessed functional deficits, the patient's age, medical history, comorbid conditions, level of function prior to injury, the potential to improve function, the potential to return home to independent living, the level of family and other supports, and, of course, the patient's preferences and goals.

Depending on the severity of a stroke, patients could conceivably be referred to any one of the four PAC settings. It is critical that the patient who needs a particular intensity and level of coordination of rehabilitative care does not get diverted into a sub-optimal PAC setting. The patient must be stable enough to engage in the appropriate intensity of therapy while the patient's medical condition is managed by the physician based on the patient's individual needs. Best practices for stroke treatment was the subject of a set of important stroke guidelines recently published by the American Heart Association/American Stroke Association and endorsed by the AAPM&R entitled, *Guidelines for Adult Stroke Rehabilitation and Recovery*.[2]

This heavily footnoted study concluded that, "Stroke rehabilitation requires a sustained and coordinated effort from a large team, including the patient and his or her goals, family and friends, [and] other caregivers..." The guidelines also state, "Communication and coordination among these team members are paramount in maximizing the effectiveness and efficiency of rehabilitation and underlie this entire guideline…. The provision of comprehensive rehabilitation programs with adequate resources, dose, and duration is an essential aspect of stroke care and should be a priority in these [health care reform] redesign efforts."[3]

---

[2] Winstein CJ, Stein J, Arena R, Bates B, Cherney LR, Cramer SC, Deruyter F, Eng JJ, Fisher B, Harvey RL, Lang CE, MacKay-Lyons M, Ottenbacher KJ, Pugh S, Reeves MJ, Richards LG, Stiers W, Zorowitz RD; on behalf of the American Heart Association Stroke Council, Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, and Council on Quality of Care and Outcomes Research. Guidelines for adult stroke rehabilitation and recovery: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. Stroke. 2016;47: e98–e169. DOI: 10.1161/STR.0000000000000098.

[3] Ibid, at page 142.

This is the type of care that is consistent with the level of rehabilitation provided in an IRF. While SNF care for some stroke patients is completely appropriate, patients in need of an intensive, coordinated stroke rehabilitation program provided by an interdisciplinary team must continue to have access to this level of care. As Congress and CMS implement reforms to improve quality and save resources in the future, they must not inadvertently erect barriers to patient access to the appropriate course of treatment and setting of post-acute care.

Improving the Quality of Post-Acute Care

As the national policy goal of paying for value rather than volume continues to shape the health care system, many strategies are being pursued to improve patient outcomes and quality while reducing the cost of care. The level of change and innovation to achieve this goal is unprecedented as CMS implements and oversees multiple shared savings programs, Accountable Care Organizations (ACOs), pioneer ACO's, the Bundled Payments for Care Improvement (BCPI) initiative, Medicare Advantage, the Comprehensive Care for Joint Replacement (CJR) mandatory bundling program, the proposed cardiac care bundling program, as well as value-based programs such as the CMS Hospital Value-Based Purchasing program, and the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models APMs) under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

Despite this extensive transformation in the way Medicare pays for and providers deliver care, the data that demonstrate whether these many different programs are meeting expectations and achieving their goals are only beginning to become available. The most important impact of these programs—the patients' experience with and outcomes from care—is simply not known in any reliable or consistent manner at present. For physicians, this is particularly true with respect to the value-based payment systems (i.e., MIPS and APMs). While physicians will be subject to withholds and incentive payments based on quality measures over the coming years, the Academy cannot speak with experience about the impact it will have on the ability to deliver care or the ultimate outcomes of patients; unfortunately, nor can CMS.

In the MACRA rule published in May of this year, CMS discussed the impact of incentive payments on physicians at levels currently being debated. CMS stated, "We have not attempted to quantify the benefits of this rule because of the many uncertainties as to both *provider behaviors* and resulting effects on *patient health* and cost reductions. For example, the applicable percentage for MIPS incentives changes over time, increasing from 4 percent in 2019 to 9 percent in 2022 and subsequent

years, and we are unable to estimate precisely how physicians will respond to the increasing incentives."[4] [Emphasis added.]

Post-acute care alone is in the midst of one of the most active regulatory stages in its history. Coupled with the value-based programs cited above, the pace of change in all four settings of PAC services is breathtaking. It presents significant challenges for providers in keeping abreast of, and adapting to, these changes which are primarily focused on quality improvement. This regulatory activity accelerated dramatically after enactment of the Improving Medicare Post-Acute Care Transformation Act ("IMPACT Act") on September 18, 2014. AAPM&R strongly supported passage of the IMPACT Act because we believe that standardized data across the four main settings of post-acute care are critical to appropriately reforming the PAC payment and delivery system in a manner that preserves patient access to the right setting of care at the right time.

In the past year alone, AAPM&R, and all PAC stakeholders including patient organizations, have had to address, interpret and comment on numerous regulatory and sub-regulatory proposals related to quality improvement. A summary of the most notable developments include the following: (1) the annual prospective payment system regulation for LTACHs, IRFs, SNFs, and HHAs which have included implementation of IMPACT-mandated quality measures in each setting; (2) National Quality Forum deliberation of many of those same quality measures; (3) announcements of draft quality measures and Technical Expert Panels (TEPs) on IMPACT-mandated measures across PAC settings, often with accelerated comment periods; (4) proposed standardized assessment-based data elements under the IMPACT Act; and (5) the annual physician fee schedule proposed rule for FY 2017.

In addition, each PAC setting is in the midst of adapting to the ICD-10 coding system, considering the implications of an IMPACT-mandated report by the Medicare Payment Advisory Commission (MedPAC) on the development of a unified PAC payment system, and grappling with implementation in several key states of a new home health "pre-claim review" procedure. In short, the capacity and ability of the PAC community to adapt to additional changes at this time is limited.

Value-Based Purchasing for Post-Acute Care

Given the pace of change in the post-acute care sector, enactment of PAC-VBP programs or reforms at this time would be a tremendous challenge. AAPM&R strongly supports the concept of value-based purchasing for Medicare providers, including post-acute care providers, and expects that the same principles that have driven payment-for-value in many other Medicare provider sectors will eventually be

[4] *Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models*, Fed. Reg. 81, No. 89 (May 9, 2016), at 28377.

applied to post-acute care. However, it is imperative that VBP for PAC providers is designed correctly and based on reliable data that are standardized across PAC settings. This is critical because without reliable data across PAC settings, there is a serious risk that creating a PAC VBP system, or a unified payment model for PAC providers, will sub-optimize care for the patients we serve.

The hallmark of all PAC reforms must be what is good for patients. Payment and delivery reforms that have the effect of diverting patients to the least common denominator, or the least expensive setting regardless of outcome, rather than the appropriate level of post-acute care, should be rejected. Stinting on patient care is the AAPM&R's primary concern with all shared savings programs, delivery models, and payment reforms. Because of this we have made public our concerns on various models of post-acute care reform and various proposed pieces of legislation and offer some comment of key components of quality incentive programs and payment reform proposals.

1. Timing: We believe passage of this legislation at this time would add major additional policy changes to a sector that is struggling to comply with the existing pace of reform. Congress should allow the IMPACT Act to be fully implemented before embarking on VBP in the PAC setting.

2. Policy Development: Although value-based purchasing is beginning to take hold in several areas of the Medicare program, the policies applicable to PAC providers must be consensus-based and validated by data from existing VBP programs. Time must be taken to permit the examination of standardized data across PAC settings generated from the IMPACT Act's requirements as well as more generic data from other VBP programs outside of post-acute care. We view quality and payment incentive programs as a work in progress and one that we intend to continue engaging in as these policy proposals mature.

3. Withhold Is Too High: The Academy has concerns if withholds are too high in any program if may create significant risks that some post-acute care providers may be forced to close their doors, risking access to care, especially in rural settings and in urban areas. These providers are more likely to already be struggling due to a variety of factors and a significant payment disruption could be too difficult to overcome. Financial incentives to improve quality must be designed to motivate provider behavior without undercutting the financial viability of a significant percentage of providers who serve rehabilitation patients in their respective communities.

   Reforms centered on financial incentives must be based on a strong financial foundation. The fact that some of the other Medicare VBP programs use carefully developed percentages to reward or penalize providers does not mean that these same percentages should apply to post-acute care. Meeting the post-

acute care needs of Medicare beneficiaries with injuries, illnesses, disabilities and chronic conditions entails many variables not present in many other health care settings. This dictates independent policy development around a PAC VBP program. We note that the Hospital VBP program withholds no more than 2 percent of Medicare payments and request the Subcommittee to consider this withhold as a template for PAC VBP.

4. MSPB: Medicare Spending Per Beneficiary (MSPB) is an economic measure, a measure that assesses the resource use of a provider or system of care. It does not measure the value the Medicare program is receiving in terms of duration, scope or intensity of health care services provided to patients, nor does it address patient outcomes and quality of care. Use of this measure as the *only* method of determining whether PAC providers receive incentive payments will skew incentive payments toward lesser levels of post-acute care (i.e., home health and SNF care) and away from providers who use greater resources to provide their level of care, such as IRFs and LTACHs.

   MSPB fails entirely to recognize patient severity, the level or resources provided to meet patient needs, and the functional gains to be achieved through higher intensity, coordinated, interdisciplinary rehabilitation. MSPB has its place in measuring resource use but to designate it as the sole measure for PAC VBP is alarming. We strongly urge the subcommittee to ensure that any PAC VBP bill contains robust and accurate risk adjusters and includes functional and quality of life measures that will distinguish between settings of post-acute care.

5. Functional Measures and Quality of Life: Extensive activity is currently underway on the development, validation, and widespread implementation of PAC measures across multiple settings of care. Many of the measures mandated by the IMPACT Act are process measures (e.g., the percentage or staff or patients provided with influenza vaccine), not outcome measures. The existing measures that are outcomes-driven (i.e., incidence of skin breakdown and urinary tract infections) are basic and make them difficult to use in distinguishing between high quality PAC settings (IRF/SNF) verses low quality settings (IRF/SNF), let alone between different provider types (e.g., between IRFs, SNFs, and HHAs, for instance).

   The fact is that outcome measures across the PAC continuum are not yet mature. We simply do not yet have outcome-based measures that answer the most salient questions patients typically have post injury or illness in terms of their recovery and functional potential. Rather than prematurely linking significant payment incentives to an immature set of quality and outcome measures, this subcommittee should allow developments in this area to advance to the point where a PAC VBP would be the next logical step.

6. Budget Neutrality: AAPM&R believes that in addition to the withheld funds that form the pool of incentive payments, that any future consideration of PAC VBP legislation should reinvest any savings from the program back into the PAC system of care. This funding could be used to implement common-sense reforms in the various PAC settings to help further improve care, lessen provider burden, streamline unnecessary paperwork, and enhance access to patient care.

Regulatory Relief for Physicians in PAC Settings

Given the Academy's concern with moving forward with PAC reform legislation on such an accelerated timeframe, it may be perceived as premature to discuss proposals to include in a bill that would lessen the regulatory burdens facing physicians practicing in PAC settings. But there are numerous proposals that could be pursued, whether through a PAC VBP bill or in another legislative vehicle, that would genuinely make patient care more accessible, reduce regulatory burdens on providers, and not cost much, if anything. We are confident that other PAC stakeholders will offer their own ideas for regulatory relief at the appropriate time, but what follows is a number of regulatory priorities for the Academy that would benefit physicians practicing in PAC settings.

1. Clarify the "Intensity of Therapy" Requirement in IRFs: The so-called "Three Hour Rule" should recognize recreational therapy as counting toward satisfaction of the intensity of therapy requirement. Recreational therapy should be counted as one of the skilled therapy modalities allowed under calculation of the Three Hour Rule when these services are prescribed by the treating physician and the rehabilitation team as part of the patient's plan of care, are considered active treatment, and are provided by a qualified recreational therapist. Currently-pending, bipartisan legislation in the House, H.R. 1906, seeks to recognize recreational therapy as an included therapy discipline under the Three Hour Rule. AAPM&R has been a strong champion for this bill, which has the support of a number of key rehabilitation providers and consumer stakeholder organizations. The modification would permit physicians to better manage their rehabilitation therapy teams in providing the appropriate mix of services required by each patient. The proposal is not expected to have a major budget impact.

2. Allow for Physician Extenders: Congress should clarify that physician extenders (e.g., physician assistants and nurse practitioners) who are acting under the supervision of the rehabilitation physicians are permitted to fulfill certain regulatory requirements in a number of PAC settings, as long as concurrence by the physician is documented. This proposal would provide additional capacity for physicians to comply with numerous documentation burdens in PAC settings, enhancing the ability of these physicians to comply with relevant deadlines. Regulatory relief designed to ease the burden of documentation would likely have a material impact on the number of Medicare claims denials based on non-clinical factors. Extending the authority to use physician extenders in this context is consistent with the expanding use of physician extenders across the health care system and would likely have no budgetary impact.

3. Permit Documentation Deadlines to Be Extended: Congress should clarify that Medicare's documentation requirements in PAC settings have some degree of flexibility in order to focus on patient care, first and foremost. For instance, documentation that is required to be signed within a certain timeframe should be permitted to be completed by noon of the next business day if the original deadline falls on a weekend or federal holiday if it does not directly impact patient care. This provides greater flexibility in the documentation deadlines, within reason, and would likely lead to greater work satisfaction levels among physicians and other rehabilitation professionals in multiple PAC settings, as well as fewer denials for documentation that contains technical deficiencies.

4. Other Policy Proposals for the Subcommittees' Consideration: The Academy has other regulatory relief proposals that it would like to discuss with the subcommittee as it continues to debate post-acute care reforms, including clarifying the rehabilitation physician's role in IRFs and other settings of post-acute care, as well as funding for Graduate Medical Education (GME) training across all PAC settings.

****

Thank you for the opportunity to testify on this important set of policy issues confronting the subcommittee. The American Academy of Physical Medicine and Rehabilitation stands ready to assist the subcommittee as it continues its important work on quality improvement in the area of Medicare post-acute care.