

**Association of Academic Physiatrists
Comments on the Essential Health Benefits Plan
US Department of Health and Human Services
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Good morning. I am Dr. Bruce Gans, a physiatrist who serves as the Executive Vice President and Chief Medical Officer for Kessler Institute for Rehabilitation in West Orange, New Jersey. I also hold an appointment as Professor of Physical Medicine and Rehabilitation (PM&R) at the UMDNJ-New Jersey Medical School in Newark, NJ. We are grateful for the opportunity to present to you the comments of the Association of Academic Physiatrists (AAP). I am a Past President of the AAP. We are extremely concerned about the potential for the Essential Health Benefits plan to adversely impact persons with disabilities for whom we care, and as a result, our ability to both train future physician practitioners and also to conduct the research and studies necessary to advance the field and improve the effectiveness and cost benefits of medical rehabilitation.

The AAP is a professional society that represents approximately 1200 teaching physicians who are members of medical school faculties in the United States who specialize in the field of PM&R. Our members provide clinical care and train medical students, residents, fellows, and other health professions students in how to care for people of all ages with physical and cognitive disabilities. PM&R specialists, referred to as physiatrists, care for children with disabling conditions such as cerebral palsy, muscular dystrophy, spina bifida and limb deficiency as well as adolescents and adults with a wide variety of neurological and musculoskeletal and medical disorders. These disorders include stroke, spinal cord injury (SCI), traumatic brain injury (TBI), amputations, arthritis, spine pain, and many other conditions.

Physiatrists also conduct research in these various conditions and the delivery systems through which we function. Our clinical model includes both traditional medical practice, with an emphasis on the use of physical modalities, as well as an emphasis on creating and directing medical rehabilitation programs and services utilizing multidisciplinary teams of professionals. We practice in short term acute care hospitals (STACH), inpatient rehabilitation hospitals and units (IRH/U), skilled nursing facilities (SNF), and offices and clinics. Many of our members provide long-term specialty care and primary care services to persons with serious disabling disorders, so we have an understanding of the long-term system issues. Furthermore, we face on a daily basis struggles dealing with insurance providers while trying to provide medical rehabilitation services to our patients.

The population we expect to serve with this insurance program now being discussed will have somewhat different characteristics than our typical Medicare and Medicaid patients, and also some differences from those we treat with commercial insurance. We expect that these individuals will have a higher incidence of traumatic conditions such as SCI and TBI, but lower incidence of stroke and amputation, when compared with the

Medicare beneficiaries we typically see. They are also much more likely to be actively employed, a situation with profound influence on what care and treatment goal setting becomes appropriate.

While there is increasing general awareness of the health and functional benefits that medical rehabilitation offers (the recent tragic example of Congresswoman Giffords has recently further highlighted this awareness), there are still many discriminatory limitations placed on coverage for rehabilitation services by both commercial and public programs. Medicare for example, has arbitrary dollar caps on the use of outpatient physical therapy, occupational therapy and speech therapy. Medicaid varies strikingly across states, some providing robust coverage for outpatient therapies, others declining any coverage at all. Commercial insurers frequently have annual visit count limits for outpatient therapies, and managed care providers apply great pressure to reduce inpatient length of stay in IRH/Us by pressing for early discharge to home care, or trying to channel patients to SNF settings instead of IRH/Us, regardless of medical recommendations.

These short-cited examples of cost containment efforts result in barriers to access for our most disabled and needy patients. Instead of controlling unnecessary utilization, these practices result in increased risks of adverse events, avoidable complications and unnecessary readmissions to STACHs. The design of the EHB program can serve as a protection from these problems and as a role model for other insurance programs to emulate.

There is a body of literature that supports our contentions that medical rehabilitation is cost effective. For example, in the world of workman's compensation, it is widely quoted that for every dollar spent on medical rehabilitation, there is a return of \$11 to \$35 in benefit. We also know that the rehospitalization rate for patients discharged from IRH/Us is literally half the rate of patients who were placed in SNFs. Furthermore, the discharge to home rate from IRH/Us is twice that of SNFs. In the current climate of concern about avoidable health care utilization, these are striking differences worthy of consideration as the benefit plan is articulated.

AAP recommends that the EHB program include:

- Coverage for the medical treatments and diagnostic procedures provided by physiatrists in offices, clinics, and institutional settings (such as evaluation and management services, electrodiagnostic testing, therapeutic injections to treat joint pain, muscle pain, and spasticity)
- IRH/U care as recommended by rehabilitation physicians
- SNF rehabilitation services when prescribed by rehabilitation physicians
- Rehabilitation therapies (PT, OT, ST, etc.) when prescribed by qualified physicians in a variety of settings
- Durable Medical Equipment
- Prosthetics and Orthotics

- Care coordination services to ensure successful navigation through the delivery system for persons with disabilities

AAP recommends that discriminatory utilization constraint practices be avoided, including:

- Arbitrary dollar caps for therapy services
- Arbitrary visit caps for therapy services
- Coercive practices to channel patients to care settings not recommended by a qualified rehabilitation physician
- Restrictions that limit coverage of powered wheelchairs to use in the home, thus preventing employment and full participation in society.

With regard to the ongoing review and monitoring of the program we recommend that both consumers who have utilized rehabilitation services and physicians who specialize in PM&R be part of an oversight or advisory board that would annually review the function of the program and recommend adjustments and changes. In part we suggest that complaints, grievances and appeals that are filed by consumers be carefully monitored and reviewed by this body to detect needed changes.

The AAP is voicing its recommendations and concerns about the EHB because, in part, we believe that our capacity to train future practitioners and conduct the research needed to advance the practice will be materially harmed if coverage is not available for the patients we treat. In addition, we know that the care we deliver can be extraordinarily meaningful to the patients and families we work with, and also be a highly responsible way to constrain health care expenditures.

Thank you for the opportunity to express our suggestions and concerns. We would be happy to respond to any questions you might have, and would welcome the opportunity to work with you to further develop, refine, and improve the EHB plan over the years to come.

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