

April 15, 2013

The Honorable Fred Upton, Chairman
House Energy and Commerce Committee
The Honorable Dave Camp, Chairman
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen Camp and Upton:

The Private Practice Section of the American Physical Therapy Association (PPS) is pleased to submit these comments and suggestions in response to your request for input on the second iteration of the proposal to repeal and reform the sustainable growth rate (SGR) formula used to determine payment rates for therapists and physicians under Medicare and ways to improve health outcomes and efficiency in the Medicare program. The over 4200 members of PPS own and operate primarily small businesses that provide convenient, cost-effective rehabilitative therapy to patients across the spectrum of impairments and functional limitations secondary to neurologic and/or musculoskeletal conditions. The PPS endeavors to foster the growth, economic viability, and business success, of physical therapist-owned physical therapy services provided for the benefit of the public.

The PPS appreciates the rapid rate at which you appear to be progressing. And, as you progress, we appreciate that you are attempting to be mindful of non-physician providers as well, including independent physical therapists who function primarily as small businesses and who are an integral element of our nation's delivery system. PPS members provide a valuable service to communities across the country and they do so in a convenient cost-effective manner. But as is typical for small businesses, narrow margins are jeopardized when a significant sector of its market cuts reimbursement without regard to the value of the services provided.

It appears that the second iteration of the committees' proposal assumes that performance measures alone lead to higher quality health care. We hope this is not the case as it is our experience that performance measures can be used to improve targeted areas of health care delivery, but quality improvement is more complicated and more individual than can be reflected in performance measures alone.

The committees' proposal also envisions a fee-for-service payment system that moves to efficiency measures to achieve savings for the health care system. But we would caution that most efficiency measures can achieve short-term savings at an individual practice level but result in cost increases for the health care system broadly. To be accurate, fair and effective, efficiency measures must take into account gain-sharing across the health care system.

In your second iteration of the repeal and reform proposal, you list twelve specific questions to which you seek responses. Following our comments on Phase I and Phase II, I will address these questions in order.

Phase I – Period of Stable, Predictable Updates

PPS Comment: A period during which payment rates are stable is essential to the successful transition from fee-for-service to new payment models. We believe the period should be identified in advance, no less than five years, during which reimbursement should be modestly and consistently increased annually. Medicare reimbursement under the SGR has been nearly flat since 2002, which is a s kind of stability, of course, but one not conducive to the provision of high quality care nor consistent with a sound business model. We believe a five year period will give therapist practices sufficient time to evaluate their investment in transforming their practices.

Phase II -- Portion of Payment Based on Quality through Update Incentive Program (UIP)

PPS Comment: PPS supports consensus-based measures adopted or endorsed by an objective third-party entity such as the National Quality Forum. With respect to data feedback, the information must be timely, which means as close to real-time as possible but no less than quarterly. The closer the feedback is to real-time, the more likely it will be that such data could be used to shape clinical decision-making and improve patient care. Feedback that is received 18-24 months after the care has been delivered (e.g., the PQRS program), is of very little value in improving care.

Responses to the 12 questions posed in the second iteration

1. How should the Secretary address specialties that have not established sufficient quality measures?

PPS Comment: PPS believes measure development should be consensus-based and endorsed by an independent third party. Allowing the Secretary to set measures could deter specialties from comprehensive and evidence-based measure development which we believe is inconsistent with the stated direction of Medicare payment.

2. Is it appropriate to reward improvement in quality over time in addition to quality compared to peers?

PPS Comment: Both quality as it is compared to peers and quality improvement over time can be part of a reward program. However, PPS would discourage consideration of a scheme that bases payment solely on relative rankings of providers which would imply that those ranking near the bottom, irrespective of the results achieved with their patients, could be at risk for adequate reimbursement. In addition, PPS discourages exclusive or excessive use of visit counts or charges when determining quality. Likewise, a system based only on practice improvement disadvantages those therapists who have already improved their quality. PPS supports reward systems that employ true benchmarks attainable by any provider. In other words, the result of the care, or outcome, is the true measure of quality.

3. Are there sufficient clinical practice improvement activities relevant to your specialty? If not, does your organization have the capability to identify such activities and how long would it take?

PPS Comment: Clinical improvement activities are of less relevance when patient outcomes are being measured. In the vast majority of physical therapy patients, the conditions are conducive to the use of valid, reliable and responsive functional status measures. Since the ultimate concern of any payment program is the effect of the care on the patient, outcomes measures are the “gold standard.” When therapists are employing such measures and using the data to improve care, other clinical improvement activities are of secondary importance.

Clinical improvement activities are relevant in patients with chronic conditions in which functional status gradually deteriorates over time such as Parkinson’s, Alzheimer’s, multiple sclerosis, rheumatoid arthritis and the like.

4. Should small practices have the ability to aggregate measurement data to ensure that there are adequate numbers of patient events to reliably measure performance? If so, how?

PPS Comment: PPS believes all practices should be allowed to aggregate measurement data and the most effective and convenient way is through a clinical registry which employs accurate risk adjustment which is critical when data are aggregated.

Phase III –Reward for Efficient Resource Use

5. How much time is needed to refine the methodology for determining and attributing efficient use of health care resources?

PPS Comment: The concept of “efficiency” in the delivery of health care services can be nebulous until precisely defined. And the definition will dictate the amount of time necessary to refine the methodology for determining and attributing the use of health care resources. Regardless, risk adjustment is an important component that must be considered when attempting to determine and measure efficiency.

In addition, predicating a reward on efficiency must consider all of the components of health care delivery, not just the therapy practice where the beneficiary received care. This is because proper investment in early intervention, and even in preventive care such as in addressing balance and falls in the elderly, can result in lower costs elsewhere in the system. Indeed, in some cases greater utilization of physical therapy can result in the avoidance of surgery, admission to a facility or various tests and measures. This thinking needs to be incorporated into the concept of efficiency.

6. Is it preferable to only have a payment implication based on efficiency for providers that meet a minimum quality threshold?

PPS Comment: Yes, PPS believes a payment implication based on efficiency for providers that meet a minimum quality threshold is the optimal design. A bonus or incentive for care that exceeds a minimum quality threshold is strongly preferred. But we do not believe it is wise to

consider using efficiency as the sole measure. Experience with managed care in the 80s and 90s has shown that to be an unsound approach.

**Provider Opt-Out for Alternate Payment Model (APM) Adoption
Questions for APM Adoption:**

7. What do you believe will be necessary to support provider participation in new payment models?

PPS Comment: For physical therapy, there must be some reasonable limits on a patient's out-of-pocket expenses. The cost-effectiveness of rehabilitation therapy is demonstrable, and even more so when functional outcomes measures are employed and data are used to guide clinical decision-making, that patients should not be dissuaded to use services that can assist in returning them to functional independence and optimal performance. High copays and deductibles can act as a deterrent to patient compliance. Arbitrary limits and policies, such as the therapy caps or not allowing therapists to use locum tenens, interfere with the continuity of care and can contribute to noncompliance, higher costs and the achievement of less than optimal outcomes. Moreover, as we have pointed out in other sections of these comments, such policies can be "penny-wise, but pound-foolish," by leading to more unnecessary expenditures elsewhere in the system.

8. What is a reasonable time frame for CMS to approve and adopt APMs?

PPS Comment: The time frame for adoption depends on the specific APM being developed and approved. PPS believes an alternative payment method, such as envisioned by the Balanced Budget Act of 1997, which created the arbitrary therapy caps, could be operational in five years which is consistent with our recommendation of a five year period of stability with predictable and annual positive updates. Such a system would be based on meaningful clinical measures with strong psychometrics that produce data that, when risk-adjusted, can be part of a reward program that employs true benchmarks that are achievable by any provider; not one that produces winners and losers.

Specifically, as has been mentioned in previous communications with the committees, the American Physical Therapy Association (APTA) is currently working on an alternative payment system for outpatient therapy services that embraces a per session methodology. Such a system that categorizes patients based on the severity of their condition and intensity of the interventions required better reflects the professional clinical reasoning and judgment of the physical therapist, improves provider compliance, reduces administrative burden surrounding current payment models, and provides policymakers and payers with an accurate payment system that ensures the integrity of medically necessary services.

Considerable work has already been accomplished on this time-consuming endeavor including the establishment of a coding development work group through the AMA Relative Value Update (RUC) process. Given the complexity of this undertaking, PPS believes transition to such a patient-centric, clinically appropriate and more accurate payment system could be implemented within the five-year time frame we have mentioned above.

9. Should providers be able to participate in more than one payment model?

PPS Comment: Just as therapists are allowed currently to assess and decide which insurers (commercial and public) are recognized by the practice, providers should continue to be allowed to participate in any payment model which they deem appropriate for their practice. This therapist choice is an important element in the development of new payment models as it is a way the market can help determine the relative merits of, and satisfaction with, any APM.

Improvements on Current Law:

10. What improvements upon current law do you believe will be required to support alternate payment model adoption?

PPS Comment: Please see our response to #7 above.

In addition, as Congress considers ways to modernize the Medicare reimbursement methods, PPS also urges serious consideration be given to correcting technical obstacles that prevent private practice physical therapists from providing care in the most streamlined of manners. These include: **locum tenens**, **direct contracting**, the **multiple procedure payment reduction**, and the **in-office ancillary exception**.

Locum Tenens

It is a longstanding and widespread practice for physicians to retain substitute physicians in their professional practices when they are absent for reasons of illness, pregnancy, vacation or continuing medical education. It is also acceptable for the regular physician to bill and receive payment for the substitute physician's services as if he, or she, performed them. The substitute physician generally has no practice of their own and moves between practices as needed.

The patient's regular physician may submit a claim and (if assignment is accepted) receive the Part B payment for covered visit of a locum tenens physician who is not an employee of the regular physician and whose services for patients of the regular physician are not restricted to the regular physician's offices, provided specific criteria are met.

However, physical therapists are not included in the locum tenens statute and this creates a hardship for independent practitioners who operate small businesses. The locum tenens provision included in section 1842(b)(6) with the enactment of Section 125(b) of the Social Security Act Amendments of 1994, only allows locum tenens for practitioners identified as "physicians" under Medicare.

To enable physical therapists to utilize locum tenens arrangements requires a slight amendment of the Medicare statute (Social Security Act section 1842(b)(6)) by adding physical therapists to the list of professionals allowed to obtain a temporary substitute provider. This patient-centric policy change does not carry a cost and is an essential modernization of Medicare reimbursement policy.

Direct Contracting with Consenting Medicare Patients

Physical therapists may not collect out-of-pocket payment from a beneficiary for a Medicare covered service and PPS recommends Congress remedy this oversight by amending the statute to allow such transactions with consenting Medicare patients. By making this change in statute, Congress will require physical therapists to comply with the same private contracting (opt-out) requirements as physicians and non-physicians who already enjoy this privilege. In

such an instance under current law, the physical therapist would not be reimbursed for treating Medicare patients for two years following the filing of the opt-out affidavit.

PPS recommends that Section 1802(b)(5)(B) of the Social Security Act be amended as follows:
Inclusion of physical therapists under private contracting authority, Section 1802(b)(5)(B) (42 U.S.C. 1395a(5)(C)) is amended by striking "the term practitioner has the meaning given such term by section 18a2ft)(18)(C)" and inserting "In this subparagraph, the term "practitioner" means an individual defined at section 18a2ft)(18)(C) or an individual who is qualified as a physical therapist. "

Multiple Procedure Payment Reduction

At the beginning of this year, Congress passed and President Obama signed the American Taxpayer Relief Act (ATRA) which saved the nation from the so-called fiscal cliff by postponing sequestration for two months. ATRA contained a provision which negatively impacts Medicare beneficiaries with complex conditions requiring extensive physical therapy and other rehabilitative services.

The law more than doubled a cut passed by Congress two years ago. This provision, known as the Multiple Procedure Payment Reduction (MPPR) reduces payment for the practice expense portion of codes when therapeutic services are delivered in multiples or combinations, which is typical in physical therapy.

In 2011, physical therapists received a 20-25 percent (20% for private practices, 25% to facilities) MPPR on outpatient therapy services delivered on the same day. This means that when a treatment involves more than one procedure or a patient requires more than one therapy service in a single day, the code with the highest practice expense value that day will be reimbursed at 100 percent and the practice expense component of the second and subsequent codes will be reduced by 20-25 percent.

Under ATRA, this percentage was increased to a 50 percent reduction of the practice expense value for both private practice and facilities beginning April 1, 2013.

The MPPR congressional actions were used in both 2011 and 2013 as a means of paying for an extension of the Medicare Physician payment rate which was scheduled to be cut due to the flawed sustainable growth rate formula. Thus, these MPPR provisions represent bad policy employed to offset the cost of legislation to patch another flawed policy, the SGR.

Therapy services are typically delivered in combinations and multiples in order to achieve the most positive outcomes. This fact is expressly recognized when the codes for therapeutic services are initially valued by the American Medical Association's Relative Value Update Committee (RUC). In other words, the practice expense component of physical therapy codes is already valued in accordance with the MPPR concept which means that the congressional actions of 2011 and 2013 are second and third insults to therapists and their patients. Moreover, this represents congressional micromanagement of the resource-based relative value scale (RVRVS), the system used to reimburse health care services for several decades.

PPS urges you to act immediately to prevent this latest MPPR provision from taking effect on April 1, 2013. It will restrict patient access to vital therapy services and especially impact patients with multiple chronic conditions, most in need of intensive therapy treatment programs

and treatment from more than one discipline (e.g., PT, OT, SLP). Moreover, CMS recognized in 2011 that a 50 percent practice expense MPPR policy is not supportable by reliable data.

This congressional manipulation of the intricacies of the Medicare Physician Fee Schedule is further evidence of the flawed system we are currently enduring. And as was recognized by several witnesses testifying before the Energy and Commerce Health Subcommittee on February 14, the transition from FFS to a system based on value and performance currently underway will take a number of years. But in the meantime, FFS must be improved and made more accurate because it will serve as the baseline for comparison of future delivery and payment models. PPS concurs with this advice and urges Congress to prevent the implementation of this MPPR adjustment as it renders the FFS system less accurate rather than the more balanced system recommended during the hearing by Medicare Payment Advisory Commission chairman Glenn Hackbarth, Dr. Bob Berenson of the Urban Institute and others.

Curbing Overutilization of Therapy

Currently under Medicare Part B there are various ways to bill for services. **One policy in particular -- the Stark II in-office ancillary services exception to the self-referral law -- carries a proven propensity for overutilization.** PPS believes, and evidence shows, that elimination of this exception could provide potential cost-savings and improve the integrity of the services delivered and paid for by the Medicare program. The Office of the Inspector General of the United States Department of Health and Human Services has continued to identify a high rate (78 to 91%) of inappropriate billing of physical therapy services billed incident to a physician's professional services. Elimination of these practices must be addressed in an effort to provide a sustainable payment system for Medicare Part B and ensure we are paying for only services delivered appropriately by qualified professionals of that discipline.

11. What improvements upon current law will help ease the administrative burden upon medical providers and allow more time caring for Medicare beneficiaries?

PPS Comment: Elimination of the use of "sampling and extrapolation" by recovery audit contractors (RACs) is an improvement that will ease the administrative burden and foster a more patient-centric therapist practice environment.

More specifically, we encourage analysis of the current Manual Medical Review (MMR) process for outpatient therapy exceeding \$3,700 in expenditures in a calendar year. While we support the use of MMR as an appropriate check on utilization, we are concerned that CMS has implemented the system in a way that does not meet the intent of the legislation that created MMR. The original congressional language expected a prompt turnaround time of MMR submissions to ensure timely patient access to medically necessary services. We are aware of delays in patient care up to a month due to challenges in dealing with the CMS system. CMS recently released new guidance on Manual Medical Review and effective April 1, 2013, the Recovery Audit Contractors (RACs) began conducting two types of review for claims processed on or after April 1, 2013: (1) prepayment review for states within the Recovery Audit Prepayment Review Demonstration, and (2) immediate post-payment review for the remaining states. As you know, RACs are paid commensurate with the number and size of denials they determine. Consequently, PPS is concerned that this results in delayed or impeded medically necessary care. Because this will only increase costs elsewhere in the system, we encourage the committees to review this process and make recommendations to improve it in the near term.

12. What improvements upon current law would support the provision of quality health care delivery for Medicare beneficiaries?

PPS Comment: The following improvements upon current law [or regulation] would support the provision of quality health care delivery for Medicare beneficiaries:

- a. Elimination of the arbitrary therapy caps and replacement with a payment system that is based on the severity of a patient's condition and the concomitant intensity of services necessary to achieve an optimal therapeutic outcome.
- b. Providing incentives for patients to use physical therapy via prevention and early intervention.
- c. See our response to #10 above.

PPS appreciates the opportunity to provide these comments and please know that we are eager to make ourselves available for any questions you might have or clarifications you might need.

PPS members of the American Physical Therapy Association commend you for your continued efforts to create a more stable, predictable and effective Medicare payment system. We look forward to more opportunities to provide input to the committees, Congress and CMS to help preserve and strengthen the Medicare program which means increasing quality, decreasing cost and improving outcomes, not only in the physical therapy sector, but throughout the Medicare system.

Sincerely,



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President
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