

February 24, 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/APTA) is pleased to submit these comments and suggestions in response to your request for information and suggestions for value-based measures and practice arrangements that can improve health outcomes and efficiency in the Medicare program. The over 4200 members of PPS/APTA own and operate 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/APTA endeavors to foster the growth, economic viability, and business success, of physical therapist-owned physical therapy services provided for the benefit of the public.

Specifically, you have solicited comments pertaining to:

- Stabilizing the fee-for-service (FFS) system
- Development of meaningful quality measures
- Rewarding quality and efficiency, including risk-adjustment
- Administrative burden on providers, including reporting requirements
- Alternative payment models

As you proceed with your efforts to reform and ensure stability of the Medicare program, particularly physician payment, we would urge you to be continuously mindful of non-physician providers as well, including the constituency we represent, the independent physical therapists who function as small businesses and who are an integral element of our nation's delivery system. PPS/APTA 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 service provided.

The Sustainable Growth Rate (SGR) formula continues to create uncertainty in the Medicare program for health professionals and beneficiaries. Because so many private insurers use the physician fee schedule as a guide for reimbursement decisions, such unpredictable economic activity taken by Medicare casts a pall over the small business environment in which independent physical therapists must function. In addition to the difficulty this causes providers, our nation's seniors, the Medicare beneficiaries, are left in a very vulnerable position, unable to

depend on the access to convenient, cost-effective, high-quality care to which they have become accustomed.

The SGR formula has proven to be flawed policy both from a reimbursement standpoint and a legislative perspective. The so-called accumulated debt that this formula has produced is artificial and an artifact of the architectural design of the formula, not a reflection of any real economic development.

For over a decade Congress has recognized the folly of this formula and should delay no longer in its pursuit of repealing this statute. We commend you for the aggressive initiative you demonstrated in beginning to tackle this important issue so early in the 113<sup>th</sup> Congress. The replacement for the SGR should be contemporary, clinically relevant and patient-centered. Moreover, the reimbursement should reflect the actual practice costs that therapists and physicians experience in running their small businesses.

### **Stabilizing the fee-for-service (FFS) system**

After the period of stability, the fee schedule updates will be based on meaningful measures of care quality and participation in clinical improvement activities. The measures used should demonstrate broad acceptance by the clinicians employing them, regardless of specialty. Rewards should be based on advancements in care quality demonstrated by individual clinicians on a per patient basis and in the aggregate.

### **Development of meaningful quality measures**

Please be continually mindful of the nonphysician professionals as you consider ways of standardizing the development process for quality measures. The measures should be clinically relevant, patient-centered, preferably outcomes-based, and demonstrate broad acceptance by the clinicians employing them. There should be greater reliance on national (as opposed to state and local) entities that have advanced valid and reliable measures through an accepted and recognized process. An excellent starting point for the rehabilitation therapies would be the patient assessment instruments recognized by the Centers for Medicare and Medicaid Services (CMS) in December 2006 in Transmittal 63 (*CMS Manual System, Department of Health & Human Services (DHHS) Pub 100-02 Medicare Benefit Policy, Transmittal 63, Change Request 5478*).

(<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r63bp.pdf>)

Education of the professionals on the use and benefits of these quality measures and clinical improvement activities should be accomplished by CMS and the national, state and local societies and related stakeholders.

### **Rewarding quality and efficiency**

The committee outline indicates that performance should be based on both risk-adjusted relative rankings amongst specialty peer groups and improvement on quality over time. In reality, an accurate risk-adjustment system is the cornerstone of any payment system that is going to reward desired behavior. With a reliable risk-adjustment system in place, the number of outliers will be minimized. When they do exist, professionals should be allowed to appeal disputes to a panel comprised of their peers. Any public reporting that is accomplished should be done only following the opportunity for the professional to review the data.

An issue related to quality and efficiency for which a resolution is long overdue is the arbitrary per-beneficiary therapy cap imposed by the Balanced Budget Act of 1997. This statute has

largely been recognized as bad policy and Congress has waived or overridden the cap nearly completely since its enactment.

The rehabilitation professions have for some time urged Congress to direct CMS to collect available clinical data that would enable the development of a payment policy that would replace the arbitrary, per beneficiary, Medicare therapy caps. In the Middle Class Tax Relief and Job Creation Act passed in late 2011, Congress did direct CMS to implement a claims-based system that would collect functional outcomes data, which is unique to the field of physical therapy.

Clinical data related to patient assessment, severity, impairment or functional status and collected by the clinician using valid and reliable methods can readily lead to means of identifying the patient's therapy needs, thus rendering the therapy caps entirely obsolete.

Collecting and using these data should enable CMS to develop a contemporary, clinically relevant, patient-centered payment policy that fosters higher quality, lower cost care within two years. To hasten this process even more, Congress should direct CMS to incentivize rehabilitation therapy professionals in all settings to collect and submit relevant functional status data by waiving the therapy caps when patients receive treatment in such a setting.

#### **Administrative burden, including reporting requirements, on providers**

The committee outline correctly insists that the reporting burden on professional practices be reduced under the new method of reimbursement. In order to achieve this goal, Medicare must harmonize the myriad programs that require reporting. For physical therapy this would mean combining and creating consistency between the Physician Quality Reporting System (PQRS) and the above-mentioned program requiring the reporting of functional status via claims submission initiated by Medicare on January 1, 2013.

#### **Alternative payment models**

As you know, the rehabilitation professions under the leadership of the American Physical Therapy Association have undertaken the development of an alternative payment system. Such a system was envisioned by the BBA of 1997, yet little progress has been made by CMS in the ensuing fifteen years. But impressive progress has been made by the APTA in just the past eighteen months.

APTA recognizes that policymakers are seeking ways to reform payment systems to achieve greater reporting accuracy, promote quality care, and control increased utilization. In 2011, APTA unveiled to the Hill a concept for an alternative payment system that proposes to reform payment for outpatient physical therapy services by transitioning from the current fee-for-service, procedural-based payment system to a per-session payment system. APTA believes that 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. The American Medical Association (AMA) has established a coding development work group through the AMA Relative Value Update (RUC) process to study this proposal and APTA continues to brief other stakeholders such as CMS and the Medicare Payment Advisory Commission (MedPAC).

This approach is consistent with policy changes recommended by CMS's contractor, Computer Sciences Corporation (CSC), in a report titled "Short Term Alternatives for Therapy Services. (July 2010)" In this report CSC included three options, one of which involves adoption a per-session bundled payment that would vary based on patient clinical presentation and the complexity of evaluation and intervention services. Following the CSC report, in the 2011 physician fee schedule final rule, CMS included extensive discussion of several potential alternatives to the therapy caps that could lead to more appropriate payment for medically necessary and effective therapy services, including the per session bundled payment approach.

Since publication of that rulemaking, APTA has continued to extensively develop a system based on this per session recommendation. Achieving this reformed payment system for outpatient physical therapy services would require changes to the existing Current Procedural Terminology (CPT) coding system. Once developed, the new codes will be valued through the AMA RUC process and could be implemented in federal, commercial, and state-based payment systems. The RUC is expected to have a final proposal ready for the establishment of new code values this fall and APTA estimates that the new alternative payment system could be implemented as early as January 1, 2015.

The construct of reimbursing on the basis of value, particularly when combined with the important patient centric data of severity and intensity, could provide guidance to Congress as it not only considers repealing and replacing the SGR, but its utility as a replacement for the Medicare therapy caps should be evident as well. When the emphasis (and reimbursement) is on value, the need for outdated visit (and dollar amount) limits such as arbitrary therapy caps is eliminated. Thus, at the appropriate time, a legislative repeal of the existing caps on outpatient therapy would be possible and necessary. Meanwhile, continued efforts by the Ways and Means and Energy and Commerce Committees to refine the therapy cap exceptions process and mitigate the harmful effects on beneficiaries are both valued and appreciated.

#### **Additional corrective action needed**

As Congress considers ways to modernize the Medicare reimbursement methods, PPS also urges serious consideration be given to correcting technical obstacles that prevent independent physical therapy practitioners 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(bX6) 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 necessitates a slight amendment of the Medicare statute (Social Security Act section 1842(bX6)) 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/APTA 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/APTA recommends that Section 1802(bX5XB) of the Social Security Act be amended as follows:

*Inclusion of physical therapists under private contracting authority, Section 1802(b)(s)(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)" end inserting "In this subparagraph, the term "practitioner" means an individual defines 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.

This reduction occurs when multiple therapy services are billed on the same date by the same practitioner or facility under the same NPI, regardless of whether those therapy services are furnished in separate sessions or by separate disciplines (physical therapy, occupational therapy and speech language pathology). Thus, this cut impacts those beneficiaries whose conditions are most complex and require more therapeutic procedures.

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 AMA'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/APTA 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/APTA 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 MedPAC chairman Glenn Hackbarth, Dr. Bob Berenson 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/APTA 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 that serve the Medicare Part B program and ensure we are paying for only services delivered appropriately by qualified professionals of that discipline.

**Conclusion**

The above-discussed issues have beneficial effects for the Medicare beneficiaries, the PT providers, and the Medicare system in the following ways. Repealing the SGR and allowing private contracting have major positive impacts on the provider and secondary benefits for the patient. The therapy cap repeal (extending the exceptions process) is primarily a Medicare beneficiary issue. Enabling non-physician providers to access health information technology is beneficial to PTs, their patients, and to the degree to which it creates efficiencies, the Medicare program. Curbing overutilization through elimination of the in-office ancillary exception enhances patient protection while simultaneously benefitting the Medicare program.

It would be ideal if instituting value-based purchasing alone could bring all the desired results in Medicare. Unfortunately, the reimbursement method is but one of a systematic series of changes that are needed in order to streamline the performance of clinicians and patients. The other elements essential to modernizing the Medicare payment system are addressed in the above discussion.

On behalf of PPS/APTA, thank you for your continued efforts to create a more stable, predictable and effective Medicare payment system. Our organization is eager to continue to work with the Committees, Congress and CMS to help preserve and strengthen the Medicare program which means increasing quality, decreasing cost and improving outcomes.

Sincerely,

A handwritten signature in cursive script that reads "Tom DiAngelis".

Tom DiAngelis, PT, DPT  
President  
Private Practice Section/APTA