

May 30, 2013

The Honorable Max Baucus, Chairman
The Honorable Orrin Hatch, Ranking Member
Senate Finance Committee
United States Senate
Washington, DC 20510
Via: sgrcomments@finance.senate.gov

Dear Senate Finance Committee:

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 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 own and operate physical therapy 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.

Specifically, you have solicited comments pertaining to:

1. Ensuring that physician services are valued appropriately.
2. Policies that will reduce unnecessary utilization in fee for service.
3. How Medicare can most effectively incentivize physician practices to participate in alternative payment models.

In the three questions posed by the Committee, we note that the term “physician” is used nine times. Combined with the absence of reference to physical therapists and other non-physician health professionals, this gives us pause. Nevertheless, we are hopeful that as you proceed with your efforts to reform and ensure stability of the Medicare program, particularly physician payment, you will be continuously mindful of non-physician providers as well, including the constituency we represent, the independent physical therapists, who are an integral element of our nation's healthcare 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 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 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 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 113th Congress. PPS believes 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.

PPS is pleased to submit these comments and suggestions in response to your request for information as the Finance Committee plans to smooth the transition from the current FFS system to a more viable alternative to the SGR.

Payment Accuracy

*1. MedPAC and others have suggested changes they believe would improve the accuracy of fee schedule payment amounts and the validity of resource inputs used to establish payments for services under the fee schedule. What **specific** reforms should be made to the physician fee schedule to ensure that physician services are valued appropriately?*

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.

The law more than doubled a cut for physical therapists 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 (applied to practice expense component) 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.

Congress used MPPR actions 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 SGR formula. Thus, these MPPR provisions represent bad policy employed to offset the cost of legislation to patch another flawed policy, the SGR. More importantly, this negative adjustment to the payment codes for the therapies has done nothing to enhance the accuracy of the

payment system. In fact, it can be demonstrated that these congressional manipulations have done just the opposite; i.e., reduced payment accuracy.

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 the second and third reductions to therapists and their patients. Moreover, this represents congressional micromanagement of the resource-based relative value scale (RBRVS), the system used to reimburse health care services for several decades.

This micromanagement challenges the integrity and methodology of the RBRVS and renders the reimbursement mechanism less accurate. Therefore, it is not a measure that Congress should consider as it desires to increase the accuracy of the FFS payment system.

Congressional manipulation of the intricacies of the Medicare Physician Fee Schedule (MPFS) is further evidence of the flawed system we are currently enduring. And this has been recognized by several witnesses testifying before the Finance Committee over the years. PPS concurs with this advice and urges Congress to rescind the implementation of this MPPR adjustment as it renders the FFS system less accurate rather than the more balanced system recommended during congressional hearings featuring Medicare Payment Advisory Commission chairman Glenn Hackbarth, Dr. Bob Berenson of the Urban Institute and others.

Ensuring accuracy of code values for payment is a responsibility that should remain with the AMA RUC. If additional direction is necessary, Congress should advise the RUC accordingly, or even consider adjusting the composition or methodology of the committee. But Congress should resist the urge to micromanage the code values of the RBRVS as this is an exercise that has repeatedly fallen short of the stated desire of the Senate Finance Committee which is to increase payment accuracy.

PPS urges you to rescind this latest MPPR provision that took effect on April 1, 2013. This policy is short-sighted, misdirected and will restrict patient access to vital therapy services, especially impacting 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.

To create a more accurate payment system that is clinically relevant and patient-centric, PPS believes Congress should direct CMS to convert as soon as possible to a rehabilitation therapy reimbursement system based on severity of patient condition and appropriate intensity necessary to produce an optimal functional outcome. This system should gradually evolve to per session reimbursement and may possibly lead to payment for an episode of care.

We would also note that MedPAC has made other recommendations relative to payment accuracy that are worthy of consideration. Namely, the equalization of payment rates for evaluation and management services performed in hospital departments and outpatient office facilities (such as physician/therapist offices). PPS supports this MedPAC recommendation.

Controlling Utilization

*2. Physician services are critical to the ongoing health of Medicare beneficiaries. Appropriate utilization of physician services can lessen disease burden and reduce avoidable emergency department visits and hospitalizations. However, inappropriate or excessive utilization of physician-related services can negatively impact beneficiary health and drive up Medicare spending. Volume control mechanisms are not an inherent component of a FFS system. The SGR was intended to address excessive volume, but its mechanism is fatally flawed. What **specific** policies should be implemented that could coexist with the current FS physician payment system and would identify and reduce unnecessary utilization to improve health and reduce Medicare spending growth?*

One of the ways Congress has chosen to attempt to curb utilization in the rehabilitation therapy field is through the imposition of the arbitrary and discriminatory annual per-beneficiary therapy caps included in the Balanced Budget Act of 1997. One needs to look no further than the numerous times Congress has waived or overridden the caps since its enactment to find evidence of the bad policy this statute represents.

The physical therapy and 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. This program is just now getting underway.

Clinical data related to patient assessment, severity, impairment and 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 for rehabilitation therapy 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. This payment policy can coexist with the FFS system.

One acceptable measure to control utilization is the use of authorization for continued therapy (ACT), a process which to some extent is currently employed by Medicare. Authorization is not required to initiate therapy but is in order to continue treatment beyond a certain threshold. This can be implemented through manual medical review or other means, but must be accomplished in a very timely manner in order to avoid interruptions in care which can jeopardize the patient's progress. Moreover, these programs are most effective for the patient, the payer and the provider when the physical therapist is required to demonstrate the effectiveness of the care delivered, the functional progress being made by the patient and the continued need for care using valid, reliable and responsive measures and comparative data from a risk-adjusted database. This is not only an effective utilization control mechanism, but represents a patient-centric model that is predicated on demonstrating value of the physical therapy being delivered. Thus, such a mechanism sets the stage for transition to value-based payment.

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 an immediate replacement for the Medicare therapy caps should be evident as well. When the emphasis (and corresponding reimbursement) is on value, the need for outdated visit (and dollar amount) limits such as arbitrary therapy caps is eliminated. Thus, authorization for continued therapy (ACT) for care beyond an established initial treatment series can safely and justifiably allow for the legislative repeal of the existing caps on outpatient therapy, and is a process that can be implemented immediately.

Physician Self-Referral

Physician self-referral has been linked to increased utilization in numerous ways and by several reputable reports. Last fall, the Government Accountability Office (GAO) issued a report showing increased utilization in imaging when physicians own sophisticated imaging equipment.

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 percent) of inappropriate billing of physical therapy services billed incident to a physician's professional services. Moreover, both the President's budget and the Bowles-Simpson Commission have recommended that the in-office ancillary services exception be eliminated. 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.

At a time when fiscal austerity for the nation coincides with the search for ways to curb utilization of Medicare services, especially inappropriate utilization, demonstrates the need to end this practice of physician self-referral by eliminating the in-office ancillary services exception.

Incentivizing Participation in Alternative Payment Models

*3. Shifting from a FFS system to an alternative payment model will be a major change for many physicians. Within the context of the current FFS system, how **specifically** can Medicare most effectively incentivize physician practices to undertake the structural, behavioral, and other changes needed to participate in alternative payment models?*

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 status and outcomes measures are employed and data are used to guide clinical decision-making. Consequently, patients should not be dissuaded from using 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. Easing of these counter-intuitive policies can serve as meaningful incentives to move rehabilitation therapists to alternative payment models.

Additional Considerations

Easing Administrative Burden

During the period of payment stability, administrative burden, including reporting requirements, on providers must be reduced. An important step would be for Medicare to harmonize the myriad programs that currently require reporting. For the rehabilitation therapies 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.

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, opting out of Medicare, the multiple procedure payment reduction, the in-office ancillary exception and electronic health records.

- *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 requires 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 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. Beneficiaries with means who are able and willing to pay out-of-pocket for services will not have an adverse effect on the Medicare program. This has been amply demonstrated by the professions who are currently allowed to opt-out. Physical Therapists simply wish to join their professional colleagues on this list.

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."

Conclusion

The above discussed issues have beneficial effects for the Medicare beneficiaries, the rehabilitation 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 (or extending the exceptions process) is primarily a Medicare beneficiary issue. Enabling non-physician providers to access health information technology is beneficial to therapists, 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.

The current reimbursement method is but one of a systematic series of changes needed in order to streamline the performance of clinicians and the care of patients. The other elements essential to modernizing the Medicare payment system are addressed in the above discussion.

On behalf of PPS, 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 Finance Committee, Congress in general, and CMS to help preserve and strengthen the Medicare program which means increasing quality, decreasing cost and improving outcomes.

Sincerely,



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President
Private Practice Section/APTA