

July 15, 2013

The Honorable Fred Upton, Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Via: SGRComments@mail.house.gov

Re: Advanced Discussion Draft Bill to Repeal and Reform SGR

Dear Chairman Upton:

The Private Practice Section of the American Physical Therapy Association (PPS) is pleased to submit these comments in response to the Committee's request for input on the advanced draft legislation to repeal and reform the dysfunctional sustainable growth rate (SGR) formula and to promote 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 private physical therapy practices that provide convenient, cost-effective rehabilitative therapy to patients across the spectrum of impairments and functional limitations secondary to neurologic and/or musculoskeletal conditions.

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 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 decreases payment for their services without regard to the value of the services provided.

The PPS appreciates that the committee seeks input regarding specific ways in which this dysfunctional SGR formula can be replaced. The Energy and Commerce Committee is working deliberately and openly to develop this badly needed legislation and the PPS applauds your leadership in making this such an inclusive process.

We also appreciate the continued emphasis on a period of stable and predictable rate increases which is absolutely essential to the successful transition from fee-for-service to new payment models. We recommend no less than five years of stability to give therapist practices sufficient time to evaluate how the adjustments to their business model and delivery methods have affected the quality of the health care they are providing and the financial viability of their businesses. Because Medicare reimbursement under the SGR has been nearly flat since 2002, we strongly urge that the statutory rates of reimbursement be positive on a year-after-year basis during the period of stability.

QUESTIONS FOR COMMENT

Below find our specific responses to your June 28 materials and your 13 questions pertaining to the advanced draft of the reform legislation.

1. *Can you provide feedback on how the draft addresses tying measurement to payment? Do you prefer one type of payment model over the other? Are there other ways to link quality to payment than those provided in the draft?*

The use of functional outcomes measures is unique to the rehabilitation field as therapy patients and their conditions are much more conducive to quantification of function and measurement of improvement. PPS supports consensus-based measures adopted or endorsed by an objective third-party entity such as the National Quality Forum. Several functional status measures have been evaluated and endorsed by NQF to date.

In addition, a new Robert Wood Johnson Foundation-funded paper from the Urban Institute provides an overview of performance measurement in U.S. health care, and includes policy recommendations aimed at improving the performance measurement enterprise. Specifically, the authors recommend how to develop better measures; when and how to use measures; and how to ensure the validity and comparability of publicly-reported performance measure data. The paper recommends that, among other steps, our system move decisively from measuring *processes* to *outcomes*; adopting other quality improvement approaches where outcomes measures fall short; and measuring the patient experience and patient-reported outcomes as ends in themselves.

The PPS cautions that tying payment to measurement can lead to provider profiling which can have negative consequences. Provider profiling is an analytic tool that uses epidemiological methods to compare practice patterns across various quality of care dimensions (process and clinical outcomes). Cost, service and resource utilization data are dimensions of measuring quality, but should not be used as independent measures of quality care. The ultimate goal is to deliver high quality, evidence-based care to improve clinical outcomes. Provider profiling should not be used to address issues of provider competency, including the evaluation of clinical knowledge, education and skills. Such issues should be addressed by the appropriate public and private credentialing bodies that exist for these purposes.

Physical therapists must have an opportunity to review payer performance profiles prior to their being publicly reported. Payers must establish and communicate a reasonable, formalized reconsideration process in which providers can appeal their performance rating and designation(s).

The PPS believes the fundamental purpose of performance measurement and reporting of the results should be to identify opportunities to improve patient care. Payers' programs for provider measurement should result in providers and consumers who are better informed.

2. *Do you think the IG report will bring integrity to the reporting process? Does this process meet the required level of oversight? Are there any other safeguards, besides the IG, that could be implemented to ensure integrity in the reporting process?*

PPS Comment:

PPS believes the process referenced does meet the required level of oversight and recommends no additional safeguards beyond the Inspector General of HHS.

3. *If providers decide not to participate in the Update Incentive Program, should they be held to the same standard? How should their payment updates be applied if they do not report on quality measures?*

PPS Comment:

PPS encourages the Committee to embrace a five-year period of payment stability described earlier in this letter. During this phase, while new models of payment and delivery are evaluated and the Update Incentive Program is prepared for implementation, the updates for all providers should be positive such as is reflected in the bipartisan *Medicare Physician Payment Innovation Act* (H.R. 574), which PPS supports.

4. *What do we do with physicians who do not bill Medicare?*

PPS Comment:

Providers who bill the patient directly are either Medicare non-participating physicians who have chosen not to accept assignment on a given claim or they are "opt out" physicians. Medicare non-participating physicians who do not accept assignment collect directly from the beneficiary, up to the limiting charge. The physician must still file a claim with Medicare on the beneficiary's behalf, but the Medicare payment in that scenario goes to the beneficiary.

"Opt-out" physicians also collect directly from their Medicare patients. However, under the terms of the private contract such physicians must have with their Medicare patients; neither the physician nor the patient is permitted to seek reimbursement from Medicare for the opt-out physician's services.

Consequently, we believe that providers who do not bill Medicare should not be affected by this proposed legislation.

Physicians and other professionals may choose to opt out of Medicare if they agree to remain out of the program for at least two years after effecting such a decision. However, physical therapists are not included in the list of professionals permitted to opt-out, and we would urge the Committee to add physical therapists to the statute and include this addition in your legislation.

5. *Do you think the policy, as outlined in the discussion draft, can accommodate early adopters and those with minimal quality standards by the time Phase II goes into effect?*

PPS Comment:

The PPS believes all specialties have had ample time and opportunity to develop relevant clinical quality measures and a five-year period of payment stability will provide additional time for further measure development. It is recognized that some specialties will be more prompt than others in converting to the new model of payment. Therefore, the early adopters should be rewarded for their effort and assumed risk. We believe the policy, as outlined in the advanced discussion draft, can adequately accommodate early adopters.

However, we also recognize that there is a considerable disparity between providers who are experienced in quality and outcomes measurement and those who are in early stages of quality measurement. For this reason, there should be incentive for continuous improvement. And incentive payments must take into consideration the degree of "improvement change" in a practice's performance as well as the health risk status of the patient population.

6. *The draft policy endeavors to ensure public and provider feedback. Do you feel that the policy succeeds in achieving this goal?*

PPS Comment:

The PPS appreciates the multiple opportunities for provider and professional input.

7. *Should the new quality system align and coordinate with PQRS in the manner in which it provides feedback at the group level?*

PPS Comment:

PPS believes the many CMS quality reporting systems should align as much as possible to minimize the burden on the reporting providers. Specifically, the Physician Quality Reporting System (PQRS) and the newly required functional limitation reporting (FLR), at minimum, should be consolidated for therapists. We would also note that the PQRS may be unnecessary if the Committee's performance system is found to be effective. Nevertheless, the PPS would not encourage Congress or CMS to hold the PQRS model as the standard to be achieved, especially in terms of providing feedback which is far from timely.

8. *The draft envisions a repertoire of quality measures and clinical practice improvement activities. Some have suggested also including efficiency measures. Should we also explore efficiency measures and other improvement activities?*

PPS Comment:

Efforts to develop efficiency measure are in the early stages and the reliability, validity, and evidence-basis have not yet been established. Moreover, most efficiency measures achieve short-term savings that accrue to the payer and the health care system broadly, but not often to the individual practice. Early physical therapy intervention can reduce downstream costs considerably. Likewise, continued care, beyond what might be viewed as "efficient" often ensures a better outcome resulting in cost-savings elsewhere in the system. Therefore, efficiency measures without gain-sharing across the health care system are likely to be ineffective.

We would emphasize that payment for efficiency requires review of all of the components of health care delivery, not just a single practitioner or practice. Appropriate efficiency also requires sufficient time-horizons. As mentioned above, investment in preventive care and effective physical therapy will lead to improved function, reductions in hospitalizations and in hospital readmissions, which are expensive. But measuring and using efficiency for the health care system overall will require up-front investments and careful, evidence-based analysis. If efficiency is measured episode-to-episode or even year-to-year, the downstream improvements will be impossible to quantify and attribute.

We would also caution that using efficiency as the primary measure could result in the revival of managed care behaviors and the myriad problems experienced by patients and providers during that era.

9. *People have expressed concerns about the effect of non-compliant patients on outcomes and thus outcome measures. Do you believe the draft policy adequately addresses the issue and protects providers who are reporting on quality outcome measures in the setting of non-compliant patients (i.e., one of many aspects of risk-adjustment)?*

PPS Comment:

To achieve optimal results in physical therapy, patient compliance is essential. Health care professionals can be very thorough and comprehensive in providing the patient with the necessary self-care advice and instructions. But the patient has the responsibility to be an important participant on the health care team. However, PPS believes that science has yet to identify the extensive algorithms, degrees of responsibility,

the critical variables and the relative weighting necessary to incorporate this element into payment methodology at this time. We do know non-compliance is a problem but recognize that it is not always equivalent to high risk, thus risk adjustment is not a suitable proxy for it.

10. Should core competency categories be defined as those set forth under the National Quality Strategy?

PPS Comment:

None

11. The draft policy envisions an updated and streamlined process to submit and test alternative payment models outside the traditional pathway. Do you think the draft policy method provides ample opportunity for formulating and submitting alternative payment models? And,

12. The draft policy provides a process to obtain input on modifying and retiring alternative payment models that are on the public list. Please provide comments on this process.

PPS Comment:

The draft policy provides extensive and detailed processes for formulating and submitting alternative payment models. However, the process for modifying and retiring alternative payment models is not clear and requires considerable deliberation.

13. Should the replacement payment model to SGR move further toward episodic care? Is this a direction that should be more fully explored, and if so how?

PPS Comment:

Surgical procedures and acute conditions with a well-defined course of care lend themselves well to episodic payment. But it is premature to move further toward episodic care at this time in physical therapy. Substantial work must be done in this field to determine the appropriate per session payment rate before development of episodic payment methods is possible. Fortunately, many physical therapists including PPS members have been collecting and reporting functional outcomes data for several years and are contributing to the accumulation of meaningful data that will advance not only payment methodologies but also, and more importantly, the quality and effects of care received by the patient. The recently required functional limitation reporting can also contribute to these data if the information is properly harnessed.

Additional Considerations

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 therapists from providing care in the most streamlined of manners. These include: locum tenens, direct contracting, the multiple procedure payment reduction, the in-office ancillary exception and limits on patient out-of-pocket expenses.

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 (practice expense component) 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 rescind this latest MPPR provision which took 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.

Limits on Patient Out-of-Pocket Expenses

In a new system of payment for the rehabilitation therapies, 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. Invariably, such developments result in greater cost to the Medicare program. Easing of these counter-intuitive policies can serve as meaningful incentives to move rehabilitation therapists to alternative payment models.

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) and limiting out-of-pocket exposure are primarily Medicare beneficiary issues. 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 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 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