

December 20, 2013

Chairman Max Baucus
Committee on Finance
United States Senate
Washington, DC

Via: sgrcments@finance.senate.gov

Dear Chairman Baucus:

On behalf of the Private Practice Section (PPS) of the American Physical Therapy Association (APTA), which represents over 4200 members nationwide, I write to submit this statement for the record with respect to the Committee's December 12th deliberations.

PPS members provide a valuable service to communities in all fifty states 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. The Medicare reimbursement rate for the past twelve years has not kept pace with the cost of providing high-quality, effective physical therapy and this has had a significant impact on PPS members' ability to survive and be competitive.

Mr. Chairman, you, your Finance Committee colleagues and staff are to be commended on the passage of S.1871 which would repeal the Medicare sustainable growth rate formula and to improve beneficiary access under the Medicare program.

PPS applauds the repeal of the Sustainable Growth Rate (SGR) formula which has proven to be flawed policy both from a reimbursement standpoint and a legislative perspective. The proposal would consolidate and restructure existing quality improvement incentive programs including meaningful use of electronic health records, the Physician Quality Reporting System and the value-based modifier, to reduce the administrative and financial burden on providers.

Progressively, Medicare payments would be tied to quality measures that include "clinical care, patient safety, care coordination, patient and caregiver experience and population health." To get bonus payments, clinicians would be compared to their peers and measures would be updated every year by the U.S. Secretary of Health and Human Services (HHS).

The Senate Finance Committee-passed bill would also repeal the annual per beneficiary therapy caps which is a positive step toward a system that will ensure those patients who need rehabilitation services the most, receive them. The repeal of the Medicare therapy cap would eliminate the requirement for a KX modifier at \$1,900 and the need for yearly extensions; would keep manual medical review at \$3,700 through 2014, then transition to a new medical review program in 2015. The improvements in the medical review process required by the bill (e.g., electronic submission and tracking, standardized and simplified forms, 10-day turnaround on requests), strengthen the program,

facilitate timely and conscientious clinical decision-making so that there is no interruption in the patients much needed care.

The new program would use prior authorization to allow therapists to request blocks of visits. The HHS Secretary would determine the level at which prior authorization applies and what services are subject to review. The bill calls for a new data collection system to replace current functional limitation reporting procedures to be operational in or around 2017.

Generally, this legislation represents considerable improvement over the status quo and PPS looks forward to continuing to work with both chambers of Congress toward an even better, more comprehensive product. We are eager to assist in the development of a modernized Medicare payment policy.

Despite our quite positive view of the legislation generally, PPS would like to share some observations and concerns about the bill that we believe, if addressed, would result in smoother implementation, fairer consideration of physical therapists and ultimately better care for our nation's seniors.

Sustainable Growth Rate

The bill freezes baseline outpatient Medicare payments for 10 years but providers could receive payments above the base rate by participating in value-based incentive programs and transitioning to alternative payment models.

Given that Medicare reimbursement rates over the past 12 years have lagged considerably behind the cost of operating a practice and providing good care, we strongly urge you to build modest annual increases into the base reimbursement rate over the next ten years or at least until the incentive payments (rewards) become available for physical therapists.

Value-Based Incentive Programs

As we have stated previously, it appears that only one of the value-based incentive programs has applicability to physical therapists (and even that program does not apply to the majority of PTs). Thus, we are concerned with the way the rewards will be calculated for PTs, the size of those rewards and the timetable upon which they will be available.

We are also concerned that the incentive rewards will set up a system of winners and losers since clinicians would be compared to their peers. Thus, even high-performing professionals or clinicians who have considerably improved performance, could be penalized if they do not rank high enough when compared to fellow providers. Since the goal of the quality-based reimbursement system ought to be raising (and rewarding) the performance of all providers and, therefore, delivering better care to Medicare beneficiaries, PPS believes that all high-quality performance and improvement in performance should be rewarded.

PPS would like to emphasize that neither the Value-Based Modifier (VBM) nor the EHR MU currently apply to therapists. The VBM is still in development and will not apply to physical therapists until 2017 at the earliest. The EHR MU does not apply to PTs since our profession was not included in that authorizing legislation.

Under the bill, professionals would be given credit for attainment and achievement, with higher overall weight given to outcomes measures. PPS strongly supports greater overall weight being given to outcomes measures.

Therapy Caps

In the section pertaining to the therapy caps, the bill describes a new medical review program for outpatient therapy services and frequently uses the term “prior authorization medical review.”

In addition, the legislation employs variations of the above terms including:

- prior authorization
- medical review
- pre-payment review
- post-payment review

Since these terms are used throughout the bill (sometimes interchangeably), their meaning is not always clear. We understand and agree with the discretion granted the Secretary but believe more clarity in the legislation is warranted. Consequently, PPS urges the inclusion of operational definitions of the above-referenced terms.

Lastly with respect to the caps, we would encourage the inclusion of some type of appeals process when prior authorization is not granted.

Alternative Payment Model Participation

Since many of the emerging models of delivery, including ACOs, can and do exclude private practice physical therapists and disadvantage Medicare beneficiaries, PPS urges an addition to the legislation that directs the Secretary to test an alternative payment system for physical therapy that considers the severity of the patient’s condition and the intensity of services necessary to bring about an optimal functional outcome. Such a system better reflects the professional clinical reasoning and judgment of the therapist, improves patient care, and provides policymakers and payers with an accurate payment system that ensures the integrity of medically necessary services. Legislative language similar to that included in HR 574, the *Medicare Physician Payment Innovation Act of 2013* is recommended.

We also recommend the inclusion of the reference to outpatient therapy that incentivizes adherence to a comprehensive list of cost, quality, and outcome measures as demonstrated by participation in a certified registry, the physician quality reporting system, use of an approved patient assessment tool, current certification as a clinical specialist, or measuring and reporting the functional status of patients. (Also in HR 574)

Transitioning to a payment system for physical therapy based on the severity of the patient’s condition and the corresponding intensity of services required to achieve optimal outcome, will ensure that the care delivered is based upon patient need and the reimbursement is based at least in part, on results of that care.

Locum Tenens

PPS supports HR 3426 the *Prevent Interruptions in Physical Therapy Act*, which adds physical therapists to the statute allowing locum tenens arrangements under Medicare. This bill would modernize the Medicare statute which currently does not include PTs in the list of providers authorized to use this mechanism to ensure continuity of care. PPS urges the inclusion of this no-cost provision in the Medicare reform legislation.

Opting-out of Medicare

Physical therapists may not collect out-of-pocket payment from a beneficiary for a Medicare covered service as can be done by physicians and other providers. PPS recommends Congress remedy this oversight by adding PTs to the existing 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. Physical Therapists simply wish to join their professional colleagues on this list in current law.

Offsets

Since S. 1871 does not include budgetary offsets, it will be important to identify funding sources sufficient to pay for these changes to Medicare payment policy. PPS suggests a change in the physician self-referral statute known as the in-office ancillary services exception (IOASE) which would render upwards of \$2 billion. Private, academic and governmental studies alike have shown a considerable propensity for overutilization of services when physicians are allowed to refer to therapy, imaging and laboratory entities in which they have ownership. By removing physical therapy (along with laboratory and imaging) services from the IOASE, inappropriate utilization can be curbed and billions of dollars can be saved.

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. Moreover, the study found that physician utilization behaviors increased dramatically when a physician became an owner or investor in such a service. A GAO study with similar results in the anatomic pathology labs was published in June.

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 FY2014 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 inappropriate utilization of Medicare services, it is imperative we end this abusive practice of physician self-referral by eliminating the in-office ancillary services exception.

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

Sincerely,



Tom DiAngelis, PT, DPT
President
Private Practice Section