PRIVATE PRACTICE SECTION, APTA

APTA
American Physical Therapy Association

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

Via: SGRcomments@mail.house.gov

Dear Chairman 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 discussion draft legislation released last week. The over 4200 members of PPS 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 endeavors to foster the growth, economic viability, and business success, of physical therapist-owned physical therapy services provided for the benefit of the public.

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 whose small businesses 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 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 undertaking this important endeavor 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.

The Committee has requested feedback on two sets of questions which are divided into Phase I and Phase II.

Questions for Comment on Phase I

1. What is an appropriate period of payment stability in order to develop and vet measures and build the necessary quality infrastructure?

PPS Comment: We appreciate the 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. With regard to the length of time, we recommended no less than five years of stability to give therapist practices sufficient time to evaluate how their investments in technology and administration have affected the quality of the health care they are providing. 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.

2. Considering the different levels of provider readiness, how do we balance the need for a stable period enabling providers to build and test the necessary quality infrastructure, while still incentivizing early innovators to move to Phase II, with opportunities for quality-based payment updates?

PPS Comment: 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. PPS believes all specialties have had ample time and opportunity to develop relevant clinical quality measures and a defined period of stability will provide additional time for further measure development.

3. What does a meaningful, timely feedback process look like for providers? What are adequate performance feedback intervals?

PPS Comment: The Committee correctly acknowledges that success of phase II will depend on the measures used and the feedback made available to therapists. With respect to the former, PPS supports consensus-based measures adopted or endorsed by an objective third-party entity such as the National Quality Forum (NQF). 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 like that from the PQRS program, which is received 18-24 months after the care has been delivered, is of very little value in improving care.

4. How should Peer Provider Cohorts be defined to ensure adequate specificity while preserving adequate comparison group size and ability to develop appropriate measurement sets? For example, is using the American Board of Medical Specialties (ABMS) list adequate? and
5. Should the list of Peer Provider Cohorts also include patient, procedural, or disease-specific cohorts in addition to the traditionally-defined specialty groupings? Pros of this approach are that it would offer a more relevant basis for measure development and comparison between physicians, since many physicians perform outside of or in a narrow range of the "stereotype" description of their primary specialty. Cons are that it may create too vast of an array of cohorts. This may dilute the ability to develop meaningful quality measurement sets and comparison groups and impose excessive financial and

administrative burden on the physician group as well as upon CMS. In addition to answering, please provide rationale.

PPS Comment: It is not possible to answer these questions with sufficient detail at this time. The concept of promoting development of Peer Provider Cohorts and how such pertains to independent rehabilitation therapists requires considerable and thorough investigation.

6. Under the proposed revision of SGR which emphasizes best quality practices, non-physician providers who are currently paid under the Medicare payment system are also expected to be rated on quality measures. Do these non-physician providers need unique measurement sets compared to physician providers?

PPS Comment: Yes, non-physician providers', particularly physical therapist, need unique measurement sets that focus on the patients functional capabilities. 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.

Questions for Comment on Phase II

1. Understanding that the proposed payment system relies on reporting, how should existing programs such as, but not limited to PQRS, EHR/Meaningful Use, VBM be transitioned into the new system? Are there aspects of the current systems that should be retained, modified, or discarded?

PPS Comment: PPS believes the above-referenced programs were adopted as incremental steps designed to hasten the move from volume to value. Once a value-based payment system is ready to be implemented, these programs should cease to exist. Congress should refrain from imposing additional layers of requirements with which therapists must comply. In the opinion of PPS, it is essential that coordinated reporting requirements, and measures with compatible and reliable systems, translate into decreased burden for practices.

2. How do we align and integrate quality measurement and reporting with existing and developing specialty registries? How can registries support provider feedback and streamline provider reporting burden? and
3. What Clinical Improvement Activities best promote high quality clinical care and should those activities be required as an integral part of a quality-based payment system?

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.

Therapists utilizing a clinical registry should be able to readily access and report on patients with a specific condition. Patient outcomes, both individual and in the aggregate, must be evaluated through population analysis rather than sampling.

4. What process or processes could be enacted that would ensure quality measures/measurement sets maintain currency and relevance with regard to the latest evidence-based clinical practices and care delivery systems? How would these processes ensure that quality measures evolve with data accumulation and advancement in measure development science, and appropriately account for the relative value of measures as they relate to best possible patient care?

PPS Comment: PPS believes it is not necessary to include in statutory language the frequency with which measures are reviewed. Moreover, annual review of measures is excessive and unnecessary. We support consensus-based measures validated or endorsed by an objective third-party entity such as the NQF. Such an entity can and should ensure the relevance and currency of measures.

5. Quality measures are categorized into process, structural, and outcome measures. Should these measures be differentially weighted in a quality scoring system? If so, how?

PPS Comment: **PPS Comment:** Except in certain circumstances, clinical improvement activities are of less relevance when patient outcomes are being measured. Rehabilitation therapy patients and their conditions are more conducive to the use of valid, reliable and responsive functional status (FS) measures. Since the ultimate concern of any payment program is the effect of the care on the patient, functional outcomes measures are the "gold standard." When therapists are employing FS measures and using the data to improve care, other clinical improvement activities are redundant and less important.

In rehabilitation therapy, clinical improvement activities do have relevance 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.

As has been recommended by the previously referenced Robert Wood Johnson Foundation-funded paper from the Urban Institute, it is time for our health system to move decisively from measuring *processes* to measuring *outcomes*. Moreover, quality improvement approaches should only be employed where measures fall short. Thus, the use of outcomes measures should be given the most weight.

As quality measurement has evolved, the early focus was on structural and process measures, which helped create the foundation for more sophisticated quality improvement activities. But initially and appropriately the emphasis was on ensuring the correct tests and measures were employed when indicated. As mentioned above, the rehabilitation professions and the patients they serve, have demonstrated the capability to move beyond structure and process to functional outcomes measures, the gold standard of measurement.

Simultaneously, mechanisms must be identified to recognize and gauge the role of the patient as an important consideration that must be addressed in the equation. Patient participation in shared decision-making and patient adherence to the treatment plan are both important metrics that cannot be overlooked.

6. From a variety of backgrounds, providers newly enter (or re-enter) the Medicare system throughout the year. Since these providers have no reference baseline with regard to quality reporting in the Medicare system, how should the system account for their payment during their "observation" year?

PPS Comment: PPS believes this is a moot point if patient outcomes are measured and emphasized.

7. Should public and multi-stakeholder input be used during the measure development and selection processes? If so, are there current CMS or non-CMS mechanisms that could be applied? and
8. In the interest of transparency, a public comment opportunity is vital to the quality measure development and approval process. Are there current mechanisms that are both substantive and nimble enough to meet the policy framework in the discussion draft of the legislative language?

PPS Comment: As mentioned above, PPS supports consensus-based measures adopted or endorsed by an objective third-party entity such as the NQF. We recognize the importance of patient/consumer input and note that it is routinely incorporated into measure development processes employed by NQF. Public input is especially important in the development of patient-centered outcome measures.

9. Methods linking quality performance to payment incentives must be fair to providers and faithful to the goals of a value-based payment system. Many strategies have been proposed; examples include comparing providers to each other versus to benchmarks. Please suggest method(s) of quality-based payment which meet the goals of fairness and fidelity, and one that promotes provider collaboration and sharing of best practices to achieve a learning healthcare system.

PPS Comment: While both of these methods (comparing providers to each other versus to benchmarks) have merit, we do not endorse a scheme that bases payment just on relative rankings of providers or on practice improvement. Such a system results in winners and losers regardless of how good the clinicians perform. And a system based on practice improvement disadvantages providers that are already at the top of their profession. Reward systems must employ true benchmarks attainable by any provider.

Alternative Payment Models
As you know, the rehabilitation professions under the leadership of the American Physical Therapy Association (APTA) 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 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 therapy practitioners from providing care in the most streamlined of manners. These include: therapy caps, locum tenens, direct contracting, the multiple procedure payment reduction, the in-office ancillary exception and electronic health records.

Therapy Caps

The arbitrary, annual per beneficiary therapy caps included in the Balanced Budget Act of 1997 (BBA) have been waived by Congress almost entirely since their inception. This itself is evidence of faulty and misdirected policy. The repeal of this errant policy is almost universally supported and PPS urges the Committee to include such action in legislation to repeal and reform of the SGR.

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.

PPS 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 (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 9l %) 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) is primarily a Medicare beneficiary issue. 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,

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