PRIVATE PRACTICE SECTION, APTA

APTA
American Physical Therapy Association

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January 8, 2014

The Honorable Joe Pitts, Chairman
The Honorable Frank Pallone, Ranking Member
Health Subcommittee, House Energy and Commerce Committee
U. S. House of Representatives
Washington, DC

Chairman Pitts and Ranking Member Pallone:

Please accept this statement for the record with respect to the hearing convened January 9, 2014, entitled "The Extenders Policies: What Are They and How Should They Continue Under a Permanent SGR Repeal Landscape?"

The Private Practice Section (PPS) of the American Physical Therapy Association (APTA) represents over 4200 members nationwide who operate their practices as small businesses.

Sustainable Growth Rate (SGR)
On March 31 of this year, a congressionally passed waiver of the statutory sustainable growth rate (SGR) formula, will expire. Without an extension, or preferably a full repeal and replacement, CMS has announced that the physician fee schedule update for the remainder of 2014 will be negative 20.1%. Moreover, because of the cumulative nature of the formula, updates for the foreseeable future will be negative as well. Not only is the SGR an example of a government policy (legislation) that does not work, but it also illustrates that efforts of Congress to undo this mistake – in the absence of complete repeal – are only making a bad situation worse.

PPS commends the House Energy and Commerce Committee which led the formal repeal effort last year by unanimously passing H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013, a bipartisan effort to transform the Medicare physician payment system in a number of important ways. First and foremost, this bill repeals the flawed SGR formula and replaces it with a stable and more predictable system of payments. Instead of looming annual cuts, therapists and physicians will be rewarded for the quality of care they provide to Medicare beneficiaries. The legislation also includes new transparency and collaboration requirements as well as directives to solicit input from expert medical organizations and other groups on the development and selection of quality measures. The bill also provides additional revenues for development of new payment and care delivery models. H.R. 2810 passed the full committee by a 51-0 bipartisan vote on July 31, 2013.

The House Ways and Means Committee and the Senate Finance Committee followed suit later in the year with Ways and Means passing a bill similar to Energy and Commerce while the Senate Finance took a broader approach that included repeal of the therapy caps and modification of the geographic practice cost index (GPCI) and other issues.

PPS is generally pleased with this direction of SGR reform and applauds Energy and Commerce for leading the way. Of the three SGR measures considered and passed by the

committees of jurisdiction, PPS prefers the Senate Finance version for several reasons, but primarily because of the inclusion of these two above mentioned “extenders.”

The Senate Finance Committee’s proposal (S.1871):

- repeals the SGR formula and freezes baseline outpatient Medicare payments (i.e., a flat update) for 10 years (providers could receive payments above the base rate by participating in value-based incentive programs and transitioning to alternative payment models);
- repeals the Medicare therapy caps effective upon passage of the legislation, eliminating the requirement for a KX modifier at $1,900 and the need for yearly extensions;
- keeps manual medical review at $3,700 through 2014, then transitions to a new medical review program in 2015. 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;
- calls for a new data collection system to replace current functional limitation reporting procedures to be operational in or around 2017;
- extends the 1.00 floor for the “work” GPCI through 2014. In 2015, the floor would become 0.995; in 2016 and beyond, the floor would be set at 0.99.

Therapy Caps

In April of this year, the arbitrary Medicare per beneficiary therapy caps will be fully imposed unless Congress acts to extend the current exceptions process or repeal the caps permanently. For the past eleven years, legislation addressing the SGR has consistently included policy to avoid application of the arbitrary therapy caps to those Medicare beneficiaries who are most in need of rehabilitation services. The caps apply to Medicare beneficiaries in all outpatient health care settings. Beneficiaries who receive Part B rehabilitation services within a skilled nursing facility, a therapist’s or physician’s office, a home health agency, or a rehabilitation agency are subject to the arbitrary cap.

Some 14.5 percent[1] or 640,000 Medicare beneficiaries who receive outpatient rehabilitation services per year are estimated to exceed the existing statutory therapy cap if Congress does not repeal the cap or extend the exceptions process. Once the limit has been reached, beneficiaries who require additional services are responsible for the total cost. Seniors and individuals with disabilities with the most significant rehabilitation needs will have to decide between foregoing necessary care, changing providers of care, or paying 100 percent of the cost out-of-pocket. Beneficiaries who experience stroke, hip fracture, Parkinson's disease, diabetes, arthritis or osteoporosis are most likely to be negatively affected by the therapy caps. Thus, beneficiaries with impairments and disabilities are adversely and unfairly impacted by this arbitrary payment policy.

The data collection system to be implemented per S. 1871 will foster the development of “an alternative payment method” which was envisioned by the Balanced Budget Act of 1997. Ideally, these data will include quality information (e.g., **functional outcomes data**) which can be used to describe the type and amount of care that is needed by specified patients or groups of patients.

[1] Ciolek, DE, Wenke H. *Utilization Analysis: Characteristics of High Expenditure Users of Outpatient Therapy Services CY 2002.* Final Report to the Centers for Medicare and Medicaid Services. November 22, 2004

PPS urges your committee to embrace the approach taken by the Senate Finance Committee with one caveat: we would encourage the inclusion of some type of appeals process when prior authorization is not granted.

This path leads to a cost-effective replacement for the caps and a payment policy that is patient-centric and provides the best return-on-investment for therapy services under Medicare.

Private Contracting
Section 4507 of the BBA of 1997 included a provision allowing physicians and other selected providers of Part B services to opt-out of the Medicare program, meaning they can collect out-of-pocket payments from Medicare beneficiaries if certain requirements for opting-out are met. But this provision was only authorized originally for physicians, osteopaths, and selected non-physician providers (clinical psychologists, clinical social workers, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse mid-wives) in the BBA of 1997. Subsequently, the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA) extended private contracting to podiatrists, dentists, and optometrists, effective December 2003. Physical therapists do not currently have the ability to opt-out because they are not included in the statutory language permitting same.

PPS prefers an expansion of the private contracting provisions as represented in HR 1310. But at minimum we urge Congress to extend to physical therapist the policy allowing these professionals to collect out of pocket from a Medicare beneficiary. Such an amendment would be beneficial to PPS members, afford beneficiaries the freedom of choice they deserve, without resulting in any greater expenditure, in fact quite likely some modest savings, for the Medicare program.

PPS recommends that the final Medicare payment reform legislation include an addition to existing law [Section 1802(b)(5)(B) of the Social Security Act] as follows:

> ***Inclusion of physical therapists under private contracting authority.***
> *Section 1802(b)(5)(B) (42 U.S.C. 1395a(b)(5)(C)) is amended by striking ``the term practitioner has the meaning given such term by section 1842(b)(18)(C)" and inserting "In this subparagraph, the term "practitioner" means an individual defines at section 1842(b)(18)(C) or an individual who is qualified as a physical therapist."*

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**.**

Offsets -- Curbing Overutilization of Therapy
Since none of the SGR reform measures presently 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 2013..

The Office of the Inspector General of the Department of Health and Human Services has continued to identify a high rate (78 to 9l 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. PPS urges Congress to include the above described policy change in legislation to reform Medicare payment.

Conclusion

The above-discussed issues have beneficial effects on the PT providers, the patient, and the Medicare system in the following ways. Repealing the SGR, allowing private contracting, and adding PTs to the locum tenens statute, all have major 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. The benefits of curbing overutilization inure specifically to the Medicare program.

On behalf of the Private Practice Section of APTA, thank you for your continued efforts to create a more stable, predictable and effective Medicare payment system.

Sincerely,

Tom DiAngelis, PT, DPT
President