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Summary of Recommendations and Excerpts from APTA's Responses to the Senate Finance, House Ways and Means, and House Energy and Commerce Committees' Requests for Comment on Reforming the Medicare Sustainable Growth Rate

APTA submitted comments to both the Ways and Means and Energy and Commerce Committees on February 25, 2013 and April 15, 2013. In addition, comments were submitted to Senate Finance Committee on May 31, 2013 Energy and Commerce on June 10, 2013 and July 9, 2013. Highlights of these responses are below.

Physical Therapy Billing under the Medicare Physician Fee Schedule

APTA strongly believes that any new payment policies examined by Congress should take into account the needs of not only physicians, but also non-physicians paid under the fee schedule, including physical therapists. Medicare outpatient therapy is a unique and complex benefit that must be examined in any reform discussion. Physical therapists provide critical services to beneficiaries under Medicare Part B to assist individuals remain in their homes, communities and society at their highest potential functional level. Outpatient physical therapy services are paid under the Medicare Physician Fee Schedule and therefore, physical therapists are acutely aware of the pending reductions in payments, the cost to repeal this flawed sustainable growth rate (SGR) formula and its impact on beneficiaries' access to health care providers.

In 2010, outpatient therapy services under Medicare Part B resulted in \$5.6 billion (4.5%) in program expenditures for services provided to almost 4.6 million beneficiaries (13.5%). In the most recent data, outpatient physical therapy (PT) services accounted for 73.5% of the outpatient therapy expenditures followed by occupational therapy (OT) services at 19.5% and speech language pathology (SLP) services at 7.0%.

Therapy Cap Repeal

It is imperative that any legislation to repeal the SGR formula also fully repeals the Medicare therapy cap, a provision that was included in the Balanced Budget Act of 1997 and created at the same time as the SGR. Since enactment of the therapy cap, Congress implemented an exceptions process to the cap for medically necessary services and has continually acted to extend this exceptions process as part of the annual SGR/Medicare extenders package. APTA believes it is imperative to provide a long-term solution to the therapy cap in any legislative effort to fix the SGR. Including therapy cap reform in the larger SGR package will ensure that Medicare beneficiaries will continue to have access to vital physical therapy services while providing a path for the therapy community to transition to a new payment system that places value on quality of care and not on arbitrary limits without regard to clinical condition.

Alternative Payment System (APS)

APTA applauds the committee for endorsing a desire to move to alternative payment systems in future years and has been working with congressional committees of jurisdiction over the past two years to develop refinements to the payment system under which outpatient therapy services are provided. These changes can be made under the current fee-for-service system and lend themselves well to future refinement in a payment system in a post SGR environment.

When the therapy cap was created in 1997, Congress charged the Centers for Medicare & Medicaid Services (CMS) to develop an alternative payment system for outpatient therapy. An effective system has not been brought forward, and the therapy community is thus proposing to reform payment for outpatient physical therapy and occupational therapy services by transitioning from the current timed codes system to a per-session system. A per-session system eliminates the 15-minute increment rules and the use of multiple codes per visit. The therapy community is working through the American Medical Association's Current Procedural Terminology (CPT) and Relative Value Update Committee (RUC) process to recommend a new payment and coding system to CMS for Physical Medicine and Rehabilitation Codes (97000 series).

APTA along with the American Occupational Therapy Association and the American Speech-Language-Hearing Association are collectively supportive of movement to a per-session payment system no later than January 1, 2016.

Under the APTA proposal to the CPT, we propose a per-session system that categorizes patients based on the severity of their condition and intensity of the interventions required. APTA believes this system 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 services.

Self-Referral

Elimination of physical therapy services from the in-office ancillary services (IOAS) exception should be considered in order to capture savings and enhance patient care under Medicare. The expansive use of the IOAS exception by physician groups in a manner not originally contemplated by the law undercuts the purpose of the law and substantially increases costs to the Medicare program and its beneficiaries. MedPAC examined the use of IOAS in their June 2010 report and raised concerns about the growth of ancillary services, such as physical therapy, in physician offices. Although they did not make recommendations in their report, they explored several options, one of which involved the exclusion of physical therapy from the IOAS exception. This issue should be addressed as part of any fundamental delivery system reform and will provide cost savings to help support reform. A recent budget score of elimination of certain services from the IOAS exception, including physical therapy, showed savings of \$6.1 billion over the 10-year budget window.

MPPR

As part of the American Taxpayer Relief Act of 2012, at the recommendation of MedPAC, Congress increased the multiple procedure payment reduction (MPPR) policy applied to outpatient therapy from 20% in private practice and 25% in facilities to 50% in all outpatient settings as of April 1, 2013. We remain concerned that this policy is based on flawed data and will have a significant impact on therapy payment and patient care, even as the therapy community is actively working to move away from multiple procedure services in an alternative payment system. The increased MPPR of 50% will result in a 7% cut for outpatient therapy reimbursement. Coupled with the previous 7% reduction in payment from the original MPPR in 2011 and the 2% sequestration cut, the cumulative reductions of over 15% in two years equate to a considerable impact for therapy services which will ultimately impact patient access and care. In addition, the way in which the MPPR is applied across disciplines on a given treatment day is inappropriate. We urge the Committee to consider placing a moratorium on the increase from 20/25% to 50% MPPR until implementation of a new coding and payment system and ensure that the MPPR is applied separately to the disciplines, as they are separate Medicare benefits and distinct services.