

OFFICIAL STATEMENT

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**Statement for the Record
by
American Physical Therapy Association**

**United States House of Representatives
Committee on Ways and Means
Subcommittee on Health**

**American Physical Therapy Association Perspectives and Recommendations
for Medicare Payment Reform**

May 20, 2011

Chairman Herger, Ranking Member Stark and Members of the House Subcommittee on Health:

On behalf of more than 77,000 physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) thanks you for the opportunity to submit official testimony regarding reforming payment under the Medicare physician fee schedule. APTA commends your bipartisan effort to address this issue in 2011 and appreciates the opportunity to weigh in on this critical matter. Physical therapists are significantly impacted by the Medicare Physician Fee Schedule and its payment policies. In 2008, outpatient therapy services under Medicare Part B resulted in \$4.8 billion (2.6%) in program expenditures for services provided to 4.5 million beneficiaries (10.5%) at an average per patient cost of \$1,057. 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%. Specifically, outpatient physical therapy services accounted for almost \$3.5 billion in program expenditures for services provided to 3.9 million beneficiaries at an average cost of \$884 per patient.

Physical therapists provide critical health care services to beneficiaries under Medicare Part B to assist individuals remain in their homes, communities and society at their highest potential functional level. The Medicare Physician Fee Schedule is used in claims to report outpatient physical therapy services and therefore, physical therapists are acutely aware of the pending 29% reduction, the cost to repeal this flawed sustainable growth rate (SGR) formula and its impact on beneficiaries' access to health care providers.

APTA believes a strong Medicare Part B program is essential to provide cost-effective, accessible and high quality health care to our nation's seniors and individuals with disabilities. The payment policies established under the Medicare program dramatically impact payment policies established by private payers, Medicaid, workers compensation, and others payers.

The opportunity to address these fundamental policy problems under Medicare Part B is vital to move towards a sustainable delivery system that is supported by sound payment policies. There are three areas of potential reforms which APTA believes should be considered in the current dialogue regarding reform of payment policies under the Medicare physician fee schedule.

A) Replacement of the Sustainable Growth Rate with an annual index of health care inflation. APTA believes that off-setting the cost of repealing the SGR should be done through reforms to payment policies under the Medicare program that ensure high quality health care is delivered by professionals licensed and qualified to provide those services thereby reducing fraud and abuse. APTA would welcome the opportunity to provide the Subcommittee with a list of policies it believes would strengthen Medicare Part B and provide savings towards the cost of repealing of the SGR. APTA strongly supports the expansion of quality reporting, value based purchasing, and use of electronic medical records under Medicare Part B as part of this reform. APTA requests the Subcommittee consider policy changes needed to ensure that all providers that are eligible in the statute to participate in quality reporting can do so. Currently, only physical therapists in private practice (PTPPs) can participate in the Physician Quality Reporting System due to issues with the claims form for other Part B settings in which physical therapists practice, such as rehabilitation agencies and skilled nursing facilities. In addition, APTA would encourage the expansion of the Medicare and Medicaid incentive program for the adoption of health information technologies that meet the meaningful use criteria to all eligible Medicare Part B providers and suppliers. Improving quality of care while also decreasing costs will require participation by all providers, including broad adoption of health information technology. Expansion of the health information technology incentive program to include other qualified health providers would facilitate the goals of health care reform to improve quality. As it exists, the capacity is limited in its ability to provide a truly integrated system across critical transitions of care across providers and settings.

B) Repeal of the therapy cap on outpatient physical therapy services. Similar to the SGR policy, the therapy caps were authorized as part of the Balanced Budget Act of 1997. Since their scheduled implementation date of January 1, 1999, Congress has intervened numerous times to place a moratorium on therapy caps or, since 2005, extended a broad-based exceptions process. The therapy caps were designed to be a temporary measure until the Centers for Medicare and Medicaid Services (CMS) provided an alternative payment methodology for therapy services for Congress' consideration. Without significant development in this alternative, APTA proposes that Congress extend a limited exceptions process for 2012, 2013, and 2014 and instruct the Centers for Medicare and Medicaid Services to develop a per visit payment system for outpatient therapy services that controls the growth of therapy utilization for implementation by January 1, 2015. Limiting the exceptions process is only meant to provide some temporary reductions in spending while providing a bridge to a long-term solution. APTA has begun work to provide a reformed payment system for outpatient physical therapy services that could be implemented as early as 2014 and stands ready to work with the Subcommittee to solve this issue in the 112th Congress.

C) Policies that would improve the integrity of services paid for by the Medicare program. Currently under Medicare Part B there are various ways to bill for services. We believe that in regards to physical therapy services, modification to the Stark II in-office ancillary services exception to the self-referral law as well as changes to “incident to” billing could provide potential cost-savings and improve the integrity of the services delivered and paid for by the Medicare program. Specifically, APTA recommends the elimination of physical therapy services from the in-office ancillary services exception to the physician self referral law and reforms to the incident to requirements for physical therapy services. 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 93%) 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 providers that serve the Medicare Part B program and ensure we are paying for only services delivered appropriately by qualified professionals of that discipline.

Conclusion

Again, thank you for your attention to this pressing health and payment policy issue under the Medicare Part B program. APTA stands ready to assist the Subcommittee and is happy to provide more specifics on the three areas of reform listed above. If the Subcommittee has questions or needs additional resources, please contact Mandy Frohlich, Director of Federal Government Affairs, at mandyfrohlich@apta.org or 703-706-8548.

Thank you for the opportunity to submit comments and provide recommendations for the record.