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Patient Inquiry®

September 17, 2011

The Honorable Wally Herger  
The Honorable Pete Stark  
Subcommittee on Health  
House Ways and Means Committee  
U.S. House of Representatives  
Washington, DC 20515

Dear Chairman Herger and Ranking Member Stark:

Focus On Therapeutic Outcomes, Inc., (FOTO) is pleased to submit this statement for the record pertaining to the hearing of the House Ways and Means Health Subcommittee on September 20 to examine expiring provisions of the Medicare payment system.

As the leading developer of quality and outcomes measurement systems for outpatient rehabilitation therapies, FOTO serves providers and facilities nationwide. For over eighteen years, FOTO has been developing, improving, perfecting and providing valid and reliable methods for the assessment of function in patients receiving outpatient physical and occupational therapy services. Using data gathered from over 3,900 clinical practice locations, FOTO has developed a robust database of over 3.1 million episodes of therapy and has advanced user-friendly, economical methods for collecting, analyzing and utilizing functional status measures.

Focus On Therapeutic Outcomes, Inc., comments on one issue in particular of relevance to the hearing; namely the Medicare Per Beneficiary Therapy Caps.

### **Medicare Therapy Caps**

In January 2012 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. While the latter is by far the preference, at minimum the exceptions process must be extended to avoid unduly affecting those beneficiaries who are most in need.

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Without congressional intervention, the therapy caps will once again arbitrarily end Medicare's coverage of outpatient physical therapy, occupational therapy, and speech-language pathology services once a beneficiary has received an artificial dollar amount of services (\$1,870) of services in an entire calendar year. This set amount is without respect to a patient's condition or the need for services or the use of services at other times during a calendar year for either the same or a different condition.

It applies to Medicare beneficiaries in all outpatient health care settings with the exception of outpatient hospital departments. 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<sup>1</sup> 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 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.

FOTO urges Congress to extend the exceptions process for three years and direct the Centers for Medicare and Medicaid Services (CMS) to prepare an "alternative payment method" which was envisioned by the Balanced Budget Act of 1997. Specifically, Congress should direct CMS to utilize the exceptions process to incentivize the collection and submission of quality information (e.g., **functional outcomes data**) which could be used to describe the type and amount of care that is needed by specified patients or groups of patients. Legislative language that would operationalize this policy ("The DCS Exception") is appended to the end of this letter.

The arbitrary, per beneficiary annual 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 preempt this errant policy by placing a moratorium on the caps or, since 2005, extending a broad-based exceptions process. These caps were intended to be temporary until "an alternative payment method" could be developed. But such an alternative has not materialized in 14 years. **Yet, one is possible** if Congress and the Centers for Medicare and Medicaid Services (CMS) would commit to collecting the necessary descriptive data upon which such an alternative could be predicated.

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<sup>1</sup> 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

A limited (and targeted) extension of exceptions process for 2012, 2013, and 2014 combined with instructions to CMS to grant the therapy cap exception for care delivered to Medicare beneficiaries in any setting that is collecting and reporting functional outcomes data would result in a database containing sufficiently robust information to design the alternative payment method envisioned by the 1997 BBA. Most importantly, such a payment model would not be based on an arbitrary limit but rather on the amount and type of care needed to achieve the desired optimal outcome.

In the Physician Quality Reporting System (PQRS), CMS has recognized 7 outcomes measures that quantify change in risk-adjusted functional status of patients with certain impairments. These measures quantify various aspects of clinical quality including patient outcome, efficiency of care and patient experience of care; are functional in nature; are administratively nonburdensome for clinicians; and can be technically implemented within the capacity of the CMS infrastructure for data collection, analysis, and calculation of reporting and performance rates.

Moreover, these seven FOTO measures facilitate alignment of care with, other Medicare, Medicaid, and CHIP programs in furtherance of overarching healthcare goals. In particular, these measures have the propensity to align financial incentives with the implementation of care processes based on best practices and the achievement of better patient outcomes as recommended by the Institute of Medicine (IOM) in *Crossing the Quality Chasm*.

Ultimately, payment for rehabilitation therapy should be based on accurate risk-adjusted measures of function or quality for an episode of care. Using the above measures to collect outcomes data on patient care will enable Congress and CMS to rapidly and accurately develop such a payment system. In doing so, the therapy cap issue will be relegated to history.

On behalf of FOTO, thank you for your continued efforts to create a more stable, predictable and effective Medicare payment system. FOTO is eager to continue to work with the Committee, Congress and CMS to advance the above-identified concepts.

Sincerely,



Ben E. Johnston, Jr., PT  
General Manager

## **ADDENDUM**

### **Proposed Therapy Cap Alternative**

#### **Exceptions Process Based on Submission of Quality and Outcomes Data**

## **“The DCS Exception”**

### **(a) BENEFICIARY CONDITION AND OUTCOMES DATA**

1. **In General.** – No later than January 1, 2012, the Secretary of Health and Human Services (“Secretary”) shall in collaboration with national professional associations representing each therapy discipline (including physical therapy, speech-language pathology, and occupational therapy) and those associations that represent providers or suppliers who offer services to beneficiaries in need of such services implement an initiative to:
  - (a) identify general and discipline-specific data elements regarding patient condition, including severity of condition,
  - (b) develop general and discipline-specific patient assessment processes to collect such data,
  - (c) identify and measure appropriate indicators, such as age, illness, severity and settings, that may be used in assessing appropriate payment for services, and
  - (d) implement a data collection system (“DCS”) using the above-referenced discipline-specific assessment tools that measure the quality and efficiency of therapy treatment.
  
2. **Sites.** --The Secretary shall ensure that the initiative includes a variety of geographic sites and practice settings including nursing facilities in which the therapy disciplines furnish services under Medicare Part B.

### **(b) SERVICES NOT SUBJECT TO PER BENEFICIARY CAP**

1. **In General.** -- Any provider or supplier that furnishes outpatient therapy services to fee-for-service Medicare beneficiaries or outpatient rehabilitation services provided in a SNF under consolidated billing provision and submits claims to the Medicare program for such services, may voluntarily agree to participate in the DCS by submitting data on quality measures or patient outcomes to the Secretary.
  
2. Beneficiaries receiving treatment from a person or entity participating in the data collection initiative described in this paragraph shall not be subject to financial limitations under section 1833(g)(2) of the Social Security Act (42 U.S.C.1385l(g)(2)).

- (c) **REPORTS.** -- The Secretary shall report to the Congress on (a) the adequacy of the assessment processes in reflecting the quality and efficiency of therapy treatment, (b) identify or recommend alternative data elements and assessment processes that would reflect the quality and efficiency of therapy treatment, and (c) payment methods based on beneficiary need and effectiveness of rehabilitation as alternatives to the beneficiary therapy caps. The Secretary shall submit an interim report to the appropriate committees of the Congress no later than October 1, 2012, and a final report to such committees no later than April 1, 2013.