May 25, 2012

Submitted via electronic mail

The Honorable Dave Camp
Chairman
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515
physician.feedbackwm112@mail.house.gov

Re: Medicare Program and Sustainable Growth Rate (SGR) Reform

Dear Chairman Camp and Committee Members:

I am writing on behalf of the American Occupational Therapy Association (AOTA), the national professional association representing the interests of more than 140,000 occupational therapy practitioners and students, in response to your request for provider comment on improving the Medicare program. The practice of occupational therapy is science-driven, evidence-based, and enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Occupational therapy practitioners and their patients are greatly impacted by Medicare rules and payment policies, and AOTA appreciates the opportunity to provide our perspective and recommendations on reforming payment and practice arrangements and ensuring the Medicare program can meet the health, prevention, and rehabilitation needs of its beneficiaries. AOTA shares the concerns of the medical community and Congress regarding the flawed formula of the Sustainable Growth Rate (SGR) and particularly the negative impact implementation of SGR based cuts would have on beneficiary access to care.

I. Outpatient Therapy Caps

In 1997, Congress passed the Balanced Budget Act (BBA) that created an annual financial cap or limit on outpatient physical therapy and speech-language pathology services and a separate cap on occupational therapy for all outpatient settings. Since that time, Congress has acted repeatedly to forestall the impact of the therapy caps on seniors and individuals with disabilities under the Medicare program. This has historically been addressed along with the (SGR) formula, as their deadlines typically coincide.

An arbitrary therapy cap on outpatient services without regard to clinical appropriateness of care discriminates against the most vulnerable of Medicare beneficiaries. The therapy caps shift costs, delay care, and reduce an individual's ability to remain independent in his or her home and community. Beneficiaries who fail to receive the rehabilitative care they need from an occupational therapist, physical therapist, or speech-language pathologist at the right time, for

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the right duration, and with the right intensity are more likely to require higher-cost interventions in the future or require additional assistance over the long run.

AOTA urges Congress to permanently prevent implementation of the caps and work toward a system that would provide more continuity and predictability to the therapy payment system. AOTA's chief priorities with regard to any new or reformed system to address outpatient therapy reimbursement include the following:

- Discipline-specific payment,
- Payments based on patient occupational needs, complexity, severity, and other factors,
- A uniform payment system across outpatient settings,
- Required or incentive data reporting to inform service delivery and valuation,
- The inclusion of quality data (both process and outcome measures),
- A phased-in approach to implementing a new system,
- Cooperation between CMS/MedPAC/Congress and professional societies, and
- A payment system that adequately reflects the resources needed to provide the services and ensure appropriate access to care.

Interwoven with the above principles is AOTA's firm belief that any coding or payment system must uphold deference for the occupational therapy practitioner's clinical reasoning and judgment (including as to the amount and type of therapy a patient receives, as opposed to arbitrary limits on care) within the bounds of Medicare coverage rules. Treatment plans for Medicare beneficiaries must be guided first and foremost by clinical evaluation and judgment of patient needs and choices.

AOTA is working closely with the American Physical Therapy Association (APTA) and the American Speech-Language-Hearing Association (ASHA) to promote such changes. We are also working with the Committees of jurisdiction, including Ways and Means Committee staff, in order to identify mechanisms to control utilization of therapy services while ensuring beneficiary access to medically necessary rehabilitation services like occupational therapy. The changes to the therapy cap exceptions process drafted by your staff in the Middle Class Tax Relief and Job Creation Act of 2011were an important step toward moving forward with a system of therapy payment that can help control and better understand therapy utilization while ensuring appropriate access to medically necessary care for Medicare beneficiaries.

II. Quality and Efficiency

Quality, efficiency, and patient outcomes should be incorporated into the Medicare provider payment system, which includes both physician and non-physician providers. Quality measures used by the Medicare program to determine payment should have at their foundation the achievement of patient-centered outcomes in terms of health and quality of life. Primary and acute care process and outcome measures are certainly necessary, but they are not sufficient for people with disabilities and chronic conditions who make up a large portion of Medicare beneficiaries.

For example, a person who experiences a traumatic injury or surgical operation may achieve completely acceptable traditional primary care outcomes (*e.g.*, blood pressure, blood sugar, heart rate, and cholesterol) six months later, but the real indicator of a successful outcome is the level of independence and continued health (*e.g.*, community participation, no hospitalizations, no falls, no depression) the person achieves. Is the person not only "healthy" but living at home as independently as possible (at a lower cost than other care) and having returned to work or normal activities? Or is the person significantly compromised in terms of their function, living in a nursing home, unemployed and out of the mainstream of normal activities, and likely to cost the Medicare program more over the long term?

Longitudinal measures that can account for these differences – such as measures to monitor hospital readmissions, depression follow-up and management, quality of life and functional outcomes, medication management, freedom from falls, participation in the community, independence in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) – are necessary for the Medicare program to successfully improve quality and outcomes while saving money. AOTA thus calls for the development, endorsement, and employment of longitudinal measures such as these in any payment system poised to replace or reform the SGR.

III. Alternative Payment Models

AOTA supports the quality and efficiency goals of alternative payment models, but concerns do arise in a system where health care providers are financially rewarded for keeping costs down. Anyone who is "expensive" – *i.e.*, has a disability or chronic condition or requires specialized or complex care – is at risk of losing access to specialized medical care, devices, technology, and other services. This includes rehabilitation care at the appropriate level of intensity, frequency and duration to meet the needs of the individual patient. Facilities operating under a bundled payment pilot or accountable care organizations (ACOs) should simply not be permitted to share in savings achieved through the denial of high quality patient care. These alternative payment models should be more than simply new payment mechanisms but rather a new way of delivering quality health care across the continuum.

In addition, these new models devote significant resources to promoting and protecting primary care. AOTA recognizes the essential importance of primary care, but urges a broader conceptualization of what it means. In order for beneficiaries to achieve optimum levels of health and function it is necessary for them to access the range of care necessary to achieve maximum health. To avoid health care silos and rotating hospital admissions, rehabilitation services like occupational and physical therapy must be considered primary services essential to the health wellness, independence, and productivity of Medicare beneficiaries.

IV. Regulatory Relief

A multiple procedure payment reduction (MPPR) policy for outpatient therapy was finalized in the 2011 Medicare Physician Fee Schedule (75 Fed. Reg. 73170 [November 29, 2010]). AOTA believes that the policy, implemented this calendar year, is administratively burdensome, wholly unnecessary, and contrary to current law and practice.

The administrative burden of the MPPR is evidenced by numerous reimbursement problems encountered by the Medicare program and its contractors in trying to implement the policy. Issues with software and algorithms have created exponentially more work for providers and their billing staff as they track reimbursement and monitor payment for mistakes, await automatic reprocessing, and manually resubmit claims for reprocessing where necessary.

The rule is also unnecessary and unjustified as it purports to eliminate payment duplication where none exist; redundancies have already been reviewed and adequately accounted for through the American Medical Association (AMA) Health Care Professionals Advisory Committee (HCPAC) and Relative Value Update Committee (RUC) process.

Finally, it is AOTA's belief that the policy is inconsistent with Medicare law. The MPPR fails to differentiate occupational therapy and physical therapy (which includes speech-language pathology services), as separate Medicare benefits to which Medicare beneficiaries have a distinct right. Outpatient occupational therapy services are separately defined under the SSA (§1861(g)), they have separate and distinct Conditions of Payment and Conditions of Participation under federal regulations (42 CFR §§410.59-60 and 410.62), and have separate and distinct coverage criteria in manual guidance (Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch. 15 §230). Further, the policy is inconsistent with the Patient Protection and Affordable Care Act (ACA), which authorizes the Medicare program to identify, review, and adjust "multiple codes that are frequently billed in conjunction with furnishing a *single service*." (ACA §3134(a) [emphasis added]). The MPPR combines distinct services as a single service ("therapy") for the purpose of payment. There is no covered Medicare benefit known as "therapy services." Instead, there are distinct services provided by distinct disciplines, and it is inconsistent with law and previous agency practice to conflate the disciplines in the administration of the MPPR.

To ensure compliance with the ACA and grant regulatory relief to providers, AOTA asks that the MPPR be eliminated or at the very least properly amended so that only occupational therapy codes that are billed in conjunction with one another on the same day are adjusted, and physical therapy and speech-language pathology codes that are frequently billed in conjunction with one another are separately adjusted, not combined all into one service.

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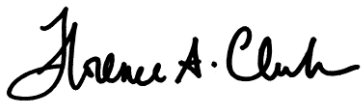
AOTA thanks the Ways and Means Committee for considering our comments and urges thoughtful action to ensure that the interests of Medicare beneficiaries are protected as the Committee goes about its important work. AOTA looks forward to working with the Committee to achieve permanent, fiscally responsible solutions for both the SGR and the outpatient therapy cap.

Sincerely,



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