

February 25, 2013

Submitted electronically to: SGRComments@mail.house.gov

Chairman David Camp
Ways and Means Committee
1102 Longworth HOB
Washington, DC 20515

Chairman Fred Upton
Energy and Commerce Committee
2125 Rayburn HOB
Washington, DC 20515

Dear Chairman Camp and Chairman Upton:

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 140,000 occupational therapy practitioners and students. We are responding 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 on repealing the Sustainable Growth Rate (SGR) formula and reforming Medicare payment and practice arrangements to ensure that the program can meet the health, prevention, and rehabilitation needs of its beneficiaries.

AOTA shares the concerns of the healthcare community and Congress on the SGR, and finds that the joint proposal would help eliminate the negative impact that implementation of SGR-based cuts would have on beneficiary access to care as well as obviate any real or perceived need for outpatient therapy caps.

AOTA recommends, however, that the proposal clearly recognize and reimburse non-physician practitioners appropriately as key partners in the provision of medically necessary care to Medicare beneficiaries.

I. Elimination of Outpatient Therapy Caps

AOTA supports the language in the joint proposal that would eliminate the SGR and, with it, any real or perceived need for the outpatient therapy caps. We urge the Committees to eliminate both the caps and the SGR in phase one of any payment reform process to ensure Medicare beneficiaries retain access to medically necessary therapy services and to lend continuity and predictability to the therapy payment system. We would expect that a reconfigured Medicare Physician Fee Schedule system would provide appropriate controls that would eliminate the need for the cap.

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 the right duration, and with the right intensity are more likely to require higher-cost interventions in the future and/or experience less than optimal outcomes. A joint repeal of the therapy caps and the SGR would both preserve access to care and emphasize the primacy of quality in the new payment system.

II. Current Work to Reform Payment for Therapy

AOTA is currently working on a coding proposal to better define therapy services and enable the collection of better data to undergird a new payment system. We are working with the American Medical Association (AMA) Health Care Professionals Advisory Committee (HCPAC) and Relative Value Update Committee (RUC). We are also working with the committees of jurisdiction, including the Ways and Means Committee, in order to identify mechanisms to control utilization of therapy services while ensuring beneficiary access to medically necessary rehabilitation services like occupational therapy.

AOTA's approach addresses the need to further clarify the actual procedures being performed by occupational therapists. CMS, MedPAC and Congress have raised concerns that recording using the existing Current Procedural Terminology (CPT)© descriptors does not provide substantive information on what problems the therapist is treating and on how that is related to goals and outcomes. There have also been concerns expressed about the number of codes, the possible duplicative payment in some cases, and the use of 15-minute increments for many of the codes. AOTA has developed fewer codes (six core codes), suggested that the codes be per session, and has used International Classification of Function language, which CMS has promoted as a standard for terminology. Another concern about the current codes is their relationship to accomplishing goals and achieving an appropriate outcome; AOTA's approach would be able to be managed in order to show progress during a course of therapy.

III. Integrating Physician and Non-Physician Quality Performance

The reform proposal calls for provider "participation in clinical improvement activities" (Phase 2, bullet 2) and "risk-adjusted relative rankings amongst physician specialty peer groups" (Phase 2, bullet 4). AOTA strongly agrees that quality, efficiency, and patient outcomes should be incorporated into the Medicare provider payment system, but notes that such a system must include both physician and non-physician providers. MedPAC has recognized that there is an essential relationship between occupational therapists, physical therapists, speech-language pathologists and physicians; payment reform and updating must reflect this as well.

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.

AOTA is concerned that by focusing solely on physician services for rewards (in hospitals, private practices, ACOs, and other payment models), as the proposal appears to do, then other professions currently paid under the fee schedule lose the opportunity for recognition of their contributions, either through risk-sharing or reward. We have serious questions about the meaning of “participation in clinical improvement activities” and “risk-adjusted relative rankings amongst physician specialty peer groups”: What does “participation” mean? What activities are included in “clinical improvement activities”? How are “peer groups” defined? We recognize the proposal is in its early stages, but we are wary of nonphysician providers being left out of the calculation leading to a failure of new systems to recognize – or reimburse for – their meaningful and necessary contributions.

We further ask the Committee to consider that a significant portion of Medicare outpatient therapy providers are not able to participate in existing quality programs that are related to services paid on the Medicare Physician Fee Schedule, which all Part B occupational therapy and other therapy services have been since 1999. Any new proposal that builds quality into the equation of payment must allow all providers (e.g., rehabilitation agencies, hospital outpatient departments) to participate if they are paid under this new system. Currently only occupational therapists in private practice are able to participate in the Physician Quality Reporting System. AOTA also urges that any quality measurement system account for difference among patient groups.

IV. Appropriate Outcome Measures

Health care is undergoing significant system and structural changes as it transforms to a system that can achieve what many call the “Triple Aim” of healthcare: improved health outcomes, improved experience of the health care system, and reduction in the rate of cost growth, particularly through a preventive and coordinated approach. Thus outcomes measures should work toward monitoring and rewarding outcomes. The Committee’s own proposal appropriately reflects these changes in stating that some of the system requirements should be to:

- Foster clinically meaningful (not government determined) care for patients;
- Encourage achievable improvements in quality, efficiency, and patient outcomes based on physician-endorsed measures;
- Be applicable to all specialties, practice arrangements, and geographic locations;
- Reward the value rather than the volume of services; and
- Motivate all stakeholders to adopt reforms.

AOTA would like the Committee to support development of measures that are not only “physician-endorsed” but also reflect other clinical perspectives. With the move to options such as Accountable Care Organizations and medical home structures in Medicare, outcome measures must be broadly related to the effectiveness not just of individual providers but of the system as a whole. Critical issues such as reducing use of institutional care, preventing unnecessary hospitalizations and re-hospitalizations, prevention (e.g., falls safety), and appropriate medication management must be components of the outcome measure system. A system of individual or single process measures will not achieve the Triple Aim.

As noted above, providing health care is the work of a team of professionals and occupational therapy should be viewed as the profession of choice for improving patient function—whether it is assuring diabetics take medication and manage lifestyle to maximize health, providing a home safety evaluation and training to prevent falls that lead to hospitalizations and other unnecessary expenditures, or keeping individuals able to care for themselves in their own homes. All of these functional outcomes are related to health outcomes and thus to health spending. As the system is developed to measure quality, AOTA believes this broad perspective that includes both process and outcomes should be considered. Occupational therapy has a body of research that shows the positive cost, health status and functional improvements achieved by appropriate and efficient use of occupational therapy. This and other research should be used to support the systemic and individual practitioner outcome measures.

Again, AOTA would ask the Committee to include non-physician clinicians when referencing physicians in its work.

V. Effective Reporting Mechanisms

Finally, the Committees have asked for feedback on successful and unsuccessful reporting mechanisms. Our member providers report that reporting mechanisms like those in the private payer system that are streamlined, simple, and electronic are the most effective. In contrast, reporting mechanisms that require the transmission of medical records via fax or postal service – such as the ongoing manual medical reviews for outpatient therapy services over \$3,700 – are administratively burdensome and time consuming. Worse, these mechanisms can be ineffective and redundant, such as when providers must re-send paperwork not received by the MACs or repeatedly try and fax materials over busy phone lines, all while Medicare beneficiaries await CMS approval for the continuation of their care.

An effective and efficient reformed payment system will include funding for CMS and its contractors to receive materials electronically and to inform providers in real time when materials have been received, reviewed, and when a final decision has been made.

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AOTA thanks the Energy and Commerce and Ways and Means Committees for considering our comments. We look forward to working with the Committees to achieve a permanent, fiscally responsible, quality-based, repeal and reform of both the SGR and the outpatient therapy caps.

Sincerely,

A handwritten signature in black ink, appearing to read "Christina Metzler". The signature is written in a cursive, flowing style.

Christina Metzler
AOTA Chief Public Affairs Officer
American Occupational Therapy Association, Inc.