Federal Affairs Advocacy Update

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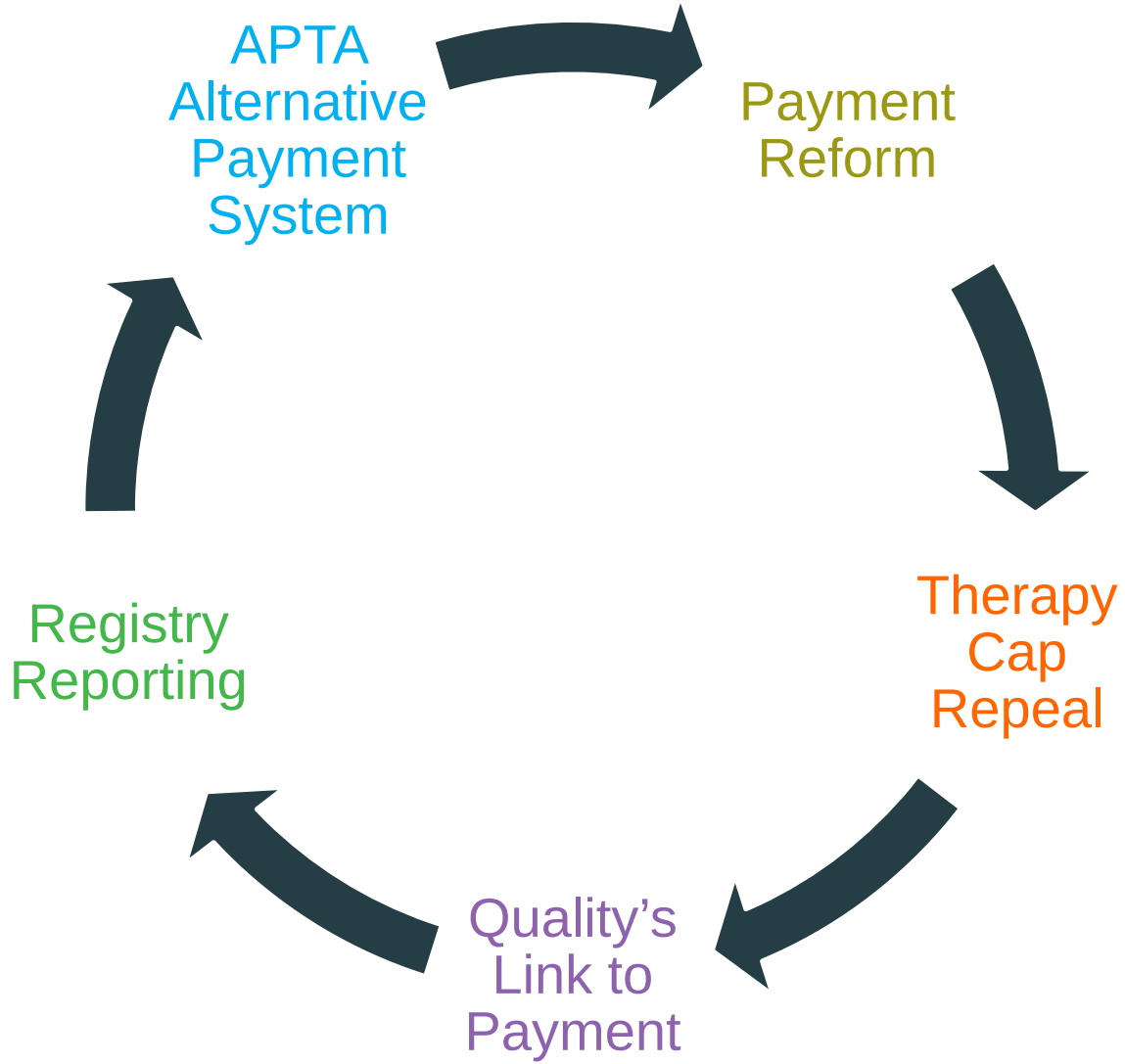
Payment Reform: Medicare Part B
Payment Reform: Medicare Post Acute Care
Quality Reporting and the Link to Payment Reform


APTA Alternative Payment System
Payment Reform
Therapy Cap Repeal
Quality's Link to Payment
Registry Reporting

Payment Reform: Medicare Part B

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APTA Alternative Payment System

- Genesis of the Proposal
- Visit/Session Based System
- Based on clinical judgment of the therapist
- Factors include:
  - severity/complexity of the patients presentation
  - required intensity of the therapist's clinical decision making
- Currently in pilot testing

Sustainable Growth Rate & Therapy Cap Repeal

What is the Sustainable Growth Rate (SGR)?

- Created in the Balanced Budget Act of 1997
- Payment formula for all outpatient Medicare services
- Intended to ensure that yearly increases match the growth in GDP
- Flawed formula results in the need for a yearly "doc fix"

How Does Congress Propose to Fix it?

Therapy Cap Repeal & Reform

- Repeals the Medicare therapy cap
- Retains manual medical review at $3,700 for 1 year
- Transitions to a new medical review system in 2015 with a prior authorization mechanism for approval of blocks of visits
- Replaces current functional limitation reporting with new therapy data collection system (around 2017)
- Starting in 2015, claim form must indicate if the service is provided by a therapy assistant

Why Fix it Now?

SGR	Therapy Cap
Created in 1997 Balance Budget Act (BBA)	Created in 1997 Balanced Budget Act (BBA)
Fixed 17 Times	Fixed 12 Times
Cost of 17 Fixes: More than a permanent fix	Cost of 12 Fixes: More than a permanent fix
Cost to Fix Permanently: $120- $140 billion	Cost to Fix Permanently: $8.8 billion

Next Steps

- SGR and Therapy Cap Exception Expiration: March 31, 2015
- Lame Duck vs. 2015 Dynamics
- Fall Awareness Campaign

Physician Fee Schedule Payment Update

- Released July 3, 2014
- Comments deadline September 2, 2014
- Final Rule expected November 1, 2014
- Due to SGR, CMS estimated a 20.9% reduction beginning April 1, 2015
- If no SGR reduction, the aggregate impact of changes in the rule on PT is positive 1%.

Alternatives to Valuation Process for New, Revised, Misvalued Codes

- Concerns raised that no meaningful opportunity to participate in valuation of CPT codes
- CMS proposes several options to allow for public comment (to be implemented in 2016, would need RUC recommended values by January 1, 2015).

Misvalued Code List

- CMS lists 65 CPT codes for RUC to review that are "High Expenditure Across Specialties with Medicare Allowed Charges of $10,000,000 or more). List includes following CPT codes:

97032	Electrical stimulation
97035	Ultrasound therapy
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97140	Manual therapy 1/> regions
97530	Therapeutic activities
G0283	Elec stim other than wound

Alternative Payment for Therapy

- CMS is interested in development of an alternative payment system for outpatient therapy.
- Includes discussions of episodic system, per diem systems, hybrid systems.
- DOTPA Research Triangle Institute (RTI) performed a study involving the use of the CARE –C and CARE-F assessment tools at admission and discharge.
- The Study was published on website May 1, 2014 http://www.cms.gov/Medicare/Billing/TherapyServices/Studies-and-Reports-Items/Developing-Outpatient-Therapy-Payment-Alternatives-Reports.html
- APTA is working on alternative payment system and CPT codes (AMA CPT workgroup is meeting to develop)

Developing Outpatient Therapy Payment Alternatives (DOTPA)

- Three Payment Alternatives:

  1) Therapy cap modifications- Example: increasing beneficiary cost sharing, risk adjustment of the cap amount, reducing provider payments above the cap
  2) Full episode based payment
  3) Hybrid approach- partial episodic payment and reduced payments above the episode payment

Therapy Cap

- Therapy Cap amount for 2014 is $1920 for physical therapy and speech therapy combined & $1920 for occupational therapy. (will increase for 2015)
- Legislation (Pathway for SGR reform act) extended the therapy cap exceptions process and manual medical review at $3700 for 3 months (January 1-March 31, 2014).
- Protecting Access to Medicare Act of 2014 (H.R. 4302) extended the therapy cap exceptions process & manual review until March 31, 2015.

RAC Transition: Changes to Review

- New RAC contractors are awaiting awards from CMS. A pause in reviews will occur until new contracts are awarded.
- Recovery Auditors will continue to complete the reviews for the ADRs they've already sent as of 2/28/2014.
- After 2/28/ 2014 no new ADR requests will be sent by the MACs/RACs for therapy cap claims exceeding $3700.
- All therapy providers will be subject to postpayment review for claims exceeding $3700 when the new RACs are awarded.
- The new RACs will not comply with the 10 day turnaround time for review due to the backlog.
- The new RACs will review the therapy claims in the order they were paid.

Therapy Cap

- Strategic Health Solutions audited claims with patterns of billing stopped at $3700.
- Selected random sample totaled 7,090 claims consisting of 357 unique providers with dates of service August 1, 2012 to March 31, 2013.
- Forty-one percent (41%) of denials were because providers did not respond to the ADR within the 45 day time frame

Number of claims	Paid	Denied	Error Rate
7,080	3,063	2,580 denied for no response	57%
		1,437 denied after review	
		Total: 4,017	

Payment Reform:
Medicare Post Acute Care

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- Improving Medicare Post-Acute Care Transformation (IMPACT)Act of 2014
  - Bicameral/Bipartisan introduced by Senate Finance and House Ways and Means Leadership
  - Standardizes patient assessment data, quality, and resource use measures for PAC providers including: HHA, SNF, IRF, LTCH
  - Based on stakeholder input; consistent with APTA's comments
  - Expected to move to a vote quickly
  - Will inform payment reform such as site neutral and bundling policies

- Requires PAC providers to begin reporting standardized patient assessment data at times of admission and discharge by October 1, 2018 for SNF, IRF, and LTCH and January 1, 2019 for HHA.
- Require new quality measures on domains beginning October 1, 2016 through January 1, 2019 including: functional status, skin integrity, medication reconciliation, incidence of major falls, and patient preference regarding treatment and discharge.

Table 1: Timeline for New Quality Domains*

Quality Domains	HHAs	SNFs	IRFs	LTCHs
Functional Status	1/1/2019	10/1/2016	10/1/2016	10/1/2018
Skin Integrity	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Medication Reconciliation	1/1/2017	10/1/2018	10/1/2018	10/1/2018
Major Falls	1/1/2019	10/1/2016	10/1/2016	10/1/2016
Patient Preference	1/1/2019	10/1/2018	10/1/2018	10/1/2018

*Displayed dates are deadlines for measure specification and data collection. Confidential feedback reporting and public reporting is required one and two years, respectively, after the dates displayed above,

- Require resource use measures by October 1, 2016 including: Medicare spending per beneficiary, discharge to community, and hospitalization rates of potentially preventable readmissions.

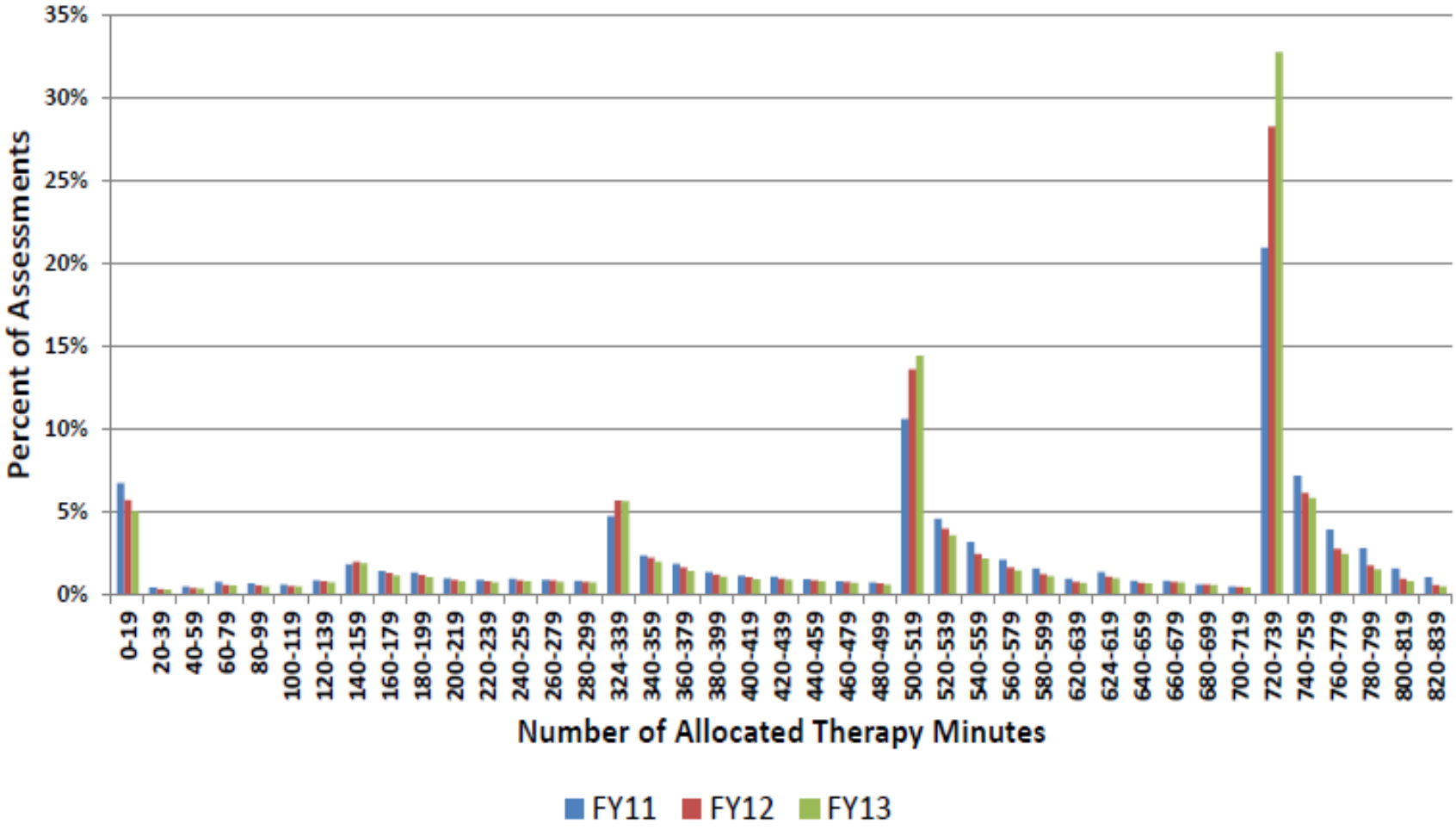
SNF Therapy Utilization Trends

- Therapy billed in the highest therapy RUG (RU)

Year	2011	2012	2013
% billed	44.8	48.6	50+

- Amount of therapy on MDS was just enough to surpass applicable therapy RUG level (especially in two highest RUG levels)

Number of Allocated Therapy Minutes per Beneficiary



SNF Therapy Research Project

CMS contracted with Acumen, LLC to identify and evaluate potential alternatives to therapy reimbursement for SNF PPS

The report explores four alternatives:

- a patient characteristics model
- a hybrid model that blends patient characteristics and a resource-based pricing adjustment
- a fee schedule
- a competitive bidding model.

Recommended and selected alternatives: patient characteristics and hybrid model concepts as basis for development of a final model.

Next Step: Model development

IRF: Definitions of Modes of Therapy (record IRF PAI for first 2 weeks)

Concurrent

- One PT, 2 patients at one time performing different activities

Co-treatment

- More than on therapist from different disciplines (PT/PTA and OT/COTA or SLP) to one patient at a time

Group therapy

- One PT/PTA to 2-6 patients at one time
- Performing same activities

Individual Therapy

- One PT/PTA to one patient at a time

Bundling Initiative: Four Models

Model 1: Inpatient Stay Only (Physician services paid separately)

Model 2: Inpatient and PAC Stay

(30 or 90 days)

Model 3: Discharge from Inpatient stay and PAC 30 days after

Model 4: Inpatient Stay (all services including physician)

BPCI Structure

- Defined patient populations with chronic and other conditions
- Target price set for entity to meet
- If target price is met and there is savings derived from bundled payment – bonus payments will be distributed to providers
- Current payment – still under fee for service (bill directly to Medicare)

Home Health

- CMS proposed rule published July 2014
- CMS notes numerous complaints from home health community regarding burden of the current therapy reassessment requirement timeframes to coincide with the 13th and 19th therapy visits for each therapy discipline and/or every 30 days.
- Proposes to change to require the therapist reassess the patient every 14 calendar days. Requirement would apply to all episodes regardless of the number of therapy visits provided.

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Quality and the Link to Payment Reform

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Congressional Focus: Quality Reporting 2014 and Beyond

- Under SGR legislation, payment beyond baseline tied to quality reporting- MIPS Program
- Therapy cap replacement calls for new data collection system which will inform payment alternatives in the future
- Passage of Post Acute Care legislation expected this fall
- Wide scale emphasis on registry reporting

Registry Reporting
2014 and Beyond

- APTA in pilot phase of outcomes registry
- Full launch expected in 2015
- Legislation and regulation continues to move toward registry based reporting

Quality Reporting Programs Under Medicare

Healthcare Setting	Mandatory Reporting	Payment Incentive/ Penalty
Inpatient (Acute Care Hospitals)	Yes	Yes P4R & P4P in 2013
Long Term Care Hospitals (LTCH)	Yes	Yes P4R Penalty 2%
Inpatient Rehabilitation Facilities (IRF)	Yes	Yes P4R Penalty 2%
Skilled Nursing Facilities (SNF)	Yes	Yes
Hospice	Yes	Yes P4R Penalty2%
Home Health	Yes	Yes P4R Penalty 2%
Outpatient PTPPs	No, payment adjustments for non-participation beginning in 2015	Yes P4R Incentive 0.5% through 2014, -1.5% 2015, -2.0% 2016 and beyond
All Outpatient: Functional Limitation Reporting (FLR)	Yes	Non-compliance = claims returned unpaid
Accountable Care Organizations (ACO)	Yes	P4P data performance tied to shared savings

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PQRS Reporting and Payment

PQRS Program Reporting Year	Data Year Utilized to Inform Payment	Incentive/ Penalty Payment
2013	2013	+0.5%
2014	2014	+0.5%
2015	2013	-1.5%
2016	2014	-2.0%
2017	2015	-2.0%

If you did not report in 2013 you will be subject to a -1.5% penalty in 2015

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2014 PQRS Measures for PTs

Claims-Based	Registry Only	Measures Group

• BMI Screening (#128)
• Medication Documentation (#130)
• Pain Assessment (#131)
• Falls Risk (#154)
• Falls Plan of Care (#155)
• Functional Outcome (#182)
• Chronic Wound Surface Culture (#245)
	• Diabetic Neurological Evaluation (#126)
	• Diabetic Footwear Evaluation (#127)
	• FOTO Outcome Measures:
	  • Knee (#217)
	  • Hip (#218)
	  • Lower Leg, Foot, Ankle (#221)
	  • Lumbar Spine (#220)
	  • Shoulder (#221)
	  • Elbow, Wrist, Hand (#222)
	  • Neck, Thoracic, General Ortho (#223)
		• Back Pain (#148-151)

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PQRS 2015:

- Will be a 2% reduction in payment in 2017 if eligible professional does not report successfully in 2015.
- CMS proposes to require reporting of at least 9 measures 50% of the time (or 1-8 if 9 do not apply) (at least 2 must be "cross-cutting measures)
- Proposes removal of back pain group measure
- Proposes to include 2015 individual PQRS data on the Physician Compare website in late 2016

Transparency: Public Reporting

- CMS wants to engage consumers in making informed decisions about their care; ensure high quality care.
- Physician Compare
- Hospital Compare
- Home Health Compare

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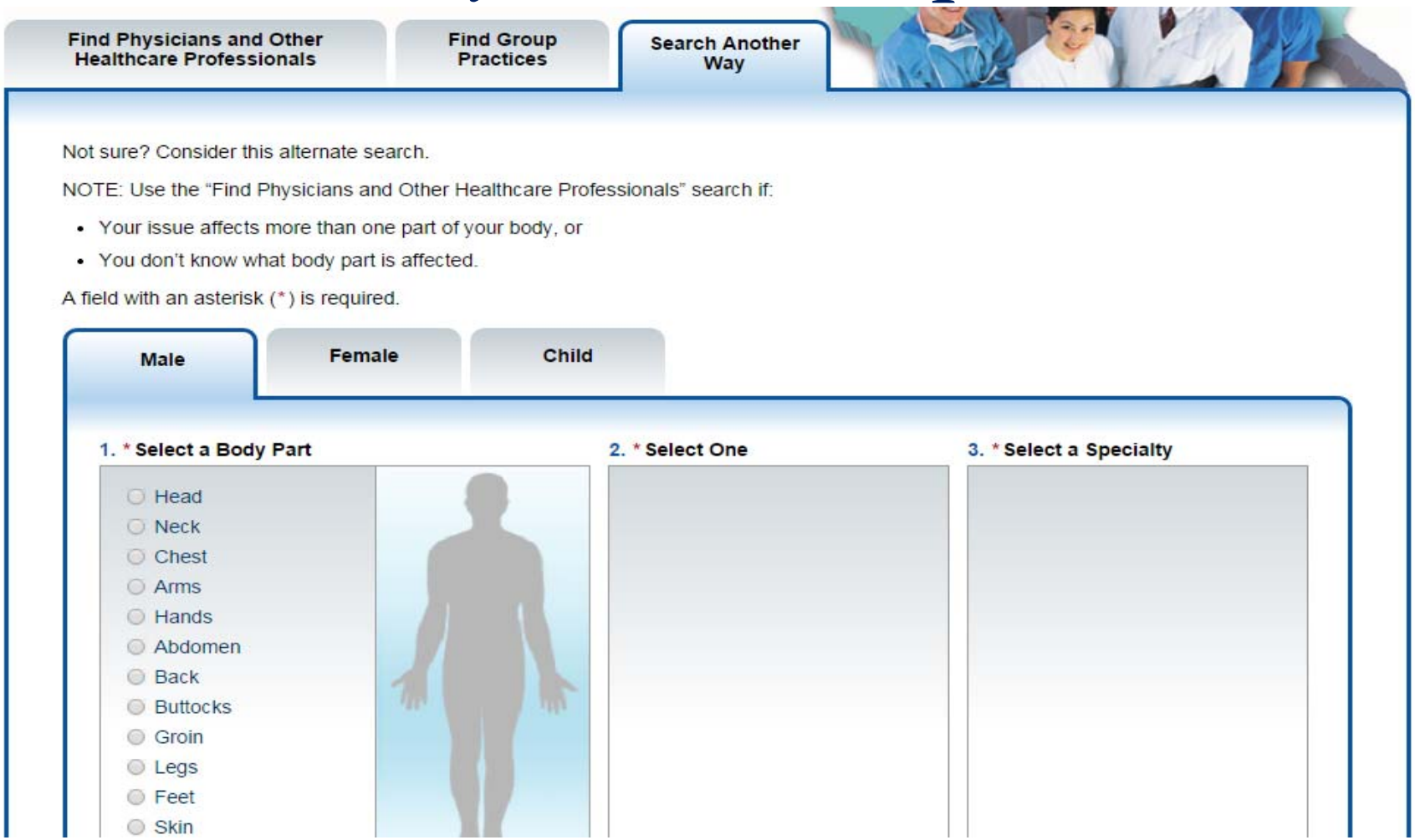
Physician Compare



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CMS Releases Data

- April 9: Historic release of 2012 CMS data on the medical services physicians, physical therapists, and other health care professionals provide and how much they are paid (discussed in context of fraud, abuse, waste, transparency)
  - http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier.html
- New York Times data search
  - http://www.nytimes.com/interactive/2014/04/09/health/medicare-doctor-database.html

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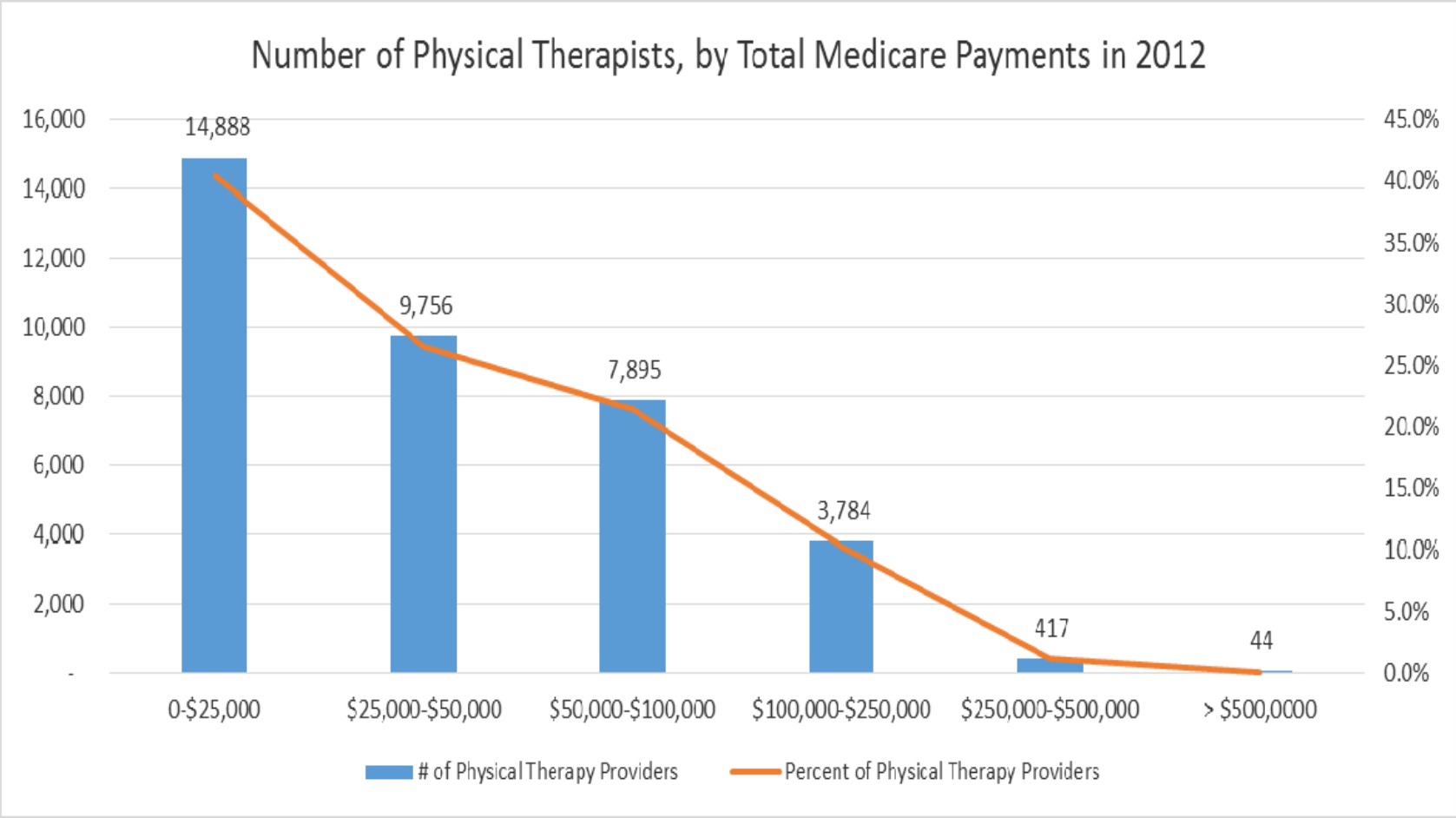
CMS Data

- File includes 36,784 physical therapists in private practice settings
- Shows services billed under the individual physical therapist Medicare enrollment number
- File does not include data for services that were performed on 10 or fewer beneficiaries.
- Many Limitations related to use of data without context (e.g. no info on expenses, multiple therapists billed under one number

CMS Data


Number of Physical Therapists, by Total Medicare Payments in 2012
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
-
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
14,888
9,756
7,895
3,784
417
44
0-$25,000
$25,000-$50,000
$50,000-$100,000
$100,000-$250,000
$250,000-$500,000
> $500,0000
# of Physical Therapy Providers
Percent of Physical Therapy Providers

CMS billing data for 2012 (private practice—from April data release)

CPT Code	Descriptor	Total Medicare Payments	Total Medicare Services	Total Number of Providers
97110	Therapeutic exercise	$985,350,917	43,332,961	43,231
97140	Manual therapy	$391,237,920	18,684,956	35,942
97112	Neuromuscular reeducation	$170,363,552	6,865,233	18,024
97530	Therapeutic activities	$180,089,452	6,922,727	15,490
97001	PT evaluation	$116,737,761	2,091,396	35,878
G0283	Electrical stimulation (unattended)	$62,549,781	6,503,702	18,798
97113	Aquatic therapy	$40,966,973	1,401,332	2,301
97116	Gait training	$28,148,332	1,382,748	5,163
97035	Ultrasound	$29,222,458	3,227,334	15,065
97002	PT reevaluation	$12,646,626	391,745	7,680

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QUESTIONS

- Health Care Reform
- Payment Reform
- Medicare Therapy Caps
- Manual Medical Review
- Functional Limitation Reporting
- Student Loan Repayment
- Medicaid
- Military/Veterans Affairs
- Self-Referral
- Direct Access
- Concussion Management
- HIPPA/Privacy
- Scope of Practice
- Clinical Practice Guidelines
- Fraud & Abuse
- Opt-Out & Locum Tenens
- Health Information Technology
- Orthotics/Prosthetics
- Durable Medical Equipment
- Prevention/Wellness
- Quality
- Innovation
- Rehabilitation Research
- Education–IDEA and ESEA
- Medicare Advantage