Policy Principles for Therapy Reform under the Medicare Physician Fee Schedule

As Congress begins to consider ways to reform the Medicare Physician Fee Schedule, the below policy principles seek to address long-standing challenges faced by outpatient therapy providers. Over the last three years, therapy providers have received some of the largest cuts of any health care providers as a result of budget neutrality policies. At the same time, therapy providers are subject to legacy reductions to payment for services that date back to the days of the sustainable growth rate formula, excessive administrative costs, and barriers to participation in innovative and value-based programs. Enacting the below policy principles will ensure access to high-quality therapy services now and into the future.

Section 1: Eliminate a Flawed and Outdated Medicare Payment Policy

The Multiple Procedure Payment Reduction Policy ("MPPR"), was first implemented in 2011 and applies to physical therapy, occupational therapy, and speech language pathology services provided under Medicare Part B. Because of MPPR, when therapists bill more than one "always therapy" service (identified by CPT code) on the same day for the same patient, all therapy services beyond the first are subject to a reduction in the practice expense portion of that code.

Under this policy, the therapy service with the highest practice expense value is reimbursed at 100%, and the practice expense values for all subsequent therapy services, provided by all therapy providers, are reduced by 50%. The work and malpractice components of the therapy service payment are not reduced.

In the 2011 Medicare Physician Fee Schedule, CMS first proposed the implementation of a 25% MPPR across therapy services. Congress reduced this reduction amount to 20% in the Physician Payment and Therapy Relief Act of 2010 (H.R. 5712). This 20% MPPR was in place from January 1, 2011, to March 31, 2013. Without any further analysis demonstrating a need to increase the MPPR, Congress implemented a permanent 50% MPPR in the American Taxpayer Relief Act of 2012, which was implemented by CMS on April 1, 2013. The average payment per therapy claim in 2013 (after MPPR) was 8.5% less than the average therapy claim in 2010 (before MPPR).

The American Occupational Therapy Association, the American Physical Therapy Association, and the American Speech-Language-Hearing Association have opposed the MPPR policy since its inception. It is inherently flawed, because the American Medical Association RVS Update Committee, which assigns values to CPT codes, already ensures that any potential duplication in work or practice expense is addressed as part of the code valuation process. Certain efficiencies that occur when multiple therapy services are provided in a single session were explicitly taken into account when relative values were established for these codes. The application of MPPR to the "always therapy" codes results in an excessive and duplicative reduction of these codes and is having a significant impact on the financial viability of therapy practices — ultimately impacting access to vital therapy services.

The percentage of payment reduction was arbitrarily decided and does not reflect actual utilization data regarding how many units of a therapy service are typically delivered in a treatment session, and it does not

recognize that OT, PT, and SLP interventions are separate and distinct from each other. When CMS first proposed the MPPR, they purposefully did not consider how therapy services are provided in facility-based settings, even stating that it does "not believe it would have been appropriate for us to consider institutional patterns of care."

With the potential exception of greeting the patient, clinical staff activities that are elements of the practice expense are not duplicative in nature and should not be reduced in value, especially when delivering different services during the therapy session. For instance, if therapeutic exercises using hand weights are provided for one unit, followed by self-care retraining in the kitchen for one unit, then the equipment, supplies, and clinical staff activities are entirely separate for each of these procedures. Each requires its own set-up, clean-up, disinfection, patient positioning, etc. before and after the procedure. Under the current policy, despite those services being separate and distinct, and having a separate and distinct practice expense, payment for the second unit is reduced even though the values of the two codes do not include any duplicative cost.

MPPR also applies across therapy disciplines delivered on the same date regardless of the distinct services and supplies provided to the patient. While the first therapy discipline would receive payment under MPPR at 100% for the first unit and 50% of the practice expense for all other units, a second or third discipline delivering services on that date would have all provided service units reduced. This occurs even though the equipment, clinical staff, and supplies utilized for one therapy service have no overlap with the other services provided. This policy penalizes providers when scheduling multiple therapies on the same date; which disproportionately affects beneficiaries in rural and underserved communities where transportation issues may require therapy services to be delivered on the same day to reduce the need for repeat visits to the clinic to receive separate therapy discipline services.

Section 2: Provide Patient Choice Under Medicare

Currently, PTs, OTs, and SLPs may not opt out of being Medicare-enrolled providers, if they provide services to Medicare-eligible beneficiaries. This prevents Medicare beneficiaries from exercising their right to select the health care professional of their choice, including allowing beneficiaries to privately contract with these therapists for their care regardless of whether the therapist has elected to enroll in Medicare. To provide true patient choice and ensure access to the most appropriate care, PTs, OTs, and SLPs must be able to opt out of the established enrollment rules set by the Medicare program and federal law along with physicians, physician assistants, dentists, podiatrists, optometrists, social workers, psychologists, nurse midwives, dietitians, and other eligible providers. Denying a patient access to a therapist with expertise because that provider is not enrolled in Medicare also negatively impacts patients' clinical outcomes. It is imperative that Medicare enrollees have the opportunity to choose the most appropriate provider and model of care to meet their needs.

Medicare's inflexible policies have stifled implementation of innovative programs that can support the long-term health and wellness of Medicare beneficiaries. Certain evidence-based therapy interventions cannot be reimbursed under current Medicare payment policies. Allowing therapy providers to opt out would give Medicare beneficiaries the opportunity to benefit from these critical interventions to which they are currently denied access.

Section 3: Reduce Administrative Burden for Therapy Services Provided Under Medicare Part B

Medicare Part B guidelines permit Medicare beneficiaries to receive therapy evaluation and treatment services with or without a physician order. The PT, OT, or SLP may evaluate that patient, formulate a plan of care, and commence treatment. However, under current certification requirements, the therapy provider must submit the plan of care to the patient's physician and have it signed within 30 days in order to receive payment. This policy would clarify a new care coordination model such that when outpatient therapy services are provided under a physician's order, the plan of care certification requirements shall be deemed satisfied if the qualified

therapist submits the plan of care to the patient's referring physician within 30 days of the initial evaluation. The order would confirm the physician's awareness of the therapy episode and proof of submission of the plan of care would demonstrate the coordination and collaboration between the physician and the therapist.

For a physician who ordered therapy services, they would have 10 business days after receiving the plan of care to modify it. When a patient began therapy services without an order, the receiving physician would have 30 calendar days to modify the plan of care.

Given the current pressures on therapy providers, including recent year-over-year fee schedule cuts, we are united in seeking opportunities to reduce administrative burden without compromising patient safety or quality of care as a way to mitigate the impact of these payment cuts for therapy providers and our physician colleagues, as well as to best serve our patients expeditiously and without financial risk to their therapist providers. The time and resources spent by both therapists and physicians in procuring a timely signature adds unnecessary cost, potentially delays essential services, and fails to contribute to improved quality of care.

Section 4: Provide Flexibility in the Supervision of Assistants and Determine Challenges Facing the Therapy Workforce in Rural and Underserved Areas

Medicare allows for general supervision of occupational therapy assistants by occupational therapists, and physical therapist assistants by physical therapists in all settings, except for outpatient private practice under Part B, which requires direct supervision. While therapy providers must comply with their state practice act if state or local practice requirements are more stringent than Medicare's, the standard in 48 states is general supervision of OTAs and PTAs, making this outdated Medicare regulation — which arbitrarily applies only to private practice — more burdensome than almost all state requirements. Standardizing a "general supervision" requirement for private practices will help ensure continued patient access to needed therapy services and give small therapy businesses more workforce flexibility to meet the needs of beneficiaries. This policy addresses this problem by enacting language to change the Medicare supervision requirement for OTAs and PTAs in private practice from direct to general supervision in states with licensure laws that allow for it. According to an independent report published by Dobson & Davanzo in September 2022, this change in supervision is estimated to save $271 million over 10 years.

The inconsistency of supervision policies between settings jeopardizes employment opportunities for OTAs and PTAs as well as the needs of Medicare beneficiaries in medically underserved and rural communities that rely so heavily on their services. Standardizing the supervision requirement from direct to general for private practices will help ensure continued patient access to needed therapy services and give private practices more flexibility in meeting the needs of beneficiaries. This small modification would better promote timely access to therapy services.

This policy would also directs the Government Accountability Office to conduct an analysis of how the Medicare Part B 15% payment differential for services provided by OTAs and PTAs, which went into effect in 2022, has impacted access to occupational therapy and physical therapy services in rural and medically underserved areas, across all Medicare Part B settings. Beneficiaries in those areas are twice as likely to receive OT or PT services from an assistant. The GAO report, due Dec. 31, 2024, will make it clear whether this payment differential is disproportionately impacting these regions.

Section 5: Reform MACRA

The 2015 Medicare Access and CHIP Reauthorization Act, known as MACRA, replaced the flawed sustainable growth rate formula with the Quality Payment Program. The QPP comprises two tracks: the Merit-based Incentive Payment System and Advanced Alternative Payment Models. CMS began implementing the QPP in 2017, with the eventual goal of moving providers out of MIPS and into Advanced APMs.

In its current form, the QPP has posed significant challenges to non-physician providers, including PTs, OTs, and SLPs. Therapists in particular have struggled to meaningfully participate in MIPS or engage in APMs, one reason being that CMS has failed to pilot or implement several alternative payment and delivery models applicable to therapy providers. Congress must enact meaningful reforms to the QPP that recognize the value of therapy providers and allow them to provide effective oversight of the QPP to determine its effectiveness at measuring therapy performance and outcomes.

The value of any quality program depends on the ability of all providers to participate. To address the current shortcomings of the QPP including limited opportunities for therapists participation in the program, this policy would create a stakeholder workgroup to identify barriers and develop recommendations for the Secretary of HHS on rulemaking to ensure that the QPP comprehensively measures the impact of all care received by Medicare beneficiaries.