Moving Forward with Payment Reform

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Planning for the Changing Paradigm in Payment for Therapy Services

Reformed Payment Key Concepts

- Overview reformed payment model
- The reform process and guiding principles
- Structure for reformed reporting model
- Projection for Implementation
Payment Challenges: Rehab Provided in OP Setting

Pressing Need for Reform

- APTA Development of a Reformed Payment model
  - Began following the BBA 1997-98
  - 2010 more aggressively due to MPPR, MEDPAC and other legislative/regulatory pressures
- Guiding Principles for Reform include;
  - Visit/Session based with eventual transition to episodic model
  - Utilizes Clinical Judgment of the PT in context with assessment tools
  - Factors influencing reporting include;
    - Severity/complexity of the patients presentation with
    - The required intensity/complexity of the therapists clinical decision making and skill/expertise of techniques in the delivery of care
Payment of the Past

- Paid for usual and customary services
- Paid what we billed
- Unrestricted number of visits
- Length of stays 30-40 visits /over months/years
Distribution of Spending (Part B)
Payment Reform:
Recommendations from “Phasing Out Fee for Service” (NEJM)

- Transition to Quality and Episodic should begin with “Blended” approaches
- Site Neutral Payments / Provider Neutral Payments
- Value “Patient Management” over “Procedures”
- Risk Sharing / Innovations Rewarded
The Value Equation: Providers Services and Patient Experience

Old Model
- Reward by unit cost
- Inadequate focus on care efficiency
- Payment for unproven services

New Model
- Reward health outcomes
- Lower cost while improving consumer experience
- Improve quality and safety

Improve quality and safety
Over time, payers should largely **eliminate stand-alone fee-for-service payment** to medical practices because of its inherent inefficiencies and problematic financial incentives.

Fee-for-service contracts should always **incorporate quality metrics** into the negotiated reimbursement rates.

For smaller practices, changes in reimbursement should **encourage methods for the practices to form virtual relationships** and thereby share resources to increase the quality of care.

Measures should be put in place to **safeguard access** to high-quality care, assess the adequacy of **risk-adjustment indicators**, and promote strong provider **commitment to patients**.

Overview and Impetus for Reform

- Unexplained growth in expenditures
- Disparity of resource costs among settings
- Increased focus on transitions in care
Impetus for Reform

Current Environment for OP Rehab

Payment Cuts

Regulatory / Administrative Requirements
### Evolution of Payment Challenges

**Payment Challenges (15% cut in 3 years / 3 New reporting Requirements)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>2011</td>
<td>First Application of MPPR (6-7%)</td>
</tr>
<tr>
<td>2012</td>
<td>2-Tier Cap Exceptions / Inclusion of Hospital OP Department</td>
</tr>
<tr>
<td>2013-2014</td>
<td>MPPR Phase II (6-7%)</td>
</tr>
<tr>
<td></td>
<td>Continuation of 2-Tier Exceptions (Manual Medical Review)</td>
</tr>
<tr>
<td></td>
<td>Functional Measures Requirement</td>
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<td></td>
<td>PQRS Penalty Phase</td>
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# Playing Defense

## Recommendations to Congress

### MedPac Recommendations

- Lower Cap ($1280)
- Changing Certification Requirements (45 days)
- Hot Spotting on High Utilization Areas
- Considering Private Sector Initiatives
  - Pre-authorization
- Use of Standardized Assessment Tools to Drive Payment
- More aggressive MPPR

### CMS

- RUC review of “Mis-valued” codes: 97110, 97112, 97140, 97530 and 97035
Methods of Payment Reform

Cut Payment
- Multiple Procedural Payment Reductions
- Rate Reductions

Limit Access
- Certification / Referrals
- Visit Limits

Manage The Benefit
- Functional Limit Reporting
- Manual Medical Review / Caps

Reform of the Benefit
- Transitions to Per Diems / Episodes
- Quality / Pay for Performance
The Healthcare Value Equation

Cost reduction without regard to the outcomes achieved is dangerous and self-defeating, leading to false “savings” and potentially limiting effective care.

Source: NEJM; What Is Value in Health Care? Michael E. Porter, Ph.D.
Alternative Payment Methodology

*We can either drive the change or be driven by it...*

- Transition to ICD-10 provides opportunity to facilitate incorporation of ICF language into communication between rehab providers and payer
- Would be consistent with transition to an episodic payment model in the future
Key Elements of Current Approach

Reporting OP Rehab Services

- Visit/Session Based Payment System
  - Movement towards reporting (coding) a session rather than specific interventions or unit based
  - Session described in context of clinical judgment of the therapist (level of care)
- Factors include the following characteristics:
  - Severity/complexity of the patients presentation
  - Required intensity/complexity of the therapist’s clinical decision making and skill/expertise of techniques/services provided
- 97000 series collapsed with some selected codes remaining as separately reportable
- Initial focus on outpatient setting, but could be modified for other settings
- Focus on accurately communicating clinical reasoning and decision making by supporting choice of treatment level
Current CPT Perspectives- Reform
Reporting Under a Per Session Payment Methodology

Basic elements should include:
- Majority of 49 current 97000 CPT codes collapsed into per visit/session code structure
- 4 codes each describing PT evaluations, OT and AT evaluations (3 Levels of IE, one code for eval of established POC’s)
- One Bundled code (ther ex, neuro re-ed, ther act, manual therapy, gt training) describing 5 levels of Interventions
- Codes to describe Cognitive, Psychosocial and ADL, IADL which would have 2 level
- Select services remain as “separately reportable”
  - (~14 services)
- Reporting based on complexity/severity of patient and intensity of therapist work
Future Payment Based On:

Patient presentation and therapist clinical decision-making
- Professional skill and judgment
- Mental and physical effort
- Psychological stress of impact of interventions
- Length of involvement to a limited extent

In other words, payment based on:
- The clinical decision making needed to address the severity (complexity) involved
- The intensity of the services provided to the patient to meet their needs to progress towards return of function

*Not primarily on Time spent*
Key Factors in Determining Payment

- A payment method based on the accurate and complete communication of the following:
  - Completed Patient Assessment Instrument
  - Evaluation of Clinical Presentation
  - Treatment and management options provided
  - Demonstration of Value associated with achievement of functional outcomes
Payment Reform
Severity and Intensity Model

What experience has taught us regarding therapists’ applications of this Model:

- Separate codes (three levels) for Evaluations demonstrates that “intensity” tends to equal “severity”
- Physical therapists can consistently and uniformly place patients into three levels of severity
- Three levels of intensity (clinical work) representing the range of physical therapist involvement can be supported
- When combined (severity and intensity) 5 levels can be supported
Overview: APTA Guiding Principles
Reformed Payment and Reporting

Guiding Principles

- Focus primarily on physical therapist practice in the outpatient setting, but could be modified for other providers use
- Recognizes the clinical reasoning and decision making by the physical therapist’s evaluative process and planned interventions
- Promote/encourage accurate reporting and appropriate payment of services and significantly reduce inappropriate use resulting in waste and fraud.
Overview: APTA Guiding Principles
Reformed Payment and Reporting

Guiding Principles

- Model assumes on each visit the physical therapist/qualified personnel interacts with the patient to determine, based on the patient’s acuity and the planned interventions, the appropriate provider.
- Model will facilitate/promote the use and reporting of quality measures and electronic health records, claim form becomes source of info
- Incorporate the World Health Organization’s (WHO) International Classification of Function (ICF) framework to the extent possible and applicable.
Overview: APTA Guiding Principles
Reformed Payment and Reporting

Guiding Principles
- Patient/Client Management is a continuum of care (episodes of care)
- Model will take extensive education of physical therapists, other health care organizations and professionals, policymakers, governmental agencies, payers, and accrediting and licensing bodies.
Timeline to Implementation:

- **June-Aug. 2014**
  - Pilot testing - CPT
  - Gathering of data

- **Sept.-Oct.**
  - Analysis of data
  - Report to APTA-AOTA

- **Oct.**
  - Interim report to AMA CPT WG
  - Discussion of revisions to potential Proposed revisions to model

- **Feb. 2015**
  - Presentation to CPT editorial Panel
  - Upon approval, referred to Relative Value Committee

- **Jan. 2016**
  - Potential implementation through Medicare Fee Schedule
Overview
Alternative Payment Methodology

Significantly change the model of payment:

- Demonstrates use of clinical judgment
- Payment is influenced by patient characteristics, intensity of clinical work with reporting of outcomes that help demonstrate value
- Administratively burdensome policies lessened with focus moving away from control of utilization and towards managing patient progress towards functional change and outcomes
### PT, OT Evaluations

| 3 Initial, Development of POC |

| 1 Re-Eval, est. POC |

<table>
<thead>
<tr>
<th>Clinical Considerations and Complexity of the Examination</th>
<th>Level of Evaluation</th>
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<tbody>
<tr>
<td></td>
<td>Problem Focused</td>
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<tr>
<td></td>
<td>Detailed</td>
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<tr>
<td></td>
<td>Comprehensive</td>
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<table>
<thead>
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<tbody>
<tr>
<td>Moderate</td>
<td></td>
<td>2</td>
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<tr>
<td>Significant</td>
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<td>3</td>
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Current CPT Perspectives
Reporting Under a Per Session Payment Methodology

**Reporting elements being considered:**

Up to 5 levels of interventions: Combine elements of patient severity and intensity of provider work

- Low Severity/Low Intensity
  - Moderate Severity/Low Intensity
- Moderate Severity/Moderate Intensity
  - High Severity/Moderate Intensity
- High Severity/High Intensity
### Evolution of Model

**Collapsing Levels of Interventions**

<table>
<thead>
<tr>
<th>Severity of Patient @ Visit</th>
<th>Intensity of Intervention</th>
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<tbody>
<tr>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Low</td>
<td>1</td>
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<tr>
<td>Moderate</td>
<td>2</td>
</tr>
<tr>
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<td>3</td>
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<td>High</td>
<td>4</td>
</tr>
<tr>
<td>High</td>
<td>5</td>
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</table>
Current CPT Perspectives
Reporting Under a Per Session Payment Methodology

Characteristics of Reporting Elements: Level 1

Severity
- Patient presentation: Stable
- Personal/environment: No impact on management
- Function: Per assessment instrument, minimal restrictions (5-24%)
- Prognosis: certain, predictable

Intensity
- Straightforward clinical decision-making
- No to minimal adjustment to supervised management
- Minimal risk
Current CPT Perspectives
Reporting Under a Per Session Payment Methodology

**Characteristics of Reporting Elements: Level 3**

**Severity**
- Pt. Presentation: Condition/complaints actively evolving, but predictable, with impact from co-morbidities
- Personal/environment: Present some challenges to pt. management
- Function: Per assessment instrument, moderate restrictions (25-49%)
- Prognosis: predictable but with risk for delayed progress

**Intensity**
- Straightforward clinical decision-making
- Intermittent adjustment required based on patient response
- Elements of supervised and direct contact management
- With risk factors taken into consideration through plan
Current CPT Perspectives
Reporting Under a Per Session Payment Methodology

**Characteristics of Reporting Elements: Level 5**

**Severity**
- Pt. Presentation: Condition/complaints actively evolving, in an unpredictable manner, with unstable co-morbidities
- Personal/environment: negatively impact pt. management
- Function: Per assessment instrument, significant restrictions (>50%)
- Prognosis: variable, requiring prioritization of objectives

**Intensity**
- Complex clinical decision-making
- Immediate response to management of response to treatment
- Continual adjustment of elements of treatment provided in direct contact with patient
- Risk factors influencing development and management through plan of care
Idea to Implementation

Concept
- Survey (Confirmation)
- Support
- Paper

Comment/Refinement
- Testing
- Member Feedback
- Stakeholder Support

Modeling
- Proposal
- Financing
- Workgroups

Implementation
- CPT
- RUC
- Private Payer
- Medicare
- Pilot
Current Work Value and PT Interventions

- Evaluations------------------ Highest Work Value
- Test and measures
- Direct contact procedures incorporating aspects of training/assessment
- Direct contact procedures
- Attended modalities
- Supervised Modalities---------- Lowest Work Value
Moving Forward- Valuing Services for Payment

- After CPT code change proposal has been accepted,
- Proceeds to AMA Relative Value Update Committee (RUC) process
  - Member surveys to establish values for the various levels of service

Outcome: Values established resulting in pricing on fee schedule
Components of Fee Schedule Payment

Establishing the Value of a Code

Payment for each service under RBRVS (Medicare Fee Schedule) is a product of 3 factors:

1. *A nationally uniform relative value for the service.*
2. A nationally uniform conversion factor (CF) for the service.
3. A geographic adjustment factor (GAF) for each physician fee schedule area.
Components of Provider Work

- Time to perform the service
- Technical Skill & Physical Effort
- Mental Effort & Judgment
- Stress associated with concern of risk to the patient

✓ AMA Surveys to Physical Therapists across the Country regarding practice and coding descriptors
The RUC Process
Survey for Work

- Clinical vignette
- Reference Code list
  - Per unit/procedure vs. per visit/session
- Pre, Intra & Post Service time
- Estimated utilization frequencies

- APTA will be soliciting/facilitating Therapists to complete Surveys
Broad Scope of the Issue

- **Coding / Value**
  - Support (Studies/Rules/Outreach)
  - Workgroups

- **Regulatory (CMS)**
  - Medicare Physician Fee Schedule (MPFS)

- **Legislative (Congress)**
  - Alternative to Therapy Cap
  - Bridge Language to 2015

- **Private Insurers**
  - Most Dynamic – Potential for Pilots
  - Innovation Center

- **Workers Compensation**
  - Similar to Models in Use (RI)
  - Demonstration / Pilots
Success is about dedication. You may not be where you want to be or do what you want to do when you're on the journey. But you've got to be willing to have vision and foresight that leads you to an incredible end.

http://www.nytimes.com/2014/07/10/business/health-insurers-are-trying-new-payment-models-study-shows.html?_r=1