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August 30, 2011

Donald M. Berwick, M.D., Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health & Human Services  
200 Independence Avenue, SW, Room 314-G  
Washington, DC 20201

**Subject: CMS-1524-P: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012**

Dear Administrator Berwick:

The American Health Care Association (AHCA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule, *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012*, 76 *Federal Register*, 42772, (July 19, 2011). Our comments focus on **Section II.B.6 (alternatives to the therapy cap)**.

As the nation's largest association representing long term and post-acute care providers, our nearly 11,000 members include non-profit and proprietary skilled nursing facilities, assisted living residences, sub-acute centers, and homes for people with developmental disabilities that range from small, independently-owned facilities to regional, multi-facility corporations.

Because the majority of Medicare beneficiaries receiving therapy services under Part B are cared for in institutional settings, our membership is especially attuned to policies that have the potential to negatively impact the care they provide for more than 1.5 million Americans each day. While the exceptions process to the therapy cap helps to provide critical therapy services to Medicare beneficiaries most at need for rehabilitative services under Part B, the more-or-less annual therapy cap threat hangs over Medicare beneficiaries and providers. The overview below highlights our chief concerns; we also provide more detailed comments, specific recommendations, and analysis for your review and consideration.

## I. DISCUSSION

### A. Therapy Caps Alternatives: The Issue for Beneficiaries and Providers

The issues surrounding how best to ensure Medicare beneficiaries receive medically necessary rehabilitation and therapy services in a cost-effective and efficient manner have been discussed, debated, and legislated since Congress placed annual payment caps on outpatient rehabilitation therapy services (*i.e.*, speech-language pathology, physical therapy, and occupational therapy services) as part of the *Balanced Budget Act of 1997 (BBA)*. Since that time, Congress has repeatedly placed moratoria on these arbitrary caps to avoid the potentially devastating effect such caps can, and have had, on Medicare beneficiaries who need these critical services. Nearly five years ago, the *Deficit Reduction Act (DRA)* mandated that CMS develop an “exceptions process” for Medicare beneficiaries with certain conditions who exceeded the cap on Part B therapy services beginning in 2006. Congress, which has extended CMS’ authority to use this exceptions process numerous times, once again extended the therapy caps exceptions process in the *Patient Protection & Affordable Care Act (PPACA)*.

While AHCA anticipates that Congress will once again extend authority to continue using the therapy caps exceptions process beyond December 31, 2011, it is important to recognize Congress’ intended this process to serve only as a “stop-gap” measure until a new, more permanent payment system could be developed. As we have noted in numerous comments to CMS, AHCA stands ready to work with CMS to develop a new payment system for Part B therapy services. With solid research, CMS could build a system that relies upon clinical factors – not artificial or arbitrary caps on payments – and that applies to all settings. Such a system would not only reflect clinical diagnoses, rehabilitation complexity, patient comorbidities, duration of episode of care, and other factors, it would satisfy longstanding *DRA* requirements and implement Congressional intent to protect Medicare beneficiaries’ access to medically necessary treatment. In the mean time, while a new payment system is under development, AHCA calls on CMS to support the continuation of the therapy caps exceptions process.

### B. Therapy Cap Alternatives and the FY 2011 Proposed and Final Rules

In last year’s proposed and final rules CMS asked for and responded to public comments on three potential alternatives to capping therapy services – the first option would collect additional clinical information on patient severity and therapy complexity on administrative claims; the second option would introduce additional edits for medical necessity to administrative claims in an effort to reduce overutilization; and the third option would establish a new “per-session bundled payment that would vary based on patient characteristics and the complexity of evaluation and treatment services furnished in the session.” While we commented on each of the three options, AHCA asked CMS to consider and undertake research on a fourth option – the development of an episodic prospective payment system (PPS) for Part B therapy.

- ***Option 1 – Better Data Are Needed: CMS Should Develop and Begin Collection Expediently***

AHCA generally supports the use of option one, which has the potential to provide CMS with critical data and information about the functional status and severity of patient needs that is not currently available on administrative claims. This option also would provide help to define treatment episodes and develop the data infrastructure needed for CMS' future work toward alternative payment reform approaches based on episodes of care, patient characteristics, functional status, rehabilitation complexity, severity of condition, and outcomes. Again, AHCA agrees with that goal and fully endorses such an approach.

- ***Option 2 – Refined Yet Arbitrary Is Not A Solution: CMS Can and Should Do Better***

The second option appears to replace the exceptions process with a mechanism that would deny Medicare beneficiaries coverage when payments for care reach some undefined, albeit predetermined value. AHCA does not view this proposal as any kind of real option for addressing beneficiaries' medical needs. Indeed, this "option" seems inconsistent with the statutory requirements of the exceptions process, as it essentially continues to place an arbitrary cap on payments for Part B therapy services irrespective of patient characteristics, rehabilitation complexity, and other clinical factors. The effect of implementing this proposal would be to shift the onus of Medicare denial of payment for medically necessary services from the beneficiary to providers. The burden on nursing facilities to appeal denied claim payments would be significant, and the risk of denial of payment could interfere with the provision of adequate therapy. CMS can, and should, do better for beneficiaries and providers alike. AHCA calls on CMS to go beyond such an arbitrary approach and target the use of scarce resources to develop a new and improved payment system that is based on the characteristics and clinical needs of Medicare beneficiaries for therapy services.

- ***Option 3 – An Intervention and Complexity Based Payment System Has Possibilities***

Though details on the coding scheme outlined in the third option are sketchy at best, we are intrigued by the potential for a new, simple and more consistent coding system that could provide a first step toward a more permanent solution. Critically, this approach should build upon and follow the work described in the first option, which would obtain critical data on patient function and severity and lead to the development of definitions of sessions and episodes of care. In addition to technical advice from clinical experts from the various sites of care, we believe that the ultimate success of this type of an approach would be critically dependent upon having the AMA CPT and RUC process receive advice and input for the new codes from therapy experts across sites of care. We encourage CMS to facilitate and sponsor such an approach and offer AHCA's assistance were this option to move forward.

- ***Option 4 - A New Episodic Prospective Payment System Should Be Developed***

As discussed above, AHCA strongly supports consideration of a fourth option: the development of a new episodic prospective payment system for Part B therapy services. Development of an episodic PPS has been hampered by inadequate data. Data collected as described under option

one, together with data and findings from the DOTPA project, offer the opportunity for data-driven research to develop a Part B PPS. Much of the work on the broad design of such a system has already been conducted by the Moran Company as part of a study for the National Association for the Support of Long Term Care (NASL). We request that CMS review the Moran Company report, which is provided in the Appendix, and initiate research to develop an episodic PPS for Part B therapy services. Again, AHCA offers its assistance and support to design and develop such a system.

### **C. Therapy Cap Alternatives: Next Steps**

In last year's final rule, CMS noted that,

We agree that the alternatives presented were not fully developed and that statistically sound methods of evaluation of the fully developed alternatives would be appropriate. We made no specific proposal to adopt an alternative beginning in CY 2011, but instead presented three potential options in order to gather additional public insight on the overall concepts and the details to inform our future developmental work in this area. We will continue to review and consider all the information provided to us and acknowledge that, in the context of any future proposal, we would need to provide further detail as part of notice and comment rulemaking in order for the public to provide meaningful comment prior to the adoption of changes to therapy payments.<sup>1</sup>

In addition to recognizing that the various options were not yet fully developed and would require further study, CMS also noted in last year's final rule that:

[The agency] did not discuss development of episode-based payments as an option in the CY 2011 PFS proposed rule because we recognize that substantially more research would be necessary to define the episodes and determine what resources would be needed for different groups or categories of patients before the episodes could be incorporated into a payment system, particularly one that also addressed quality, efficiency, and good health outcomes. However, the absence of discussion in our proposed rule of an episode-based payment methodology as a short term-therapy cap alternatives option should not be interpreted as our reluctance to pursue the definition of episodes or the refinement of the concept of episode-based payments.<sup>2</sup>

In last year's final rule<sup>3</sup>, CMS seemed to suggest that it will be undertaking additional research and analysis to develop alternatives to the therapy cap, as witnessed by:

- “As we progress in the analysis of payment alternatives to therapy caps” ...

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<sup>1</sup> 75 Federal Register, 73287.

<sup>2</sup> 75 Federal Register, 73269.

<sup>3</sup> 75 Federal Register, 73293.

- ... “[We] continue to be committed to developing alternatives to the therapy caps” ...
- “We are committed to finding alternatives to the current therapy cap limitations on expenditures” ...
- “We continue to dedicate our resources to identifying alternatives” ...
- “We are optimistic that the STATS project has identified short-term, feasible alternatives that may be tested in the future”.<sup>4</sup>

In a recent meeting with CMS staff on therapy cap alternatives in late May, we got the distinct impression that CMS was not undertaking any research nor did it have any projects in the pipeline to further develop, test, and adopt alternatives to therapy caps (DOTPA notwithstanding). This is a grave concern. Alternatives to therapy caps are desperately needed, particularly in the current budgetary environment.

The therapy cap threat repeatedly hangs over Medicare beneficiaries and Part B therapy service providers. A solution needs to be found to this confounding payment system problem. While potentially helpful in measuring outcomes, DOTPA will not be a panacea for determining and establishing a new payment system for Part B therapy services. We urge CMS to allocate the funds, and identify and commit the resource necessary to developing and implementing alternatives to the therapy caps.

#### **D. Exception Process Should Be Continued Until Alternative Prospective Payment System is Implemented**

In the mean time, while a new payment system is being developed, the exception process should be continued. The lack of an appropriate and improved payment system alternative, together with the cost of repeal, appears to be important factors in the continuation of the therapy cap. Many senior citizens, especially the sickest and most vulnerable nursing home residents, would likely find that their medical needs are compromised by the reinstatement of the therapy cap. As a result, seniors may delay or go without necessary therapy services which could in turn impact their return to community and affect their quality of life.

The “exceptions process” instituted with the DRA of 2005 provides Medicare beneficiaries with a medical necessity-based exemption to the financial limitations on Part B therapy services imposed by the BBA of 1997. The exceptions process provides relief for many senior citizens whose opportunity for rehabilitation would otherwise be at risk. While an improvement over therapy cap, the exceptions process is and should nevertheless be a temporary stop-gap measure, a transitory bridge to a new reimbursement system for Part B therapy services. Until there is a permanent fix, the exceptions process should be continued to maintain beneficiary access to medically necessary therapy services. We call on CMS to support the continuation of the therapy caps exception process until a new permanent Part B post-acute payment system is established.

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<sup>4</sup> 75 Federal Register, 73293.

## II. Conclusion

As we noted in our comments last year, AHCA is committed to providing advice and assistance in support of CMS' and its contractors' efforts to reforming the payment system for Part B therapy services. Excerpts from our comments on therapy cap alternatives from last year are in the attached appendix. As we describe further in our comments, options 1 and 3 show promise, option 2 continues to apply arbitrary (albeit refined) caps on therapy services, and we urge CMS to also examine the development of an episodic payment system for Part B therapy services. If you have any questions or would like additional information, please do not hesitate to contact me (T: 202-898-2819; Email: [pgruhn@ahca.org](mailto:pgruhn@ahca.org)). We welcome the opportunity to work with CMS as part of the solution.

Sincerely,

Peter Gruhn  
Director of Research

## **Excerpt from AHCA Comments on CMS CY 2011 Medicare Physician Fee Schedule Notice of Proposed Rule Making**

### **I. Alternatives to the Cap on Part B Therapy Services** *(Comments on Section II.B.6: Code-Specific Issues)*

#### ***AHCA Recommendations on Option #1: Revising the Therapy Caps Exception Process to Require Reporting of New Patient Function-Related Level II HCPCS Codes and Severity Modifiers:***

- *CMS should proceed with the development and reporting of new Level II HCPCS codes and severity modifiers;*
- *CMS should develop the codes and severity modifiers with input from therapists and other stakeholders and test the codes and severity modifiers in different sites of care before implementing nation-wide;*
- *CMS should develop the codes and severity modifiers with a goal of utilizing the data to define episodes of care by different therapy disciplines and combinations thereof, and examine the development of codes and severity modifiers to include multi-disciplinary care; and*
- *In order to improve transparency and provide researchers and stakeholders with the necessary data to undertake independent and replicate CMS research to develop alternative payment systems for Part B therapy services, CMS should make available public use data files with the new codes and severity modifiers as well as date of service information to sequence claims and define and track episodes of care.*

#### ***AHCA Recommendations on Option #2: Enhancing Existing Therapy Caps Exceptions Process by Applying Medical Necessity Edits When Per-Beneficiary Expenditures Reach a Predetermined Value:***

- *CMS should not proceed with the proposal to replace the exceptions process by denying claims when payments for episodes of care reach an as yet undefined predetermined threshold;*
- *At a minimum, CMS should alter the proposal such that:*

- *thresholds are not fixed but rather variable and based on patient characteristics and conditions, episodes of care, and other clinical criteria;*
- *thresholds should not be a basis for denial of claims but rather for triggering medical review;*
- *the proposed policy take into account delivery of multi-disciplinary care, encourage care coordination, and reflect clinical issues in the delivery of therapy services, particularly in institutional settings such as nursing homes;*

***AHCA Recommendations on Option #3: Introduce Per-Session “Evaluation/Assessment and Intervention” (E&I) Codes to Bundle Payment for Groups of Current Therapy HCPCS Codes Into a Single Per-Session Payment:***

- *CMS should move forward with examining the development of an E&I system for Part B therapy services provided that it is built on better data collected based on option #1 and that the development process includes input from a broad range of expert therapists and tested in all care settings both office-based as well as institutional settings;*
- *CMS should develop the HCPCS codes with greater therapist input than would otherwise be provided through the AMA CPT RUC process; and*
- *CMS should develop the E&I code based system in a transparent process that would provide information on the development and valuation of the codes with the opportunity for public review.*

***AHCA Recommendations on Option #4: Development of an Episodic Prospective Payment System for Part B Therapy Services:***

- *Using better data available from the implementation of option #1, the DOPTA project and other data initiatives, CMS should undertake research to develop a new episodic prospective payment system (PPS) for Part B therapy services;*
- *As part of its research to develop such a system, CMS should examine the following factors (See Moran Company report in Appendix B):*
  - *Payment based on an “episode of care” (EOC),*
  - *Payment groups developed based on patient clinical characteristics,*
  - *Establishment of weights and rates based on the mean cost for EOC and that could reflect short-term outlier cases,*
  - *Provide for an exception process for unusually high-cost complex cases,*
  - *Include default payment group(s) for unmapped EOC,*
  - *Include a provision for partial payments for interrupted EOC (outside the provider’s control),*
  - *Adjust payments using an appropriate wage index, and*

- *Provide for an annual (market basket) payment rate update;*

***AHCA Recommendation on the Exception Process:***

- *Until a new Part B payment system for therapy services is implemented, AHCA asks CMS to support the continuation of the therapy caps exceptions process.*

**A. Introduction and Background**

Therapy services are provided to Medicare beneficiaries in both office-based as well as in institutional settings. Nursing facilities (NFs), in particular, provide critical and life-saving rehabilitative therapies to many medically frail, disabled, and elderly patients under the Medicare Part B program. As part of the *Balanced Budget Act of 1997 (BBA)*, the Congress placed annual payment caps on outpatient rehabilitation therapy services (i.e. speech-language pathology, physical therapy, and occupational therapy services). Since the passage of the BBA, the Congress has repeatedly placed moratoria on these caps, and with the *Deficit Reduction Act of 2005 (DRA)* mandated that the CMS develop an “exceptions process” for Medicare beneficiaries with certain conditions who exceeded the cap on Part B therapy services in 2006. In the intervening years since the passage of the DRA, Congress has extended authority for continued use of this exceptions process numerous times. The most recent extension of the therapy caps exceptions process was included in the *Patient Protection & Affordable Care Act (PPACA)*, and is set to expire on December 31, 2010. While the therapy caps exceptions process recognizes the acuity and unique vulnerability of nursing facility residents and has helped to maintain access to much needed therapy services for Medicare beneficiaries, it was intended only as a “stop gap” measure. A new and improved payment system is required for Part B therapy services.

**B. A Prospective Payment System for Part B Therapy Services**

AHCA supports the concept of a single payment for a Part B covered post-acute episode of therapy care. For a number of years now, AHCA has called on CMS to undertake research to develop a new and permanent episodic-based prospective payment system (PPS) for Part B therapy services that is built upon solid clinical factors and without artificial or arbitrary caps on payments. AHCA believes that the new system should be applicable to all settings, and reflective of clinical diagnoses, rehabilitation complexity, patient comorbidities, and duration of care, among other factors. If designed properly, such a payment system could provide additional incentives for providers to be innovative in the deliver of therapy services, help to preserve Medicare program integrity, reduce costs, drive quality improvement, and help to ensure beneficiary access to high quality rehabilitation services. We urge CMS to move forward with undertaking research to develop an episodic PPS and finally resolve this vexing patient care, provider payment, and Medicare spending issue.

We are encouraged that CMS is making progress on reforming the payment system for Part B therapy services. Research initiatives such as the Short Term Alternatives to Therapy Services (STATS) project which seeks to develop recommendations for improving outpatient therapy

payment policy in the short-term, and the Developing Outpatient Therapy Payment Alternatives (DOTPA) project which seeks to identify, collect, and analyze therapy-related information tied to beneficiary need and the effectiveness of outpatient therapy services to develop payment method alternatives to the current financial cap on outpatient therapy services, are important and necessary steps along the way to reforming the payment system. These projects, together with the request for comment on interim measures that could lead to more appropriate payment for medically necessary, effectively provided, and efficiently furnished therapy services in the proposed rule, can help to move the process forward. AHCA is committed to providing advice and assistance in support of CMS' and its contractors' efforts to continue toward reforming the payment system for Part B therapy services.

### **C. Exception Process Needed Until New Prospective Payment System is Implemented**

The lack of an appropriate and improved payment system alternative, together with the cost of repeal, appears to be important factors in the continuation of the therapy cap. Many senior citizens, especially the sickest and most vulnerable nursing home residents, could find that their medical needs are compromised by a payment capping system that restricts rehabilitation therapy based simply on a calendar and a calculator, rather than weighing medical diagnosis and the needs of the patient. As a result, rehabbing seniors may delay or go without necessary services which could in turn impact their return to community and affect their quality of life. The impact of these caps constitutes a clear example of arbitrary budget policy obstructing common-sense health policy.

The "exceptions process" instituted with the DRA of 2005 provides Medicare beneficiaries with a medical necessity-based exemption to the financial limitations on Part B therapy services imposed by the BBA of 1997. The exceptions process provides relief for many senior citizens whose opportunity for rehabilitation would otherwise be at risk. While an improvement over therapy cap, the exceptions process is and should nevertheless be a temporary stop-gap measure, a transitory bridge to a new reimbursement system for Part B therapy services. Until there is a permanent fix, the exceptions process should be continued to maintain beneficiary access to medically necessary therapy services. We call on CMS to support the continuation of the therapy caps exception process until a new permanent Part B post-acute payment system is established.

### **D. Next Steps Toward a Part B Prospective Payment System**

In the proposed rule, CMS requests comment on several potential alternatives that could lead to more appropriate payment for medically necessary, effectively provided, and efficiently furnished therapy services. The first option described in the proposed rule would allow for the collection of additional clinical information on patient severity and therapy complexity on administrative claims. The second option would introduce additional medical necessity edits on administrative claims with a goal to reduce overutilization. The third option would establish a new "per-session bundled payment that would vary based on patient characteristics and the complexity of evaluation and treatment services furnished in the session". AHCA proposes that

CMS undertake research on a fourth option – the development of an episodic prospective payment system for Part B therapy services.

**i. Option 1: Collection of Better Data**

Overall, AHCA is supportive of option one (the improved data option). This option has some potential to provide CMS with critical information on the functional status and acuity level of patients using ICD-9 coding and other information not currently available on administrative claims. The coding scheme described in the proposed rule is relatively vague, and will need considerable refinement however.

This option would also provide information on administrative claims for researchers and CMS to define treatment episodes and develop the data infrastructure needed for CMS' future work toward payment reform based on episodes of care, patient characteristics, functional status, rehabilitation complexity, severity of condition, and outcomes. Data could be used by CMS to learn more about the variation in therapy settings and episodes, particularly for those patients with complex rehabilitation and medical diagnoses commonly treated in nursing facilities. This is a goal and approach that we fully endorse.

As described further in the attached AHCA/AQNHC/NASL technical appendix (See Appendix A), CMS should include coding and modifiers to be able to better understand and devise a new payment system for Part B post-acute services. New and improved codes should be devised to allow researchers and CMS to capture information on therapy provided in different settings, by various disciplines (both independently and in combination). The improved coding and data could be used to define the episode of care as well as identify therapy “sessions” to better track and understand different patterns and intensities of care.

**ii. Option 2: Refined Yet Arbitrary Is Not A Solution: CMS Can and Should Do Better**

AHCA does not support option two (the hard therapy cap option). This option appears to replace the exceptions process with a process that would deny payment of claims when payments for care reaches some as yet undefined predetermined value.

In addition to being potentially inconsistent with the statutory requirements of the exceptions process, this option would continue the arbitrary cap on payments for Part B therapy services irrespective of patient characteristics, rehabilitation complexity, etc., and would shift the onus of Medicare denial of payment for medically necessary services from the beneficiary to providers. The burden on nursing facilities to appeal denied claim payments would be significant, and the risk of denial of payment could interfere with the provision of adequate therapy.

Analysis of historic claims data does not at present provide an adequate basis for establishing the predetermined values discussed in the proposal. Current data sources do have inadequate ICD-9 coding, lack data on the functional or severity status of patients, and are unable to be used to define session or episodes of care. Without improved data, it will be difficult to undertake analysis and develop episodes of care and the needed thresholds (predetermined values). Improved data and additional research are needed to ensure that thresholds would be defined

appropriately and take into account patient characteristics, rehabilitation complexity, and other critical factors that are not uniform across different sites of care.

With this option, CMS would in effect be replacing an artificial and arbitrary cap on payments with a refined yet nevertheless arbitrary cap on payments for Part B therapy services. CMS can and should do better for beneficiaries and providers alike. We call on CMS to go beyond the arbitrary, and target scarce resources to develop a new and improved payment system that is based on the characteristics and clinical needs of Medicare beneficiaries for therapy services.

### **iii. Option 3: An Intervention and Complexity Based Payment System**

Option three (the intervention and complexity option) is intriguing. Though details on the coding scheme are sketchy in the proposed rule, the option offers the potential for the development of a new simple and more consistent coding system that could provide a first step toward bundled payment for episodes of care. Critically, this approach should build upon and follow the work on option 1 that would obtain vital data on patient function and severity and lead to the development of definitions of sessions and episodes of care. In addition to technical advice from clinical experts from the various sites of care, we believe that the ultimate success of this type of an approach would be critically dependent upon receiving the full range of advice and input necessary for the new codes to adequately reflect delivery of care across settings. If this approach is to be successful, advice from rehabilitation services experts across provider settings will be necessary as part of the code definition and valuation process of the AMA CPT and RUC process. We call on CMS to facilitate and sponsor such an approach were this option to move forward. Please let us know how AHCA can best help.

### **iv. Option 4: A New Episodic Prospective Payment System Should Be Developed**

AHCA would also like to request CMS' assistance in undertaking the necessary research for a fourth option: the development of a new episodic prospective payment system for Part B therapy services. Development of an episodic PPS has been hampered by inadequate data. Data collected as part of option one together with data and findings from the DOTPA project offer the opportunity for data-driven development of a Part B PPS. Much of the work on the broad design of such a system has already been conducted by the Moran Company as part of a study for the National Association for the Support of Long Term Care (NASL).

Key components of an episodic PPS could include:

- Payment based on an "episode of care" (EOC),
- Payment groups developed based on patient clinical characteristics,
- Establishment of weights and rates based on the mean cost for EOC and that could reflect short-term outlier cases,
- Provide for an exception process for unusually high-cost complex cases,
- Include default payment group(s) for unmapped EOC,
- Include a provision for partial payments for interrupted EOC (outside the provider's control),
- Adjust payments using an appropriate wage index, and
- Provide for an annual (market basket) payment rate update;

We invite and encourage CMS to review the Moran Company report, and initiate research to develop an episodic PPS for Part B therapy services. AHCA offers its assistance and support to design and develop such a system.