Welcome to APTA’s podcast series on value-based care, which explains how value is measured in the provision of health care, and describes different aspects of the Quality Payment Program, including the Merit-based Incentive Program, or MIPS, and Advanced Alternative Payment Models, or Advanced APMs. Episode 5 is How Are PTs Measured? To get the most from this episode, you may want to check out earlier episodes first.

I’m Heather Smith, APTA’s Director of Quality.

The health care system is moving from volume-based payment to value-based payment. One of the components of the value equation is quality, and measuring quality is a critical part of assessing value. Given this shift to value-based payment, it is important to understand how physical therapists are measured today.

One of the most widely used measures for PTs in almost any setting is utilization—the volume of patient visits for physical therapy services. Both federal and private payers gather utilization data through claims, and they use the information to manage physical therapy benefits to beneficiaries. One of the applications of utilization data is control of variation in care. Unfortunately, physical therapy utilization rates are extremely variable, and claims data do not contain needed explanations for these variations. For example, a therapist might see 2 patients with a primary diagnosis of gait abnormality, but 1 patient is seen for 6 visits, the other for 24. We could easily imagine why these patients are different—patient 1 is an uncomplicated ankle sprain, while patient 2 is a patient who suffered a stroke. But the claims data only include the visit and diagnosis information, and so it is difficult for the payer to discern why the variation exists. This is why it is important to have quality measures that go beyond claims data, and use clinical data.

What quality measures do PTs currently use that are based on clinical data? In the former Physician Quality Reporting System, or PQRS, PTs reported on a number of clinical quality measures, and they will continue to do so under MIPS, the Merit-based Incentive Payment System, for Medicare Part B patients. These include measures on diabetic patient evaluation and education, screening of body mass index, pain assessment, documentation of medications, falls risk screening and plan of care, and use of a functional outcome assessment. Some PTs have also used quality measurement systems such as FOTO and Care Connections. The PQRS/MIPS program traditionally has only involved PTs in private practice. So how are other PTs measured?

PTs in post-acute care settings, long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health agencies also collect data and report quality measures. Each post-acute care setting paid under Medicare part A requires the collection and submission of data by the facility. In the post-acute care settings, there is a shift to using the same data items so that function is measured in the same way across the post-acute care settings. An example of a
quality measure in these settings is change in mobility score for medical rehabilitation patients. It is important to note that as all of these quality measures are reported by the facility and not by individual provider, they reflect the total impact of care delivered in that setting. This also means that the measure is reported for all rehabilitation patients in the setting—those who have received physical therapy services or a combination of physical therapy and other rehabilitation services during their stay. This makes it difficult to attribute changes in function to physical therapy alone. It is possible that we will need physical therapy-specific measures in these settings in the future to better demonstrate the value of our services, especially as these settings move to a unified payment system.

In acute care, there are no required measures for PTs. The same holds true of outpatient facilities such as hospital outpatient departments and services delivered in SNFs under Medicare Part B. Additionally, there is no national structure for quality measures for commercial payers. PTs in these settings may—or may not—collect measures, but in no way is this a standardized process.

As the shift to value-based payment continues, we will need to articulate our value across the care continuum to a variety of payers. This is why having a diverse portfolio of quality measures for PTs is so important. Currently, the quality measure portfolio for physical therapy services comprises measures included in the Medicare quality programs. APTA’s goal is for this portfolio to have measures that better represent the value of physical therapy services across settings. The PT Outcomes Registry allows the profession to collect data and develop measures for our future.

One final note: Although PT-specific measures are important, to fully show the value we bring to the overall health care system our portfolio will also need measures that reflect the voice of the patient, and measures that are important in overall health care, such as readmissions or return to community living. To keep up-to-date on these overall health care measures that matter to PTs, see our new resource, “Quality Measures That PTs Can Impact” on the website at www.apta.org/Payment/ValueBasedCare.

This has been Episode 5 of the podcast series on value-based care. To find all episodes of this series, go to www.apta.org/MACRA/. You also can find these and all APTA podcasts on iTunes by searching APTA Podcasts or by going to www.apta.org/Podcasts. Thanks for listening.

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