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Via Electronic Submission

September 8, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1631-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1631-P, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Proposed Rule, Fed. Reg. Vol. 80, No. 135, (July 15, 2015).

Dear Mr. Slavitt:

This letter represents the collective comments of the Alliance for Physical Therapy Quality and Innovation (the "APTQI") to the Centers for Medicare and Medicaid Services (CMS) regarding the above referenced "Proposed Rule to Payment Policies Under the Physician Fee Schedule" for calendar year 2016, published in the Federal Register on July 15, 2015 ("Proposed Rule").

By way of introduction, we are among the nation's leading providers of outpatient rehabilitation care, and collectively employ or represent several thousand physical and occupational therapists, and furnish physical therapy services on an annual basis to hundreds of thousands of Medicare beneficiaries. The following is a brief description of each of our APTQI Board member companies, which in aggregate currently operate and represent over 3,000 outpatient rehabilitation clinics:

- **Athletico Physical Therapy** currently operates approximately 350 outpatient rehabilitation clinics in 9 states;

- **ATI Physical Therapy** currently operates approximately 475 outpatient rehabilitation clinics in 16 states;

- **Drayer Physical Therapy Institute** currently operates approximately 125 outpatient rehabilitation clinics in 16 states;

- **Physiotherapy Associates** currently operates approximately 558 outpatient rehabilitation clinics in 28 states;

- **Select Medical Corporation** currently operates approximately 1028 outpatient rehabilitation and/or occupational therapy clinics in 31 states and the District of Columbia;

- **Upstream Rehabilitation Inc.** currently operates approximately 305 outpatient rehabilitation clinics in 22 states; and

- **U.S. Physical Therapy, Inc**. currently operates approximately 502 outpatient rehabilitation and/or occupational therapy clinics in 42 states.

I. Preliminary Statement

We appreciate the opportunity to comment on the Proposed Rule. Many of the areas where feedback is sought regarding Medicare Outpatient Part B therapy services are important to the APTQI's core mission: "*Ensuring patient access to value driven physical therapy care*." We support The Centers for Medicare and Medicaid Services (CMS) commitment to enhance its partnerships with a delivery system in which providers are supported in achieving better patient outcomes at a lower cost for Medicare beneficiaries. The APTQI shares the core belief that any coding and payment reform related to physical therapy services should drive payment in line with the value physical therapy services deliver to the patient and other providers in the continuum of care; reduce unnecessary regulatory and administration burdens unrelated to improving the quality of patient care; and be transparent to all parties.

II. The Reevaluation of Potentially Misvalued Therapy Codes Should be Delayed While the AMA Works With Stakeholders and CMS to Develop a Value Based Model.

The Social Security Act requires CMS to identify and review potentially misvalued codes and make appropriate adjustments to the relative values of those services identified as being potentially misvalued. The Protecting Access to Medicare Act of 2014 (PAMA) amended the law to expand the categories of services that CMS is directed to examine for the purpose of identifying potentially misvalued codes to 9 categories, in addition to the 7 categories that already existed. The legislation also establishes an annual target from 2017-2020 for reductions in physician fee schedule expenditures resulting from adjustments to relative values of misvalued services.

In the Proposed Rule, CMS includes a list of 118 CPT codes for review that fall into the category of "High Expenditure Services Across Specialties with Medicare Allowed Charges of $10,000,000 or more." CMS states its belief that a review of the codes (included in Table 8, FR 41706, of the Proposed Rule) is warranted to assess changes in provider work and to update direct practice expense inputs since these codes have not been reviewed since CY 2009 or earlier. This list includes the following CPT codes reported commonly by physical therapists.

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**
97535	**Self-care management training**
G0283	**Elec stim other than wound**

Initially, it should be noted that several of these codes related to therapeutic exercise (marked with * in the table above) are the very essence of rehabilitation interventions common to virtually every diagnostic category such as developmental delay, brain injury and sports injury. Therefore, utilization and expenditure viewed in isolation should not be an automatic justification for change.

The APTQI agrees with the importance of ensuring that services are appropriately valued. However, the evidence is that these therapy codes are undervalued given the past reimbursement cuts (MPPR, etc.) in the face of increasing practice, work and malpractice expenses incurred in the cost of delivering care over the past two decades. The RVS Update Committee / Health Care Professional Advisory Committee Review Board (RUC HCPAC) should have the opportunity to review survey data from a large cross section of therapy providers. CMS should allow this AMA coding process to continue without interruption and with more transparency as set forth in the Proposed Rule. Over the past several years, given the scrutiny involving therapy payments and caps (including the application of the MPPR policy to therapy payments), CMS and the RUC HCPAC have taken increasingly significant steps to address potentially misvalued therapy codes. The APTQI supports the role of the AMA RUC in refining and enhancing the accuracy of therapy services, including the "rolling" five year review process. However, the conclusion that the above therapy coding with charges greater than $10 million should automatically result in a code being potentially misvalued is unwarranted. In addition, CMS should provide the AMA RUC, trade groups and the public with any data used that would explain why charges of greater than $10 million would automatically translate into misvalued codes.

This valuation policy is also inconsistent with other parts of the Patient Protection and Affordable Care Act (PPACA). The PPACA features provisions that encourage the use and development of less costly interventions such as physical therapy services. One of the goals of health care reform is to minimize the use of high-cost interventions when there is a clinically comparable, but better value alternative. There is a plethora of research supporting the proposition that the implementation of high quality care by a physical therapist earlier in the course of treatment is more cost-effective by promoting recovery and reducing the need for comparatively more invasive and costly or unnecessary interventions. For example, instead of undergoing surgery for back pain, therapy is generally seen as a less costly, less invasive option. An over emphasis on actuarial science in

isolated parts of patient care fails to consider the clinical science regarding the total episode of care of beneficiaries across the health care system. In the past, this has led to the unintended consequence of increasing program health care costs due to more costly invasive procedures, whether diagnostic and/or surgical.

Furthermore, the success of health care reform will not only involve looking at the total cost of care, but will also depend on whether there are enough providers to deliver care for the millions of new covered lives. Drastically reducing payment for qualified therapists may hinder both their ability to provide high-value, cost effective care as well as further increase patient access barriers and decrease competition. An arbitrary misvalued codes policy reviewed in isolation will, in the long term, exacerbate the current shortage of physical therapists, occupational therapists, and speech language pathologists, and increase the risk of reduced access to therapists when more providers are needed as the baby boomers enter the Medicare program.

III. The Proposed Physical Therapy Classification and Payment System Under Evaluation at AMA is Flawed and Should be Replaced With a Value Based Model.

APTQI strongly believes that the proposed Physical Therapy Classification and Payment System ("CPT Coding Proposal") model working its way through the AMA CPT Editorial Panel and RUC process should be discontinued in favor of a valued based model more consistent with the goals of the triple aim of health care – i.e., improve patient experiences (satisfaction, quality and outcomes); decrease program costs, and improve population health.[1] The proposed coding model recommends the adoption of a new coding system that bases payment on a patient severity/intensity framework in lieu of the current fee-for-service system based predominantly on the use of procedure codes. Last year, given our concerns based on preliminary information, the APTQI suggested to the APTA and PM&R Workgroup that the proposed coding should be subject to more formal clinical modeling, data analytics, and piloting. Subsequently, the PM&R Workgroup publicly announced that it would test the reliability and validity of the proposed codes. The previously developed vignettes were refined and tested at four different locations across the country. The results of the study, as set forth below, raise serious concerns.[2] The APTQI has requested the PM&R Workgroup refocus its efforts on true valued based reform for the following reasons:

A. The research report provided by the Post-Acute Care Research Center (PACCR) clearly demonstrates that that the CPT Coding Proposal lacks evidence based and statistical validity, reliability, and accuracy. The PACCR Report substantiated that testing of the evaluation and intervention codes was statistically weak. There were several notable weaknesses and concerns with the results. The four city pilot study, which was followed by live testing at two

[1] Although the APTQI does not support the proposed intervention codes under the CPT Coding Proposal, we have publicly stated our support for the revised evaluation codes subject to the final results of the current valuation process at the RUC HCPAC and CMS approval.

[2] The APTQI has signed a Confidentiality Agreement with the APTA in order to review the preliminary report on the reliability and validity of the proposed CPT codes. Therefore, our comments only take into consideration what has been publicly announced in other industry settings, disclosed to us by an independent third party, or was otherwise disclosed to us in prior meetings and communications with APTA staff.

healthcare systems, did not yield a statistically reliable and valid result. In fact, no study is capable of validating this flawed CPT Coding Proposal. The limited live testing is especially compelling here since it allowed for testing the extent to which the CPT Coding Proposal could be operationalized based on current charting practices. The lack of reliability and absolute inherent variability that emanates from therapists' subjective perceptions leaves us wondering how this proposal could possibly be implemented given the obvious flaw in the results.

We strongly urge CMS to review the entire PACCR report (not just an edited summary of the quantitative and qualitative results) from both phases of the pilot survey testing. If you do, we believe CMS will agree with our assessment that: (1) in terms of reliability, the CPT Coding Proposal does not accurately and consistently assess the performance of therapists providing the care assessed in the measure; (2) in terms of inter-rater reliability, the coding practices of two or more therapists are incongruent with each other; and (3) in terms of validity, the study does not actually measure what is intended to be measured. We also believe a review of the results will clearly demonstrate that the CPT Coding Proposal does not meet the level of statistical reliability necessary for CMS to ultimately adopt these alternative codes. If this is the case, and the proposed CPT codes (evaluations and interventions) move forward to the RUC HCPAC evaluation phase, it would cause more harm than good to an entire industry already under regulatory and payment pressure. Our respective companies at the APTQI Board level and those hundreds (and growing) private practice locations at our "affiliate membership level" believe this system will be seriously damaging to their ability to bill and code reliably, and given the rather complete coding overhaul, result in massive unnecessary and unproductive upheaval and distress at the private practice level.

B. The APTQI is unsure or unclear on how past research efforts or projects by CMS will influence, or be integrated with, the CPT Coding Proposal. We have been advised that the PM&R Workgroup was formed to address concerns expressed by CMS in past Medicare Physician Fee Schedule Rules. CMS has already spent considerable resources in an effort to find an alternative therapy payment system for physical therapy services. Most recently, The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA), enacted by Congress, mandated the implementation of such an alternative payment system. As a result of this legislation, CMS created a "claims-based data collection strategy" designed to assist in reforming the Medicare payment system for outpatient therapy services through the creation of non-payable G codes and severity modifiers that is currently being used to gather information on beneficiary function and condition, therapy services furnished, and outcomes achieved. In the past, several of our APTQI members have also actively participated in both the *Development of Outpatient Therapy Payment Alternatives* (DOTPA) and *Short Term Alternatives for Therapy Services* (STATS) projects. Several clinical and technical experts involved with our APTQI provided critical feedback and guidance on both of these projects utilizing our extensive experience collecting patient reported outcomes data for the Medicare population in the outpatient setting. We actively sought to facilitate a collaborative process and assist in providing guidance in a proactive manner across all provider types and disciplines. The APTQI does not believe the CPT Coding Proposal takes into consideration the key factors considered in these past and current efforts by CMS to reform the Medicare payment system for outpatient therapy services.

C. The CPT Coding Proposal that categorizes patients based on the severity of their condition and intensity of intervention is largely subjective without specific quantifiable and objective criteria. Establishing new codes that physical therapists report for their services would be a significant change that would require therapists to learn the new code sets and update billing systems. This would involve massive and expensive changes to existing computer documentation and billing systems. The APTQI, through its members, has considerable experience with how the coding and payment system works at the "*individual practitioner level*." If the CPT Coding Proposal is "pushed" through AMA and approved by CMS, it will be subject to the subjective clinical reasoning and decision-making of the therapist that will vary depending on experience, background and training. For example, a classification of "high severity" by one may be perceived as "low severity" by another. If "high severity/complexity" patients received a higher bundled evaluation, the system could easily be subject to abuse and/or the inability of providers to defend their coding choices that will vary considerably as evidenced by the PACCR study. We believe that a review of the results of the PACCR pilot study will provide further proof of this concern. This subjectivity will, in our view, be a step backwards from the current coding system and lead to further significant coding and audit concerns.

D. CMS has not clarified how existing regulations would be eliminated or applied under the CPT Coding Proposal. Any transformational modification to the coding and payment system for therapy services should preserve the ability of outpatient physical therapy providers to deliver the necessary treatment required by Medicare beneficiaries. The current Medicare Part B outpatient therapy policy is made up of a cumbersome collection of rules and regulations that have unintended consequences that are not always in the best interest of the patient. Providers and Medicare program beneficiaries are already confused and, in some cases, clinically, financially, and administratively burdened by the existing rules and reimbursement policies. Eliminating the therapy cap and developing a replacement system remains a major goal for CMS, MedPAC, APTA, other professional associations, and the provider community including the APTQI. However, there are other CMS regulatory requirements that should be considered now <u>before</u> final approval of an alternative coding payment system. We believe there should be formal collaboration with CMS on whether and, to what extent, the layers of Medicare rules and regulations applicable to Part B therapy services will be applied under a new coding system including: therapy caps and the exceptions process; manual medical review (MMR) process; multiple procedure payment reduction (MPPR); Physician Quality Reporting System (PQRS); Merit-based Incentive Payment System (MIPS); total time rules; group and concurrent therapy rules. If this is not addressed now, the CPT Coding Proposal will be further burdened with superimposed rules and regulations that add significant unexplained variation and unnecessary cost as well as complexity. As this new payment model is tested, these rules and regulations should not be ignored or CMS risks approving a therapy coding system of "practice patterns" that do not optimize patient outcome or efficiency.

IV. A "Fee for Value" Alternative to the CPT Coding Proposal Should Take Into Consideration the Expansion of CMS Quality Initiatives That are Inclusive of Eligible Professionals Providing Therapy Services in all Settings.

There are other better alternatives to physical therapy payment reform that meet the triple aim of healthcare – **i.e., improve patient experiences (satisfaction, quality and outcomes); decrease program costs, and improve population health.** The APTQI supports the recent passage of The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). CMS acknowledged in the Proposed Rule that the primary goals of MACRA included the repeal of the sustainable growth rate (SGR) formula; revisions to the physician fee schedule update for 2015 and subsequent years; and establishing a Merit-based Incentive Payment System (MIPS), which would authorize the end of the exiting Physician Quality Reporting System in 2018 and the development of alternative payment models (APMs). CMS has specifically requested public comment on MIPS and APMs and has stated it will continue to do so over the next few years in the standard rulemaking process and also through the release of a formal Request for Information (RFI). In addition, the Department of Health and Human Services announced in January that it plans to shift thirty (30) percent of Medicare provider payments from fee for service to alternative models by 2016 and half of all payments by 2018, as well as the subsequent formation of a provider-payer alliance known as the Health Care Transformation Task Force. The APTQI appreciates the willingness of CMS to collaborate with all interested stakeholders but is concerned that therapy services may not benefit from the MIPS and APMs without CMS' willingness to become more inclusive and flexible when evaluating the total cost of care to program beneficiaries across the continuum of care.

This, of course, begs the question: "*How exactly does one measure the value of physical therapy services?* In technical terms, value can be illustrated by using the simple equation of value equals outcomes divided by costs. For several decades, the CMS payment system has attempted to increase value by cutting the denominator in this equation – costs. Most providers would agree that we've reached a point where further cost reductions create a risk of declining outcomes if they have not already done so. No value is realized when the outcomes numerator decreases in parallel with a reduction in the costs denominator. In addition to the cost of the care, true value should measure quality combined with customer service or patient experience and convenient access. This approach to value is also consistent with other parts of the Patient Protection and Affordable Care Act (PPACA). As previously stated, the PPACA features provisions that encourage the use and development of less costly interventions such as physical therapy services. One of the goals of health care reform is to minimize the use of high-cost interventions when there is a clinically comparable, but better value alternative.

CMS has acknowledged that alternative payment reform includes offering rewards for achieving cost or quality goals such as the PQRS program. The proposed MIPS would contain similar quality initiatives for "eligible professionals." While we commend CMS for its attempts at quality reporting, admittedly, many professionals remain disappointed with CMS's implementation of PQRS as it has excluded eligible professionals providing covered therapy services to Medicare Part B beneficiaries in institutional settings (SNFs, Rehab Agencies, outpatient HH). The Tax Relief and Health Care Act of 2006, which established PQRS, specifically defined physical therapists, occupational

therapists and qualified speech-language pathologists as eligible professionals. Unfortunately, therapists who provide care to hundreds of thousands of Medicare patients in an institutional setting are unable to report under PQRS. Therapy services should not be limited to a subset of eligible professionals under PQRS or the yet to be developed MIPS program. Nothing in the legislative history of PQRS or MIPS suggests that Congress intended for a significant segment of professional Medicare Part B therapy services to be excluded. We believe that the restrictive manner of collecting quality reporting information that has been adopted by CMS inadvertently undermines the validity of the therapy data that are being reported in this program. With value based purchasing taking on such a central role in CMS reimbursement policies, the continued exclusion of such a large segment of providers from PQRS or MIPS undercuts the agency's efforts to promote and achieve a truly successful program for beneficiaries served in all Part B outpatient settings. Furthermore, forcing these institutional practice settings to use registries in order to participate in the PQRS program would add cost and increase the inherent administrative burden that currently exists in the program. CMS should consider updating and enhancing a therapy quality reporting program that involves all eligible professionals and settings.

The APTQI believes that CMS and all stakeholders in the profession should focus on creating a comprehensive quality reporting program. In the Proposed Rule, CMS' commitment to APMs offers an opportunity to create functional therapy payment models that focus on the total value and quality of care as opposed to cost and quantity of care. The APTQI believes that a comprehensive quality reporting program for therapy services provided across all settings is a better "valued based" payment reform approach than the AMA PM&R Workgroup CPT Coding Proposal. The APTQI is in favor of a value based payment program that includes quality measures to demonstrate the outcome and value of therapy. Moving from a purely volume to value based payment system can and should involve benchmarks and metrics to measure progress and hold ourselves accountable to each other. We feel that the use of the aforementioned existing PQRS tools, as well as expansion of the functional limitation categories under future programs such as MIPS to allow for more granularity, would be more effective to obtain the end goal on determining functional improvement and thus value.

V. Conclusion

APTQI is in favor of a value based payment program and the inclusion of reliable and valid outcome and quality measures to demonstrate the outcome and value of therapy both for an individual patient episode of care as well as across the entire continuum of care. APTQI believes that the expansion of the existing functional limitation reporting system with the addition of an outcomes measure similar to measure 182 under PQRS would better serve Medicare to value therapy services over the inclusion of quality measures as structured under the current PQRS program. The MIPS, if and when expanded to include all providers of therapy services, will provide a platform to improve the quality of care for Medicare beneficiaries across the continuum of care. APTQI believes that to be successful and satisfy the needs of beneficiaries, CMS, and providers, an alternative coding and payment system for therapy services must have the following elements: adequate pay to the provider with the flexibility to enable delivery of planned services; accountability by the provider to the patient for successfully achieving the intended outcomes; and protection from significant variation in financial risk. To

satisfy these elements, the transition to an alternative physical therapy payment system approach based on quality and value should start with testing new alternative models of care over at least a 2-year period and incorporating them into an increasing number of practices with the goal of broad adoption at the end of this transition period. The failure to do this could lead to widespread dissatisfaction among beneficiaries and providers, an unintended increase in program health care costs, and a disruption in access to high quality therapy services.

CMS' proposal to permanently eliminate its "Refinement Panel" makes the clinical input of groups such as the APTQI even more compelling to avoid a negative impact on therapy services provided to program beneficiaries. The APTQI appreciates the opportunity to provide comments on the Proposed Rule. We encourage CMS to continue to work with AMA and professional societies such as the APTQI through the rulemaking process in order to create a stable and equitable therapy coding and payment system. The APTQI looks forward to continued dialogue with CMS officials about these and other issues affecting therapy services. If you have any questions, or would be interested in further collaboration, please feel free to contact John F. Duggan, J.D., M.B.A., Senior Vice President and Senior Counsel – Select Medical Corporation, at 202-507-6354 or JDuggan@SelectMedical.com.

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Very truly yours,

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