ALLIANCE FOR PHYSICAL THERAPY QUALITY AND INNOVATION

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Via Electronic Submission

September 27, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-6082-NC
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1715-P, Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations: Proposed Rule, Fed. Reg. Vol. 84, No. 157, (August 14, 2019).

Dear Administrator Verma:

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 et al." for calendar year 2020, published in the Federal Register on August 14, 2019 ("Proposed Rule").

By way of introduction, we are among the nation's leading providers of outpatient rehabilitation care, and collectively employ or represent over 20,000 physical and occupational therapists, and furnish physical and occupational therapy services on an annual basis to Medicare beneficiaries throughout the United States. APTQI membership consists of affiliate and board member entities of varying size and geographic scope, which in aggregate provide patient care services in more than 5,000 outpatient rehabilitation clinical sites.

I. Preliminary Statement

We appreciate the opportunity to comment on the Proposed Rule. Many of the areas where CMS seeks feedback 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 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. APTQI shares the core belief that any coding, documentation and payment proposals related to physical therapy services should (a) drive payment in line with the value physical therapy services deliver to the patient and other providers in the continuum of care; (b) reduce unnecessary regulatory and administrative burdens unrelated to improving the quality of patient care; and (c) be transparent to patients and all stakeholders.

II. APTQI Opposes CMS' Proposed Work and Practice Expense RVU Changes for Physical/Occupational Therapy for CY 2021.

APTQI opposes the value redistributions for physical and occupational therapy set forth in the Proposed Rule. The cuts, if finalized, will cause a serious financial strain on outpatient physical therapy providers; as demonstrated in Table 111 in the PFS proposed rule, physical therapy (and occupational therapy) providers would see a combined impact of negative 8% in 2021. The proposed drastic reduction in payment is an arbitrary, across-the-board cut, which, if implemented, would be in addition to the 2% sequestration reduction, thereby amounting to a 10% cut in reimbursement. APTQI recognizes that CMS must implement any increase in work values for the office/outpatient E/M codes with budget neutrality. However, the magnitude of potential impact to physical and occupational therapy providers is staggering when history and other factors are taken into account.[1]

This proposed cut is the latest in a history of cuts to physical therapy services over the past decade. If implemented, the proposed 2021 reduction would come after a 2011 multiple procedure payment reduction (MPPR); a further deepening of the MPPR in 2013; and reductions to two of the most common procedural codes used by physical therapists, Therapeutic Exercise (97110) and Manual Therapy (97140), which were instituted in 2018 after they went through the misvalued code initiative. In addition, the 15% reduction applied to services provided by therapist assistants mandated by Congress will take effect in 2022. Considering the magnitude of the cuts proposed in this rule for 2021, it is essential for CMS to ensure that the process it uses to develop policies is transparent and that decisions are based on accurate information. The information provided in the rule is very limited and does not provide enough information regarding the data and analysis used to determine the cuts to specialty providers. CMS is proposing these cuts to specialty providers, including physical therapists, without seeking the input of any health care professionals and providers who furnish outpatient therapy services. Further, CMS has offered no explanation regarding how the agency may redistribute the cuts across the code set.

The effect of these significant reductions in such a short period of time is that access to outpatient physical therapy will be compromised. Margins for physical therapists are already so low that many providers, particularly in rural and underserved areas, will likely be forced to close if this additional cut is implemented in 2021. Looking toward the future, APTQI is also concerned what these cuts could mean for our physical therapy workforce. There is already a national shortage of physical therapists and physical therapy professionals– and estimates indicate that an additional 27,000 PTs will be needed to meet demand by 2025. At a time when we need to be incentivizing individuals to join the profession, APTQI fears that the shrinking reimbursement for physical therapy services will discourage individuals from choosing this profession in the future.

Furthermore, if CMS wants to reach the stated goal of decreasing opioid use, access to physical therapy should be expanded– not cut. In its Guideline for Prescribing Opioids for Chronic Pain, the Centers for Disease Control and Prevention (CDC) recommends physical therapy as an alternative to opioids for the treatment of chronic pain. The CDC notes physical therapy is especially effective at reducing pain and improving function in cases of low back pain, fibromyalgia, and hip and knee osteoarthritis. Providing this

[1] These cuts are also much more severe than the reductions projected by MedPAC in their June 2018 report to Congress regarding the rebalancing of the Medicare Physician Fee Schedule to accommodate the changes to E/M codes. http://www.medpac.gov/docs/default-source/reports/jun18_ch3_medpacreport, accessed September 23, 2019.

type of nonpharmacological therapy is only possible if we are able to keep our doors open and continue seeing Medicare patients.

Moving forward, it is imperative that CMS acknowledge the important role physical therapists play in the prevention and treatment of acute and chronic pain. The solution requires more than limiting access to drugs. Rather, Medicare payment policies should incentivize collaboration, assessment, and care coordination with foundational care team partners, particularly physical therapists. CMS and Congressional policies to reduce reimbursement for physical therapy services is misguided (i.e., through MPPR, misvalued codes, PTA/OTA proposal, PT/OT value redistributions, etc.) at a time when benefit design and reimbursement models should support early access to nonpharmacological interventions -- including physical therapy for the primary care of pain conditions. The continuing payment reduction policies for physical therapy services impose greater challenges on physical therapy clinics to keep their doors open, thus placing at risk Medicare beneficiary access to nonpharmacological treatments for pain. It is critical that CMS, in conjunction with other state and federal agencies, examine how to reduce barriers to nonpharmacological treatment options such as physical therapy that serve as an alternative to opioids. If CMS, policymakers, and other stakeholders remain silent on the benefit of nonpharmacological treatments, this will only reinforce the idea that pharmaceuticals are the only option—an option with significant risk of harm.

Finally, the availability of physical therapy should be encouraged among older Americans because of the critical role it plays in preventing harmful senior falls. Accounting for roughly 300,000 hip fractures, 800,000 hospitalizations, and 27,000 deaths every year, falls are the leading cause of injury-related emergency room visits for older Americans.[2] It is estimated that medical expenditures attributable to fatal and nonfatal falls are roughly $50 billion annually, underscoring the need to support fall prevention strategies and treatments.[3] With fall deaths increasing every year, undermining beneficiary access to fall prevention treatments offered by physical therapy is both short sighted and financially ill-advised. As aforementioned, the costs that falls incur on America's healthcare system are exorbitant and unsustainable. Siphoning resources away from physical therapy services as the fall epidemic increases in size and scope will only result in more injury-related costs further down the line. Diminishing access to physical therapy services that save lives and reduce downstream medical costs is counterproductive, plain and simple. APTQI urges CMS to alter their recently Proposed Rule to ensure beneficiary access to physical therapy is preserved well into the future.

In summary, any changes to payments under the physician fee schedule for outpatient therapy services have a significant and direct effect on Medicare payments across the entire spectrum of the therapy delivery system. Physical therapists are subject to dwindling payment from Medicare, Medicare Advantage, Medicaid, and other payers. Low reimbursement rates have a significant impact on budget and resource allocation and limit a provider's ability to repair or enhance equipment or invest in technologies that could improve efficiency and patient outcomes. The continuing proposed reductions in payments for physical therapy services threatens Medicare beneficiaries' access to care, limiting one of the most cost-effective interventions for musculoskeletal care that allows beneficiaries to stay longer in their homes, and avoiding costly inpatient facilities. APTQI has serious concerns that commercial payers, as well as state Medicaid

[2] https://www.ncoa.org/news/resources-for-reporters/get-the-facts/falls-prevention-facts, accessed September 23, 2019.

[3] https://www.ncbi.nlm.nih.gov/pubmed/29512120, accessed September 23, 2019.

agencies, will follow CMS's lead when it comes to applying the payment reduction for PTA services and PT/OT RVU value redistributions. Such action could prove extremely detrimental to the physical therapy profession, and APTQI urges CMS to take into consideration its proposal's widespread implications on the future of payment when finalizing the RVU values for physical and occupational therapy services.

III. APTQI Opposes Requirements to Assign the CQ/CO Modifiers When a Therapist Performs the Service.

APTQI acknowledges that CMS must implement Section 1834(v) of the Social Security Act that requires services provided by therapist assistants to be paid at 85% of the rate paid for services provided by the therapist. The Congressional intent was that a discount would apply to physical therapy services, or parts of service, furnished ***independently*** by the therapist assistant. APTQI does not believe the Congressional intent was to apply any adjustments to therapy services when the therapist was providing the care.

In the proposed rule, CMS states that "if the PTA/OTA participates in the Service concurrently with the therapist for only a portion of the total time that the therapist delivers a services, the CQ/CO modifiers apply when the minutes furnished by the therapist assistant are greater than 10 percent of the total minutes spend by the therapist furnishing the service." In practice, the need for a therapist and a therapist assistant to provide services concurrently to a patient arises when the therapist believes a second set of hands is required to ensure patient safety and eliminate risk of falling or injury. The CQ/CO modifier should not be applied when the patient's condition requires the presence of a therapist and therapist assistant at the same time, especially if this is for safety reasons. APTQI does not see any logical explanation to reduce the payment of a service by 15% when two qualified providers are engaged with a patient at the same time.

APTQI believes that applying the de minimis standard to total service time of a code rather than the units of time will result in the CQ/CO modifiers being applied to services where the therapist provided full units of treatment independently, and thus not in line with congressional intent. For example, according to the proposed rule, if a therapist provided 30 minutes of therapeutic exercise (97110) independently, and that was followed by another 15 minutes of therapeutic exercise provided by a therapist assistant independently, the therapist would be required to apply the CQ/CO modifier to all three units of 97110 because the 15 minutes of therapist assistant time was in excess of the 10% of the 45 minutes of total time for 97110. This would result in a 15% reduction in payment applied to two units of 97110 where the therapist assistant did not participate in care in any way.

APTQI urges CMS not to apply the de minimis standard to total treatment time when the therapist and therapist assistant are providing services at separate times. CMS should allow the therapist to report a code on two different lines on the claim in order to apply the CQ/CO modifier to only those units where the therapist assistant provided services.

IV. APTQI Opposes Increasing Documentation Requirements Surrounding Application of the CQ/CO Modifiers.

CMS is proposing requiring therapists to "explain, via a short phrase or statement, the application or non-application of the CQ/CO modifier for each service furnished that day." APTQI opposes this new administrative burden that does nothing to improve clinical quality or patient care. In fact, requiring a qualified provider to document why they did not apply or do something is quite unprecedented and goes directly against CMS' goals to put patients over paperwork. The Medicare Benefit Policy Manual (MBPM), Chapter 15, Section 220, includes extensive documentation requirements and states that "a separate

statement is not required if the record justifies treatment without further explanation." APTQI asks CMS to consider no new documentation requirements regarding the application of the CQ/CO modifiers.

V. APTQI Urges CMS to Adopt the HCPAC-Recommended work RVUs for CPT Codes 205X1 and 205X2.

CMS chose to reduce the work RVUs from the levels recommended by HCPAC. The rationale used by CMS is flawed. CPT code 205X1 (needle insertion without injection, 1 or 2 muscles) requires more time and intensity than CPT code 36600. CPT code 205X1 requires constant assessing and reassessing of soft tissue response and service time would depend on the severity of the presentation. APTQI urges CMS to adopt the HCPAC-recommended work RVU of .45 for CPT code 205X1.

Similarly, CPT code 205X2 (Needle insertion, without injection, 3 or more muscles) is more intense and requires a completely different set of skills than CPT codes 97113 and 97542. The HCPAC-recommended work value of .60 was accurate and should be adopted.

VI. APTQI Supports the Concept of MIPS Value Pathways (MVPS) if Developed With Provider Input and Implemented on an Appropriate Timeline.

In the 2020 proposed rule, CMS embraced a proposed concept for streamlining MIPS. The agency outlined a high-level framework and seeks feedback on an episode-based approach to MIPS, which it is calling the MIPS Value Pathways (MVP). In the APTQI's view, an MVP-type approach could be a turning point for the program because an option that ties MIPS to episodes of care has the potential to be more clinically relevant, less burdensome, and a stepping-stone to alternative payment models. APTQI commends CMS for including physical and occupational therapists in the Quality Payment Program through MIPS. CMS has acknowledged that alternative payment reform includes offering rewards for achieving cost or quality goals such as the current MIPS program; however there are significant challenges that need to be rectified as the current program exists today for physical and occupational therapists. The current MIPS contains quality initiatives for "eligible professionals" such as physical and occupational therapists but lacks non commercially available. It is important that the MIPS program (and proposed MVP) for physical and occupational therapists collect meaningful data that will ultimately drive value-based care. APTQI believes that MIPS plays an important and essential role in offering a pathway for therapists who continue to be reimbursed under the traditional Medicare fee for service system to make changes in their practices that will (a) improve the value of care provided to patients and (b) provide a bridge towards participating in more transformative alternative payment models. MVP can be a practical solution to the problems with the current MIPS program; however, APTQI is concerned about the following issues related to the application of MIPS/MVPs to physical and occupational therapists in 2020:

A. APTQI Supports the Concept of MIPS Value Pathways (MVPs) if Developed With Provider Input and Implemented on an Appropriate Timeline.

We also believe developing and implementing MVPs by 2021 is not feasible. We caution CMS to carefully consider the potential implications that a complete overhaul of the MIPS program would have not only on clinicians participating in MIPS but on those administrative, support, and technical staff that are responsible for implementing yet another program with a new set of requirements by 2021. If CMS moves forward with the MVP framework in 2021 or later, we implore CMS to provide robust transition materials and support to stakeholders to ensure a smooth transition from MIPS to MVPs and then into APMs. While the APTQI agrees that the MIPS program must move to a more cohesive and simplified state, the APTQI

is concerned that CMS is moving at an accelerated pace on a significant programmatic change that would put increased burden on specialty societies to develop MVPs in a short timeframe while they are still attempting to ensure their members are well positioned in reporting for MIPS and QPP. In addition, the APTQI strongly encourages CMS to ensure that all providers be able to continue participating in MIPS in its current form for several years—without penalty for not participating in MVPs—due to the limited comment period and rapid implementation timeframes CMS is proposing. The APTQI strongly urges CMS to delay the implementation of MVPs, ensure providers can continue to participate in MIPS in its current form for several years without penalty, and ensure MVPs align with the MACRA legislative mandate to encourage QCDR use.

The APTQI strongly urges CMS not to set a date certain for implementing the MVP approach; rather, CMS should first issue a standalone RFI on the MVP framework prior to developing and issuing a proposal. The APTQI is aware of frameworks that are already in use that meet CMS' stated goals for MVPs. These frameworks are validated and have data indicating that they increase quality while reducing costs. The APTQI believes a change to MIPS of this magnitude warrants continued engagement between the agency and relevant stakeholders and believes that CMS will need additional feedback as the MVP framework is developed and clarified. CMS must ensure that using an MVP approach will provide a fair and equitable comparison of performance across clinician group types. As experts in providing physical therapy services, we appreciate CMS' willingness to work with APTQI and other industry stakeholders in developing MVPs that are meaningful to physical therapy providers. The APTQI believes that specialty societies such as ours will be the most appropriate venue for MVP development. The APTQI looks forward to continued conversation and collaboration with CMS regarding the development of MVPs for physical therapy providers to meaningfully report and participate in value-based care reporting programs.

B. Providers Should Not Bear the Cost of Qualified Clinical Data Registries (QCDRs) and QCDR Measures.

By increasing requirements for Qualified Clinical Data Registries (QCDRs) and QCDR measures, CMS continues to shift costs and burden of administering the MIPS programs onto providers, via special interest groups that that create measures and have QCDRs. This is a hidden cost of the program that is ultimately being borne by providers. CMS should not require QCDRs to do the significant pre-submission audits of all categories without some remuneration for providing this service on behalf of CMS. Specialty societies responded to CMS when the QPP was initiated by investing heavily in QCDRs and in measure development. These investments to support our physical therapists in MIPS continue to increase, without recognition of the costs of administering the program.

C. CMS Should Implement a Performance Threshold "Phased in Approach" for all Nonphysician Providers.

CMS is proposing a performance threshold of 45 points for the 2022 MIPS payment year and a performance threshold of 60 points for the 2023 MIPS payment year to avoid a negative payment adjustment. CMS' proposal to increase the minimum threshold for successful participation or the data completeness percentages for newly eligible clinicians such as physical therapists is problematic. Many of the applicable measures do little more than create increased administrative burden, decrease the time the therapist can spend with the patient, and have little impact on the delivery of care and patient outcomes. Therefore, APTQI recommends that CMS lower the performance threshold of newly eligible nonphysician clinicians to 40 points for the 2022 payment year, or alternatively, add in 5 bonus points to the Quality category. We have concerns that providers will struggle to achieve 45 points in year 4 pf the

MIPS program, particularly physical therapist providers and other recent newly eligible clinicians. We urge CMS to implement a phased in approach for recent eligible nonphysician clinicians. Any new individual eligible nonphysician clinician who meets the low-volume threshold and submits at least 1 measure on 1 patient should receive a neutral payment adjustment. Adding this program flexibility is more equitable and allows the new nonphysician providers a greater probability of success in the early years of the program, similar to what physicians were afforded at the commencement of the 2017 MIPS performance year.

CMS also seeks comment on whether they should adopt a different performance threshold in the final rule if they determine that the actual mean or median final scores for the 2020 MIPS payment year are higher or lower than their estimates for the 2024 MIPS payment year. CMS should update the performance and additional performance thresholds should the actual mean or median final scores for the 2020 MIPS payment year be lower than their estimates for the 2024 MIPS payment year. However, CMS should not increase the thresholds, even if the actual mean or median scores are higher. To maintain transparency, CMS should, however, make public the actual mean and median scores when they are available.

VII. Conclusion

APTQI is in favor of value driven care and reimbursement. We ask that CMS revisit the proposed reductions for physical/occupational therapy and fully consider the impact of those cuts on two of the most important health issues of our day, opioid misuse and falls resulting in injury and hospitalization. Considering the enormity of these cuts, it is clear that physical therapy for Medicare patients is at serious risk. If CMS proceeds with the 2021 cuts as proposed, the country will undoubtedly see practice closures and providers opting out of the Medicare program, which would then stifle access to important therapy treatments.

APTQI appreciates the opportunity to provide comments to CMS on the Proposed Rule for CY 2020. We encourage CMS to continue to work with professional societies such as the APTQI through the rulemaking process in order to create a stable and equitable therapy coding and payment system. 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 Nikesh "Nick" Patel, PT, DPT Executive Director, at 713-824-6177 or npatel@aptqi.com.

Very truly yours,

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