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Via Electronic Submission

September 6, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1654-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1654-P, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements: Expansion of Medicare Diabetes Prevention Program Model; Proposed Rules, Fed. Reg. Vol. 81, No. 136, (July 15, 2016).

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 2017, published in the Federal Register on July 15, 2016 ("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 and occupational therapy services on an annual basis to hundreds of thousands of Medicare beneficiaries. The APTQI membership consists of affiliate and board member entities of varying size and geographic scope, which in aggregate operate and represent over 5,000 outpatient rehabilitation clinics. The following is a brief description of each of our APTQI board member level entities:

- **Athletico Physical Therapy** currently operates approximately 388 outpatient rehabilitation clinics in 9 states;

- **ATI Physical Therapy** currently operates approximately 620 outpatient rehabilitation clinics in 24 states;

- **Drayer Physical Therapy Institute** currently operates approximately 138 outpatient rehabilitation clinics in 15 states;

- **Physical Therapy Business Alliance** is a not for profit professional organization representing approximately 1,000 independent physical therapy clinics in 27 states;

- **Select Medical** currently operates approximately 1900 outpatient rehabilitation and/or occupational therapy clinics in 37 states and the District of Columbia;

- **Upstream Rehabilitation** currently operates approximately 333 outpatient rehabilitation clinics in 21 states; and

- **U.S. Physical Therapy** currently operates approximately 521 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 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 patients and all stakeholders.

II. The Proposal for New Therapy Evaluation and Reevaluation CPT Code Descriptors is Flawed and Should be Rejected by CMS and Replaced With a Value Based Model.

CMS proposes to adopt new CPT code descriptors for physical therapy evaluations and reevaluations created by the American Medical Association (AMA) CPT Code Editorial Panel, effective January 1, 2017. The new code descriptors stratify therapy evaluations by complexity, creating 3 new evaluation codes and 1 new reevaluation code. The APTQI, through its members, has considerable experience of how the coding and payment system works at the "*individual practitioner level*." If the proposed codes are approved by CMS, it will be vulnerable to the subjective clinical reasoning and decision-making of the therapist that will vary depending on experience, background and training. This subjectivity will, in our view, be a step backwards from the current coding system for evaluation services and lead to further significant coding and audit concerns.

CMS recognized these same concerns by proposing to price the new therapy evaluation codes as a group – using the same value for all 3 codes – rather than individually, as recommended by the American Medical Association's (AMA) Relative Update Committee (RUC). Additionally, CMS elected to retain the existing RVU for the new reevaluation code. CMS noted that "[g]iven our concerns regarding appropriate valuation, work neutrality, and potential upcoding, however, we do not believe that making

different payment based on the reported complexity for these services is, at current, advantageous for Medicare or Medicare Beneficiaries." Despite the additional time and effort associated with the tiered evaluation service codes, providers will receive the same payment as they would under the current evaluation coding system. The provider community should not be saddled with the additional burdensome documentation and training requirements that add costs, not value, to the patient encounter and experience. Therefore, as set forth in more detail below, we strongly urge CMS to reject implementation of the proposed evaluation and reevaluation codes and work with stakeholders on the development of a value based model 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.

A. The research report provided by the Post-Acute Care Research Center (PACCR) clearly demonstrates that the proposed codes for evaluation services lack evidence based and statistical validity, reliability, and accuracy. The PACCR Report[1] substantiated that testing of the evaluation 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 healthcare systems, did not yield a statistically reliable and valid result. The limited live testing is especially compelling since it allowed for testing the extent to which the evaluation service codes be operationalized based on current charting practices. The APTQI does not believe clinicians will be able to clearly and objectively delineate between the evaluation levels for several reasons including: the varying experience level of therapists and typical time associated with the codes will cause significant confusion over choice of level; most physical therapy plans of care address more than 4 elements from body structures, systems, activity, and participation restriction; the proposed codes do not include or advance quality measures; and the proposed codes do not in any way address potential access issues amongst beneficiaries. The lack of reliability and absolute inherent variability that emanates from therapists' subjective perceptions leaves us wondering how the proposed evaluation and reevaluation codes could possibly be implemented given the obvious flaw in the past testing results. No further "fine tuning" or modification of these evaluation service codes, or the proposed intervention services codes lingering within the AMA PM&R work group, will fix these flaws.

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 proposed evaluation service codes do 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 proposed evaluation service codes do not meet the level of statistical reliability necessary for CMS to ultimately adopt these alternative codes. As previously stated, 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

[1] The American Physical Therapy Association (APTA) contracted with the PACCR to test the validity and reliability of the new proposed PM&R codes, including the evaluation services codes. 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.

level" believe this system will be seriously damaging to their ability to bill and code reliably, and given the rather complete intervention coding overhaul that may follow, result in massive unnecessary and unproductive upheaval and distress at the private practice level.[2]

B. The APTQI is unsure or unclear regarding how past research efforts or projects by CMS will influence, or be integrated with, the proposed evaluation service codes. 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 proposal of new evaluation service codes 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. CMS has not clarified how existing regulations would be eliminated or applied under the proposed CPT Codes. CMS noted in the Proposed Rule that the evaluation services codes are considered "always therapy" codes and, therefore, subject to therapy MMPR and statutory therapy caps. Any transformational modification to evaluation service codes 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, financially 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. However, there are other CMS regulatory requirements that should be considered now before 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); Comprehensive Care for Joint Replacement Model (CCJR); total time rules; group and concurrent therapy rules. If this is not addressed now, the proposed evaluation service codes will be further burdened with superimposed rules and regulations that add significant unexplained variation and unnecessary cost as well as complexity. As new therapy codes and payment models are

[2] The PACCR report also confirmed that the proposed intervention codes, based on a severity and intensity framework, do not meet the level of statistical reliability necessary for CMS and the profession to adopt and would be harmful to Medicare beneficiary access and patient care.

tested, these rules and regulations should not be ignored or CMS risks approving a therapy coding system of "practice patterns" that do not optimize efficiency.

III. 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 identified several 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 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 musculoskeletal, neurological and vestibular dysfunction. 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 appropriately valued as demonstrated by the continuous on-going reviews of the AMA CPT Editorial Panel and the RVS Update Committee / Health Care Professional Advisory Committee Review Board (RUC HCPAC). CMS should allow this AMA coding valuation process to continue without interruption and with more transparency. 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 notion that 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.[3] This 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 inclusive of diagnostics and the use of opioids which is an epidemic problem in the United States. In the past, this has led to the unintended consequence of increasing program health care costs due to more costly invasive procedures, whether diagnostic, medication and/or surgical. We urge CMS to work collaboratively with stakeholders to ensure history does not repeat itself as we attempt to move toward the triple aim of health care reform.

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.

IV. A "Fee for Value" Physical Therapy Payment Reform Model 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.** CMS has acknowledged that the primary goals of The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) were to repeal the sustainable growth rate (SGR) formula; revise the physician fee schedule update for 2016 and subsequent years; and establish 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. In addition, the Department of Health and Human Services recently announced that it plans to shift thirty (30) percent of Medicare provider payments 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.

[3] For example, instead of undergoing surgery for back pain, therapy is generally seen as a less costly, less invasive option.

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. 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, and proposed MIPS, as it has excluded eligible professionals providing covered therapy services to Medicare Part B beneficiaries in institutional settings (SNFs, Rehab Agencies or Outpatient Rehabilitation Facilities, Outpatient Home Health, etc.). 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 professional 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. 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 successful program for all beneficiaries served in Part B settings. 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. Furthermore, forcing these institutional practice settings to use registries in order to participate in the PQRS or MIPS 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. 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 proposed evaluation service codes and 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 continuum of care. APTQI believes that the expansion of functional limitation reporting with the addition of an outcomes measure 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.

There are quite a number of challenges for CMS to address that weigh statutory limitations with available administrative flexibility. The APTQI appreciates the opportunity to provide comments to CMS on the Proposed Rule that help address these challenges. 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 Troy Bage, PT, DPT, Executive Director, at 410-627-7533 or tdbage@gmail.com.

Very truly yours,

ALLIANCE FOR PHYSICAL THERAPY
QUALITY AND INNOVATION

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