

September 6, 2018

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-1693-P
Room 445-G
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically

RE: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program [CMS-1693-P]

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants (PTAs), and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments on the Centers for Medicare and Medicaid Services' (CMS) Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for Calendar Year (CY) 2019; Medicare Shared Savings Program Requirements; Quality Payment Program (QPP); and Medicaid Promoting Interoperability Program proposed rule. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for otherwise avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

The physical therapy profession is committed to the restoration, maintenance, and promotion of optimal physical function. Physical therapists are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status across all age populations. Physical therapists also help patients maintain health by preventing further deterioration or future illness. Maintaining access to physical therapist services is integral to ensure patients' recovery and to prevent further deterioration of patients' conditions.

Recommendations

Fee Schedule

- **APTA supports CMS's proposal to refine the "obtain vital signs" clinical labor task for Current Procedural Terminology (CPT) codes 97124, 97750, and 97755. We agree with the agency's rationale for refining the clinical labor task times for each of these codes.**
- **APTA supports CMS's efforts to modernize Medicare physician payment for communication technology-based services and requests that CMS clarify in final rulemaking whether physical therapists are considered eligible by the agency to furnish and bill for such services.**
- **APTA recommends CMS conduct a pilot or demonstration program to evaluate the clinical benefit of physical therapists, occupational therapists, and speech-language pathologists furnishing telehealth services to Medicare beneficiaries across settings.**
- **APTA recognizes the destruction that opioid addiction has caused in communities throughout the United States and is committed to helping fight this public health crisis in any way that we are able. We recommend that CMS institute regulatory and subregulatory revisions that promote payment models and integrated team approaches that support early access to nonpharmacological interventions, including physical therapy, for the primary care of pain conditions. There also must be appropriate payment for a broad range of pain management and treatment services, including alternatives to opioids, such as physical therapy. Further, in conjunction with CMS's current efforts to limit access to certain drugs, CMS must also develop and promote accompanying policies that *increase* access to nonpharmacological alternatives. Additionally, CMS should remove barriers to effective care by reducing or eliminating copays that prevent beneficiaries from accessing person-centered, nonpharmacological pain management and treatments interventions. CMS also should support broader access to interdisciplinary, comprehensive pain management models that evaluate and treat the different factors influencing the presence of pain, which will enhance the effectiveness, efficiency, and safety of care delivered to patients with pain. Further, training and educational resources for prescribers and other health care professionals should convey the value of nonpharmacological treatments and offer guidance on how to recognize when they are the safer, more effective option for the patient's condition. Finally, as stated in previous comments, we recommend that CMS, in conjunction with other federal agencies, expand its public awareness campaign on nonpharmacological treatment options for pain.**
- **While APTA has concerns with the consolidation of payment rates for all evaluation and management (E/M) codes, we also are troubled that members of the American**

Medical Association (AMA) Health Care Professionals Advisory Committee (HCPAC), such as podiatry, are targeted under this proposal. Therefore, we urge CMS not to finalize its proposal to provide differential payment to podiatrists by requiring them to utilize separate E/M codes.

- APTA appreciates CMS's acknowledgment of the permanently extended exceptions process instituted for outpatient therapy services. We recommend that CMS issue additional clarification and guidance on the appropriate use of the KX modifier for outpatient therapy claims and any applicable definitions.
- As discussed in greater detail below, APTA recommends CMS modify the definition of services furnished "in part" by PTAs and occupational therapy assistants (OTAs). We also urge the agency to delay adopting a definition of services furnished "in part" until CY 2020 rulemaking.
- APTA strongly supports CMS's proposal to discontinue functional limitation reporting (FLR) requirements for services furnished on or after January 1, 2019. We strongly urge CMS to finalize this provision as proposed.
- APTA recommends that CMS adopt tiered payment levels for the physical therapy evaluation codes (CPT codes 97161-97163) to align with the stratified code descriptors.

QPP

- APTA supports the inclusion of physical therapists in the Merit-based Incentive Payment System (MIPS). APTA is pleased that CMS is affording several significant flexibilities to physical therapists and other newly included MIPS-eligible clinicians in their inception year(s) in the program. However, we have concerns that physical therapists will face challenges in their participation efforts and urge CMS to consider applying certain amnesties to our providers.
- APTA recommends that if facility-based physical therapists are added to the program in the future, the agency should allow providers in facilities to report measures relevant to their respective settings.
- APTA supports the creation of the Physical and Occupational Therapy Specialty Measure Set. We encourage CMS to make 2 additional measures available to physical therapists (#126 Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation; #127 Diabetic Foot and Ankle Care, Ulcer Prevention Evaluation of Footwear) and 3 additional measures available to occupational therapists (#134 Screening for Depression and Follow-Up Plan; #181 Elder Maltreatment Screen and Follow-Up Plan; #226 Tobacco Use: Screening and Cessation Intervention).
- APTA supports the modifications to the low-volume threshold and the creation of an opt-in policy for the MIPS program. However, APTA encourages CMS to allow providers to opt-in at the time of data submission, as this would create the least amount of burden on providers who wish to opt into the program.
- While APTA supports CMS's policy that MIPS-eligible clinicians and groups that have fewer than the required number of measures and activities applicable and available under one submission mechanism could be required to submit data on additional measures and activities via one or more additional submission mechanisms, we question the ability of our providers to take advantage of this policy

in the first year of their participation, given the complexities associated with learning how to participate in the program.

- **APTA supports CMS’s proposal to include opioid-related quality measures within the definition of a high-priority measure. We encourage CMS to look beyond measures that focus strictly on opioid use to include patient-reported outcomes measures that look at symptom management and pain interference.**
- **APTA supports CMS’s proposal to place measures that perform at the 98th to 100th percentile range on the topped-out list. Should these measures remain extremely topped out in the following year, they should be removed from the program.**
- **APTA recognizes the importance of moving to outcomes measures and meaningful process measures. However, to promote robust, successful participation of physical therapists in MIPS, APTA recommends that CMS not remove process or outcomes measures used by physical therapists until performance year 2021.**
- **APTA supports the concept of valuing or weighting measures. We recommend that CMS consider listing measures in the provider specialty sets with that information as a means to decrease provider burden with the measure selection process.**
- **APTA supports CMS’s proposal to assign a weight of zero to the Promoting Interoperability category for physical therapists, as currently none of our physical therapy-specific electronic health record (EHR) vendors have achieved Certified Electronic Health Record Technology (CEHRT) certification. It is our goal to assist the industry, through our advocacy efforts, to move toward the adoption of more CEHRT products for our providers.**
- **APTA supports CMS’s alternative proposal for weighting the Quality and Improvement Activities categories at 70% and 30%, respectively, as this weighting will better enable providers to earn points in the MIPS program.**
- **APTA recommends that CMS lower the performance threshold to 25 points. We also strongly recommend that CMS implement a modified “pick your pace” for all nonphysician providers entering into the MIPS program in 2019. Alternatively, we request that CMS consider an alternative performance threshold for first-year MIPS participants.**
- **APTA supports CMS’s proposed definition change for Qualified Clinical Data Registries (QCDR) to state that the approved entity must have clinical expertise in medicine and quality measure development. APTA supports CMS’s proposed measures selection criteria and encourages CMS to have dialogue with QCDRs regarding the submission of measures.**
- **APTA opposes CMS’s proposal to require that, beginning with the 2021 payment year, the QCDR measure owner agrees to enter into a license agreement with CMS permitting any approved QCDR to submit data on the QCDR measure (without modification) for purposes of MIPS and each applicable MIPS payment year.**
- **APTA supports CMS’s proposal to implement the Medicare Advantage (MA) demonstration beginning in 2018.**
- **APTA has serious concerns that the CEHRT criterion for the MA demonstration, Medicare Advanced Alternative Payment Models (APMs), and Other Payer Advanced APMs imposes a significant barrier to physical therapists’ participation in APMs. Therefore, APTA strongly recommends that CMS modify the CEHRT**

criterion for the demonstration, Advanced APMs, and Other Payer Advanced APMs that will help to promote physical therapist participation.

- **As CMS undertakes the development of new APMs, we also urge the agency to include quantitative and qualitative metrics, including meaningful performance-based and patient-reported outcome measures, by which CMS can ensure that coordinated, patient-specific, outcome-based care is being delivered safely by properly qualified professionals to patients.**
- **APTA supports CMS’s proposal to allow for claims run-out for 60 days before calculating the threshold scores, so that the 3 Qualifying APM Participant (QP) determinations will be completed approximately 3 months after the end of that determination time period.**
- **APTA supports CMS’s proposal to add a third alternative to allow requests for QP determinations at the Tax Identification Number (TIN) level when all clinicians who reassigned billing rights under the TIN participate in a single APM entity. We encourage the agency to finalize this third option within final rulemaking.**
- **APTA supports CMS’s proposal to clarify that it allows eligible clinicians or APM entities to meet the minimum Medicare and All-Payer Combination thresholds using the most favorable of the payment amount or patient count.**
- **APTA supports CMS’s appropriate-use criteria proposal and encourages the agency to modify 42 CFR 410.32 to include physical therapists within the list of personnel who may order diagnostic tests under Medicare.**
- **APTA’s comments in response to the Price Transparency Request for Information (RFI) reflect the issues we have identified as a profession with respect to price transparency.**

Please find below our detailed comments on the proposed rule.

Physician Fee Schedule

Obtain Vital Signs

CMS proposes to refine the “obtain vital signs” clinical labor task back to the previous time of 1 minute for CPT codes 97124 and 97750 and to 3 minutes for CPT code 97755. CMS also proposes to refine the equipment time for input code EF028 (table, mat, hi-lo, 6 x 8 platform) for CPT code 97124 to reflect the change in the clinical labor time.

APTA supports CMS’s proposal to refine the “obtain vital signs” clinical labor task for CPT codes 97124, 97750, and 97755. We agree with the agency’s rationale for refining the clinical labor task times for each of these codes.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code GVCII)

CMS proposes to pay separately, beginning January 1, 2019, for a newly defined type of physicians’ service furnished using communication technology. This service would be billable when a physician or other qualified health care professional has a brief non-face-to-face check-in with a patient via communication technology, to assess whether the patient’s condition necessitates an office visit. The proposed code would be described as “GVCII (Brief

communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion).”

APTA appreciates CMS’s efforts to modernize Medicare physician payment for communication technology-based services and requests that CMS clarify in final rulemaking whether physical therapists are considered eligible by the agency to report E/M codes. Physical therapists are qualified health care professionals under the definition put forth by the AMA. That is, a “physician or other qualified health care professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.” However, it is unclear from the definition above for the brief communication technology-based service whether a physical therapist, who is a qualified health care professional, would be included under the definition of “other qualified health care professionals who can report evaluation and management services, provided to an established patient...”

Permitting coverage of communication-based technology services furnished by physical therapists directly aligns with current treatment trends. Physical therapists use technology in treatment to shorten healing times, improve comfort and quality of life, and increase the overall quality and options of care available. Although the proposal references CMS’s intent to improve *physician payment*, we strongly recommend that physical therapists be included within the definition of health care professionals who can furnish and bill HCPCS code GVC11, and we request that CMS clarify that it intends for physical therapists to be encompassed within the code’s definition.

Adding Services to the List of Medicare Telehealth Services

As stated in previous comments, APTA strongly recommends that CMS establish a pilot or demonstration program to evaluate the clinical benefit of physical therapists, occupational therapists, and speech-language pathologists furnishing telehealth services to Medicare beneficiaries. With the increased use of telehealth to deliver health care, clinicians need to be able to practice across geographic boundaries. In an effort to improve licensure portability for physical therapists and PTAs, the Federation of State Boards for Physical Therapy, with support from APTA, recently developed an [interstate Physical Therapy Licensure Compact \(PTLC\)](#). The purpose of the PTLC is to increase consumer access to physical therapy services by reducing regulatory barriers to interstate mobility and cross-state practice. Under the compact, physical therapists and PTAs will be able to apply for privileges to practice in participating states while maintaining licensure in their home state. The PTLC, currently adopted in 21 states and operational in 5, also will allow physical therapists located in states that have signed onto the compact to use telehealth to expand their practices and enhance patient access.

The Department of Veterans Affairs (VA) has recognized the immense benefit of telehealth services for veterans. In June, the VA clarified through regulation that VA health care providers may exercise their authority to provide health care through the use of telehealth, notwithstanding

any state laws, rules, licensure, registration, or certification requirements to the contrary, when the VA provider and VA beneficiary are located in the United States. As CMS looks to expand access to telehealth services, the compact is a viable solution to the any interstate licensure concerns. Ultimately, the expansion of Medicare coverage for telemedicine would be a cost- and lifesaving solution to the critical access to care concerns that impact the Medicare population. Proper application of telehealth rehabilitation therapy services, particularly in underserved areas, can have a dramatic impact on improving care and reducing negative consequences and costs of care.

APTA strongly encourages the agency, through the Center for Medicare and Medicaid Innovation, to conduct a pilot or demonstration program to evaluate the clinical benefit of physical therapists, occupational therapists, and speech-language pathologists furnishing telehealth services to Medicare beneficiaries in all settings—in states that permit such services. APTA encourages CMS to examine the development of models that are focused on population-based preventive innovations around prevalent conditions or risks. However, to inform the development of such models, CMS would need to first solicit and collect feedback from the applicable provider and research communities on appropriate target areas. As an example, the physical therapist community might encourage condition-specific models that focus on low back pain, diabetes/hypertension, obesity, and/or falls.

Moving forward, we encourage CMS to consider and assess how to encourage provider participation in these more nontraditional alternative delivery models and the role of telehealth. The results of this demonstration would help to inform policymakers as they consider whether to include physical therapists, occupational therapists, and speech-language pathologists as authorized providers of telehealth.

Comment Solicitation on Creating a Bundled Episode of Care for Management and Counseling Treatment for Substance Use Disorders

CMS seeks public comment and suggestions for regulatory and subregulatory changes to help prevent opioid use disorders and improve access to treatment under the Medicare program. CMS seeks comment on methods for identifying nonopioid alternatives for pain treatment and management, and for identifying barriers that may inhibit access to these nonopioid alternatives, such as payment or coverage.

Physical therapy is a dynamic profession with an established theoretical and scientific basis for therapeutic interventions capable of restoring, maintaining, and promoting optimal physical function. Physical therapists work both independently and as members of multidisciplinary health care teams to enhance the health, well-being, and quality of life of their patients, who present with a wide range of conditions including those that commonly cause pain. The US Centers for Disease Control and Prevention's (CDC) recommendations point to "high-quality evidence" that treatments provided by physical therapists are especially effective at reducing pain and improving function in cases of low back pain, fibromyalgia, and hip and knee osteoarthritis. Additionally, a number of studies show the efficacy of physical therapist interventions in preventing, minimizing, and, in some cases, eliminating pain in patients post-surgery, in patients with cancer, and in other clinical scenarios.

The presence of pain is one of the most common reasons people seek treatment from health care providers. The source of pain for any individual can vary, whether it's an injury or an underlying condition such as arthritis, heart disease, or cancer. Because pain can be so difficult to treat and presents differently in every individual, its prevention and management require an integrated, multidisciplinary effort that takes into consideration the many variables that contribute to it, including the underlying cause(s) of the pain and the anticipated course of that condition; the options that are available for pain prevention and treatment, and patient access to these options; and the patient's personal goals, and their values and expectations around health care. That evidence, in fact, was the driving force behind recent recommendations by the CDC in its Guideline for Prescribing Opioids for Chronic Pain. "Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain," the CDC states. The report goes on to explain that "many non-pharmacologic therapies, including physical therapy...can ameliorate chronic pain."

APTA recognizes the destruction that opioid addiction has caused in communities throughout the United States and is committed to helping to fight this public health crisis in any way that we are able. We strive to educate policymakers, clinicians, consumers, and other stakeholders on pain management options that best suit patients' needs, goals, and desires, which ultimately can play a major role in turning around our nation's opioid epidemic. There is a role for opioids, but there also needs to be a focus on prevention of addiction. In addition, providers must understand—and convey to their patients—that the use of opioids comes with significant risks and that effective nonpharmacological solutions to pain management are available. The best way to prevent opioid abuse and addiction? Prevent exposure to opioids in the first place when they are not the optimal or appropriate choice for an individual patient. Please find below our detailed recommendations for CMS's consideration.

First, Medicare should institute regulatory and subregulatory revisions that promote payment models and integrated team approaches that support early access to nonpharmacological interventions, including physical therapy, for the primary care of pain conditions. Medicare must encourage these integrated team approaches. Research has demonstrated that when a patient in pain receives early access to a physical therapist, the patient experiences improved functional outcomes with a significant reduction in overall costs. Moreover, the CDC has concluded that there is insufficient evidence that opioid usage alone improves functional outcomes for those in pain. Unfortunately, incentives still are lacking that would steer or encourage prescribers to consider nonopioid and nonpharmacological treatments for pain, despite overwhelming evidence that they often are the safer and more effective option.

Second, CMS should remove barriers to effective care by reducing or eliminating copays that prevent beneficiaries from accessing person-centered, nonpharmacological pain management and treatments interventions. For example, to promote early intervention, CMS could waive copayments for initial visits, early or no referral requirements for conservative therapies, and direct contracting with employers to ensure early access to conservative therapies. In an effort to decrease opioid prescriptions in both inpatient and outpatient settings, APTA recommends the reduction or elimination of copays for nonpharmacological treatments for pain. Beneficiaries across the health spectrum encounter access barriers due to copay and cost-sharing requirements. Medicare copays create a significant financial burden for patients requiring multiple encounters

over an extended period of time. Patients are usually presented with a single copay for a month's supply of opioids versus a copay for *each* physical therapy visit, not to mention the fact that prescription copays often are lower than therapy visits. Unless we incentivize appropriate management of the cause of pain, patients will avoid treatment, either allowing their pain to worsen or seeking immediate albeit short-term relief via an opioid prescription. Eliminating or reducing financial barriers such as copays will promote access to physical therapy services that often are the safer, more effective option.

Third, there must be appropriate payment for a broad range of pain management and treatment services, including alternatives to opioids such as physical therapy. This sentiment was expressed by the President's Commission on Combating Drug Addiction and the Opioid Crisis in its final report, recommending that "CMS review and modify rate-setting policies that discourage the use of non-opioid treatments for pain, such as certain bundled payments that make alternative treatment options cost prohibitive for hospitals and doctors, particularly those options for treating immediate post-surgical pain."¹

Fourth, in conjunction with CMS's current efforts to limit access to certain drugs, the agency must also develop and promote accompanying policies that *increase* access to nonpharmacological alternatives. By doing so, CMS will ensure that it gives beneficiaries, including MA enrollees, adequate options to receive medically necessary, appropriate care. For example, CMS could require the MA plan sponsor's clinical staff to work with the beneficiary's prescribers to develop a nonpharmacological, multidisciplinary pain-management treatment plan. Moving forward, it is imperative that CMS acknowledge the important role physical therapists and other nonphysician health care professionals play in the prevention and treatment of acute and chronic pain. If CMS continues to remain silent on nonpharmacological treatment options that serve as an alternative to drugs, then, ultimately, the idea that pharmaceuticals are the only option—an option with significant potential harm, will only be reinforced.

Fifth, patients need an integrated team approach that focuses on pharmacological and nonpharmacological multidisciplinary management and interventions for acute pain to decrease the potentially disabling effects of chronic pain. Given the seriousness of the opioid crisis (and, more broadly, the chronic pain crisis), there should be broader support by CMS for the development of and access to interdisciplinary, comprehensive pain management models that evaluate and treat the different factors influencing the presence of pain, which will enhance the effectiveness, efficiency, and safety of care delivered to patients with pain. CMS should publicly support this approach; in its capacity as a regulator, the agency could incentivize the reduction of opioid-based medicine prescriptions.

The agency should examine the benefits of multidisciplinary treatment models for patients with pain and addiction, and consider how such models can be more widely adopted. Interdisciplinary, comprehensive pain-management models that evaluate and treat the different factors influencing the presence of pain will enhance the effectiveness, efficiency, and safety of the care delivered. The opioid crisis will not be resolved solely by restricting access to drugs.

¹ The President's Commission on Combating Drug Addiction and the Opioid Crisis. Final Report. https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf. Accessed July 8, 2018.

Rather, it requires an interdisciplinary approach that focuses on nonpharmacological, multidisciplinary management and interventions for acute and chronic pain.

Sixth, primary care physicians and providers should be educated on the value of nonpharmacological, person-centered interventions and how to appropriately assess, treat, and refer patients with pain. Overprescription of opioid-based medications has been a primary driver of the current opioid crisis. Far too often, health care professionals prescribe opioids, not cognizant of the very real risks of addiction or overdose that these medications pose. In many cases, a nonopioid, interdisciplinary treatment plan for pain management is the superior option, avoiding opioids' potential side effects. One roadblock to the broader implementation of an interdisciplinary comprehensive pain-management approach is that many primary care providers and physicians are unaware that such an approach even exists. While prescription of opioid-based medicine sometimes is appropriate, overprescription is a common problem. Health care professionals, as well as their patients, often lack sufficient knowledge about the range of available therapies for acute or chronic pain, which therapies may be helpful for pain treatment, and when a nonpharmacological therapy should be used as part of an interdisciplinary approach to pain management.² Without sufficient education on nonpharmacological pain management solutions and how such options may suit patients' needs, providers will neither discuss nor offer treatments that address the biological, psychological, and social needs of the patient. This not only places patients at a significant disadvantage during the course of treatment but also encourages the overuse of opioids to treat pain. To that end, APTA recently contributed to the development of the National Quality Forum's opioid playbook, focused on realistic, patient-centered, scalable actions to transform health care's approach to pain.³

Training and educational resources directed to prescribers and other health care professionals should convey the value of nonpharmacological treatments and how to recognize when they are the safer, more effective option for the patient's condition. Physicians should also be educated about the need to give patients more information about alternative options for pain management. Moreover, the message that successful pain management requires an interdisciplinary approach that incorporates nonpharmacological therapies must be conveyed and reinforced to clinicians, as well as to Medicare beneficiaries. Dissemination of information and education about nonpharmacological interventions for the treatment of pain, such as physical therapy, will help to move this nation forward in its efforts to improve pain management and promote safe opioid prescribing.

While prevention of opioid dependency is the ideal, we must address the problem as it currently exists. Accordingly, physicians must be trained to recognize when opioids are already being abused. We recommend that CMS and other federal agencies not only educate medical professionals on alternatives to opioids but also on prescribing patterns, signs of opioid

² Thackery A, Hess R, Dorius J, et al. Relationship of opioid prescriptions to physical therapy referral and participation for Medicaid patients with new-onset low back pain. *J Am Board Fam Med.* 2017;30(6):784-794. <https://www.ncbi.nlm.nih.gov/pubmed/29180553> Accessed July 8, 2018.

³ National Quality Partners Playbook: Opioid Stewardship. Washington, DC: National Quality Forum; 2018. https://www.qualityforum.org/National_Quality_Partners_Opioid_Stewardship_Action_Team.aspx Accessed July 8, 2018.

dependency, and treatment options for opioid addiction. Unless we address the crisis at every stage, we will not achieve a complete solution.

Finally, as stated in previous comments, we recommend that CMS, in conjunction with other federal agencies, expand its public awareness campaign on opioids to include health care providers, payers, regulators, employers, and, particularly, the general public on pain assessment and options for pain management. The strategy should reference both pharmacological *and* nonpharmacological treatment options for pain, and discuss how each treatment works in conjunction with the other. This strategy should include consistent, educational messages on pain and pain management specifically for patients. Patients often do not have the knowledge or opportunity to engage in informed, shared decision-making about the different treatment possibilities for their acute or chronic pain. They desire results and rely on the wisdom of their health care providers for the best treatment option. Communication is a vital tool in reversing the trend of the overutilization of opioids. With adequate information, patients will feel more empowered and better able to articulate their needs, goals, and desires, which in turn will lead to more effective treatment plans.

CMS and other stakeholders must ensure that not only is education for prescribers enhanced, but that a clear, direct path exists for patients in pain to access all treatment options, including physical therapy. Given that the CDC has concluded there is insufficient evidence that opioid usage alone improves functional outcomes for those in pain, we recommend that clinicians who prescribe an opioid for pain also must be required to refer a patient to physical therapy. Research has demonstrated that patients in pain who receive early access to a physical therapist experience improved functional outcomes, and there is a significant reduction in overall costs.⁴

Documentation Changes for Office or Other Outpatient E/M Visits and Home Visits

While APTA has concerns with the consolidation of payment rates for all E/M codes, we also are troubled that members of the AMA HCPAC, such as podiatry, are targeted under this proposal. CMS's proposals would effectively serve to provide differential payment for the same E/M services based on specialty, singling out podiatry for reduced payment. Social Security Act Section 1848(c)(6) expressly prohibits differential valuation (and thereby payment) of services paid under the Physician Fee Schedule based on specialty. CMS does not provide any rationale for why the evaluation and management required for patients seeking care from health care professionals, such as podiatrists, is distinct from that provided to patients seeking medical care from other physicians, for patients with similarly complex care needs. Therefore, we urge CMS not finalize its proposal to provide differential payment to podiatrists by requiring them to utilize separate E/M codes.

Repeal of the Therapy Caps and Limitation to Ensure Appropriate Therapy

APTA appreciates CMS's acknowledgment of the permanent exceptions process instituted for outpatient therapy services. However, APTA, our members, and our members' employers continue to seek official guidance from the agency on a number of outstanding issues related to use of the KX modifier and reprocessing of claims. Specifically, we request the following: (1)

⁴ Horn M, Brennan G, George S, et al. A value proposition for early physical therapist management of neck pain: a retrospective cohort analysis. *BMC Health Serv Res.* 2016;16:253. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4942887/> Accessed July 8, 2018.

that prior to final rulemaking, CMS provide information on the number of therapy claims with the KX modifier reprocessed and the time schedule for reprocessing the remaining incorrectly denied claims; (2) that CMS clarify whether the provider will be able to resubmit the claim with the appropriate modifier when the KX modifier was not originally applied; and (3) that CMS clarify whether providers who were furnished an Advance Beneficiary Notice (ABN) between January 1 to February 9, 2018, for outpatient therapy services over \$2,010 that were medically necessary should reimburse Medicare beneficiaries and resubmit a claim to Medicare.

APTA also recommends that the agency emphasize to outpatient therapy providers and to Medicare beneficiaries that the \$3,000 threshold is not a cap; rather, it is merely a targeted medical review threshold. Finally, we request that CMS require Noridian Healthcare Solutions, the new Supplemental Medical Review Contractor, to develop a website that offers instructions on the targeted medical review process. We also urge CMS to share with providers data collected from targeted reviews conducted since 2016, such as the number of reviews conducted, trends in denials, the percentage of providers who request a discussion/education period, and the percentage of providers who are successful in overturning the initial review results.

Proposed Payment for Outpatient PT and OT Services Furnished by Therapy Assistants

CMS proposes to define “in part,” for purposes of the new modifiers, “to mean any minute of the outpatient therapy service that is therapeutic in nature, and that is provided by the [physical therapist assistant] PTA or occupational therapy assistant [OTA] when acting as an extension of the therapist. Therefore, a service furnished ‘in part’ by a therapy assistant would not include a service for which the PTA or OTA furnished only non-therapeutic services that others without the PTA’s or OTA’s training can do, such as scheduling the next appointment, greeting and gowning the patient, preparing or cleaning the room.”

APTA strongly disagrees with CMS’s interpretation of the definition of outpatient therapy services furnished “in part.” Given that a physical therapist and PTA frequently deliver collaborative, team-based care, we have serious concerns that requiring the modifier to be applied if any minute of outpatient therapy is delivered by the PTA has serious implications for beneficiary access to care. Reimbursement should be driven first by the therapist’s time associated with the service. CMS must also take into consideration the practical difficulties associated with implementing the policy as proposed day-to-day practice. As the baby boomer generation continues to retire and age, there will be an increased demand for physical therapy services. Further, there will be an increase in the number of Medicare beneficiaries suffering from multiple chronic conditions which require caregiver training; mobility and self-care; and home safety and home modification to enable “aging in place.” Physical therapists and PTAs serve a critical role in the health and vitality of this nation. It is imperative that Medicare beneficiaries continue to have access to high quality physical therapy services, given the critical role physical therapists and PTAs play in ensuring the health and vitality of this nation.

CMS has proposed a definition of the PTA modifier, as mandated by the Bipartisan Budget Act of 2018 (BBA) Section 53107, which requires that CMS must establish not later than January 1, 2019. However, it is evident that CMS is not statutorily mandated to define “in whole or in part” before January 1, 2020. Therefore, while APTA urges the agency to consider revisions to the proposed policy, as discussed in more detail below, given that the PTA and OTA modifier and

payment differential may create new access barriers, we recommend that CMS not advance implementation of the definition of “in whole or in part” within the CY 2019 final rulemaking. Rather, to better understand the full implications of the PTA and OTA modifier and payment differential on care delivery, and ensure the definition of “in part” is developed in a way that minimizes the negative impact on patient access, APTA recommends CMS not move forward with finalizing the definition of “in part” until CY 2020 rulemaking. This will allow CMS more time to engage in an extensive discussion with the health care industry, including APTA, the American Occupational Therapy Association, Part B therapy providers, and health information technology (IT) vendors regarding defining and implementing the therapy assistant modifier and differential policy. Moreover, a delay in the defining of “in part” until CY 2020 proposed rulemaking will still allow providers to voluntarily report the modifier during the latter half of 2019, albeit based on the definition of “in part” as put forth in the 2020 proposed rule.

Construction of BBA Section 53107

BBA Section 53107 allows for significant latitude on the part of the agency in its interpretation of the term “in part.” We note that the BBA does not require the modifier for services furnished “in any part.” Words that are not terms of art and that are not statutorily defined are customarily giving their ordinary meanings, frequently derived from the dictionary.⁵ Merriam Webster defines *in part* as *in some degree; partially*. Partially is then defined as *to some extent; in some degree*.

Here, the term “in part” in relation to the furnishing of health care services has not been previously defined in statute or elsewhere in the United States Code. As such, there is no statutory definition to govern such term.⁵ As discuss in greater detail below, APTA encourages CMS to use the discretion afforded to it by Congress and adopt a definition of “in part” that better allows the Medicare coding and billing structure to capture the delivery of physical therapy services by a physical therapist working in collaboration with a PTA.

Modify “In Part” Definition

Mid-Point Rule

APTA has serious concerns that applying the proposed “in part” definition to service-based and time-based codes will impede patient access to physical therapy services. The policy as proposed would require the provider to affix the PTA modifier for each patient who received any minute of service by an assistant. Consequently, to avoid facing a financial “penalty,” physical therapist private practices and other outpatient therapy providers will be forced to stop delivering certain services and/or stop utilizing PTAs when they require assistance in furnishing a service. The result will be reduced patient access, lower overall productivity, and further reduction in therapists’ reimbursement. At a time when many providers are operating on severely thin margins, the payment differential policy, if implemented as proposed, is likely to have a serious impact on the physical therapy profession as a whole and, consequently, on patients. Medicare payment and coverage policies should afford flexibility to physical therapists and other therapy professionals to develop an individualized care plan tailored to the needs of each patient.

⁵ Statutory Interpretation: General Principles and Recent Trends. Congressional Research Service, citing *FDIC v. Meyer*, 510 U.S. 471, 476 (1994). See also, e.g., *Mohamad v. Palestinian Authority*, 566 ___, No. 11-88, slip op. (April 18, 2012) (“individual,” as used in the Torture Victim Protection Act, does not include an organization). <https://fas.org/sgp/crs/misc/97-589.pdf> Accessed August 16, 2018.

If the therapist furnishes the service, any involvement of the assistant is irrelevant. The rate of reimbursement should not be defined by the amount of participation by the assistant, but rather by the amount of participation by the therapist. For example, a therapist may be furnishing the service while instructing the assistant to perform a test or measurement; however, the therapist is actively engaged with the patient throughout the entire treatment session.

It is imperative that physical therapists and other therapy professionals have the ability to exert their authority in addressing each patient's specific needs. Imposing additional reductions to reimbursement for physical therapy services has significant implications for Medicare beneficiaries and ultimately will result in the loss of access to services they depend upon. To ensure that patient access is not detrimentally impacted by the policy, we encourage CMS to modify the definition of "in part" to clarify that if the majority of services are furnished by the physical therapist, then the service is paid at 100%. Specifically, we recommend that CMS implement a mid-point policy, similar to AMA's CPT mid-point rule. That is, if the physical therapist furnishes the service for more than half of the time, regardless of the assistant's involvement, the code would be affixed with the GP modifier.

There is precedent to use the mid-point rule when adopting coding policies; for example, CMS cites the mid-point rule for the advanced care planning codes (CPT 99497-99498). As such, when the preponderance of service delivery is by the physical therapist, indicating that the therapist is actively engaged with the patient throughout the course of treatment, it would be unjust to reimburse for those services at 85%. However, much like the evidentiary standard in civil cases, the preponderance of documentation must support the physical therapist's active engagement in the delivery of care.

Adopting the mid-point rule also would help to alleviate concerns regarding physical therapy evaluations and the reevaluation. The Medicare Benefit Policy Manual (MBPM), Chapter 15 states that "PTAs may not provide evaluative or assessment services, make clinical judgments or decisions; develop, manage, or furnish skilled maintenance program services; or take responsibility for the service. They act at the direction and under the supervision of the treating physical therapist and in accordance with state laws." The MBPM further states that "a clinician may include, as part of the evaluation or re-evaluation, objective measurements or observations made by a PTA or OTA within their scope of practice, but the clinician must actively and personally participate in the evaluation or re-evaluation. The clinician may not merely summarize the objective findings of others or make judgments drawn from the measurements and/or observations of others."⁶

The physical therapist is solely responsible for completion of the examination, evaluation, diagnosis, and prognosis as well as the development of the plan of care. Once he or she has established the plan of care, the physical therapist may involve the PTA to assist with selected interventions. The physical therapist considers the following prior to directing interventions to the PTA:

- Are the interventions within the scope of work of the PTA?
- Is the patient's condition sufficiently stable?

⁶ Medicare Benefit Policy Manual, Chapter 15. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf> Accessed August 16, 2018.

- Are the intervention outcomes sufficiently predictable?
- Is the intervention within the PTA’s personal knowledge, skills, and abilities?
- Are there risks and liabilities that should be considered prior to directing interventions to the PTA?
- Would any payer requirements be affected by the involvement of the PTA in providing interventions?

When the physical therapist directs an intervention to the PTA, the physical therapist continues to (1) maintain responsibility of patient management; (2) provide direction and supervision to the PTA in accordance with applicable laws and regulations; (3) conduct periodic reassessment/reevaluation of the patient as directed by the facility, federal and state regulations, payers, and the needs of the patient; and (4) provide support to the PTA and, when appropriate, assist in developing the PTA’s knowledge and skills necessary to perform selected interventions and related data collection.⁷

As acknowledged by CMS, conducting a low-, moderate-, or high-complexity physical therapy evaluation requires clinical judgment and the decision-making of a physical therapist. The physical therapist is responsible for conducting the evaluation, and, as such, when a PTA is involved in the furnishing of a physical therapy evaluation, the PTA is providing assistance to the physical therapist. In such instances, the physical therapist is personally supervising and directing the assistant’s activities. For example, an evaluation may require 30 minutes of the physical therapist’s time. Although the assistant might have assisted in furnishing a portion of the evaluation between minutes 12-16, at the physical therapist’s direction, the physical therapist actively conducted the evaluation from start to finish and, in fact, was the primary practitioner for 26 of the 30 minutes. Accordingly, it should be expected that the evaluation is paid the full fee schedule amount. Unfortunately, the proposed definition of “in part” essentially guarantees that a physical therapist will be forced, for financial reasons, to no longer utilize a PTA during the evaluation, placing the onus on the physical therapist to solely conduct the evaluation without assistance, thus diminishing the overall quality of care.

As previously stated, CMS has significant flexibility in its interpretation of the BBA therapy assistant modifier provision. Applying the mid-point rule would continue to ensure that when services are primarily furnished by the therapist, the services are paid at 100% of the fee schedule amount. If the PTA primarily furnishes the service anywhere beyond the mid-point, even though not entirely, the services would be paid at 85% of the fee schedule. Requiring a PTA modifier to be affixed to the claim if the assistant delivers any minute of a service that is therapeutic in nature fails to align with current physical therapist practice and would unfairly penalize outpatient therapy providers. Therefore, APTA recommends that CMS adopt a mid-point rule in defining “in part” to alleviate patient access issues as well as provider burden.

Blended Rate

Alternatively, APTA recommends that CMS consider adopting a blended fee schedule rate when service-based codes are furnished “in part” by the PTA. A blended rate policy could be easily applied, such that the claim line item would include both the GP modifier as well as the new

⁷ APTA PT/PTA: Models in Delivering Patient Care.
<http://www.apta.org/SupervisionTeamwork/ModelsInDeliveringPatientCare/> Accessed August 17, 2018.

PTA modifier, indicating a blended rate should be applied. For example, if the full fee schedule amount of the selected code is \$100, it would be calculated as 100% of \$50 and 85% of \$50, equating to a blended rate of \$92.50. Such calculation acknowledges that the service was not wholly furnished by either the physical therapist or the PTA. Adopting a blended rate policy would help to ensure that Medicare reimbursement accounts for the involvement of the physical therapist while also complying with the statute that mandates services furnished in part by the PTA to be reimbursed at the lower rate.

8-Minute Rule

APTA also recommends that CMS consider aligning the therapy assistant modifier policy with the 8-minute rule for time-based codes. CMS has stated that it has engaged in a number of efforts to streamline and align a wide variety of Medicare and Medicaid regulations, policies, and operations, the agency's goal being to more effectively bring together the Medicare and Medicaid programs. As such, it is appropriate to attempt align the new therapy assistant modifier policy with the 8-minute rule.

The Medicare Claims Processing Manual, Chapter 5, Section 20.2(C) states that when only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes, through and including 37 minutes, then 2 units should be billed.”⁸

Given that CMS has acknowledged that a service performed for less than 8 minutes should not be billed, if an assistant delivers 7 or fewer minutes of a service that is therapeutic in nature, the new therapy assistant modifier should not be applied. “Aligning” the 8-minute rule with the therapy assistant modifier policy would help to minimize the overall impact of the financial “penalty” on the physical therapist when using a PTA to assist him or her in delivering care. Consequently, this also could help to ease the expected effect of the payment differential on current and future PTA employment, which in turn may constrain the potential limitations on beneficiaries’ accessibility to physical therapy. Given that CMS has prohibited billing for amounts less than 8 minutes, it would be illogical to define a “part” of a service as anything less than 8 minutes.

Provide Billing Clarification When the Physical Therapist and PTA Jointly Provide Services Throughout the Treatment Session

Reducing reimbursement for services when both the physical therapist and PTA are working collaboratively in a team-based manner is counter to the health care system's shift toward rewarding value over volume. Value-based payment models highlight the importance of a team approach to improve the health of individuals and populations as well as the quality and efficiency of health care delivery.

APTA seeks clarification from CMS regarding its billing expectations when a physical therapist and PTA jointly furnish services to a patient at the same time, to the same patient. In many

⁸ Medicare Claims Processing Manual, Chapter 5. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf> Accessed July 25, 2018.

instances, the physical therapist is directly involved in delivering treatment to the patient but is working alongside the PTA, relying on the assistant to support him or her in furnishing the service. Pursuant to CMS guidance, “CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same patient(s). Where a physical and occupational therapist both provide services to one patient at the same time, only one therapist can bill for the entire service or the PT and OT can divide the service units. For example, a PT and an OT work together for 30 minutes with one patient on transfer activities. The PT and OT could each bill one unit of 97530. Alternatively, the 2 units of 97530 could be billed by either the PT or the OT, but not both. Similarly, if two therapy assistants provide services to the same patient at the same time, only the service of one therapy assistant can be billed by the supervising therapist, or the service units can be split between the two therapy assistants and billed by the supervising therapist(s).”⁹

CMS’s team therapy policy indicates that when services are being furnished at the same time to the same patient by a therapist and that of another therapist or therapist assistant, only one therapist can bill for such services. Accordingly, when the physical therapist is actively and directly involved in the provision of services, in conjunction with the PTA, who may be furnishing the same or different services at the same time, to the same patient, the GP modifier should be affixed to the claim.

Team-based care is defined by the National Academy of Medicine as “...the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care.”¹⁰ Team-based care is widely recognized as a more valuable way to deliver health services. Patients being treated by a physical therapist and PTA at the same time are receiving better value than had they been treated alone. In the real world, the interaction of the physical therapist and PTA involves a collaborative effort to achieve the best patient outcomes. Therefore, the reimbursement should not be diminished when value is increased. In an effort to formalize the therapy assistant modifier policy in a manner that supports a value-based payment system, APTA strongly encourages CMS to adopt and formalize this recommendation in future rulemaking.

Allow for Reporting of Modifiers on Different Line Items on Claim

Additionally, we strongly recommend that CMS permit time-based codes to be billed on separate lines when a physical therapist and PTA are able to differentiate the amount of time/units delivered by each provider on the same day for the same beneficiary, thereby allowing the same code to be listed on 2 separate line items on the claim, one with the physical therapist modifier and one with the PTA modifier. For example, a physical therapist delivers 30 minutes (2 units) of manual therapy (97140), and a PTA delivers 15 minutes (1 unit) of manual therapy under the supervision of the physical therapist. In such example, CMS would permit 2 units of 97140

⁹ CMS 11 Part B Billing Scenarios.

https://www.cms.gov/Medicare/Billing/TherapyServices/Downloads/11_Part_B_Billing_Scenarios_for_PT_and_OTs.pdf Accessed August 18, 2018.

¹⁰ Creating Patient-centered Team-Based Primary Care. AHRQ. <https://pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care#ref1> Accessed August 18, 2018.

affixed with the GP modifier to be on line item 1 of the claim and 1 unit of 97140 affixed with the new PTA modifier on line item 2 of the claim. We urge CMS to clarify that affixing the 2 different types of modifiers to the claim to differentiate the delivery of services is permitted under the finalized policy.

Consider the Proposed Policy's Impact on Provider Burden

Providers are constantly faced with modifier reporting challenges, given the numerous updates to the National Correct Coding Initiative (NCCI) and CPT manuals, new CMS guidance, and recent regulatory updates. With the implementation of the therapy assistant modifier policy, providers will be forced to familiarize themselves with when and how to report another new modifier, creating an inordinate amount of burden on providers. The proposed policy would force providers to develop a system to accurately track each minute of a PTA's day, an activity that seems contrary to CMS's Patients over Paperwork initiative, the internal process established by the agency to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience. The policy as proposed would only impose additional regulatory obstacles "that get in the way of providers spending time with patients."¹¹ APTA strongly encourages CMS to consider the impending burden of the proposed policy on therapy professionals and how the policy fails to effectively align with the goal of delivering high-quality, value-based care within a patient-centered health care delivery system.

Exempt Rural, Medically Underserved, and Health Professional Shortage Areas

When Congress acts, it does not intend to directly address all ancillary issues stemming from the action.¹² Given the late nature by which the PTA and OTA modifier and payment differential policy was included in the BBA, without soliciting input from provider and patient advocacy groups, we believe Congress did not fully consider the implications of this policy on patient access, particularly in rural areas, health professional shortage areas (HPSAs), and medically underserved areas (MUAs).

APTA has serious concerns that the reduction in Medicare reimbursement will harm access to outpatient physical therapy services across the nation, particularly in rural areas, HPSAs, and medically MUAs that may already have a shortage of physical therapy practitioners. Data collected by the Federation of State Boards of Physical Therapy show that in 2017, the total number of licensed physical therapists was 293,112, while the total number of licensed PTAs was 118,538.¹³ Many of the states that suffer from a shortage of physical therapists have a great need for PTAs; in these areas, PTAs often receive higher salaries than in other locations and other incentives to increase recruitment and retention, thereby ensuring beneficiary accessibility to medically necessary physical therapy services. Accordingly, we anticipate that the cut in reimbursement for outpatient therapy services furnished by PTAs will not only result in workforce shortages, as physical therapists are forced to reduce wages or eliminate assistant positions altogether, but also to further restrict access to care across settings, including private practice, home health, and skilled nursing facilities, as well as across whole communities.

¹¹ ¹¹ CMS Patients over Paperwork. <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/PatientsOverPaperwork.html> Accessed August 29, 2018.

¹² Statutory Interpretation: General Principles and Recent Trends. Congressional Research Service. <https://fas.org/sgp/crs/misc/97-589.pdf> Accessed August 16, 2018.

¹³ APTA Workforce Data. <http://www.apta.org/WorkforceData/> Accessed August 29, 2018.

Further reducing reimbursement for physical therapy services has significant implications for Medicare beneficiaries and ultimately would result in the loss of access to services they depend upon.

Therefore, we recommend that CMS exclude rural areas, MUAs, and HPSAs from the payment differential policy, unless and until CMS can ensure that beneficiary access in these areas will not be harmed. To that end, we also encourage CMS to monitor beneficiary access to outpatient therapy services in all regions, including both rural and urban areas, and continually evaluate whether modifications to the policy may be necessary to ensure appropriate access and care delivery.

Interaction Between Therapy Assistant Payment Differential and Other Medicare Payment Policies

APTA has serious concerns that reconciliation of the modifier and differential policy with other Medicare payment policies will create serious confusion among providers and patients. We seek clarification from CMS regarding how the 15% reimbursement cut will be impacted by other Medicare payment policies. For example, how will the Multiple Procedure Payment Reduction (MPPR) be applied; is the 15% reduced from the fee schedule amount prior or subsequent to application of MPPR? How will this policy impact calculation of the relative value unit (RVU)? We also request clarification on how the beneficiary coinsurance will be calculated if the service is wholly or partially furnished by the PTA, as well as how the proposed new modifier and differential policy will interact with the NCCI edits, sequestration, the KX modifier exceptions process permanently extended by BBA, and the 59 modifier, as well as any other applicable modifiers.

Consider the Impact on Commercial Payer Reimbursement

Physical therapists are currently subject to dwindling reimbursement from Medicare, MA, Medicaid, and other payers. Low reimbursement rates have a significant impact on budget and resource allocation, and they limit a provider's ability to repair or enhance equipment or invest in technologies that could improve patient outcomes. APTA has serious concerns that commercial payers, as well as Medicaid, will follow CMS's lead when it comes to applying the modifier policy. However, commercial payers' claims-processing systems are not equipped to process claims with modifiers. As such, being unable to differentiate between services furnished by physical therapists and PTAs, we anticipate that payers may institute an across-the-board cut to physical therapy services. Again, such actions in the future could prove extremely detrimental to the physical therapy profession. We urge CMS to be cognizant of this policy's widespread implications on the future of payment and take such considerations into account when finalizing this policy.

Finally, as initially stated, we encourage CMS to delay finalizing the definition of "in part." We recommend CMS continue to solicit input and engage in meaningful dialogue with stakeholders, including APTA, as it undertakes the task of defining "in part," to ensure implementation of the new payment differential policy imposes minimal disruption on patient access to physical and occupational therapy services.

FLR Requirements

CMS proposes to discontinue FLR requirements for services furnished on or after January 1, 2019.

APTA appreciates CMS's efforts to reduce the burden of unnecessary rules and requirements on Medicare providers. Physical therapists and other providers must be able to focus on delivering care to patients rather than on completing paperwork. We strongly support the discontinuation of FLR. As CMS is aware, the functional reporting requirements for outpatient therapy services are overly complex and burdensome. The elimination of FLR aligns with the goals of the Patients over Paperwork Initiative and promotes putting patients first. We strongly urge CMS to finalize this provision as proposed.

APTA also recommends that CMS eliminate, or at minimum, modify, the therapy plan of care 30-day initial certification and 90-day recertification requirements. Compliance with the physician signature requirement is a logistical and administrative burden on therapy providers, taking valuable time and resources away from delivering patient care. Although unintended, unsigned plans of care result in therapy providers having to delay treatment in order to obtain a physician signature, thus placing the beneficiary at risk and/or leaving the provider unable to bill for the services rendered. Moreover, in instances of delayed certifications, the therapist must then identify and compile evidence that is necessary to justify the delay, further increasing his or her administrative burden.

While the medical record may illustrate the medical necessity of therapy services, CMS will deny payment or seek recoupment if the plan of care is missing a signature, if the signature was not obtained within the required timeframe, or if the signature is of marginal or questionable legibility. Physical therapists and other therapy providers should not be held responsible and possibly subject to medical review due to a physician's inaction. The administrative burden of this regulation is untenable, and we strongly encourage CMS to eliminate the requirement for a plan of care signature. Alternatively, we request that CMS consider the plan of care "certified or re-certified" if the physician does not sign within 3-7 days of its receipt. Additionally, to ensure a more equitable approach toward conducting medical review of therapy claims, we recommend that CMS direct Medicare Administrative Contractors, Recovery Audit Contractors, and other contractors to make review of the signature on the plan of care a low priority for medical record reviews.

Physical Therapy Evaluation Codes

Effective January 1, 2017, CMS implemented new CPT code descriptors for physical therapy evaluations. The new code descriptors stratified physical therapy evaluations by complexity, creating 3 new evaluation codes and 1 new reevaluation code. Currently, the payment for the 3 evaluation codes is not stratified. As stated in previous comments, APTA recommended that CMS adopt stratified payment levels to align with the new stratified code descriptors. However, the agency expressed concerns that the coding stratification may result in upcoding incentives, especially as therapists became familiar with the new required components. CMS also expressed concerns that potentially higher payment will be an inherent incentive to upcode to a higher complexity level than was actually furnished.

In proposing and successfully defending the 3 level evaluation codes and revised reevaluation code in 2016, APTA demonstrated a good faith effort to work through the AMA process to better align coding with the direction that both CMS and private payers are heading in seeking additional information about patient condition. At the time of this revision, APTA successfully demonstrated through the RUC process that the clinical staff time for physical therapy evaluation (and reevaluation) services had changed since the previous AMA Practice Expense Advisory Committee (PEAC) review in 2001, due to several factors. These included new mandatory reporting requirements regarding performance, outcomes measurement, and quality reporting; a shift in the complexity of the patient population that was more diverse, accessing services earlier and living with more chronic comorbidities; and more use of technology in the administration and clinical practice of physical therapy that creates opportunity for additional types of treatment approaches. Through the RUC process, including the rigorous defense of the work values of these codes, all 3 levels of complexity were determined to have work relative value units (RVUs) of 1.20.¹⁴ The impact on the work values as described continues to support the work for both the physical therapist and other clinical staff in the evaluation and reevaluation of their patients.

APTA will continue to work to ensure coding accuracy under the stratified physical therapy evaluation coding structure. Our educational plan for physical therapists and stakeholders focuses on gaining an understanding of the evaluation codes and adequately documenting to support the clinician's choice of complexity level. Since 2017, APTA has released numerous educational resources to both members and nonmembers, including complimentary webinars, a podcast series, an interactive self-paced online course, a list of frequently asked questions, a train-the-trainer slide deck, and articles through APTA publications. The resources educate physical therapists about the new codes and enable them to practice codifying patient vignettes into the appropriate complexity levels. APTA also has dedicated web space and an interactive listserv for members to ask clarifying questions regarding the codes. Realizing that clinical decision-making represents the biggest challenge in terms of documentation, APTA will continue to focus on documentation educational efforts and other assistive resources to ensure that physical therapists thoroughly document what services were provided to the patient and why. Finally, as the agency is aware, APTA initiated its own payment research efforts in 2018 and would greatly appreciate the opportunity to share with the agency the information we collected.

QPP

MIPS-Eligible Clinician

CMS proposes to add physical therapists to MIPS as eligible professionals beginning in the 2021 payment year (corresponding to the 2019 data reporting year). APTA supports the inclusion of physical therapists in MIPS, as they provide care to a large number of Medicare beneficiaries under the Medicare Part B benefit—4.1 million beneficiaries in 2010,¹⁵ and act as integral members of the health care delivery team in outpatient settings. However, while APTA is

¹⁴ The work RVU for CPT codes 97161-97163 in CY 2018 is 1.20; the proposed work RVU for codes 97161-97163 in CY 2019 is 1.20.

¹⁵ CMS DOTPA 2010 Utilization Report.

<https://www.cms.gov/Medicare/Billing/TherapyServices/Downloads/2010-DOTPA-Utilization-Report.pdf> Accessed July 29, 2018.

pleased that CMS is affording several significant flexibilities to physical therapists and other newly included MIPS-eligible clinicians in their inception year(s) in the program, we have concerns that physical therapists will face challenges in their participation efforts, and we urge CMS to consider applying certain amnesties to our providers.

One unique challenge APTA anticipates is low participation in quality reporting due to the lack of formal inclusion in the MIPS program in the inception years. In 2015, of the 52,458 eligible physical therapists, 79.8% reported under the Physician Quality Reporting System (PQRS) program; this was 10% higher than the national average participation rate of 69.1% that year (per the 2015 PQRS experience report appendix). As APTA has stated in previous comments, we have appreciated the opportunity physical therapists have had to voluntarily participate in the MIPS program in the 2017 and 2018 performance years with no performance-based payment adjustments. While, based on anecdotal information, we know that many of our providers chose not to participate in the MIPS program in 2017, we have continued to encourage our members to stay involved in quality reporting through MIPS in order to use the 2017 and 2018 years to gain experience in reporting under QPP. We welcome the opportunity to work with CMS on member education to increase awareness of what physical therapists need to know to successfully participate as MIPS-eligible providers in 2019 for the 2021 payment year.

Facility-Based Billing Under Medicare Part B

As CMS is aware, historically, physical therapists in private practice participated in PQRS. However, a large number of physical therapists who work in facility-based settings and bill under Medicare Part B were unable to participate in the PQRS program, given their inability to independently bill in such settings. Excluding this large swath of facility-based providers from QPP would leave a significant number of providers outside of the evolving value-based payment systems. APTA encourages CMS to explore the possibility of adding these providers to MIPS in future years. Facility-based physical therapists could participate in MIPS under the group reporting option; however, due to current billing practices, we realize this may pose a challenge. One potential solution is to allow facility-based groups with rehabilitation providers to report in MIPS as a group using the revenue code to identify services.

Should CMS add facility-based physical therapists to the program in the future, we encourage the agency to consider allowing providers in facilities to report measures relevant to their respective settings, as do their physician colleagues. For example, physical therapists billing Part B in skilled nursing facilities (SNFs) may wish to report the same functional measures they report under the SNF Quality Reporting Program. This would enable CMS to begin to align the new Improving Medicare Post-Acute Care Transformation (IMPACT) Act measures with the MIPS program. APTA welcomes the opportunity to work with CMS to determine how to add facility-based providers to both MIPS and Advanced APMs in future years.

Physical and Occupational Therapy Specialty Measure Set

APTA supports the creation of the Physical and Occupational Therapy Specialty Measure Set. We are pleased to see the publication of this measure set in the proposed rule, which includes many of the previously PQRS-specific measures familiar to physical therapy providers. Physical therapists and occupational therapists have additional QPP measures that they are able to report that were not included on this list, and we encourage CMS to add 2 measures available to

physical therapists (#126 Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation; #127 Diabetic Foot and Ankle Care, Ulcer Prevention Evaluation of Footwear) and 3 measures available to occupational therapists (#134 Screening for Depression and Follow-Up Plan; #181 Elder Maltreatment Screen and Follow-Up Plan; #226 Tobacco Use: Screening and Cessation Intervention).

APTA requests that the agency denote that these measures are reportable by these specific professionals. Adding these measures to the specialty measure set will assist rehabilitation providers in identifying the best measures that fit their practice. Additionally, APTA intends to pursue inclusion of measures #134, #181, and #226 for future reporting years. APTA also has advocated for inclusion of other MIPS measures, such as MIPS measure #109 Osteoarthritis (OA): Function and Pain Assessment, to increase the size of our measure portfolio for 2020 and allow our providers as much flexibility as possible in choosing the measures they report in MIPS. We encourage CMS to allow us the flexibility to implement these changes to the measure set in 2019 and additional changes in 2020 as physical therapists move through their first reporting years in the MIPS program.

MIPS Low-Volume Threshold and Opt-in

CMS proposes to modify the low-volume threshold for the 2021 MIPS payment year and future years, in that eligible clinicians or groups who meet at least 1 of the following 3 criteria during the MIPS determination period would not exceed the low-volume threshold: (1) those who have allowed charges for covered professional services less than or equal to \$90,000; (2) those who provide covered professional services to 200 or fewer Part B-enrolled individuals; and (3) those who provide 200 or fewer covered professional services to Part B-enrolled individuals. Additionally, CMS proposes that beginning with the 2021 MIPS payment year, an eligible clinician or group that meets or exceeds at least 1, but not all, of the 3 low-volume threshold criteria may choose to opt into MIPS for a limited potential performance-based payment adjustment. (Eligible clinicians that do not meet even 1 of the low-volume criteria still could report voluntarily with no potential payment adjustment).

APTA supports the modifications to the low-volume threshold and the creation of an opt-in policy for the MIPS program. Using the 2016 CMS publically available provider data, we estimate that 96% of all physical therapists in private practice would have the ability to opt in by exceeding the professional services criteria, although we are unsure how the professional services are calculated in this data file. Therefore, APTA recommends that in calculating professional services for physical therapists, CMS include all services provided, including the number of units billed for that service. Our providers typically bill multiple units on any given date of service. For instance, if a physical therapist bills 3 units of CPT code 97110 and 1 unit of CPT code 97140 on 1 date of service, CMS should calculate 4 professional services on that date of service.

Given that 2019 will likely be the first year that physical therapists are required to participate in MIPS, it is unclear how many physical therapists will choose to opt in to MIPS. However, we are hopeful that our providers will take advantage of the flexibilities being afforded to them under the program. APTA encourages CMS to allow providers to opt in at the time of data submission, as this would create the least amount of burden on providers who wish to opt into the program.

MIPS Performance Category Measures and Activities

Collection Types, Submission Types, and Submitter Types

CMS previously proposed and finalized that beginning with performance periods occurring in 2019, individual MIPS-eligible clinicians and groups will be allowed to submit data on measures and activities, as applicable, via multiple data submission mechanisms for a single performance category (specifically, the quality, improvement activities, or advancing care information performance category). Under this proposal, eligible clinicians and groups that have fewer than the required number of measures and activities applicable and available under 1 submission mechanism could be required to submit data on additional measures and activities via 1 or more additional submission mechanisms, as necessary, provided that such measures and activities are applicable and available to them to receive the maximum number of points under a performance category.

APTA supports this policy; however we question the ability of our providers to take advantage of it in the first year of their participation, given the complexities associated with learning how to participate in the program. For this reason, and as discussed in more detail below, we request that CMS consider an alternative performance threshold for first-year MIPS participants.

CMS proposes to make the Medicare Part B claims collection type available to MIPS-eligible clinicians in small practices beginning with the 2021 MIPS payment year. The agency acknowledges that while this would limit the current availability of Medicare Part B claims measures for individual clinicians, it would expand the availability of such measures for groups, which currently do not have any claims-based reporting option.

APTA supports the decision to allow claims-based reporting for small practices. We appreciate that CMS wants to move away from claims as a collection type, but we encourage CMS to consider continuing to allow individuals to report using claims, as the agency has in previous years. Given physical therapists' previous experience in legacy reporting programs, including PQRS, we are aware that many providers who report as individuals favor this collection type.

Selection of MIPS Quality Measures for Eligible Clinicians and Groups Under the Annual List of Quality Measures Available for MIPS Assessment

Background and Policies for the Call for Measures and Measure Selection Process

CMS proposes to amend the definition of a high-priority measure to include quality measures that relate to opioids and to further clarify the types of outcome measures that are considered high priority. Beginning with the 2021 payment year, CMS proposes to define a high-priority measure to mean an outcome, appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure.

APTA supports CMS's proposal to include opioid-related quality measures within the definition of a high-priority measure. We encourage CMS to look beyond measures that focus strictly on opioid use to include patient-reported outcome measures that look at symptom management and pain interference (short forms already exist in the PROMIS database). These additional measures would provide important information about patient function in the presence of pain.

Topped-Out Measures

CMS proposes that once a measure has reached an extremely topped-out status (for example, a measure with an average mean performance within the 98th to 100th percentile range), the agency may propose the measure for removal in the next rulemaking cycle, regardless of whether or not it is in the midst of the topped-out measure lifecycle, due to the extremely high and unvarying performance for which meaningful distinctions and improvement in performance can no longer be made, after taking into account any other relevant factors.

APTA agrees that measures that perform at the 98th to 100th percentile range should be placed on the topped-out list. We disagree, however, with CMS's proposal to immediately remove these measures from the program, as providers need sufficient notification of impending measure removal. APTA recommends that extremely topped-out measures be placed on the topped-out list and monitored in the following year. Only if these measures remain extremely topped-out in the following year should they be removed from the program.

Additionally, CMS proposes to exclude QCDR measures from the topped-out timeline that was finalized in the CY 2018 QPP final rule. As such, when a QCDR measure reaches topped-out status, as determined during the QCDR measure approval process, it may not be approved as a QCDR measure for the applicable performance period. APTA supports this proposal.

Removal of Measures

CMS proposes, beginning with the 2019 performance period, to implement an approach to incrementally remove process measures where, prior to removal, considerations will be given to but not limited to:

- Whether the removal of the process measure impacts the number of measures available for a specific specialty.
- Whether the measure addresses a priority area highlighted in the [Measure Development Plan](#).
- Whether the measure promotes positive outcomes in patients.
- Considerations and evaluation of the measure's performance data.
- Whether the measure is designated as high priority or not.
- Whether the measure has reached a topped-out status within the 98th to 100th percentile range, due to the extremely high and unvarying performance for which meaningful distinctions and improvement in performance can no longer be made, as described in the proposal in the above topped-out measures section.

APTA recognizes the importance of moving to outcomes measures and meaningful process measures. However, many of the measures physical therapists report are process measures. It is unreasonable to propose to remove many of the measures used by physical therapists in their first years of MIPS participation for the following reasons: First, these are the measures physical therapists are most familiar with, having reported these measures in PQRS. Second, given the complexity of the MIPS program, including measures that are familiar to newly eligible clinicians, including physical therapists, is important to ensuring their success in the program. Third, the existing outcomes measures are not available for claims-based reporting and so their removal will disadvantage individuals and small practices submitting data via claims. Finally, it takes a significant amount of time to build APTA's measure repository and bring measures forward for formal inclusion in MIPS; the development of new measures will take more than a

year. As highlighted by APTA to CMS in previous comment letters, excluding physical therapists from MIPS in 2017 and 2018 has had unintended consequences; specifically, although APTA has maintained a QCDR in 2017 and 2018, physical therapists were not incentivized to collect data because they were not included in MIPS. Thus, participation in the registry was low. Therefore, to promote robust, successful participation of physical therapists in MIPS, APTA recommends that CMS not remove process or outcomes measures used by physical therapists until performance year 2021 (for payment year 2023).

Categorizing Measures by Value

CMS seeks comment on a system that would classify measures as a particular value level (gold, silver, or bronze) and award points based on the value of the measure. For example, higher-value measures would be considered “gold” standard and could include outcome measures, composite measures, or measures that address agency priorities (such as opioids). The CAHPS for MIPS survey, which collects patient experience data, may also be considered a high-value measure. Measures that are considered a “silver” standard would be process measures that are directly related to outcomes, have a good range in performance (there is no high, unwavering performance), and demonstrate room for improvement; or topped-out outcome measures. Lower-value measures, such as standard-of-care process measures or topped-out process measures would be considered “bronze” measures.

APTA supports the concept of valuing or weighting measures. Although physical therapists do not yet have experience with formally participating in MIPS, moving to a more streamlined system for the quality category that allows providers to select fewer, but more highly-valued, measures would reduce reporting burden as well as encourage the reporting of higher-value measures. APTA recommends that CMS consider listing measures in the provider specialty sets with that information as a means to decrease provider burden with the measure selection process.

Promoting Interoperability

Within the rule, CMS acknowledges the burden associated with development and deployment of new technology, but understands that requiring use of the most recent version of CEHRT is important in ensuring that health care providers will use technology that has improved interoperability. Beginning with CY 2019, MIPS-eligible clinicians must use EHR technology certified to the 2015 Edition certification criteria.

APTA supports this decision and appreciates the agency reweighting the category for our providers. It is important that our providers have CEHRT products available in the future, and we discuss in our comments below our suggestions for how CMS and ONC may assist us in the certification of physical therapist-specific products in future years.

Additional Considerations

CMS proposes to include physical therapists and other clinician types as MIPS-eligible clinicians beginning in 2019. CMS acknowledges there is little evidence whether there are sufficient measures applicable and available to these clinician types under the promoting interoperability performance category. Hence, CMS is assigning a weight of zero to this category if there are insufficient measures. However, CMS encourages newly eligible clinicians to report on these measures to the extent they are applicable and available. CMS notes it will use the first

performance period to further evaluate the participation of these clinicians in the promoting interoperability performance category.

APTA supports the reweighting of this category for physical therapists and other newly eligible clinicians. Currently, no physical therapy-specific EHR vendors have achieved appropriate certification. It is our goal to assist the industry, through our advocacy efforts, to move toward the adoption of more CEHRT products for our providers. However, given that several of the 2015 Edition certification criteria do not apply to physical therapists, it is unclear how APTA and physical therapy-specific EHR vendors can successfully move forward in obtaining CEHRT products. These issues are discussed in further detail below.

Redistributing Performance Category Weights

CMS proposes 2 alternatives for reweighting the 2 remaining performance categories, after removing the cost and promoting interoperability categories. In the first alternative the quality performance category would be weighted at 85% and the improvement activities category at 15%. The second alternative would weight the quality performance category at 70% and the improvement activities category at 30%.

APTA supports the 70% and 30% weighting, as it will better enable providers to earn points in the MIPS program. Weighting the quality category at 85% limits a provider's ability to maximize their performance in the improvement activities category. As CMS is aware, the collection of data is only one part of improving quality; without adequately measuring meaningful improvement in the delivery of care, the collection of data highlights issues with quality but does not encourage the use of strategies to engage in improvement activities.

Establishing Performance Threshold

CMS proposes a performance threshold of 30 points for the 2021 MIPS payment year, an increase from 15 points for the 2020 MIPS payment year. This would provide a gradual and incremental transition to the performance threshold the agency would establish for the 2024 MIPS payment year, which would be between 63.50 and 68.98 points.

APTA recommends that CMS lower the performance threshold to 25 points for the 2021 payment year. APTA has concerns regarding the use of legacy program data to establish this performance threshold. Additionally, we have concerns that providers will struggle to achieve 30 points in year 3 of the program, particularly physical therapists and other newly eligible clinicians, given that 2019 will be their first year in the program. Therefore, we strongly recommend that CMS implement a modified "pick your pace" for all nonphysician providers entering into the MIPS program in 2019 (Table 1). Any individual eligible clinician who meets the low-volume threshold and submits at least 1 measure on 1 patient should receive a neutral payment adjustment. Providers who submit on multiple measures would be indicating their desire to fully participate in MIPS, based upon the year 3 performance threshold, and their willingness to receive a downward, neutral, or positive payment adjustment.

Adding this program flexibility is more equitable and allows the new nonphysician providers a greater chance of success in their first year in the program, similar to what their physician colleagues were afforded in the 2017 MIPS performance year.

Table 1.

Provider Eligibility	Test	Partial Year	Full Year
2017 (MDs, etc.)	<ul style="list-style-type: none"> • Submit some data after January 1, 2017 • Neutral or small payment adjustment 	<ul style="list-style-type: none"> • Report for 90-day period after January 1, 2017 • Small positive payment adjustment 	<ul style="list-style-type: none"> • Fully participate starting January 1, 2017 • Modest positive payment adjustment
2019 (nonphysicians)	<ul style="list-style-type: none"> • Submit some data after January 1, 2019 • Neutral payment adjustment 		<ul style="list-style-type: none"> • Fully participate starting January 1, 2019 • Payment adjustment based on performance

Qualified Clinical Data Registry

Proposed Update to Definition of a QCDR

CMS proposes to amend the definition of a QCDR to state that the approved entity must have clinical expertise in medicine and quality measure development. As a part of the self-nomination process, CMS would look for entities that have quality improvement expertise and a clinical background. The agency would also follow up with the entity via, for example, email or teleconference, if it questions whether or not standards are met. Specifically, a QCDR would be defined as an entity with clinical expertise in medicine and in quality measurement development that collects medical or clinical data on behalf of a MIPS-eligible clinician for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.

APTA supports this change in definition. QCDRs should support quality improvement in clinical practice well beyond the reaches of quality-reporting programs such as MIPS. Our experience as a QCDR (via the [Physical Therapy Outcomes Registry](#)) has allowed us to become familiar with the depth of staff required to ensure that our registry incorporates the most recent evidence-based medicine to serve our physical therapists in their day-to-day practice. The combination of clinical and quality measurement expertise is essential to ensure that professional registries can be facile and evolve over time with practice. That same expertise is also required to create and maintain clinical practice guidelines and corresponding quality measures for the patient populations served by clinician specialties.

Application period

CMS proposes to update the self-nomination period from September 1–November 1 of the calendar year prior to the applicable performance period to July 1–September 1 of the year prior to the applicable performance period.

APTA recommends that CMS continue with the September 1–November 1 self-nomination period. Although we recognize that CMS needs time to review QCDR measures, registries also need time to prepare data to support measures in the application process following the Quarter 1 data submission period. Therefore, we encourage CMS to maintain the current self-nomination period.

QCDR Measure Requirements

CMS proposes to apply the following criteria beginning with the 2021 MIPS payment year when considering QCDR measures for possible inclusion in MIPS:

- Measures that are beyond the measure concept phase of development
- Preference given to measures that are outcome-based rather than clinical process measures
- Measures that address patient safety and adverse events
- Measures that identify appropriate use of diagnosis and therapeutics
- Measures that address the domain for care coordination
- Measures that address the domain for patient and caregiver experience
- Measures that address efficiency, cost and resource use
- Measures that address significant variation in performance

APTA supports these measures selection criteria and encourages CMS to have dialogue with QCDRs regarding the submission of measures.

QCDRs Seeking Permission from Another QCDR to Use an Existing, Approved QCDR Measure

CMS proposes that beginning with the 2021 MIPS payment year, as a condition of a QCDR measure's approval for purposes of MIPS, the QCDR measure owner would be required to agree to enter into a license agreement with CMS permitting any approved QCDR to submit data on the QCDR measure (without modification) for purposes of MIPS and each applicable MIPS payment year. CMS proposes that other QCDRs would be required to use the same CMS-assigned QCDR measure ID.

APTA opposes CMS's proposal to require the QCDR measure owner to enter into a license agreement with CMS permitting any approved QCDR to submit data on the QCDR measure for the purpose of MIPS. APTA appreciates that having multiple QCDRs report on the same QCDR measure allows CMS to collect a larger pool of measures, which statistically helps establish more reliable benchmarks and a wider performance range. However, this approach disregards the original intent of QCDRs, which is to submit data on non-MIPS measures focused on condition, procedure, or therapy-specific patient populations.

Medical specialty societies devote extensive resources to measure development, data collection, and data validation. The data collected through QCDRs are used not only for MIPS reporting, but also for research and analysis used to support guideline development and quality initiatives. Allowing CMS to permit any QCDR to report another QCDR's measures would place a significant strain on QCDR and medical specialty staff, as any data collected from an outside source would have to be subject to the same extensive quality review process prior to use for research.

Therefore, APTA recommends that CMS not finalize the requirement that QCDRs permit CMS to allow another QCDR to submit data on the first QCDR's measure. Should CMS finalize a revised QCDR definition as discussed above, this may limit the need for one QCDR to license another QCDR's measures, as each entity would have its own measure development expertise. The QCDR reporting mechanism allows QCDRs to develop their own quality measures for use

in the MIPS program; as such, QCDRs should not be required to license a measure from another QCDR in lieu of developing their own measure.

2018 Exclusion of MIPS-Eligible Clinicians Participating in the MA Qualifying Payment Arrangement Incentive (MAQI) Demonstration

The MAQI Demonstration is designed to test whether excluding MIPS-eligible clinicians who participate to a sufficient degree in certain payment arrangements with Medicare Advantage Organizations (MAOs) from the MIPS reporting requirements and payment adjustment will increase or maintain participation in payment arrangements similar to Advanced APMs with MAOs and change the manner in which clinicians deliver care.

APTA supports CMS's proposal to implement the MAQI demonstration beginning in 2018. At present, very few payment models qualify as Advanced APMs in which physical therapists may successfully participate. We are encouraged by the agency's efforts to improve the level of clinician participation in APMs. However, we continue to have concerns that the minimum use CEHRT threshold (50% in 2018) will bar many physical therapists from participation in the demonstration. As discussed in further detail below, physical therapists have been exempt from meaningful use [promoting interoperability] and have not been afforded the same resources as physicians and hospitals for health information technology adoption.

While the Office of the National Coordination of Health Information Technology (ONC) certification process has established standards and other criteria for structured data that EHRs must use, there is no standard certification criteria for EHRs for physical therapists. As such, only a limited number of EHRs certified through ONC encompass the necessary components for the documentation and transmission of information regarding physical therapy services. Therefore, it is unreasonable to presume that physical therapists and other providers excluded from meaningful use will be eligible to participate in the MAQI demonstration, in addition to Medicare Advanced APMs and Other Payer Advanced APMs.

To promote participation of nonphysician providers within the demonstration, including physical therapists, APTA strongly recommends that CMS modify the CEHRT criterion for the demonstration. For example, until CMS puts forth standard certification criteria for EHRs for physical therapists, the agency could impose a *voluntary* CEHRT threshold criterion for payment arrangements that include physical therapists and other providers excluded from meaningful use. In such instances, the payment arrangement would certify to CMS that the CEHRT threshold criterion could not be satisfied due to the lack of eligible clinicians with CEHRT. While it would be recommended that each APM Entity that includes physical therapists and other providers excluded from meaningful use attempt to satisfy the threshold, the APM Entity would not be disqualified from participation if it failed to satisfy the threshold.

CMS should afford flexibilities to physical therapists and other nonphysician providers to encourage their participation in the MAQI demonstration (in addition to other Advanced APMs). To ensure that CMS's demonstration adequately assesses whether MAQI changes the manner in which clinicians deliver care, it is critical that providers in the demonstration represent the entire care continuum. APTA also requests that CMS clarify within the final rulemaking the date by

which participating clinicians will be notified whether or not they meet the relevant threshold score during at least one of the date ranges (between January 1 through August 31).

Overview of the APM Incentive

As stated in previous comment letters, physical therapists are well-positioned to be rewarded based on the value of the care they provide to their patients. However, the existing Medicare APMs fail to promote collaboration with small and medium-sized physical therapy and other nonphysician practices, as these providers frequently are not viewed as foundational partners by larger providers, such as integrated health systems. Secretary Azar has expressed that HHS is committed to creating a “true competitive playing field” that rewards value. To achieve this objective, CMS must take into greater consideration the differences between physical therapists and other providers, and account for those differences as it pursues the development of new APMs. Otherwise, physical therapists will continue to be unable to meaningfully participate in Medicare APMs, despite their desire to do so, potentially impeding patient freedom of choice and access to the highest quality of care.

APM Criteria

Use of CEHRT

Within the rule, CMS proposes to specify that an Advanced APM must require at least 75% of eligible clinicians in each APM Entity to use CEHRT to document and communicate clinical care with patients and other health care professionals.

Integrated technology plays a vital role in a provider’s ability to function in a value-based care system. APTA recognizes that the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) mandates that Advanced APMs must require eligible clinicians to use CEHRT. However, physical therapists have been exempt from meaningful use [promoting interoperability] and have not been afforded the same resources as physicians and hospitals for health information technology adoption. Currently, physical therapists are essentially barred from participating in Advanced APMs due to the lack of physical therapy-specific CEHRT, placing physical therapists at a significant disadvantage and further hindering their ability to succeed in future value-based care models. To promote physical therapist participation in Advanced APMs, we recommend CMS consider, to the greatest extent possible, modifying the CEHRT requirement. To that end, we offer the following suggestions for CMS’s consideration:

Address Lack of EHR Standards for Physical Therapists

APTA recommends that CMS develop standardized certification criteria for EHRs for physical therapists and other nonphysician providers. To ensure inclusion of these providers within Advanced APMs, a sufficient number of certified EHRs must address rehabilitative care. Therefore, we urge CMS and ONC to work together, along with nonphysician stakeholders, to ensure a sufficient number of certified products that have this capability. Moreover, it would be beneficial if ONC and CMS could provide implementation assistance and/or consultant support to physical therapists and other nonphysician providers as they adopt certified EHRs.

Implement Temporary CEHRT Waiver

Additionally, as CMS moves to establish guidance for CEHRT for nonphysician providers, including physical therapists, we recommend that the agency temporarily allow APMs to “waive” the CEHRT threshold requirement for APM Entities that include physical therapists

while a policy for physical therapy-specific CEHRT is developed and implemented. In conjunction with the waiver and working within its statutory authority, we encourage CMS to allow physical therapists and other providers exempt from meaningful use to adopt a gradual phase-in of CEHRT. These providers should be afforded the same opportunities as physicians to gradually phase into adoption of certified EHRs to ensure their successful participation in APMs.

Modify the CEHRT Threshold for APMs That Include Physical Therapists

When assessing the impact of health IT and interoperability, a successful model cannot be implemented unless it addresses all providers, not just the interoperability between providers who were initially included in meaningful use, primarily physicians and hospitals. To promote the inclusion in Advanced APMs of physical therapists and other providers excluded from meaningful use, we recommend that CMS exempt Advanced APMs from the minimum use CEHRT threshold requirement. Rather, models should be deemed as satisfying the CEHRT criterion by requiring only those health care providers who were included in meaningful use to use CEHRT, whereas those providers not included in meaningful use would only have to show use of EHRs.

Modify the 2015 Edition Health IT Certification Criteria

APTA recommends that CMS modify the requirements of the 2015 Edition Health IT Certification Criteria for physical therapy EHR vendors. APTA has reviewed the CEHRT categories and has identified criteria that would not apply to physical therapist practice (Table 2).

Table 2.

CEHRT Category	CEHRT Criteria
Clinical Processes	<ul style="list-style-type: none"> • Computerized provider order entry (CPOE) medications • CPOE laboratory • Drug-drug, drug allergy interaction checks for CPOE • Drug-formulary and preferred drug list checks • Implantable device list
Care Coordination	<ul style="list-style-type: none"> • Electronic prescribing* (for medications)
Public Health	<ul style="list-style-type: none"> • Transmission to immunization registries • Transmission to public health agencies—syndromic surveillance • Transmission to public health agencies—reportable laboratory tests and values/results • Transmission to cancer registries • Transmission to public health agencies – electronic case reporting • Transmission to public health agencies – antimicrobial use and resistance reporting • Transmission to public health agencies – health care surveys

*Electronic prescribing may be utilized for referrals and DME

Additionally, several data elements are included in the Common Clinical Data Set that would not be relevant in typical physical therapist practice including: laboratory tests, laboratory values/results, immunizations, and unique device identifiers for a patient's implantable devices. To promote participation of providers across the care continuum within Advanced APMs, APTA strongly encourages CMS to modify the 2015 Edition Health IT Certification Criteria for physical therapy and other nonphysician EHR vendors. Much like with measure development and other initiatives undertaken by the agency, we also recommend that prior to finalizing the modified certification criteria CMS collaborate with a broad group of nonphysician stakeholders on the development and implementation of modified health IT certification criteria. CMS should obtain feedback from multi-stakeholder groups, public comment, and discussions with nonphysician EHR vendors.

Provide Assistance to Providers Excluded From Meaningful Use

It is critical that CMS offer assistance to physical therapists and other nonphysician providers, particularly small and rural providers, in the form of funding and technical support to assist them in preparing for and participating in Advanced APMs, as well as guidance on how to reduce administrative burden. As these providers are often the sole provider for a region and face serious financial concerns and a lack of funding, payment models must consider their unique situation or risk excluding swaths of the population from participation in Advanced APMs. We request that CMS provide appropriate resources and support, including implementation assistance and/or consultant support, to physical therapists and other nonphysician providers as they adopt certified EHRs, to better enable these practices to participate in these new models of care.

Other types of support CMS should offer include education on risk sharing, guidance on interdisciplinary collaboration and data sharing, education on required data elements, education on data analysis and iterative practice changes based on results, physician/referral source education on direct access to physical therapy for musculoskeletal conditions, and education on total cost of care and how to assess upstream and downstream costs impacts. CMS also should provide guidance and support to providers on interoperability. It also is important for CMS to continue to support the development and success of professional registries as we move toward outcomes-based payment and advanced quality-reporting structures that will rely heavily on electronic data submission. Development of these registries has been spurred by the need to create meaningful quality measures to assist providers in the shift to value-based payment and models of care. These registries will be critical to the success of innovative payment models in the future, as they have the ability to deliver real-time data to providers for monitoring, assessing, and responding to new and dynamic models of care delivery.

QCDRs, such as the Physical Therapy Outcomes Registry, capture relevant data from EHRs and billing information, and transform this data into meaningful, intuitive, and actionable feedback for providers on the frontline of patient care. New models of care will require physical therapists to have access to real-time data so they can successfully identify and modify care design to maximize patient outcomes. The use of real-time data also allows for better coordination throughout the continuum of care and can be used to break down traditional silos of care.

Therefore, we recommend that CMS provide financial support to small and rural physical therapy practices to facilitate their involvement in the Physical Therapy Outcomes Registry.

MIPS Comparable Quality Measures

As previously stated, rehabilitation services such as physical therapy are integral components of APMs. Unfortunately, many of the metrics that have been developed to assess progress are exclusive of nonphysician specialties, including physical therapy. Additionally, some metrics are not attributed to nonphysician specialties due the measure attribution methodologies; this includes cost metrics and metrics for readmissions at the provider level. Both team-based metrics and specialty-specific metrics are important to the delivery of high quality care. Without such metrics, future APMs developed by CMS will continue to fail to promote collaboration with small and medium-sized physical therapist and nonphysician provider practices.

To that end, to promote physical therapist participation in APMs, we recommend that CMS consider including the following list of measures within future APMs/Advanced APMs. (Table 3).

Table 3.

Process Measures (Current in MIPS Measure Set)	Outcomes Measures	Patient-Reported Outcome Measures (PROMs) using PROMIS
Fall screening risk assessment and plan of care to prevent future falls (claims; registry)	Functional status change for patients with knee, hip, shoulder elbow, foot, or ankle impairments using FOTO (Focus On Therapeutic Outcomes) (registry)	Pain interference
Preventive care and screening: BMI screening and follow-up plan (claims; registry)	Functional status change for patients with back impairments using modified low back pain questionnaire (registry)	Fatigue
Documentation of current medications in medical record (claims; registry)	Functional status change for patients with neck impairments using neck disability index (NDI) (registry)	Mobility (currently under development)
Pain assessment and follow-up (claims; registry)	Functional status change for patients with knee impairments using knee outcome survey (KOS) (registry)	
Percentage of episodes of care with 2 functional scores (underdevelopment - registry)	Functional status change for patients with lower extremity impairments using lower extremity functional score (LEFS) (registry)	
	Functional status change for patients with upper extremity	

	impairments using disabilities of the arm, shoulder and hand questionnaire (DASH) (registry)	
	Functional status change for patients with general impairments using modified PROMIS questionnaire (in development - registry)	
	Gait speed: Timed over a short distance (maximum 50 ft. or 15 m). Measured as a straight walk on a level indoor surface with no turns. Timed under same conditions (not yet developed)	

As CMS undertakes the development of new APMs, we urge the agency to ensure that a robust set of quality measures apply to APMs, to reduce any financial incentives to decrease utilization and to ensure that APMs meet the goals of the program. It is imperative that APMs include quantitative and qualitative metrics, including meaningful performance-based and patient-reported outcomes measures, by which CMS can ensure that coordinated, patient-specific, outcomes-based care is being delivered safely by properly qualified providers to patients. The variety of measures within the APM must include measures applicable to multiple types of clinicians, contribute to coordinated care, be correlated to positive health outcomes, and not impose an undue burden on providers. For example, we recommend that CMS incorporate into future models measures that monitor and track patient outcomes, provider performance, and changes in utilization of services. Including a robust set of quality measures within APMs will help to show the positive effects of nonphysician providers’ interventions on patient outcomes, thus incentivizing cross-collaboration.

We also recommend that to ensure that APMs are multidisciplinary, CMS require the inclusion of functional outcome measures that show the value of providers who have traditionally been excluded from APM participation. It is critical that new models include appropriate measures that address function and illustrate the value of each type of provider to the APM patient population.

Finally, APTA recommends that CMS examine the success of measures currently in existence and determine which measures could be standardized across providers and settings. For example, CMS currently works with QCDRs to collect and analyze outcomes measures being used by stakeholders. Given that QCDR measure developments are under way to ensure that duplicative measures are streamlined and standards are implemented across disciplines, CMS should encourage and support these existing measure development programs to identify commonalities and gaps in existing systems rather than create new programs to identify new measures.

QP and Partial QP Determinations

QP Performance Period

CMS proposes that for each of the 3 QP determinations, the agency will allow for claims run-out for 60 days before calculating the threshold scores, so that the 3 QP determinations will be completed approximately 3 months after the end of that determination time period.

APTA supports CMS's proposal to allow for claims run-out for 60 days before calculating the threshold scores. It is critical that clinicians are notified of their QP status as quickly as possible, while also allowing adequate time for claims to be processed. However, APTA continues to have concerns that the current methodology to make a QP determination makes it extremely difficult for our providers to ever satisfy either the Partial QP or QP threshold. Further, as the Partial QP and QP thresholds increase over time, it will become impossible for physical therapists, as well as other providers, to achieve Partial QP or QP status. Thus, without being able to meaningfully participate in any Medicare APMs and achieve either threshold, physical therapists will be forced to participate in MIPS, which seems contrary to the agency's efforts to move more providers into value-based payment models. We request that CMS discuss within final rulemaking whether there are any alternative QP methodologies for specialty providers that CMS is permitted to explore.

All-Payer Combination Option

Beginning in payment year 2021, in addition to the Medicare Option, eligible clinicians may become QPs through the Combination All-Payer and Medicare Payment Threshold Option, referred to as the All-Payer Combination Option. The All-Payer Combination Option does not replace or supersede the Medicare Option; instead, it allows eligible clinicians to become QPs by meeting the QP thresholds through a pair of calculations that assess a combination of both Medicare Part B-covered professional services furnished through Advanced APMs and services furnished through Other-Payer Advanced APMs.

APTA recommends that CMS afford greater consideration to the significant financial and administrative risk that physical therapists and other nonphysician providers face when joining 1 or more Advanced APMs. For example, a physical therapist who fails to meet the QP threshold may be required to report under MIPS and unwittingly face a downward adjustment for the payment year. Alternatively, a clinician who has chosen not to participate in MIPS and cannot satisfy the QP threshold to participate in an Advanced APM is left without a Part B payment update or incentive payment. Clinicians determined to be Partial QPs have agreed to take on significant risk when entering into agreements with APM Entities, fully expecting to satisfy the QP threshold, and are proactively working to improve patient care. Therefore, as CMS works towards finalizing APM policies in 2019 and beyond, we encourage the agency to bear in mind the risks facing physical therapists, and, consequently, their needs, which may differ from other providers.

Other-Payer Advanced APM Criteria

Increasing the CEHRT Use Criterion for Other-Payer Advanced APMs

CMS proposes that a payer or eligible clinician must provide documentation to CMS that CEHRT is used to document and communicate clinical care under the payment arrangement by at least 50% of eligible clinicians in 2019, and 75% of the eligible clinicians in 2020 and beyond, whether or not such CEHRT use is explicitly required under the terms of the payment

arrangement. Alternatively, the payer and eligible clinicians could meet the criterion by documenting CEHRT use among participating APM Entities.

APTA reiterates the comments and concerns outlined above regarding mandatory CEHRT use for physical therapists and other nonphysician providers excluded from meaningful use. We encourage CMS to consider our recommendations as it moves forward with finalizing the 2019 QPP rule. Moreover, as stated in previous comments, APTA urges the agency to require that payers participating in Other-Payer Advanced APMs provide clear and concise instructions to participants on compliance and quality-reporting requirements. CMS should mandate that all payers participating in APMs furnish APM Entities and eligible clinicians with timely information regarding their performance as eligible participants. With the advent of registries and other repositories for the collection of clinical data, it is imperative that providers receive critical information about the quality metrics of the APM and how their care is contributing toward meeting these metrics. Payer communication with APM Entities and eligible clinicians should also include timely notification of when and how the APM has determined that a participant is in noncompliance with the stated terms of their contractual agreement and/or MIPS requirements. This level of transparency is needed to ensure that participants are not susceptible to unfair business practices and that they are treated on a level playing field with the APM convener.

APTA also recommends that CMS require all payers participating in Advanced APMs to transmit information about beneficiary assignment, patient mix, condition, and diagnosis in a timely manner to APM Entities and eligible participants. Physical therapists and the settings in which they are employed often experience significant delays in receiving patient information. These delays severely hinder rehabilitation providers from making critical infrastructure and clinical adjustments to meet QPP quality metrics. Therefore, we recommend that CMS mandate that payers transmit applicable patient information to all APM entities and eligible clinicians within, for example, 2 weeks after receipt of such information from CMS.

Calculation of All-Payer Combination Option Threshold Scores and QP Determinations

QP Determinations Under the All-Payer Combination Option

CMS proposes to add a third alternative for QP determinations, allowing requests for QP determinations at the TIN level in instances where all clinicians who reassigned billing rights under the TIN participate in a single APM Entity. CMS would assess QP status at the most advantageous level for each eligible clinician.

APTA supports CMS's proposal to add a third alternative to allow requests for QP determinations at the TIN level in instances where all clinicians who reassigned billing rights under the TIN participate in a single APM Entity. We encourage the agency to finalize this third option within final rulemaking.

Use of Individual or APM Entity Group Information for Medicare Payment Amount and Patient Count Calculation Under the All-Payer Combination Option

Flexibility in the Medicare Option and All-Payer Combination Option Threshold Methods

CMS proposes to expressly allow eligible clinicians or APM Entities to meet the minimum Medicare threshold using the most favorable of either the payment amount or patient count

method, and then to meet the All-Payer Combination threshold using either the same method or the other method.

APTA supports CMS’s proposal to clarify that it allows eligible clinicians or APM Entities to meet the minimum Medicare and All-Payer Combination thresholds using the most favorable of the payment amount or patient count.

Appropriate Use Criteria Consultation for Advanced Diagnostic Imaging Services

CMS proposes that auxiliary personnel may perform the appropriate use criteria (AUC) consultation when under the direction of, and incident to, the ordering professional’s services. Due to this proposed change, CMS estimates that as many of 90% of practices would use auxiliary personnel to interact with the qualified clinical decisions support mechanisms for AUC consultation for advanced diagnostic imaging orders.

APTA recommends that CMS modify the regulations at 42 CFR §410.32 and include physical therapists within the list of personnel who may order diagnostic tests under Medicare. Imaging content is foundational in physical therapy education; it is included in doctor of physical therapy education programs and mandated by accreditation standards, allowing for basic competencies in imaging use and decision-making at entry-level practice.¹⁶ In the US military, physical therapists have had the authority to order diagnostic imaging since 1972. Physical therapists in the Public Health Service, Indian Health Service, Veterans Administration Health System, and Bureau of Prisons also have imaging privileges. Further, physical therapists also have been granted imaging privileges in the private sector.¹⁷

Allowing physical therapists to order diagnostic imaging “can be effective at reducing the number of extraneous images ordered while maintaining high levels of diagnostic accuracy.”¹⁸ Therefore, we strongly encourage CMS to formalize an acknowledgement within current regulations that physical therapists may order diagnostic imaging for Medicare beneficiaries where permitted by state practice act.

Price Transparency RFI

APTA appreciates the opportunity to provide information on the challenges faced by patients and providers regarding price transparency. The American health care system is complex, and, frequently, neither providers nor payers fully understand the cost of a service until after it is performed. APTA and its members recognize this is a concern and applaud CMS for taking initiative to begin to grapple with this problem.

¹⁶ APTA Orthopaedic Section. Diagnostic and Procedural Imaging in Physical Therapist Practice. https://www.orthopt.org/uploads/content_files/files/DxProcImagPhysTherPractice_FINAL.pdf Accessed August 27, 2018.

¹⁷ Physical Therapist Practice and the Role of Diagnostic Imaging. <https://www.jospt.org/doi/pdf/10.2519/jospt.2011.3556> Accessed August 27, 2018.

¹⁸ APTA Orthopaedic Section. Diagnostic and Procedural Imaging in Physical Therapist Practice. https://www.orthopt.org/uploads/content_files/files/DxProcImagPhysTherPractice_FINAL.pdf Accessed August 27, 2018.

State-Level Action

Before undertaking any price transparency initiatives, we recommend that CMS evaluate the impacts of similar policies currently being implemented in the states. There has been a recent wave of state legislation and rulemaking with regard to health care price transparency, and the benefits of many of these policies have yet to be assessed. At least 28 states have passed legislation related to health care price transparency or disclosure.¹⁹ Laws include those that require health care providers to provide patients with an estimate of the costs of treatment, that require hospitals to provide charge data to state regulators, and that create websites intended to educate consumers about average prices in their area. We recommend that CMS examine the relative successes of these models weighted against the burden they create upon providers.

Definition of Cost

If a specific price transparency initiative is undertaken, we caution CMS to carefully consider the definition of cost. Given the complexities of health care, the term “cost” is inherently misleading, as is evidenced by the fact that CMS is soliciting comments on how to define it. Providers charge different amounts to different payers, whether commercial insurers, Medicare, or Medicaid. Providers are rarely reimbursed at the rate they charge; moreover, the rate of reimbursement varies across payers. We also note that as the health care system begins to pivot toward accountable care and quality-based payment, standard charges will become even more misrepresentative of actual cost.

Additionally, neither charge nor reimbursement figures help consumers. Consumers need to know the amount of money they will have to pay out-of-pocket. Unfortunately, to determine this amount requires a provider to take into account a number of factors: deductible amount, amount already contributed to the deductible, copay amount, coinsurance amount (which cannot be calculated unless the charged amount plus network discount is considered), maximum out-of-pocket amounts, and finally any visit limits that might be imposed. On top of this, consumers have to consider if a provider or facility is in or out of network; they also must ensure that there are no ancillary providers participating in their care who may be out-of-network but practicing at an in-network facility. Providers alone cannot produce all of this information. Even when providing quotes on cost, clinicians must consult with payers to calculate an estimate.

Quality

We also note that even if a consumer were to obtain an accurate quote of their out-of-pocket costs, this would not reflect the quality of care they will receive. In most retail exchanges, consumers expect the quality of an item or service to be reflected in the price. However, because of the history of convoluted payment systems in health care, market forces have been unable to keep price tethered to outcomes. With the trend toward better aligning payment with quality, progress is being made to end this discrepancy. However, unless quality is incorporated into the price of services, consumers will not truly be able to make informed decisions about their care.

¹⁹ National Conference of State Legislatures, “Transparency and Disclosure of Health Costs and Provider Payments: State Actions.” <http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx> Accessed August 24, 2018.

We appreciate CMS’s work to fill the need for quality reporting. The Five-Star Quality Rating System is one of the best quality programs yet developed, although additional improvements are necessary. For instance, when CMS assigns a star rating to a facility, it rates the facility as a whole, without the ability to dive into ratings for specific treatments, procedures, diagnosis, or even sections of the hospital (e.g., pediatrics and oncology). Without the ability to differentiate between the services being sought, a consumer may choose an expensive, five-star hospital because they are seeking the best treatment available, when in fact the specific care they seek may have much poorer outcomes. Conversely, high-quality care for certain procedures may be available from facilities that do not perform well in other measures, deterring patients from selecting the facility.

In addition, while star ratings are fairly common for facilities, they are not as frequently available for outpatient providers, such as physical therapists in private practice. Outpatient care is where consumers have the most control over where and when to receive care, and therefore the setting for which they are most likely to seek information on cost and quality. Accordingly, there is a significant need for information on outpatient providers. Association- and specialty-specific registries can be utilized by CMS to help fill this gap. For example, CMS currently works with QCDRs, including the Physical Therapy Outcomes Registry administered by APTA, to collect and analyze outcomes measures being used by stakeholders. These registries offer granular provider and procedure-specific data that consumers may need to make informed decisions about their health care. Further investment into these registries will save CMS time and resources, as these registries are already producing meaningful data and can save the agency the effort of building outpatient registries from scratch.

However, we caution CMS to consider the downstream effects of quality-based payments and price transparency. Once value-based payments are implemented, better performing providers will be reimbursed at higher rates. This may then deter consumers from seeking this higher quality care.²⁰ Accordingly, we recommend that any price transparency measures incorporate both quality ratings as well as appropriate explanations of any value-based payments that may affect those prices.

Consumer Education

Given these complexities, we recommend that CMS devote additional resources to consumer education before imposing additional burdens on providers. Unless consumers know what questions to ask and to whom, there is a significant likelihood they will not find the answers they need. We suggest that any public information on price be accompanied by basic information on copayments, deductibles, network issues, and visit limitations that will alter any information a

²⁰ Herring, Bradley, Health Affairs, “An Unfortunate Inconsistency Between Value-Based Purchasing And Price Transparency”
https://www.healthaffairs.org/doi/10.1377/hblog20180817.858519/full/?utm_term=An+Unfortunate+Inconsistency+Between+Value-Based+Purchasing+And+Price+Transparency&utm_campaign=Health+Affairs+Today+Newsletter&utm_content=email&utm_source=Act-On_2018-08-21&utm_medium=email&cm_mmc=Act-On+Software-_-email-_-Value-Based+Purchasing+And+Price+Transparency%3B+State+Flexibility+Grants%3B+Coverage+For+Self-Employed+And+Others+Without+Employer+Offers-_-An+Unfortunate+Inconsistency+Between+Value-Based+Purchasing+And+Price+Transparency Accessed August 27, 2018.

consumer may receive. Unless the information given to consumers is accompanied by the appropriate explanations, CMS risks making the task of navigating the health care system more ambiguous than it currently is. Patients will over-rely on data, not taking into account their particular situation, and consequently be left with surprise financial responsibilities not initially anticipated.

Conclusion

APTA thanks CMS for the opportunity to provide comments on the CY 2019 Physician Fee Schedule Proposed Rule. We look forward to working with the agency in making revisions to the proposed policies in this rule prior to its finalization to ensure that Medicare beneficiaries have access to medically necessary physical therapy services in the outpatient setting. Should you have any questions regarding our comments, please contact Kara Gainer, director of regulatory affairs, at karagainer@apta.org or 703/706-8547, or Heather Smith, director of quality, at heathersmith@apta.org or 703/706-3140.

Thank you for your consideration.

Sincerely,

A handwritten signature in cursive script that reads "Sharon L. Dunn".

Sharon L. Dunn, PT, PhD
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy
President

SLD: krg, hls