

1111 North Fairfax Street
Alexandria, VA 22314-1488
703 684 2782
703 684 7343 fax
www.apta.org

September 6, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted Electronically

Re: File Code-CMS-1654-P; Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Proposed Rule

Dear Acting Administrator Slavitt:

On behalf of our 93,000 member physical therapists, physical therapist assistants, 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) proposed rule regarding “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017,” published in the July 15, 2016, *Federal Register*. APTA’s goal is to foster advancements in physical therapy practice, research, and education. The mission of APTA is to further the profession’s role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the physical health and functional abilities of members of the public.

The physician fee schedule is currently the basis of payment for outpatient therapy services furnished by therapists in private practice as well as outpatient therapy services furnished by hospitals, outpatient rehabilitation facilities, public health agencies, clinics, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities. Therefore, any changes to payments under the physician fee schedule for outpatient therapy services have a significant and direct effect on Medicare payments across the entire spectrum of the therapy delivery system.

APTA is committed to being a vested partner with the Department of Health and Human Services (HHS) as it moves swiftly toward its goal of shifting from Medicare payment based solely on fee for service to a value-based payment system. To that end, APTA has put significant resources into collecting data to aggregate and analyze the impact of physical therapy, as well as to overhaul the current coding structure. We wholeheartedly support the concepts presented in this proposed rule, such as initiatives to improve pricing and increase transparency, but we do have serious concerns about the manner in which these proposals are being carried out. Therefore, we strongly urge CMS to consider and adopt APTA's recommendations as articulated below.

Recommendations

- 1) APTA urges CMS to exercise its discretionary authority under §1115A of the Social Security Act to allow physical therapists to perform telehealth services while participating in alternative payment models such as the Medicare Shared Savings Program and the Comprehensive Care Joint Replacement Bundled Payment Model.
- 2) APTA strongly urges CMS to reverse its current proposal and adopt the original proposal submitted by the American Medical Association Relative Update Committee's Health Care Professionals Advisory Committee for the stratified payment level for physical therapy evaluations and reevaluation. In addition, we strongly urge the agency to delay the development of any payment adjustments as a result of analyzed claims data during CY 2017 after the implementation of the stratified code descriptors until a full analysis can be completed in partnership with APTA and other stakeholders.
- 3) APTA requests that CMS allow the requisite time for APTA to work through the AMA RUC process to survey and value the physical therapy codes identified on the potentially misvalued codes list, as we are committed to working through that process in an expeditious manner starting this fall. APTA would appreciate the opportunity to discuss our progress with CMS at the beginning of next year prior to the publication of the 2018 physician fee schedule proposed rule.
- 4) APTA supports the release of Medicare Advantage (MA) pricing and medical loss ratio data, and urges CMS to take the requisite additional steps to hold MA plans accountable for the implementation of appropriate payment policies.
- 5) If CMS decides to require MA providers and suppliers to be enrolled in Medicare in an approved status, then APTA would ask that CMS extend the timeline for implementation of this regulation. The proposed rule sets the effective date as the first day of the next plan year that begins 2 years from the publication of the CY 2017 physician fee schedule final rule with comment period. We recommend that CMS extend the implementation period another 2 years.
- 6) APTA supports the expansion of the Diabetes Prevention Program and urges CMS to clarify the critical role that physical therapists will play in this program, especially in home and community-based settings.
- 7) APTA strongly supports initiatives to improve the safety and quality of patient care, and is a vested partner with HHS in increasing participation in Medicare value-based payment models including alternative payment models and

- accountable care organizations (ACOs). APTA recommends that CMS consider adding measures that capture patient function to the ACO quality-reporting program in the future. We encourage CMS to work with relevant stakeholders to implement more measures of patient function into quality-reporting programs.
- 8) APTA urges the Secretary of HHS to exercise its given authority to add physical therapy as a nonqualifying designated health service that cannot be furnished to Medicare patients under the in-office ancillary services exception of the physician self-referral laws.

Our comments on each of these recommendations are discussed in further detail in the following paragraphs.

Medicare Telehealth Services

In 2015, CMS received a request to add the following services as Medicare telehealth services for calendar year 2017: Physical and Occupational Therapy and Speech-Language Pathology Services CPT codes 95207-08, 92521-24, 92526, 92610, 97001-04, 97110, 97112, 97116, 97532, 97533, 97535, 97537, 97542, 97550, 97555, and 97660-02. CMS has decided not to add these codes as Medicare telehealth services. CMS states that physical therapists are not authorized practitioners of telehealth services as defined by statute. Therefore, CMS rejects the requester's contention that the agency can add practitioner types to the definition without legislation.

APTA appreciates this clarification of the agency's statutory authority under §1834(m) of the Social Security Act. APTA strongly believes that allowing providers such as physical therapists to provide telehealth services under Medicare will help reduce health care expenditures, increase access to care, and improve a provider's ability to manage chronic disease in rural and underserved areas. As telehealth technology continues to improve, it is essential that physical therapists are afforded the appropriate legal and regulatory opportunities to treat patients cost effectively while preserving high standards of care. To that end, APTA has been steadfast in our advocacy efforts for the passage of the Medicare Telehealth Parity Act (H.R. 2948), introduced by Reps Thompson (D-CA) and Harper (R-MS), which would add physical therapists and several other therapy provider groups to the list of authorized telehealth providers under Medicare.

APTA will continue to work with Congress to secure the appropriate statutory language, but in the interim we urge CMS to exercise its discretionary authority under §1115A of the Social Security Act to allow physical therapists to perform telehealth services while participating in alternative payment models such as the Medicare Shared Savings Program (MSSP) and the Comprehensive Care Joint Replacement Bundled Payment Model (CJR).

Valuation of Specific Codes (Physical Therapy Evaluation and Reevaluation)

In the proposed rule, CMS adopts new CPT code descriptors for physical therapy evaluations and reevaluation created by the CPT Code Editorial Panel, effective January

1, 2017. The new code descriptors stratify physical therapy evaluations by complexity, creating 3 new evaluation codes and 1 new reevaluation code. CMS proposes to price the new therapy evaluation codes as a group rather than individually as recommended by the American Medical Association Relative Update Committee (AMA RUC). Therefore, CMS proposes to retain the longstanding relative value unit (RVU) of 1.20 for the new group of therapy evaluation codes. Additionally, CMS proposes an RVU of .60 for the new reevaluation code, again retaining the same value as the former reevaluation code.

The agency states that it is concerned that the coding stratification may result in upcoding incentives, especially as therapists still are becoming familiar with the new required components. CMS is especially concerned that potentially higher payment will be an inherent incentive to upcode to a higher complexity level than was actually furnished.

APTA would like to express our deep disappointment that CMS has failed to adopt the proposal of the Health Care Professionals Advisory Committee (HCPAC) in its entirety, and we strongly urge the agency to reconsider adoption of the stratified payment levels in addition to the stratified code descriptors. The new physical therapy evaluation codes essentially split the current physical therapy evaluation code (97001) into 3 levels: low-complexity (97X61), moderate-complexity (97X62), and high-complexity (97X63). As articulated in the proposed rule, we assert that prospective utilization for the 3 levels will break down as follows: 25% utilization for the low-complexity evaluation code, 50% for the moderate-complexity evaluation code, and 25% for the high-complexity evaluation code.

When APTA developed our recommendations for the AMA RUC, we solicited input from the physical therapy community, including providers in skilled nursing facilities, hospital outpatient settings, and independent physical therapy practices. According to our expert physical therapists, the work and practice expense values submitted reflect typical physical therapist practice today. We maintain that the minutes presented and accepted by the AMA RUC represent typical practice.

Therefore, we believe the adoption of the new values of: .75 for the PT Low Complexity Evaluation, 1.18 for the PT Medium Complexity Evaluation, 1.50 for the High Complexity Evaluation, and .75 for the PT Reevaluation are wholly appropriate and should be adopted in the final rule. There is a CMS precedent to allow stakeholders the opportunity of implementing the proposals as approved and vetted by the AMA RUC HCPAC, and then apply the appropriate payment adjustments if it has been determined that the value construct is not adequate to meet CMS budget neutrality requirements.

APTA is dismayed that CMS is not allowing the new stratified physical therapy evaluation and reevaluation codes that longstanding opportunity and believes that accepting one part of the AMA recommendation while ignoring the other is detrimental to patient care. APTA worked in good faith 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. As such, in late July APTA requested that AMA delay publication of the new evaluation and reevaluation codes. APTA felt a delay

was necessary to allow additional time for education of physical therapists given CMS' proposal in Physician Fee Schedule proposed rule. Due to impending printing of the 2017 AMA manual the request could not be considered. Nevertheless, if a viable option exists to delay implementation of the new codes for CY 2017 that does not disrupt patient care, APTA would like to discuss this with CMS.

As articulated in our compelling evidence presented to the AMA RUC, APTA believes the clinical staff time for physical therapy evaluation and reevaluation services has changed since the previous AMA Practice Expense Advisory Committee (PEAC) review in 2001, due to the types of patients that are being seen, earlier access to physical therapy services, use of technology, and an increase in documentation requirements.

In addition, the PEAC review in 2001 was related to the physical therapist work; however, the physical therapist work has not been reviewed since 1997, and the work related to physical therapy evaluation and reevaluation has increased. Reasons for this include new mandatory requirements regarding performance, outcomes measurement, and quality reporting; a patient population that is diverse, living with more chronic comorbidities, and accessing services earlier; and technology that is creating opportunity for additional types of treatment approaches. Moreover, there are increased documentation requirements, reflecting the emphasis on quality of care and outcomes-focused management with increased accountability. This has increased the work for both the physical therapist and clinical staff.

The emphasis of Medicare and other insurers on medical necessity has continued to grow. Similar to increased documentation required for E/M office visit services, the documentation for physical therapy evaluation and reevaluation services has increased. The 2015 Medicare Benefit Policy Manual, Chapter 15, delineates the documentation that is a necessary part of a physical therapy evaluation or reevaluation (please see attached excerpt from Section 220.3 of the manual).

These extensive documentation requirements were implemented in 2005 and subsequently amended in 2008 (after the 1997 HCPAC review and after the 2001 PEAC review of 97001 and 97002 codes). Specific policy related to documentation of functional status, reporting treating diagnosis, contents of the plan of care, certification of the plan of care, progress reports, treatment notes, and discharge summaries are detailed in this chapter of the Medicare Benefit Policy Manual. The functional reporting requirement, a result of The Middle Class Tax Relief and Job Creation Act of 2012, included a mandate for the collection and reporting on claim forms of information regarding the beneficiary's function and condition, therapy services furnished, and outcomes achieved. The goal was to use the data in the future to reform payment policies. The functional limitation reporting program implemented on July 1, 2013, requires therapists to capture data on the patient's functional limitations at the outset of the therapy episode (i.e., as part of the evaluation), specified points during the episode, and at discharge on the patient's functional status and projected goal. This reporting must be performed in conjunction with a patient visit and documented by the physical therapist with the assistance of clinical staff.

The complexity of data to be evaluated has increased over the past several years, requiring increased integration of much more information than when 97001 and 97002 were last reviewed. During this time the publication of clinical guidelines related to physical therapy evaluation and intervention has exponentially increased, with new and updated documents being published at least annually. These changes have increased the clinical staff work.

In this post-ACA¹ era, patients expect timely access to their health information. Physical therapists and their clinical staff, like other health care providers, need to be responsive in their practices and communications with their patients. More-informed patients and their families are and should be actively involved in decision-making about their care, and they are much more prepared when choosing health care providers. This not only brings a more-informed person to therapy but also creates a need for physical therapists to be aware of the potential for care and for resources related to care. A much higher level of expectation is placed on the therapists and their clinical staff. As a result, the physical therapy evaluation today requires more time in both the preparation and the execution of its key elements. To meet the challenges and responsibilities of being a practitioner today (versus 18 years ago), not only must the physical therapist be able to effectively examine the patient, evaluate the findings, and communicate to multiple parties (patient, caregiver, and payer) the best plan for managing the patient's complaints, functional impairments, access to resources, and return to function; the therapist also must report the projected and actual outcomes to the patient, caregiver, payer, and other involved health care providers downstream. As the therapist's work increases, so does the clinical staff's.

Speaking to the complexity issue and how patients have changed in presenting for their physical therapy care, the CDC in 1994 reported that almost all states had prevalence of obesity less than 18%. In 2000, only 13 states had a prevalence of less than 18%, and 11 states exceeded 22%. In 2013, no state had a prevalence of less than 18%; almost all states exceeded 22%, and 38 of these states exceeded 26%. Nationally, in 2013 more than one-third of the US population was overweight, and 28% was labeled obese. These alarming statistics point to a host of other concerns about obesity-related comorbidities such as type 2 diabetes, COPD, hypertension, heart failure, and joint and spine degeneration. These comorbidities require more time and physical effort during therapy evaluation and reevaluation.

Finally, disability goes hand-in-hand with the demographics of our aging population. In 2010, more than two-thirds of Medicare beneficiaries had 2 or more chronic conditions, such as hypertension, heart disease, arthritis, diabetes, heart failure, chronic kidney disease, and depression. According to census data, 98.2% of all people in their 90s who lived in a nursing home had a disability and/or condition that prevented them from taking care of themselves, and 80.8% of people in their 90s who did not live in a nursing home also had 1 or more disabilities. Overall, the proportion of people aged 90-94 with disabilities is more than 13% higher than that of the 85- 89-year-old age group. These older patients present a special challenge, because in addition to physical disabilities they also often have concurrent cognitive decline, polypharmacy, and complex psychosocial

¹ The Patient Protection and Affordable Care Act of 2010

issues, all of which take additional effort and time in physical therapy evaluation and treatment.

Therefore, APTA strongly urges CMS to reverse its current proposal and adopt the original proposal submitted by the AMA RUC HCPAC.

To ensure coding accuracy under the stratified physical therapy evaluation coding structure, APTA has established an educational plan for physical therapists and its stakeholders that will address, first, understanding the new evaluation codes and complexity levels; and, second, adequately documenting to support the clinician's choice of complexity level. Successful implementation of the educational plan will require commitment and broad participation by all stakeholders involved. Following the release of the AMA CPT language in September, APTA is releasing numerous educational resources to both members and nonmembers. Educational resources will include complimentary webinars, an interactive self-paced online course, a list of frequently asked questions, a train-the-trainer slide deck, documentation resources, and articles through APTA publications.

The resources will educate physical therapists about the new codes and enable them to practice codifying patient vignettes into the appropriate complexity levels. APTA has dedicated web space and an interactive list serve for members to ask clarifying questions regarding the codes. Realizing clinical decision-making represents the biggest challenge in terms of documentation, APTA will focus on documentation educational efforts and other assistive resources to ensure physical therapists thoroughly document what services were provided to the patient and why.

CMS specifically requests more information on how the physical therapist differentiates the number of personal factors that affect the plan of care. In addition, CMS is interested in understanding more about how the physical therapist selects the number of elements from any of the body structures and functions, activity limitations, and/or participation restrictions to make sure there is no duplication during the physical therapist's examination of body systems.

Personal factors, include gender, age, coping styles, social background, education, profession, past and current experience, overall behavior pattern, character and other factors that influence how disability is experienced by the individual. The physical therapist takes a patient's history—which for physical therapy is a systematic gathering of both past and present data—related to why the individual is seeking the services of the physical therapist. Among other data, these include demographic information, social history, employment and work history, growth and development, living environment, general health status, social and health habits (past and current), family history, medical and surgical history, current conditions or chief complaints, functional status and activity level, medications, and other clinical tests. While taking the history, the physical therapist also identifies health restoration and prevention needs and coexisting health problems that may have implications for intervention. This history typically is obtained by gathering data from the individual, family, significant others, caregivers, and other

interested parties (e.g., rehabilitation counselor, teacher, workers' compensation case manager, and employer); through consultation with other members of the health care team; and through review of the individual's record.

Data from the history provide the initial information that the physical therapist uses to determine the existence and origin of impairments in body functions and structures, activity limitations, and participation restrictions that are commonly related to medical conditions, sociodemographic factors, or personal characteristics.

Regarding body functions, physical therapists use tests and measures to gather data about the individual, to pinpoint causes of impairment in body structures and functions, activity limitations, and participation restrictions.

The tests and measures are performed as part of an initial examination to (1) confirm or reject a hypothesis about the factors that contribute to making the individual's current level of function less than optimal, and (2) support the physical therapist's clinical judgments about the diagnosis, prognosis, and plan of care. Before, during, and after administering the tests and measures, the physical therapist gauges responses, assesses physical status, and obtains a more specific understanding of the individual's condition and the diagnostic and therapeutic requirements.

As the examination progresses, the physical therapist may identify additional problems that were not uncovered by the history and systems review, and may conclude that other specific tests and measures or portions of other specific tests and measures are required to obtain sufficient data to perform an evaluation, establish a diagnosis and a prognosis, and determine the plan of care.

CMS does propose to use the direct PE inputs forwarded by the HCPAC for the typical physical therapist evaluation and also for the typical occupational therapist evaluation in the development of PE RVUs for the PT and OT codes as a group of services. As such, CMS proposes to include the recommended 4 sheets of laser paper without an association to a specific equipment item, but seeks comment regarding the paper's use. As asserted by the AMA in the HCPAC comments, the 4 sheets of laser paper are for the printout of the evaluation overview, medical reports, and/or other documentation that therapists will use to review their evaluation findings with patients. In addition, medical records are sometimes printed and shared to justify medical necessity to payers, IPAs, or referring providers. Equipment item EQ219 rehab and testing system (BTE primus) includes a computer as part of the station, and other documents can be printed from that computer if needed.

Finally, at the point the codes are adopted by CMS, we strongly urge the agency to delay the development of any payment adjustments as a result of analyzed claims data during CY 2017 after the implementation of the stratified code descriptors. It is imperative that CMS work closely with APTA and other stakeholders to make payment decisions that are in the best interest of patient care. To fully derive the best data to make sound future payment policies, CMS must have a comprehensive picture of all of the factors facing the payment environment. Thus, it is critical that CMS work with APTA and other clinicians

as we all seek to ensure proper use and coding accuracy. APTA plans to initiate its own payment research efforts over the next year, and we look forward to sharing more information with the agency in CY 2018.

Potentially Misvalued Services under the Physician Fee Schedule

In the proposed rule, CMS has identified 10 physical therapy codes as part of its continued efforts to update payment accuracy through the potentially misvalued codes initiative. They are 97032 Electrical stimulation, 97035 Ultrasound therapy, 97110 Therapeutic exercises, 97112 Neuromuscular reeducation, 97113 Aquatic therapy/exercises, 97116 Gait training therapy, 97140 Manual therapy 1/regions, 97530 Therapeutic activities, 97535 Self-care management training, and G0283 Electrical stimulation other than wound. CMS acknowledges that APTA and other specialty societies are working on coding changes through the CPT process for these modality and procedures services and therefore requests input on valuation of the codes listed above.

APTA is committed to providing CMS the requisite information to appropriately value the above-referenced codes and will be working diligently over the next several months to do so. As CMS is aware, APTA, along with other stakeholders through an AMA-convened work group, made a concerted effort to refine the physical medicine and rehabilitation (PM&R) code family over the last few years in order to weave the complexity of the patient's condition into the PM&R codes and to reflect contemporary practice. Unfortunately, the PM&R work group was disbanded and instructed to go through the CPT process for any code changes. In April 2016, APTA, along with other stakeholders, presented an action plan to the AMA Relativity Assessment Workgroup regarding its intent to survey or submit CPT code changes of the PM&R code family. APTA will work with AMA and stakeholders in surveying the 10 physical therapy codes identified in the proposed rule.

APTA believes that the AMA RUC process affords the appropriate venue in which to survey and value the codes, and we are committed to working through that process expeditiously starting this fall. Also, we would appreciate the opportunity to discuss our progress with CMS at the beginning of next year prior to the publication of the 2018 fee schedule proposed rule.

Medicare Advantage Provider Enrollment

CMS seeks to increase fairness and transparency in Medicare Advantage (MA). Specifically, CMS proposes to require health care providers and suppliers to be screened and enrolled in traditional Medicare before they can contract with MA health plans in order to provide services to MA patients. In addition, CMS discusses plans to release MA pricing and medical loss ratio (MLR) information.

Overall, APTA supports CMS' efforts to increase transparency in the area of Medicare Advantage. These plans have for too long contravened Medicare policy and instituted payment policies that have greatly disserved Medicare beneficiaries. Among these flawed

policies has been the unreasonable copays levied among patients receiving physical therapy. **Therefore, we support the release of MA pricing and MLR data and urge CMS to take the requisite additional steps to hold MA plans accountable for such egregious behavior.**

Under current Medicare regulations, providers and suppliers who meet specific guidelines are able to enroll in the Medicare program if they are able to meet the proper screening and enrollment requirements. The proposed rule would require MA organization providers and suppliers to be enrolled in Medicare in an approved status. CMS considers approved status to be enrolled in, and not currently revoked from, the Medicare program. The underlying rationale for the proposed rule is to ensure that unqualified individuals and entities are not able to improperly bill the Medicare program, and that the Medicare Trust Funds are protected.

APTA supports CMS's goal of preventing fraud, waste, and abuse as well as protecting Medicare enrollees from unscrupulous providers and suppliers. That being said, APTA is also concerned that imposing unnecessarily restrictive standards of regulation will lead to upstanding physical therapists being unduly burdened. This in turn could lead to a critical lack of access to physical therapy services as Medicare Advantage plans struggle to find physical therapy providers to sign up for their networks. At this time, APTA does not believe there have been enough instances of fraud or malfeasance by providers and suppliers to justify the proposed Medicare Advantage provider enrollment provision.

If CMS decides to finalize this rule and require Medicare Advantage organization providers and suppliers to be enrolled in Medicare in an approved status, then APTA would ask that the timeline for implementation of this regulation be extended. The proposed rule is set to be effective the first day of the next plan year that begins 2 years from the publication of the CY 2017 physician fee schedule final rule with comment period. We recommend that CMS extend the implementation period another 2 years. Any regulation of this magnitude requires significant lead time to ensure that providers and suppliers are able to adequately prepare for and maintain compliance with the proposed regulation. We believe that 4 years would be an adequate time to prepare and would not hinder the operation of the Medicare program in any way.

Proposed Expansion of the Diabetes Prevention Program Model

CMS reaffirms the expansion of the Diabetes Prevention Program (DPP), the first-ever prevention model under the CMS Innovation Center, beginning in January 2018. DPP is a structured lifestyle intervention that includes dietary coaching, lifestyle intervention, and moderate physical activity, all with the goal of preventing the onset of diabetes in individuals who are prediabetic. CMS is asking for comment on a number of aspects of the program including the enrollment of providers and suppliers under the program, and eligibility requirements for beneficiaries.

CMS proposes to expand the duration and scope of the DPP model as the Medicare Diabetes

Prevention Program (MDPP) with an effective date of January 1, 2018. CMS proposes a basic framework for the MDPP and, if the program is finalized, plans to engage in additional rulemaking to establish the specific requirements of the MDPP.

APTA supports the expansion of this program on a national basis and recommends that CMS adopt the program as soon as possible. Physical activity, along with diet and medication, is a cornerstone of treatment for diabetes—and physical activity is a cornerstone for prevention of diabetes. After performing an evaluation, including a review of the individual’s medical history and medications, physical therapists can develop an individualized exercise program for people who are diabetic or prediabetic. Physical therapist-directed exercise counseling combined with fitness center-based exercise training results in high adherence and significant improvements in muscular strength and exercise capacity in people with type 2 diabetes, with outcomes comparable to those of supervised exercise training. Physical therapists make evidence-based choices of prescribing either exercise counseling combined with fitness center-based exercise training or supervised exercise training for people with type 2 diabetes. **Therefore, in the governing rules and regulations, we urge CMS to clarify the critical role that physical therapists will play in this program, especially in home and community-based settings.**

Medicare Shared Savings Program

CMS proposes changes to the Medicare Shared Savings Program (MSSP, or Medicare ACOs). Among the proposals are updates to the reporting of quality measures within the Medicare ACOs to align with the implementation of alternative payment models (APMs), a system to capture beneficiary preferences for provider assignment in the ACO, and other changes to protect beneficiaries’ access to services within the ACO. Specifically, CMS proposes to add the following measures regarding care coordination: ACO-12 Medication Reconciliation Post-Discharge (NQF #0097), ACO-44 Use of Imaging Studies for Low Back Pain (NQF #0052), and ACO-43 Ambulatory Sensitive Condition Acute Composite (AHRQ PQI #91).

APTA strongly supports initiatives to improve the safety and quality of patient care and is a vested partner with HHS in increasing participation in Medicare value-based payment models including APMs and ACOs. APTA supports the inclusion of the 3 new care coordination proposed measures to the ACO quality reporting program: ACO-12 Medication Reconciliation Post-Discharge (NQF #0097), ACO-44 Use of Imaging Studies for Low Back Pain (NQF #0052) and ACO-43 Ambulatory Sensitive Condition Acute Composite (AHRQ PQI #91). APTA supports the inclusion of these measures. However, APTA feels that the majority of the quality measures included in the ACO quality reporting program, although broad-based in coverage, continue to be physician-centric. We believe that in exploring APMs, CMS should take into account the importance of the entire multidisciplinary team that make safe, high-quality care possible. We have expressed concerns around the ability of physical therapists to be included in the ACO model, and these concerns are only fortified by the lack of quality measurement standards for ACO providers beyond the physician. We recommend that as

we move forward with the development of ACOs and other APMs, attention be given to creating or including all providers in quality measures where appropriate. One area of measurement that is relevant to our providers, as well as to patients, are quality measures that capture patient function.

APTA recommends that CMS consider adding measures that capture patient function to the ACO quality reporting program in the future. A patient's ability to function and participate in society is critical to obtaining positive outcomes. A growing percentage of the US population has disabling conditions that limit their ability to carry out the major activities of their age group. As the number of older adults increases, the vulnerability of that population to injury and limitations on their activities of daily living increases as well. This increased vulnerability and decreased function results in an escalation of the utilization of health care resources. A focus on ensuring that individuals remain independent and functioning members of society throughout their lives will lessen the burden on health care resources. For example, a physician may prescribe medication to a patient with a cardiac disease to manage his or her cholesterol and blood pressure, but if the patient is not active or participating in regular activities of daily living, he or she will become more dependent on medication and other costly medical treatments, and will require more health care resources. Measures of patient function are currently being implemented in the postacute care settings under the requirements of the IMPACT Act, and patient-reported outcome measures of function are a voluntary reporting requirement of the CJR model. **We encourage CMS to work with relevant stakeholders to implement more measures of patient function into quality reporting programs.**

Physician Self-Referral Updates

The proposed rule updates the physician self-referral statute to prohibit per-unit charges only where the physician-lessor obtains payment from the lessee through a referral of service provided in the rented space. We commend CMS for recognizing the need to better align the physician self-referral law to the practical misuses of physician-owned office space. We also commend CMS for appropriately applying the Secretary's broad authority to modify self-referral requirements to protect against program and patient abuse. We agree that further updates to the physician self-referral statute are necessary over time to ensure the law continues to be effective in discouraging referrals for profit.

With these same goals in mind, APTA strongly urges CMS to narrow the scope of the "in-office ancillary services" (IOAS) exception of the physician self-referral law by removing physical therapy from the exceptions list. Physical therapy does not meet the original purpose of the IOAS exception, because patients typically require multiple therapy visits, which cannot be completed in-office during the patient's visit with the physician. Further, physicians have misused this exception to hire physical therapists and bill therapy services to the physician's practice, rather than to the therapist. Further, the inclusion of physical therapy in the exceptions list does not further the law's original purpose, which was to ban profits through referrals altogether. In fact, physicians often profit from referrals for therapy services due to this exception.

We urge CMS to apply the same authority for its proposed modification to the physician self-referral law to remove physical therapy from the in-office ancillary services exception list. In its proposal to modify the physician self-referral law, CMS relies upon a 2015 circuit court opinion, *Council for Urological Interests v Burwell*, which discusses the Secretary's authority under the physician self-referral provisions to modify the law as necessary to prevent abuse. In this case, the court explained that "the statutory text of the exception clearly provides the Secretary with the discretion to impose any additional requirements that she deems necessary 'to protect against program or patient abuse.'" **We request that CMS modify the physician self-referral law under the authority granted to the Secretary by Congress to prevent abuse of the law's provisions and to uphold the original purpose of the law.**

The IOAS exception to the physician self-referral laws was intended to improve coordination of care and promote patient convenience by allowing physicians to self-refer for designated health services integral to their primary care that are furnished in their group practices. Unfortunately, the current use of this exception goes well beyond its original intent. This is evident in the Medicare Payment and Advisory Commission's (MedPAC) June 2010 report to Congress. MedPAC found that physical therapy services were provided on the same day as the initial appointment only 3% of the time, clearly illustrating that these are not services that are provided for a patient's convenience.

Abuse of the IOAS exception has been examined by the Government Accountability Office, the Office of the Inspector General of the US Department of Health and Human Services (HHS), and the *New England Journal of Medicine* (NEJM), among others. MedPAC also raised questions about abuse under the IOAS exception in the aforementioned June 2010 report, and CMS asked for feedback from stakeholders in its 2008 notice of proposed rulemaking. Both MedPAC and CMS found that the existing IOAS exception has substantially diluted the self-referral law and its policy objectives, allowing Medicare providers to avoid the law's prohibitions by structuring arrangements that meet the technical requirements for physical therapy services while violating the true intent of the exception. Based on the NEJM study and the government reports, abuse of the IOAS exception has also led to overutilization of several services. For these reasons, APTA strongly urges Congress to remove physical therapy as a designated health service (DHS) permissible under the IOAS exception to the federal physician self-referral laws.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required HHS to submit a report to Congress in April 2016. This report, which has yet to be released, should contain "... options for amending existing fraud and abuse laws in, and regulations related to, titles XI and XVIII of the Social Security Act (42 U.S.S 301 et seq.), through exceptions, safe harbors, or other narrowly targeted provisions, to permit gainsharing arrangements that otherwise would be subject to civil money penalties ... or similar arrangements between physicians and hospitals, and that improve care while reducing waste and increasing efficiency." (Pub. L. 114-10 §512.) We believe that closing the IOAS exception loophole would surely fall under this mandate. Since Medicare fee for service is still in place, it should remain a priority to close the loophole by removing physical therapy, advanced diagnostic imaging, anatomic pathology, and

radiation oncology as designated health services, which will eliminate unnecessary care for patients and stop abuse. Furthermore, we believe the promulgation of laws to end the unintended abuses under the IOAS exception are essential to the success of alternative payment models such as accountable care organizations and bundled payment.

APTA asserts that care furnished under the IOAS exception is often degraded, raising serious quality concerns. There is evidence that, actually, beneficiaries may receive higher-quality care—and therefore better outcomes—when self-referral is not involved. A recent study on low back pain episodes of care, published in the July 2015 issue of the *Forum for Health Economics and Policies* by Jean Mitchell, PhD, of Georgetown University, found that non-self-referred episodes of care were far more likely to provide “active,” or hands-on, services than self-referral episodes—52% compared with 36%. This, according to the study’s authors, suggests the care delivered by physical therapists in non-self-referred episodes is more tailored to promote patient independence and a return to performing routine activities without pain. It is important to note that “passive” treatments, which are more likely found in self-referring episodes, can be performed by a person who is not a licensed physical therapist. The authors of this paper also cite evidence that these passive physical therapy modalities are “ineffective” in treating low back pain.

Of note, the study highlights the difference in overall expenditures for episodes of care provided by self-referring vs non-self-referring physicians. The study examines the total insurer-allowed amounts for low back pain episodes of care and parses out expenditures on physical therapy only. On average, spending for self-referring providers was \$144 compared with only \$73 for non-self-referring providers. This is a significant difference for a very common episode of care. Even more, when the expenditures for the entire episode of care are calculated—not just physical therapy but all care for the episode—self-referral episodes averaged \$889 compared with only \$602 for non-self-referral episodes. The implication is clear: not only is this a problem for physical therapy, it has spread far beyond.

Another study published in February of this year in *Health Services Research*, also by Jean Mitchell, PhD, examined the use of physical therapy following total knee replacement surgery for Medicare beneficiaries. Patients that were treated by an orthopedic surgeon who had an ownership interest in the physical therapist who treated the patient after the surgery received 8.3 more physical therapy visits as well as 6.6 fewer physical therapy service units per episode than patients who had surgery from an orthopedic surgeon with no ownership interest in the subsequent physical therapy. Since patients were under Medicare, the study was also able to examine the codes billed for these episodes. It found that episodes directed by a self-referring orthopedic surgeon consisted of billing for 8.2% fewer therapeutic exercise codes but higher billing for group therapy and manual therapy, the latter of which consists mainly of joint massage and mobilization to reduce swelling.

This second study, which mirrors findings of the first, shows patients treated by physicians with a financial self-interest in the follow-up physical therapy receive less

active, less hands-on, and less one-on-one care than patients who are treated by physicians who have no financial interest in the follow-up therapy. The incentive exists to extend care for more visits while billing less-intensive therapy codes that do not necessarily expedite patient recovery.

In § 1877(b) of the Social Security Act, it states that additional regulations may be imposed by the Secretary of Health and Human Services “to protect against program and patient abuse” of physician ownership and interest in the furnishing of DHS under the IOAS exception. **As illustrated, the physician ownership of physical therapy services creates a thriving environment for fraud and abuse, and, therefore, the Secretary should exercise his authority to add physical therapy as a nonqualifying DHS that cannot be furnished to Medicare patients under the in-office ancillary services exception.**

If CMS continues to include physical therapy as a DHS under the in-office ancillary services exception, then APTA strongly recommends that CMS tighten elements of the exception to restrict abusive practices.

Conclusion

Once again, we thank CMS for the opportunity to comment on these policy changes. If you have any questions regarding our comments, please contact Roshunda Drummond-Dye, director of regulatory affairs, at 703/706-8547 or roshundadrummond-dye@apta.org. Thank you for your time and consideration.

Sincerely,

A handwritten signature in black ink that reads "Sharon L. Dunn". The signature is written in a cursive style with a large, prominent 'S' at the beginning.

Sharon L. Dunn, PT, PhD
President

SLD: rdd