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Seema Verma, MPH; Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Attn: CMS-1678-P
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted Electronically
Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1678-P)

Dear Administrator Verma:

On behalf of our 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) appreciates the opportunity to submit comments to CMS on the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs proposed rule for calendar year (CY) 2018. 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. Physical therapy is an integral service provided to patients in the inpatient acute care and long-term care settings. Therefore, we appreciate the opportunity to provide the following comments regarding the outpatient and ambulatory surgical center policy updates for CY 2018.

In this rule, CMS proposes to increase hospital outpatient payment rates by 1.75%, after accounting for the projected hospital market basket update and the proposed outpatient prospective payment system (OPPS) policy changes. APTA supports this proposed increase in payment and urges CMS to conduct regular payment impact analyses to ensure appropriate payment levels for outpatient services.

We ask that the agency carefully consider the comments and recommendations we have articulated below regarding pertinent sections of the proposed rule, as well as our response to the request for information.

Summary of APTA's Recommendations:

I. **APTA recommends that CMS provide specific guidance to CMS contractors regarding the nonenforcement of direct supervision requirements for outpatient therapy services in critical access hospitals (CAHs) and rural hospitals with fewer than 100 beds, to ensure that providers within these facilities are not subject to inapplicable audits and reviews.**

II. **APTA recommends that CMS make adjustments to the target cost calculations to account for the change in the case-mix that likely will result from the proposal to remove total knee arthroplasty (TKA) from the inpatient-only procedures list.**

Direct Supervision for Outpatient Therapy Services in CAHs

We support CMS' proposal to reinstate nonenforcement of the direct supervision requirement for outpatient therapeutic services for CAHs and small rural hospitals having 100 or fewer beds for 2018 and 2019. This proposal would be an extension of the recent moratorium on enforcement of direct supervision for outpatient therapy services, which expired on December 31, 2016. As stated within the rule, this proposal would give CAHs and rural hospitals sufficient time to comply with direct supervision requirements.

While APTA stands by this proposal, we urge CMS to publish clear instructions for CMS contractors to ensure that contractors do not enforce the direct supervision policy for CAHs and small rural hospitals. Within such guidance, we strongly encourage CMS to instruct contractors that they are prohibited from "looking back" at claims submitted between December 16, 2016, and the effective date of the subsequent final rule. A retroactive policy will best reflect CMS' acknowledgement of the unique burden that CAHs and rural hospitals face to employ a sufficient number of health care professionals to meet direct supervision requirements for specialty services such as physical therapy.

Further, we urge CMS to consider an update to this policy to require only general supervision for outpatient therapy services, similar to the level of supervision required by hospital conditions of participation. General supervision would require that outpatient therapy services be provided under the provider's overall direction. This change to CMS policy concerning outpatient therapy services could help to alleviate the burden placed on CAHs and small rural hospitals that must work to employ multiple providers to maintain high-quality care in compliance with CMS' current direct supervision requirements. It also would eliminate the need for the moratorium in the future.

Removal of TKA from the Inpatient-Only Procedures List

CMS has proposed to remove the TKA procedure from the inpatient-only procedures list, thereby allowing the procedure to be performed in an outpatient setting based upon the physician's clinical judgement.

While APTA supports the removal of knee replacement procedures from the inpatient-only list, we believe that CMS must make adjustments to the target cost calculations to account for the change in case mix that likely will result from this regulatory change. This change would lead to a shift toward less-complex, lower-cost knee replacement procedures being performed in the outpatient setting, and an increase in the overall complexity of procedures performed in the inpatient setting. Although this is an intended consequence, the shift in procedures from the inpatient setting to the outpatient setting will alter the case mix for inpatient facilities. Because CMS uses 3 years of historical data to set 90-day-episode payment targets for each participant in the Comprehensive Care for Joint Replacement model, the historic case-mix and episode rates upon which the targets are based would no longer accurately reflect the case mix that will exist in facilities after TKA procedures are removed from the inpatient-only procedures list.

APTA strongly encourages CMS to analyze the impact of such a change to the case-mix rates for knee replacement patients and appropriately adjust its methodology to reflect the changes that will result from TKR procedures being performed in outpatient settings. If CMS does not make adjustments to the case-mix rates, it could lead to unintended consequences such as a decline in patient referrals to necessary postoperative services, such as physical therapy, in efforts to lower the episode cost to meet an unrealistic target.

Response to CMS' Request for Information

APTA appreciates CMS's efforts to transform the health care delivery system, including the Medicare program, by emphasizing a strong focus on patient-centered care. We are encouraged by CMS's efforts to solicit ideas from stakeholders on policies and practices to help the Medicare program achieve transparency, flexibility, program simplification, and innovation. In response to the request for information, APTA makes the following recommendations in the areas of direct access, physician self-referral, telehealth, the SNF 3-day waiver, the therapy cap, and functional limitation reporting requirements.

Direct Access

APTA recommends that CMS revisit its referral requirements for physical therapy services. The physician authorization requirements inadvertently create significant delays in the provision of physical therapy services to individuals who would benefit from treatment by a physical therapist. These delays often lead to higher costs, decreased functional outcomes, and frustration for patients. Physical therapists are qualified to furnish therapy independent of a referral, given their extensive education and clinical training in the examination, evaluation, diagnosis, and intervention of patients with a variety of clinical conditions, and their ability to

improve patient outcomes. We strongly encourage CMS to adopt a broad policy that eliminates physician referral requirements for physical therapy services to ensure that patients have timely access to medically necessary care.

Physician Self-Referral

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. The IOAS exception is 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. APTA has significant concerns, however, that the current use of this exception goes well beyond its original intent, specifically in regards to physical therapy. While including physical therapy in the IOAS exception list was intended to offer convenience to patients, it is incredibly rare for a patient to receive physical therapy services during a regularly scheduled physician visit.

The IOAS exception allows physician practices to legally own a practice with multiple satellite offices that furnish physical therapy services without the physician on site. These physicians are able to refer their patients to these satellite offices and bill Medicare for the services furnished to them. Unfortunately, physician self-referral of ancillary services creates incentives to increase volume under Medicare's current payment system, resulting in overutilization. As previously acknowledged by the Medicare Payment Advisory Commission (MedPAC), there has been a significant increase in physician ownership of entities that provide physical therapy. Moreover, there is an inherent financial conflict created by physician ownership of health care businesses to which they refer.

Both MedPAC and CMS have found that the 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 meeting the technical requirements for physical therapy services while violating the true intent of the exception. Abuse of the IOAS exception also has been examined by the Government Accountability Office, the Office of the Inspector General of the US Department of Health and Human Services, and the *New England Journal of Medicine*, among others.

APTA believes that care furnished under the IOAS exception is often degraded, raising serious quality concerns. In fact, there is evidence that beneficiaries may actually receive higher-quality care—and therefore better outcomes—when self-referral is not involved. A 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 between self-referring and 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 services by self-referring providers was $144 as opposed to only $73 for services by 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 *Health Services Research,* also by Jean Mitchell, PhD, examined the use of physical therapy following total knee replacement surgery. This study, which mirrors findings of the first, shows that patients treated by physicians with a financial self-interest in follow-up therapy receive less active, hands-on, and 1-on-1 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.

APTA opposes referral for profit and physician ownership of physical therapy services. We believe that such arrangements pose an inherent conflict of interest, impeding both the autonomous practice of the physical therapist and the fiduciary relationship between the therapist and patient.

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 designated health service that cannot be furnished to Medicare patients under the IOAS exception. Should CMS continue to include physical therapy as a designated health service under the IOAS exception, then APTA strongly recommends that CMS tighten elements of the exception to restrict abusive practices.

We urge CMS to apply the same authority for its proposed modification to the physician self-referral law to remove physical therapy from the IOAS exceptions list. If CMS continues to include physical therapy as a designated health service under the IOAS exception, then APTA strongly recommends that CMS tighten elements of the exception to restrict abusive practices.

Telehealth Services

Allowing providers such as physical therapists to provide telehealth services under Medicare will help to reduce health care expenditures, increase access to care, and improve management of chronic disease in rural and underserved areas. Telehealth services may also help to ensure

access to specialized care in isolated rural areas facing difficulties in maintaining and staffing full-service hospitals.[1]

To realize these benefits, APTA first 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. As noted by MEDPAC in its June 2016 Report to Congress, several Center for Medicare and Medicaid Innovation (CMMI) models involving bundled payment and accountable care organizations include coverage of telehealth services broader than the standard Medicare benefit. Within such models, CMS exercised its authority to waive the requirement that benefits offered in these programs be equivalent to the standard benefit. Also in the report, MedPAC stated CMS could consider expanding these waivers to include a broader range of telehealth services in either current or future CMMI programs.[1]

Second, APTA recommends that CMS establish a demonstration program to evaluate the clinical benefit of physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) furnishing telehealth services to Medicare beneficiaries. Many states permit these providers to furnish telehealth services, and they do so safely and effectively. Proper application of telehealth rehabilitation therapy services, particularly in underserved areas, can potentially have a dramatic impact on improving care and reducing negative consequences and costs of care. In the SNF setting, telehealth therapy services in underserved areas may make the difference in preventing falls, functional decline, costly emergency room visits, and hospital admissions/readmissions. APTA strongly encourages that CMS, through CMMI, conduct a demonstration to evaluate the clinical benefit of PT, OTs, and SLPs furnishing telehealth services to Medicare beneficiaries in all settings, including SNFs, in states that permit such services. The results of this demonstration would help inform policymakers as they consider whether to include PT, OTs, and SLPs as authorized practitioners of telehealth services.

To that end, APTA will continue to work with Congress to secure the appropriate statutory language. We have been steadfast in our advocacy efforts for the passage of the Medicare Telehealth Parity Act (H.R. 2550), which would add physical therapists and several other therapy provider groups to the list of authorized telehealth providers under Medicare. We also are supportive of the CONNECT for Health Act of 2017 (S. 1016/H.R. 2556), which would expand where telehealth can take place, as well as which patients and providers can participate, including physical therapists participating in some bundled payment models, accountable care organizations, and Medicare Advantage plans.

SNF 3-Day Waiver

APTA strongly recommends that CMS modify the SNF 3-day inpatient hospital stay requirement to consider days spent in observation toward satisfying the requirement for Part A

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[1] Medicare Payment Advisory Commission June 2016 Report to Congress, Chapter 8. http://www.medpac.gov/docs/default-source/reports/chapter-8-telehealth-services-and-the-medicare-program-june-2016-report-.pdf?sfvrsn=0. Accessed July 22, 2017.

coverage of SNF care. Congress also has expressed support for such a policy change, as members in both the House and Senate have introduced the *Improving Access to Medicare Coverage Act of 2017* (H.R. 1421/S. 568). The legislation expands the definition of "inpatient" for purposes of the 3-day inpatient stay requirement and counts time spent in observation toward satisfying the requirement.

Therapy Cap

APTA strongly believes that hospitals should be appropriately reimbursed for the services they provide during the inpatient and observation periods. The decision to admit should be based solely on the clinical condition of the patient and the setting in which their medical needs can most safely and effectively be addressed. However, one policy that continues to impact this decision-making is the therapy cap. Per statutory requirements, CMS places an annual per-beneficiary Medicare financial limitation (cap) on outpatient therapy services. Each year this annual amount is updated, and the 2017 therapy cap amount is $1,980 for physical therapy and speech language pathology services combined.

Due to the confusion that still exists around inpatient admission criteria, APTA continues to be concerned about coverage for therapy provided on an inpatient basis that is later denied by auditors and rebilled under Part B. Often, due to the risk of denials when classifying patients for an inpatient stay, there are instances in which a patient's entire stay in the hospital(s), which sometimes spans as many 16 days, is classified as an outpatient hospital stay. Therefore, all physical therapy services received during this period are counted toward the cap. We believe this is unfair to these patients, as it may limit their access to physical therapy in the outpatient setting when in fact these services should have been billed as inpatient services. We strongly encourage CMS to establish an exception to the outpatient therapy requirements, as outlined in the Medicare Benefit Policy Manual, for observation-status patients.

Another Part B payment policy that poses serious implications for patients and providers during an outpatient hospital stay governs therapy functional limitation reporting. The Middle Class Tax Relief Act mandated that as of July 1, 2013, CMS collect information on claim forms regarding beneficiaries' function and condition. All practice settings that provide outpatient therapy services must include this information on their claim forms. Specifically, the policy applies to physical therapy, occupational therapy, and speech-language pathology services furnished in hospitals, critical access hospitals, SNFs, comprehensive outpatient rehabilitation facilities, rehabilitation agencies, home health agencies (when the beneficiary is not under a home health plan of care), and in private offices of therapists, physicians, and nonphysician practitioners.

Under the functional limitation reporting requirement for outpatient therapy services, nonpayable G-codes and modifiers are mandated on the claim forms to capture data on the beneficiary's functional limitations at the outset of the therapy episode, at a minimum of every 10th visit, and at discharge. The ability to clearly discern whether the patient is receiving services under the outpatient therapy benefit or as part of the patient's inpatient stay is critical

to compliance for hospitals under functional limitation reporting requirements, which makes reporting under observation status all the more complicated. Therefore, we strongly urge CMS to waive functional limitation reporting for observation-status patients. CMS could establish this exemption with the use of a modifier when billing. This same modifier could be affixed to therapy services billed under observation status as well as when rebilled under Part B for denied admissions.

Policies such as the therapy cap and functional limitation reporting were intended for patients receiving therapy in the outpatient setting, and are nonsensical in their application to patients in observation status. We believe that addressing payment and defining these categories will help to ensure that patient access to outpatient therapy is not unreasonably limited, while also helping hospitals maintain continuous compliance with Medicare rules and regulations.

Conclusion

APTA thanks CMS for the opportunity to comment on the OPPS proposed rule for CY 2018 as well as the request for information concerning improvements to the health care delivery system. We look forward to working with the agency to continue to provide efficient and high-quality care to Medicare beneficiaries. If you have any questions regarding our comments, please contact Sharita Jennings, JD, senior regulatory affairs specialist, at 703/706-3391 or sharitajennings@apta.org.

Sincerely,

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President
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