

September 21, 2018

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1695-P
Room 445-G
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically

RE: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs and Request for Information on Price Transparency: Improving Beneficiary Access to Provider and Supplier Charge Information [CMS-1695-P]

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit the following comments on the Calendar Year (CY) 2019 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (OPPS) 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 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.

In outpatient hospitals and ambulatory surgical centers (ASCs), physical therapists deliver medically necessary services to patients with varying medical diagnoses and conditions that are typically reimbursed under the Medicare physician fee schedule (MPFS); but outside of reimbursement, physical therapists are subject to a number of policies that are included under the OPFS. Please find below our detailed comments.

Proposed CY 2019 ASC Packaging Policy for Nonopioid Pain Management Treatments

CMS seeks public comment and suggestions on regulatory, subregulatory, policy, practice, and procedural changes to help prevent opioid use disorder and improve access to treatment under the Medicare program. CMS seeks comments identifying barriers that may inhibit access to nonopioid alternatives for pain treatment and management or access to opioid use disorder treatment, including barriers related to payment methodologies or coverage. Consistent with the “Patients Over Paperwork” Initiative, CMS is interested in suggestions to improve existing requirements in order to more effectively address the opioid epidemic.

APTA recommends that CMS focus more resources on nonpharmacological treatments to help prevent opioid use disorder. Too often, in response to the opioid epidemic, regulators, providers and payers seek to replace opioids with nonopioid drug. However, while pain management medication is often a critical component to many acute or chronic pain disorders, it merely masks the pain rather than treat its cause. Accordingly, we encourage CMS to promote innovative pain management therapies, such as physical therapy, to help patients treat the source of their pain, rather than only the symptoms.

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, as well as their values and expectations around health care. That evidence, in fact, was the driving force behind recent recommendations by the Centers for Disease Control and Prevention (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.”

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 CDC’s 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 postsurgery, in patients with cancer, and in other clinical scenarios.

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 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.

Regulatory Changes to Prevent Opioid Use Disorder and Improve Access to Treatment

APTA recommends that CMS institute regulatory and subregulatory changes that promote integrated team approaches that support early access to nonpharmacological interventions, including physical therapy, for the primary care of pain conditions. 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.¹ A review of more than 60 randomized controlled trials evaluating exercise therapy for adults with low back pain found that such treatment can decrease pain, improve function, and help people return to work.² Additionally, the American College of Physicians has stated that “non-pharmacologic interventions are considered first-line options in patients with chronic low back pain because fewer harms are associated with these types of therapies than with pharmacologic options.”³ Moreover, a review of 35 randomized controlled studies with a total of nearly 3,000 patients found that in patients undergoing total hip arthroplasty, preoperative exercise and education led to significant reductions in pain, shorter lengths of stay postoperatively, and improvements in function.⁴ Additional studies have shown that therapeutic exercise programs can reduce pain and improve physical function among individuals with hip and knee osteoarthritis.^{5,6} Moreover, the

¹ 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 September 12, 2018.

² Hayden JA, van Tulder MW, Malmivaara A, Koes BW. Exercise therapy for treatment of non-specific low back pain. *Cochrane Database Syst Rev*. 2005;Jul 20(3):CD000335. <https://www.ncbi.nlm.nih.gov/pubmed/16034851>. Accessed April 2, 2018.

³ Qaseem A, Wilt TJ, McLean RM, Forciea MA. Noninvasive treatments for acute, subacute, and chronic low back pain: a clinical practice guideline from the American College of Physicians. *Ann Intern Med*. 2017;166(7):514-530. <http://annals.org/aim/fullarticle/2603228/noninvasive-treatments-acute-subacute-chronic-low-back-painclinical-practice>

⁴ Mover R, Ikert K, Long K, Marsh J. The value of preoperative exercise and education for patients undergoing total hip and knee arthroplasty: a systematic review and meta-analysis. *JBJs Rev*. 2017;5(12):e2. <https://www.ncbi.nlm.nih.gov/pubmed/29232265>. Accessed September 12, 2018.

⁵ Fransen M, McConnell S, Hernandez-Molina G, Reichenbach S. Exercise for osteoarthritis of the hip. *Cochrane Database Syst Rev*. 2014;22(4):CD007912. <https://www.ncbi.nlm.nih.gov/pubmed/24756895>. Accessed April 2, 2018.

⁶ Messier SP, Mihalko SL, Legault C, et al. Effects of intensive diet and exercise on knee joint loads, inflammation, and clinical outcomes among overweight and obese adults with knee osteoarthritis: the IDEA randomized clinical trial. *JAMA*. 2013;310(12):1263-73. <https://www.ncbi.nlm.nih.gov/pubmed/24065013/>. Accessed April 2, 2018.

CDC has concluded that there is insufficient evidence that opioid usage alone improves functional outcomes for those in pain.⁷ Accordingly, we strongly encourage CMS to look beyond alternative pharmacological solutions, and instead focus on evidence-based nonpharmacological therapy that improves patient outcomes.

Second, there must be appropriate reimbursement for a broad range of pain management and treatment services, including evidence-based 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.”⁸ We recognize that due to the exclusion of reimbursement for outpatient physical therapy services under the OPPTS, CMS cannot utilize its authority under section 1833(t)(2)(E) of the Social Security Act to increase reimbursement for such services. However, while physical therapy services are excluded from payment under OPPTS, physical therapists are subject to a number of policies that *are* included under the OPPTS, and CMS has the power to incentivize access to physical therapy within the hospital outpatient setting. We encourage CMS to better promote multidisciplinary treatment models that require clinicians providing services under OPPTS to develop a comprehensive nonpharmacological treatment plan which incorporates outpatient physical therapy services. Moreover, CMS could increase reimbursement under the physician fee schedule, include physical therapy in more alternative payment models, and/or increase access to coverage in the programs it oversees in order to ensure that these effective, evidence-based practices are adequately incentivized.

Third, 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. By doing so, CMS will ensure that beneficiaries have adequate options to receive medically necessary, appropriate care. For example, CMS could require physicians to work with the beneficiary’s prescribers to develop a nonpharmacological, multidisciplinary pain-management treatment plan.

Fourth, 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. This 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.

⁷ Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. *MMWR Recomm Rep.* 2016;65(No. RR-1):1–49. DOI: <http://dx.doi.org/10.15585/mmwr.rr6501e1>. Accessed September 11, 2018.

⁸ 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.

Barriers That Inhibit Access to Nonopioid Alternatives for Pain Treatment and Management

Additional barriers to nonpharmacological care programs or treatments for acute or chronic pain include geography, lack of education and training, and payment and coverage. While opioid addiction has affected all communities, rural and underserved areas have been disproportionately harmed. Payers, policymakers, and other stakeholders should develop policies that will increase access in those communities to incentivize the broader delivery of care, such as expanded student loan repayment programs for health care providers who practice in those areas. Another potential solution is including physical therapy within the definition of Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services. Currently, physical therapy may be furnished incident to a physician in the FQHC or RHC. However, when furnished by a physical therapist incident to a visit with an RHC or FQHC practitioner, they are not billable visits, but the charges are included in the charges for an otherwise billable visit. Moreover, if the services are furnished on a day when no otherwise billable visit has occurred, the PT, OT, or SLP service provided incident to the visit would become part of the cost of operating the RHC or FQHC and there would be no billable visit.⁹ Reimbursing services furnished by physical therapists in a FQHC or RHC at the visit rate would help not only to prevent the development of acute or chronic pain, but also further minimize the overuse of unnecessary pain medication.

Additionally, given the seriousness of the opioid crisis (and, more broadly, the chronic pain crisis), there should be broader support of the delivery of pain management services to patients via telehealth, as this will help to expand the availability of chronic pain treatment options and reduce the likelihood of future opioid addiction. Moreover, more strongly advocating for the development of and access to 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 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.

Addressing the opioid crisis requires an interdisciplinary approach that focuses on nonpharmacological, multidisciplinary management and interventions for acute and chronic pain. Should CMS take this position, it will be in good company. The President's Commission on Combating Drug Addiction and the Opioid Crisis supported this approach and recommended that individuals with acute or chronic pain have early access to nonopioid pain-management options, including physical therapy.¹⁰ Moving forward, it is imperative that public and private payers, as well as federal, state, and local agencies acknowledge the important role physical therapists and other nonphysician health care professionals play in the prevention and treatment of acute and chronic pain. The solution requires more than limiting access to drugs. Rather, policies should be adopted that incentivize collaboration, assessment, and care coordination across multiple disciplines. If payers, policymakers, and other stakeholders continue to remain silent on nonpharmacological treatment options that serve as an alternative to drugs, then, ultimately, the

⁹ Medicare Benefit Policy Manual, Publication 100-02, Chapter 13. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf>. Accessed September 12, 2018.

¹⁰ 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 September 12, 2018.

idea that pharmaceuticals are the only option—an option with significant potential harm, will only be reinforced.

Specific Considerations for Wound Care

APTA recommends CMS consider the unique challenges patients and providers face when treating wounds. Most wound care patients have serious multifaceted and/or chronic comorbid medical conditions. Non-healing wounds occur among patients with diabetes, peripheral vascular disease, as a result of unique medical problems (e.g., sickle cell anemia, vasculitis), or in association with immunosuppression (e.g., AIDS, steroid use or transplantation medications). Chronic wounds are clinically devastating and have an extraordinary impact on Medicare beneficiaries.

Wound management needs to be addressed by a multidisciplinary team, with physical therapists playing a key role throughout. In this role, physical therapists adjust examination techniques, evaluation, interventions, and goals as necessary to meet the individual needs of patients in each setting. While governed by their individual state practice act, physical therapists routinely provide treatment to patients with complicated burns, traumatic injuries, and post-surgical wounds. Additionally, physical therapists utilize wound management techniques such as debridement, compression, total contact casting, and the application of biophysical technologies including negative pressure, pulsed lavage, and electrical stimulation. Incorporation of therapeutic exercise into the wound management plan is also important as is maximizing functional movement. Improving mobility and independence is frequently also a primary goal.¹¹

As a member of the Alliance of Wound Care Stakeholders (Alliance), APTA has worked diligently to ensure these specific challenges are addressed and the appropriate regulatory bodies have the information they need to ensure patients receive adequate care. The Alliance is a nonprofit multidisciplinary trade association of physician specialty societies, clinical and patient associations whose mission is to promote evidence-based quality care and access to products and services for people with chronic wounds through effective advocacy and educational outreach in the regulatory, legislative, and public arenas. The Alliance has submitted separate comments specifically detailing the concerns of wound care patients and providers. These comments were written with the advice of Alliance clinical specialty societies and organizations, including APTA, who not only possess expert knowledge in treating complex chronic wounds, but also in wound care research. APTA supports the comments submitted by the Alliance and recommends CMS take into consideration their unique expertise and recommendations.

Request for Information on Price Transparency: Improving Beneficiary Access to Provider and Supplier Charge Information

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

¹¹ ACEWM The Role of Physical Therapists in Wound Management: An Update. <https://acewm.org/wp-content/uploads/2017/01/The-Role-of-Physical-Therapists-in-Wound-Management.pdf>. Accessed September 19, 2018.

performed. APTA and its members recognize this is a concern and applaud CMS for taking initiative to begin to grapple with this problem.

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 rule making 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.¹² 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 they are uninsured consumers, Medicare beneficiaries, or Medicaid patients. Charges even vary between commercial insurers. Moreover, providers are rarely reimbursed at the rate they charge, and, again, 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,

¹² 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.

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.

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 (eg, 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 Qualified Clinical Data Registries (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.¹³ 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

¹³ 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.

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 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 OPPS and ASC payment systems and quality reporting programs proposed rule. Should you have any questions regarding our comments, please do not hesitate to contact Kate Gilliard, senior regulatory affairs specialist, at kategilliard@apta.org or 703/706-8549. Thank you for your consideration.

Sincerely,



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

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