Sept. 8, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically at http://www.regulations.gov

RE: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program (CMS-1784-P)

Dear Administrator Brooks-LaSure:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association submits the following comments on the Centers for Medicare & Medicaid Services' 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; (CMS-1784-P) proposed rule. APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span, helping individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles 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.

Please find below our detailed comments on the proposed rule.

Medicare Physician Fee Schedule Reform

APTA urges CMS to identify and implement solutions to the recurring payment cuts under the Medicare physician fee schedule. Since the initial proposal to overhaul payment for evaluation/management codes in 2019, the agency has received tens of thousands of comments imploring it to take action to preserve payment for the dozens of provider types forced to foot the bill for the policy. While Congress has intervened three times to thwart the impact of the agency's policies, CMS has done nothing to mitigate the damage to payment — despite the COVID-19 pandemic, the opioids crisis, and extreme health care shortages. It has become clear that the agency is comfortable proceeding with its annual payment reductions without consideration of the reality we live in; CMS is content to either rely on Congress to mend these systematic issues, or it severely underestimates the significance of what these cuts mean to the provision of health care in the United States. Year after year, CMS introduces policies that widen the disconnect between payment and the costs of operating a clinical practice, appearing to ignore the chorus of clinicians, patient advocates, and other stakeholders urging the agency to focus on increasing access

to care. We are deeply concerned that the agency will not take action until it is too late: after providers have stopped accepting Medicare patients, moved to other settings, or simply closed their doors.

Impact on Physical Therapy

Medicare's inadequate reimbursement rates are felt by dozens of Medicare provider types, but physical therapists have been subject to some of the worst reductions in payment in recent years. By examining the most common CPT codes used by physical therapists, a dire payment landscape is illustrated:

HCPCS	Description	2014 Payment	2024 Payment	Change
97110	Therapeutic exercises	$32.24	$28.82	-11%
97112	Neuromuscular reeducation	$33.67	$33.08	-2%
97116	Gait training therapy	$28.66	$28.82	1%
97140	Manual therapy 1/> regions	$30.09	$26.53	-12%
97530	Therapeutic activities	$35.11	$36.02	3%

The five codes in the table above represent some of the most frequently used codes for physical therapy. This marked reduction in payment for physical therapy services is unjustifiable given that a dollar 10 years ago has the same buying power as merely $1.31 today. Further, the relative value units of these codes have increased for three out of five of the codes listed. Accordingly, it is the conversion factor, and CMS' continued reduction in payment generally, that is driving the downward trend in payment. This calculation also does not include the reductions attributable to multiple procedure payment reduction, the physical therapist assistant differential, or sequestration. **The bottom line remains that physical therapists will be paid significantly less in 2024 than they were in 2014.**

PT Wages and Staffing

The constant downward pressure on reimbursement has had a real impact on physical therapist and physical therapist assistant wages. APTA's 2023 report "A Physical Therapy Profile: Wages Earned in the Profession, 2021-22," notes that between 2004 and 2013, PT and PTA annual wages matched or exceeded cost-of-living increases, but between 2016 and 2021, wages either met or began to lag behind the rate of inflation in all geographic regions except the West North Central region for PTs and the Middle Atlantic and New England regions for PTAs. Further, when comparing settings, the report noted that private outpatient office or group practice physical therapy, the settings paid under the fee schedule, had the second lowest wages, with only PTs in K-12 school systems paid less. Acute care, home care, SNF, IRF, and academia not only paid PTs more, but also saw a greater percent change from 2016 to 2021. Private outpatient office or group practice has had the lowest rate of wage growth of all settings, with only a 6.2% increase in wages from 2016 to 2021.

The data above is consistent with another APTA report, "Hiring Challenges in Outpatient Physical Therapy Practices," released in 2022. This report sought to better understand what physical therapy leaders had known anecdotally: that clinics were facing dire challenges employing and retaining physical therapists and physical therapist assistants. The survey quantified that struggle, noting three key points: First, outpatient physical therapy practices have significant vacancy rates. The vast majority of practices have openings of at least 5%, with a 16% total vacancy rate across all employee categories — physical therapists, physical therapist assistants, and support personnel. There are more openings for PTs than for PTAs and support personnel.

Second, hiring challenges are worsening. Most practices have more staffing openings now compared with December 2019, and many practices (40.8%) are facing higher turnover rates now than they were two years ago. While the report sought to identify the impact of the pandemic on staffing, CMS' action in the same time period makes it difficult to ascertain if the pandemic or payment policy is more to blame.

Imagine the following events from the perspective of a physical therapy clinic owner:

- 2019: Medicare begins telegraphing an 8% cut to physical therapy services in its 2020 PFS.
- 2020: The cut is increased to 9% in the 2021 PFS; later reduced to 3.3% by Congress.
- 2021: The 2022 PFS includes a 3.75% cut; later reduced to 1.2% by Congress.
- 2022: The 2023 PFS includes a 4.46% cut; later reduced to 2% by Congress; 15% reduction in reimbursement for services delivered in whole or in part by a PTA; and phase-in of 2% sequestration.
- 2023: The 2024 PFS proposes 3.3% reduction in payment.

It's no wonder that private practices have been unable to increase wages. The constant threat of reductions in reimbursement, with only the hope of Congress mitigating the damage at the last minute, has left practices struggling to predict their financial solvency for the following year, let alone budget cost-of-living wage increases for their staff.

Accordingly, the third take away from the APTA report is hardly surprising: Pay was a primary reason for the vacancies. Of the various reasons respondents ranked why a staff person left their position 25.4% of respondents indicated pay was the primary reason, but 63.5% of respondents placed it within the top three reasons. Only relocation was ranked as a higher cause. Despite the ongoing public health emergency, concern over COVID-19 was ranked as the primary reason for leaving by only 1.7% of respondents, and only 11.9% of respondents placed it within the top three. Though COVID-19 played a role in these concerning staffing trends, the data paints a clearer picture: payment policy represents a more continuous and significant threat to stable and appropriate staffing.

Administrative Burden

APTA's report also identified a significant factor frequently overlooked in the payment equation: administrative burden and its impact on a provider's well-being. The third-most-cited reason staff left their position was work-life balance (reduction of hours/stress). We have no doubt that onerous regulatory requirements motivate clinicians to leave the field because they prevent providers from treating patients: the very purpose of pursuing their advanced training, and the core of their mission as medical professionals. Instead, many requirements, which have no meaningful connection to patient safety or program integrity, force providers to spend hours upon hours documenting irrelevant information, tracking down signatures or completing other tedious tasks.

Conducted in fall 2022, the APTA Administrative Burden Survey received responses from 773 APTA members across various facility and institutional settings and sought to collect measurable survey results that offer insight into how administrative burden impacts patient clinical outcomes.

The survey noted that 86.3% of providers agree or strongly agree that administrative burden contributes to burnout. Nearly 3 out of 4 respondents indicated that prior authorization requirements delay access to medically necessary care by more than 25%. Further, when asked what policy changes would most reduce administrative burden, the second-most-reported request was elimination of the Medicare plan of

care signature and recertification. APTA met with CMS on this issue in early 2022 and again in 2023, and we are disappointed the agency has not attempted any policy change on an issue that could have such significant and immediate administrative relief for the physical therapy profession.

Currently, CMS does not require a referral or order for a physical therapist to treat a Medicare patient. Neither does CMS require a physician's signature on the plan of care for a physical therapist to begin treatment. However, CMS does require a physician to sign the patient's plan of care in order for the physical therapist to be **paid** for the services. A physician's signature on the plan of care is not required by statute. In fact, the statute indicates that the "plan for furnishing such services has been established by a physician or by the qualified physical therapist or qualified occupational therapist, respectively, providing such services and is periodically reviewed by a physician." 42 U.S.C. 1395n (a)(C).

APTA does not take issue with the requirement to collaborate with physicians. We support interdisciplinary care and welcome the input of primary care providers on physical therapy plans of care. However, the specific requirement of obtaining a signature does more damage than good and prevents patients from accessing necessary services. Although a signature on a plan of care may seem like a small burden, physicians – primary care providers especially, are already overwhelmed with paperwork of their own. Our members have reported spending **months** trying to obtain signatures from physicians' offices, contacting them via phone, email, and fax more than 30 times, just to obtain one signature.

One might argue that the physician's signature ensures that the plan of care is appropriate for the patient, and so it provides an important function of patient safety. However, CMS allows treatment to begin before the signature is obtained, meaning patient safety is not an adequate justification for the requirement. Failure to obtain the signature simply means the physical therapist will not be paid for any services they deliver. So, the certification requirement forces physical therapists to make a choice: begin treatment in the best interests of the patient, or delay care to ensure that payment can be obtained. This is a flawed policy.

Reimbursement for physical therapy services should be determined by the medical necessity of the service and whether the physical therapist has completed their statutory and regulatory requirements – not whether another provider has followed up. Physical therapists have no control over whether a physician will or will not sign a document, and it should therefore not be a factor in physical therapist payment.

APTA has presented CMS with a number of ways this administrative burden can be relieved without sacrificing the physician's role in physical therapy. For instance, when the patient has an order or referral on file, the statutory requirement that the patient be under the care of a physician is not only satisfied but documented. CMS should in these situations require the physical therapist to deliver the plan of care to the physician to satisfy the requirement that the physician review the plan and remove the requirement that a signature be returned. APTA would even support CMS requiring proof the plan was delivered, such as via fax receipt or other confirmation of delivery. This way, physicians still have the opportunity to provide input on the plan of care, but physical therapists won't be penalized because the physician fails to return the plan of care. As stated earlier, physical therapists are already permitted to begin treatment before obtaining the signature, so timing is not a concern in this situation. Further, because these patients have an order or referral on file, any specific instructions the physician needs to communicate will have already been delivered. Similarly, if a patient has an order or referral, or if the original plan of care has been delivered, then the same requirements should apply to re-certification of the plan of care.

We also encourage CMS to allow for evaluations to be performed and reimbursed without requiring a physician signature. Currently, when an evaluation is performed and the patient's needs can be addressed during the evaluation visit, or the physical therapist must make a referral to another provider before proceeding with developing a plan of care, the physical therapist still has to get the evaluation signed by the physician to be reimbursed. (Medicare Benefit Policy Manual Chapter 15 Section 220.3 C). There is no statutory basis for this requirement. Physical therapists may have the ability to address a patient's needs in a single visit by recommending an individualized home exercise plan, connecting the patient to community services, recommending other lifestyle changes, or making a referral to another provider, without developing a plan of care and continuing treatment. The immense administrative burden relative to payment for a single evaluation is a barrier to the delivery of these very effective and necessary services. Removing these requirements for evaluations without treatment would allow Medicare beneficiaries to benefit from the expertise of a physical therapist in meeting self-management needs, addressing risk factors, or supporting intermittent intervention for chronic conditions. Patients with acute needs or high risk could receive necessary care to prevent expensive events such as falls, while lower-acuity patients can be given one-time advice that could ultimately prevent the need for Medicare to cover myriad future services.

This type of simple regulatory change can significantly increase access to the services described above and ultimately save Medicare from spending more in the long run. Multiple studies (Sun, 2018; Stevens, 2018; Phillips, 2015) show that early access to physical therapy is directly correlated to better outcomes and decreased need for services. Allowing physical therapists to treat patients immediately without risking their reimbursement would benefit Medicare patients and Medicare as a whole.

The Future of Physical Therapy and Medicare

APTA provides the above data on wages, staffing, and administrative burden to CMS to underscore the relationship between Medicare payment, wages, beneficiary access to care, provider well-being, and staffing shortages. Ultimately, CMS is creating – and has continued to implement over nearly six years – a payment landscape that will ultimately leave many Medicare beneficiaries without providers.

APTA appreciates that CMS is bound to maintain budget neutrality in the Medicare Physician Fee Schedule through several mechanisms, primarily through adjustment of the conversion factor. Historically, this process has ensured that the Medicare trust fund is protected from annual adjustments that exceed $20,000,000 as required by Section 1848(c)(2)(B)(ii)(II) of the Act. Should CMS implement any changes in payment or coverage, the costs of those policies can be offset by reducing the conversion factor, which reduces payment for all services under the PFS and maintains budget neutrality.

However, CMS has over-relied on reductions to the conversion factor to pay for sweeping policy changes that benefit one provider group without regard to the damage it causes other providers. Many have lost hope that CMS has any concern for providers who do not bill E/M services. Accordingly, most professional societies look to Congress to reform the fee schedule. The American Physical Therapy Association, American Occupational Therapy Association, American Speech-Language-Hearing Association, and APTA Private Practice have released Policy Principles for Outpatient Therapy Reform under the Medicare Physician Fee Schedule.

The principles center on five key reforms needed to ensure rehabilitation therapy services remain available for Medicare beneficiaries:

1. Eliminate the multiple procedure payment reduction for therapy services.

2. Allow PTs, OTs, and SLPs to opt-out of Medicare.
3. Provide flexibilities to the plan of care certification requirement.
4. Change PTA and OTA supervision in private practice from direct to general.
5. Reform MACRA and the quality payment program.

While these principles are intended for Congress, some of the reforms including plan of care certification flexibilities and PTA supervision requirements are within CMS' power to implement today.

We also wish to note that constant reduction in payment for physical therapy services has become so unsustainable that APTA has undertaken the effort to pass legislation that would allow physical therapists to opt out of Medicare. Currently, physicians have the authority to opt out of the Medicare program and privately contract with Medicare beneficiaries. Medicare allows other practitioners, such as physician assistants, dentists, podiatrists, optometrists, social workers, psychologists, nurse midwives, dietitians, and other eligible providers to do so as well. While these providers are barred from providing services to Medicare beneficiaries for two years, they at least have the option to refuse Medicare's burdensome billing process and inequitable payment. Physical therapists currently do not even have the choice. They must enroll in Medicare or else they cannot provide Medicare-covered services to Medicare beneficiaries.

Accordingly, APTA has supported legislation that would provide physical therapists with the ability to opt-out of Medicare, privately contract with patients, remove the two-year ban on treating Medicare beneficiaries, and allow beneficiaries to submit out-of-network claims for payment.

We only bring this bill to the agency's attention to stress the seriousness of the payment inequity under Medicare. APTA fully supports a robust, efficient, and effective Medicare program wherein beneficiaries are not burdened by having to seek out-of-network care and submit claims themselves. However, for many physical therapy practices, accepting Medicare payment rates as they currently stand, not to mention that they will continue to be reduced under current policy, would put the financial health of the clinic at risk. Out-of-network clinics are easier to access than nonexistent clinics. While APTA strongly encourages its members to participate in Medicare and supports the efforts of CMS to sustain the program, ultimately it is better for patients to have to seek out-of-network care than to have no care at all.

Accordingly, we implore CMS to take action. The agency has received tens of thousands of comments decrying the reduction in payment since first proposing the E/M policy in 2018, yet it has done nothing to mitigate the damage. Either by revising the E/M policy, or by some other means, the agency must do something to support physical therapists and ensure that Medicare beneficiaries can continue to access these providers. Payment, clinician workforce, and patient access are inextricably linked, and no clinical specialty operates in a vacuum — clearly CMS understands this. The agency's efforts around care coordination, interoperability, and value-based payment are evidence of its understanding. Unfortunately, this balance that CMS is responsible for is the knife's edge upon which PTs and others operate. Support for some specialties without adequate support for others means the foundation upon which safe, quality care rests upon erodes. It results in breakdowns in care coordination, and it results in entities taking on more than they can afford to, to provide care the best they can until they cannot provide it anymore. These are preventable situations. But until CMS works through a permanent solution to ensure true payment adequacy for all providers under the system, then all actors in the care continuum will suffer, providers and patients alike. And under the PFS, these issues are magnified exponentially for PTs, who are treated to the same cuts as their physician counterparts, but with a payment baseline and operating margins that are meager by comparison. In other words, the windfalls that exist for physicians do not exist

for PTs; our clinicians feel these cuts more acutely, and their ability to operate and serve the Medicare population is threatened at a more rapid pace.

Office/Outpatient (O/O) E/M Visit Complexity Add-on Implementation

APTA strongly recommends that CMS revisit its policy on the HCPCS code G2211. We support the comments submitted by The American Medical Association/Specialty Society RVS Update Committee as well as numerous other stakeholders that have questioned the need and valuation for such a code. Given the significant impact to the conversion factor and payment to other providers, and the legitimate and profound questions that experts such as the AMA RUC have posed to the agency, CMS must not implement this code. At a minimum, CMS should delay implementation until it can adequately respond to these concerns.

Misvalued Codes

APTA thanks CMS for accepting the nomination we submitted with the American Occupational Therapy Association of 19 therapy codes as potentially misvalued and recommending the AMA/RUC Practice Expense Subcommittee recommendations from January 2017 be re-reviewed. It appears that significant underpayment of physical therapy services has occurred over the last five years, and we appreciate CMS' acknowledgement of this error.

In the 2017 Medicare Physician Fee Schedule, CMS indicated that they were seeking information regarding appropriate valuation for the following codes: 97032, 97035, 97110, 97112, 97113, 97116, 97140, 97530, 97535 and G0283. The remaining codes were added as part of this family of services and reviewed for work and practice expense. At the 2017 AMA RUC meeting, the family of Physical Medicine and Rehabilitation codes was presented by APTA and AOTA for re-valuation. During the presentation to the Practice Expense Subcommittee the associations were asked to confirm that multiple units or codes are billed in a session. Based on that confirmation, the PE Subcommittee adjusted the clinical staff time to account for MPPR. The result of this action on the part of the subcommittee was a 50% reduction in clinical labor recommendations by the RUC. Since MPPR results in an additional 50% reduction when a claim is submitted, the cumulative result is a 75% overall reduction in clinical labor inputs even when there is no duplication of the clinical labor time, such as in cleaning equipment after a procedure.

At the RUC meeting the associations recommended and presented the clinical labor practice expense inputs for the 19 PM&R codes. The RUC Practice Expense Subcommittee reduced these recommended values by half or one-third to address potential duplication of practice expense based on applying the statutory MPPR calculation. It is our understanding that for CPT codes subject to MPPR, the application and calculation of the MPPR policy is done by the Medicare program at the time of claims processing and is not the role of the AMA RUC during code valuation. At the April RUC 2023 Practice Expense Subcommittee Meeting it was expressly stated that if MPPR does not apply, then the subcommittee needs to consider overlapping inputs; but if MPPR applies, then the subcommittee should not consider overlapping inputs. Since MPPR applies to all of these codes, the subcommittee should not have adjusted the inputs. APTA believes some confusion arose during the PE subcommittee meeting because when the codes were previously reviewed and valued in 2013, they had not been subject to MPPR.

These modifications have resulted in a cumulative devaluation of the practice expense for codes routinely billed by physical therapists and occupational therapists. Accordingly, we thank CMS for directing the AMA RUC PE Subcommittee to reconsider its clinical staff practice expense recommendations for these codes.

APTA additionally requests that CMS consider any options for addressing this duplicate reduction for the 2024 fee schedule given any action taken by the RUC will likely not result in resolution of the issue until 2025.

Payment for Caregiver Training Services

APTA appreciates CMS' recognition of the importance of caregiver training without the patient present for certain patients and/or under certain conditions. APTA also appreciates CMS' acceptance of the RUC recommended values for these codes. As it relates to specific information in the proposed rule related to these codes, APTA offers the following comments.

APTA supports the definition of a caregiver as an individual who is assisting or acting as a proxy for a patient with an illness or condition of short- or long-term duration (not necessarily chronic or disabling); involved on an episodic, daily, or occasional basis; and includes but is not limited to a legal guardian. APTA's position is that a caregiver includes a layperson assisting the patient in carrying out components of a treatment plan and that caregivers are trained in strategies and specific activities that improve symptoms, functioning, and adherence to treatment. APTA agrees that caregiver understanding and competence in assisting and implementing these interventions and activities is critical for patients with functional limitations resulting from various conditions.

APTA advises that CMS include rehabilitative therapy care in addition to complex health care and assistive technology activities at home as a management component for caregiver training. APTA further advises that CMS add qualified health care professionals as providers who establish a treatment plan, in addition to the treating physician or practitioner, to ensure inclusion of physical therapists, occupational therapists, and speech language pathologists. Finally, APTA advises that the training apply to the primary clinical diagnoses as well as to contributing conditions, complexities, or comorbidities and that the techniques or strategies the caregiver is trained in may apply to the performance of a prescribed home exercise or self-management plan in addition to activities of daily living.

As it relates to patient permission for the training of a caregiver without the patient present, APTA recommends this requirement be satisfied by documentation in the clinical record by the physician, practitioner, or qualified health care professional that the patient has consented to, or evidence that the caregiver is the legal guardian or health care proxy for the patient. APTA recommends that CMS not require formal signed consent, or any additional administrative burden as it relates to the provision of these services. Physical therapists routinely engage caregivers in the therapeutic intervention model and consistently meet HIPAA requirements as a standard of their practice.

Finally, we urge CMS to add these codes to the Category 3 Telehealth List of CPT Codes. These codes are extremely well suited for telehealth given that the patient is not present. Further, many patients who are dependent on their caregivers face challenges in traveling to therapy appointments, and caregivers may face challenges finding time to receive their training given their responsibilities to the patient. Accordingly, to ensure receipt of these services by the most vulnerable Medicare beneficiaries, we

strongly encourage CMS to make this service available via telehealth, at least as long as other therapy services are available.

Telehealth

Place of Service for Medicare Telehealth Services

CMS proposes that for 2024, providers will no longer bill telehealth claims with Modifier 95 along with the POS code that would have applied had the service been furnished in person, and telehealth claims will instead be billed with the POS indicators "02 - Telehealth Provided Other than in Patient's Home" or "10 - Telehealth Provided in Patient's Home." CMS has further proposed that services billed with POS "02" will be paid at the facility rate and services billed with POS "10" will be paid at the nonfacility rate.

APTA has a number of questions with regard to how this policy will be applied to therapy services. Since 1999, Medicare has paid all outpatient therapy providers the same nonfacility fee schedule rate. (63 FR 58860). This payment has been the same rate whether the therapist was working in a private practice or a facility, including rehabilitation agencies, skilled nursing facilities, hospital outpatient departments, home health agencies, or other facilities. The Medicare Claims Processing Manual, Chapter 12 Section 20.4.2 states:

> Nonfacility rates are applicable to outpatient rehabilitative therapy procedures, including those relating to physical therapy, occupational therapy and speech-language pathology, regardless of whether they are furnished in facility or nonfacility settings. Nonfacility rates also apply to all comprehensive outpatient rehabilitative facility (CORF) services. In addition, payment is made at the nonfacility rate for physician services provided to CORF patients and appropriately billed using POS code 62 for CORF.

So ingrained is this approach to paying all therapy settings under Medicare Part B the same nonfacility rate, that CMS' own Rule Addendum B Relative Value Units and Related Information, published annually along with the PFS, does not even contain facility PE RVUs for most therapy codes (See Addendum B Relative Value Units and Related Information CY 2024 CMS 1784-P).

However, with the implementation of the new POS codes, we have concerns that significant claims processing errors will occur in early 2024 in several scenarios:

- For institutional billers, which use a UB-04 claim form, there is no field in which to document the POS code. We wish to ensure that MACs are prepared to process those claims as they have during the PHE.

- Should institutional therapy providers continue to use the 95 modifier? We assume CMS would want to continue to track whether a service is performed via telehealth, and absent a POS code, these billers would have no way to indicate telehealth was used.

- Additionally, although institutional billers are "facilities" in the traditional sense, these billers have always been paid at the nonfacility rate, as described above. We wish to confirm that institutional billers of Part B therapy services will continue to be paid at the nonfacility rate.

- For private practices, which use the 1500 claim form and can document the POS code, occasionally the patient will be present at the clinic and the therapist will provide treatment via

telehealth from another location. In this scenario, the appropriate POS code would be POS "02 - Telehealth Provided Other than in Patient's Home." However, we again wish to confirm that payment in this scenario will be the nonfacility rate given that private practices are nonfacility billers, and therapy services are always paid at the nonfacility rate.

Accordingly, we ask CMS to confirm that all outpatient therapy services under Medicare Part B will continue to be paid at the nonfacility rate regardless of the POS code. We also ask CMS to ensure that MACs are appropriately informed about therapy billing and payment requirements to ensure that claims are processed smoothly in early 2024.

Payment for Outpatient Therapy Services, Diabetes Self-Management Training, and Medical Nutrition Therapy When Furnished by Institutional Staff to Beneficiaries in Their Homes Through Communication Technology

CMS proposes to continue to allow institutional therapy providers to bill for services when furnished remotely in the same manner they have during the PHE for COVID-19 through the end of CY 2024.

APTA thanks CMS for its continued attention to this matter. While we disagreed with CMS' initial interpretation of the Consolidated Appropriations Act of 2023 (Pub. L. 117-328, September 29, 2022) and the Hospitals Without Walls waiver, we are grateful that the agency continued to work with stakeholders to consider alternative interpretations that ensure Medicare beneficiaries have continued access to rehabilitation services via telehealth regardless of the specific type of outpatient clinic from which they receive care. We strongly support this new policy that allows for institutional therapy providers to continue to furnish telehealth services until the end of 2024 along with private practices.

Direct Supervision via Use of Two-way Audio/Video Communications Technology

CMS proposes to maintain until the end of 2024 the new definition of "direct supervision" to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. This updated definition was set to expire at the end of the year in which the PHE ends, but CMS has extended this flexibility to align with the Consolidated Appropriations Act, 2023's extension of telehealth flexibilities until the end of 2024.

APTA strongly supports this policy and encourages CMS to continue to examine ways it can increase access to services and ease provider burden through these simple regulatory updates. We are encouraged by CMS' other actions on PTA supervision, discussed below, and hope that the need to use this flexibility will become obsolete due to CMS changing the supervision requirements of PTAs in private practice from direct to general. However, in the meantime we appreciate the extension of the policy to the end of 2024.

Supervision of Outpatient Therapy Services in Private Practices

Remote Therapeutic Monitoring for Physical Therapists and Occupational Therapists in Private Practice

Current regulations at §§ 410.59(a)(3)(ii) and 410.60(a)(3)(ii) specify that all occupational and physical therapy services are performed by, or under the direct supervision of, the occupational or physical therapist, respectively, in private practice. While CMS amended the supervision standard for RTM services in last year's rule, it did not amend the regulations governing PTA and OTA supervision.

Accordingly, this year CMS proposes to establish an RTM-specific general supervision policy at §§ 410.59(a)(3)(ii) and (c)(2) and 410.60(a)(3)(ii) and (c)(2) to allow private practice OTPPs and PTPPs to provide general supervision only for RTM services furnished by their OTAs and PTAs, respectively.

APTA strongly supports this revision. We hope that CMS will move quickly to change supervision of PTAs and OTAs in private practice from direct to general and thereby uniform across all settings, as discussed below, but we appreciate CMS' recognition of RTM as a service particularly well suited for general supervision.

General Supervision for PTs and OTs in Private Practice Comment Solicitation

In the proposed rule, CMS has requested comments on potentially changing the supervision requirements of physical therapist assistants and occupational therapy assistants in private practice. Current regulations at §§ 410.59(c)(2) and 410.60(c)(2), require all services in private practice not performed personally by the OTPP or PTPP be performed by employees of the practice under the direct supervision of the therapist. However, other settings that provide outpatient therapy services under Medicare Part B are subject to a more flexible general supervision standard. This includes hospital outpatient clinics, skilled nursing facilities, rehabilitation agencies, comprehensive outpatient rehabilitation facilities, and even home health agencies. APTA has long sought a uniform supervision policy across Medicare settings and has held several meetings with the agency on the issue over the years.

Accordingly, we were pleased to see CMS request information on the implications of a general supervision policy for PTAs and OTAs in private practice. APTA recognizes the ability of PTAs to use general supervision to perform at the top of their licensure as being consistent with the guidelines of the profession. APTA supports a minimum level of supervision required for the safe and effective delivery of physical therapy services and recognizes that a higher level of supervision may occur based on jurisdictional law, patient or client needs, the skills and abilities of personnel being supervised, and other factors.

We thank CMS for including this important comment solicitation in the proposed rule and offer the following feedback in response to the agency's specific questions below:

Because we want to ensure quality of care for therapy patients, could the general supervision policy raise safety concerns for therapy patients if the PT or OT is not immediately available to assist if needed?

The relationship between the PT and the PTA is already heavily regulated to ensure that the PT is always responsible for the patient's safety and treatment. Guidance from APTA, Medicare, and state law all require that PTAs only operate under the direction of the PT. APTA believes the existing framework of various authorities on the PT-PTA relationship is sufficient to ensure patient safety under a general supervision policy.

APTA maintains a comprehensive policy on the duties and abilities of the PTA, defining a PTA as a provider who implements components of patient care, obtains data related to the treatments provided, and collaborates with the PT to modify care as necessary. Most importantly, PTAs assist the PT in the provision of physical therapy. Accordingly, the PT is directly responsible for the actions of the PTA in all practice settings, and the PTA may provide services only under the direction and, at minimum, general supervision of the physical therapist. The PT considers a number of factors before delegating treatment to the PTA: the complexity and acuity of the patient's need; the proximity and accessibility of the physical therapist; the likelihood of emergencies or critical events; the education and experience of the PTA; and

type of setting in which the service is provided. The ability of the PTA to treat the patient is then continually assessed by the supervising PT.

Accordingly, a plan of care is never delivered solely by a PTA. Chapter 15, Section 220.3, Sub-section D. progress report of the Medicare Benefit Policy Manual, and the APTA House of Delegates Guidance on direction and supervision of a PTA both mandate that the plan of care be executed by either a PT or a PT-PTA team. The PT always develops the plan of care, determines the delegation of components of the plan of care to a PTA, provides ongoing management of the plan of care, and determines the need to modify the plan of care. PTAs then carry out that plan when determined appropriate by the PT.

Florida's state practice act serves as an example of how states also regulate the relationship between PTs and PTAs. In Florida statute, the PT provides an initial evaluation of the patient, identifies precautions, special problems, and contraindications that would affect the PTA's ability to treat the patient, develops a treatment plan and directs the PTA on what components of the plan they can implement by assigning out tasks. The PT then reassess the patient's goals and PTA's ability to serve the patient as necessary.

Accordingly, regardless of the level of supervision, the PT is always responsible for the patient's safety and overall treatment and will only delegate treatment that is appropriate for the patient and the PTA to safely perform.

Further, we believe CMS can rely on two analogous situations to determine if a change in supervision will result in safety concerns: first, other outpatient therapy settings operating under general supervision; and, second, private practices that have utilized direct supervision via use of two-way audio/video communications technology during the PHE.

Other Outpatient Therapy Settings

As previously stated, hospital outpatient clinics, skilled nursing facilities, rehabilitation agencies, comprehensive outpatient rehabilitation facilities, and even home health agencies are allowed to provide outpatient physical therapy under general supervision. In the case of SNFs, these patients are frequently higher acuity with a greater number of complexities and comorbidities, resulting in a higher risk profile during the provision of services. While it is true that SNFs have more personnel on site at any given time, the fact remains that a PT — the author of the plan of care and clinician ultimately responsible for the patient — is not required to be on site. Providers who are on site, such as nurses certainly provide an additional layer of safety should an incident occur, but they do not have the same rehabilitation expertise that a PT has acquired through their doctoral-level education. Other settings, such as hospital outpatient clinics, CORFs, and RAs, are virtually indistinguishable from private practice therapy clinics, aside from their regulatory requirements. **APTA is unaware of any data to suggest that HOPDs, CORFs, or RAs are any less safe than private practices.** We ask CMS to review Medicare data to determine if there is any discrepancy between safety in these settings.

Additionally, Medicare Benefit Policy Manual Chapter 15 Section 220.1.4 allows for outpatient therapy services to be delivered in a limited number of locations:

1. A provider to its outpatients in the patient's home;
2. A provider to patients who come to the facility's outpatient department;
3. A provider to inpatients of other institutions, or;

4. A supplier to patients in the office or in the patient's home. (Note: CORF rules differ on providing therapy at home.)

Accordingly, the settings subject to general supervision are currently providing outpatient therapy via a PTA in the patient's home. There is no additional layer of safety in a patient's home, yet PTAs have been working in the home setting without an onsite supervisor for years. APTA again is unaware of any data or reports alleging that the delivery of therapy services by a PTA in the patient's home is any less safe than in the clinic. Again, we stress that a PTA will only be sent to a patient's home when the supervising PT has deemed it suitable based on the individual patient's condition and the skills of the individual PTA. **We believe this is proof that the existing safeguards regulating the relationship between PTs and PTAs are safe, effective, and robust enough to ensure that patients are consistently receiving high-quality, appropriate care from PTAs in all settings.**

Private Practices Using Virtual Direct Supervision

Through the March 31, 2020, COVID-19 interim final rule, CMS changed the definition of "direct supervision" during the PHE for COVID-19 to allow for direct supervision to be accomplished via two-way audio-video communications technology rather than on-site availability (85 FR 19245 through 19246). CMS confirmed that this new definition of direct supervision was applicable to private practice therapists and assistants in a later FAQ. In this year's proposed rule, CMS has indicated it will extend this policy until the end of 2024, and is considering making it permanent in certain scenarios, which APTA strongly supports.

With this policy in place since 2020, CMS has had ample time to analyze whether an increased risk to patients has manifested due to the supervising clinician being off-site. While we appreciate that the virtual direct supervision standard requires the supervisor be available via audio-video telecommunication, and general supervision only requires availability via traditional telecommunication, we argue that the virtual direct supervision standard is more analogous to general supervision than it is to traditional direct supervision because of the off-site component. This is also true given the prevalence of smart phones with built-in audio-video telecommunication capabilities, meaning most instances of general supervision are probably also satisfying direct virtual supervision requirements at any given time. APTA again has no knowledge of any increase in patient harm or decrease in quality of care for patients receiving treatment from PTAs in private practice who were utilizing the virtual direct supervision flexibility. On the contrary, we have heard from our members that this flexibility has extended the capabilities of the physical therapy workforce to better serve rural and underserved communities that report shortages of qualified therapy personnel. Accordingly, we believe there is no risk to patients should CMS move to general supervision of PTAs in private practice.

Do state laws and policies allow a PTA or OTA to practice without a therapist in a therapy office or in a patient's home?

PTAs are governed by state physical therapy licensure laws, which are adopted by their states' physical therapy licensure board. A qualified PTA is licensed or certified and has passed a national examination for PTAs. The Federation of State Boards of Physical Therapy furnishes the national examination for PTAs, known as the National Physical Therapy Exam. The curriculum is provided by the Commission on Accreditation in Physical Therapy Education or by another credentialing body identified by APTA. Under 42 CFR 484.4, all U.S. jurisdictions require licensure or certification of PTAs. Therefore, PTAs must pass the National Physical Therapy Exam to be eligible for state licensure or certification and must meet the continuing education and competency requirements in their state to maintain their licensure or

certification. Requirements for transcripts, jurisprudence assessment, criminal background checks, and professional liability insurance vary by state.

PTAs are also governed by corresponding regulations adopted by their state's physical therapy licensure board. These regulations often include supervision minimums that vary from state to state, but some states leave setting-specific supervision requirements undefined. For a comprehensive list of state supervision laws, refer to the Federation of State Boards of Physical Therapy. A summary of some of the trends in states' supervision requirements is below:

- 49 states have some form of general supervision.
- 44 states require general supervision in all settings.
- New York and the District of Columbia are the only jurisdictions that require on-site supervision of PTAs in all settings.
- Only five states expressly require a PT to be on-site when a PTA provides in-home care.
- 30 states expressly allow general (or off-site) supervision of PTAs providing in-home care.
- 36 states limit the number of personnel a PT can supervise at a given time.

APTA is unaware of any state or jurisdiction having greater risk or complications due to their supervision levels. Accordingly, we believe that states are responsibly regulating supervision in their jurisdiction. If a state has deemed off-site supervision or in-home care as appropriate, CMS should not impose additional standards.

Could any safety concerns be addressed by limiting the types of services permitted under a general supervision policy?

Both Medicare regulations and state law already limit the types of services permitted to be performed by PTAs. The Medicare Benefit Policy Manual states that PTAs may not provide evaluation services, make clinical judgments or decisions, or take responsibility for the service (Chapter 15 Section 220.1(C)). Rather, PTAs are permitted only to perform a subset of therapy services, while all complex therapeutic and evaluative procedures are reserved for PTs.

At the state level, there are many additional restrictions. For example, Pennsylvania does not allow a PTA to perform evaluation, testing, interpretation, planning, or modification of patient programs; and a licensed physical therapist must provide direct on-premises supervision of a PTA for at least 50% of the hours worked.

In total, individual states specify both licensure and scope of practice requirements for PTAs in their state and determine what services a PTA can safely provide to patients both in a health care setting and off the premises.

Would a general supervision policy be enhanced with a periodic visit by the PT or OT to provide services to the patient? If so, what number of visits or time period should we consider?

Medicare already requires the PT treat the patient at least every 10 treatment days, per the progress note requirement. Chapter 15, Section 220 of the Medicare Benefit Policy Manual requires the PT to complete a progress report at least once every 10 treatments. To complete the report PTs must actively treat the

patient. PTAs are permitted to write elements of progress reports occurring within the 10-day period; however, reports written by PTAs are only considered supplementary to reports completed by the PT.

Many states also mandate that PTs provide periodic reevaluations or in-room supervisory visits of PTAs more frequently than is required by Medicare. For example, Nevada's physical therapy practice act requires PTs to provide the required treatment and reevaluate the patient no less than every seventh day of treatment or within 21 days. Likewise, Georgia's physical therapy regulations require that a PT be on-site at all institutional settings at least 25% of any work week, Monday through Friday, during which a PTA is providing care; and that the PT be readily available to the assistant at all other times, including weekend coverage, for advice, assistance, and instruction.

Accordingly, CMS does not need to impose any additional requirements, as both Medicare and state law already require periodic visits by the PT.

Would a general supervision policy potentially cause a change in utilization? Would such a change in the supervision policy cause a difference in hiring actions by the PT or OT with respect to therapy assistants?

Utilization of therapy services is not expected to increase due to a change in supervision levels for PTAs. While this is a complex question, APTA is happy to provide reasoning and data to support this assertion. First, CMS must consider changes in utilization in two ways. First, general utilization of therapy services may change. Second, the ratio of services performed by therapists compared to assistants may change. APTA asserts that the general utilization of therapy services would remain the same, but therapy clinics would increase the ratio of services performed by PTAs versus PTs, which would result in savings to Medicare because PTA services are paid at a lower rate.

First, all patients must receive an evaluation from a PT and have a plan of care developed before a PTA can treat a patient. Accordingly, the current shortage of PTs, as previously discussed, will continue to limit therapy utilization since new patients will still need to wait for the availability of a PT. Changing supervision levels may result in modest increases in utilization due to the fact that PTs will be able to supervise PTAs in other locations; however, this will have a greater impact on improving continuity of care, thereby reducing the average length of an episode of treatment. We have heard anecdotally that most clinics will continue to have a PT on site the majority of the time, but this flexibility will allow patients to continue to receive care in case the PT is unavailable due to illness, vacation, or other short-term scenarios. Currently, should the supervising PT leave a private practice, even for a short period of time — for instance, to eat lunch or attend a personal errand — the PTAs must stop treatment. This causes significant disruption to care and can result in patient setbacks, delayed visits, and overall greater costs to Medicare. Under general supervision, these disruptions would not be an issue.

Further, APTA has data to support the fact that due to the PTA differential, wherein services are delivered in whole or in part by a PTA are paid at 85% of the fee schedule amount, Medicare stands to achieve significant savings from implementing a policy that increases utilization of PTAs versus PTs.

In 2022, APTA, the American Health Care Association, American Occupational Therapy Association, Alliance for Physical Therapy Quality and Innovation, National Association of Rehabilitation Providers and Agencies, National Association for the Support of Long-Term Care, and the Private Practice Section of APTA commissioned Dobson DaVanzo & Associates to evaluate the financial impact and medical consequences of various provisions included in the Stabilizing Medicare Access to Rehabilitation and Therapy (SMART) Act, (H.R. 5536). One of those provisions was standardizing the supervision requirement for therapy assistants across all settings, a provision which has been re-introduced in the

118th Congress as the Enabling More of the Physical and Occupational Workforce to Engage in Rehabilitation Act, or EMPOWER Act, (H.R. 4878/S. 2459).

The report sought to predict whether a change in supervision would result in an increase in therapy utilization generally, and whether a change in utilization of PTAs versus PTs will occur. The report examined utilization of PTA services in the two states that require direct supervision by PTs across all settings (New York and District of Columbia) and compared the results with other states that do not have these requirements. Similarly, the report examined utilization of OTA services in the one state that requires direct supervision by OTs across all settings (Kentucky) compared with other states that do not have these requirements. The report found that states with direct supervision requirements had similar or higher utilization of Medicare therapy services compared with other states in their census region and nationally, even though the use of PTAs was lower in New York and the District of Columbia relative to the comparison areas, and the use of OTAs was lower in Kentucky relative to the comparison areas. (See Exhibit 6 Percent of Medicare Physical/Occupational Therapy Services Performed by PTAs/OTAs by State in CY2021, Page 10). Thus, the analysis determined:

> Based on observations of Medicare therapy utilization in New York, the District of Columbia, and Kentucky we assume that **reducing the supervision requirement will result in an increased use of therapy assistants but not a corresponding increase in total Medicare utilization of therapy services.** The increased use of therapy assistants that we assume will occur under a less stringent supervision requirement might free the therapist to focus on diagnosing patients and developing rehabilitation programs tailored to patient's prognosis while allowing therapy assistants to execute rehabilitation plans. An increased number of therapy assistants in a practice would also require PTs or OTs to allocate additional supervision and administrative time. Thus, we assume that practices would substitute PTA or OTAs for certain services that would have been performed by a PT or OT, but would not increase patient load or overall utilization of services. (Page 11).

Accordingly, Medicare stands to achieve savings by implementing this policy.

Exhibit 11: Impact of Amending the Current Medicare Direct Supervision Requirements of Therapy Assistants in Private Practice Settings to General Supervision on Medicare Expenditures (2022 – 2031) in Millions of Dollars

Provision	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2022-27	2022-31
Standardize the current Medicare ***supervision*** requirement across all settings + no exemption to payment differential	$0.0	-$7.3	-$16.9	-$20.6	-$24.4	-$29.2	-$34.1	-$40.1	-$46.1	-$52.7	-$98.3	-$271.3

Source: Dobson | DaVanzo estimates using Medicare Carrier and Outpatient Research Identifiable Files for 2021.

(Table adapted from the Dobson DaVanzo report.)

While the report analyzed a number of different scenarios based on various other provisions of the SMART Act, **the analysis of the impact of amending solely the current direct supervision requirements of PTAs demonstrated that Medicare spending would be reduced by $271.3 million over 10 years.** While this data assumed the policy would be implemented in January of 2023, the fact remains that Medicare stands to recoup significant savings by implementing this policy.

A detailed Dobson DaVanzo report which includes data, assumptions, and methodology can be found here.

Clarifications for Remote Monitoring Services

Data Collection Requirements

CMS notes that it is not extending beyond the end of the PHE the interim policy to permit billing for remote monitoring codes, which require data collection for at least 16 days in a 30-day period, when less than 16 days of data are collected within a given 30-day period.

APTA believes CMS may have misconstrued the code descriptors for the various RTM codes. APTA would like to clarify that only 98975, 98976, 98977, and 98978 require 16 days of monitoring and are billed per a 30-day period. However, 98980 and 98981 are billed based on the amount of time spent in a calendar month inclusive of one synchronous interaction with the patient without requirement for a certain number of days of data collection. 98980 is billed when 20 minutes of monitoring and treatment management is provided in the calendar month, and 98981 is billed when an additional 20 minutes is provided in a calendar month. It appears that CMS intends to require data collection for at least 16 days in a 30-day period for all RTM when only 98975, 98976, 98977, and 98978 have that requirement in the official code descriptor.

Accordingly, we encourage CMS to clarify that the 16-day data collection requirement only applies to 98975, 98976, 98977, and 98978 and does not apply to 98980 and 98981.

New Versus Established Patient Requirements

CMS notes that it will require that RPM services be furnished only to an established patient. Patients who received initial remote monitoring services during the COVID-19 PHE are considered established patients for purposes of the new patient requirements that are effective after the last day of the PHE.

APTA requests that CMS clarify this requirement, as the terms “new patient” and “established patient” are defined by CMS specifically as it relates to physicians and the billing of E/M codes. APTA requests that CMS clarify that RTM services may be billed when provided under a physical therapist plan of care that is developed based on the completion of a physical therapy evaluation.

Use of RPM, RTM, in Conjunction With Other Services

CMS proposes to clarify that RPM and RTM may not be billed together, so that no time is counted twice by billing for concurrent RPM and RTM services. CMS further states that when the same patient receives RPM and RTM services, there may be multiple devices used for monitoring, and in these cases, CMS will apply its existing rules, meaning that the services associated with all the medical devices can be billed by only one practitioner, only once per patient, per 30-day period, and only when at least 16 days of data have been collected; and that the services must be reasonable and necessary (85 FR 84544 through 84545).

APTA urges CMS to reconsider this position. As indicated by the descriptions of RPM and RTM, these services involve the analysis of different data for unique purposes. Additionally, different providers utilizing RPM or RTM would do so in the context of a specific plan of care and to support the achievement of unique goals. APTA supports the ability of multiple providers to bill for RPM and/or RTM services during the same time period so long as the data being analyzed is not duplicative.

Other Clarifications for Appropriate Billing

CMS also proposes to clarify that, when an individual beneficiary may receive a procedure or surgery and related services that are covered under a payment for a global period, RPM services or RTM services (but not both RPM and RTM services concurrently) may be furnished separately to the beneficiary, and the practitioner would receive payment for the RTM or RPM services, separate from the global service payment, so long as other requirements for the global service and any other service during the global period are met. CMS further states that for an individual beneficiary who is currently receiving services during a global period, a practitioner may furnish RPM or RTM services (but not both) to the individual beneficiary, and the practitioner will receive separate payment, so long as the remote monitoring services are unrelated to the diagnosis for which the global procedure is performed, and as long as the purpose of the remote monitoring addresses an episode of care that is separate and distinct from the episode of care for the global procedure. This means that the remote monitoring services address an underlying condition that is not linked to the global procedure or service.

APTA urges CMS to clarify that this policy does not apply when RTM is furnished as part of an outpatient physical therapy plan of care, and that RTM may be billed for a related diagnosis in this instance. CMS, in the 2022 physician fee schedule, noted that the primary billers of RTM would be physiatrists, NPs, and physical therapists. (86 FR 65115). As physical therapy is not included in the global period payment and is billed and paid for separately, RTM services should be treated similarly when furnished as part of a physical therapist's plan of care. Failing to make this clarification risks eliminating the RTM benefit for many postoperative Medicare beneficiaries.

Request for Information on Digital Therapies, Such as, but not Limited to, Digital Cognitive Behavioral Therapy

APTA is pleased to respond to several specific questions posed in the proposed rule:

How do practitioners determine which patients might be best served by digital therapeutics?

Patients who will benefit from RTM are those who have the ability individually, or with the assistance of a caregiver, to effectively utilize the remote monitoring technology, and are willing to participate in RTM when physical therapy digital therapeutics supporting RTM are integrated into the physical therapy plan of care. Some examples include but are not limited to:

- Support and track a patient's execution of a prescribed home exercise or self-management plan that reinforces skills acquired during the skilled therapy session and ensures effective carry-over for timely achievement of goals. Data is used to manage, modify, and progress the home program in real time, or during the next therapy visit as needed.

- Monitor response to therapy interventions and prescribed home exercise or self-management plans including but not limited to pain levels, levels of perceived exertion, activity tolerance, and engagement in functional activities and tasks. Data is used to optimize the patient's engagement in their own recovery and ensure that techniques to manage pain and pace activity level are being appropriately employed.

- Remote gait monitoring whereby a patient is instructed to download an app and record a walk daily. The app analyzes the gait and stores the data in a secure cloud-based system where the therapist or provider can access that data for analysis. Providers can also use this type of monitoring to track gait speed and therefore gauge overall health status and potentially detect a decline in factors that are strongly correlated with slowing gait speed, including cardiovascular decline, cognitive decline, increased fall risk, and functional mobility decline.

- The future use of individual wearables to monitor wound status in real time and ensure a better recovery, decreasing patients' visits to providers and mitigating their financial burden.

- Use of wearable devices that measure physical activity and physiometric signals to improve the assessment and treatment of pain.

How do practitioners monitor the effectiveness of prescribed interventions for their patients on an ongoing basis once the intervention has begun?

Physical therapists who incorporate RTM into the physical therapy plan of care monitor the effectiveness of the RTM by monitoring the data gathered to ensure that the prescribed home or self-management program is producing the desired results and that symptom management techniques are effective. Additionally physical therapists utilize objective tests and measures to ensure the prescribed monitoring program is contributing to goal achievement.

What best practices exist to ensure that patients have the necessary support and training to use applications effectively?

Prior to implementing RTM, the physical therapist screens the patient to assess whether or not they have the digital literacy to use the application with or without family/caregiver support at home. Additionally, the therapist verifies that the patient has the proper technical device requirements to allow for remote monitoring to be effective from appropriate personal device to connectivity requirement.

Once it is determined that the patient is able to participate and will benefit from the use of RTM, the physical therapist, or physical therapist assistant under the supervision of a physical therapist, instructs the patient and, when indicated, caregiver(s) in the use of the device or application, and then use return demonstration to ensure competency. In addition, follow-up communication occurs frequently to address any questions that arise. Finally, the patient is given a support contact for any device- or application-specific issues they might encounter.

What practitioners and auxiliary staff are involved in furnishing RPM and RTM services, including training patients on their use, and to what extent is additional training or supervision of auxiliary staff necessary to provide an appropriate for and/or recommended standard of care in the delivery of these services?

As it relates to physical therapy, patients are trained in the use of RTM devices by a licensed physical therapist, or physical therapist assistant under the supervision of a physical therapist. The physical therapist always serves as the initial point of contact for any issues and will engage the vendor of the device or application as needed.

How are data that are collected by the technology maintained for recordkeeping and care coordination?

Data is either entered by the patient or collected by sensors on the devices. If collected by the device, this is sometimes "immediately" sent to a secure cloud location and other times is maintained on the device and submitted on a set frequency (1-6x/day) to a secure location.

Data is maintained (currently) for a period of seven years for both recordkeeping and care coordination. This does create additional costs for both storage and data security, which CMS needs to be aware of as they look at reimbursement and such for these services.

What information exists about how an episode of care should be defined, particularly in circumstances when a patient may receive concurrent RTM or digital CBT services from two different clinicians engaged in separate episodes of care?

A physical therapy episode of care is defined by the time between the initial evaluation or assessment and the documented formal discharge from an active therapy plan of care.

We noted in previous rulemaking that even when multiple medical devices are provided to a patient, the services associated with all the medical devices can be billed by only one practitioner, only once per patient, per 30-day period, and only when at least 16 days of data have been collected.

APTA would like to clarify that only 98975, 98976, 98977, and 98978 require 16 days of monitoring and are billed per a 30-day period. To ensure there is no confusion, APTA would like to reinforce that 98980 and 98981 are billed based on the amount of time spent in a calendar month inclusive of one synchronous interaction with the patient, without requirement for a certain number of days of data collection. 98980 is billed when 20 minutes of monitoring and treatment management is provided in the calendar month, and 98981 is billed when an additional 20 minutes is provided in a calendar month.

We seek information on the type and frequency of circumstances that involve multiple medical devices and multiple clinicians.

It is important to note that RPM and RTM are two very distinct types of services, and it is reasonable for two different providers to bill for each service during the same time period. Multiple providers should be able to bill RTM in the same time period if the services are for distinct therapeutic purposes and are not duplicative. APTA agrees that a single provider should only be able to bill RTM services once in a time period.

How might allowing multiple, concurrent RTM services for an individual beneficiary affect access to health care, patient out of-pocket costs, the quality of care, health equity, and program integrity?

Beneficiaries receiving multiple therapy services at the same time (PT, OT, SLP) may benefit from RTM services specific to each service that promote early activation and engagement of the patient in their therapeutic program. RTM services provide the opportunity for therapists to assess a patient's ability to carry over skills learned during a therapy session or exercises/activities prescribed by the therapist in real time, and modify the plan of care as needed to optimize the therapy episode of care. RTM services enable patients to engage with their therapist without having to come into the clinic in between scheduled visits, reducing demands on patients and caregivers and ensuring care plan adjustments are not delayed and patients' questions and concerns are answered in a timely manner.

Do interested parties believe digital CBT could be billed using the existing remote therapeutic monitoring codes described by CPT codes 98975, 98980, and 98981?

APTA believes CBT could be billed using 98975, 98980, and 98981. CPT codes 98975, 98980, and 98981 are not system-specific by definition. Only 98986, 98977, and 98978 are system-specific.

In the past, commenters generally supported the concept of a generic RTM device code and offered a wide variety of possible use cases, including where FDA-approved devices and devices that have gone through other premarket pathways exist for the purpose of monitoring various conditions that do not meet the current scope of the existing RTM codes.

Under current practice models, are these products used as incident-to supplies or are they used independent of a patient visit with a practitioner?

In the practice of physical therapy, RTM devices and services are used as an adjunct to a patient visit with a practitioner but as an integrated aspect of the physical therapy plan of care. RTM in physical therapy is utilized to essentially extend the reach of the therapist to assess and support the performance and progress of the patient outside of the therapy clinic or session.

If used independently of a clinic visit, does a practitioner issue an order for the services?

Physical therapists are required to include RTM services in the physical therapy plan of care when indicated.

Rural Health Clinics and Federally Qualified Health Centers

Virtual Direct Supervision for "Incident to" Services

Currently, CMS requires that "incident to" services in FQHCs (which includes physical therapy services) are subject to direct supervision. CMS proposes to extend its PHE flexibility, which allows direct supervision to be met using interactive audio and video telecommunications, through Jan. 1, 2024. CMS is also soliciting comments on whether it should consider extending the definition of direct supervision to permit virtual presence beyond Dec. 31, 2024, specifically seeking comment from interested parties on "potential patient safety or quality concerns when direct supervision occurs virtually in RHCs and FQHCs."

APTA supports CMS' proposal to extend the flexibility through 2024. We also recommend that CMS consider making the flexibility permanent as it relates to physical therapists. As CMS mulls whether requiring a physician's direct supervision of PT and other "incident to" services is necessary to preserve patient safety, we remind CMS that PTs are doctorate-level clinicians. APTA believes that the existing plan of care requirements, paired with virtual direct supervision is more than appropriate oversight for PTs to provide the clinical services that they are trained to do; even without the plan of care requirements, they could operate safely under virtual direct supervision.

APTA has received several concerns from PTs that FQHCs and RHCs are extremely cautious in the provision of PT services in these settings; this is often tied back to a PT's "incident to" status when PT services are provided in these settings. CMS notes, when compared with professionals paid under the PFS, RHCs and FQHCs have a different model of care and payment structure, which values rehabilitative services differently. FQHCs and RHCs furnish services that are typically provided in outpatient clinic settings — outpatient PTs operate with existing plan of care requirements and do not require direct physician oversight to carry out their services. It is not clear the extent to which PT services are not provided as a result of the direct supervision requirement but given the level of training and the type of care provided in these settings, CMS should not require a higher standard of supervision than is absolutely necessary. It would be completely appropriate to make permanent the direct virtual supervision standard for PTs who practice in RHCs and FQHCs.

RTM in FQHCs/RHCs and G0511 Payment

CMS proposes that RHCs and FQHCs be able to bill RTM services using HCPCS code G0511 (general care management), either alone or with other payable services on an RHC or FQHC claim for dates of service on or after Jan. 1, 2024. Historically, RTM has not been separately billable in FQHCs and RHCs, and instead the payment is included in the base rate for FQHCs or in the all-inclusive rate in RHCs. These rates, however, have not typically accounted for non-face-to-face services, such as RTM; the proposed changes would better account for the collection, transmission, and analysis of data that happens outside of the face-to-face visit. APTA appreciates the inclusion of RTM in G0511. As noted above, PTs have been limited in their ability to perform PT services in FQHCs and RHCs, in part due to "incident to" status and uncertainty around coverage and payment for their services in these settings. Inclusion of separately payable RTM services through the G0511 rate is an important change to ensure that PT services are appropriately available in these settings, and that PTs can provide care as needed for their patients.

Further, existing payment methodology in RHCs and FQHCs calculates rates based on the average of nonfacility rates, which would be much lower with the addition of RPM and RTM. To avoid significant rate drop-off, CMS proposes to use a weighted average to account for actual utilization but would use CY 2021 physician office data as a proxy, as there is a lack of data available for RHCs and FQHCs. APTA appreciates the update to the G0511 rate, proposed at $72.98, which is appropriate for RTM services.

Updates to the Definitions of Certified Electronic Health Record Technology

APTA is deeply concerned about the increasing gulf between providers who have and those who do not have certified EHR technology. This issue has never been more relevant as CMS proposes to end the exemption for physical therapists from reporting the Promoting Interoperability category of the Merit-based Incentive Payment System. As CMS is aware, physicians and hospitals were afforded funding through the former Meaningful Use incentive program (now the Promoting Interoperability category in MIPS), and adoption of EHRs was staged to enable them to learn how to successfully exchange patient information using CEHRT. Physical therapists in private practice, other nonphysician health care professionals, and long-term and post-acute care facilities were ineligible to participate in the Meaningful Use program and have received little to no direction, time, or resources to support adoption and implementation of comprehensive, interoperable EHR systems that promote care coordination and improve patient outcomes.

Moreover, while large provider groups and health systems may be on a compatible EHR system, most independent practices use EHRs that are not standardized, making it that much more imperative that these providers, and their specific health information technology needs, are front and center in health IT discussions. To ensure the future health care system is patient-centric and dedicated to improving care quality and increasing patients' access to their information, all providers and other stakeholders across the continuum need and deserve financial and administrative support to help them implement CEHRT and adopt measures that enable patients to manage their health information. It is vitally important that patient information flows between various sectors of the care continuum, including physicians, hospitals, physical therapists in private practice, post-acute care and long-term care providers, and other health care providers.

The Office of the National Coordinator for Health Information Technology's certification process has established standards and other criteria for structured data that EHRs must use. However, CEHRT requirements are designed for prescribing professionals and do not capture tasks performed by

nonphysician professionals using different types of EHRs. Consequently, the vast majority of EHR technology developed for use by physical therapists and other nonphysician providers cannot fully satisfy the technology requirements outlined in 42 CFR 414.1305, therefore hindering these providers' capability to participate in the Promoting Interoperability category of MIPS, not to mention participation in Advanced Alternative Payment Models and other value-based payment programs.

Modifying and building upon the existing health information technological structure to satisfy future CEHRT requirements requires significant financial investment, is time-consuming, and is disruptive to workflow. To better leverage health IT functionality, as well as to incentivize physical therapist and other nonphysician provider participation in the Quality Payment Program and other value-based models in the future, it is critical that CMS recognize that much of the updated 2015 edition of certification criteria may not apply to physical therapist practice or to other nonphysician providers, including:

CEHRT Category	CEHRT Criteria
Clinical Processes	Computerized provider order entry (CPOE) medications (prescribing) CPOE laboratory Drug-drug, drug allergy interaction checks for CPOE Drug-formulary and preferred drug list checks (CPOE) Implantable device list
Care Coordination	Electronic prescribing* (for medications)
Public Health	Transmission to immunization registries Transmission to public health agencies — syndromic surveillance Transmission to public health agencies — reportable laboratory tests and values/results Transmission to cancer registries Transmission to public health agencies — electronic case reporting Transmission to public health agencies — antimicrobial use and resistance reporting Transmission to public health agencies — health care surveys
*Electronic prescribing may be utilized for referrals and DME.	

It is critical that CMS work with ONC to offer financial and technical assistance to help nonphysician providers, including physical therapists, adopt and implement CEHRT. Moreover, to ensure that the CEHRT adoption process is equitable and fair for all parties, we recommend that CMS set a date by which it expects all EHRs to achieve certification. To that end, we request that CMS afford EHR vendors and health care providers a transition period of three-to-five years to develop, adopt, and integrate certified products. We also recommend that CMS work with ONC to educate providers on the certification process in a manner that clearly conveys what providers need to know, actions to take now and in future years, and the anticipated costs associated with adopting and implementing certified technology.

Updates to the Quality Payment Program

MVP Development, Maintenance, and Scoring

Rehabilitative Support for Musculoskeletal Care

In the proposed rule, CMS includes five new MIPS Value Pathways, including the Rehabilitative Support for Musculoskeletal Care MVP to be available for Performance Year 2024. APTA applauds CMS'

inclusion of this landmark MVP, the first of its kind that will allow a subset of physical therapists to meaningfully participate in the Quality Payment Program and be compared with their clinical peers.

APTA offers several specific comments across the quality measures and improvement activities below, and notes the changes between the most recent round of the MVP Candidate Feedback Process and this proposed rule. We believe that the MSK MVP can be improved to provide more meaningful participation for PTs.

- **Quality Measures.** Compared with the most recent round of the MVP Candidate Feedback Process, CMS has proposed a similar measure set as identified in the most recent draft. We appreciate that CMS accepted our recommendation for the inclusion of MIPS Measure Q487 (Screening for Social Drivers of Health). However, as proposed, CMS has removed the "Failure to Progress" IROMS measures from the available quality measures (IROMS12, IROMS14, IROMS16, IROMS18, and IROMS20), leaving a limited pool of FOTO measures for participants to choose from.
    - **FOTO Measures.** We remind CMS that the cost of participating in any part of the QPP, including the MSK MVP, is a challenge for PTs. While these measures can be reported via registry, seven of the 10 total quality measures will require the use of FOTO. It is APTA's understanding that FOTO measures have historically required an annual subscription based on the practice's size. This means most physical therapists are not using FOTO measures and may not have access to them. Accordingly, this is yet another increased cost of participating, the sum of which will be challenging, if not impossible for PTs to earn back in program incentives. Practices that are not financially able to contract with FOTO are left with only two-to-three measures that they can report, making it impossible to report on the minimum four measures.
    - **Removal of IROMS Measures.** The fact that IROMS measures were removed from the set without explanation exacerbates this, and we recommend at least including the IROMS measures. In our last comments on the MVP, we noted that since all but two measures were FOTO and IROMS measures, which are limited to specific body parts, it is conceivable that certain specialty practices may struggle to meet the four-measure minimum, creating avoidable barriers to participation. The proposed measure set, since it excludes IROMS, creates an even more narrow opportunity to participate. We ask CMS to include these measures in the final measure set.
    - ***Inclusion of PROMIS measures*:** As noted above, APTA urges CMS to err on the side of providing as many options for physical therapy practices in the measure set. We strongly recommend that in this first iteration of the MVP the agency include PROMIS measures associated with physical function, pain interference, and Global Health 10 or 29. In future rulemaking, we believe that CMS should further explore the PROMIS measure set for broader inclusion in the future of the MVP. Notably, including PROMIS measures offers critical options that are not represented in the measures offered in the proposed set. The PROMIS measure set distinguishes itself as a non-disease specific, whole-person (patient centered) option, and allows considerable flexibility for use across a range of practice sizes, EHR systems, and sophistication of the practice in question. Importantly, in contrast with the FOTO options, administration with short forms is free and low-price options are available for computer adaptive versions. We note that CMS has repeatedly stated that the goal of MVPs is to promote patient-centeredness, with repeated emphasis that patient-reported measures are a critical component of each MVP. To this end, the PROMIS measure set includes important patient-reported metrics and a focus on the patient's overall symptoms and function. Further, these measures are

used in some of the country's most prestigious heath care facilities, notably those that are spearheading value-based care initiatives through systematic, transdisciplinary implementation of quality measures – this includes the Cleveland Clinic, Washington University in St. Louis, the University of Rochester, Henry Ford hospital, and Duke University.

- **CMS Should Include the Following Measures in the MVP.** APTA suggests including several additional quality measures that would promote meaningful participation for physical therapists and other nonphysicians:
    - MIPS Measure 182 (Functional Outcome Assessment).
    - MIPS Measure 134 (Preventive Care and Screening: Screening for Depression and Follow-Up Plan).
    - MIPS Measure 226 (Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention).
    - MIPS Measure 431 (Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling).

- **Improvement Activities.** CMS proposes significant additional improvement activities options from its most recent draft. The proposed rule includes the IA_PSPA_21 (Implementation of Falls Screening and Assessment Programs), which APTA pleased to see its inclusion in the measure set. APTA's previous comments noted the limited improvement activities for PTs; the inclusion of six additional options also offers several additional options that PTs may be able to use. These include IA_BMH_12 (Promoting Clinician Well Being) and IA_EPA_3 (Collection and Use of Patient Experience and Satisfaction Data). We encourage CMS to include additional IA options that PTs can use, including IA_PM_13: Chronic Care and Preventative Care Management for Empaneled Patients (Medium). We appreciate that CMS accepted several recommendations that APTA provided during the comment process and have proposed them in this rule.

- **Promoting Interoperability.** It is unclear how CMS anticipates that physical therapists can meet the interoperability requirements, particularly those associated with e-Prescribing and Query of the Prescription Drug Monitoring Program. While some flexibility exists in the PI category, these are required elements. Their presence in the MVP effectively lowers nonphysicians' ceiling in scoring on this category, who also have few (if any) CEHRT options available to them. As outlined below, CMS needs to maintain the reweighting of scoring for PTs in both traditional MIPS and MVPs. In MVPs CMS should ensure PTs are not scored on their performance in categories they cannot participate in, such as e-prescribing.

MIPS Performance Category Measures and Activities

Promoting Interoperability Performance Category

APTA strongly opposes' CMS' proposal to end physical therapists' automatic exemption from the Promoting Interoperability category of MIPS. Since their initial inclusion in the MIPS program, physical therapists have been subject to CMS' reweighting policy wherein it will assign a weight of zero to the Promoting Interoperability performance category in the MIPS final score. This is largely due to the fact that physical therapists were not eligible to participate in the Medicare or Medicaid Promoting Interoperability Program (formerly known as Meaningful Use Program) and there are not sufficient

CEHRT vendors or measures applicable and available to them under the Promoting Interoperability performance category.

As we discussed above, the lack of CEHRT available for physical therapists is in large part due to the ONC certification standards which are designed for prescribing professionals and do not capture tasks performed by nonphysician professionals using different types of EHRs. Consequently, the vast majority of EHR technology developed for use by physical therapists and other nonphysician providers cannot fully satisfy the technology requirements outlined in 42 CFR 414.1305, therefore hindering these providers' capability to participate in the PI category of MIPS, MVPs, or Advanced Alternative Payment Models.

To APTA's knowledge, no vendors of EHR designed for physical therapy have received ONC certification to date. Accordingly, it is impossible for physical therapists to comply with the promoting interoperability reporting requirements.

Further, we understand that small practices are excepted from reporting promoting interoperability, and § 414.1380(c)(2)(C) provides MIPS clinicians with an exception to the Promoting Interoperability performance category when a significant hardship exists. The statute includes a number of criteria for obtaining the exception, one of which is:

> ***(4)*** The MIPS eligible clinician demonstrates through an application submitted to CMS that 50 percent or more of their outpatient encounters occurred in practice locations where they had no control over the availability of CEHRT. § 414.1380(c)(2)(C)(4).

The Quality Payment Program website states: "Simply lacking the required CEHRT doesn't qualify you for reweighting," but no additional information is provided as to how clinicians can prove CEHRT is not available. We request that the agency provide more information on how an individual clinician would be able to demonstrate that no CEHRT is available. We are hopeful that the burden of proof placed on clinicians is not overly taxing, which would further challenge PT participation in the program.

Finally, because APTA believes that every PT in the MIPS program should be granted the hardship exception to the Promoting Interoperability performance category, CMS has essentially implemented a meaningless administrative burden for already overwhelmed and underpaid providers. An exception that applies to all but requires an application for approval means that clinicians who file late or make an error on their application will be punished for these administrative errors — not for the quality of their services, which is the reason the QPP was designed. CMS and the QPP should reward clinicians who deliver quality care and punish clinicians who deliver subpar care. They should not penalize clinicians who fail to submit the proper paperwork for an exception that they should be granted automatically.

Accordingly, we urge the agency to continue to exempt physical therapists from the Promoting Interoperability performance category for 2024 and beyond.

Low Back Pain Cost Measure

CMS is proposing to add five new episode-based measures to the Cost Performance category beginning with the CY 2024 performance period/2026 MIPS payment year. These five proposed measures are Depression, Emergency Medicine, Heart Failure, Low Back Pain, and Psychoses and Related conditions. The LBP cost measure is the first cost measure included in MIPS that will be available to physical therapists.

APTA strongly supports inclusion of this measure in MIPS. As APTA has noted in past comments and elsewhere in this letter, PTs have extremely limited options to participate in any QPP track, primarily because there are so few physical therapy-inclusive measures. This means that the financial incentives available through these programs are generally less available to PTs. The opportunity to have applicable measures available in MIPS is the first step to improving PT participation in the quality space.

While APTA is grateful for the development of this measure, the fact remains that only one cost measure will be available for physical therapists in 2024, seven years after the implementation of MACRA and QPP. Ultimately, CMS must continue to improve the processes currently in place to review and introduce measures in MIPS, MVPs, and AAPMs. The challenges associated with developing an MVP or other measure proposals — cost, burden, overall complexity of quality measurement — are left almost entirely to the applicants; as such, we fear that these programs will never be able to meaningfully offer a framework under which PTs and other nonphysicians can participate that reflects the QPP's aim to shift health care toward a value-based model.

QPP: Request for Feedback

CMS seeks comment on how the agency can modify its policies under the QPP to foster clinicians' continuous performance improvement and positively impact care outcomes for Medicare beneficiaries. Many of the questions CMS poses in the request for feedback concern increasing or adding performance standards to continuously improve care. We are concerned that CMS appears concerned only with raising the bar for current QPP participants rather than opening doors to new participants.

Fewer than half of all providers paid under PFS are required to participate (52% of all Medicare Part B providers are exempt from mandatory participation in 2022). We believe CMS can work to solve problems simultaneously but note that many of the barriers to the QPP's success are more fundamental in nature, and merely increasing the requirements for QPP participants is not likely to result in significant change given the low participation rate. Further, while we support CMS' desire to ensure continuous quality improvement in the program, we are concerned that by focusing only on existing participants, just as it did with Meaningful Use/Promoting Interoperability, the agency is creating two disparate groups of providers, and the gulf between them will only continue to grow.

Accordingly, APTA offers the following recommendations to improving the QPP:

Improve Meaningful Participation for Nonphysician Clinicians

QPP was intended to help solve payment instability within the Medicare Physician Fee Schedule; a solution to the consistent, year over year payment cuts. The payment stability sought through MACRA, primarily accomplished through the repeal of the sustainable growth rate model, was intended to work in concert with QPP — it was inherently premised upon providers having opportunities to receive positive adjustments through either QPP track once the statutory updates were removed. This meant that, after a certain point, stable and fair payment under PFS necessitated participation in one of these pathways.

While physicians represent most providers paid under PFS, many nonphysicians, including PTs, with considerably disparate practice models and financial margins, are paid under this same system. While all clinicians under the system uniformly bemoan the annual cuts, PTs and other nonphysicians face greater concerns related to practice closure and are forced to entertain the decision of whether to participate in Medicare or not to stay financially viable.

This problem is exacerbated by the fact that the QPP was designed for physicians and has not grown to meaningfully incorporate nonphysicians, despite growing to require their participation. As we have outlined elsewhere in this letter, 2024 will be the first year that a cost measure is available for physical therapists. The fact that physical therapists have been statutorily required to participate in a quality program for four years without any mechanism available to measure their impact on cost speaks to lack of investment in meaningfully including them. Additionally, we echo our previous comments on the total lack of support in helping nonphysicians upgrade EHR to participate in the Promoting Interoperability category of MIPS.

Physical therapists view QPP as an obligation with almost no upside. It is an administrative burden that is not designed or currently capable of measuring PTs' actual impact on patients. Until more investment is made to ensure nonphysicians can be accurately assessed and measured by the QPP, most will seek any means to be exempt from the program.

Reward Performance Rather Than Participation

Because MIPS was created as a budget-neutral program, there is no avenue for all providers to achieve meaningful bonuses. Payment adjustments in MIPS are deceptively low. In theory, payment adjustments achieved through MIPS were +/- 9% in 2022. The opportunity, however, to earn up to a 9% payment increase (or any high-end increase), is effectively a mirage within a budget-neutral system. In 2016, policy experts optimistically clung to the theoretical opportunities of the program, noting that "consistently high performers in MIPS [could] actually financially outperform physicians in APMs for many years." Of course, this optimism failed to account for the budget-neutral system, which inherently relies on poor performance from some providers to achieve the high-end bonuses. However, given extraordinary leniency both in mandatory participation and self-selecting reporting measures, participants have, historically, only participated in MIPS when they know they will receive a positive adjustment under the system. As such, budget-neutrality meant, and still means, that the overwhelming majority of participating MIPS providers receive a positive adjustment (96.68% in 2021), which in turn reduces the opportunity for any provider to earn high-end bonuses. The highest bonus ever earned under MIPS for a perfect score is only slightly more than 2%, meaning there is realistically no avenue to achieve meaningful bonuses under MIPS for all providers, and even more acutely for nonphysicians. And for smaller and less sophisticated nonphysicians, there is almost no chance at all, regardless of whether they are or are not required to participate. We also note that the PFS is slated for a 3.3% reduction in 2024, meaning that QPP, even for the best-performing clinicians, serves only to mitigate reductions in payment rather than reward quality. It bears repeating that the incentives providers can earn through these programs are a critical element of the payment stability envisioned under MACRA — for this reason, budget neutrality is a foundational feature of the system that works against MACRA's original, dual aims to promote value-based care and stabilize payment under PFS.

In MIPS, providers self-select their own measures within each reporting category that determines their future payment adjustments. Through this, they are essentially self-determining their performance in the program. Because providers can cherry-pick the measures they consistently perform well in, there is no incentive to improve care in other areas, and the goals of QPP become null. MACRA, in its inception, provided no mechanism for unbiased, valid reporting and data collection. Therefore, the success of the program in elevating provider performance is drastically inflated given that it is not accurately reporting the quality of care a provider furnishes but rather their ability to submit data that highlights their highest-quality outcomes. Recent literature suggests that CMS could have foreseen this issue, as studies on the precursors of MIPS suggest that providers will continue to game the system for their benefit; the findings of this report recommend ending measure selection in MIPS altogether. CMS must work with Congress to

standardize the QPP measures within provider groups to increase the reliability of the QPP data and accurately measure provider performance. Given the uncertainty of MVPs, it is crucial that any forms of bias be removed from MIPS data collection and reporting processes.

Level the Playing Field With the Appropriate Risk-Adjustment Mechanisms

Inadequate and, at times, nonexistent risk adjustment provides an uneven playing field and limits, overall, the comparative nature of quality between providers. At present, there is not sufficient evidence demonstrating that providers who reach more at-risk groups are consistently scoring lower than other providers. However, to ensure that all providers within QPP are properly measured against their counterparts, there must be an effective mechanism to measure the impact of social risk factors of severely limited and high-risk patient groups on provider quality scores. While, at this time, research does not correlate unmeasured risk factors with lower provider scores, collecting additional data regarding individual social risk will assist CMS in evaluating whether provider quality of care is linked to worse patient outcomes or association is more acute to the risk factors the patient presents with. Conflicting evidence exists simultaneously, arguing that when examining the MIPS scores of surgeons who treat higher- versus lower-risk patients, outcomes were not comparable. Surgeons who performed on higher-risk patients had a statistically higher chance of receiving a lower overall score and were much less likely to receive an exceptional bonus. Health Affairs has also recently reported that clinicians with a higher social-risk caseload had significantly lower mean MIPS performance scores, with a 99% higher likelihood of receiving a negative payment adjustment. The evidence suggests that health care providers who care for socially at-risk populations may be disproportionately penalized, even with the additional complex patient bonus that is truly of little value to clinicians, as most low-resource practices lack the capacity to meet the reporting requirements. Because of this contradictory information, CMS must dig deeper into the impact of risk adjustment on episodic-based models to understand whether they are necessary and the extent of their impact on final clinician scores.

Reduce the High Costs of Participation

High burden has plagued MIPS since its introduction in 2017, but for select clinicians, such as PTs and other nonphysicians, who were only permitted to participate beginning in 2019, the administrative burden and associated costs with implementing and maintaining a MIPS reporting system are magnified due to their substantially lower revenue streams compared with their physician counterparts. While MDs and nonphysicians alike have reported burden concerns, the costs associated with compliance and participation in the program disproportionately impacted nonphysicians who see considerably less revenue and operate substantially different types of practices with thinner margins than most physicians do. Still, a 2021 study from the Journal of General Internal Medicine that identifies themes across MIPS participants found that "nearly all participants reported substantial administrative burden associated with MIPS participation, and many described yearly changes to the program as a particular source of frustration." While nonphysicians were not interviewed in this study, APTA's own conversations with member PTs and policy experts echo these sentiments for those who are able to participate in MIPS.

APTA members revealed several similar themes that have deterred participation in MIPS; these themes include, though are not limited to, cost of compliance, lack of resources, frequent introduction and removal of quality measures, changes in the weighting of MIPS score domains, new requirements to stay abreast of, and lingering uncertainty around the size of rewards and penalties. In particular, the lack of meaningful rewards under the program is a strong deterrent for nonphysicians who wish to participate, as the cost of participating will almost always outweigh the opportunity to receive additional funds.

Provide More Timely Feedback on Participation

For qualifying providers, MIPS performance feedback is the only mechanism by which to measure performance in the program. However, instead of receiving timely feedback on the previous performance period, MIPS participants are often not able to access their scores until halfway through their current performance period. For clinicians looking to continuously improve their scores, this is not timely or actionable. CMS must reconsider the feedback timeline and seek to provide clinicians with ample time to improve their scores in advance of the next performance period.

Encourage Innovation by Promoting Specialty Measure Sets

In its current form, QPP lacks effective and expedient mechanisms to innovate within each pathway. In a 2017 MGMA survey on QPP, 80% of respondents expressed concern over the clinical relevance of MIPS and its quality measures. This sentiment is consistent across participants, and it has been long believed that the ability to introduce new and updated measures (or measure sets) geared toward specific specialties could alleviate at least some of these persisting concerns.

In response to provider concerns, CMS developed and introduced MVPs, which sought to both reduce the complexity and, as CMS notes on the QPP website, "move away from siloed reporting of measures and activities towards focused sets of measures and activities that are more meaningful to a clinician's practice, specialty, or public health priority." Despite only recently going into effect, MVPs theoretically offer solutions to several issues present in QPP, including the opportunity to innovate by specialty and practice, but the challenges associated with developing an MVP or other measure proposals do not allow these programs to meaningfully enter the framework under which health policymakers envision the future of health care delivery. Instead, CMS should consider the relationship between MIPS scores and patient outcomes, as providers are measured against other specialties and few measures are specialty-specific.

A 2021 JAMA investigative research study looking at the association between MIPS score and performance found limited connection between higher scores and better outcomes. The study theorized that the cause of this limited connection was driven by a number of factors, "including the unusually high number of physicians with very high MIPS scores, the preponderance of process measures as opposed to outcome measures, the lack of specialty-specific mandatory measurement sets, the absence of a fixed data submission period, and scoring adjustments by CMS unrelated to physician performance."

A lack of specialty measure sets is a significant issue present within the program, not only because it may account for the attenuated relationship between MIPS scores and outcomes, but also as a barrier to participation in the program. Providers who must voluntarily opt into MIPS reporting need incentive to do so. Without specialty-specific measure sets, clinicians are forced to choose unrelated and incomparable measures. The result is lower participation among the opt-in providers, and lower or less comparable scoring across clinicians. Both are unacceptable within a program that aims to promote participation in value-based care under QPP. Further, these problems associated with lack of specialty measure sets are exacerbated by the slow and limited innovation opportunities. By creating additional opportunity under MIPS/MVPs to offer new measures, participation could grow rapidly.

Address Barriers to APM Participation, Rather Than Incentives for Current Participants

To participate in the APM pathway, providers must meet the "Qualifying Participant" threshold defined under statute. Meeting the QP threshold is, for most providers, essentially the threshold determinant of whether they can receive the incentives afforded to providers who assume risk in an APM. For many providers, earning these bonuses promotes payment stability and offsets cuts under the PFS.

Unfortunately, APTA fears that for PTs and other nonphysicians it is impossible to achieve QP status. To become a QP, entities must receive at least 50% of Medicare Part B payments or see at least 35% of Medicare patients through an AAPM entity during the QP performance period. There is also an all-payer combination option, which takes into account the entity's participation in AAPMs with both Medicare and other payers, but both the patient and payment thresholds have Medicare minimums of 25% and 20%, respectively.

For some physicians, the QP thresholds may be achievable, but the thresholds would be challenging if not impossible to meet for physical therapy practices — especially given the compounding challenges with Medicare payment and lack of available opportunities under QPP programs. As such, it is difficult to envision progress toward meeting these thresholds; they must be lowered to meet realistic provider patient and payer mixes, especially since the profile of a financially viable practice is constantly changing. And while we anticipate that physicians fare better, even physician-based entities and ACOs are broadly considered unachievable and serve as an impediment to promoting value-based care.

Given that CMS is currently considering transitioning to making QP threshold determinations at the clinician rather than APM Entity level, APTA recommends that CMS reconsider the entity (and potential clinician-level) thresholds for PTs and nonphysicians, who have different payer and patient mixes than the average physician practitioner. Of course, without changes to CEHRT requirements, APMs are not an option for PTs or nonphysicians, but as it looks toward the future, CMS should consider changes to the thresholds under the all-payer combination option, which will generate the most opportunity for participation in the program from nonphysicians. APMs offer significant payment incentives — larger than any bonus that providers have received in MIPS — yet PTs and nonphysicians cannot participate in them. Unless CMS works with nonphysician stakeholders to draft more nuanced policy options through these programs, a significant minority of clinicians paid under the PFS will effectively be blocked from APM participation to the detriment of the team-based, patient-centered, and value-based care priorities that both Congress and CMS have been working toward.

Conclusion

APTA thanks CMS for the opportunity to provide feedback on the 2024 Medicare Physician Fee Schedule proposed rule. Should you have any questions regarding our comments, please contact Kate W. Gilliard, JD, director, health policy and payment, at kategilliard@apta.org or 703-706-8549.

Sincerely,

Roger Herr PT, MPA
President