September 6, 2023

FILED ELECTRONICALLY

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

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; 88 Federal Register 52,262 (Aug. 7, 2023, CMS-1784-P) ("Proposed Rule")

Dear Administrator Brooks-LaSure:

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 80,000 physical therapists, occupational therapists, and speech language pathologists through our member organizations who provide therapy across the United States to Medicare beneficiaries. They provide therapy in all settings across the continuum such as outpatient clinics, skilled nursing facilities (SNFs), assisted living facilities, retirement communities, hospital inpatient and outpatient, and in the beneficiary's home. As a member-driven organization, NARA promotes best practice and business success of physical therapy, occupational therapy, and speech-language pathology providers through education, support, and advocacy. NARA's membership demographics give us a unique insight into payment and quality programs for the payment policies under the Physician Fee Schedule. We appreciate the opportunity to provide the following comments related to the above proposed rule.

Reimbursement Reductions

The proposed 3.34% reduction to the conversion factor for CY2024 will have a negative impact on Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Pathology (SLP) services needed by Medicare beneficiaries. This reduction, combined with sequestration, will result in an approximate 6% reduction in reimbursement for therapy providers in CY2024.

Since 2011, PT, OT, and SLP services have been **disproportionately affected by these reductions.** These therapy specific payment reductions include:

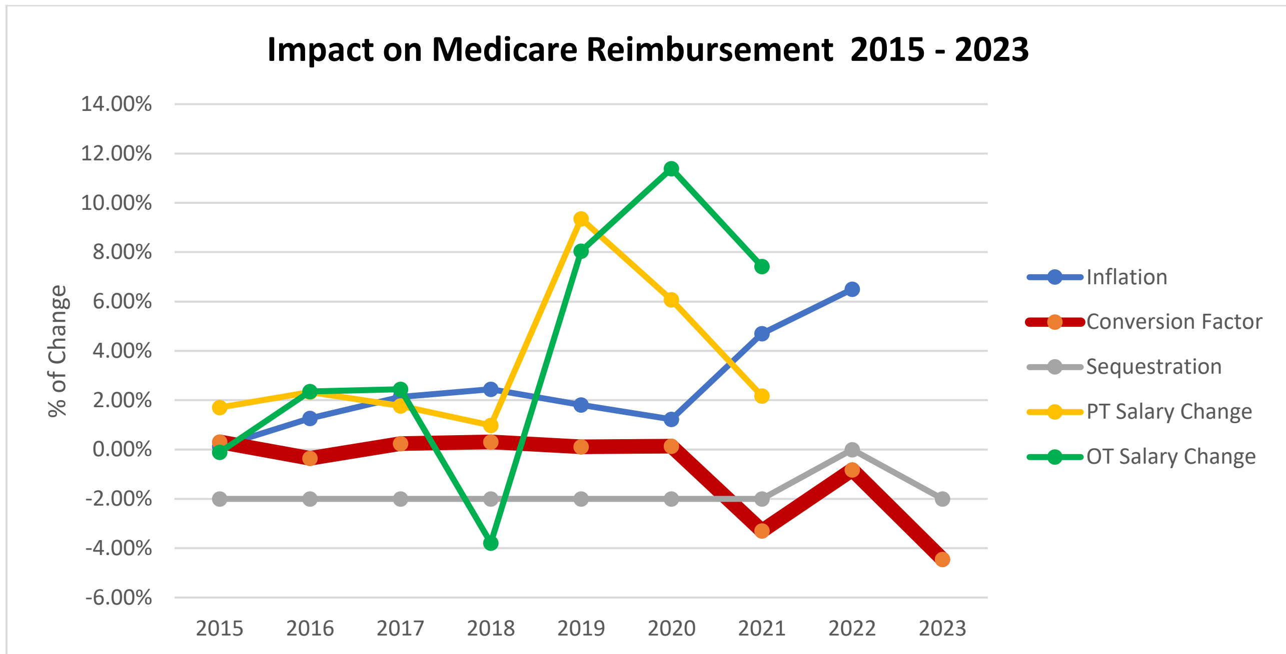
- Multiple Procedure Payment Reduction (MPPR) of the practice expense (PE) which began in 2011 with a 25% reduction and increased in 2013 to a 50% reduction in PE. The estimated impact of MPPR is a 6-7% reduction in reimbursement annually for rehabilitation providers.
- Fee Schedule Reductions since 2021 (including this proposed decrease for CY2024) of nearly 9.5% to increase reimbursement to a few select not widely used CPT codes mainly used by primary care physicians
- Physical Therapist Assistant and Occupational Therapy Assistant reduction of 15% on reimbursement effective January 1, 2022.

When combined with the proposed reductions in this year's CY 2024 Proposed Rule and sequestration, the total cuts to therapy payments amount to nearly 30% and soars to 45% when you factor in the reduction for services provided by physical or occupational therapy assistants as of January 1, 2022.

The cuts are untenable at any time but particularly over the past few years due to the financial impact of the COVID-19 Public Health Emergency, the rise in inflation and significant wage increases. These year-over-year reductions have created an unsustainable challenge for rehabilitation providers, and if imposed will severely reduce the number providers, particularly those in rural and underserved areas.

The services provided by rehabilitation providers are essential for Medicare beneficiaries who wish to age in place, particularly for the growing demographic with chronic conditions. In June 2023, the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary[1] estimated that Medicare beneficiaries totaled 63.6 million in 2022 and by 2031 this would increase to 76.4 million. Since 2015, inflation has increased by 13.69%, salaries for Physical and Occupational Therapists have increased on average 21%, while CMS has decreased the conversion factor by 7.76% (which is projected to exceed 10% with this proposed rule) as shown in the graphic below. The combination of year over year reimbursement cuts will undoubtedly lead to a significant access to care issues for Medicare beneficiaries in need of physical therapy, occupational therapy, and speech language pathology services as the projected number of Medicare beneficiaries continues to climb steadily through 2031.

[1] CMS Office of the Actuary Releases 2022-2031 National Health Expenditure Projections
https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2022-2031-national-health-expenditure-projections



Moratorium on G2211 Add-On Code

The American Medical Association (AMA) Relative Value Scale (RVS) Update Committee (RUC) has previously outlined concerns with how CMS is implementing the G2211 visit complexity code. To date, CMS has not been transparent with stakeholders about the need and purpose for the code, and why separate reporting of the code is necessary since the services are included in other codes. The G2211 code is duplicative of work already described in CPT codes such as prolonged services, chronic care management services, complex chronic care management services, principal care management or transitional care management services. Therefore, NARA requests CMS put a moratorium on the implementation of G2211. NARA supports the comments and findings submitted by the AMA on August 14, 2023 on this topic. While this code will only be able to be utilized by a small subset of providers, due to budget neutrality of the Physician Fee Schedule (PFS), all other providers must absorb a reimbursement decrease to implement this new code. We urge CMS to work with providers to reform the Physician Fee Schedule (PFS), including annual inflation updates to the conversion factor based on the Medicare Economic Index (MEI) and eliminating the outdated budget neutrality requirement that continues to create untenable instability for the PFS. Additionally, CMS should work with Congress as the House recently introduced HR 2474[2] Strengthening Medicare for Patients and Provider Act that calls for reform of the Medicare PFS including some of our recommendations. The PFS is broken and detrimental to the future of access to the growing number of Medicare beneficiaries who need services from therapy practitioners to age in place and maintain their quality of life.

[2] H.R. 2474 – 118th Congress (2023-2024) https://www.congress.gov/bill/118th-congress/house-bill/2474

Misvalued Codes
NARA fully supports the proposed review of the AMA RUC HCPAC recommendations from January 2017 for these 19 therapy procedure codes. NARA believes that the RUC's analysis will find duplication of their RVU adjustments and the MPPR policy. We ask that once those findings are known, CMS immediately cease MPPR deductions for CY 2024 and retroactively adjust provider claims for these deductions beginning January 1, 2024.

Telehealth
NARA supports the CMS proposal to allow institutional settings (including comprehensive outpatient rehabilitation facilities, rehab agencies, skilled nursing facilities, hospitals, and home health agencies providing Part B therapy services) to continue to bill for these services when furnished remotely in the same manner they successfully have during the PHE for COVID-19 through the end of CY 2024. Per CMS's request, NARA will continue to work with our members to demonstrate support that CPT codes utilized by therapy practitioners for telehealth produce similar outcomes as when used in person.

We do request clarification from CMS on how to document the use of telehealth on the institutional claim. The new place of service (POS) codes are effective January 1, 2024 and institutional provider claims (the UB-04) do not have a field for a POS code. We recommend that CMS instruct the Medicare Administrative Contractors (MACs) to continue to accept modifier -95 for telehealth visits on the UB-04. Additionally, we request CMS clarify their proposal that beginning in CY 2024, claims billed with POS 10 (Telehealth Provided in Patient's Home) would be paid at the facility PFS rate (88 FR 52698). However, therapy services are paid at the non-facility rate, regardless of the site of services. Since it is possible that therapists would use POS 10 for telehealth services, we request CMS clarify that therapists would continue to be paid at the non-facility rate regardless of where the telehealth therapy service occurs as there is no facility rate available for Medicare Part B billing for therapy services.

Supervision
NARA supports CMS's proposal to continue to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2024.However, beyond this date, we encourage CMS to apply the same supervision standard to private practice outpatient therapy setting that exists in other therapy settings such as a rehabilitation agency. Currently, direct supervision of physical therapist assistants (PTAs) by physical therapists (PTs) and occupational therapy assistants (OTAs) by occupational therapists (OTs) is required in the private practice setting for Medicare patients. Under direct supervision, the PT or OT is required to be physically present on-site and immediately available for direction and supervision of the PTA or OTA. The PHE-related waivers permit PTs and OTs to achieve direct supervision of PTAs and OTAs via audio-visual telecommunications, but this is not equal to general supervision.

In comparison, all other outpatient provider settings (i.e., hospitals, SNFs, rehabilitation facilities, etc.) require general supervision of PTAs or OTAs by PTs and OTs. Under general supervision, the PT or OT is not required to be physically on site for direction and supervision but must be available by audio telecommunications. There is no evidence of safety or quality of care concerns or the ability for an assistant to effectively consult with the therapist through audio telecommunications. This practice has been proven safe and effective in all other therapy practice settings which have a higher level of acuity of the patients treated compared to the private practice therapy setting. **We urge CMS to standardize the supervision requirement to GENERAL SUPERVISION under Medicare across all settings which will bring Medicare policy in line with the vast majority of state-level requirements.** Making the supervision requirement consistent across all settings will decrease administrative burden and confusion as well as ease compliance on the part of providers who work and manage staff in more than one type of setting.

Caregiver Training Codes
NARA appreciates the addition of these beneficial caregiver training codes and applauds CMS for recognizing the need for caregiver training. We would encourage CMS to ensure these codes are appropriately valued and broadly applicable to all circumstances where a caregiver is needed to help implement a beneficiary's plan of care. NARA recommends CMS consider adding these codes to the telehealth list for therapists so that they can provide training to caregivers who are unable to participate in in-person training.

In response to CMS's request for feedback on their definition of "caregiver", NARA recommends that CMS include private duty staff who offer caregiving support within a person's home or the nursing facility as part of their definition. Laypersons who are paid by the patient or their family to offer care are not the same as trained medical personnel delivering care within a nursing facility or hospital and could benefit from the same training as other informal caregivers under the same circumstances. NARA would encourage CMS to include these paid, informal caregivers within their definition to prevent inadvertent gaps in training resulting from too narrow of a definition.

MIPS
NARA strongly encourages CMS to determine avenues to allow all eligible rehabilitation providers regardless of setting or billing methodology to have a cost-effective method of participating in the Merit-based Incentive Payment System (MIPS) to help mitigate the continuous cuts to Part B reimbursement.

Currently, PTs, OTs, and SLPs who provide outpatient therapy services under Medicare Part B and bill through rehabilitation agencies, skilled nursing facilities (SNFs), and hospital outpatient departments are unable to participate in MIPS because they bill on the UB-04 Institutional Claim form (CMS 1450). Therapists in private practice bill for services under their own NPI on the CMS 1500 form, and as such, can participate in MIPS. Per the MedPAC report on outpatient therapy services payment

system in November 2021[3], 61% of therapy providers spending for Part B services was submitted by providers on the UB-04 (CMS 1450) form and, as a result, MIPS applies to less than 39% of Part B therapy providers. **NARA recommends modifying the current program to allow the vast majority (61%) of therapy providers, who cannot currently participate in MIPS, solely due to billing methodology, to have the opportunity to provide patient outcome data and share in the opportunity for higher reimbursement.** NARA welcomes the opportunity to work with CMS to provide feedback on how to make these changes.

NARA encourages CMS to explore ways that all eligible clinicians can participate in the evolution of the value-based payment systems. Facility-based therapists could participate in MIPS under the group reporting option. However, due to current billing practices, this may pose a challenge for tracking the individual therapist. One potential solution is to allow facility-based groups with rehabilitation providers to participate in MIPS as a group using the revenue code to identify services and track the group as a whole rather than the individual therapists. Another potential solution would be to modify the UB-04 (CMS1450) to include a box on each service line for the treating therapist's NPI. This would require more therapists to apply for provider NPIs which could cause a strain on the NPPES system for a brief time. However, CMS would be able to continue tracking performance based on the individual therapist as they do with other eligible providers.

Should CMS make accommodations to allow facility-based therapy providers to participate in the program in the future, we encourage CMS to consider allowing therapy providers in facilities to report measures relevant to their respective settings like their physician colleagues. For example, therapists billing for services for a Medicare Part B beneficiary in a skilled nursing facility (SNF) may wish to report the same functional measures they report under the SNF Quality Reporting Program. This would enable CMS to begin to align the new Improving Medicare Post-Acute Care Transformation (IMPACT) Act measures with the MIPS program. Again, NARA welcomes the opportunity to work with CMS to determine how to add facility-based providers to the MIPS program and other future programs such as advanced alternative payment models (APM). NARA recommends that CMS engage with therapy practitioner stakeholders to develop and approve MIPS Value Pathways (MVPs) with measures available to therapists.

Promoting Interoperability Changes in QPP

NARA disagrees with the cessation of the automatic reweighting of the Promoting Interoperability (PI) category for all therapy practitioners for the following reasons:

- There is a lack of availability of CEHRT that is specific to this subset of clinicians who may be required to or elect to opt-in to traditional MIPS.
    - Many of the CEHRT requirements for MIPS participation in the PI category do not apply to the clinical practice of therapy practitioners, for example 170.3159(a)(1-3). PTs, OTs, and SLPs cannot prescribe medications, order labs, or order imaging. Requiring these items as

[3] https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_opt_final_sec.pdf

part of CEHRT, which will not be utilized by providers who use the software, places unnecessary burden on health IT vendors to certify and maintain.

- Requiring participation in the PI category for a subset of clinicians who have historically been reweighted, while increasing the participation requirements to 180 days and requiring an attestation of "Yes" on the SAFER Guides, does not afford the ability for therapy practitioners to understand the category requirements and incrementally participate in the PI category as other providers have been able to do. Providers who would be newly required to participate in PI beginning January 1, 2024 would be subject to high standards of participation in the category which would likely result in poor performance.

We recommend that CMS consider a modification of the definition of CEHRT for providers who participate in MIPS that wish to participate in interoperability but do not participate in certain currently required components as determined by their licensure, such as e-prescribe. Additionally, we request that CMS extend the reweighting of PI for therapy practitioners to CY 2026 to allow for both modification of the CEHRT definition and for health IT vendors to successfully complete certification requirements.

CMS has stated they would like to increase participation in quality programs, including MIPS, while decreasing provider burden (an example of this is the transition to MVPs). The requirement of CEHRT as it stands increases the burden for health IT vendors supporting specialty providers. In addition, by ending the reweighting policy, CMS is disincentivizing therapy practitioners from participating in traditional MIPS since many currently opt-in and the interoperability requirements are a deterrent to participation.

MIPS Value Pathways for Therapy Practitioners

NARA supports CMS's efforts to improve MIPS by continuing to transition to the MVP framework as it may lead to greater value for the program while reducing the burden to clinicians. We appreciate the addition of the new MVP: Rehabilitative Support for Musculoskeletal Care. We request that CMS partner with stakeholders to develop other MVPs for physical therapy, occupational therapy, and speech language pathology practitioners. We encourage CMS to continue to review other measures such as the IROMs measures that can be included in the MVPs.

Additionally, we encourage CMS to make necessary reforms to MIPS, so the incentive payments are aligned with the administrative burden that comes with participation. NARA supports payment models that reward therapy practitioners for the quality of their services and achieving positive outcomes for beneficiaries; however, these models should not create an excessive administrative burden that negatively offsets the incentive. For the therapy industry, cost barriers (registries, staff training, etc.) and eligibility to participate exist making it difficult to separate the "winners" and the "losers". If CMS can find a way for facility-based therapy providers to participate in MIPS and MVPs, where most of these practitioners practice, then it would allow more providers to participate in quality payment programs and easily identify providers who are not providing quality services.

We thank you for the opportunity to provide comments related to this proposed rule. Should you have any questions concerning these comments, please contact Christie Sheets, NARA Executive Director at christie.sheets@naranet.org.

Respectfully submitted,

Kelly Cooney, M.A., CCC-SLP, CHC
President
National Association of Rehabilitation Providers and Agencies