September 13, 2021

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 Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements. [CMS-1751-P]

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.

Assistant Payment Reduction

NARA requests that CMS delay the implementation of the therapy assistant payment reduction till at least January 1, 2023. This would better facilitate successful implementation and help rehabilitation providers who have been experiencing the devastating impact of COVID-19 during the public health emergency (PHE). The regulations for implementing the therapy assistant differential are very complex and although the original legislation provided a four-year implementation timeframe to allow CMS to prepare for the provisions and to prepare providers for this change, there are continued unanswered questions and a lack of clarity. Furthermore, some of the guidance provided by CMS a year ago in the final rule for CY 2021 has changed in the proposed rule for CY 2022. Now, with the anticipated implementation date just a few months

away, providers and other stakeholders still lack the proper guidance, education, and necessary time to prepare to put the proposed changes into practice by January 1, 2022.

While the updated guidance introduced in the proposed rule provided additional information on application of *de minimis* standard with additional examples, we still need clarification on several items. Some examples include:

- Will the adjustment be applied to 100% of the allowable amount or only the 80% portion covered by Medicare? How will this be processed?
- Will the adjustment be applied before or after the multiple procedure payment reduction (MPPR) adjustment for therapy?
- Can Medicare Administrative Contractors (MACs) software systems accept 2 lines of the same CPT on a given date of service by a therapist and a therapy assistant may provide (one line with a CO/CQ modifier and one line without a modifier)?

Once the details are better defined by CMS, providers require time to educate their organizations and understand the impact on their business. Electronic health record system vendors need time to program, test then finalize their systems and then provide training to their provider partners. The MACs will need to interpret CMS' guidance and program and update their systems accordingly. With the anticipated publishing of the final rule, there will only be 30-60 days to implement the policy. Historically, a hastily implemented policy has been a conduit for costly mistakes during implementation and unnecessary administrative burden. And as a result, provider payments are at risk for being held, at a time where that would have devastating effects, and all stakeholders are subject to unnecessary rework.

Moreover, the detrimental and widespread impact of COVID-19 on all providers of therapy could not have been anticipated when Congress passed this policy four years ago. Throughout the pandemic, providers of occupational therapy and physical therapy have been significantly challenged to keep their patients and staff safe given the need for regular physical contact and close proximity in delivering services. Clinicians have functioned in an exhausting care environment for the past 18 months. Many have experienced burnout and NARA is seeing many physical and occupational therapists transitioning to other roles or out of the therapy profession altogether. Continuing to treat patients during a PHE is difficult, and clinician availability is becoming more limited. Thus, this assistant payment reduction hits hardest where therapy assistants are needed most especially in underserved areas - both rural and urban.

Additionally, as the CDC's interim guidance on management of post-COVID conditions explains, both occupational therapy and physical therapy services will be needed to help COVID-19 long-haulers recover from the long-lingering effects of the disease. Therapy is also an important alternative to opioids for dealing with acute and chronic pain. However, the capacity to provide physical and occupational therapy care is limited without sufficient therapy providers to furnish these services. **To protect access to care and give providers some reprieve from additional reimbursement cuts during the PHE, NARA strongly urges CMS to delay implementation of therapy assistant differential until at least January 1, 2023.**

<u>Conversion Factor and Cuts to Therapy Reimbursement</u>

Therapy providers have had to disproportionately absorb continuous reductions to reimbursement since 2011 with:

- Medicare 2% sequestration
- Multiple Procedure Payment Reduction (MPPR) of 50% of the practice expense
- Medicare Access and CHIP Reauthorization Act of 2015 which froze annual increases to the Medicare physician fee schedule through 2024
- Proposed 9% reduction in 2021 (which was reduced to on average 4% reduction by Congressional action)
- PayGo 4%
- The 15% payment reduction for services provided by a physical or occupational therapy assistant beginning on January 1, 2022.

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In addition, for CY 2022, physical therapy, occupational therapy, and speech language pathology providers are facing another 3.75% reduction due to the proposed conversion factor. By our calculations, the accumulation of these cuts equates to as much as a 30% reduction in reimbursement since 2011 – with nearly 7% of those reductions coming in just the past 2 years. This is simply not sustainable and if the proposed reductions are implemented, NARA expects there will be limitations in access to physical therapy, occupational therapy, and speech language pathology services to Medicare beneficiaries. The harm caused by these cuts will be likely be greatest in rural and underserved areas without a delay or mitigating actions such as exemptions for these areas.

Therapy providers have not fully recovered from the financial challenges experienced from the beginning of the PHE. Providers have continued to experience significant increased expenses, such as implementation and maintaining virtual health platforms to provide vital care to patients, additional personal protective equipment, extra cleaning costs, and changes to physical environments to promote the need for social distancing within therapy clinic settings.

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. The impact of these constant reimbursement reductions puts providers in an unsustainable situation. These payment reductions will affect physical therapy, occupational therapy, and speech language pathology services provided in all settings including outpatient private practices, Rehabilitation Agencies (ORFs), Certified Outpatient Rehab Facilities (CORF), SNFs, home health agencies and for observation patients in acute care hospitals. **NARA urges CMS to stop cutting reimbursement to physical, occupational and speech therapy providers.**

Mitigating Cuts with 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 Incentive Payment System (MIPS) to mitigate the continuous cuts. Currently, there are limitations in the eligibility for therapy providers, such as:

- Facility-Based (Institutional) Providers vs. Private Practice Providers: Currently therapists who bill through rehabilitation agencies, SNF part B, and hospital outpatient are unable to participate in MIPS because they bill on the UB04 Institutional Claim Form (CMS 1450) and CMS is unable to attribute services to the individual NPI of the treating clinician. Therapists in private practice bill for services under their own NPI on the CMS 1500 form, and as such are able to participate in MIPS as individual clinicians or as a group. Per the MedPAC Analysis of Part B outpatient therapy claims in 2015[1], 62% of therapy providers bill on the UB04 (CMS 1450) form and therefore, are unable to participate in the current MIPS program. As a result, MIPS in its current format applies to less than 38% of Part B therapy claims. However, only 5% of all Medicare-enrolled physical therapists in private practice were required to participate in MIPS in calendar year 2019. (There are about 60,000 enrolled PTs in private practice). **NARA recommends modifications to allow the vast majority (62%) of therapy providers, who cannot currently participate in the program, solely due to the billing methodology, to have the opportunity to provide patient outcome data and share in the opportunity for higher reimbursement for obtaining quality metrics.** NARA welcomes the opportunity to work with CMS to provide feedback on how to make these changes.
- The financial burden of registry reporting is prohibitive and may cause more small practices to not accept Medicare beneficiaries. **NARA strongly encourages CMS to extend the ability to upload data directly to CMS beyond 2021.**

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 report 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 UB04 (CMS1450) to include a box on each service line for the treating therapists NPI. One consideration is that 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 the outcomes based on the individual therapist as they do with other eligible providers.

[1] MedPAC analysis of 100 percent Medicare Part B outpatient therapy claims, 2015

Should CMS make accommodations to allow facility-based therapy providers to participate in the program in the future, we encourage CMS to consider allowing providers in facilities to report measures relevant to their respective settings similar to their physician colleagues. For example, therapists billing for services for a Medicare Part B beneficiary in a 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 additional alternative payment models (APM).

Telehealth in Rehabilitation

NARA opposes CMS's decision to omit the following CPT codes used by therapy providers from the list of permanently covered telehealth services: 97161-97168, 97110, 97112, 97116, 97129, 97130, 97150, 97530, 97535, 97537, 97542, 97763, 92607, 92608, 92609, 92610, and 92526. NARA notes inconsistency with the expiration of some CPT codes in the List of Telehealth Services for Calendar Year 2021 (updated August 12, 2021). NARA requests codes 92526, 92610, 97129, 97130, 97150, 97530, and 97542 be modified to the status of "Available up Through the Year in Which the PHE Ends" rather than "Temporary Addition for the PHE for the COVID-19 Pandemic".

The expansion of telehealth payment and practice policies allowing therapists to provide services via telehealth has demonstrated that many patient needs can be effectively met via the use of technology along with improved access to skilled care by leveraging these resources. Adding these CPT codes permanently to the list of covered telehealth services will better ensure a seamless transition when additional practitioners, such as physical therapists, occupational therapists, and speech-language pathologists, become eligible to furnish and bill for telehealth services under Medicare.

Prior to the COVID-19 pandemic, telehealth in rehabilitation was used mostly to treat patients in rural areas. However, during the pandemic providers have been able to utilize it to minimize the spread of the virus and ensure continued progress of isolated beneficiaries by limiting the number therapists treating a patient during an inpatient or skilled nursing stay. During the PHE, rehabilitation providers have provided skilled care via telehealth to patients to improve or maintain functional abilities; prevent delays in care; and provide treatment to patients in rural areas. According to a survey of NARA members, 54% indicated that up to 25% of their services were provided via telehealth at the peak of the pandemic. Many providers have learned how to effectively use telehealth to ensure patients continue to progress toward their goals during the PHE. We have gained an invaluable mode of therapy delivery with telehealth that allows providers to continue delivering vital therapy services with similar outcomes. It is critical that therapy providers maintain this tool after the PHE as a compliment to in-person care.

In the proposed rule, CMS states that the CPT codes 97110, 97112, 97116, 97150, 97161 – 97164, 97530, 97535, 97537, 97542, 97750, and 97763 do not meet the criteria for Category 1 or Category 2. NARA disagrees with this conclusion. A 2019 study examined the efficacy of home-based telerehabilitation versus in-clinic therapy for adults after stroke and found that post stroke activity-based training resulted in substantial gains in patients' arm motor function, whether provided via telerehabilitation or in person.[2] Telehealth is well-suited for rehabilitation therapies, especially when used in conjunction with in-clinic visits rather than exclusively as a replacement. Education and home exercise programs, including those focused on activities of daily living and fall prevention, are particularly well suited for telehealth because the therapist can evaluate and treat the patient within the real-life context of their home environment. A patient and/or caregiver's ability to interact with a therapist from their own living environment can be invaluable in supporting the adoption of effective strategies to improve function, enhance safety, promote engagement, and prevent costly medical procedures. Telehealth has been shown to improve access to physical, occupational, and speech therapy for patients who live in rural areas. It has allowed patients to gain desired outcomes for a variety of health problems, including post-traumatic stress syndrome, chronic pain, stroke, and other neurological and musculoskeletal conditions.[3]

Therapy interventions delivered via two-way audio video technology have the potential to prevent falls, functional decline, costly emergency room visits, and hospital admissions/readmissions. Telehealth helps to overcome access barriers caused by distance, lack of availability of specialists or subspecialists, or impaired mobility, as well as preventing unnecessary exposure during a pandemic. This is not always easily replicated in the clinic setting. For patients who have difficulty leaving their homes without assistance, lack transportation, or need to travel long distances, the ability to supplement or replace in-clinic sessions with those furnished by telehealth greatly reduces the burden on the patient and family. Patient and caregiver self-efficacy are inherent goals for care provided by occupational therapists, physical therapists, and speech-language pathologists, and the use of technology can facilitate this by offering a way to modify a home program and assess progress in the patient's real-world environment.

NARA believes due to these benefits that select groups of patients could continue to receive the same benefit through telehealth as they would with in-clinic visits beyond the PHE. We also believe telehealth visits could result in downstream savings and potentially reduce readmissions to higher cost settings. The therapists who provide the service would be able to use their clinical judgement and engage in a shared decision-making process with their patients to determine whether or not the patient would benefit from receiving care via telehealth or through in-person visits or a combination of both. We understand legislation is required to make therapy

[2] Cramer SC, Dodakian L, Le V, et al. Efficacy of Home-Based Telerehabilitation vs In-Clinic Therapy for Adults After Stroke: A Randomized Clinical Trial. *JAMA Neurol.* 2019;76(9):1079–1087. doi:10.1001/jamaneurol.2019.1604

[3] Telehealth Use in Rural Areas, Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/telehealth

practitioners Medicare eligible providers of telehealth service. However, the PHE has demonstrated that rehab therapists can effectively and efficiently provide services using audio visual technology in the same manner as current eligible providers. Thus, ensuring telehealth is a permanent option of providing therapy services is important in all settings of care.

NARA understands the potential hesitation of permanently adding these codes to the Category 1 or Category 2 listing. We appreciate the opportunity to maintain these codes on the temporary Category 3 list so that providers can continue to collect data and evidence that supports their permanent addition to the Category 1 or Category 2 list. Permanent adoption of such policies will also provide greater flexibility to providers and patients and increase access to medically necessary care, especially to those living in rural or medically underserved areas or individuals living with impaired mobility. We believe that maintaining coverage to include the delivery of telehealth by therapy practitioners will lead to reduced health care expenditures, increased patient access, and improved management of chronic disease and quality of life. Patient geography would no longer be a barrier to receiving timely, appropriate medical care. Access to telehealth services will also serve to reduce caregiver burden by providing an alternative means by which to access the specialized knowledge and skills of an occupational therapy practitioner, physical therapy practitioner, and speech-language pathologist.

Access To Remote Therapeutic Monitoring (RTM) Codes

NARA appreciates CMS's proposal to begin reimbursement for the RTM codes, but we disagree with CMS' determination that these codes as constructed cannot be billed by occupational therapists, physical therapists and speech language pathologists. In the rule, CMS correctly points out that:

> "according to RUC documents, primary billers of RTM codes are projected to be nurses and physical therapists. Stakeholders have suggested that the new RTM coding was created to allow practitioners who cannot bill RPM codes to furnish and bill for services that look similar to those of RPM. RPM services are considered to be E/M services and physical therapists, for example, are practitioners who cannot bill E/M services. The RTM codes, instead, are general medicine codes."

However, CMS further states "[b]y modeling the new RTM codes on the RPM codes, 'incident to' services became part of the three direct practice expense-only (PE-only) codes (that is, CPT codes 989X1, 989X2, and 989X3) as well as the two professional work codes (that is, CPT codes 989X4 and 989X5). As a result, the RTM codes as constructed currently cannot be billed by, for example, physical therapists." This statement contradicts the above quote from the rule that states the RUC documents indicate the primary billers of the RTM codes would be physical therapists. NARA was informed that the RUC noted an error in the original Summary of Recommendation Forms (SORs) for these codes and has provided revised SORs stating "Nurse Practitioner" in the utilization section, not "Nursing."

NARA does not believe the construction of the RTM codes results in the conclusion that the codes represent “incident to” services. Although the RUC has suggested that RN/LPN/MA represent the clinical staff utilizing these codes most often because the services will be reported by physicians or nurse practitioners similarly when this service is provided under a physical therapy plan of care, for example, physical therapists would supervise physical therapist assistants in the provision of this service. Since the tasks performed by physical therapist assistants are billable when provided under the direct supervision of the physical therapist and under the physical therapist NPI number in some settings, the incident to policy does not apply.

These codes unlike the RPM codes are in the General Medicine section of the CPT manual rather than the Evaluation and Management section, therefore, therapists and other qualified health care practitioners can bill the RTM codes. **NARA recommends that CMS clarify that the codes, as currently proposed, do allow therapists who can independently bill can bill the RTM codes**. If the interpretation issue cannot be resolved prior to the final rule being issued, **NARA requests that CMS provide G codes to support the use of remote monitoring by occupational therapists, physical therapists, and speech language pathologists as part of a therapy plan of care.** The G codes developed would need to take into consideration the following aspects of the work and expense involved in the delivery of these services by an occupational therapist, physical therapist, or speech language pathologist:

- Time spent instructing the patient in the use of a remote monitoring technology
- Time spent analyzing the data and using the information to make decisions regarding the patient’s plan for care and decisions as care is ongoing
- Cost of the remote therapeutic monitoring technology

Remote Monitoring is an important component of an occupational therapist’s, physical therapist’s, and speech language pathologist’s practice with the potential to improve patient care, enhance the effectiveness of home exercise and self-management programs, accelerate recovery, and promote patient and/or caregiver self-efficacy. Occupational therapists, physical therapists and speech and language pathologists routinely prescribe home exercises, physical and cognitive activity plans, and self-management plans that are a critical component of the overall therapy plan of care. Remote technologies provide therapists with the ability to determine in, or close to, real-time if a patient is engaged in these prescribed activities, the frequency with which the programs are being done and, in some cases, the quality of the patient’s performance without having to rely on patient self-reporting or observing performance during an in-person treatment session to assess the patient’s proficiency with these programs. Additionally, important patient-reported information can be gathered including the response to home exercise and self-management programs like pain level, level of confidence, and rating of perceived exertion to name a few.

Supervision of Assistants in Private Practice Setting

NARA members have appreciated the temporary exception to allow the immediate availability for direct supervision through virtual presence during the PHE. This has lightened the burden of supervision of therapy assistants to ensure patient safety and maintain access to therapy care during a period of short-term staffing shortages caused by the PHE. The exception has also allowed providers to limit the number of therapy personnel who interact with a given patient to reduce the risk of exposure. This remote access supervision has been successful in other therapy settings historically and has proven to be sufficient in the private practice during the PHE. **NARA sees the long-term benefit and supports continuing this flexibility beyond the PHE but does not see the need to identify these visits with a modifier.**

Collection of Health Equity Data

CMS also included a Request for Information in the CY 2022 Physician Fee schedule Proposed Rule. NARA would like to provide comment on behalf of its members.

Closing the Health Equity Gap in CMS Clinician Quality Programs. NARA appreciates CMS addressing this issue and asking for feedback. NARA members are quite aware of the disparities and inequities that exist throughout the healthcare system since many of our members directly work with these beneficiaries in finding community-level solutions. NARA believes CMS should begin to collect more information on social determinants of health (SDOH) since we believe this information will help to inform future care processes. This could start with collecting information in the physician's office which is then required to be passed on to the next provider of care. It could also benefit all providers if CMS began collecting key pieces of information upon Medicare enrollment. This information could be updated annually or whenever a provider assesses a change or a patient reports one. In the meantime, members would be supportive of CMS' suggestion to provide confidential feedback on clinician-level quality measure results stratified by social risk factors that are currently available. In response to CMS request for information on using risk adjustment methodologies for quality measures in the future, NARA would ask that CMS involve stakeholders in any future discussions about this. Risk adjustment methodologies using SDOH could have unintended consequences of lowering expectations for quality of care. Therefore, any future use of the data should be carefully thought through.

Measure Changes for Swallowing

CMS proposes to update the measure specifications for Measure 182: Functional Outcomes Assessment to include the concept of swallowing, hearing, and balance function. The specifications are updated to include the EAT-10: Swallowing Screening Tool, the Health Partners Hearing Assessment, and the Tinneti Performance Oriented Mobility Assessment as eligible assessment tools. The proposed rule also updates the definition of functional outcome deficiencies to include the "impairment or loss of function related to speech or language capacity,

included but not limited to swallowing, hearing, and balance disorders." **NARA supports these revisions to the measure specifications.**

However, NARA does not believe this measure should no longer be reported on claims. Physical and occupational therapists and speech-language pathologists were not eligible for meaningful use incentive payments and are not subject to the promoting interoperability performance category. Many therapists work in small therapy practices where the adoption of an electronic medical record system remains cost prohibitive. As a result, removing the ability to report this measure via claims limits the ability of non-physicians to report this measure and effectively participate in MIPS. Eliminating claims-based reporting would lower their score in the quality performance category and the MIPS score overall, potentially leading to an unfortunate and undeserved payment penalty. **For these reasons, NARA opposes CMS's proposal to remove this as a claims-based measure.**

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,

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