



September 6, 2022

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 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts [CMS-1770-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 eliminate the 15% therapy assistant payment reduction for the rural and underserved areas to protect access to care for beneficiaries in rural and underserved areas. The rehabilitation therapy sector continues to be challenged nationally by the devastating impact of COVID-19 as providers and staff continue to provide services during the public health emergency. Everyday continues to bring additional challenges to ensure access to therapy, for patients as a result of therapist isolation due to COVID or choosing to leave the workforce due to

burnout and exhaustion. The therapy workforce is strained particularly in rural and underserved areas, where therapy assistants play a crucial part of the team that helps extend the services of licensed occupational and physical therapists. Medicare beneficiaries who reside in rural and underserved areas face a variety of barriers to accessing healthcare services. The availability of physical therapy and occupational therapy services in rural and medically underserved communities is especially dependent on physical therapist assistants and occupational therapy assistants to overcome workforce shortages. We believe, the 15% Medicare Physician Fee Schedule payment differential that went into effect on January 1, 2022, combined with the current burdensome direct supervision requirement and workforce shortages has a significant impact on patients' access to therapy services disproportionately in these rural and underserved areas. We urge CMS to eliminate the therapy assistant reduction for rural and underserved areas which depend on physical therapist assistants and occupational therapy assistants to preserve care. The workforce challenges and increased cost of providing care in these rural and underserved areas, the payment reduction for services provided by assistants will limit access to physical and occupational therapy services for beneficiaries need to return to prior levels of function and for quality of life.

Conversion Factor and Cuts to Therapy Reimbursement

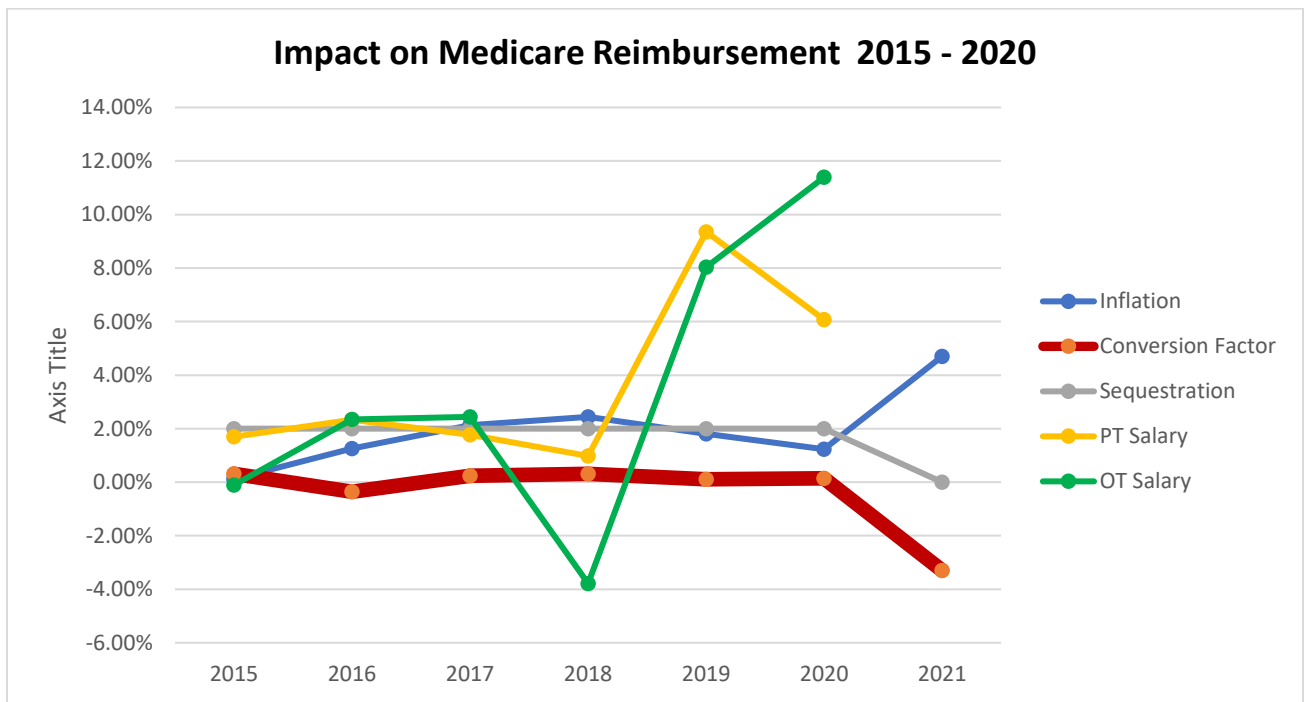
Therapy providers have experienced continuous reductions to reimbursement since 2011 at a disproportionate rate. Some examples of therapy specific payment reductions include:

- Multiple Procedure Payment Reduction (MPPR) of the practice expense (PE) which began in 2011 at 20% reduction of the PE 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.
- Physical Therapist Assistant and Occupational Therapy Assistant reduction of 15% on reimbursement service effective January 1, 2022.

The combination of the above listed reductions in reimbursement along with inflation, significant wage increases, conversion factor changes, and sequestration, have created an unsustainable challenge for rehabilitation providers. The cuts have accumulated to an estimated 30% in reimbursement cuts for therapy providers since 2011 and have been more difficult to absorb over the past few years due to the PHE. The reductions above over the past 4 years in addition to increased expenses, changes in care delivery due to COVID, and staffing shortages have been detrimental to providers needing to expand the services they provide and/or improving those services via technology in order to be able to provide services. Without action, these financial constraints will become great with the anticipated 4% cut beginning January 1, 2023, related to the Statutory Pay-As-You-Go Act (PAYGO) and up to a 6% reduction in the Physician Fee Schedule in CY2024 due to the expiration of the moratorium on the implementation of G2211.

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. MedPAC

has indicated in their June 2015 report that the number of Medicare beneficiaries is projected to increase by nearly 50 percent by 2030. The impact of these constant reimbursement reductions puts providers in an unsustainable situation. Since 2015, inflation has increased by nearly 13.69%, salaries for Physical and Occupational Therapists have increased by on average 21%, while CMS has decreased the conversion factor by 7.76% as shown in the graphic below. The combination of year over year reimbursement cuts is 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.



These payment reductions 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), skilled nursing facilities (SNF)s, home health (HH) agencies and for observation patients in acute care hospitals. **NARA urges CMS to stop cutting reimbursement to physical, occupational and speech language pathology 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 2015¹, 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. 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.

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

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

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).

Additionally, CMS is proposing to eliminate the exemption from promoting interoperability for therapists beginning with the 2024 performance year. **NARA strongly encourages CMS to not remove this exemption because therapy practitioners did not earn meaningful use payments.** There is no certified technology for therapy practitioners and many of the measures like ePrescribing are not applicable to them.

Telehealth in Rehabilitation

NARA supports moving 97150, 97530, 97542, 92507 and 96105 to the Category 3 set of codes that would be available through the end of CY 2023 for telehealth. NARA respectfully disagrees with CMS' assertion that 97110, 97112, 97116, 97150, 97161-97164, 97530, 97535, 97537, 97542, 97750, 97755, and 97763 codes do not meet the criterion for being added to Category 1 or 2. These codes have been successfully used during the PHE with positive outcomes in line with in-person therapy outcomes. NARA appreciates CMS adding several of the speech-language pathology CPT codes to the authorized Category 3 telehealth services list through the end of 2023. The expansion of telehealth reimbursement 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 assist in ensuring 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. We believe the additional time will help develop the evidence necessary to qualify as telehealth services on a permanent basis under the Category 1 or 2 criteria established by CMS.

NARA also recommends that CMS add CPT code 96125, primarily billed by speech-language pathologists, be added to the telehealth services list on a Category 3 basis. This code is currently proposed for deletion from the temporary telehealth services list at the end of the PHE (and the 151-day extension). It would be inappropriate to remove this service while many other speech-language pathology services remain on the list on a Category 3 basis. CPT code 96125 describes standardized cognitive performance testing, which is the evaluative component to cognitive function intervention (CPT codes 97129 and 97130), which CMS has already proposed to add to the Category 3 list, as outlined in Table 8. **NARA urges CMS to add the 96125 CPT code to the Category 3 telehealth services list through CY 2023 as it is appropriate to deliver via telehealth.**

During the pandemic providers have been able to provide therapy via telehealth as a mode of therapy to minimize the spread of the virus and to ensure continued progress of isolated beneficiaries by limiting the number therapists treating a patient during an inpatient or skilled nursing stay. For example, therapy services could be preserved to ensure continued progress of isolated beneficiaries in a skilled nursing facility while limiting the risk of infection or therapy

could be provided to beneficiaries who were either isolating at home or fearful of attending in-person therapy visits. 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 as an adjunct to in-person therapy and ensure patients continue to progress toward their goals during the ongoing PHE. Therapy providers and practitioners have gained an invaluable mode of therapy delivery with telehealth that allows providers to continue delivering vital therapy services virtually for select beneficiaries and deliver similar outcomes. It is critical that therapy providers and therapy practitioners maintain this tool after the expiration of the PHE as a compliment to in-person care.

Data/Studies That Support Telehealth Services

- Intermountain Healthcare, a Salt Lake City based health system, conducted a pilot study² between 2013-19 on patients receiving a hip arthroscopy for femoroacetabular impingement. The patients were divided into three groups for post op physical therapy. Group one received their visits via telehealth (with at least 2 required in-person visits at specific times); group two was full in person treatments with same therapist; and group three was full in person with different therapists. Intermountain reported the same high-quality outcomes for all three groups via online questionnaires. They also found a cost savings with group one compared to the other 2 groups.
- FOTO, a Net Health Company, analyzed data from over 40,000 episodes of care in their database³ and found that based on functional outcomes, patient satisfaction and number of visits at discharge from treatment, telehealth and non-telehealth were equally as effective for improving functional status at all intensity levels. The study also found that on average telehealth care had 2-3 fewer visits and patients were equally satisfied with their therapy care regardless of in-person or telehealth visit.
- In February 2021, the Physical Therapy & Rehabilitation Journal⁴ published an article that concluded that telehealth in physical therapy could be comparable or better to in-person rehabilitation with certain conditions such as osteoarthritis, low-back pain, hip and knee

² Transition to Telehealth Physical Therapy After Hip Arthroscopy for Femoroacetabular Impingement, The Orthopaedic Journal of Sports Medicine, 2021, <https://journals.sagepub.com/doi/pdf/10.1177/2325967121997469>

³ Telehealth is as Effective in Rehab Therapy as In-Person Care, September 21, 2020, https://1qblb015q58ipcln51ov1m9g-wpengine.netdna-ssl.com/wp-content/uploads/2020/09/FOTO-Telehealth-Data_Infographic.pdf

⁴ Pamela Seron, PT, PhD, MSc, María-Jose Oliveros, PT, MSc, Ruvistay Gutierrez-Arias, PT, MSc, Rocío Fuentes-Aspe, PT, MSc, Rodrigo C Torres-Castro, PT, MSc, Catalina Merino-Osorio, PT, MSc, Paula Nahuelhual, PT, MSc, Jacqueline Inostroza, PT, MSc, Yorschua Jalil, PT, MSc, Ricardo Solano, PT, MSc, Gabriel N Marzuca-Nassr, PT, PhD, Raul Aguilera-Eguía, PT, MSc, Pamela Lavados-Romo, PT, MSc, Francisco J Soto-Rodríguez, PT, MSc, Cecilia Sabelle, PT, MSc, Gregory Villarroel-Silva, PT, MSc, Patricio Gomolán, PT, MSc, Sayen Huaiquilaf, PT, Paulina Sanchez, PT, Effectiveness of Telerehabilitation in Physical Therapy: A Rapid Overview, *Physical Therapy*, Volume 101, Issue 6, June 2021, pzab053, <https://doi.org/10.1093/ptj/pzab053>

replacement, and multiple sclerosis and also in the context of cardiac and pulmonary rehabilitation

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. Although there may be cost savings overall when providing telehealth services, the majority of telehealth services for rehabilitation are provided in a supportive setting where an onsite facilitator is required; thus 2 professionals are present during the therapy session. Additionally, there are significant costs for providers who are purchasing appropriate software and training therapy practitioners.

Telehealth helps to overcome access barriers caused by distance, lack of availability of specialists or subspecialists, or impaired mobility, as well as preventing unnecessary disease 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.

Even as the PHE expires and the threat of COVID-19 eventually lessens, telehealth will continue to provide these benefits which are particularly valuable for beneficiaries with disabilities and in need of rehabilitation. We therefore support increased access to care through the expanded use of telehealth past the expiration of the PHE to ensure that patients can benefit from advances in technology that make virtual care possible. We encourage CMS to continue to work under the agency's current authority and with Congress to ensure that patient-centered telehealth is available long-term to as many patients as possible, in as many appropriate forms as possible, while ensuring that telehealth adds to existing forms of available care without replacing or supplanting in-person treatment options.

NARA believes telehealth visits could result in downstream savings and potentially reduce readmissions to higher cost settings. The therapists who provide the service are able to use their clinical judgement and engage in a shared decision-making process with their patients to determine whether 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 practitioners Medicare eligible providers of telehealth service. However, the PHE has demonstrated that rehabilitation professionals 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.

Supervision of Assistants in Private Practice Setting

CMS is encouraged to revisit the supervision standard it applies to private practice outpatient therapy settings. 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 and immediately available for direction and supervision of the PTA or OTA. The PT or OT will have direct contact with the patient/client during each visit, as well as all encounters with a patient/client in a 24-hour period. Current PHE-related waivers permit PTs and OTs to achieve direct supervision of PTAs and OTAs via audio-visual telecommunications; however, this temporary policy is not equal to direct supervision and will expire at the end of the year in which the PHE ends.

In comparison, all other outpatient provider settings (i.e., hospitals, SNFs, rehabilitation facilities, etc.) only 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 concerns or ability for an assistant to effectively consult with the therapist through audio-visual 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 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 outpatient 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 outpatient setting.

Congress is currently evaluating the *Stabilizing Medicare Access to Rehabilitation and Therapy Act*, or *SMART Act* (H.R. 5536) introduced in the U.S. House of Representatives by Representative Bobby Rush, D-Ill. and Representative Jason Smith, R-Mo. A provision of the *SMART Act* would standardize Medicare's supervision requirements of OTAs and PTAs under Medicare Part B in all settings where Medicare beneficiaries receive therapy services, instead of having a separate regulation for therapist in private practices.

The American Physical Therapy Association, 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 the American Physical Therapy Association commissioned Dobson DaVanzo & Associates to evaluate that provision of the *SMART Act*. The results show Medicare could save between \$168 and \$242 million over 10 years by standardizing the supervision requirement for PTAs and OTAs. This cost savings to Medicare would also reduce the administrative burdens on physical and occupational therapists, make therapy services more accessible to millions of Americans experiencing challenges accessing health care, and implement common-sense consistency with state laws and across all Medicare settings. The detailed Dobson

DaVanzo report which includes data, assumptions, and methodology can be found here https://www.dobsondavanzo.com/index.php?src=directory&view=Publications&submenu=publications&category=Cost%20Estimation&srctype=Publications_lister_redesign.

Therefore, **NARA strongly recommends CMS use its authority to wholly modify the supervision requirements from direct to general supervision for physical therapist assistants and occupational therapy assistants in private practice settings as outlined in 42 CFR 410.60(a)(3)(ii) and (c)(2). This change, without limitation, would allow for supervision to be satisfied through audio-only communication.**

Remote Therapeutic Monitoring (RTM) Codes

CMS is proposing to split the RTM treatment management services codes into 2 groups – GRTM 1 and GRTM 2 for physicians and non-physician providers; and GRTM 3 and GRTM 4 for non-physician qualified health care professionals (e.g., physical therapists (PTs), occupational therapists (OTs), speech language pathologists (SLPs), licensed clinical social workers). In the proposed rule, GRTM 3 and GRTM 4 practice expenses are significantly reduced by removing the clinical staff inputs. The RTM codes for PTs, OTs, and SLPs were recently introduced in CY 2022 and reducing the practice expense in the year following implementation undermines CMS' aim to increase patient access to RTM services. Evidence shows that early and adherent therapy is critical to improving patient outcomes and lowering Medicare MSK spending by avoiding surgeries, opioids, and MRIs which is why RTM is such a promising and important service. Although PTAs and OTAs may provide support for RTM codes, these codes are not provider specific because these services require all providers of the services to perform the same tasks with similar resources. **NARA requests that CMS restore the practice expense RVUs for payments for GRTM 3 and GRTM 4 or maintain 98980 and 98981 in their current work and practice expenses RVUs.** Further assessment could be more effectively completed in future with more data than the initial implementation year.

New HCPCS for Chronic Pain Management

CMS is proposing 2 new HCPCS G-codes for monthly chronic pain management and treatment services for CY 2023. CMS specifically points out that PT and OT practitioners are relevant practitioners for furnishing care related to chronic pain management. **NARA requests should CMS finalize these new codes, that education be provided to physicians on referring patients to PTs and OTs for chronic pain management interventions.**

Additional Comments

- Methodology Calculating GPCI updates: this has the potential to negatively impact reimbursement. NARA believes this is not the time to make updates to calculations that have the potential to impact reimbursement further negatively for therapy practitioners.

- Medicare Potentially Underutilized Services: NARA believes that services provided by therapy practitioners in significantly underutilized in the community setting and underserved/rural areas. Therapy practitioners can provide support for Medicare beneficiaries with diabetes, chronic pain, behavioral health and provision of wellness 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,

A handwritten signature in black ink, appearing to read "Kelly Cooney". The signature is fluid and cursive, with a large initial "K" and a long, sweeping underline.

Kelly Cooney, M.A., CCC-SLP, CHC
President

National Association of Rehabilitation Providers and Agencies