



January 2, 2020

James Mathews, PhD
Executive Director
Medicare Payment Advisory Commission
425 I Street, NW
Suite 701
Washington, DC 20001

Dear Dr. Mathews:

The American Physical Therapy Association (APTA), representing more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy; Private Practice Section of the APTA (PPS), a component of the APTA that is comprised of 4,178 physical therapists nationwide who own, operate, or work in an outpatient private practice setting; and Alliance for Physical Therapy Quality and Innovation (Alliance), an alliance among the nation's leading providers of outpatient rehabilitation care who collectively employ or represent over 20,000 physical and occupational therapists, and furnish physical and occupational therapy services on an annual basis to hundreds of thousands of Medicare beneficiaries, appreciate the opportunity to submit comments to the Medicare Payment Advisory Commission (MedPAC or Commission) in response to the Commission's December 5, 2019 public meeting regarding payment adequacy assessment for physician and other health professional services.

Pursuant to the 2020 Physician Fee Schedule (PFS) final rule, the Centers for Medicare and Medicaid Services (CMS) intends to implement an estimated 8 percent reimbursement reduction for physical therapy/occupational therapy in 2021. **Accordingly, APTA, PPS, and the Alliance respectfully request that MedPAC consider and discuss at an upcoming meeting how such reduction to reimbursement will exacerbate the overall inadequacies of physical therapy reimbursement under the Medicare PFS and harm the value of the physical therapy benefit.** As the Commission acknowledged at its most recent meeting, CMS intends to increase the work values for the office/outpatient evaluation and management (E/M) codes in 2021. However, the resulting redistributive adjustments to 36 specialties, including physical therapy, are significant. This is especially true for those many providers who cannot bill for office visits using the E/M codes. We recognize that under the requirement to maintain budget neutrality, when significant increases are implemented by CMS, other specialties are negatively impacted; however, we would like to point out the cumulative and crippling impact of current and planned reimbursement reductions to physical therapy.

As demonstrated in Table 120 in the 2020 PFS final rule, **physical/occupational therapy providers will see a combined impact of -8 percent in 2021.** This estimated 8 percent cut to Medicare reimbursement would be in addition to the 2 percent sequestration reduction, thereby amounting to up to a 10 percent cut in reimbursement. On top of that, this 10 percent reduction will be added to the 50 percent multiple procedure payment reduction (MPPR) policy, which reduces Medicare payment for practice expense (PE) on second and subsequent procedures, and the Correct Coding Initiative edits, which have already decimated reimbursement for skilled physical therapy services by imposing a significant penalty on code combinations that represent standard and necessary care. Furthermore, the PE portion of several of the codes frequently used by physical therapists were significantly cut as a result of the recent revaluation of codes used by physical therapists. Another contributing factor is that outpatient physical and occupational therapy providers will be faced with a 15 percent reimbursement reduction for services furnished in whole or in part by their physical therapist assistant or occupational therapy assistant beginning in 2022.

During its December 5 meeting, MedPAC staff stated that median physician compensation (all specialties) was \$302,000 in 2018, noting that compensation was much lower for primary care (\$243,000) than radiology (\$448,000) and nonsurgical, procedural specialties (\$428,000). Staff further noted that “physician compensation from all payers reflects the structure of Medicare’s fee schedule because many private insurers use RVUs that are similar to Medicare’s RVUs.”¹ Pursuant to the Bureau of Labor Statistics Occupational Outlook Handbook, as of May 2018, the median annual wage for physical therapists was \$87,930² and the median annual wage for physical therapist assistants was \$58,040.³ Additionally, the average amount of education debt owed by entry-level physical therapists is significant; a recent small-scale study concluded the average debt is equal to almost 2 years’ average salary, a 197% debt-to-income ratio. According to the study, that is more than the average debt-to-income ratio for new family medicine physicians and veterinarians.⁴ The cost of physical therapy education is a burden that can contribute to burnout and attrition. Thus, implementing an 8 percent cut to outpatient physical therapy services—which is likely to be adopted by many private insurers—will certainly cause a serious financial strain on outpatient physical therapy providers. Clinics that provide necessary care but are not sufficiently reimbursed will be unable to afford to remain open.

Due to inadequate access, beneficiaries will be forced to delay or forgo necessary care, leading to negative health outcomes and greater overall cost to the system. The federal government, patients, and taxpayers are better served in the long run by ensuring the Medicare program promotes efficient treatment of beneficiaries. This cannot happen unless there are enough providers to do so. It is unrealistic to expect physical therapy providers to continue operate their practices without affording them sufficient payment. Because physical therapists are not currently a provider type that may opt out of Medicare, physical therapists will simply choose to stop treating Medicare beneficiaries. **It is unclear how CMS intends to respond to the likely**

¹ MedPAC December 2019 Public Meeting Transcript, page 13. http://medpac.gov/docs/default-source/meeting-materials/medpac-december-2019-transcript_rev121219_sec.pdf?sfvrsn=0

² BLS Occupational Outlook Handbook. <https://www.bls.gov/ooh/healthcare/physical-therapists.htm#tab-5>

³ BLS Occupational Outlook Handbook. <https://www.bls.gov/ooh/healthcare/physical-therapist-assistants-and-aides.htm#tab-5>

⁴ Ambler, S. The Debt Burden of Entry-Level Physical Therapists, *Physical Therapy*, pzz179, <https://doi.org/10.1093/ptj/pzz179>

significant decline in beneficiary access as a result of the 8 percent reimbursement reduction.

As discussed in further detail below, physical therapists and physical therapist assistants serve a critical role in the health and vitality of this nation. Medicare beneficiaries' use of physical therapist services has steadily risen over the years. From 2013 to 2017, the number of patients seeking treatment from physical therapists in private practice rose from 2 million to nearly 2.7 million—a 35 percent increase. According to the Bureau of Labor Statistics Occupational Outlook Handbook:

[D]emand for physical therapy will come in part from the large number of aging baby boomers, who are staying more active later in life than their counterparts of previous generations. Older people are more likely to experience heart attacks, strokes, and mobility-related injuries that require physical therapy for rehabilitation. In addition, a number of chronic conditions, such as diabetes and obesity, have become more prevalent in recent years. More physical therapists will be needed to help these patients maintain their mobility and manage the effects of chronic conditions. Advances in medical technology have increased the use of outpatient surgery to treat a variety of injuries and illnesses. Medical and technological developments also are expected to permit a greater percentage of trauma victims and newborns with birth defects to survive, creating additional demand for rehabilitative care. Physical therapists will continue to play an important role in helping these patients recover more quickly from surgery.⁵

At the same time, federal payment to physical therapists has steadily declined. **The 8 percent reimbursement cut for physical therapy fails to align with Congress' and the Administration's efforts to drive better patient access to care and management.** At a time when the federal government is focused on increasing the delivery of integrated, team-based care, expanding chronic disease management, and reducing hospital admission/readmission rates, **it is counter-productive to reduce the reimbursement for physical therapists who have knowledge and skills in identifying, measuring and improving balance system deficits, functional limitations, and strength and flexibility deficits that have been shown to contribute to falls.**

The role of physical therapists in falls prevention includes:

- Assessing risk for falling;
- Designing an individualized plan for a patient's fall-prevention needs;
- Providing appropriate exercises and balance training;
- Working with other health care professionals to address any underlying medical conditions that could increase fall risk; and
- Providing recommendations on evidence-based community programs.

Physical therapists are a vital component of interventions that address risk factors for falls. Interventions provided by physical therapists are targeted and dosed to provide neural plasticity

⁵BLS Occupational Outlook Handbook. <https://www.bls.gov/ooh/healthcare/physical-therapists.htm#tab-6>

adaptation that move toward increased anticipated and reactive balance strategies under varying conditions. Progression in the multifactorial components of the balance systems and body structure/function domains leads to enhanced effectiveness of the activities and participation domains that support life and social role success.⁶⁷⁸⁹ Physical therapy also is an alternative mechanism that may reduce long-term opioid medication because it is an effective means to decrease preventable falls in community dwelling older adults.¹⁰¹¹ As documented by HHS in the Physical Activity Guidelines for Americans: Second Edition, physical activity reduces the risk of falling and injuries from falls.¹² Further, individually prescribed muscle strengthening and balance retraining exercises can reduce the number of falls and fall-related injuries by 35 percent.¹³

Medicare Reimbursement Should Support Early Access to Nonpharmacological Interventions for the Primary Care of Pain Conditions

The ongoing opioid crisis in the United States reflects the unintended consequences of a nationwide effort to help individuals control their physical pain. Since the mid-1990s, the health care system has employed an approach to pain management that focuses on pharmacologically masking pain, rather than treating its underlying cause. This strategy has resulted in a dramatic increase in prescribing opioids, which in turn has resulted in widespread opioid misuse and addiction. It also recently has led to a growing realization that current strategies for managing pain have to change—that opioid-centric solutions for dealing with pain at best only mask patients’ physical problems and delay or impede recovery, and at worst may be dangerous or even deadly.

Physical therapists work both independently and as members of multidisciplinary health care teams to enhance the health, well-being, and quality of life of their patients, who present with a wide range of conditions including those that commonly cause pain. The US Centers for Disease Control and Prevention’s (CDC) recommendations point to high-quality evidence that treatments provided by physical therapists are especially effective at reducing pain and improving function in cases of low back pain, fibromyalgia, and hip and knee osteoarthritis. Additionally, studies

⁶ El-Khoury F, Cassou B, Charles MA, Dargent-Molina P. The effect of fall prevention exercise programmes on fall induced injuries in community dwelling older adults: systematic review and meta-analysis of randomised controlled trials. *BMJ*. 2013;347:f6234.

⁷ Goodwin, V AR, Whear R, Bethel A, Ukouminne O, Thompson-Coon J, and Stein K. Multiple component interventions for preventions falls and fall-related injuries among older people. *BMC Geriatrics*. 2014;14(15):1-8.

⁸ Nematollahi A, Kamali F, Ghanbari A, Etminan Z, Sobhani S. Improving Balance in Older People: A Double-Blind Randomized Clinical Trial of Three Modes of Balance Training. *J Aging Phys Act*. 2016;24(2):189-195.

⁹ Cadore EL, Rodríguez-Mañas L, Sinclair A, Izquierdo M. Effects of different exercise interventions on risk of falls, gait ability, and balance in physically frail older adults: a systematic review. *Rejuvenation Res*. 2013;16(2):105-114.

¹⁰ Krebs, E., Paudel, M., Taylor, B., Bauer, D., Fink, H., Lane, N., & ... Ensrud, K. E. (2016). Association of Opioids with Falls, Fractures, and Physical Performance among Older Men with Persistent Musculoskeletal Pain. *JGIM: Journal of General Internal Medicine*, 31(5), 463-469. doi:10.1007/s11606-015-3579-9.

¹¹ Patricia, Z., Ming-Chih, K., Karayannis, N. V., Smuck, M., Zheng, P., & Kao, M. (2017). Stagnant Physical Therapy Referral Rates Alongside Rising Opioid Prescription Rates in Patients With Low Back Pain in the United States 1997-2010. *Spine* (03622436), 42(9), 670-674. doi:10.1097/BRS.0000000000001875.

¹² Physical Activity Guidelines for Americans Second Edition. *US Department of Health and Human Services*. 2018. <https://health.gov/paguidelines/>

¹³ Non-Pharmacological Management of Osteoporosis: a Consensus of the Belgian Bone Club. *Osteoporosis Intl*. 2011;22(11):2679-88.

show the efficacy of physical therapist interventions in preventing, minimizing, and, in some cases, eliminating pain in patients postsurgery, in patients with cancer, and in other clinical scenarios.¹⁴¹⁵¹⁶

The presence of pain is one of the most common reasons people seek treatment from health care providers. The source of pain for any individual can vary, whether it is an injury or an underlying condition such as arthritis, heart disease, or cancer. Because pain can be so difficult to treat and presents differently in every individual, its prevention and management require an integrated, multidisciplinary effort that takes into consideration the many variables that contribute to it--including the underlying cause(s) of the pain and the anticipated course of that condition, the options that are available for pain prevention and treatment, and patient access to these options, and the patient's personal goals, as well as their values and expectations around health care. That evidence, in fact, was the driving force behind recent recommendations by the CDC in its Guideline for Prescribing Opioids for Chronic Pain. "Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain," the CDC states. The report goes on to explain that "many non-pharmacologic therapies, including physical therapy...can ameliorate chronic pain."¹⁷

Research has demonstrated that when a patient in pain receives early access to a physical therapist, the patient experiences improved functional outcomes with a significant reduction in overall costs.¹⁸ Moreover, the CDC has concluded that there is insufficient evidence that opioid usage alone improves functional outcomes for those in pain. Unfortunately, CMS and many private insurers have promoted the use of medications for the management of pain, while simultaneously restricting access to safer, more effective nonpharmacological therapies. Despite overwhelming evidence that non-opioid and nonpharmacological treatments for pain often are safer and more effective, insufficient incentives and education exist that would both encourage and support prescribers' utilization of physical therapy to address their patients' acute and chronic pain.

To decrease opioid prescriptions in both inpatient and outpatient settings, there must be appropriate reimbursement for a broad range of pain management and treatment services, including alternatives to opioids such as physical therapy. This sentiment was expressed by the President's Commission on Combating Drug Addiction and the Opioid Crisis in its final report, recommending that "CMS review and modify rate-setting policies that discourage the use of

¹⁴ Physical Therapy as good as surgery and less risky for one type of low back pain. *Harvard Health Blog*. April 9, 2015. <https://www.health.harvard.edu/blog/physical-therapy-as-good-as-surgery-and-less-risky-for-one-type-of-lower-back-pain-201504097863>

¹⁵ Physical therapy as a first point of care to treat low back pain: an instrumental variables approach to estimate impact on opioid prescription, health care, utilization, and costs. *Health Services Research*. 2018. <https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12984>

¹⁶ Cancer pain: a critical review of mechanism-based classification and physical therapy management in palliative care. *Indian J Palliat Care*. 2011. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3183600>

¹⁷ CDC Guideline for Prescribing Opioids for Chronic Pain. *Centers for Disease Control and Prevention*. 2016. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1.htm

¹⁸ Physical therapy as a first point of care to treat low back pain: an instrumental variables approach to estimate impact on opioid prescription, health care, utilization, and costs. *Health Services Research*. 2018. <https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12984>

non-opioid treatments for pain, such as certain bundled payments that make alternative treatment options cost prohibitive for hospitals and doctors, particularly those options for treating immediate post-surgical pain.”¹⁹

Therefore, it is imperative that MedPAC and CMS acknowledge the important role that physical therapists and other nonphysician health care professionals play in the prevention and treatment of acute and chronic pain. The solution requires more than limiting access to drugs. Medicare payment policies should incentivize collaboration, assessment, and care coordination with foundational care team partners, particularly physical therapists. Benefit design and reimbursement models should support early access to nonpharmacological interventions including physical therapy for the primary care of pain conditions. It is critical that MedPAC and CMS promote policies that reduce barriers to nonpharmacological alternatives to opioids.

Availability of Positive Payment Adjustments

During the December 5 meeting, MedPAC acknowledged that under current law, there is no update to the fee schedule conversion factor for 2021 but noted that clinicians can receive an adjustment ranging from minus 7 percent to plus 7 percent for those covered by the Merit-based Incentive Payment System (MIPS). Clinicians covered by MIPS can also receive an extra payment increase for “exceptional” performance if they meet certain thresholds. Alternatively, clinicians substantially participating in an advanced alternative payment model (APM) can receive a lump sum incentive payment equal to 5 percent of their total professional service billings.

APTA, PPS, and the Alliance believe that physical therapists are well-positioned to be rewarded based on the value of the care they provide to their patients. However, the existing Medicare and Medicaid APMs fail to promote collaboration with small and medium-sized physical therapy and other nonphysician practices, as these providers frequently are not viewed as foundational partners by larger providers, such as integrated health systems. Secretary Azar has expressed that the US Department of Health and Human Services is committed to creating a “true competitive playing field” that rewards value. Unfortunately, CMS has failed to address our requests that it take into consideration the differences between physical therapists and other providers, and account for those differences as it pursues the development of new APMs. Unless and until CMS creates a more level playing field between different types of providers, physical therapists will continue to be unable to meaningfully participate in Medicare and Medicaid APMs. This will harm patient choice and access to quality care.

Moreover, because physical therapists were excluded from the Meaningful Use program, these health care professionals have not received any financial or technical assistance to adopt and implement certified electronic health information technology (CEHRT). Moreover, given that the 2015 Base EHR definition and several of the 2015 Edition certification criteria are not applicable to physical therapists, vendors that develop and offer EHRs for physical therapists are not attempting to certify their products because their EHRs do not encompass the necessary components to satisfy the CEHRT definition under the Quality Payment Program. Accordingly, physical therapists are essentially barred from participating in Advanced APMs.

¹⁹ The President’s Commission on Combating Drug Addiction and the Opioid Crisis. Final Report. *White House*. https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf

While we recognize the existing capability of clinicians to receive a positive payment adjustment by participating in MIPS, in 2019 only 5 percent of all Medicare-enrolled physical therapists in private practice are required to participate in MIPS. Given the lack of CEHRT in the rehabilitation industry and the unavailability of cost measures for physical therapists, current CMS policy is that only the quality and improvement activities categories are scored for physical therapists. Thus, most of our providers are only able to gain points in 2 of the 4 MIPS categories. With each year, gaining points from a limited number of categories will become increasingly challenging for physical therapists, again placing them at a disadvantage. Additionally, we find ourselves faced with several quality measure challenges that are impacting physical therapists' ability to maximize their points in the Quality category, which currently accounts for 85 percent of their total score. Thus, under the current outlined scoring methodologies, physical therapists will knowingly be taking a penalty in the 2023 payment year with a threshold score of 60 points should they still only be able to participate in and be scored in 2 MIPS categories.

Improving the Accuracy of the Medicare PFS

Physical therapy is comprised of activities that require the clinician's time and do not lend themselves to "efficiency gains." Therefore, we encourage MedPAC to call for the reevaluation of services in ways that align with the shift to value-based care. We believe that scientific evidence and best practice should be taken into consideration when developing work and PE value recommendations. For example, evidence shows that active therapy interventions—such as manual therapy and therapeutic exercises—deliver greater outcomes than do passive interventions. However, scientific outcomes play no role in code valuations, and, as a result of the 2016-2017 misvalued codes process, the values for these active therapies declined, while the value for therapies not supported by the literature, including massage therapy, or passive in nature like ultrasound, were increased.

APTA, PPS, and the Alliance encourage MedPAC to strongly consider the positive impact the practice of evidence-based physical therapy has on functional improvement, overall service utilization, and downstream spending and other outcomes such as emergency department use and hospital admissions, in order to appropriately promote payment policies that emphasize evidence-based practice and incentivize therapeutic innovation. Research has shown that treatment that adheres to evidence-based recommendations for active therapy results in far lower downstream costs than does non-evidence-adherent treatment. Frustratingly, regulatory policy does not track this known value of evidence-based physical therapy. When CMS imposes fee schedule reductions for services for which clinicians are required to conscientiously use current best evidence in clinical decision-making, this conveys to health care professionals that CMS sees little value in such services. It is further baffling that CMS simultaneously affords greater clinical value to therapies which are not supported by evidence. We encourage MedPAC to take such data into consideration when developing fee schedule payment recommendations in the future. While most physical therapists and other health care professionals deliver care in line with the best scientific evidence regardless of payment changes, it is imprudent to believe broad brush reimbursement cuts have no significant impact on care delivery trends and patterns.

Conclusion

APTA, PPS, and the Alliance urge MedPAC to consider how changes to payments under the PFS for outpatient therapy services have a significant and direct effect on reimbursement across

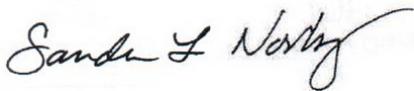
the entire spectrum of the care delivery system and will harm the value of the physical therapy benefit. Medicare margins for physical therapy providers are already low and have challenged the sustainability of practices. An estimated 8 percent reimbursement reduction will create challenging and predictably untenable financial circumstances that are likely to adversely impact patients' access to care. Rising debt and shrinking reimbursement provide the perfect storm for discouraging individuals from choosing to enter the profession in the future. Such shortages would be problematic as the baby boomers reach Medicare age and more individuals seek access to services. Modifications in payment and policy should be designed to maintain and enhance a robust network of participating providers. Unfortunately, we foresee that physical therapy providers, particularly those in rural and underserved areas, will be unable to sustain these lower Medicare payments and be forced to reduce essential staff or even close their doors as a result of this change, thus restricting beneficiary access to medically necessary physical therapy services.

APTA, PPS, and the Alliance are committed to working with MedPAC to advance health care reform initiatives, reduce spending across the program, and improve the quality of life for Medicare beneficiaries, and welcome the opportunity to meet with you in person to discuss our comments in further detail. Should you have any questions regarding our comments, please contact Kara Gainer, APTA Director of Regulatory Affairs at 703-706-8547 or karagainer@apta.org, Alpha Lillstrom Cheng, PPS Lobbyist at 301-787-0877 or alpha@lillstrom.com, or Nick Patel, Executive Director of the Alliance at 713-824-6177 or npatel@APTQI.com. Thank you for your consideration.

Sincerely,



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



Sandy Norby, PT, DPT
President
Private Practice Section
American Physical Therapy Association



Nick Patel, PT, DPT
Executive Director
Alliance for Physical Therapy Quality and Innovation