June 15, 2020

Alex M. Azar II
Secretary
U.S. Department of Health & Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave., S.W.
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Dear Secretary Azar and Administrator Verma:

On behalf of the more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy represented by the American Physical Therapy Association and the more than 4,000 members of the Private Practice Section of the American Physical Therapy Association, we appreciate the Executive Order issued on May 19, 2020 by President Trump entitled "Regulatory Relief to Support Economic Recovery" in which the President directed federal agencies to remove regulatory barriers to economic recovery as well as identify actions taken in response to COVID-19 which would promote economic recovery if made permanent. Each agency is to report its findings to the Director of the Office of Management and Budget, the Assistant to the President for Domestic Policy, and the Assistant to the President for Economic Policy.

The COVID-19 pandemic has forced health care providers, public and private payers, and policymakers to rethink how best to deliver and support access quality care that ensures that health care resources are efficiently distributed and effectively spent. Additionally, the current public health emergency has reinforced the importance ensuring the continued delivery of non-COVID-19 related health care services while also highlighting that physical therapy interventions — when accessed early and without administrative barriers — are safe and decrease downstream health care utilization.[1]

Reducing administrative burdens will allow physical therapists and physical therapist assistants to provide care to Medicare beneficiaries at the full ability of their education and license while preventing delays as well as reducing unnecessary and wasteful tasks that simply limit the time providers are able to spend on patient care.

APTA and PPS appreciate the opportunity to identify regulatory barriers to economic recovery and request that you include the following policy changes in the U.S. Department of Health and Human Services report required by the Executive Order.

[1] Three studies: Kazis LE, et al. "Observational retrospective study of the association of initial healthcare provider for new-onset low back pain with early and long-term opioid use." *BMJ Open.* September 20, 2019. https://bmjopen.bmj.com/. Sun E, et al. "Association of Early Physical Therapy With Long-term Opioid Use Among Opioid-Naive Patients With Musculoskeletal Pain." *JAMA Network Open.* December 14, 2018. https://jamanetwork.com/. Garrity B, et al. "Unrestricted Direct Access to Physical Therapist Services Is Associated With Lower Health Care Utilization and Costs in Patients With New-Onset Low Back Pain." *Phys Ther*. 2019 Oct 30. https://www.ncbi.nlm.nih.gov/pubmed/31665461.

Permanently Extend Access to Physical Therapist Services Provided Via Telehealth

We greatly appreciate the actions taken by the Department of Health and Human Services and the Centers for Medicare & Medicaid Services during the PHE to provide flexibilities to how health care providers may serve their patients. The expansion of telehealth payment and practice policies during this PHE have demonstrated that many needs can be effectively met via the use of technology and that patients can have improved access to skilled care by leveraging these resources. Additionally, the HHS Office for Civil Rights decision to modify HIPAA enforcement processes has been extremely beneficial mostly due to the flexibilities that permitted the use of more affordable, familiar, and accessible audio-visual technologies such as smartphones, tablets, and readily available software. Physical therapists who deployed telehealth services — including those in less than ideal situations — were still able to support patients and positively impact outcomes. The termination of these options and resources would unnecessarily interrupt care and contradict the Agency's commitment to supporting patients when and where their needs exist.

Therapy interventions delivered through an electronic or digital medium have the potential to prevent falls, functional decline, costly emergency room visits, and hospital admissions and readmissions. Telehealth helps to overcome access barriers caused by distance, lack of availability of specialists and/or subspecialists, and impaired mobility. Using these virtual engagement tools can prevent unnecessary exposure during a pandemic, epidemic, or even the annual flu season, a feature especially important for frail and immunocompromised persons.

Consistent with Sections 4 and 7 of the Executive Order, we strongly encourage HHS to work with Congress to amend the Social Security Act to provide CMS with the statutory authority to permanently extend the current policy that allows telehealth services furnished by all physical therapy providers to be reimbursed under Medicare, as well as make permanent the flexibilities associated with the originating site geography, authorized originating site, and audio-visual technology to allow all Medicare beneficiaries to receive telehealth services from their home, whether that home is in the community or part of an institutional setting. In the meantime, we suggest that at minimum, CMS should maintain these policies which impact a particularly vulnerable population until an effective COVID-19 vaccine is available and widely deployed. This will protect Medicare beneficiaries while Congress fully considers legislation to make such changes permanent.

Modify Therapy Plan of Care Certification Requirement

Pursuant to Medicare Benefit Policy Manual Chapter 15 Section 220, a plan of care must contain diagnoses, long-term treatment goals, and type, amount, duration, and frequency of therapy services. CMS requires physicians or nonphysician practitioners to certify a patient's therapy plan of care, with a dated signature on the plan of care or with another document that indicates approval of the plan of care. The manual states that it is not appropriate for a physician or NPP to certify a plan of care if the patient was not under the care of some physician or NPP at the time of the treatment, or if the patient did not need the treatment. By certifying an outpatient plan of care for physical therapy, a physician or NPP is certifying that: services are or were required because the individual needed therapy; a plan for furnishing therapy has either been established by a physician or NPP or by the therapist providing such services and is periodically reviewed by a physician; and services are or were furnished while the individual was under the care of a physician. Chapter 15 further states that there is no Medicare requirement for an order. However, "when documented in the medical record, an order provides evidence that the patient both needs therapy services and is under the care of a physician." The manual also states that *if the signed order includes a plan of care, no further certification of the plan is required* (emphasis added).

Compliance with the requirement for a physician signature on therapist-developed plan of care imposes a significant logistical and administrative burden for both therapy providers and physicians, taking valuable time and resources away from delivering patient care. Although an unintended consequence, care is frequently delayed while awaiting a physician signature — often after multiple requests — placing the beneficiary's health at risk due to the delay. While signing plans of care may not be a priority for a busy physician, this results in avoidable and perhaps harmful delays to receiving physical therapy care.

Forcing physical therapists to develop the plan of care and then to send it to the physician for signature is a burdensome and unnecessary process that during normal circumstances often takes weeks. Moreover, in some instances, physicians ask beneficiaries to come to their office for a visit before they will sign the plan of care. This visit typically results in checking of vital signs, medication review, and a request for a referral. Beneficiaries have voiced frustration that this requested visit results in out-of-pocket costs for the beneficiary and a cost to Medicare — but provides no clinical benefit — instead it is for the sole purpose of obtaining an approval to activate their right to receive therapy services.

During normal circumstances, delays and a lack of physician response are common. In cases where the physical therapist has performed due diligence in requesting a physician signature on the plan of care, but has not received a physician response, the therapist is left with an inadequate paper trail of the interaction. Moreover, the financial burden unfairly falls on the physical therapist if a signature is not obtained. Furthermore, in instances of delayed certifications, the therapist must identify and compile evidence necessary to justify the delay, further increasing his or her administrative burden. Frustratingly, while the medical record may illustrate the medical necessity of therapy services, CMS contractors will deny payment or seek recoupment if the plan of care is missing a signature, if the signature was not obtained within the required timeframe, or even if the signature is of marginal or questionable legibility. The administrative burden of this regulation is untenable. A physician's inaction should not result in patients suffering a delay in care and a shifted burden where physical therapists are held responsible and possibly subject to medical review simply because they were unable to compel a response.

Moreover, the plan of care signature requirement is at odds with contemporary physical therapist practice. Every state, the District of Columbia, and the U.S. Virgin Islands have removed from their statutes all or some of the referral requirements or order provisions for physical therapist evaluation and treatment. Physical therapists can provide evaluation and treatment services within their respective disciplines without the need for an order or referral from any other health care professional in accordance with state law.

State laws have recognized that physical therapists are highly educated health care professionals who can provide evaluation and treatment services within their respective disciplines without the need for an order or referral from any other health care professional. **APTA and PPS recommend that CMS eliminate the plan of care certification requirement if there is evidence in the record that the patient is under the care of a physician.** Should this change be made, in cases where there is evidence in the record of the patient being under the care of a physician or NPP, such as the presence of a referral, the therapist would not be required to share the plan of care with the physician or NPP. However, if there is no evidence in the record of the patient being under the care of a physician, the physical therapist would be required to share the plan of care with the physician/NPP but not be required to obtain a signature.

Review Impact of Budget Neutrality and Conversion Factor Adjustment on Specialty Providers

APTA and PPS urge CMS to reconsider its approach for revaluing the office/outpatient evaluation and management codes due to the significant negative impact it will have on physical therapy providers and dozens of other providers who do not bill CPT E/M codes in 2021 and beyond.

These concerns are magnified by the significant economic hit providers have taken in the past few months as a result of the COVID-19 PHE.

Table 120 in the 2020 Physician Fee Schedule final rule illustrates the specialty payment impacts if CMS maintains the proposal for the office/outpatient E/M code value increases without modification in the 2021 PFS. Of primary concern is the cut to reimbursement for services furnished by our provider members due to the redistribution of the E/M code value increases. When modifying the values to accommodate increases for the E/M codes, it appears that CMS may not have considered the overall impact that the E/M value increases would have on budget neutrality, resulting in consequential payment decreases for health care professionals who do not bill E/M codes. When proposed in July 2019, it was immediately clear to physical therapists and physical therapist assistants that this significant reduction in reimbursement would lead to a decreased workforce and therefore an inability to meet the needs of the Medicare population.

The unanticipated PHE declared in early 2020 and the subsequent sharp decline in patient visits combined with incredible economic challenges have added significantly to concerns of whether or not providers will be able to afford to keep their clinics open. Furthermore, it is clear that the recovery and restoration to full patient utilization will be drawn out. Looking longer term, the inevitable issues of access to care, rising debt, and shrinking reimbursement will provide the perfect storm for discouraging the next generation of individuals from choosing to enter the physical therapy profession at all. Shortages of physical therapists will only become more problematic as baby boomers (both patients and retiring providers) are of Medicare age at the same time that more individuals are seeking access to effective and non-pharmacological services.

Moreover, the 8% reduction in Medicare Part B reimbursement for physical therapy should not be viewed in isolation. Over the last 9 years, Congress and the Administration have implemented several changes to reimbursement practices and policies that have resulted in multiple cuts to physical and occupational therapy reimbursement rates. Starting in 2011, CMS applied the Multiple Procedure Payment Reduction (MPPR) to “always therapy” services. Then, in 2013, MPPR increased to 50% for CMS providers in all settings. Beginning that same year, sequestration required a 2% reduction in Medicare fee-for-service rates. In 2018, physical therapy codes were revalued that resulted in sizeable cuts to the work and practice expense RVUs. Additionally, the Bipartisan Budget Act of 2018 dictated that reimbursement be reduced to 85% of the otherwise applicable fee schedule amount for outpatient therapy services provided by physical therapist assistants and occupational therapy assistants beginning in 2022.

Medicare payments are already low in comparison to many private insurer payments. It is important to note that further cuts to Medicare will have a secondary impact at the practice level, because the vast majority of private contracts reference the Medicare rates set forth in the fee schedule. Deep cuts to Medicare payment rates thus have a negative cascading effect on private practices and will cause significant erosions in access to physical therapy far beyond the Medicare system.

While some policymakers have pointed to the Merit-based Incentive Payment System as an opportunity to offset these cuts, yet again, physical therapists have been treated differently than other providers and as such, access to MIPS cannot be considered a meaningful or accessible offset. Although clinicians participating in MIPS can receive an adjustment ranging from minus 7% to plus 7%, under current law, there is no update to the fee schedule conversion factor for 2021. 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 can receive a lump sum incentive payment equal to 5% of their total professional service billings.

These options are not meaningfully available to the vast majority of private practice physical therapists. While we recognize the existing capability of clinicians to receive a positive payment adjustment by participating in MIPS, in 2019 only 5% of all Medicare-enrolled physical therapists in private practice were required to participate in MIPS. Given the lack of certified electronic health record technology in the rehabilitation industry and the lack of availability 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 two of the four MIPS categories. Furthermore, as the thresholds increase each year, gaining enough 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% of their total score. Under the current outlined scoring methodologies, physical therapists will inevitably 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 two MIPS categories.

We would like to point out that while physical therapists are well-positioned to be rewarded based on the value of the care they provide to their patients, the existing Medicare and Medicaid APMs fail to promote collaboration with small- and medium-sized physical therapist practices, as these providers frequently are not viewed as foundational partners by larger providers, such as integrated health systems. Secretary Azar has expressed that HHS is committed to creating a "true competitive playing field" that rewards value. Unfortunately, CMS has failed to address our requests to 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 impede access to quality care.

Moreover, because physical therapists were excluded from the Meaningful Use program, they have not received any financial or technical assistance to adopt and implement CEHRT. Given that the 2015 Base Electronic Health Record 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.

The economic impact that the increases in the office/outpatient E/M codes and the corresponding negative redistributive adjustments to payment for services physical therapists and other nonphysician specialties who are not eligible to bill E/M codes will be devastating. **Accordingly, CMS must explore alternative approaches to achieve budget neutrality without forcing providers who furnish little or no E/M services to pay for the E/M coding and payment changes. We also request that CMS consider deferring or canceling implementation of the add-on code GPC1X. In addition, as suggested by the Medicare Payment Advisory Commission in its June 2018 Report to Congress Chapter 3, CMS could consider a smaller increase to office/outpatient E/M codes, thereby reducing payment rates for other services by much less than currently projected for 2021.**

Implement General Supervision Requirement of Physical Therapist Assistants in Private Practice

For the duration of the PHE, CMS has allowed direct supervision of physical therapist assistants to include virtual presence through audio/video real-time communications when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider. We greatly appreciate this flexibility which has supported uninterrupted care to Medicare beneficiaries while enabling health care

providers and patients to comply with the Centers for Disease Control and Prevention's social distancing and other recommendations to reduce the spread of COVID-19.

Physical therapists are responsible for providing safe, accessible, cost-effective, and evidence-based services. Services are rendered directly by the physical therapist and with responsible utilization of physical therapist assistants under the direction and supervision of the physical therapist. The physical therapist's practice responsibility for patient and client management includes examination, evaluation, diagnosis, prognosis, intervention, and outcomes. Physical therapists may use physical therapist assistants in components of intervention and in collection of selected examination and outcomes data.

Under Medicare, the level and frequency of physical therapist assistant supervision differs by setting and by state or local law. Physical therapists are licensed (and physical therapist assistants are either licensed or certified) in all states, the District of Columbia, and the USVI. Medicare currently allows for general supervision for physical therapist assistants in all settings except for private practice, which requires direct supervision. However, if state or local practice requirements are more stringent, the physical therapist and physical therapist assistant must comply with their state practice act. Currently, 44 states call for general supervision; in six states, supervision level differs by settings; the District of Columbia requires onsite supervision; and in both Puerto Rico and the USVI, the supervision level is undetermined.[2] **APTA and PPS encourage CMS to recognize the value and benefit of modifying the supervision requirement from direct to general for physical therapist assistants in private practice, as such modification would better promote unrestricted, non-delayed access to therapy interventions.**

Adjusting this Medicare policy would have an immediate impact in those 44 states which permit general supervision, because the only obstacle at this time is Medicare's direct supervision requirement. When treating Medicare beneficiaries, a physical therapist assistant may only provide care to Medicare beneficiaries during the hours the physical therapist works. As a result, the practice is severely limited if the supervising physical therapist is ill or unable to be in the clinic. **Delays in care may be harmful to functional outcomes and quality of life. Modifying the supervision requirement would better align with state law. Therefore, APTA and PPS recommend that CMS allow general, not direct, supervision of physical therapist assistants in private practice.**

Permanently Authorize Physical Therapist Assistants to Perform Maintenance Therapy Across Settings Under Both Medicare Part A and Part B

Currently, physical therapist assistants are allowed to furnish maintenance therapy in the SNF and home health settings under Medicare Part A. **APTA and PPS appreciate CMS' recent action allowing physical therapist assistants to perform maintenance therapy under Part B during the COVID-19 public health emergency.** Apart from the expected outcomes and goals of treatment, skilled maintenance therapy is not different from skilled restorative therapy. The physical therapist is professionally trained to oversee and direct a patient's course of care, and to assign responsibilities to the assistant as clinically appropriate. Moreover, the qualified therapist determines whether it is clinically appropriate for the therapist assistant to perform maintenance therapy. Allowing physical therapist assistants to perform maintenance therapy across settings would promote regulatory alignment and afford providers more latitude in resource utilization. **Accordingly, APTA and PPS encourage CMS**

[2] Federation of State Boards of Physical Therapy Jurisdiction Licensure Reference Guide https://www.fsbpt.net/lrg/Home/SupervisionRequirementLevelsBySetting.

to permanently allow physical therapist assistants to furnish maintenance therapy under Medicare Part B across settings.

Thank you for your consideration of our suggestions. In addition to their economic impact, these recommendations would further the goals of HHS and CMS to reduce administrative burden and improving care. We look forward to continuing to work with you to protect and improve the health of our nation. If you would like additional information, please contact Kara Gainer, APTA's Director of Regulatory affairs, at karagainer@apta.org or Alpha Lillstrom Cheng, PPS Lobbyist, at alpha@lillstrom.com.

Thank you for consideration of our request.

Sincerely,

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cc:
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