PRIVATE PRACTICE SECTION, APTA

1421 Prince Street
Suite 300
Alexandria, VA 22314
(800) 517-1167
www.ppsapta.org
info@ppsapta.org

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MACRA Cost Measure Team
Acumen, LLC
500 Airport Blvd., Suite 1000
Burlingame, CA 94010

Submitted electronically

Dear MACRA Cost Measure Team:

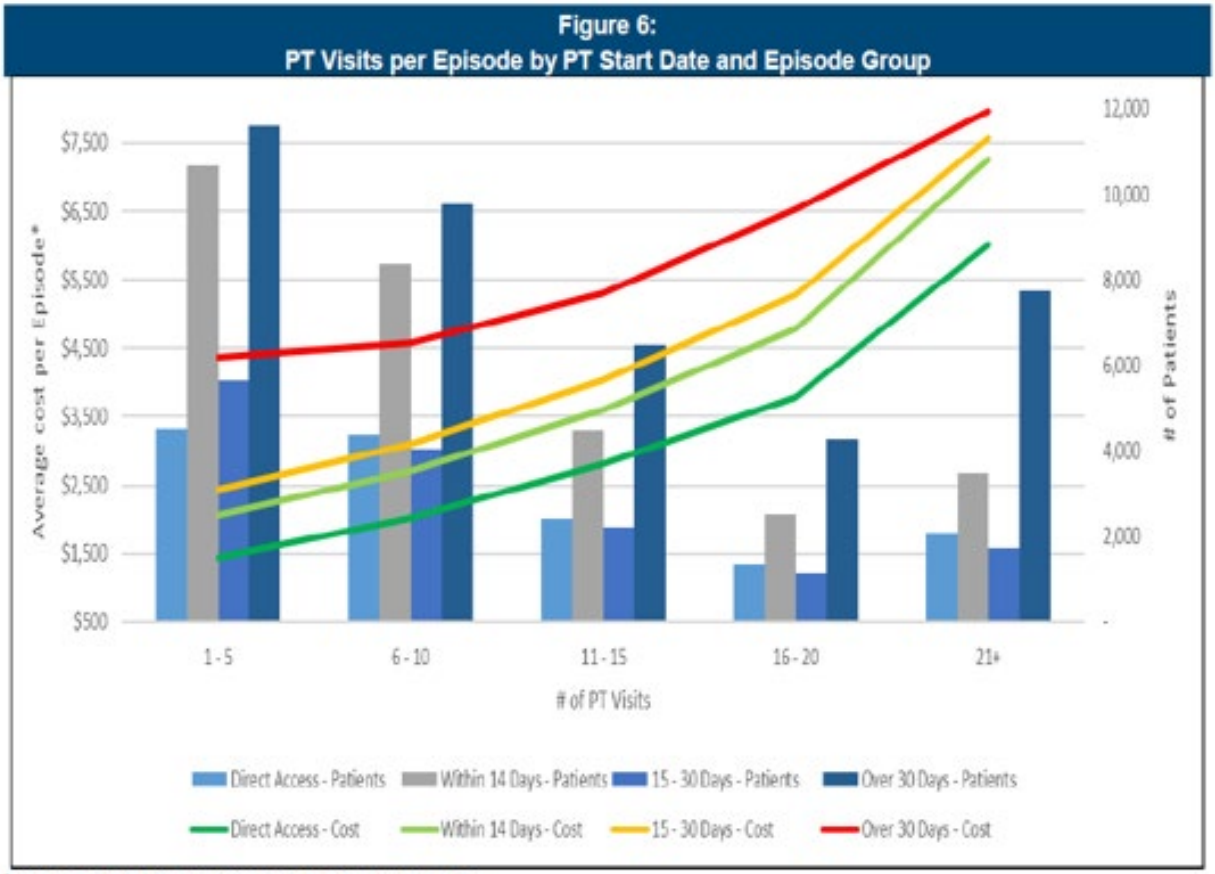
On behalf of the almost 4,000 members of the Private Practice Section (PPS) of the 100,000-member American Physical Therapy Association, I write to provide feedback on proposed MACRA Episode-Based Cost Measure 4.3: Therapy and Rehabilitation.

PPS is an organization of physical therapists in private practice who use their expertise to restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities in patients with injury or disease. The rehabilitative and habilitative care they provide restores, maintains, and promotes overall fitness and health to a range of patient types. Representing physical therapists who are also independent small business owners, PPS encourages and supports policies that enable our members to focus on providing high-quality, cost-effective, and clinically appropriate outpatient physical therapy. Our members are proud of the quality of care they provide, and deeply appreciate CMS's inclusion of a proposed cost measure focused on physical therapy as part of its WAVE 4 efforts.

The Milliman Study

Initially, we hope to highlight for CMS work that PPS has conducted to date related to the physical therapy contribution to total cost of care. PPS recognized years ago that musculoskeletal rehabilitation was being targeted under alternative payment methodologies, including bundled payments, for musculoskeletal episodes of care and wanted to contribute to the effort. PPS has shared the results of a commissioned study, "Impact of Physical Therapist Services on Low Back Pain Episodes of Care," (the Milliman study) with private payers across the country and PPS leaders have endeavored to educate PPS members about its conclusions through various educational venues. These venues include multiple presentations available to PPS members that can be used to both educate themselves and advocate with payers to restructure their payment policies to encourage better health outcomes at lower cost by allowing for early access to physical therapy or direct access.

What the Milliman study shows is that starting physical therapy early results in lower overall costs. Major data points for the study are reflected below, and the entire study is available at https://ppsapta.org/userfiles/File/ImpactofPhysicalTherapistServicesonLowBackPainEOC.pdf



Average Medicare Allowed Cost per Episode.

Again, the conclusions of the Milliman study illustrate three main points: First, if a physician chooses to refer a patient to a physical therapist, referrals sent early - in the first 14 days - result in lower costs and less use of invasive/higher cost procedures. Second, when accessing physical therapy for low back pain, direct access to physical therapy is the lowest cost method and results in less use of invasive/higher cost procedures. Third, clinical care of patients with recommended/active care results in lower cost and quicker outcomes than with passive care.

Application to Medicare Advantage

Beyond our focus on the Milliman study, PPS also appreciates the opportunity to express our desire for CMS to apply eventual cost measures like the one proposed in measure 4.3 to extend beyond traditional Medicare (Part B) and also be applied in Medicare Advantage (Part C, or MA). Government is at its best when it sets broad-based rules and standards for industry to work within. Including MA plans in the group of payers that will implement cost measures will help to create industry-wide standards that decrease administrative burden and the chaos at the practice level caused by multiple value-based schemes established by disparate payers. Physical

therapists in private practice would benefit from uniformity in payer policies. Greater uniformity will also ultimately help improve patient care.

MA is important to patients and to physical therapists, and enrollment in the program is growing quickly.[1] In addition, MA enrollment is highly concentrated within a handful of large insurers.[2] In certain counties, MA plans account for more than 60% of Medicare enrollment.[3] The actions of large insurers can have a large impact on small and large physical therapy practices and the variability they can create in value-based care systems can help or hurt a practice and its patients. The growth in MA enrollment is only poised to accelerate, and including these plans in the cost measure regime will have important smoothing effects for patient care.

Questions Posed by CMS

Initially, we wish to thank you and express our delight and enthusiasm that CMS is considering the development of a physical therapy-specific measure. Physical therapists in private practice have much to offer the health system by decreasing total cost of care while keeping quality of care high - and perhaps higher than with common surgical interventions. Focus on low back pain in particular seems wise as it is widespread within the Medicare population. Fundamentally, from the physical therapist in private practice perspective, treatment for low back pain as a whole seems reasonable and may include less surgical interventions than an extremity-related group.

The remainder of our comment response focuses on the specific questions posed by CMS as part of its presentation of Wave 4 proposed cost measure 4.3, language for which is reproduced below:

4.3 Therapy and Rehabilitation.

The Therapy and Rehabilitation clinical area would represent the new measure framework we are exploring for Wave 4, focusing on the care and treatment provided by physical therapists and related specialties for broad conditions such as Low Back Pain or both Low Back and Neck Pain. This is a framework that is ripe for development, as it may build from the chronic condition framework to capture the care provided by therapists. Low back and neck pain are also common conditions that are impactful for patients, and a measure for these conditions would address the variation in treatment techniques (e.g., duration/frequency, use of higher cost interventions like imaging). A broad topic such as Low Back Pain would also be a strong candidate for a MVP, as it is a broad and common condition with applicable MIPS quality measures. Additionally, we have received input suggesting the development of a Low Back Pain measure from our TEP and other stakeholders, noting the need for cost measurement centered on the care provided by therapists participating in MIPS.

Question 1: We identified 2 concepts for this clinical area, which includes Low Back Pain or an alternative approach for both Low Back and Neck Pain. Given the criteria for measure prioritization and the essential features of cost measures described above, which of the options would be preferable for the first therapy episode-based cost measure, and why? Are there

[1] https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/.
[2] Id.
[3] Id.

additional concepts that would be valuable to explore within this clinical area? For a cost measure focused on the ongoing treatment and care for these conditions, what are some areas of opportunity for improvement a measure may be able to capture regarding care and potential mitigation of complications?

Question 1 Answer from PPS: Care for patients with low back pain and care for patients with neck pain is not similar enough to justify a unified cost measure for both conditions. Low back pain and neck pain arise from different conditions and are treated in different ways, and often by different specialists. As it is much more prevalent and treatment standards for low back pain are widely known and implemented by physical therapists across the country, we would urge CMS to consider focusing on low back pain for this cost measure. While the population that could be included in the cost measure would be larger if both conditions are included, it is also clear that physical therapists work with occupational therapists to treat neck pain and thus attribution can become less clear. We recognize that there are strategic considerations in regards to overall Medicare spending as to why CMS may wish to choose a larger population that includes both neck pain and low back pain, but are convinced that clinical care for both conditions is different enough to warrant a focus on low back pain alone.

Physical therapists commonly utilize several tools that are helpful in ensuring patients with low back pain start with the appropriate provider, incorporate comorbidities commonly associated with low back pain into the prognosis and measure the effectiveness of the care delivered. We welcome the conversation on how we can best utilize the current standards of care to deliver higher valued care to Medicare patients.

With this in mind, there are important nuances to even the low back pain population that may or may not be reflected in the documentation associated with the condition. For instance, CMS has stated that the "framework … is ripe for development, as it may build from the chronic condition framework to capture the care provided by therapists." We are uncertain if the intent of this statement is thus for patients to be included only if they experience low back pain as a chronic condition. We are concerned that limiting the cost measure to only those with low back pain experienced as a chronic condition could further limit the number of patients involved, and thus the impact of the measure. In addition, we are uncertain how this further separation be accomplished under the rubric of the cost measure. Would the beneficiary be included only if their beneficiary's Evidence of Coverage (EOC) is explicit about this division? If so how is chronicity" defined by the measure and the EOC?

In the private sector, the majority of pricing models do not effectively address chronicity. They are often based only on the episode of care without chronic vs acute sub-categories. We would be very interested to work with Acumen and CMS to identify cost indicators that help define the contours and associated elements of chronicity (such as the use of opioids, repetitive imaging, or Electromyography) but we are unaware of a case rate model for these categories that has effectively and efficiently included these aspects of care. We raise this issue with some concern as CMS's adoption of specific aspects or definitions of chronicity may drive care in negative ways. CMS is such an important force in the US health system that its decisions in this area could move the rest of the health insurance system in ways that could be detrimental to physical therapy practice and patient care. Nevertheless, we stand ready to work with Acumen and CMS

to explore the contours of chronicity as we value transparency and hope to make any eventual cost measure as impactful as possible. We note the excellent CMS resources available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/Methods_Overview.pdf which may help Acumen consider the chronicity question.

One other possible approach would be to create three categories to address chronicity. Acute could be defined as 1 to 4 weeks, subacute as 4 to 12 weeks and chronic as greater than 12 weeks. It is important to note that there is a growing body of clinical literature supporting the reality that patients with chronic pain are too often treated with opioids even if the comorbidities of depression, anxiety, PTSD, or substance use disorder are present.

If CMS/Acumen decides to disregard our recommendation and includes neck pain in the measure, the measure could benefit from a similar division. CMS/Acumen could consider a category for neck/shoulder, neck/thoracic or low back hip/Sacroiliac Joint Dysfunction which commonly occur together.

Functionally, we recognize that categorization of diagnoses complicates the administrative burden of measure implementation, and also that important information may not be adequately reflected in the data available to measure developers. In a perfect world, we believe that lumbar and cervical and non-surgical/surgical would also be important indicators to improve the accuracy of the measure, but also recognize that further divisions may serve to limit the impact of the measure on total cost of care or increase the administrative burden experienced by practicing physical therapists in implementing it. In working on the Milliman study, PPS and Milliman came to an agreement that it was beneficial to keep the granularity of their data's categorization (in particular, radiating and non-radiating). We hope that in our future work on the cost measure with CMS and Acumen that additional information will be presented that would help us understand why the population for the cost measure may be limited to those seeking care for chronic low back pain versus the spectrum of patient presentations.

Question 2: Based on the draft approach described in the "Appendix_Framework" tab of the Preliminary Specifications of Wave 4 Candidate Episode Groups workbook, which refinements would you recommend? What are types of services to use as indication of ongoing therapy management and care?

Question 2 Answer from PPS: In regards to "types of services to use as an indication of ongoing therapy management and care," we believe that referring to CPT codes would be fairly straightforward. Thus, in the instance of using E&M code reporting to trigger an episode, the use of CPT codes 97161-97163 would trigger an episode for physical therapy. We are uncertain if CMS/Acumen may also be proposing to use a "DC indicator" to end the EOC as well, as the way CMS/Acumen is defining the episode seems to be from the physician lens. We note that every state now allows some degree of direct access to physical therapists. In addition, as of 2005, the Medicare Benefit Policy Manual (Publication 100-02) states that Medicare beneficiaries may seek physical therapy services without seeing a physician or obtaining a referral as long as the state's practice act allows for such access and the requirements for the

required certification of the plan of care are met. This reality also impacts the way that a patient's care can be "attribute(d) to a clinician," and would urge CMS and Acumen to consider how such attribution can be defined to include care provided by physical therapists.

Finally, in regards to Question 2, we urge CMS and Acumen to consider our experience with the Milliman Study. During our work with Milliman, we chose to include an indicator for 'recommended' vs. 'non-recommended' care. The proposed categorization for Measure 4.3 may be beneficial, but in our work with Milliman, we found value in changing initial recommendations by including manual therapy as a recommended intervention. Fundamentally, it would be important to exclude palliative care from the cost model.

Question 3: Based on the draft triggering approach, how should a therapy cost measure address the variation across patients for the need of therapy regarding Low Back Pain or for Low Back and Neck Pain (e.g., patients with chronic pain versus patients with a recent spinal surgery)? Some options include sub-grouping, risk adjusting, or excluding. Similarly, what recommendations do you have for how a measure may address patients with radicular syndrome/pain or arthritis?

Question 3 Answer from PPS: In response to this question, we urge CMS/Acumen to pay close attention to our experience with the Milliman Study. The Milliman model is helpful in highlighting the decreased cost of early intervention for low back pain and realizing down-stream savings. In addition, one pilot from ATI Physical Therapy has shown that while utilization of PT increases due to early intervention and direct access, overall costs per patient were lower. We are hopeful that any eventual cost measure will support and incentivize patients to pursue PT direct access with no utilization management barriers, as these barriers are becoming increasingly common in private practice physical therapy.

In addition, PPS supports surgical subcategories for low back such as fusion, ORIF for trauma and other more complicated diagnosis combinations such as Low back pain with stenosis, spondylolisthesis, SI instability, severe RA, OA, and osteoporosis. We are working with the APTA orthopedics section to confirm their most common categories and look forward to sharing the results of our findings.

Question 4: Are there any other concerns that may be present with assessing the care for patients with these conditions? If so, what are some potential approaches to address these concerns for a cost measure?

Question 4 Answer from PPS: Initially, one concern would be the limitation of the current episode-based cost measure reflecting treatment of chronic low back pain. Additionally, by tying a cost measure to a chronic population, there may be difficulty in isolating the physical therapy component from overall pricing as there are significant interdisciplinary inflections that occur when managing this population. Finally, the inclusion of models of trauma-informed care noted above will be important to consider as the measure moves forward through the approval and implementation process.

Conclusion
We appreciate the opportunity to comment. For questions related to this or other private payer issues, please contact Robert Hall, PPS Senior Consultant, at RHall@ppsapta.org.

Sincerely,

Mike Horsfield, PT, MBA
President, Private Practice Section of APTA