APTA Private Practice
A Section of the American Physical Therapy Association

September 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Attn: CMS-1770-P

Submitted electronically

RE: Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, etc. (CMS-1770-P)

Dear Administrator Brooks-LaSure:

On behalf of the almost 4,000 members of APTA Private Practice, a Section of the 100,000+ member American Physical Therapy Association (APTA), I write to provide feedback on the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2023 Payment Policies under the Medicare Physician Fee Schedule (MPFS) and Other Changes to Part B Payment Policies proposed rule. APTA Private Practice 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 that they provide restores, maintains, and promotes overall fitness and health across the age span to a range of patient types.

Representing physical therapists who are also independent small business owners, APTA Private Practice 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, but as small business owners are quick to realize the impact of drastic and unreasonable reductions to the payment they would receive for providing clinically appropriate care. They also struggle with the burdensome and duplicative administrative tasks which take time away from the care they provide to their patients to improve their function and facilitate a safe return to their activities of daily living as well as the prevention of the need for additional health care services.

In response to the 2023 MPFS proposed rule, APTA Private Practice strongly urges CMS to consider the following recommendations and feedback informed by experiences of private practice physical therapists:

PHYSICIAN FEE SCHEDULE

Conversion Factor

The proposed 2023 conversion factor (CF) is 33.0775 which is a 4.42% decrease from 2022's conversion factor of 34.6062. This reduction is a result of two factors, the annual CMS RVU budget neutrality update which reflects a reduction of about 1.5% and the expiration of the 3% funding boost to the 2022 CF. I will expand on these below.

While APTA Private Practice is frustrated with the proposed 4.42% reduction to the 2023 CF, we understand that CMS is required by statute to maintain budget neutrality in the Medicare Physician Fee Schedule (MPFS) and that the adjustment to the conversion factor is one of the tools that the Agency uses to do so. While CMS is constrained by budget neutrality, healthcare costs in the United States are not budget neutral. APTA Private Practice members like so many other healthcare providers are struggling to keep up in a system that doesn't meet the needs of either beneficiaries or providers. We assure the Agency that we are working with stakeholders to encourage Congress to preserve access to services under Medicare by revisiting how best to provide appropriate payment to providers who care for Medicare beneficiaries, including but not limited to efforts to reform the payment processes of the MPFS.

MPFS rates set by CMS also impact the fee schedules of private payors. APTA Private Practice would like to remind CMS that any decision to cut Medicare reimbursement will inevitably result in decreased payment rates when our members provide care for Veterans, TRICARE enrollees, Medicare Advantage beneficiaries, and commercially insured patients. It is unreasonable and irresponsible for CMS and Congress to create an environment where private practice physical therapists—who are both small business owners and providers—are asked to deliver high-quality, cost-effective care without being afforded sufficient payment. APTA Private Practice takes this opportunity to remind policy makers that because physical therapists are not currently a provider type who may opt out of Medicare, a significant number of physical therapists may simply choose to stop treating Medicare beneficiaries all-together. While not their preference, therapists may need to do so in order to maintain a viable business. Should CMS share our concern, ***APTA Private Practice suggests that the Agency provide Congress the necessary technical assistance and support for legislation such as the Medicare Patient Empowerment Act (H.R. 3322/S. 826) which would add physical therapists to the list of providers that may opt out of Medicare, on a case-by-case basis, in order to truly protect patient access in communities across America.***

The second factor is the expiration of the 3% funding boost to the 2022 CF that Congress provided in the December 2021 *Protecting Medicare and American Farmers*

from Sequester Cuts Act. Our members are still recovering from the economic impact of COVID-19 and thus APTA Private Practice encourages CMS to support Congressional efforts to once again provide supplemental funding to Medicare providers via a boost to the conversion factor.

Rebasing and Revising the Medicare Economic Index

In the proposed rule, CMS is considering updating RVU component weights based on the Medicare Economic Index (MEI). We noticed that CMS predicts physical therapists will receive a positive 2% adjustment to payment as a result of this proposed policy. However, given the key impact of the policy is to increase the relative weight of practice expense, it is crucial to know whether CMS has taken into account the impacts of multiple procedure payment reduction (MPPR) when calculating its impact. As you know, MPPR reduces the value of practice expense by 50% for codes deemed "always therapy" when multiple codes are billed on the same day. APTA currently estimates that MPPR reduces payment approximately 15% per visit. Should CMS move forward with the MEI update, the practice expense portion of therapy codes will increase, meaning more of the code is subject to MPPR. This means CMS' estimate of a 2% increase may be inaccurate causing qualified healthcare providers who bill "always therapy" codes to be disproportionately impacted by underpayment of their services. ***APTA Private Practice therefore requests CMS confirm that MPPR was accounted for in Table 148 and its estimated impact using rebased and revised MEI cost share weights. APTA Private Practice can neither support nor oppose this policy without this information.***

Chronic Pain Management

CMS is proposing to create two HCPCS G codes to describe monthly chronic pain management (CPM). The descriptor of the HCPCS code GYYY1 is to include "ongoing communication and care coordination between relevant practitioners furnishing care (e.g. physical therapy and occupational therapy, and community based care), as appropriate."[1] CMS also proposes to permit billing of the HCPCS code GYYY1 by up to two practitioners in the same calendar month because it anticipates "that there could be occasional instances where care of an individual with chronic pain is transferred to a pain specialist or other specialist during the same month they received the CPM services from a primary care practitioner, for ongoing care."[2] GYYY2 would be for an additional 15 minutes or more of CPM per calendar month.

APTA Private Practice is very appreciative that CMS understands that access to physical therapy and other rehabilitation services are a necessary component to address chronic pain issues. However, it appears that this proposal remains physician-centric and categorizes the expertise of the physical therapist as supplemental instead of fundamental. Physical therapists specialize in providing neuromusculoskeletal interventions and should be the point of entry for treatment of movement disorders—including those which result in chronic pain. Pain management interventions provided by physical therapists have been shown to reduce the use of pain medications or costly

[1] CMS-1770-P, Federal Register, Vol. 87, No. 145, pp.45935.
[2] *Ibid*., pp.45936.

surgeries. Therefore, ***APTA Private Practice respectfully requests that CMS add clarity to the description and requirements of these codes to ensure that other clinicians such as physical therapists who are prepared and suited to function as primary coordinators of care for patients with chronic pain are able to bill the CPM codes independently of a physician provider***.

Coordination with other practitioners may be necessary so we appreciate that the Agency plans to allow billing of the HCPCS code GYYY1 by up to two practitioners in the same calendar month. Furthermore, ***payment for CPM should include reimbursement for time that interdisciplinary providers spend in consultation with each other as they coordinate a care strategy for complex patients. This would ensure that all engaged providers were compensated for their time*** while also reducing conflicting or over-utilization of services, making sure patients have a cohesive team addressing their complex cases, and fostering interdisciplinary learning.

Remote Therapeutic Monitoring

Value of GRTM3 and GRTM4

CMS has proposed two new remote therapeutic monitoring (RTM) HCPCS G codes which would be billable by non-physician providers-including physical therapists. GRTM3 will be for "remote therapeutic monitoring treatment assessment services, 20 minutes personally furnished by qualified nonphysician health care professional over a calendar month requiring at least one interactive communication with the patient/caregiver during the month."[3] GRTM4 will be for "each additional 20 minutes personally furnished by qualified nonphysician health care professional."[4] These codes would replace the CPT codes approved for RTM in last year's rule. APTA Private Practice appreciates that CMS continues to work to improve and refine the RTM codes.

APTA Private Practice joins APTA in seeking clarification related to CMS's determination of the direct practice expense (PE) inputs for CPT codes 98980 and 98981 as "incident to" services. The clinical staff time identified for these CPT codes include "communications with the patient" and "perform procedure/service not related to physician work time". These activities are included in the PE codes frequently billed by physical therapists and are performed by physical therapist assistants (PTAs) as part of the direct practice expense. Although PTAs would not update and modify a care plan, they assist the physical therapist in communications with the patient as well as gather and review the data. Accordingly, removal of these inputs is not only unnecessary but also inappropriate as this type of labor still must be performed in order to complete the services described by these codes.

Should CMS maintain the position that the services described fall under the definition of "incident to" APTA Private Practice supports APTA's suggestion that CMS reconsider deletion of all PE inputs for HCPC codes GRTM3 and GRTM4. The process and resources needed to provide RTM services is similar regardless of the type of provider doing the task; therefore, ***APTA Private Practice recommends that CMS include all***

[3] *Ibid*., pp.45965.
[4] *Ibid*.

practice expense inputs of 98980 and 98981 in GRTM3 and GRTM4, regardless of the type of provider. While a great benefit could come from the expanded use of RTM services in physical therapy settings, ***should the significant reduction in PE for GRTM3 and GRTM4 be implemented, this could create a strong disincentive for physical therapists and PTAs to perform RTM services.***

Billing Logistics

The requirement that CPT code 98975 and 98976 or 98977 be billed before billing GRTM3 or GRTM4 creates a scenario where a provider may meet all of the requirements for billing RTM treatment assessment services but are prohibited from doing so because the criteria for billing 98975 and 98976 or 98977 cannot yet be met.

In many instances, it will take fewer than 16 days of data for a physical therapist to be able to effectively use RTM for treatment assessment. Furthermore, it would not be possible to complete 16 days of assessment within a calendar month should treatment begin past the 15th day of that month. Accordingly, ***APTA Private Practice recommends that the 16-days of data requirement be removed and that the timeframe of data collection should be based on a 30-day period instead of a calendar month.***

Remote Supervision

Finally, in response to CMS' request for comment on whether or not it should permanently allow the "immediate availability for direct supervision through virtual presence using real-time, audio/video technology for only a subset of services"[5] ***APTA Private Practice believes that due to the inherently virtual nature of RTM services, the use of a virtual presence for supervision of a PTA providing RTM services in a private practice setting should be made permanent.***

Telehealth

151-day extension of PHE-related Waivers

With the enactment of the *Consolidated Appropriations Act of 2022* (CAA) rehabilitation therapists were granted an additional 151-days of coverage for care provided via telehealth after the PHE expires. APTA Private Practice appreciates that CMS acknowledges and incorporates the extension in this proposed rule.

Category 3 vs. Category 1

CMS noted that it received requests to add CPT codes 90901, 97110, 97112, 97116, 97150, 97161-97164, 97530, 97535, 97537, 97542, 97750, 97755, 97763, and 98960-98962 to the Category 1 list of permanently covered Medicare telehealth services. APTA Private Practice is disappointed that CMS declined the request. Instead, CMS states that it plans to augment the therapy CPT codes included in Category 3 (those services added to the Medicare Telehealth Services list and allowed to remain available for use through the end of 2023). APTA Private Practice appreciates that despite the denial to add the codes to Category 1, CMS is proposing to add CPT codes 90901, 97150, 97530, 97537, 97542, 97763, and 98960-98962 to Category 3 as well as

[5] CMS-1770-P, Federal Register, Vol. 87, No. 145, pp.45901

retaining those CPT codes they added to Category 3 in the CY 2022 MPFS: 97110, 97112, 97116, 97161-97164, 97535, 97750, and 97755.

The 2023 MPFS comment letter submitted by APTA includes an expansive list of examples of the value of providing physical therapy services using a combination of telehealth and in-person visits. APTA Private Practice urges CMS to explore those examples which indicate similar or superior patient outcomes, particularly as telehealth can be used to reduce disparities in rural and underserved communities by providing more options for prevention, treatment, and rehabilitation. Telehealth is a cost-effective way that physical therapists, particularly APTA Private Practice members, can extend the reach of their expertise to serve patients in their communities. Therefore, APTA Private Practice continues to ***urge the Agency to recognize the proven value of care provided via telehealth, identify how they are similar to professional consultations and office visits currently on Medicare's telehealth services list, and include the following CPT codes in Category 1***: 90901, 97110, 97112, 97116, 97150, 97161-97164, 97530, 97535, 97537, 97542, 97750, 97755, 97763, and 98960-98962.

APTA Private Practice points out that regardless of whether therapy codes are listed as telehealth eligible through the end of 2023, patients who seek care from independently practicing physical therapists 151 days after the PHE has been lifted will be denied. This is because at that time rehabilitation therapists and their assistants will no longer be eligible to provide care via telehealth unless they are providing care "incident to" an eligible distant-site provider. APTA Private Practice is aware that regulators do not have the authority to alter which provider types are granted distant-site provider status. Instead, Congress will have to pass the *Expanded Telehealth Access Act* (S.3193/H.R.2168) to permanently grant rehabilitation therapists and their assistants distant-site provider status. Therefore, ***APTA Private Practice requests that CMS provide technical assistance to Congress as it pursues expansion of the list of provider types who are permanently able to provide care via telehealth***.

Address Administrative Burdens which Detract from Patient Care

Flexibility for Virtual Supervision of Physical Therapist Assistants in Private Practice Settings

PTAs provide physical therapist services under the direction and supervision of a physical therapist. As a result of the flexibilities granted for the duration of the COVID-19 Public Health Emergency (PHE), supervisors of PTAs continue to be able to "meet the immediate availability requirement for direct supervision through the use of real-time, audio/video technology". The prompt issue of supervision flexibility in 2020 has supported uninterrupted care for Medicare beneficiaries during the PHE.

In this proposed rule, CMS indicates that it is still considering making this flexibility permanent so that direct supervision could always be achieved through the virtual presence of the supervising physician or practitioner using real-time, interactive audio/video (A/V) communications technology without limitation. APTA Private Practice would like to see administrative burden reduced by making virtual supervision of PTAs

an option. However, under this proposal, having this flexibility is moot if the supervising physical therapist is unable to use **both** the audio and visual components of telecommunication. In contrast, current CMS general supervision policy only requires the use of "telecommunications", with no visual component. This disparity could impact patient care—especially for patients located in rural areas where broadband or cellular infrastructure is lacking or limited. Through no fault of their own, patients in rural areas would not have as many choices as their suburban or urban counterparts who have better access to the infrastructure necessary to utilize combined audio and visual technologies. ***APTA Private Practice fully supports being able to permanently achieve direct supervision via A/V technologies, and requests flexibility in instances where technology and infrastructure insufficiencies obstruct the ability of providers or beneficiaries to use the visual functions of their technologies. In those instances, APTA Private Practice suggests that as long as the technology used includes the capacity to share images that the requirement of the use of A/V technologies has been met. Furthermore, APTA Private Practice requests confirmation that the use of A/V technologies to achieve direct supervision will not be restricted to instances when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider.***

Permanent General Supervision for Physical Therapist Assistants in Private Practice Settings

While we appreciate that CMS is willing to modify PTA supervision standards for private practice settings, ***instead of this incremental change, APTA Private Practice strongly recommends that CMS use its authority to wholly modify the supervision requirements from direct to general supervision for physical therapist assistants in private practice 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. Temporary, PHE-related waivers permit PTs and OTs to achieve direct supervision of PTAs and OTAs via A/V telecommunications, but this is not equal to direct supervision and is set to expire at the end of the year in which the PHE ends.

In contrast, only general supervision of PTAs or OTAs is required by PTs and OTs in other outpatient provider settings (i.e., hospitals, SNFs, rehabilitation facilities, etc.). Under general supervision, the PT or OT is not required to be on site for direction and supervision, but must be available by audio telecommunications. 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. Currently, only New York and the District of Columbia require direct supervision of PTAs by PTs and only one state, Kentucky, requires direct supervision of OTAs by OTs. Furthermore, 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 singling private therapist practices out for direct supervision.

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.

Therefore, ***APTA Private Practice strongly recommends that 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.***

Modify therapy Plan of Care Certification requirement

In light of the perennial Medicare reimbursement cuts, APTA Private Practice recommends the Agency utilize its regulatory authority to reduce administrative burdens on those same providers. One such opportunity would be to modify the requirement that a therapy plan of care be certified by a physician or nonphysician practitioner (NPP). 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 NPPs 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 also 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.”

Compliance with the requirement for a physician signature on a therapist-developed plan of care is redundant and imposes a significant logistical and administrative burden for both therapy providers and physicians/NPPs—taking valuable time and resources away from delivering patient care. Forcing physical therapists to develop and then send the plan of care to the physician for signature is a burdensome and unnecessary process that often takes weeks or months. The wait-times for the return of signed certifications from large facilities or hospital-based outpatient health systems is even greater. Because signing plans of care may not be a priority for a physician, care (despite multiple requests) is frequently delayed while awaiting a physician signature. Although an unintended consequence, this avoidable delay places the beneficiary’s health at risk. 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 superficial visit results in out-of-pocket costs for the beneficiary and a cost to Medicare, but provides no clinical benefit; instead, the visit is for the sole purpose of obtaining an approval to activate their right to receive therapy services.

It is unique in the Medicare program that in order for physical therapists to be compliant with Medicare policy and be paid for patient care, they must rely on another providers’ administrative efficiencies and timeliness. Additionally, in situations 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. Furthermore, in instances of delayed certifications, the therapist must identify and compile evidence necessary to justify the delay, when often they have no way of knowing nor control over why the physician/NPP has not certified a submitted plan of care. If a provider does not have the documentation to support the delayed certification or recertification, this leads to denials by Medicare Administrative Contractors and other CMS contractors when they are performing a pre-payment or post-payment medical record review. Frustratingly, while the medical record may clearly illustrate the medical necessity of therapy services, CMS contractors 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 (as stamped signatures are not allowed). The administrative burden of this regulation is indefensible, anti-patient, and unnecessary. It also reflects the fact that Medicare has not updated key portions of its’ benefit policy manual (chapter 15, sections 220-230) for well over 25 years. Fundamentally, a physician’s inaction or administrative inefficiency should not result in patients suffering a delay in care and physical therapists are taking on significant financial risk simply because they were unable to elicit a response from a physician.

In further support of our request that CMS review this policy, APTA Private Practice notes that 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. So that Medicare beneficiaries have equal access to care, CMS policy should align with state laws which have recognized that physical therapists are highly educated healthcare 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 Private Practice suggests that where there is evidence in the record of the patient being under the care of a physician or NPP (such as the presence of an order for physical therapy care), the statutory requirement that the patient be under the care of a physician is not only satisfied but also documented, therefore the therapist should not be required to share the plan of care with the physician/NPP. As an alternative, APTA Private Practice suggests CMS accept documented proof that the plan of care was delivered to the physician (e.g. a fax receipt or other confirmation of delivery) instead of requiring a signed plan of care. Finally, we recommend that the requirements for re-certification should be the same as the requirements for certifying the plan of care.

MERIT-BASED INCENTIVE PAYMENT SYSTEM

Re-weighting of MIPS Categories

APTA Private Practice appreciates that CMS has retained the reweighing policy of 85% of the final score being based on Quality and 15% based on Improvement Activities for physical therapists who participate in MIPS. For small practices, 50% of the final score is based on Quality and 50% based on Improvement Activities.

The Promoting Interoperability Category

Since rehabilitation therapists have been included in MIPS, they have been exempted from the requirement to report in the promoting interoperability (PI) category. ***APTA Private Practice thanks CMS for continuing to exempt rehabilitation therapists from the PI category for CY 2023 performance/CY 2025 payment year.***

In this proposed rule, CMS suggests that physical therapists and other rehabilitation therapists will be required to participate in the PI category beginning in CY 2024. As CMS is aware, physical therapists were not included in the *HITECH Act's* electronic health record program from the outset and therefore have not been monetarily incentivized nor supported to invest in this communication link; nor were physical therapists included in the *21st Century Cures Act* provisions affecting how Certified Electronic Health Record Technology (CEHRT) impacts the Quality Payment Program. Therefore, ***APTA Private Practice feels strongly that it would be inappropriate to require physical therapists to be scored on the PI category beginning in CY 2024 performance year. The score for PI should not be a factor in a rehabilitation***

therapist's QPP final score until they have access to federal financial support for such an investment.

Should CMS move forward with its plan to require PI category data in CY 2024, APTA Private Practice recommends that it also continue to accept applications for reweighting the PI performance category to zero percent due to extreme and uncontrollable circumstances, insufficient internet connectivity, lack of control over the availability of a CEHRT, or as a result of a decertification of an EHR that is currently in place for those who must report PI data. We also recommend that those providers who fall under the low-volume threshold but are voluntarily reporting in MIPS, be able to choose whether or not to be scored on the PI category of MIPS. Without these flexibilities, there will be little to no incentive for physical therapists to voluntarily participate in MIPS.

CONCLUSION

Thank you for the opportunity to comment on the CY 2023 Medicare Physician Fee Schedule and QPP proposed rule. We hope our insight and perspective will prompt CMS to reconsider some of its proposals and remember that when access to care is diminished, beneficiaries will be forced to delay or forgo necessary care which leads to negative health outcomes and greater overall cost to the system. The federal government, as well as patients and taxpayers, are better served in the long run by ensuring that the Medicare program supports providers and enabling them to readily participate in the timely treatment of beneficiaries. APTA Private Practice welcomes the opportunity to work with CMS to identify solutions that will safeguard the financial health of the Medicare program while ensuring that beneficiaries have adequate access to high-quality physical therapy services in safe, cost-effective community-based settings.

Sincerely,

Mike Horsfield, PT, MBA
President, APTA Private Practice: a Section of the American Physical Therapy Association