



August 13, 2018

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 a private practice setting; and the Alliance for Physical Therapy Quality and Innovation (Alliance), an alliance among the nation's leading providers of outpatient rehabilitation care, and 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, are pleased to submit comments to the Medicare Payment Advisory Commission (MedPAC or Commission) in response to the Commission's June 2018 Report to Congress, Chapter 3: *Rebalancing Medicare's physician fee schedule toward ambulatory evaluation and management services*. Our organizations have concerns about the Commission's recommendations to reduce the value of physical therapist services. Physical therapists and physical therapist assistants serve a critical role in the health and vitality of this nation. Such reduction to reimbursement would exacerbate the overall inadequacies in physical therapy reimbursement under the Medicare Physician Fee Schedule and harm the sustainability of the value of the physical therapy profession, and in turn diminish clinical care and outcomes and increase the cost of care to thousands of Americans each and every day. We urge MedPAC to consider the full impact of all regulatory changes that affect physical therapists' reimbursement and propose policies that ensure fair and equitable reimbursement for services furnished by physical therapists.

The physician fee schedule is currently the basis of payment for outpatient therapy services furnished by physical therapists in private practices, hospitals, outpatient rehabilitation facilities, public health agencies, clinics, skilled nursing facilities (SNFs), home health agencies, and comprehensive outpatient rehabilitation facilities. Over the last decade, the number of Medicare beneficiaries accessing physical therapy has increased. In 2008, 3.96 million beneficiaries received outpatient physical therapy services; in 2010, 4.16 million beneficiaries received

outpatient physical therapy services.¹ Therefore, any changes to payments under the physician fee schedule for outpatient therapy services have a significant and direct effect on Medicare payments across the entire spectrum of the therapy delivery system.

Introduction

Within Chapter 3 of the June 2018 Report to Congress, MedPAC discusses a budget-neutral approach to rebalance the fee schedule that would increase payment rates for ambulatory evaluation and management (E&M) services while reducing payment rates for other services (e.g., procedures, imaging, and tests). The Commission puts forth this proposal as a means to address the problem of passive devaluation of ambulatory E&M services. MedPAC defines ambulatory E&M services as office visits, hospital outpatient department visits, visits to patients in other settings, and home visits, and notes that such services are essential for a high-quality, coordinated health care delivery system. The Commission further states “these visits enable clinicians to diagnose and manage patients’ chronic conditions, treat acute illnesses, develop care plans, coordinate care across providers and settings, discuss patient preferences, and engage in shared decision-making with patients. These services are critical for both primary care and specialty care.”² The Commission believes clinicians should be incentivized to provide ambulatory E&M services, and as such, these services should not be priced too low relative to other services.

We appreciate MedPAC’s efforts to ensure adequate pricing in the fee schedule for physicians and other health care professionals. However, we have concerns that to offset the increase in payment for ambulatory E&M services, MedPAC recommends payment reductions up to 3.8% for specialties that the Commission believes provide few ambulatory E&M services, including physical therapy.³ The Commission suggests these reductions are warranted because procedures, imaging, and tests are more likely to experience efficiency gains than ambulatory E&M services. Over time, clinicians can complete these procedures faster and with less mental effort, skill, and risk; consequently, they are able to provide more of these services per day. Thus, the Commission suggests it is appropriate that for services which experience efficiency gains, the work relative value units (RVU) should decline.

While our organizations agree with the importance of maintaining accurate work RVUs for services billed under the fee schedule, for the reasons articulated below, we dispute the Commission’s rationale for including physical therapy in the group of “specialties” that warrant a reduction in reimbursement. We request that MedPAC carefully consider our comments regarding the commission’s proposal to modify fee schedule reimbursement as discussed within Chapter 3 of the June 2018 Report to Congress.

¹https://www.cms.gov/Medicare/Billing/TherapyServices/downloads/CY_2008_Outpatient_Therapy_Utilization_Report.pdf; see also <https://www.cms.gov/Medicare/Billing/TherapyServices/Downloads/2010-DOTPA-Utilization-Report.pdf> Accessed July 23, 2018.

² MedPAC June Report to Congress. Chapter 3. Page 69. http://medpac.gov/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf?sfvrsn=0 Accessed July 11, 2018.

³ *Id.* at page 67.

Consideration Must Be Afforded to Medicare Payment Policies Which Impact Reimbursement

MedPAC's proposal to reduce payment for certain specialties, particularly physical therapy, fails to account for several key policies that impact Medicare Part B payment for physical therapy services, including the misvalued codes initiative and the multiple procedure payment reduction (MPPR).

Misvalued Code Initiative

APTA, PPS, and the Alliance have worked diligently to advocate for payment levels that would continue to allow physical therapists to deliver high-quality care to Medicare beneficiaries. Our organizations recognize the importance of ensuring services are appropriately valued and concur with MedPAC that maintaining current estimates of time and intensity is critical to ensuring accurate work RVUs. We believe the misvalued coding initiative plays an important role in helping to identify mispriced services and redistribute payments from overpriced services to underpriced services. Through the misvalued codes process, potentially misvalued codes are identified and reviewed; for those codes which are identified as misvalued, appropriate adjustments to the relative values of those services are made. However, the misvalued codes initiative is not without its flaws. As acknowledged by MedPAC, after a service has been identified as potentially misvalued, it may take several years for the American Medical Association (AMA) to develop a recommendation for that service. Moreover, as noted by the Commission, a number of services which account for a significant portion of fee scheduling spending have not yet been reviewed.

Rather than viewing this issue in a vacuum and calling for a reimbursement reduction for specialties that furnish few ambulatory E&M services, we recommend that in the future, the Commission evaluate any fee schedule payment changes within the context of the misvalued codes initiative. For example, from 2016-2017, 19 physical medicine and rehabilitation CPT codes frequently utilized by physical therapists were reviewed under the potentially misvalued code initiative. As a result of this process, the values for many of these codes were just updated in 2018, with many codes declining in value. We expect these same codes to be reviewed again by the AMA in several years. Our organizations have serious concerns that payment policy recommendations which supersede the misvalued codes initiative would not only harm beneficiary accessibility to services offered by physical therapists, but also compound the payment challenges facing small, medium, and large-sized physical therapy practices. To that end, we fail to see where in Chapter 3 of the Report the Commission assessed how beneficiary access to physical therapy would be impacted should their recommendation be adopted by CMS.

Additionally, while we support MedPAC's assertion that the review of potentially mispriced services is insufficient in many ways, we dispute the Commission's blanket assertion that the value of services which experience growth should decline over time as "clinicians become more familiar with these services and can perform them faster." Physical therapy is comprised of activities that require the clinician's time and do not lend themselves to "efficiency gains." Therefore, rather than continuing to issue recommendations that promote the adjustment of code values based on utilization trends, we encourage the Commission to develop recommendations that call for the revaluation 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 practice expense (PE) value recommendations. For example, active therapy modalities, including manual therapy, therapeutic activities, and therapeutic exercises are supported by the evidence as delivering greater outcomes. However, scientific outcomes play no role in code valuations. As a result of the misvalued codes process, active therapies experienced a decline in value. Such therapies include manual therapy and therapeutic exercise, common techniques which are supported by literature. Conversely, therapies that are unsupported by peer-reviewed literature, such as massage therapy and therapies which are passive in nature, including ultrasound, increased in value.

Our organizations encourage the Commission to more 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 as well as hospital and substance abuse/addiction recovery facility admissions. In turn, we encourage the Commission to promote payment policies that emphasize evidence-based practice and incentivize therapeutic innovation. Research has shown that treatment which adheres to evidence-based recommendations for active therapy results in far lower downstream costs than treatment that does not adhere to evidence. Unfortunately, fee schedule reductions for services for which clinicians are required to *conscientiously use current best evidence in clinical decision-making* conveys to health care professionals that CMS sees little value in such services. Hence, health care providers interpret such valuation refinements as the agency affording greater clinical value to therapies **not** supported by the evidence. 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. We encourage the Commission to take such recommendations into consideration when developing proposed fee schedule payment changes in the future.

MPPR

Effective January 1, 2011, the MPPR policy applies to outpatient physical, occupational, and speech language pathology services provided to a beneficiary that are paid under the Medicare Physician Fee Schedule. The payment reductions under the MPPR apply to therapy services provided in physician offices, private practices, SNFs, home health, comprehensive rehabilitation facilities, rehabilitation agencies, and outpatient hospital departments. Under the MPPR policy, CMS makes full payment for the therapy service or unit with the highest practice expense value and reduces payment of the PE component by 50% for the second and subsequent procedures or units of service furnished during the same day for the same patient.

We have concerns that the Commission, in putting forth its proposal to reduce payment for physical therapy services, failed to account for the reduction in the PE values for physical therapy services as a result of MPPR. Thus, should CMS move forward with the Commission's suggestions to further reduce reimbursement for services furnished by physical therapists, the 50% MPPR on the PE for physical therapy services would duplicate the payment adjustments that MedPAC is recommending to account for the "efficiencies" in therapy services. Moreover, because commercial payers frequently follow CMS's lead regarding code valuations, physical therapists would be subjected to even lower reimbursement from such payers, further challenging their ability to continue to deliver care to patients.

Reimbursement rates have a significant impact on budget and resource allocation, and limit a provider's ability to repair or enhance equipment or invest in technologies and continuing education that could improve clinical outcomes as well as the overall cost of care. Given the lack of evidence that the Commission took MPPR into account when developing its recommendation, we believe the Commission's recommendation is unfounded. Additionally, we recommend that in future discussions, MedPAC review payment policies that would eliminate the need for MPPR while also serving to constrain the overutilization of "always therapy" codes. We stand ready to work with MedPAC to identify payment policy solutions that will safeguard the financial health of the Medicare program while ensuring beneficiaries have adequate access to high-quality physical therapy services.

Medicare Reimbursement Should Support Early Access to Nonpharmacological Interventions such as Physical Therapy for Musculoskeletal 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. Recently it has become abundantly clear 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 United States 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, a number of studies 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.⁴

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's 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

⁴ <https://www.health.harvard.edu/blog/physical-therapy-as-good-as-surgery-and-less-risky-for-one-type-of-lower-back-pain-201504097863>; see also <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3183600/> Accessed July 23, 2018.

to explain that “many non-pharmacologic therapies, including physical therapy...can ameliorate chronic pain.”

We recognize the human and economic destruction that opioid addiction has caused in communities throughout the United States. Our organizations, as well as our individual members, strive to educate policymakers, clinicians, consumers, and other stakeholders on pain management options that best suit patients’ needs, goals, and desires, which ultimately can play a major role in turning around our nation’s opioid epidemic. There is a role for opioids, but there also needs to be a focus on the prevention of acute and chronic pain. In addition, providers must understand—and convey to their patients—that the use of opioids comes with significant risks and that effective nonpharmacological solutions to pain management are readily available.

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.⁵ Moreover, the CDC has concluded that there is insufficient evidence that opioid usage alone improves functional outcomes for those in pain. Unfortunately, CMS as well as many private insurers have promoted the use of medications for the management of pain, such as by making incentive payments to hospitals based upon patient satisfaction surveys related to pain, while restricting access to safer, more effective nonpharmacological therapies. Although CMS has since modified hospitals’ pain survey questions and is now providing incentives to programs that offer medication-assisted treatment (MAT), including training and certification for more providers to become authorized MAT prescribers, incentives still are lacking that would steer or encourage prescribers to consider nonopioid and nonpharmacological treatments for pain, despite overwhelming evidence that they often are the safer and more effective option.

In an effort 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 nonpharmacological 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 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.”⁶

Moving forward, it is imperative that CMS acknowledge the important role physical therapists play in the prevention and treatment of acute and chronic pain. The solution requires more than limiting access to drugs. Rather, Medicare payment policies should incentivize collaboration, assessment, and care coordination with foundational care team partners, particularly physical therapists. MedPAC’s proposal to reduce reimbursement for physical therapy services at a time when benefit design and reimbursement models should support early access to nonpharmacological interventions—including physical therapy—for the primary care of pain conditions, is short-sighted and unfounded. The Commission’s proposed payment reduction

⁵ <https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12984> Accessed July 23, 2018.

⁶ The President’s Commission on Combating Drug Addiction and the Opioid Crisis. Final Report. https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf Accessed July 8, 2018.

would only impose greater challenges on physical therapy clinics to keep their doors open, thus placing at risk Medicare beneficiary access to nonpharmacological treatments for pain. It is critical that MedPAC, in conjunction with CMS, examine how to reduce barriers to nonpharmacological treatment options such as physical therapy that serve as an alternative to opioids. If CMS, policymakers, and other stakeholders remain silent on the benefit of nonpharmacological treatments, this will only reinforce the idea that pharmaceuticals are the only option—an option with significant risk of harm.

Conclusion

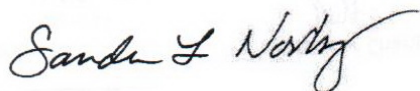
APTA, PPS, and the Alliance thank MedPAC for the opportunity to provide comments on its proposal to reform payment for ambulatory E&M services. We are committed to working with the Commission to address this needed area of reform and to advance health care reform initiatives, reduce spending across the program, and improve the quality of life for Medicare beneficiaries. 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 713-297-6385 or npatel@aptqi.com.

Thank you for your consideration.

Sincerely,



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