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Via Electronic Submission

September 10, 2018

The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1693-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1693-P, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program: Proposed Rule, Fed. Reg. Vol. 83, No. 145, (July 27, 2018).

Dear Administrator Verma:

This letter represents the collective comments of the Alliance for Physical Therapy Quality and Innovation (the "APTQI") to the Centers for Medicare and Medicaid Services (CMS) regarding the above referenced "Proposed Rule to Payment Policies Under the Physician Fee Schedule et al." for calendar year 2018, published in the Federal Register on July 27, 2018 ("Proposed Rule").

By way of introduction, we are 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. APTQI membership consists of affiliate and board member entities of varying size and geographic scope, which in aggregate provide patient care services in more than 5,000 outpatient rehabilitation clinical sites.

I. Preliminary Statement

We appreciate the opportunity to comment on the Proposed Rule. Many of the areas where CMS seeks feedback regarding Medicare Outpatient Part B therapy services are important to the APTQI's core mission: "*Ensuring patient access to value driven physical therapy care*." We support CMS' commitment to enhance its partnerships with a delivery system in which providers are supported in

achieving better patient outcomes at a lower cost for Medicare beneficiaries. APTQI shares the core belief that any coding and payment proposals related to physical therapy services should (a) drive payment in line with the value physical therapy services deliver to the patient and other providers in the continuum of care; (b) reduce unnecessary regulatory and administration burdens unrelated to improving the quality of patient care; and (c) be transparent to patients and all stakeholders.

II. APTQI Opposes CMS' Proposed Definition of Therapy Services Provided "In Part" by a Therapy Assistant.

APTQI recognizes that CMS is statutorily required to implement a payment reduction under the Bipartisan Budget Act of 2018 (2018 BBA) for services rendered after January 1, 2022, in whole or in part, by a therapy assistant. However, under the 2018 BBA, Congress specifically authorized CMS to define when a therapy service is provided in whole, or in part.[1] Within the rule, CMS proposes to define "*in part*," for purposes of the new modifiers, "to mean any minute of the outpatient therapy service that is therapeutic in nature, and that is provided by the physical therapist assistant (PTA) or occupational therapy assistant (OTA) when acting as an extension of the therapist. Therefore, a service furnished '*in part*' by a therapy assistant would not include a service for which the PTA or OTA furnished only non-therapeutic services that others without the PTA's or OTA's training can do, such as scheduling the next appointment, greeting and gowning the patient, preparing or cleaning the room."[2]

CMS should consider the practical difficulties associated with implementing this policy in day-to-day practice. Frequently, physical therapy services are furnished by the physical therapist and PTA interchangeably. In such instances, there is no clear line between when the physical therapist might stop delivering treatment and the PTA resumes treatment. The PTA is often times acting as a second pair of hands, or the "eyes and ears," for the physical therapist. Besides devaluing a service in which an assistant "lent a hand" literally or figuratively to a therapist for a moment or two by requiring that service to be paid as though the assistant provided the care, recordkeeping for such an event would be time-consuming and problematic at best, and almost impossible at worst. Requiring the modifier to be applied when any minute of outpatient therapy is delivered by the PTA has serious implications for beneficiary access to care. Therefore, we strongly encourage the agency to consider the following revisions to the proposed policy as outlined below.

A. CMS Should Modify the "In Part" Definition

The Medicare Claims Processing Manual, Chapter 5, Section 20.2(C) states that when only 1 service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment that is delivered for between 8 and 22 minutes. If the single modality or procedure is delivered for between 23 and 37 minutes, then 2 units are billed.[3] APTQI recommends that CMS modify its definition of "*in part*" to better align with Medicare's 8-minute rule, wherein if an assistant delivers 7 or fewer minutes of a service that is therapeutic in nature, the new therapy assistant modifier would *not* be applied. As such, the definition of services furnished "*in part*" would be revised to mean outpatient therapy services that are therapeutic in nature and delivered for 8 or more minutes by a PTA. APTQI

[1] BBA 2018, Pub. L. No. 115-123 § 53107 (2018).
[2] Proposed Rule, pp. 35851-35852.
[3] Medicare Claims Processing Manual, Chapter 5. **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf.** Accessed August 25, 2018.

believes this definition would help to minimize the overall impact of the financial "penalty" on therapists when using a PTA or OTA to assist them in delivering care. Consequently, this also could help to ease the expected effect of the payment differential on current and future PTA employment, which in turn may constrain the potential limitations on beneficiaries' accessibility to physical therapy.

B. CMS Should Allow for Reporting of Modifiers on Different Line Items on the Claim

APTQI recommends that CMS permit providers to differentiate between the same type of therapy service delivered by a physical therapist and PTA on the same day for the same beneficiary, allowing the same code to be listed on 2 separate line items on the claim, one with the physical therapist modifier and one with the PTA modifier. For example, a physical therapist delivers 30 minutes (2 units) of manual therapy (97140), and a PTA delivers 15 minutes of manual therapy under the supervision of the physical therapist. CMS would permit 2 units of 97140 affixed with the GP modifier to be on line item 1 of the claim and 1 unit of 97140 affixed with the new PTA modifier on line item 2 of the claim.

CMS has significant flexibility in its interpretation of the 2018 BBA's therapy modifier provision. Because imposing additional reductions to reimbursement for physical therapy services has significant implications for Medicare beneficiaries and ultimately will result in the loss of access to services they depend upon, APTQI recommends that CMS permit physical therapist and PTA time-based services to be billed on separate lines. As the baby boomer generation continues to retire and age, demand for therapy services will increase, as will the number of Medicare beneficiaries suffering from multiple chronic conditions. Given the critical role physical therapists and PTAs play in ensuring the health and vitality of the US population, it is imperative that Medicare beneficiaries continue to have access to high-quality physical therapy services. Therefore, APTQI urges the agency to adopt the recommendation above and clarify as such in final rulemaking.

C. CMS Should Exclude Physical Therapy Evaluations and Re-Evaluation Codes (CPT 97161, 97162, 97163, and 97164)

The Medicare Benefit Policy Manual (MBPM), Chapter 15 states: "PTAs may not provide evaluative or assessment services, make clinical judgments or decisions; develop, manage, or furnish skilled maintenance program services; or take responsibility for the service. They act at the direction and under the supervision of the treating physical therapist and in accordance with state laws."[4] The MBPM further states that "a clinician may include, as part of the evaluation or re-evaluation, objective measurements or observations made by a PTA or OTA within their scope of practice, but the clinician must actively and personally participate in the evaluation or re-evaluation. The clinician may not merely summarize the objective findings of others or make judgments drawn from the measurements and/or observations of others."[5]

As acknowledged by CMS, conducting a low-, moderate-, or high-complexity physical therapy evaluation requires clinical judgment and the decision-making of a physical therapist. Given the limited role that CMS allows a PTA to play in conducting the therapy evaluation, as outlined in the MBPM, requiring a PTA modifier to be affixed to the claim if the assistant delivers a service that is therapeutic in nature, even if it is to assist the therapist, is unwarranted. For example, when a PTA is involved in the re-

[4] Medicare Benefit Policy Manual, Chapter 15. **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf.** Accessed August 25, 2018.
[5] *Id.*

evaluation, the PTA is providing assistance to the physical therapist, and in such instances, the physical therapist is directly, if not personally, supervising the assistant's activities. However, the pending payment differential essentially guarantees that a physical therapist will be forced, solely for financial reasons, to no longer utilize a PTA during the re-evaluation, placing the onus on the physical therapist to solely conduct the re-evaluation without assistance. CMS's restrictions on the role a PTA may play in the delivery of an evaluation or re-evaluation, and the effect the impending payment differential will have on physical therapists -- forcing them to stop using a PTA -- will hinder the physical therapists' ability to properly and appropriately conduct a physical therapy evaluation or re-evaluation. APTQI therefore strongly recommend that CMS exclude physical therapy evaluations and re-evaluations from this new payment differential policy.

D. CMS Should Exclude the Group Therapy Code (CPT 97150)

Medicare payment and coverage policies should be flexible to enable physical therapists and other therapy professionals to develop an individualized care plan tailored to the needs of each patient. Therefore, it is imperative that physical therapists and other therapy professionals have the authority to address each patient's specific needs, which may or may not require group therapy. As such, APTQI has concerns that applying the payment differential policy to the group therapy code will impede a physical therapist's willingness to deliver group therapy services. To help to ensure that patients continue to receive the care they need and that physical therapy practitioners are not financially penalized, APTQI recommends that CMS exempt the group therapy code (CPT 97150) from the proposed payment differential policy. As discussed above, in many instances the physical therapist and PTA work together as a team. The policy as proposed would require the provider to affix the PTA modifier for each patient who received group therapy services. Consequently, solely for financial reasons, private practices and other therapy providers would stop delivering group therapy and/or utilizing PTAs to deliver group therapy, thus lowering productivity and further reducing therapists' reimbursement. At a time when many physical therapist private practices are operating on severely thin margins, the payment differential policy, if implemented as proposed, is likely to have a serious impact on the physical therapy profession as a whole and, consequently, on patients. Hence, it is critical that CMS incorporate exceptions to the policy.

In summary, 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. Physical therapists are subject to dwindling payment from Medicare, Medicare Advantage, Medicaid, and other payers. Low 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 that could improve efficiency and patient outcomes. The continuing proposed reductions in payments for physical therapy services threatens Medicare beneficiaries' access to care, limiting one of the most cost-effective interventions for musculoskeletal care that allows beneficiaries to stay longer in their homes, and avoiding costly inpatient facilities. APTQI has serious concerns that commercial payers, as well as state Medicaid agencies, will follow CMS's lead when it comes to applying the payment reduction for PTA services. Such action could prove extremely detrimental to the physical therapy profession, and APTQI urges CMS to take into consideration its proposal's widespread implications on the future of payment when finalizing this policy.

III. Medicare Reimbursement Should Support Early Access to Nonpharmacological Interventions such as Physical Therapy for Musculoskeletal Pain Conditions Rather than Payment Cuts and Regulatory Hurdles

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

Physical therapists work both independently and as members of multidisciplinary health care teams to enhance the health, well-being, and quality of life of their patients, who present with a wide range of conditions including those that commonly cause pain. The US Centers for Disease Control and Prevention's (CDC) recommendations point to "high-quality evidence" that treatments provided by physical therapists are especially effective at reducing pain and improving function in cases of low back pain, fibromyalgia, and hip and knee osteoarthritis. Additionally, a number of studies show the efficacy of physical therapist interventions in preventing, minimizing, and, in some cases, eliminating pain in patients post surgery, in patients with cancer, and in other clinical scenarios.[6]

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

APTQI recognizes the human and economic destruction that opioid addiction has caused in communities throughout the United States. Our organization, 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.

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[6] **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 August 25, 2018.

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.[7] 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."[8]

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. CMS's past policies to reduce reimbursement for physical therapy services is misguided (i.e., through MPPR, misvalued codes, PTA/OTA proposal etc.) 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. The continuing payment reduction policies for physical therapy services 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 CMS, in conjunction with other state and federal agencies, 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.

IV. APTQI Supports CMS' Decision to Eliminate Functional Limitation Reporting and Other Burdensome Regulations

APTQI strongly supports CMS's efforts to eliminate functional limitation reporting (FLR) thereby reducing the burden of unnecessary rules and requirements on physical therapists. Capturing this data was time consuming, especially since the data was both flawed (as we have pointed out in previous comments

[7] https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12984 Accessed August 25, 2018.
[8] 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 August 25, 2018.

to CMS) and was not utilized. Physical therapists and other providers must be able to focus on delivering care to patients, rather than completing paperwork. Excessive time spent on documentation is an ongoing issue for many outpatient therapy providers, even outside of FLR reporting. CMS regulatory changes that ease the burden of unnecessary work and streamline documentation will reduce the potential for errors, minimize frustration and give therapists back much needed time to focus on providing quality patient care. Therefore, we strongly recommend that CMS finalize it proposal to discontinue functional limitation reporting requirements for services furnished on or after January 1, 2019.

In the future, proposed modifications to the therapy services coding and payment system evaluation should preserve the ability of outpatient physical therapy providers to deliver the necessary treatment required by Medicare beneficiaries without burdensome regulations. The current Medicare Part B outpatient therapy policy is made up of a cumbersome collection of rules and regulations that have unintended consequences that are not always in the best interest of the patient. Providers and Medicare program beneficiaries are already confused and, in some cases, financially burdened by the existing rules and reimbursement policies. The development of a valued based payment system for physical therapy services remains a major goal for CMS, MedPAC, APTQI, APTA, other professional associations, and the provider and payor communities. However, there are other CMS regulatory requirements that should be considered now before final implementation of alternative coding payment adjustments. APTQI believes there should be formal collaboration with CMS on whether and, to what extent, the layers of Medicare rules and regulations applicable to Part B therapy services will be applied under APMs or MIPS including: therapy cap manual medical review (MMR) process; multiple procedure payment reduction (MPPR); Comprehensive Care for Joint Replacement Model (CCJR); total time rules; group and concurrent therapy rules.

The burdensome mandates imposed on providers have not gone unnoticed by Congress. Just recently, the House Ways and Means Health Subcommittee announced a new initiative ("*Medicare Red Tape Relief Project*") to deliver relief from the regulations and mandates that impede innovation, drive up costs, and ultimately stand in the way of delivering better care for Medicare beneficiaries. Working with doctors, nurses, clinicians, and other health care professionals, the goal of the Committee is very clear: To identify opportunities to reduce legislative and regulatory burdens on Medicare providers to improve the efficiency and quality of the Medicare program for seniors and individuals with disabilities.

V. CMS Should Support Congressional Efforts to Expand Telehealth to Therapy Services

APTQI recognizes that providing telehealth therapy services to Medicare beneficiaries is currently restricted by statute. Currently, physical therapists cannot bill Medicare for telehealth services due to statutory restrictions. The current statute limits the qualifying eligible services, the eligible originating sites (defined by geography and provider setting), and the distant site practitioners. APTQI urges CMS to support two separate pending legislative bills that would have the combined effect of expanding where and how telehealth services can take place, which patients are permitted to receive the services, and the list of health care professionals who can provide the services. The two bills are known as follows: *the Medicare Telehealth Parity Act, and the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act*. These two pieces of legislation propose changes to the way Medicare handles a number of issues, from remote monitoring of patients with chronic conditions, to a reworked definition of reimbursable telehealth codes. In addition, the parity act expands the list of providers who can provide telehealth services to include physical therapists, respiratory therapists, occupational therapists, speech language pathologists, and audiologists, while the CONNECT act would

allow PTs in some bundled payment arrangements, accountable care organizations (ACOs), and Medicare Advantage plans to participate in telehealth arrangements.

APTQI believes that physical therapy telehealth services will ultimately improve patient engagement as many beneficiaries will be able to receive more immediate treatments and diagnoses. For example, under the Comprehensive Care for Joint Replacement (CCJR) program, the bundled payment program relaxes some rules related to the use of telehealth for CCJR patients. Extending the reach of physical therapists into the home using a digital healthcare platform can provide remote guidance and supervision for a home-based therapy program. CMS should take note that approximately 21 states have already signed and approved the "Physical Therapy Licensure Compact" and several other states are very close to joining. Additionally, 3 states (Missouri, North Dakota, and Tennessee) now permit telehealth therapy services to treat patients in other states. The compact will provide a multi-state licensing framework for therapy health professionals using advanced technologies. In the future, telehealth has great potential to open new doors to more efficient and effective care delivery (e.g., as an alternative treatment for dealing with the opioid epidemic). Therefore, we strongly urge CMS to collaborate with industry stakeholders and Congress to expand the use of telehealth to Medicare beneficiaries requiring therapy services.

VI. APTQI Supports CMS' Proposal to Include Physical and Occupational Therapists in the Merit-Based Incentive Payment System (MIPS)

APTQI commends CMS for proposing to include physical and occupational therapists in year three of the Quality Payment Program through MIPS. CMS has acknowledged that alternative payment reform includes offering rewards for achieving cost or quality goals such as the current MIPS program. The proposed MIPS contains quality initiatives for "eligible professionals" such as physical and occupational therapists. It is important that the MIPS program for physical and occupational therapists collect meaningful data that will ultimately drive value-based care. APTQI believes that MIPS plays an important and essential role in offering a pathway for therapists who continue to be reimbursed under the traditional Medicare fee for service system to make changes in their practices that will (a) improve the value of care provided to patients and (b) provide a bridge towards participating in more transformative alternative payment models. However, APTQI is concerned about the following issues related to the application of MIPS to physical and occupational therapists in 2019:

A. CMS Should Create an Opt-In Policy for New Clinicians in 2019

CMS should create an opt-in policy for new clinician types such as physical and occupational therapists in 2019 with mandatory participation starting in 2020. Although some providers have been voluntarily participating, many small private practitioners have not done so. Also, to the extent clinicians have been participating, they have been doing so without the risk of being penalized. If the final rule is issued around November 1, 2018, with a start date of January 1, 2019, new clinicians would have only 2 months to prepare, including selecting quality measures and identifying clinical practice improvement activities. An opt-in policy the first year for newly eligible clinicians will avoid some of the confusion that was created when physicians began participations in MIPS. To this day, many physicians remain concerned that reporting on many of the measures used by MIPS is overly burdensome, has costly technology requirements, measures the wrong things, and is not likely to bring about real improvements in outcomes. Therefore, APTQI suggests that 2019 be designated as a reporting preparation year and 2020 "be a year of judgment."

B. CMS Should Modify the Performance Thresholds for New Clinicians

In year one of MIPS, participating physicians' performance threshold was set at 3 points. In a similar manner, CMS should lessen reporting obligations in year one for the newly added clinicians (e.g., 3 points) to avoid negative pay adjustments for newly eligible clinicians. The initial proposed threshold of 30 points is 10 times the threshold of 3 that was required of newly eligible physicians in the first year of MIPS. New participating clinicians, including physical therapists in private practice, could face investment costs and a downward payment adjustment in their first year of MIPS. CMS should also create other scoring accommodations as it did for physicians a few years ago. Physical and occupational therapists should be allowed to "ramp up" in terms of what level of reporting is required in order to meet a threshold which will allow them to be eligible for positive payment adjustments.

C. CMS Should Include Facility Based Providers in MIPS

While we commend CMS for its attempts at quality reporting, admittedly, many professionals remain disappointed with CMS's implementation of MIPS, as it would continue to exclude eligible professionals providing covered therapy services to Medicare Part B beneficiaries in institutional settings (SNFs, Rehab Agencies or Outpatient Rehabilitation Facilities, Outpatient Home Health, etc.). Total Medicare spending on outpatient therapy services was $7.2 billion in 2015; however, only 33% of this amount was in the "Physical Therapist Private Setting."[9] The remaining therapy services spending was in facility or institutional settings.[10] The Tax Relief and Health Care Act of 2006, which initially established PQRS, specifically defined physical therapists, occupational therapists and qualified speech-language pathologists as eligible professionals. Unfortunately, therapists who provide care to hundreds of thousands of Medicare patients in an institutional setting are unable to report under MIPS. Ironically, in the Proposed Rule, CMS noted that institution or facility based PTAs/OTAs would be subject to the reduced payment rate. Therapy services should not be limited to a subset of eligible professional under the MIPS program. Nothing in the legislative history of MIPS suggests that Congress intended for a significant segment of professional Medicare Part B therapy services to be excluded.

With value based purchasing taking on such a central role in CMS reimbursement policies, the continued exclusion of such a large segment of providers from MIPS undercuts the agency's efforts to promote and achieve a successful program for all beneficiaries served in Part B settings. We believe that the restrictive manner of collecting quality reporting information that has been adopted by CMS inadvertently undermines the validity of the therapy data that are being reported in this program. Furthermore, forcing these institutional practice settings to use registries in order to participate in the MIPS program would add cost and increase the inherent administrative burden that currently exists in the program. CMS should consider updating and enhancing a therapy quality reporting program that involves all eligible professionals and settings with outcome measures developed in collaboration with stakeholders.

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9 MedPAC Payment Basics: Outpatient Therapy Services Payment System. Oct. 2017, **http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_17_opt_final.** Accessed August 25, 2918.
10 *Id.*

VII. Conclusion

APTQI is in favor of a value based payment program and the inclusion of reliable and valid outcome and quality measures under MIPS to demonstrate the outcome and value of therapy both for an individual patient episode of care and across the continuum of care. The MIPS, if and when expanded to include all providers of therapy services, will provide a platform to improve the quality of care for Medicare beneficiaries across the continuum of care. APTQI believes that to be successful and satisfy the needs of beneficiaries, CMS, and providers, a payment system for therapy services must have the following elements: adequate pay to the provider with the flexibility to enable delivery of planned services; accountability by the provider to the patient for successfully achieving the intended outcomes; and protection from significant variation in financial risk. The failure to do this could lead to widespread dissatisfaction among beneficiaries and providers, an unintended increase in program health care costs, and a disruption in access to high quality therapy services.

There are quite a number of challenges for CMS to address that weigh statutory limitations with available administrative flexibility. APTQI appreciates the opportunity to provide comments to CMS on the Proposed Rule that help address these challenges. We encourage CMS to continue to work with professional societies such as the APTQI through the rulemaking process in order to create a stable and equitable therapy coding and payment system. APTQI looks forward to continued dialogue with CMS officials about these and other issues affecting therapy services. If you have any questions, or would be interested in further collaboration, please feel free to contact Nikesh "Nick" Patel, PT, DPT, Executive Director, at 713-824-6177 or npatel@aptqi.com.

Very truly yours,

ALLIANCE FOR PHYSICAL THERAPY QUALITY AND INNOVATION

By: _____
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