June 14, 2024

The Honorable Ron Wyden Chairman Senate Committee on Finance United States Senate 219 Dirksen Senate Office Building Washington, DC 20510-6200 The Honorable Mike Crapo Ranking Member Senate Committee on Finance United States Senate 219 Dirksen Senate Office Building Washington, DC 20510-6200

## VIA ELECTRONIC SUBMISSION

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the undersigned organizations, we thank you for the opportunity to provide our collective perspective on reforms to the Medicare Physician Fee Schedule (PFS) to support stable and sufficient payments to underpin patient access to care. Below we offer several recommendations that would support rehabilitation therapy services under Medicare Part B for Medicare beneficiaries. An important point to note is that many types of non-physician clinicians and providers are reimbursed under the Physician Fee Schedule – and unfortunately, too often, other non-physician providers only ever experience the negative effects of payment changes. Because rehabilitation therapists, as a specialty, cannot ever bill Evaluation and Management (E/M) codes, we will never have the opportunity to mitigate the impact of significant changes to relative value units (RVUs) such as has happened under the E/M policy. Therefore, as the Committee considers reform, it must take a broad perspective of the types of providers affected by this payment system and consider how non-physician providers can be protected or walled-off from dramatic changes under this system in order to protect patient access to care.

### **Recommendations**

We recommend the following policies be considered and included in Physician Fee Schedule reform in order to ensure patient access to care and stability of providers and provide greater stability under the MPFS for non-physician providers such as rehabilitation therapists, and to help account for a decade of cuts to payments for rehabilitation therapy services.

# Eliminate the Multiple Procedure Payment Reduction Policy.

The Multiple Procedure Payment Reduction Policy (MPPR), first implemented in 2011, applies to physical therapy, occupational therapy, and speech-language pathology services provided

under Medicare Part B. Because of MPPR, when therapists bill more than one "always therapy" service (identified by CPT code) on the same day for the same patient, all therapy services beyond the first are subject to a reduction in the practice expense portion of that code.

Under this policy, the therapy service with the highest practice expense value is reimbursed at 100%, and the practice expense values for all subsequent therapy services, provided by all therapy clinicians, are reduced by 50%. Our organizations have opposed the MPPR policy since its inception. It is inherently flawed, because the American Medical Association RVS Update Committee, which assigns values to current procedural terminology (CPT) codes, already ensures that any potential duplication in work or practice expense is addressed as part of the code valuation process. Certain efficiencies that occur when multiple therapy services are provided in a single session were explicitly taken into account when relative values were established for these codes. The application of MPPR to the "always therapy" codes results in a duplicative and excessive reduction of these codes and is having a significant impact on the financial viability of therapy practices — ultimately impacting access to vital therapy services.

The MPPR policy does not recognize that occupational therapy (OT), physical therapy (PT), and speech-language pathology (SLP) interventions are separate and distinct from each other but rather it applies payment reductions across therapy disciplines delivered on the same date regardless of the distinct services and supplies provided to the patient during these separate therapy discipline services. While the first therapy discipline (e.g. physical therapy) would receive payment under MPPR at 100% for the first unit and 50% of the practice expense for all other units, a second or third discipline (e.g. occupational or speech-language therapy) delivering services on that date would have all provided service units reduced. This occurs even though the equipment, clinical staff, and supplies utilized for one therapy service have no overlap with the other therapy services provided. This policy penalizes providers when scheduling multiple therapies on the same date which disproportionately affects beneficiaries in rural and underserved communities where transportation issues may require therapy services to be delivered on the same day to reduce the need for patients to repeat visits to the clinic to receive separate therapy discipline services. **Congress should repeal the MPPR policy to promote better access to rehab therapy services for Medicare beneficiaries**.

# <u>Provide Flexibility in the Supervision of Assistants and Determine Challenges Facing the</u> <u>Therapy Workforce in Rural and Underserved Areas</u>

Medicare allows for general supervision of occupational therapy assistants (OTAs) by occupational therapists, and physical therapist assistants (PTAs) by physical therapists in all settings, except for outpatient private practice under Part B, which requires direct supervision. While therapy providers must comply with their state practice act if state or local practice requirements are more stringent than Medicare's, the standard in 48 states is general supervision

of OTAs and PTAs, making this an outdated Medicare regulation — which arbitrarily applies only to private practice — more burdensome than almost all state requirements. Standardizing a "general supervision" requirement for private practices will help ensure continued patient access to needed therapy services and give small therapy businesses more workforce flexibility to meet the needs of beneficiaries. This policy addresses this problem by enacting language to change the Medicare supervision requirement for OTAs and PTAs in private practice from direct to general supervision in states with licensure laws that allow for it. According to an independent report published by <u>Dobson & Davanzo in September 2022</u>, this change in supervision is estimated to save \$271 million over 10 years.

Congress should also direct the Government Accountability Office to conduct an analysis of how the Medicare Part B 15% payment differential for services provided by OTAs and PTAs, which went into effect in 2022, has impacted access to occupational therapy and physical therapy services in rural and medically underserved areas, across all Medicare Part B settings. Beneficiaries in those areas are twice as likely to receive OT or PT services from an assistant. Rehabilitation therapy providers report that rural areas suffer significantly from the ongoing workforce shortage.

### **Reform MACRA to Allow Broader Participation**

Therapists who work in long-term care institutional settings have not been able to participate in the Merit-based Incentive Payment System (MIPS) since its creation because Medicare's policy of consolidated billing requires certain providers to collect and submit all claims together, and all facility-based providers to submit a CMS-1450 (UB-04) claim rather than an office-based CMS-1500 claim – removing the ability of Medicare to link specific services to unique clinician identifiers. This denies these providers the ability to mitigate the zero percent update by earning quality payments. To date, Medicare has not produced a solution to address this issue. It is unfair for facility-based providers to be excluded from the opportunity to mitigate the zero-percent payment update. **Congress should provide that all providers that bill through the Physician Fee Schedule should be eligible for payment updates.** 

#### **Reduce the Impact of Inflation on Providers and the Patients They Serve**

Providers paid under the Medicare Physician Fee Schedule do not receive the annual inflationary update upon which virtually all other Medicare providers can rely on to better weather periods of fiscal uncertainty. **Providing an annual inflationary payment update to the Medicare Physician Fee Schedule's conversion factor (CF) based on the Medicare Economic Index** (**MEI**) will provide much-needed stability to the Medicare payment system. According to an American Medical Association analysis of <u>Medicare Trustees data</u>, when adjusted for inflation, Medicare payments to clinicians have declined by 26% from 2001-2023. The failure of the MPFS to keep pace with the true cost of providing care, combined with year-over-year cuts resulting from the application of budget neutrality, sequestration, and alternative payment model/value-based care models which are unavailable to therapists, clearly demonstrates that the fee schedule needs significant reform. Providing an annual inflation update equal to the MEI for fee schedule payments is essential to enabling practices to better absorb payment distributions triggered by budget neutrality rules, performance adjustments, and periods of high inflation. A more stable payment system will also help providers to invest in their practices and implement new strategies to provide high-value care.

## Reduce Administrative Burden for Therapy Services Provided Under Medicare Part B

Medicare requires the beneficiary's physician to sign and certify an outpatient rehabilitation therapy plan of care within 30 days – and then every subsequent 90 days – even when the physician referred the beneficiary to receive the rehabilitation therapy in the first place. Necessary care is often interrupted as a therapy provider cannot submit a claim without first having the physician signed certification. This duplicative requirement should be eliminated and instead, the plan of care certification requirement should be considered fulfilled if the therapist submits the plan of care to the referring provider within the designated timelines. This outdated, burdensome, and unreimbursed manual process of obtaining a physician signature for certification of the plan-of-care in an electronic era is redundant and time consuming for both the therapist and physician. Eliminating the physician signature requirement for certification of a PT, OT, or SLP plan of care would remove a barrier to patients receiving uninterrupted care. **Legislation has been introduced on this matter as H.R. 7279, the Remove Duplicative Unnecessary Clerical Exchanges (REDUCE) Act.** 

### Enact a Permanent Medicare Policy for Therapy Services Delivered via Telehealth

In response to the coronavirus public health emergency in 2020, Congress passed and the President signed into law legislation that authorized CMS to significantly expand Medicare's coverage of telehealth services during the PHE to protect the health and safety of Medicare patients. Under the authority of Section 1135 of the Social Security Act, CMS permitted virtually all medical providers, including physical therapists, occupational therapists, and speech-language pathologists, to provide services via telehealth to Medicare beneficiaries. In late 2022, Congress approved legislation that extended Medicare's telehealth flexibilities for another two years. Medical providers will be permitted to treat Medicare patients via telehealth until Dec. 31, 2024. After that date, unless Congress acts Medicare patients may lose coverage of telehealth visits.

Continued access to telehealth services provided by physical therapists, occupational therapists, and speech-language pathologists would allow Medicare beneficiaries to maintain access to

critical health care services utilizing the method of delivery, in-person or telehealth, of their choice. The June 2023 Medicare Payment Advisory Commission (MedPAC) Report highlighted that over 90% of Medicare beneficiaries surveyed who had at least one telehealth visit with a clinician stated that they were very or somewhat satisfied. Additionally, clinicians surveyed by MedPAC indicated that, on average, less than 10% of their services were delivered via telehealth. Finally, a report by the U.S. Department of Health and Human Services Office of Inspector General found that less than 0.2% of Medicare telehealth claims were considered high risk.

Telehealth presents a way to provide access to care for patients both in rural and urban areas who may have trouble getting to appointments due to distance, mobility or transportation issues, or who cannot afford to take time off of work. Further, in many areas of the country where there are very few therapists available, services delivered using telehealth also provide access to therapy for patients to maintain or improve their ability to function safely, which helps prevent more costly emergency room, hospital, or other facility-based care.

Telehealth has been demonstrated to be a services delivery mechanism that is used judiciously by health care providers in consultation with their patients who maintain high levels of satisfaction. Furthermore, initial data indicates concerns over fraud, waste, and abuse may not be as significant as initially feared. **Our organizations support the Expanded Telehealth Access Act (H.R. 3875), legislation that would add therapy providers in private practice, as well as facility-based outpatient therapy providers under Medicare Part B, as permanent authorized providers of telehealth services under Medicare. H.R. 3875 was introduced by Reps. Mikie Sherrill, D-N.J., and Diana Harshbarger, R-Tenn.** 

### Conclusion

Our organizations appreciate the opportunity to provide our recommendations to the committee that will provide long-term stability and reform to the Medicare Fee Schedule.

Sincerely,

ADVION (formerly the National Association for the Support of Long Term Care) American Health Care Association/National Center for Assisted Living (AHCA/NCAL) American Occupational Therapy Association (AOTA) American Physical Therapy Association (APTA) American Physical Therapy Association Private Practice American Speech-Language-Hearing Association (ASHA) National Association of Rehab Agencies and Providers (NARA)