Submitted Electronically

October 5, 2020

The Honorable Seema Verma
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244


Dear Administrator Verma:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we write in response to the proposed rule for the Calendar Year (CY) 2021 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) published in the Federal Register on August 17, 2020. AMRPA is the national trade association representing more than 650 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals, referred to by Medicare as inpatient rehabilitation facilities (IRFs). The vast majority of our members are Medicare-participating providers and in 2018, IRFs served 364,000 Medicare beneficiaries with more than 408,000 inpatient IRF stays.1

In addition to inpatient services, AMRPA members also provide rehabilitation services across the continuum of care, including hospital outpatient departments, physician offices, comprehensive outpatient rehabilitation facilities (CORFs) and therapy clinics. As part of this continuum of care, our members submit claims under Part B of the Medicare program for a variety of services, including physician visits, physical therapy, occupational therapy services, speech-language pathology and a number of other elements of care.

IRFs specialize in treating patients with some of the most complex and serious conditions. Continued rehabilitation is an essential component of recovery from these types of conditions, and it is important that CMS keep the need for rehabilitation services for the more complex and vulnerable patients in mind when modernizing the Medicare program. There are a number of proposals in this year’s proposed rule that would have notable effects on patients in need of continued rehabilitation services, and we offer comment on those proposals in the following sections of this letter. We are also particularly concerned about the effect some of CMS’ proposals would have on the ability of hospitals and other providers to respond to the COVID-19

public health emergency. We provide immediately below a summary of our recommendations prior to our more in-depth discussion:

1. Application of the sizeable budget neutrality factor to fee schedule services as a result of CMS’ change to physician evaluation and management (E/M) codes will significantly reduce access to critical services, especially for those most in need of extensive rehabilitation care. AMRPA urges CMS to take steps to avoid these cuts.

2. CMS should work with stakeholders to allow facility-based therapy services to be included in MIPS to properly incentivize value-based care under the fee schedule, and to avoid an unfair disparity in reimbursement.

3. CMS should add therapy services to the list of permanent telehealth services and seek authority to permanently add therapists to the list of telehealth providers.

4. AMRPA recommends CMS expand the availability of audio-only services for Medicare beneficiaries.

5. AMRPA supports the creation of additional “virtual check-in” service codes and the ability of therapists to provide such services.

I. CMS Must Take Steps to Avoid Cuts that Would Jeopardize Access to Essential Physician and Rehabilitation Services During a Pandemic (Outpatient Evaluation and Management (E/M) Services)

CMS proposes to move forward with its previously finalized policy that would significantly increase the value of physician outpatient evaluation and management (E/M) visit codes. AMRPA agrees in principle that the outpatient E/M code values should be updated, and that ideally those updates would be consistent with the American Medical Association (AMA) recommended values. However, the resulting budget neutrality cuts to other services could devastate access to needed rehabilitation and other services across the continuum of care – which is especially problematic in light of the COVID-19 public health emergency (PHE). Therefore, AMRPA strongly urges CMS to avoid these cuts using its discretionary authority.

In response to last year’s Physician Fee Schedule (PFS) proposed rule, AMRPA agreed that these new E/M code values better correspond with the resources spent furnishing E/M services to patients, and that updating them would be appropriate in light of the need to ensure access to primary care and other outpatient physician services. At the same time, AMRPA urged CMS to only move forward with these changes if the agency could avoid cuts to other vital services. In this year’s proposed rule, CMS took certain steps to address AMRPA’s concerns about budget neutrality effects, including updating the value of “E/M equivalent” services, such as physical and occupational therapy evaluation visit codes.

Unfortunately, it is apparent from CMS’ own estimates that these remedial steps will not sufficiently offset the budget neutrality cuts stemming from the outpatient E/M code updates. CMS still estimates that critical rehabilitation services, such as outpatient physical and occupational therapy, as well as speech-language pathology services, will see a 9 percent
reduction in payment. In addition, commonly billed physician services in IRFs and other hospitals will receive a 10 percent reduction in payment.²

Both therapy services and inpatient physicians play a vital role in caring for some of the most vulnerable Medicare beneficiaries. Reimbursement reductions to these services will exacerbate an already tenuous access situation, likely harming beneficiaries with disabilities and chronic conditions. Further, the reduction in reimbursement would come at a particularly inauspicious time, threatening the very services COVID-19 patients need, right as front-line providers are facing a potential second wave of the virus.

While the fee schedule reductions only directly apply to Medicare providers and beneficiaries, CMS must recognize that the agency’s payment policies set precedent for a variety of commercial payers and other federal health care programs, broadening the impact of these cuts throughout the nation’s health care system. The projected impact of these payment cuts on rehabilitation patient outcomes and access to rehabilitation services is significant, as detailed below. For all these reasons, AMRPA urges CMS to consider several actions to negate the impact of the current proposal.

A. Reductions to Therapy Services Could Devastate the Ability of Beneficiaries with COVID-19 and Other Conditions to Achieve Full Recoveries

The hallmark of IRF care is a multi-disciplinary team approach, combining physician medical management with multiple therapy disciplines and often numerous other specialties of care, such as psychological services. The need for these multiple therapy disciplines does not cease once the patient leaves the hospital. Many IRF patients require long-term physical, occupational, speech, and other therapies to continue to recover from their injury or illness after leaving the hospital.

CMS estimates that as a result of its E/M proposal, therapy service payments under the PFS will be reduced by 9 percent. A 9 percent cut in payment would force a consequential scaling back of services, and therapy would be particularly impacted. During the early months of the COVID-19 PHE, nearly 20 percent of physical therapists reported being either laid off or furloughed due to loss of revenue.³ This indicates there is little margin for rehabilitation services to sustain a steep cut in revenue without risk of closure or consolidation. While there might be some benefit to patients and the health care system related to increasing the outpatient E/M code values, for many patients those benefits may be offset by the reduction in access to therapy services caused by the budget neutrality adjustments.

While cuts of this magnitude would always result in negative reverberations on the affected providers and patients, the proposed cuts (set to take effect in January 2021) would serve as a double-hit to therapists who, like all providers, are still in the midst of the COVID-19 PHE.

---

² CPT Codes 99223 (initial hospital care), 99356 (prolonged inpatient service), 99232-33 (subsequent hospital care) and 99239 (hospital discharge day) will all receive at least a 9% reduction in reimbursement.
Due to mandated or voluntary reduction in volume of services to reduce the risk of COVID-19 infection, or patients delaying or foregoing care, revenue has dropped significantly for most practices. Even in areas that have entered later stages of re-opening, providers have not been able to resume business as usual, continuing to treat a reduced number of patients to ensure proper infection control and social distancing. In addition, any re-opening that has occurred may just be temporary as additional waves of the virus move throughout the country, creating serious financial uncertainty for many practices.

Providers also face substantial and sustained increases in costs due to COVID-19. Physical and occupational therapy practices, for example, must spend significant time and resources on cleaning therapy space and equipment, in addition to spacing outpatient visits. Further, providers have incurred meaningful cost increases due to utilization of personal protective equipment (PPE). This is especially true of clinicians offering rehabilitation services. The nature of therapy services involves hands-on contact with patients, as clinicians work with patients to regain functional losses. This makes these types of services particularly expensive to maintain, as they are unable to modify practices to minimize use of PPE or the need for cleaning protocols.

A cut to professional services in January would be particularly ill-timed given that so many COVID-19 patients are in dire need of the very rehabilitation services that would bear the brunt of these cuts. IRFs across the country have seen firsthand the long-term rehabilitation needs of recovering COVID-19 patients, and many have set up dedicated outpatient centers to provide survivors with the rehabilitation needed after their acute stays. As more people survive the disease, there likely will be a greater demand for rehabilitation therapies. This demand is projected to spike at the same time CMS would be significantly reducing reimbursement for therapists, creating a potentially perilous situation for the long-term recovery of COVID-19 survivors.

In addition to its value for those recovering from serious injury and illness, including COVID-19, therapy services represent a non-pharmacological option for management of patients with injuries or chronic pain. Therapists thus play a key role in decreasing use and abuse of opioids. Reductions to these services runs contrary to CMS’ and the Trump Administration’s efforts to increase access to non-opioid therapies and its commitment to combatting the opioid epidemic. CMS risks cutting off a vital alternative therapy if the agency proceeds with these cuts.

---

4 Id.
In summary, therapy services play a critical role in the recovery of millions of Americans from serious injury and illness, including COVID-19. Reimbursement reductions of this magnitude will surely reduce access to these services. Particularly in light of the health care system’s strained state due to COVID-19, AMRPA recommends that CMS do everything under its existing authority to not proceed with these budget neutrality cuts in reimbursement.

B. Cuts to Inpatient Physician Services Threatens Access to Hospital Services
Due to the E/M budget neutrality cuts, commonly billed physician services in the inpatient hospital setting, including in IRFs, will also receive an approximately 10 percent reduction in payment. As is the case with therapy services, any benefit gained from updating E/M code values will likely be outweighed by the resulting cuts in access to inpatient physicians. Further, the timing of these cuts to physicians on the front lines during a pandemic could have a particularly devastating result, and therefore should be avoided.

Physician practices are already reeling financially from the COVID-19 pandemic. More than 50 percent of all practices report a decrease in revenue and patient volume since the beginning of the PHE. At least half of all practices report the need to lay off or furlough staff due to the pandemic. The tenuous situation facing many physician practices may be severely exacerbated by an additional 10 percent cut to reimbursement.

Similar to the impact of therapy service payment reductions, cuts to inpatient physician payments are particularly problematic during the PHE. As AMRPA has highlighted in correspondence to CMS and other policymakers, IRFs are playing a key role in rehabilitating recovering COVID-19 patients, who often face severe functional deficits and ongoing medical complications after being discharged from an acute-care hospital. Care in an IRF is led by a specialized rehabilitation physician, and their medical supervision and oversight of treatment is what ensures the best chance at a meaningful recovery. These physicians have enabled IRFs to play a key frontline role during the PHE. As a result, these cuts would seriously hinder the health care system’s ability to respond to this novel disease.

Even without the added demands of the COVID-19 pandemic, there is already difficulty ensuring access to high-quality specialists in IRFs. AMRPA member hospitals have consistently reported difficulty in recruiting and retaining highly trained rehabilitation physicians. Physical Medicine and Rehabilitation (PM&R) specialists, also known as physiatrists, are the specialists most often serving as the physician leading care in an IRF. Physiatrists practicing in IRFs report one of the highest “burnout” rates among all physician specialists.

---

7 Physicians in IRFs most commonly bill CPT codes 99223, 99356, 99232, 99233 and 99239, all of which will receive at least a 9 percent reduction in payment.
9 Id.
10 CMS requirements at 42 C.F.R. § 412.622 require that care in an IRF be directed by a physician with specialized training and experience in inpatient rehabilitation.
Implementing these cuts on a beleaguered workforce, amid a pandemic, seriously threatens the effectiveness of the health care system. Therefore, in addition to avoiding any cuts, CMS should also invest additional resources into ensuring the continued availability of rehabilitation physicians, particularly in light of the rising need for acute rehabilitation due to COVID-19.

Presently, there are several required services a rehabilitation physician must provide to IRF patients that are not required in other hospital settings. These include a mandated pre-admission screening, an individualized plan of care, and leading of a weekly interdisciplinary team meeting. Despite these additional requirements, rehabilitation physicians can only bill the same hospital management codes for face-to-face visits that other hospital physicians can bill, and the additional time spent by rehabilitation physicians meeting CMS requirements for IRF patients is not billable.

CMS is proposing a complex-patient code for outpatient E/M services (GPC1X) in this proposed rule. CMS should similarly recognize the additional time and effort required of rehabilitation physicians in directing patient care in IRFs and create a similar code for inpatient services. By taking steps to recognize the additional time and work that rehabilitation physicians spend caring for Medicare’s most vulnerable and complex beneficiaries, CMS can ensure continued access to these vital services.

In conclusion, continued access to high-quality physician care for hospital inpatients should be a top priority for Medicare, and this is especially true during a pandemic. Further, the availability of rehabilitation physicians that lead care in IRFs will be especially important in the long-term recovery and rehabilitation of COVID-19 patients. Therefore, we urge CMS to take steps to avoid cutting reimbursement to these physicians at this time.

C. CMS Has Multiple Available Options to Avoid Harmful Cuts to Vital Services for Medicare Beneficiaries

AMRPA recognizes statutory constraints on CMS when it comes to the budget neutrality requirements of the PFS. AMRPA nonetheless suggests several potential actions, in addition to seeking Congressional authority, to avoid these cuts. Potential solutions include some combination of:

1. Use CMS’ broad discretionary authority for Public Health Emergencies to waive the budget neutrality factor applied to the fee schedule.
2. Lowering the amount by which CMS will raise outpatient E/M code values, at least temporarily, until CMS receives additional authority or another compromise can be reached.


12 CMS requirements 42 C.F.R. § 412.622 require the rehabilitation physician to fulfil these requirements and that documentation be kept in the medical record at the IRF.
3. Phasing in the increase in outpatient E/M code values gradually over several years.
4. Temporarily delaying the availability of the outpatient E/M add-on code (GPC1X) which would significantly reduce the budget neutrality factor.

CMS’ overarching goal of properly accounting for and reimbursing outpatient E/M services is admirable and supported in principle by a broad consensus in the medical community. However, it is also clear to the medical community that the reimbursement offsets due to budget neutrality impact certain providers much more negatively than others. The reality of the COVID-19 pandemic amplifies this disparity and problem. Ultimately, the downstream costs of a rehabilitation population never achieving its fullest recovery potential from this disease will be larger and longer lasting than these cuts to reimbursement rates.

Application of the budget neutrality factor to PFS services will significantly reduce access to critical services, especially for those most in need of extensive rehabilitation care. These cuts, particularly in light of the COVID-19 PHE, are unsustainable and must be mitigated. AMRPA urges CMS to take steps to avoid these cuts by altering its proposal and seeking additional authority from Congress.

II. CMS Must Make Accommodations for Institutional Therapists to Participate in MIPS

As CMS is aware, the Medicare Access and CHIP Reauthorization Act (MACRA) requires a zero percent annual update to payments under the PFS for 2021. This was instituted by Congress in part because the Quality Payment Program (QPP) and Merit-Based Incentive Payment System (MIPS) would provide clinicians the ability to receive upward payment adjustments based on quality of care. AMRPA agrees with the emphasis on incentivizing quality of care and tying increases in reimbursement to performance. However, due to what amounts to a technicality in how facility-based physicians submit claims, such as those submitted by hospitals for outpatient therapy, only independently rendered, “private practice” outpatient therapy services are included in MIPS scoring.

The result of this technical exclusion of institutional therapy services from MIPS is that payments for outpatient therapy services will remain flat, and not rise with inflation, for the foreseeable future. Failure to include these services and providers in MIPS is both inequitable to these clinicians and self-defeating to the objectives of Congress and CMS. Clinicians such as physical, occupational and speech-language therapists provide essential care to patients. In medical rehabilitation, for example, therapists are essential to the rehabilitation process and wield an enormous impact on patient outcomes, working extensively with patients, often for multiple hours per day. Therefore, linking payment to performance for these services should be fundamental to any initiative seeking to move from a volume-based to a value-based payment system.
Annual Medicare spending on outpatient therapy services is approximately $8 billion.\textsuperscript{13} The vast majority of these services do not take place in independent, private practice settings. According to MedPAC, only 39 percent of Medicare Part B therapy occurs independent of a facility, while approximately 61 percent occurs in facility-based settings, including hospitals and nursing facilities.\textsuperscript{14} Therefore, CMS includes only 39 percent of all Part B therapy spending in MIPS. In a system like MIPS, which is intended to encourage care coordination and accountability, AMRPA questions the rationale of failing to provide a value-based incentive for approximately $4.8 billion in therapy services that are so essential to patient outcomes.

In addition to leaving such a large amount of Medicare dollars unaccounted for, leaving facility-based therapy services out of MIPS is inequitable to these providers. By being excluded from MIPS, these clinicians will have their payment rates remain flat, while their counterparts in private practice will continue to have the opportunity for upward payment adjustments. AMRPA urges CMS to remedy this arbitrary and inequitable financial disadvantage.

These facility-based therapy providers are already facing notable reimbursement strain. As discussed previously in this letter, CMS’ E/M physician proposals may lead to a notable budget neutrality cut to outpatient therapy services. In addition, beginning in 2022, CMS will be instituting a 15 percent cut to therapy services that are provided in whole or in part by a therapy assistant. This translates to a potential 24% cut to many therapy services beginning in 2022. Therefore, it is essential that CMS take timely steps to include facility-based therapy services in MIPS.

AMRPA stands ready to work with CMS and other stakeholders to find solutions to these problems. For example, AMRPA would welcome the opportunity to discuss with CMS whether it could operationalize the inclusion of these facility providers in MIPS by treating the facility National Provider Identifier (NPI) as a MIPS-participating NPI and allowing the facility to report measures under MIPS. CMS could then apply the MIPS payment adjustment to the Part B professional service claims submitted by the facility in future years as it does for other providers. This would avoid a requirement for each individual clinician in the facility to report under MIPS but would still hold the facility accountable for the quality of outpatient therapy services being provided to Medicare beneficiaries. In addition to extensive stakeholder outreach to operationalize this change, CMS should consider beginning with an opt-in policy for facility providers to participate in MIPS.

These therapy providers must be offered the opportunity to be included in MIPS in order to provide accountability for the large amount of therapy services that would otherwise go unaccounted for under CMS’ current approach. Proceeding to include these services in MIPS would also allow these providers to stand on financially equal footing with other providers through the opportunity for payment adjustments. Therefore, in order to make MIPS a comprehensive and effective value-based payment system, and to avoid creating an unreasonable financial disadvantage for facility-based therapy providers, CMS should work with stakeholders


\textsuperscript{14} Id.
to develop a technical adjustment to allow facility-based outpatient therapy providers to be included in MIPS in the least burdensome manner possible.

Recommendation:

1. In order to properly incentivize value-based care under the fee schedule, and to avoid an unfair disparity in reimbursement, CMS should work with stakeholders to allow facility-based therapy services to be included in MIPS.

III. CMS Should Include Therapy Services in The List of Approved Telehealth Services

CMS is proposing to add additional services to the list of approved telehealth services for CY 2021 on both a temporary and permanent basis, some of which are already authorized on a temporary basis under the COVID-19 public health emergency (PHE). During the PHE, physical and occupational therapists have been permitted to conduct telehealth services; however, in this proposed rule, CMS asserts that the agency does not have the authority to permanently include therapists in the prescribed list of provider types that may furnish telehealth services. Therapy services could, however, be added to the list of telehealth services. CMS states concern that it may cause confusion if therapy services, but not therapists, are approved for telehealth services. Practically speaking, CMS proposes that therapy telehealth services could only be reimbursed if billed “incident to” physician services.

AMRPA greatly appreciates CMS’ actions taken in response to the PHE, including the temporary expansion of telehealth and the agency’s other waivers and flexibilities, especially those that apply to IRFs. Due to the expansion of telehealth services, AMRPA members have been able to maintain continuity of services and ensure patients have adequate access to care despite shortages of equipment, including PPE. AMRPA members report that the experience of utilizing telehealth to provide therapy services during the PHE has been beneficial for both clinicians and patients, and believe such services can continue to be safely and effectively provided even after the PHE is declared over. In addition, AMRPA agrees with the Federal Trade Commission (FTC)’s May 29, 2020 assertion to CMS that authorizing therapists as telehealth providers on a permanent basis “could enhance the availability of therapists, access to care, choice of provider, competition, quality and also could reduce costs” and that “such improvements may especially benefit rural and underserved communities, as well as patients for whom travel is difficult.”

Increased access to telehealth and remote therapy services on an ongoing outpatient basis following an IRF stay can substantially benefit patients, who often remain vulnerable or face difficulties traveling due to the severity of their injury or illness. AMRPA supports the permanent inclusion of therapy services on the list of approved telehealth services. The PHE has demonstrated that therapy services can be safely and effectively administered through telehealth, without sacrificing quality of care.

---

We recognize CMS will need additional authority to fully allow therapy to be provided by therapists via telehealth on a permanent basis. However, adding therapy services to the permanent list of telehealth services is an appropriate first step. Due to the experience of providers during the PHE, many have become aware of the nuances of the two distinct telehealth authorization lists, and AMRPA does not think this change would cause undue confusion.

Alternatively, CMS should at minimum, include therapy services under the proposed “Category 3” list to allow for further data collection to facilitate permanent implementation in the future. Concurrent with either action, AMRPA urges CMS to seek authority from Congress to ensure Medicare beneficiary access to these critical therapy services.

**Recommendations:**

1. **CMS should add therapy services to the list of permanent telehealth services and seek authority to permanently add therapists to the list of telehealth providers.**

**IV. AMRPA Encourages Expansion of Telephone-Only Services and Development of Coding and Payment for Longer Virtual Check-In Services**

While AMRPA understands that CMS is limited in its authority to permanently include telephone-only services for reimbursement in the Medicare Physician Fee Schedule, our members—particularly in rural areas—have concerns that requiring both audio and visual capabilities for the provision of telehealth will dramatically increase preexisting disparities within the Medicare population. Throughout a significant portion of the United States, broadband internet access—a necessity for audio/visual telehealth communications—continues to be limited.

Even for those who do not live in an area without broadband there are also other barriers to use of virtual technology. Many Medicare beneficiaries do not have access to a smartphone, tablet, computer, or other internet-connected camera. Further, many patients, particularly those in need of rehabilitation, have cognitive and/or linguistic deficits that may limit the practical use of virtual technology. Requiring that technology used for telehealth include both audio and visual capabilities would only serve to create additional disparities for already potentially vulnerable populations.

AMRPA appreciates that CMS expanded the availability of audio-only services during the PHE. We recommend CMS extend this flexibility to as many services as possible for the duration of the PHE. Further, we ask that CMS find other ways to expand the availability of audio-only services, such as adding them to the Category 3 telehealth list for services that will be available after the PHE on a temporary basis. We also encourage CMS to seek the authority to include audio-only telehealth services within the telehealth regulations on a permanent basis.

In addition, AMRPA urges CMS to permanently implement the extended availability of “virtual check-ins” for therapy providers. AMRPA providers report these check-in services have been very helpful during the PHE to encourage social distancing and safely provide direction to patients remotely. However, there are other instances where these services would be beneficial to
patients, such as when they are unable to secure transportation to an in-person visit or may have some other infectious condition that requires distancing. Therefore, AMRPA encourages CMS to finalize its plans to expand the availability and access to these services.

AMRPA also supports the development of coding and reimbursement for virtual check-ins with a longer unit of time. For many patients, a virtual check-in can be very helpful; however, the current unit of time included for a virtual check-in is often not adequate. Creating an additional code with a longer unit of time would grant providers and patient’s flexibility to provide the appropriate level of care. Lastly, AMRPA urges that therapists and other non-physician providers be permitted to bill for virtual check-ins, including the addition of a new virtual check-in code with the longer unit of time. AMRPA urges CMS to explicitly include this in the final rule and issue guidance on how therapists and other non-physician providers can utilize the new codes.

Recommendations:

1. AMRPA recommends CMS expand the availability of audio-only services for Medicare beneficiaries.

2. AMRPA supports to creation of additional “virtual check-in” service codes and the ability of therapists to provide such services.

***

AMRPA appreciates CMS’ efforts to engage stakeholders as it continues to modernize the Physician Fee Schedule and the Quality Payment Program. AMRPA and our members remain committed to working with CMS to create a more patient-centered Medicare program. If you have any questions regarding our comments, please contact Jonathan Gold J.D., Director of Government Relations and Regulatory Counsel (jgold@amrpa.org/202-860-1004).

Sincerely,

Robert Krug, MD
Chair, AMRPA Board of Directors
President and Medical Director, Mount Sinai Rehabilitation Hospital