AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Submitted Electronically

September 6, 2022

The Honorable Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1770-P
P.O. Box 8016
Baltimore, MD 21244

Re: Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; 87 Fed. Reg. 45,860 (July 29, 2022).

Dear Administrator Brooks-LaSure:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we write in response to the proposed rule for the Calendar Year (CY) 2023 Medicare Physician Fee Schedule published in the *Federal Register* on July 29, 2022. AMRPA is the national trade association representing more than 700 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals, referred to by Medicare as inpatient rehabilitation facilities (IRFs). In addition to the inpatient physician services provided in IRFs that are covered by the Physician Fee Schedule, AMRPA members also provide rehabilitation services across the continuum of care, including in 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, such as stroke, traumatic brain injury, and traumatic spinal cord injury. 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. This is particularly true as the nation continues to grapple with the COVID-19 pandemic. There are a number of proposals in this year's rule that would adversely impact access to rehabilitation services for patients in need of continued rehabilitation services, and we offer comment on those proposals in the following sections of this letter. Immediately below, we provide a brief summary of our recommendations prior to our more in-depth discussion of these issues:

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Recommendations:

1. **Conversion Factor Reduction:** Outpatient therapy services are proposed to be reduced by 25% relative to CY 2020 levels. This will result in devastating cuts to services for vulnerable Medicare beneficiaries. CMS should minimize or phase-in increases to high-volume code values to avoid disastrous cuts to critical services like outpatient rehabilitation.
2. **Inpatient ("Other") Evaluation and Management (E/M) CPT Codes:** CMS' proposed approach to coding policies for E/M CPT codes used in the inpatient hospital setting undervalues the skill and expertise of inpatient physicians and incentivizes inefficiencies**.** CMS should revise its inpatient E/M policy to ensure inpatient physicians are properly incentivized to deliver care in an efficient and effective manner. Further, CMS should withdraw its policy regarding split/shared E/M services because of its failure to adequately account for the unique role of physicians in hospitals.
3. **Telehealth Therapy Services:** CMS should consider permanent inclusion of speech-language pathology and other therapy services on the telehealth list, including allowing exceptions for patients with documented challenges participating in in-person visits.

I. Application of the Budget Neutrality Factor Threatens Access for Vulnerable Medicare Beneficiaries in Need of Rehabilitation

Over the last several years, CMS has applied significant budget neutrality adjustments to the conversion factor (CF) under the physician fee schedule (PFS). This has resulted in an approximately 4.5% reduction in the CF since 2020. CMS is again proposing an approximately 4.4% reduction to the CF for this year. This would result in an approximate 9% reduction in the CF compared to CY 2020 levels. This type of payment reduction, especially in light of the current economic environment and combined with other adjustments, may result in damaging service cuts and patient access issues for certain rehabilitation services.

For some types of specialties, the reduction to the CF is offset by the increase in value of the relative value units (RVUs) for certain service codes. This is particularly true for certain physician practices that bill a high volume of evaluation and management (E/M) code services. However, for other vital services, including rehabilitation providers, that is not the case. As CMS knows, rehabilitation providers, including physical therapists (PTs), occupation therapists (OTs), and speech-language pathologists (SLPs), do not bill E/M services. This means that, unlike other provider types, the budget neutrality reduction to the CF is not simply a shifting of reimbursement from one code to another. Instead, it is a complete reduction in total reimbursement.

The timing of further cuts could not come at a worse time for rehabilitation providers. First, there is an extraordinary shortage of PTs, OTs and SLPs nationwide, and the difficulty of securing clinical staff continues to grow.[1] Salary demands have risen at unprecedented rates in the last

[1] A Model To Project The Supply And Demand Of Physical Therapists 2010-2025. American Physical Therapy Association (retrieved from http://www.apta.org/WorkforceData/ModelDescriptionFigures/).

year, with providers reporting 10-30% increases.[2] This is in addition to other inflationary pressures, including rising costs for practice expenses and auxiliary staff that are not reflected in a timely manner in the fee schedule. CMS has also implemented a 15% payment reduction for therapy services that utilize a therapy assistant. Given the shortage of therapists and the need for most practices to regularly utilize therapy assistants, this means **that most services will be cut by approximately 25% relative to 2020 levels.** As the operators of outpatient therapy clinics, AMRPA members have already begun working to find ways to best minimize care disruption due to these potential reductions. However, without a change of course from CMS, providers may be left with no choice but to reduce access to Medicare beneficiaries, close service locations and/or cancel expansion plans, provide less resource intensive services, and other steps that will have a direct impact on patient care.

AMRPA would also like to point out that this cut has the potential to exacerbate health equity issues for persons with disabilities or complex chronic conditions. These patient types are the ones in need of the longest-term and most intensive services, and therefore the patient types that therapy clinics will be the most hard-pressed to take on as patients as Medicare beneficiaries due to the lowered reimbursement levels. Therefore, this policy will disproportionally impact the most seriously afflicted Medicare beneficiaries. This should also be concerning from a financial standpoint, since the less access to rehabilitation services beneficiaries have, the more likely these beneficiaries will incur events that result in rehospitalization and the need for additional costly care.

Finally, a further cut to professional services will be particularly ill-timed given that so many recovering COVID-19 patients are in dire need of the very rehabilitation services that would bear the brunt of these cuts.[3] 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 (including "long COVID"). As more people survive the disease, there likely will be greater demand for rehabilitation therapies, and these reductions will limit the ability of providers to meet this demand.

We recognize the limited authority CMS has to modify statutorily mandated budget neutrality adjustments when calculating updates to the CF. Full resolution of this issue will require action by Congress and others outside of CMS, and we urge the agency to coordinate with these entities to ensure appropriate reimbursement for physicians and access for patients. At the same time, we urge CMS to use its existing authorities and seek to preserve payment updates to the maximum extent in CY 2023.

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[2] Kaufman Hall; National Hospital Flash Report: August 2022 (https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-august-2022).

[3] Simpson, R., & Robinson, L. (2020). Rehabilitation After Critical Illness in People With COVID-19 Infection. American Journal of Physical Medicine & Rehabilitation, *99*(6), 470–474. (https://doi.org/10.1097/PHM.0000000000001443).

Recommendations:

1. **CMS should minimize or phase-in increases to high-volume code values to avoid disastrous cuts to critical services like outpatient rehabilitation.**

II. Proposed Updates to Inpatient Evaluation and Management (E/M) Codes Fails to Account for the Complexity of Hospital Care

AMRPA appreciates that CMS is proposing to modernize the evaluation and management (E/M) services codes used by physicians in acute-care hospitals and IRFs. Overall, AMRPA supports efforts undertaken by CMS to reduce administrative burden and complexity for these codes, as well as ensure these codes are valued appropriately. However, physicians charged with the care of patients in IRFs are concerned that some of CMS' proposed approach devalues the complexity of inpatient care and the expertise needed to care for patients in the hospital setting.

In the proposed rule, CMS stated that it doubted care for patients in facility settings such as hospitals was "inherently more complex or work was more intense" than in the office setting since "practitioners furnishing visits in the office setting face particular uncertainties in their estimates of illness and treatment courses, and the office settings have fewer resources close at hand." AMRPA member physicians strongly disagree with this assessment. Based on their experience of caring for patients on both outpatient and inpatient basis, physicians find that inpatients are, almost by definition, less heterogenous, drastically more complex and less stable, and seriously more debilitated than most outpatients.

Despite the resources that a hospital brings to bear, the intensity and level of complexity for a physician managing care for inpatients is not lessened. On the contrary, physicians treating inpatients have a myriad of additional clinical staff to coordinate with, must closely and more regularly monitor the medical status and progress of these more ill patients, and at the same time must be working to coordinate discharge options and long-term goals for the patients. This is not to say that physicians caring for outpatients are not faced with regular challenges on how to best manage care, but challenges that extend beyond the capabilities of their office setting are more of an exception than a regular occurrence. On the other hand, patients in the inpatient setting have typically experienced a drastic life-changing illness or injury, and physicians must work through novel challenges faced by these patients to try to return them to the community.

AMRPA is therefore concerned with CMS' approach to modifying the coding policies for 99223 (initial hospital care), 99231-99233 (subsequent hospital care) and new G-code GXXX1 (prolonged service inpatient). CMS appears to place great value on the ability of physicians to now bill solely using time. So much so, that it is only proposing to allow for use of the prolonged service code when billing is based on time. AMRPA believes this creates distorted incentives that devalue the level of specialization and expertise of physicians working in the inpatient settings.

Complex inpatients, such as those treated in the inpatient rehabilitation setting, require highly specialized physicians. These experts are very skilled at delivering close medical management

and coordinating an intensive rehabilitation course of treatment for these complex patients. Due to this, these physicians often bill the codes 99322 and 99323, the higher level inpatient E/M visits, based on the MDM and other factors of the visit. However, because these specialized physicians are very efficient at delivering this care, they typically would not reach the 80-minute threshold to be allowed to bill the prolonged service code. In fact, even for more complex patients, they often may not be able to reach the 50 minutes required to bill 99233 (the highest level E/M code) if they were billing solely based on time. Therefore, it is unlikely that inpatient physicians will base visit levels based solely on time, and will be ineligible to use the prolonged service code.

This creates a financial incentive gap for physicians to spend important time on coordinating care and other care management aspects that are essential for proper discharge management and long-term outcomes for patients. For example, a physician may be able to deliver a 99233 level of E/M service in 30 minutes when basing that decision on MDM. If the physician needed to spend additional time on that patient, they could spend an additional 49 minutes before being eligible for any additional financial compensation. With a shortage of needed physicians, this approach is potentially harmful to beneficiaries, especially to those with more complex needs, since it doesn't create incentives for physicians to maximize their capacity by caring for a greater number of patients in an efficient timeframe.

This policy will also likely contribute to physician burnout, which is a serious and continuously growing phenomenon. In particular, specialties with a focus on caring for inpatient and other complex patients, such as physical medicine and rehabilitation and critical care, consistently rank among those with the highest levels of burnout.[4] Prioritizing total time over efficiency, as well failing to reward physicians who can deliver complex care in a timely fashion, will encourage longer hours rather than better care. This will exacerbate burnout among physicians, who already are struggling to find their practice to be a rewarding experience.

CMS should more closely align its new policies for E/M coding with American Medical Association (AMA) recommendations. This includes adopting the midpoint rule for E/M visit billing, allowing physicians to bill for an E/M code when they have reached a lower threshold of time. This will create more incentive for physicians to reduce administrative and documentation burden by selecting billing visit based solely on time. It will also more readily allow for reimbursement through the prolonged service code as more physicians elect to bill solely based on time. Adopting the AMA policies will align incentives to encourage physicians to deliver care efficiently, rather than extend the time of the visit to be able to bill higher visit level or utilize the prolonged service code. It will also adequately compensate when physicians do need to spend extended time with more complex patients.

AMRPA has similar concerns with CMS' proposal regarding "split or shared" E/M services, which we provided in response to last year's proposed rule. AMRPA is pleased to see CMS is proposing to delay this policy by a year to collect additional feedback. As stated in our prior comment letter, this finalized policy for split or shared services devalues physician expertise and

[4] 'Death by 1000 Cuts': Medscape National Physician Burnout & Suicide Report 2021. January 2021 (https://www.medscape.com/slideshow/2021-lifestyle-burnout-6013456).

efficiency in the same way the proposed E/M policies do by falsely equating the value of the time of non-physician practitioners (NPPs) with physicians. This is contrary to the unique training, expertise and role that physicians play in hospitals. Rather than utilizing NPPs to see patients in the most efficient way possible, physicians will need to ensure NPPs spend no more time with the patient than the physician to receive full reimbursement. Like the E/M policy, this not only disincentivizes efficiency but also contributes to potential burnout of physicians since it creates increased time and documentation requirements to maximize reimbursement.

Recommendations:

1. **CMS should revise its inpatient E/M policy to ensure inpatient physicians are properly incentivized to deliver care in an efficient and effective manner.**
2. **CMS should withdraw its policy regarding split/shared E/M services because of its failure to adequately account for the unique role of physicians.**

III. CMS Should Take Further Steps to Expand Access to Telehealth Rehabilitation

AMRPA greatly appreciates the steps CMS has taken to allow the provision of rehabilitation services, including PT, OT and SLP services to Medicare beneficiaries via telehealth during the COVID-19 PHE. This includes adding PT and OT services to the "Category 3" list of telehealth services for consideration of permanent inclusion. AMRPA encourages CMS to continue its evaluation and strongly recommends the addition of these services on a permanent basis.

Rehabilitation providers report that the experience of utilizing telehealth to provide therapy services during the PHE has been beneficial for both clinicians and patients and believe that such services can continue to be safely and appropriately provided on a permanent basis. 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. The PHE has demonstrated that therapy services can be safely and appropriately administered through telehealth, without sacrificing quality of care. AMRPA supports opportunities to provide data and other information from the field to CMS to demonstrate the effectiveness and safety of providing rehabilitation services via telehealth.

While AMRPA is strongly supportive of CMS taking all available steps to allow for the virtual provision of PT and OT services, AMRPA is concerned to see that CMS has not added SLP services to the Category 3 telehealth list, and does not appear to be considering more permanent expansion of virtual SLP services following the PHE. AMRPA members report that virtual SLP services have been instrumental in the ability of providers to maintain continuity of care during the PHE. Like PT and OT services, AMRPA believes these services can be safely and effectively delivered to patients following the PHE, and these virtual services may be especially beneficial to discharged IRF patients who continue to recover from conditions causing serious functional deficits. We would like to work with CMS to share the experience of the field in delivering SLP services via telehealth during the PHE so that CMS can consider adding these services to the Category 3 telehealth list, and eventually consider them for permanent addition on a Category 2 basis.

To the extent that CMS has program integrity concerns regarding the provision of rehabilitation services remotely, AMRPA would like CMS to consider a balanced approach to allowing telerehabilitation. More specifically, CMS could consider allowing services that don't otherwise qualify for telehealth to be provided if the therapist documents patient characteristics that make such visits appropriate. For example, patients with mobility issues, or who would otherwise be at risk from frequent travel back and forth to a clinic should be considered priority candidates for remote services. In addition, CMS could consider documented transportation or other resource challenges of beneficiaries when allowing such visits. This type of approach would be consistent with CMS' stated health equity goals to ensure more vulnerable beneficiaries are not more limited in their access to care.

More broadly, AMRPA strongly believes that the availability of virtual therapy services is an issue of health equity. The same beneficiaries that CMS has stated it is prioritizing in its health equity efforts would benefit from the expansion of virtual therapy. This includes beneficiaries in areas with clinician shortages, those who may struggle securing transportation to in-person visits, as well as those with disabilities or other conditions that may have difficulty with mobility to attend in-person visits.

Recommendation:

1. **CMS should consider permanent inclusion of SLP and other therapy services on the telehealth list, including allowing exceptions for patients with documented challenges participating in in-person visits.**

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AMRPA appreciates CMS' efforts to engage stakeholders as it continues to modernize the Physician Fee Schedule. 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,

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