American Occupational Therapy Association

October 31, 2022

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Submitted Electronically: macra.rfi@mail.house.gov

Dear Members of Congress:

On behalf of the American Occupational Therapy Association, I would like to thank you for the opportunity to respond to your request for information (RFI) on the current state of the Medicare Access and CHIP Reauthorization Act (MACRA). The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 213,000 occupational therapists, occupational therapy assistants, and students of occupational therapy (OT). The science-driven, evidence-based practice of occupational therapy enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Occupational therapy practitioners help to improve clients' quality of life and participation in meaningful life occupations.

While the challenges of the current payment system cut across multiple specialties, they have been particularly difficult for therapy providers, including occupational therapy practitioners. From the beginning, the Quality Payment Program (QPP) offered few options for participation for therapy practitioners, and outpatient therapy services provided in facility-based settings were never eligible for the QPP. This, combined with cuts resulting from budget neutrality requirements, and other therapy payment policies of the last decade, has led to a dramatic erosion in payments for Medicare Part B therapy services. As Congress considers policies to create a more affordable, sustainable, and patient-centered health care system, we ask that these policies consider all Medicare-eligible professionals equally.

Medicare Quality Payment Program (QPP)

Merit-based Incentive Payment System (MIPS)

MIPS is complex program that has failed to achieve the hoped-for outcome of incentivizing high value, high quality care. In addition to requiring a high level of administrative burden for little to no reward, MIPS does not reflect the actual interventions, or current reality, of many non-physician providers, including occupational therapy practitioners.

Lack of appropriate quality measures: Occupational therapy clinicians often have difficulty locating information on how to report on measures and there are different rules for different providers based on clinician type, practice size, location, and other factors. Additionally, the measures available in the PT/OT specialty set are very limited and do not reflect the full value of OT services. For example, by combining occupational therapy and physical therapy into one specialty set, there is no distinction between the services that these separate professionals provide, which limits possible measures each specialty could use. For example, an occupational therapy evaluation, as defined by the American Medical Association Common Procedural Terminology (CPT®) includes an analysis of physical, cognitive, and psychosocial deficits impacting performance and participation. It follows that it would be appropriate for an occupational therapy set to include measures related to cognition and psychosocial skills. Currently only depression screening and a cognitive assessment related to dementia are included in the set. Further measures in these areas could be appropriate for an occupational therapy practitioner but might not be appropriate for a physical therapist. Even without separating these two disciplines the current set is limited. To date, there are only fifteen process measures and seven patient reported outcome measures (PROMs). These PROMS currently require the use of a specific outcomes management system – FOTO, which is not used by all practitioners. Ultimately, the measures by which an occupational therapy practitioners' services are judged under MIPs – bear little relationship to true high-quality services OT and outcomes.

Shut out from cost measures: To date, occupational therapy practitioners have not been provided the opportunity to report on cost measures under Medicare Part B. AOTA appreciates the time and resources CMS has devoted to ensuring that clinical input, including input from occupational therapy practitioners, is obtained by its contractor, Acumen. However, despite such input from AOTA, there is no cost measure associated with occupational therapy services that would allow engagement in the Cost performance category. Without associated cost measures, occupational therapy services continue to be automatically reweighted to the Quality category. This creates disparity in the MIPS system as other professions are able to impact their overall score positively through activity and improvement in all categories; whereas activity in the Quality category disproportionally affects therapy professionals compared to other professions, which is particularly troublesome as the quality measures available to occupational therapy practitioners is limited and may not be reflective of quality practice, or the individual patient's outcomes. This disparity can have significant influence on therapy practitioners' success with MIPS and potentially make it more difficult for occupational therapy practitioners to receive a payment bonus.

Lack of equal access to electronic health record (EHR) systems: AOTA supports current efforts to standardize data elements for quality measurement and continued transition to FHIR-based quality reporting as these seem to be the best options available to standardize the MIPS process across locations and settings long term; however, we believe that there must be a thoughtful, iterative approach to rolling out digital quality measures as many rural and even some non-rural facilities may not be ready for this approach. We remain especially concerned that this transition may be detrimental and burdensome to small and rural therapy practices that do not have access to EHR systems with these capabilities. The original incentives and funding for the adoption of EHR included in the HIGH Tech Act of 2009, did not include occupational therapy practitioners among the eligible professionals. Many small practices still submit MIPS measures via claims as more elaborate EHR systems are often cost prohibitive and include functionality that a small therapy office will never use.

AOTA appreciates that the adoption of certified electronic health record technology (CEHRT) by MIPS eligible clinicians would contribute to increased interoperability and data exchange nationwide. But we remained concerned that mandatory reporting and interoperability measures are still a barrier to occupational therapy practitioner engagement with any quality payment program. As discussed above, many small and rural occupational therapy practices do not have access to an electronic health record (EHR) or lack consistent internet connectivity necessary to meet the minimum criteria for reporting. Additionally, nonphysician providers are at a disadvantage in this category as it exists currently, because not all "promoting interoperability" measures are applicable to nonphysician practices. Occupational therapy practitioners have none as they are currently exempt from these measures.

Options for low-volume practitioners: Many occupational therapy clinicians don't treat a sufficient number of cases to produce statistically reliable scores on performance measures and wind up exempt from reporting;

however, many practices won't know that they are exempt until the end of the performance year when it's determined that they didn't see enough patients to qualify to report. Additionally, the incentive payment is often very low, and for those practices where the patient numbers didn't support reporting, their efforts to improve quality go uncompensated.

Recommendations:

1) In order to move to a payment system that truly values quality and patient outcomes, all providers involved in such a program must be engaged from the outset. CMS's current one-size-fits all development of MIPS eligible quality measures has focused primarily on physicians and does not reflect the services (and outcomes) of many providers paid through the PFS. CMS, and future payment systems must provide a way for all clinicians to more easily participate in these programs. This includes identification of cost measures that occupational therapy practitioners can participate in, outcomes measures that are reflective of the services provided by occupational therapy practitioners and other non-physician providers, and outcomes measures that are not limited to the use of a specific outcomes management system (such as FOTO). There are many different specialty physicians and non-physician providers paid through the PFS; all of them must have a viable way to participate in any future payment system. Congress must make sure that future policies require that CMS consider this wide range of service providers.

2) If promoting interoperability reporting is to become a requirement in future years, CMS must review measure applicability and adjust measure requirements to allow for easier nonphysician practitioner reporting of these measures. Congress could direct CMS to review current CEHRT systems and take necessary steps to make sure these systems appropriately account for all PFS providers. We will not have true interoperability if EHRs do not integrate care provided by non-physician providers.

3) Any future program value-based payment program should provide a way for low-volume practices to know, ahead of time, whether or not they are eligible to participate in that program. Should certain low-value practices continue to be exempted from these programs, Congress should provide a pathway for them to receive a yearly payment update.

Alternative Payment Models (APM)s

Occupational therapy practitioners have very limited opportunities to participate in MIPS APMs. Understanding that certain practitioners may have less access to existing APMs, Congress created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) so that ideas on value-based care could be generated from the diverse provider community. The ability of the PTAC to approve smaller, innovative APMs is now more important than ever, as the Center for Medicare and Medicaid Innovation (CMMI) has pledged to focus on fewer, larger alternative payment models. Despite the promise of the PTAC, it has failed to create a pathway for meaningful participation in APMs.

Over forty APMs were submitted to PTAC[1], and while seventeen were recommended to the Health and Human Services Secretary for approval or pilot testing, CMS failed to implement any of them. Two of these programs, the "CAPABLE Provider Focused Payment Model" and the "Bundled Payment for All Inclusive Outpatient Wound Care Services in Non-Hospital Based Setting" include services provided by occupational therapy practitioners. The CAPABLE model was first developed through funding from CMMI research grants. This program has demonstrated Medicare savings of $922 per beneficiary, per month for at least 24 months after completion of the intervention, due to a reduction in hospitalizations and other institutional based care[2]. CAPABLE interventions allow people to successfully age in place and stay healthy in their homes longer. This is exactly the kind of care that should be incentivized, but under the current Medicare payment structure the CAPABLE program can only be provided through grant-based programs, or as a Medicare Advantage supplemental benefit, and not through traditional Medicare.

[1] https://aspe.hhs.gov/collaborations-committees-advisory-groups/ptac/ptac-proposals-materials#1061
[2] https://aspe.hhs.gov/sites/default/files/private/pdf/255731/CAPABLE_PTAC_Proposal_20181030.pdf

In In 2019, several PTAC members resigned on the ground that PTAC had failed in its mission to introduce more physician-focused APMs and that HHS was opposed to implementing ideas submitted from providers in the field with first-hand experience on what would and would not work. There is a disconnect between the concept of alternative payment models, and the reality of implementing them on a larger scale that needs to be addressed. The only way these practitioner-generated ideas can be explored for real-world testing is if they are implemented - even on a pilot basis). Then CMS can evaluate which ones hold promise and can be expanded or alternatively abandoned if they do not show promise in improving quality or lowering costs.

Recommendation:

4) Congress should allow for practices to pilot test PTAC-approved APM models. This is not allowed under current law, but granting such permission would allow participants to show CMS and other policymakers how the model would work and perform in real-world settings for the benefit of Medicare beneficiaries. Once the pilot period concludes and an appropriate amount of data has been collected and analyzed, CMS could make its final approval or denial decision. If approved, this would allow for other providers to more easily replicate real-world use of the piloted model and build off of lessons learned during the pilot to allow for more effective, broad-scale implementation.

Therapy Specific PFS Policies

Facility Based Outpatient Therapy Services

While Medicare Part B private practice therapy services are paid under the PFS, services provided in facility-based settings, such as hospital outpatient departments (HODs), rehabilitation agencies (CORFs) and skilled nursing facilities (SNFs) are not considered to be a part of the PFS. Rather, the 1997 Balanced Budget Act required that payments for facility-based outpatient therapy services be “based-on” the value of those services as set forward in the MPS. While therapy services provided under the fee schedule are billed through an individual’s National Provider Identifier (NPI), all facility-based outpatient therapy services are billed through the facility, and not the individual therapist.

This distinction is not insignificant. Seventy percent of occupational therapy Part B services are provided as a part of facility-based outpatient services but are not eligible to participate in the QPP, or any program that requires an individual NPI number. The end result is that facility-based outpatient therapy services providers have had no way to receive payment updates or bonus payments. However, these services are still subject to budget neutrality cuts and any other policy affecting therapy payments through the physician fee schedule - such as the multiple procedure payment reduction and cuts to services provided by occupational therapy assistants.

Recommendations:

5) Future quality and value-based payment programs must include facility-based services, in order to ensure these providers are eligible for payment updates and to ensure the provision of high quality, high value therapy services in these settings.
6) Congress should direct CMS to develop a way to assess the quality of services provided in facility-based settings, without having to connect these services to the individual clinician.

Payment Differential for Occupational Therapy and Physical Therapists Assistants

On January 1, 2022, Medicare outpatient services provided by occupational therapy assistants (OTAs) and physical therapist assistants (PTAs) began receiving a 15% reduction in payment. This cut is the result of a provision in the Balanced Budget Act of 2018, and is separate from, and in addition to, other cuts to therapy payments under the Medicare Physician Fee Schedule that have been imposed over last several years. OTAs and PTAs are a crucial part of the therapy workforce and ensure that beneficiaries have access to necessary therapy services, especially in rural and underserved areas. OTAs and PTAs are required to complete a two-year Associate degree; many of these programs are run through community colleges helping to meet local therapy workforce needs.

A study of 2021 Medicare claims data[3] showed that OTAs in rural and underserved areas provide 46% of all Medicare Part B occupational therapy services compared to 34% in all other geographic areas. This means the proportion of therapy services provided by assistants in rural and underserved areas is 50% greater than in other areas, and that therapy providers in these areas will be more affected by the cut to assistant services. On its own, this payment cut would have been difficult for therapy providers, but taken together with other PFS cuts, it means a 23.25% cut to services provided by an occupational therapy assistant since 2020, (if the proposed 2023 fee schedule is adopted). These cuts do not account for the reduction in payments for therapy services caused by the Multiple Procedure Payment Reduction.

Recommendation:

7) In order to preserve access to occupational and physical therapy services in rural and medically underserved areas, we recommend that Congress adopt the provisions of the SMART Act (H.R. 5536), including exempting rural and medically underserved areas for the 15% payment differential for OTAs and PTAs.

Medicare's Multiple Procedure Payment Reduction (MPPR)
Medicare's MPPR policy is a per-day reimbursement policy intended to prevent Medicare from overpaying for certain services. For Medicare therapy services, a 25% MPPR was originally put into place through a rule making process by CMS beginning in 2011[4]. Later in 2013, Congress codified this portion of the 2010 rule, but increased the MPPR for therapy services to 50%. The MPPR therapy policy fails to consider the fact that the problem of potential over payment is already addressed during the valuation process for each code. Accordingly, MPPR is an arbitrary cut to payment that puts providers billing therapy codes on a different playing field from other providers paid through the PFS. This decade-old reimbursement cut to therapy services compounds the recent cuts that have been the result of the budget neutrality policy, and the lack of payment adjustments to account for inflation instituted by MACRA.

The American Medical Association develops The Current Procedural Terminology (CPT®) codes that are used to bill for medical services in Medicare. Each code is a highly technical description of a service and is accompanied by a relative value unit or "RVU"– a value determined through extensive surveys and analysis that is intended to reflect the true cost of delivering that care. One element of an RVU is the "practice expense." This expense addresses the costs of maintaining a practice including rent, equipment, supplies and nonphysician staff costs. Because each CPT code has a practice expense amount, some policy makers mistakenly believe that when a provider delivers multiple services, represented by multiple CPT codes, in one visit, they are being over-paid for this expense. MPPR was developed as a solution. MPPR reduces the value of the practice expense by 50% for every "always therapy" code billed on the same day, except one, across all therapy disciplines. The American Physical Therapy Association has estimated that MPPR reduces total payment approximately 15% per visit.

Unfortunately, the MPPR does not account for the valuation process of the "always therapy" codes. In this process, the AMA RUC divides the practice expense clinical staff time to account for any duplication that might occur. In fact, in valuing therapy codes the RUC *assumes* that two or three codes will be billed during the same encounter, and therefore reduces the PE values of the codes to reflect this duplication. For example, an element of the practice expense involved calculating the time and cost of the task described as "clean room/equipment by clinical staff." The standard amount allocated to a CPT code by the AMA is three minutes however the allocation for therapy procedures and modality codes is one minute – to reflect the billing of multiple codes during one therapy session. As another example, although the allocation of time for the direct practice expense task described as "prepare room/equipment by clinical staff" is two minutes for other CPT codes, it is one minute for therapy procedure and modality codes. These examples demonstrate that the AMA has already considered the provision of multiple units and/or procedures when valuing therapy codes. Conversely, the radiology codes

[3] https://acrobat.adobe.com/link/track?uri=urn:aaid:scds:US:afa395e4-8b46-30fc-9687-fd85ecb1aa95
[4] https://www.govinfo.gov/content/pkg/FR-2010-11-29/pdf/2010-27969.pdf

subject to MPPR did not have these elements discounted during the RUC valuation process. For the same element of "prepare room/equipment by clinical staff" for CPT code 70450 2 minutes is allocated. Applying MPPR to this code addresses the potential duplication and reduces this element by 50%. Applying MPPR to an "always therapy code" for which the allocated time has already been reduced by 50% during the RUC valuation process results in a 100% reduction.

Additionally, MPPR "applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines such as, physical therapy, occupational therapy, or speech-language pathology." This means a reduction will apply to all therapy providers treating a patient on the same day, regardless of discipline or relationship. Accordingly, a patient may receive speech-language pathology services in the morning, then later in the afternoon attend a physical therapy session in a different setting. MPPR will treat all codes billed that day as if they were delivered by the same practitioner and cut all but the first CPT code billed.

Therapy services are not typically provided in tandem, or with use of the same equipment. Each therapy discipline delivering service that day, must gather and set up their own equipment, perform their own chart review, greet the patient, provide their unique service, coordinate with other caregivers, then transport the patient from the clinic and clean/disinfect used equipment and supplies. Occupational therapy, physical therapy, and speech-language-pathology services also have separate and distinct guidance in the Medicare policy manual requiring independent plans of care for each service. Applying the MPPR policy without separation of the disciplines diminishes the unique nature of each therapy services, does not account for how therapy is actually provided, especially in facility-based settings, and can negatively impact beneficiary access to coordinated clinically appropriate care.

While Medicare rules are adjusted every year, statute is not. When Congress codified the 2010 rule making the therapy MPPR permanent policy, it removed the flexibility inherent in the rule making process. Even in 2010, Medicare stated that it did not know to what extent there was overlap in the practice expense portion of therapy services and made a guess that it was somewhere between twenty-five and fifty-six percent. Furthermore, they specifically stated, "Our analyses and policy development regarding the therapy MPPR were based solely on claims for office-based therapy services" and that they did not do an analysis of facility-based outpatient therapy services, which are also subject to the MPPR.

Recommendation:

8) As Congress considers revisions to MACRA, it should also revisit legacy policies such as the MPPR; a built-in payment cut to Medicare therapy providers that does not account for the dynamic process of AMA RUC – the process by which code values are supposed to be set. Because the MPPR policy was put into statute, there is no way to adjust this 50% reduction except through the passage of legislation - even to account for further analysis of actual therapy expenditures in various settings, or changes to the valuation of therapy services through the AMA process.

Structural Challenges with the Current PFS

The last few years have demonstrated the increasing instability of the Medicare Physician Fee Schedule. Even without the challenges and uncertainty of COVID, current policies have significantly eroded reimbursement for Medicare therapy services. Because few occupational therapy practitioners have been able to participate in the QPP, either through MIPS or in APMS, few have had any way to receive updates or bonuses since 2016. While this lack of any automatic or inflationary update has been harmful, occupational and physical therapy services have been one of the most hard hit by recent cuts to the conversion factor. If the conversion factor outlined in the 2023 proposed rule goes into effect, reimbursement rates for occupational therapy services will be roughly equal to 2009 rates – not adjusted for inflation, and not including the newly implemented 15% reduction to occupational therapy assistant services. This erosion in payment for therapy services is not sustainable and will only continue if Congress does not act on these broader challenges to the PFS.

Budget Neutrality

The 2020 Physician Fee Schedule highlighted a significant flaw in the budget neutrality process. The 2020 policy was meant to better reward primary care physicians who have a higher evaluation and management

(E&M) volume. However, it disproportionately cut payments to providers who do not, or cannot bill E&M codes. Medicare's payment charts included with the 2020 PFS showed that health care professionals who do not bill E&M codes were subject to the largest cuts as a result of this policy change. The majority of non-primary care physicians were able to offset cuts to their code set because they bill some E&M services. However, non-physician providers are not able to bill E&M codes and therefore had no way to offset the decrease to the conversion factor. The budget neutrality process is not required to consider issues such as patient access, however policymakers should consider the impact of new payment policies on beneficiaries. A redistribution of the fee schedule on the magnitude of the E&M value change, significantly affected a specific group of providers (those who do not bill E/M codes) to such an extent that the standard budget neutrality process should not have been applied, without modifications, in this case.

Recommendations:

9) Expand exemptions from budget neutrality adjustments, to include a broader range of policy changes such as regulatory policies that are designed to increase quality care and patient outcomes, or policies designed to expand benefits or patient access to services.
10) Consider policies to help mitigate dramatic changes to the conversion factor or payments for specific services. This could include capping the allowable yearly reduction in payment for a given service if this reduction is caused by budget neutrality adjustments.

Lack of Inflationary Update
While the purpose of MACRA was to put in place a system where providers receive payment increases based on quality outcomes and value, the lack of an automatic or inflationary increases assumed that all Medicare professionals would have equal ability to participate in the QPP. Additionally, MACRA failed to account for the naturally occurring increased in practice costs and did not envision a time of inflation like we are currently experiencing. In their 2021 report, the Medicare Trustees raised concerns that payment updates did not vary economic conditions or keep pace with traditional cost increases.

Recommendation:

11) As future payment programs build in incentives for quality, value-based services, this payment program must have a baseline of dependable, annual updates that account for inflation and other cost increases.

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Thank you for your attention to the improving payments under the Medicare Physician Fee Schedule through revisiting the MACRA Quality Payment Program. AOTA strongly supports efforts to improve the health outcomes of Medicare beneficiaries and to pay for value-based care. Any future reform should take into consideration all services paid through (or based-on), the fee-schedule, including those provided by non-physician providers, and outpatient therapy services provided in facility-based settings. Future systems should be protected from large shifts in payment rates, such as those that occurred with the new valuation of E/M codes and should provide a path for testing and potential adoption of new APMs. Finally, as you consider reform, we encourage you to look at legacy payment policies that still impact reimbursement for Medicare Part B services, but that may no longer be appropriate under a new payment system. Please let me know if I can be of any assistance to you in these efforts at hparsons@aota.org.

Sincerely,

Heather Parsons
AOTA Vice President of Federal Affairs