The American Occupational Therapy Association, Inc.

Occupational Therapy: Living Life To Its Fullest®

Via online submission to https://www.regulations.gov

September 26, 2019

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: CMS – 1715 – P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; CY2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations

Dear Administrator Verma:

The American Occupational Therapy Association (AOTA) is the national professional organization representing the interests of more than 213,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. 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 services are reimbursed under the Medicare Physician Fee Schedule (MPFS) and are affected by Medicare Part B payment policies under the Quality Payment Program (QPP). We appreciate the opportunity to comment on this proposed rule published at 84 Federal Register 40482 on August 14, 2019.

I. Repeal of the Therapy Caps and Limitation To Ensure Appropriate Therapy

The Bipartisan Budget Act of 2018 (BBA18) included a permanent repeal of the cap on Medicare outpatient therapy services. The CY 2020 proposed rule does not present any substantive changes to the therapy cap repeal, use of the KX modifier, or the targeted medical review process; rather, it clarifies and codifies the changes outlined in the BBA18. AOTA supports the CMS proposal to add a paragraph to existing Medicare regulations clarifying that the previous annual limitation known as the "therapy cap" is now a threshold amount. Additionally, CMS is proposing adding a paragraph to the regulation clarifying that the annual threshold amount for targeted medical review continues to be $3,000 for occupational therapy services and will remain at that amount until 2028 without change. These CMS proposals are consistent with the underlying legislation addressing the therapy cap repeal.

II. Proposed Payment for Outpatient OT and PT Services Furnished by Therapy Assistants

The Bipartisan Budget Act of 2018 requires payment for Medicare Part B services furnished "in whole or in part" by a therapy assistant at 85% of the applicable Part B payment amount for the service, effective January 1, 2022. In the proposed rule CMS proposes to establish two new therapy modifiers to designate services that are to be paid at 85%—one for OT assistants (OTAs) and another for PT Assistants (PTAs). These are to be used in addition to the three existing therapy modifiers (GO, GP, and GN) which identify the type of therapy provided. The new therapy modifiers for services furnished by OTAs and PTAs are required to be reported on claims beginning on January 1, 2020. AOTA has significant concerns regarding the CY 2020 proposed rule recommendations as compared to the CMS CY 2019 final rule recommendations and urges CMS **NOT TO** finalize the OTA and PTA modifier implementation policies as proposed in CY 2020 when therapy services are provided by the therapist and assistant at the same time for the reasons outlined below.

In the CY 2019 final rule, CMS adopted a "de minimis standard" to define when services are furnished "in part" by a therapy assistant. CMS defined it to mean a service furnished by the PTA or OTA that exceeds 10% of the total "service". A key question that AOTA, APTA and other stakeholders raised last year in comments was how we should define a "service." In the CY 2019 final rule, CMS stated that:

1. The 10% de minimis standard would apply to total treatment time when it was for an untimed service (e.g., OT/PT evaluations or group therapy);
2. When different services are being performed by the therapist and assistant (using different "timed" CPT code interventions) OR when the same service intervention is furnished independently by the therapist and assistant during a session, the 10% de minimis standard would apply only to the timed unit of the service furnished in whole or in part by the assistant (based on the therapy convention of 15 minute unit increments using the "8 minute rule"), not the total treatment time. CMS indicated they would provide more guidance in the CY 2020 proposed/final rules, particularly in relation to how to apply the modifier when care is delivered concurrently, or by the therapist and assistant at the same time.
3. CMS did not clarify how services performed "concurrently", together by an assistant along-side the therapist would be handled, especially when the therapist is present for the entire service. Instead, CMS indicated that the de minimus standard may only apply *in the absence of a therapist*, with additional scenarios to be provided in CY2020 rule making. In the CY 2019 MPFS final rule, CMS states:

> *However, the extent to which the modifiers apply to clinical scenarios in which the therapist and therapy assistant work together to furnish services collaboratively may be dependent on whether the therapy assistant's services are furnished in the absence of the therapist, whose time could then no longer be attributed to that patient. We do not agree that services in which the therapist and therapy assistant work collaboratively or in tandem are necessarily services that are not furnished ''in part'' by a therapy assistant. Rather, when a therapist and therapy assistant work together in furnishing a therapy service, we would generally view that service as being furnished in part by a therapy assistant,* ***especially when the therapist is absent for a portion of the service****, as explained above.* ***We recognize there are other clinical scenarios and types of services***

> ***where it is less obvious whether the service should be considered furnished ''in part'' by a therapy assistant when a therapist and therapy assistant work collaboratively together to treat one patient, and we anticipate addressing applicability of the modifiers in additional clinical scenarios through further rulemaking for CY 2020*** (emphasis added).

However, in the CY 2020 proposed rule, CMS is proposing to apply the 10% de minimus standard to the total treatment time when the care is provided by the therapist and assistant at the same time, with none of the above clarifying distinctions. In essence, this means that when an occupational therapist requires the skilled assistance of an OTA to help transfer, position and stabilize a chronically ill Medicare patient for a bathing training activity, for example, the entire session reimbursement will be reduced to 85% of the fee schedule amount merely because the OTA was involved in the patient's treatment. Ironically, the OTA involvement in this example is based on the therapist's clinical judgement that skilled OTA assistance would contribute to the safety, stability and quality of the patient care.

> **Example:** *A therapist performs therapeutic activities, 97535, for 45 minutes. During that time, the therapist asks for the assistance of an OTA for 8 minutes to help position the patient for the activity. According to the 2020 proposed rule, the entire 45 minutes of service would be subjected to the 15% reduction because 8 minutes is 18% (greater than 10%) of 45 minutes, even though the therapist was delivering care for the entire service time.*

2019 Rule

97535 OT/OTA
97535 OT
97535 OT

15% adjustment applies to first unit of service only

2020 Rule

97535 OT/OTA
97535 OT
97535 OT>>

15% adjustment standard applies to all units of service

For payment purposes, CMS is ignoring the time the therapist spent delivering the care independently, for if the assistant spent more than 10% of that total time assisting in care delivery, the entire service would get paid at 85% of the fee schedule rate, even though the therapist was present and delivering care for the entire service. In this instance, the beneficiary is receiving services from two skilled practitioners, yet under the 2020 rule, the entire service will be subject to a 15% payment adjustment. The de minimus rule should not apply for concurrent services when the therapist is delivering care for the entire service. The rule should only apply when the OTA is performing services independently. At a minimum, the application of the payment adjustment should apply to the unit of service increment for which the

assistant is providing services concurrently with the therapist (as in the 2019 rule), not the entire service time of the therapist. This flawed de minimus standard application de-values the work of the therapist, which is unprecedented in current regulations.

This policy also creates a negative and inconsistent reimbursement result in a different scenario where, as part of the same session, the therapist and assistant each furnish part of the service *separately*, such as in the case where a patient may be first seen by a therapist alone, then seen by an assistant alone.

Example: *A therapist performs therapeutic exercise, 97110, for 30 minutes. The therapist leaves, and the PTA takes over the exercises, 97110, for another 15 minutes. According to the 2020 proposed rule, the entire 45 minutes of service (all three 15 minute units) would be subjected to the 15% reduction because 15 minutes is 33% (greater than 10%) of 45 minutes.*

2019 Rule

97110 PT
97110 PT
97110 PTA

15% adjustment applies to last unit of service only

2020 Rule

97110 PT
97110 PT
97110 PTA

15% adjustment applies to all units of service

AOTA asserts that only those *units* of services provided in whole or in part by the assistant should be subject to the 15% payment adjustment, not the total patient's treatment time. Yet in CY 2020, CMS proposes to reduce the entire session if an assistant is present for greater than 10% of the total time. This newly proposed policy devalues the services of the therapist and flies in the face of the Congressional intent in the BBA 2018 legislation, which clearly targeted the payment reduction to services provided by an assistant independently from the therapist.

Finally, CMS is proposing new therapy documentation requirements beginning January 1, 2020 to explain why a modifier **was or was not** used. Such a requirement is duplicative of current documentation requirements, which are extensive, therefore imposing undue burden on providers for documenting why the modifier was used. Moreover, requiring providers to document that a modifier was **NOT** used is also a significant and unnecessary administrative burden, which may create provider confusion and is especially illogical for those providers who do not employ assistants at all. Further, imposing this new documentation requirement to begin on January 1, 2020 is setting up therapy practices to face potential audits or be involved in documentation reviews. CMS must allow sufficient time following the publication of the final rule for providers to be educated on the new documentation requirements and to prepare their staff and systems, especially electronic health records systems, to incorporate such changes.

AOTA strongly opposes the CY 2020 proposed application of the 10% de minimus standard. AOTA, along with APTA and other therapy stakeholders, has submitted extensive written

comments and met with CMS staff in-person multiple times during 2018 and 2019 to recommend a reasonable approach to implementation of the OTA/PTA modifier. Further, we have provided detailed written clinical scenarios to demonstrate our perspectives. AOTA urges CMS to revisit those comments, clinical scenarios and meeting recommendations in formulating a more practical and equitable OTA/PTA modifier policy.

Therefore, AOTA recommends:

- ***The 10% de minimus standard should be applied ONLY to assistant services furnished independently of the therapist;***
- ***The 10% de minimus standard should be applied per unit, not based on total treatment time;***
- ***CMS must not add new documentation requirements, which are duplicative, highly burdensome and inconsistent with the Administration's Patients over Paperwork initiatives.***

a) Replace Terminology of "Concurrent" with "In Tandem" in Final Rule

In the OTA/PTA modifier policy discussed above, CMS is using the confusing terms "concurrent" and "concurrently" to describe clinical scenarios where the OTA/PTA works alongside the respective OT or PT to provide a skilled therapeutic assistance, often for safety, enhanced quality or effectiveness purposes, when an alternative term such as "in tandem" would be appropriate and create less confusion. The usage of term concurrent in the proposed rule to describe a care team of a two-clinicians to one patient scenario under this proposed Part B policy is the exact opposite of the existing and long-standing Medicare Part A Skilled Nursing Facility (SNF) definition of "concurrent" therapy as depicted in this excerpt from page O-16 of the CMS Minimum Data Set Resident Assessment Instrument (MDS-RAI) Manual v1.17.1, October 2019[1]:

> *Concurrent minutes— Enter the total number of minutes of therapy that were provided on a concurrent basis in the last 7 days. Enter 0 if none were provided. Concurrent therapy is defined as the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident. For Part B, residents may not be treated concurrently: a therapist may treat one resident at a time, and the minutes during the day when the resident is treated individually are added, even if the therapist provides that treatment intermittently (first to one resident and then to another). For all other payers, follow Medicare Part A instructions.*
>
> AOTA respectfully requests in the 2020 final MPFS rule CMS define the clinical scenario where a therapist and an assistant are jointly furnishing services to a patient at the same time, that CMS replace the term "concurrent" with "in tandem".

[1] CMS MSD 3.0 RAI Manual Page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

b) Impact of Assistant Modifier Policy Other Third Party Payer Reimbursement Policies

Medicare payment and coverage policies typically are the gold standard that other third party payers adopt. If this therapy payment differential modifier policy is finalized as proposed, an inequitable reimbursement structure that fails to recognize the collaborative process of the OT and OTA will result. If other third party payers such as Medicaid, Medicare Advantage and private insurance follow CMS's proposal it will be extremely harmful to the occupational therapy profession across age, life-span, condition and health care setting. AOTA urges CMS to closely consider the issues outlined in this section of the comment letter with an understanding of the negative long-term impact and potential repercussions to Medicare beneficiaries and consumers that could result. Further, given the long time frame in place prior to the 2022 payment reduction implementation, AOTA encourages CMS to work together with AOTA, APTA and other impacted societies to establish a logical policy that recognizes the ever growing therapy needs of the aging baby boomer population.

c) Harms Beneficiary Access to Medically Necessary Occupational Therapy Services

AOTA continues to have serious concerns about patient access to occupational therapy in rural, medically underserved and health professional shortage areas under this policy. AOTA urges CMS to review Bureau of Labor Statistics and other available therapy staffing data to understand the ratios of Therapists to Assistants across the United States. CMS should consider an exemption for regions where the number of Therapists is limited compared to the number Assistants because this could create a serious access issue to medically necessary therapy services. As the baby boomer generation continues to live to older ages and frequently suffer from multiple chronic conditions, demand for therapy services will only increase. It is critical that Medicare beneficiaries continue to have access to occupational therapy services.

d) Modifier Testing Notice and Timeline

AOTA respectfully requests that CMS alert and educate therapists and therapy assistants in advance of testing the OTA and PTA modifiers in 2020. CMS could do this by engaging in additional education, including but not limited to developing a MedLearn Matters article for providers of therapy services and conducting a Special Open Door Forum on this topic well in advance of the modifier testing time frame.

Finally, AOTA requests that CMS consider the payment reduction implications for other payment reductions and the order of application of such policies as the Multiple Procedures Payment Reduction, Sequestration reductions and the overlay of National Correct Coding Edits on the application of the OTA modifier policy.

III. Background and Proposed E&M Policy for CY 2021

In the CY 2019 final rule, CMS finalized several policies (coding, payment, and documentation changes) related to E&M office and outpatient visits (99201-99215). During and after the comment period, CMS received extensive negative comments about these policies, and consequently, is proposing to revise many of those E&M policies in this Proposed Rule. Instead, CMS proposes to align with the E&M coding changes established by the CPT Editorial Panel, effective January 1, 2021.

In doing so, CMS proposed to retain the 5 separate levels of coding and payment for established patients, 4 levels for new patients, and will not proceed with a blended rate. CMS proposes to accept the AMA recommendations on valuation, which will increase reimbursement for these services.

Given that E&M visits comprise approximately 40 percent of allowed charges for MPFS services and that office/outpatient E&M visits comprise approximately 20 percent, these changes will reflect a significant redistribution of value within the MPFS. CMS offers an illustration of how these changes might impact different specialties in Table 111 of the Proposed Rule, noting that the estimates are intended to provide insight into the effects if they were implemented this year and do not reflect what will actually occur in CY 2021. However, AOTA is very concerned that in Table 111, therapy services are listed as being one of the hardest specialties hit, taking up to an 8% reduction beginning in 2021.

The number of Medicare beneficiaries accessing occupational therapy and physical therapy services has been increasing due in part to the aging of our population and increase in the number of beneficiaries with multiple chronic conditions. This trend is positive in that expanded utilization of outpatient physical therapy and occupational therapy means reduced necessity for costly hospitalization and readmission. The timing of these cuts is particularly alarming as occupational and physical therapists are on the front lines addressing pain management for many who would otherwise have no other option than to utilize opioid medications to address their pain. Early access to occupational and physical therapy holds the promise of reducing opioid use among patients with pain. However, a proposed 8 percent reduction in the reimbursement rate for these essential services will create significant hardships for therapists attempting to address the needs of this population of beneficiaries.

Further, a severe and arbitrary reimbursement reduction will create challenging and likely unsustainable financial circumstances that may adversely impact patients' access to care and the ability of providers to continue to furnish care to beneficiaries. The significant reduction in reimbursement will result in a decreased workforce and an inability to meet the growing needs of the Medicare population. Rising debt and shrinking reimbursement provide the perfect storm for discouraging individuals from choosing to enter these professions in the future. Such shortages would be problematic as the baby boomers reach Medicare age and more individuals seek access to services as health care reform provisions become effective.

While we recognize the interest of CMS to address the reimbursement rate of those health care professionals who bill for E/M codes, we believe that CMS must reassess the impact of such a sizable redistribution of the Medicare Part B fee schedule, which is conducted in a budget neutral manner. We are particularly concerned for beneficiaries in rural and urban underserved areas who need occupational therapy and physical therapy services.

Moreover, this proposed cut comes on the heels of other significant cuts that physical therapy and occupational therapy providers have sustained in recent years. Namely, the 2 percent Medicare sequestration, 50 percent multiple procedure payment reduction (MPPR) imposed in 2013 (an increase from a 20 percent reduction that began in 2011), National Correct Coding Initiative (NCCI) edits that impose a significant penalty on code combinations that represent standard and necessary care, and the 15 percent reimbursement reduction for services furnished by physical therapist assistants and occupational therapy assistants beginning in 2022. The weight of these combined reductions could mean that occupational therapy practices reduce personnel and thus critical services at a time when the Medicare population is multiplying.

The Proposed Rule states that professions that do not bill Evaluation and Management services will take the largest cuts to balance the E&M increases. These cuts undermine the assigned work and Practice Expense (PE) values given to therapy service CPT codes, based on the professional work/ skill set and the overhead/equipment costs undertaken to perform them as part of the AMA's RVS Update Committee (RUC) process.

The RUC process reviews codes for revaluation based upon a detailed specialty survey process, where specialists respond to a series of questions about work and practice expense costs in real time. AOTA supports the RUC process, and when cuts of this magnitude are proposed, we believe that a proper vetting should be done by CMS to seriously examine the overall impact to Medicare beneficiaries to access the services being reduced, in place of what appears to be an arbitrary cut to therapy codes that are non-E/M codes. We participated in the RUC revaluation process for most of our therapy CPT codes and those values were finalized in the CY2018 rulemaking. The work and PE values of therapy codes should remain consistent with 2018 values because no significant practice changes have occurred to warrant a decrease within the past 1-2 years. Randomly assigning an 8% cut for the purposes of budget neutrality and finalizing such a policy devalues the RUC valuation process. Further, since 2013, CMS has applied a 50% MPPR reduction to the PE portion of payment for outpatient occupational therapy and physical therapy services. MPPR is designed to avoid duplicate payment for practice expenses when multiple procedures are delivered to the same patient on the same date of service. However, the application of MPPR is already duplicative, given the PE values for these CPT codes were already reduced to avoid duplication during the AMA RUC process. Efficiencies that exist when multiple therapy services are provided in a single session were explicitly considered when relative values were established for these codes.

Therefore, in many instances, reducing the PE on the second and subsequent codes results in underpayments. If CMS adopts an 8% cut to codes billed by occupational therapists, which includes a 3% reduction in PE value, the underpayment will be even greater, devaluing the established RUC PE values even further. This proposal makes further reductions where duplication of practice expense has already been addressed, through both the revaluation of the codes and application of MPPR. AOTA urges CMS to redistribute the budget neutrality offset in a manner that achieves ongoing access for Medicare beneficiaries to vital therapy and rehabilitation services and consistency with CPT code values that were established by CMS in the CY 2018 final rule.

IV. Occupational Therapy Evaluation Codes (CPT 97165, 97166, 97167)

In 2015, AOTA proposed revisions to OT evaluation codes that transitioned from a single code that described OT evaluation services to three new codes based on patient complexity. Despite AOTA's advocacy for stratified relative value unit (RVU) values for each code based on complexity level, in the CY 17 MPFS Final Rule CMS finalized a work RVU of 1.20 for each of the OT evaluation CPT codes because of concerns of potential abuses and budget neutrality.

	AOTA Recommended Values	HCPAC Accepted Values	CMS Values in Final Rule
97165	.93	.88	1.20
97166	1.42	1.20	1.20
97167	1.80	1.70	1.20

In the CY 17 MPFS Final Rule, CMS tasked AOTA to collect data on the use of the evaluation codes and based on the collected data, CMS indicated that they would revisit stratified code values for the three evaluation codes. In addition, CMS has indicated during meetings over the past year that the agency is also collecting utilization data.

A continued utilization review based on available Medicare Part B data used for RVU development indicate that AOTA's predicted utilization values have continued to be correct. AOTA's evaluation frequency for 2018 is 54% low complexity, 38% moderate complexity, and 8% high complexity. These results fall squarely within the 50%, 40%, and 10% (low, moderate, and high) estimates AOTA proposed to CMS.

	AOTA Projected Utilization Percentage	2017 RUC Database Units	2017 RUC Database Percentage	2018 RUC Database Units	2018 RUC Database Percentage
97165	50%	113.821	52%	126,686	54%
97166	40%	83,520	38%	89,131	38%
97167	10%	21,696	10%	20,790	8%

AOTA thanks CMS for continuing to monitor the use of the OT evaluation codes. AOTA continues to be a resource to provide data and collaborate with CMS about future decisions regarding the OT evaluation codes.

a) OT Evaluation Code Practice Expense Issue

Based upon the above explanation and analysis, it is AOTA's understanding that, until CMS examines the data collected and determines to propose changes to the three Occupational Therapy evaluation codes, the three levels of evaluation codes will continue to be valued at the same total RVU level of 2.58 respectively. Yet, in the CY 2020 Proposed Rule, calculations indicate that 97166 and 97167 have a PE value that is being reduced by .01 from current year CY 2019, and that are both .01 lower than 97165. As these codes have only been in existence for two years, it appears to be too soon to be devaluing the PE values as sufficient data has not been collected to make that determination. Similarly, as shown in the table above, the distribution of code usage has not changed in any manner to justify a reduction in the code values. Until the codes are stratified, all three evaluation codes should reimburse the same rate. We urge CMS to review these calculations and make the correction to maintain the practice expense values at CY 2019 rates for 97165, 97166 and 97167.

V. Health and Behavioral Assessment and Intervention

We are pleased that CMS is accepting the CPT Editorial Panel proposal for 9 new Health and Behavioral Assessment and Intervention codes. The Occupational Therapy evaluation focuses on (1) Body structure/function (2) Cognitive function (3) Psychosocial function. If psychosocial performance deficits are identified, occupational therapists should be able to use these new intervention codes to address those deficits in order to improve or avoid decline in the patient's functional capacity and independence.

Occupational therapy practice addresses behavioral or cognitive issues which affect health overall and result in measureable outcomes under the beneficiary's specific care plan. Nationally, programs and payers inconsistently acknowledge and cover these important aspects of "whole person" care. AOTA requests that occupational therapists will be one of the qualified health care professions permitted to perform health and behavioral assessment and intervention services. Due to the comprehensive training in mental and behavioral health that is required to become an occupational therapy practitioner, AOTA believes this service can and should also be performed by occupational therapists, working as part of the primary care team.

VI. Cognitive Function Intervention

We are pleased that CMS is accepting the RUC recommendations for the new and revised CPT codes 971XX and 9XXX0.

Occupational therapy practitioners are experts in skilled teaching and training on compensatory activities that account for cognitive function deficits and they work to improve or maintain function where possible. For Medicare beneficiaries, early detection of performance-based cognitive impairments by occupational therapists also facilitates the selection of the most appropriate levels of care, the appropriate resources to support and train caregivers and reduce caregiver burden, and client-centered discharge options, and contributes to reduced hospital readmissions and increased safety at discharge, all important goals of the Triple Aim and recognition of medically necessary services. AOTA has engaged CMS officials in face-to-face meetings to discuss the collection of data on functional cognition across Medicare settings, and will continue to provide research studies and related materials to CMS to advocate that assessment of functional cognition be incorporated into CMS assessments of cognition.

VII. Online Digital Evaluation Service

While we are pleased that CMS is valuing the non-physician digital services with the new HCPCS codes GNPP1, GNPP2, and GNPP3, we request that occupational therapy be deemed a qualified provider for these services.

Occupational therapists are in a key position to perform digital assessments and should be included within the category of non-physician providers allowed to deliver these services. Occupational therapy interventions delivered via a digital service can be instrumental in helping patients regain, develop, and build functional independence in everyday life. Such service availability alternatives may also address provider shortages and access problems, making necessary occupational therapy services available to underserved beneficiaries in remote, inaccessible or rural settings and to beneficiaries with limited mobility outside their home. Further, with extensive expertise in activities of daily living in the context of both the community and home, occupational therapy is the profession best situated to engage with

clients in their natural environment through digital services. Occupational therapy practitioners can provide online digital assessment services to Medicare beneficiaries efficiently and effectively.

VIII. Care Management Services

Providing comprehensive chronic care management will decrease caregiver burden, increase key functional independence, and ultimately decrease utilization that is often disproportionately—and perhaps unnecessarily-- high in this population. We applaud and support CMS's call for additional codes, whether they are add-on codes or codes for additional encounters. Inclusion of payment for such interactions is particularly important for those patients that have multiple chronic conditions or disabilities.

IX. Determination of Malpractice Relative Value Units

In the 2020 proposed rule, five of the sixteen specialties for which premium data was newly acquired are non-physician health care professions that were formerly cross-walked, including anesthesiologist assistants, chiropractor, optometry, certified nurse midwife, and certified registered nurse anesthetist (CRNA). For all other non-MD/DO specialties, CMS continues to cross-walk or "map" to the lowest physician specialty risk factor of allergy/immunology. Thus, the default risk factor for specialties for which insufficient data were available, and that do not clearly have premiums like those of another group for which data are available, continues to be 1.00. According to CMS, these "specialties are mapped to allergy/immunology as a matter of necessity, not clinical relationship."

AOTA appreciates this decision to continue to cross-walk the malpractice expense. Along with the other payment reductions occupational therapists are going to face with potentially up to an 8% cut and the occupational therapy assistant modifier, an additional payment reduction in the form of malpractice expense would create an overwhelming undue burden on the specialty.

X. Geographic Practice Cost Indices

As required by statute, CMS has completed a review of the geographic practice cost indices (GPCIs) and proposes new GPCIs, which will be phased in during 2020 and 2021. These GPCIs include the permanent 1.5 work GPCI floor for Alaska and the permanent 1.0 practice expense (PE) GPCI floor for frontier states (MT, WY, NV, ND, and SD). The proposed GPCIs do not include the current 1.0 work GPCI for localities outside Alaska, since that statutory provision is set to expire at the end of 2019. CMS proposes to use updated data for this GPCI update and make two technical refinements applicable to the work GPCI and the employee wage index and purchased services index components of the PE GPCI.

AOTA has concerns about the potential for additional payment reductions to therapy services in rural areas if the payment floor is discontinued. The GPCI formula needs to account for the unique practice needs of rural therapy practitioners. These potential cuts in addition to the other cuts discussed early in this letter would be devastating to rural communities.

XI. CY 2020 Updates to the Quality Payment Program and Merit Based Incentive Payment System (MIPS)

Section 1848(q)(1)(C) of MACRA defines a MIPS Eligible Clinician (EC) for the first 2 years of the CMS Quality Payment Program (QPP) to be a physician, a physician assistant, nurse practitioner, and clinical nurse specialist, a certified registered nurse anesthetist and a group that includes such

professionals. Beginning with the third year of the program (2019) and for succeeding years, the statute gives the Secretary discretion to specify additional ECs, as that term is defined in section 1848(k)(3)(B) of the Act, which could include an occupational therapist, a physical therapist, or a qualified speech-language pathologist, among other professionals. AOTA appreciates that CMS added occupational therapists to the list of ECs beginning in 2019. The profession of occupational therapy will benefit from continued learning and participation in quality reporting under MIPS to work on quality improvement efforts within practices that are positioned to participate in MIPS ***meaningfully***. Other occupational therapy practices will not be ready to participate in MIPS. AOTA is pleased that a low volume threshold was proposed to permit opting- in to MIPS in 2019 and no proposed changes were made in 2020. AOTA strongly supports CMS' thoughtful and sequential approach to the inclusion of occupational therapy practitioners into the program, and makes recommendations regarding how that thoughtful approach can continue in 2020 and beyond.

a) MIPS Value Pathways Program (MVP)

CMS has requested feedback on the MIPS Value Pathways Program (MVPs). Being new to MIPS as of 2019, occupational therapists are at a disadvantage, as we are still figuring out how MIPS reporting fits most appropriately within the intended structure of promoting patient outcomes, and enhancing practice improvement, interoperability and small business operations/efficiency for our private practices. While CMS states that the current number of choices are too expansive and need to be narrowed, AOTA is concerned that by limiting the quality reporting choices within the MVPs, clinicians will not be able to successfully participate because occupational therapists work in highly varied settings and practice types. There is not a "one size fits all" solution for a field with a diverse scope of interventions, such as occupational therapy. AOTA strongly supports efforts to consider population health and public health priorities. At the same time, therapists need to continue to have the option to choose measures that they feel best fit their scope of practice. Also, as occupational therapists are not required yet to report for promoting interoperability, having multiple reporting options under MIPS continues to be important as most therapy practices need an alternative to EHR and registry submission.

As MVPs are developed, it will be important that the current MIPS structure remains in place for occupational therapy practitioners as an option for the foreseeable future as clinicians learn the new system. AOTA further requests that the MVP be implemented in stages by specialty. As a new specialty to MIPS that hasn't had any experience with the promoting interoperability category, we feel it would be more appropriate for occupational therapy to be phased in later in the overall transition to gain reporting experience and an understanding for the more highly reported measures to identify patterns within MIPS. This would give time for both our clinicians to participate and get a better understanding of MIPS, and for CMS to work out the best format for MVPs that will not be detrimental to the patients we serve, given our unique scope of practice.

As occupational therapy practices are included in MVPs, we request that individual practices are permitted to choose and seek approval for individual pathways under the MVP even if different from another OT practice pathway choice. For example, an OT hand therapy clinic may choose quality measures that are more orthopedic in nature such as quality measures from the FOTO set of measures, while a home health care private practitioner billing under Medicare Part B might choose measures that look more at self-care and ADL function, as well as falls risk. Each of those practices could identify a

narrow set of strong measures for their practice but those measures must be different. Occupational therapy practices are being set up to fail if they are forced to report on identical measures across practices simply because they are occupational therapists. The characteristics of the patients they are treating in different types of settings also differ significantly and the patient's plan of care, goals and anticipated outcomes could logically drive a variety of different MVP pathway choices from the measures currently available to therapists in 2019. In this regard, occupational therapy is more analogous to the medical specialty of primary care than dermatology, for example, because occupational therapy practices generally treat a wide range of conditions that may trigger functional deficits. Clinicians will also need clear parameters on MVP participation. Clinicians like occupational therapists, who work with beneficiaries across diagnostic categories, must be able to determine if and which MVP is credited to their practice and which beneficiaries are included in the MVP.

b) Low Volume Threshold

AOTA supports CMS's proposal to maintain the 2019 low-volume threshold policy to exclude individual eligible clinicians or groups that (1) have Medicare Part B allowed charges less than or equal to $90,000, (2) that provide care for 200 or fewer Part B-enrolled Medicare beneficiaries, or (3) who provide 200 of fewer Medicare services. This policy will help small health care practices, especially in rural areas, by excluding a significant number of clinicians from MIPS in CY2020 who are not ready to participate in quality reporting from an administrative and systems perspective. While quality reporting and quality improvement are critical goals in health care, our many solo and small practices are unable to withstand the financial and administrative burdens immediately imposed by QPP and should be given opportunities to be excluded so they can ramp up and prepare for QPP participation in a future year.

At the same time, AOTA strongly supports CMS continuing for the 2020 reporting year to provide clinicians meeting the low volume threshold the ability to *opt-in* to MIPS if they meet or exceed one, but not all, of the low-volume threshold determinations, as defined by dollar amount, beneficiary count or services. Such an approach gives those clinicians who have had the time and education to participate fully in MIPS and strive to achieve incentive payments and to avoid the anticipated 0% Medicare Physician Fee Schedule payment update.

c) Support for Small and Rural Practices

AOTA applauds CMS for allotting tailored flexibilities in MIPS specifically for small and rural practices. Specifically AOTA appreciates and supports CMS' proposal to retain a small practice bonus for MIPS under the quality performance category. There are a large number of hand therapy rehabilitation private practices comprised of occupational therapy practitioners that do not typically have the funding to engage in measure development and quality improvement activities and would benefit greatly from the support of a small practice bonus, community resources and free technical assistance while they begin engaging in quality measure development for MIPS reporting.

Overall, AOTA strongly supports CMS continuing to accept reporting of both process and outcome measures in MIPS. We understand the continued emphasis in moving away from claims based reporting. But, for occupational therapy and other newly eligible clinicians, claims based reporting is an important method to gain experience in QPP. Process measures are an important means to implement critical quality actions into daily practice and ongoing quality patient care for occupational therapists and will

remain important as therapists join the QPP program and develop additional outcome measures. AOTA is eager to work with CMS and other stakeholders to develop more meaningful measures.

d) Cost/Resource Use Category

To date, occupational therapists do not have any experience reporting on Cost measures under Medicare Part B. The CMS proposed rule discusses the proposal to include new Episode-based Cost Measures in this category. AOTA appreciates the time and resources CMS has devoted to assuring that clinical input, including the input from occupational therapy, is obtained by its contractor, Acumen. However, as a participant in several of the clinical subcommittee discussions with Acumen, AOTA is well aware of the lengthy debates and vexing questions that concern committee members as they develop episodes. Issues such as identifying the correct length of the episode window and assigning services to the episode (like rehabilitation therapy or imaging, etc.) each take hours to resolve. While AOTA is cognizant that this performance category relies solely on administrative claims data, critical resource use related questions like attribution and risk adjustment for medically complex patients still need solutions that can only be answered with additional time and through ongoing CMS collaboration with the relevant professions.

XII. Medicare Telehealth Services under Section 1834(m) of the Act

AOTA recognizes that the Medicare statute does not explicitly identify occupational therapists as professionals permitted to bill for telehealth services. However, many states do permit PT, OT, and SLP practitioners to furnish telehealth services, and they do so safely and effectively. In recent years there have been significant changes and innovations in healthcare delivery models that have incorporated incentives to improve care coordination and quality, and to reduce resource use as part of the Triple Aim. Proper application of telehealth therapy services, particularly in underserved areas, can have a dramatic impact on improving care and reducing the negative consequences and costs of care. AOTA believes that occupational therapy telehealth services in underserved areas can make the difference in preventing falls, functional decline, costly emergency room visits, and hospital admissions/readmissions.

In many ways, occupational therapy is a perfect match for telehealth technologies that enable completion of one of the key aspects of occupational therapy: defining and enabling function within a specific context and environment, such as a patient's home. Occupational therapy practitioners have engaged in telehealth services in a variety of areas of therapy service delivery.

The AOTA Telehealth Position Paper[1] sets forth how occupational therapy practitioners use telehealth technologies as a method for service delivery for evaluation, intervention, consultation, monitoring, and supervision of students and other personnel. Further it references the results of research on the use of telehealth in rehabilitation or habilitation which include occupational therapy.

There is a growing base of evidence demonstrating the efficacy of technologically mediated occupational therapy.[2] Thus, occupational therapy should be tested and utilized fully. AOTA asserts

[1] American Occupational Therapy Association (2013). Telehealth. *American Journal of Occupational Therapy*, *67*(6 Suppl.), S69-S90. http://dx.doi.org/10.5014/ajot.2013.67S69.

[2] Cason J (2009). A Pilot Telerehabilitation Program: Delivering Early Intervention Services to Rural Families. International Journal of Telerehabilitation, 2009;1(1):29-37. Hoffmann T, Russell T, Thompson L, Vincent A, Nelson M. (2008). Using the Internet to assess activities of daily living and hand function in people with Parkinson's disease. NeuroRehabilitation, 23,

that the same ethical and professional standards that apply to the traditional delivery of occupational therapy services also apply to the delivery of services received via telehealth. Occupational therapy interventions delivered via telehealth can assist patients regain, develop, and build functional independence in everyday life activities to significantly enhance a Medicare beneficiary's quality of life. Telehealth may also address provider shortages and access problems, making necessary occupational therapy services available to underserved beneficiaries in remote, inaccessible or rural settings and to beneficiaries with limited mobility outside their home. Further as noted above, occupational therapy is the chief profession with expertise in activities of daily living and community environments, which may be better observed and evaluated through telehealth services.

AOTA recommends that CMS use its authority under the Center for Medicare and Medicaid Innovation (CMMI) to conduct a pilot demonstration project to evaluate the clinical benefit of occupational therapists furnishing telehealth services to Medicare beneficiaries as permitted by states. Such a pilot could be done in conjunction with the physical therapy and/or speech-language pathology professions. The results of a pilot study on the Medicare population would help inform decisions about whether and how best to include OTs, PTs and SLPs as authorized practitioners of telehealth services.

XIII. Medicare Telehealth Services under Medicare Advantage Plans

AOTA also requests that CMS clarify in final rulemaking whether it has the authority to enable Medicare Advantage (MA) plans to include occupational therapy telehealth services as a basic benefit. AOTA would appreciate clarification as to whether CMS has the authority to enable MA plans to include occupational therapy, physical therapy and speech-language pathology services furnished via telehealth as basic benefits pursuant to Section 50323 of the Bipartisan Budget Act (BBA) of 2018.

Section 50323 of the Bipartisan Budget Act of 2018 defines "*additional telehealth benefits*" as:

> ''(I) for which benefits are available under part B, including services for which payment is not made under section 1834(m) due to the conditions for payment under such section; and
> (II) that are identified for such year as clinically appropriate to furnish using electronic information and telecommunications technology when a physician (as defined in section 1861(r)) or practitioner (described in section 1842(b)(18)(C)) providing the service is not at the same location as the plan enrollee…
> ''(3) REQUIREMENTS FOR ADDITIONAL TELEHEALTH BENEFITS.— The Secretary shall specify requirements for the provision or furnishing of additional telehealth benefits, including with respect to the following:
> ''(A) Physician or practitioner qualifications (other than licensure) and other requirements such as specific training.
> ''(B) Factors necessary for the coordination of such benefits with other items and services including those furnished in-person.
> ''(C) Such other areas as determined by the Secretary.

253–261. Ng EM, Polatajko HJ, Marziali E, Hunt A, Dawson DR (2013). Telerehabilitation for addressing executive dysfunction after traumatic brain injury. Brain Inj. 2013;27(5):548-64.

While the language in the BBA does appear to limit the "provision of additional telehealth services" to a physician and practitioner, the language included in the same section, below in (C), would seem to grant CMS the regulatory authority to go beyond what is outlined in the BBA:

> ***"(3) Requirements for additional telehealth benefits: '(C) Such other areas as determined by the Secretary.'"***

Moreover, since occupational therapy, physical therapy and speech-language pathology services **are** available under Part B but **are not** currently payable under Section 1834(m) of the Social Security Act, this language would seem to be consistent with the CY 2020 Medicare Advantage (MA) Program proposed rule, specifically where CMS omits the physician and practitioner language.

In the CY 2020 MA proposed rule, CMS made no reference to the physician/practitioner terminology and proposed to define additional telehealth benefits as services that meet the following:

> (1) Are furnished by an MA plan for which benefits are available under Medicare Part B but which are not payable under section 1834(m) of the Act; and
> (2) Have been identified by the MA plan for the applicable year as clinically appropriate to furnish through electronic exchange.

CMS also stated in the proposed rule that Section 50323 of the BBA requires the Secretary to solicit comment on what types of items and services should be considered to be additional telehealth benefits, stating: "*Therefore, we are also soliciting comments on whether we should place any limitations on what types of Part B items and services… can be additional telehealth benefits provided under this authority."*

It appeared in the CY 2020 MA proposed rule that CMS was taking the broadest possible approach to this statute, which is supported by CMS stating that MA plans "are in the best position to identify each year whether additional telehealth benefits are clinically appropriate to furnish…" Accordingly, if a MA plan chose to cover telehealth…occupational therapy services within its basic benefits package, AOTA believes it would not be limited to services furnished solely by a physician or practitioner.

Based on the above analysis, AOTA submitted comments in support of the CMS proposal to allow MA plans the flexibility to provide therapy services via telehealth as part of their "basic benefit" packages. However, in the CY 2020 MA final rule, CMS updated the definition of additional telehealth benefits to mimic the language of Section 50323:

42 CFR § 422.135 Additional telehealth benefits.

a. Definitions. For purposes of this section, the following definitions apply:
   Additional telehealth benefits means services:
   (1) For which benefits are available under Medicare Part B but which are not payable under section 1834(m) of the Act; and
   (2) That have been identified by the MA plan for the applicable year as clinically appropriate to furnish through electronic exchange when the physician (as defined in section 1861(r) of the Act) or practitioner (described in section 1842(b)(18)(C) of the Act) providing the service is not in the same location as the enrollee.

It is clear that Congress intended to afford authority to CMS to include telehealth occupational therapy, physical therapy and speech language pathology services within the definition of additional telehealth

benefits that can be part of the basic MA benefit package. However, given the definition of additional telehealth benefits finalized by CMS in the MA final rule, we question whether CMS believes it has the statutory authority do so. **Therefore, we respectfully request that CMS clarify in final rulemaking, or through correspondence directly with AOTA, the extent to which it has the authority to include occupational therapy, physical therapy and speech-language pathology services within the definition of additional telehealth benefits that can be offered as a basic benefit by MA plans.**

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Thank you for the opportunity to comment on the Medicare Part B payment and policy changes. AOTA looks forward to a continuing dialogue with CMS on coverage and payment policies that affect the ability of occupational therapy practitioners to provide quality, cost effective outpatient therapy and SNF services to Medicare beneficiaries.

Sincerely,

Sharmila Sandhu, JD

Vice President, Regulatory Affairs