October 5, 2020

SUBMITTED ELECTRONICALLY VIA www.regulations.gov

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

RE: CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies Proposed Rule [CMS-1734-P; RIN: 0938-AU10]

Dear Administrator Verma:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the Proposed Rule entitled, *CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies* (the Proposed Rule). This letter focuses on the Centers for Medicare and Medicaid Services' (CMS) proposals to expand certain telehealth services beyond the end of the declared COVID-19 Public Health Emergency (PHE) as well as the proposed changes to the Physician Fee Schedule (PFS) conversion factor and related reimbursement rates which, we believe, could have a negative impact on patient access to physician and rehabilitation services.

CPR is a coalition of more than 50 national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain the maximum level of health and independent function. CPR is comprised of organizations that represent patients – as well as the providers who serve them – who are frequently in need of medical rehabilitation services.

Overview

In the Proposed Rule, CMS includes two major proposals relevant for patient access to rehabilitation services. First, the agency proposes to significantly expand the provision of telehealth in the Medicare program beyond the PHE. Using temporary authorities granted during the PHE, CMS has allowed all Medicare beneficiaries, not just those located in rural or medically underserved areas, to receive telehealth services; authorized a wide list of Current Procedural Terminology (CPT©) service codes to be provided via telehealth; and expanded the types of providers who are eligible to provide telehealth services.

CMS proposes to permanently add several services to the Medicare telehealth services list and further to create a new temporary list of Medicare telehealth services authorized for provision through the calendar year in which the PHE ends. CMS also notes that an additional list of services currently authorized on a temporary basis during the PHE are *not* proposed for telehealth authorization past the expiration of the PHE, including therapy services and certain psychological and neuropsychological testing services. CMS states that physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services (all services that are critical for rehabilitation for patients with a variety of conditions treated in post-acute care settings) are excluded from the Medicare telehealth services list because they are predominantly furnished by therapists, who will no longer be approved to provide telehealth services once the PHE expires, unless Congress acts to authorize coverage of these services through telehealth.

In order to align with changes finalized in the Calendar Year 2020 final rule, CMS will increase payment for office and outpatient evaluation and management (E/M) services and certain analogous visits. Due to the budget neutrality requirement imposed on the Physician Fee Schedule, this change will result in an overall decrease to the conversion factor used to calculate total reimbursement for PFS services, a nearly 11% cut across the board. While certain specialties, especially primary care and family practice, are expected to see their average reimbursement increase in 2021 due to the E/M changes, others (including PT, OT, SLP, and physical medicine and rehabilitation physician services) are expected to see significant decreases in overall reimbursement, which may impact patient access to care.

Expansion of Telehealth under the Physician Fee Schedule

We note that the proposals in the Proposed Rule are necessarily limited by the authority CMS currently possesses to expand telehealth beyond the duration of the PHE. However, as the Medicare population grows accustomed to the widespread adoption of telehealth over the last six months, we also recognize that Congress may consider permanent extension of certain authorities provided to the agency during the PHE. Accordingly, we encourage CMS to consider our comments below not only with regard to the policies in the Proposed Rule, but for future rulemaking impacting telehealth in the Medicare program.

CPR appreciates that the rapid expansion of telehealth has allowed many Medicare beneficiaries to safely access medically necessary health care while protecting themselves from threat of infection with COVID-19. Especially for vulnerable patients with injuries, disabilities, and chronic conditions, the ability to receive medical rehabilitation services virtually has been critical for improving health and function while limiting the risk of infection by abiding by social distancing protocols. As CMS reviews the regulations governing the use of telehealth, we strongly encourage the agency to ensure that patient access to care, and patient-centered policy more generally, is the driving factor behind expansions of telehealth.

Access to telehealth has been particularly helpful for people with disabilities, even aside from the circumstances of the PHE. For example, many beneficiaries with mobility impairments have seen tremendous benefit from the ability to receive virtual evaluations and other services, given the complications associated with planning, transportation, and accessibility of in-person visits.

Mobility impairments themselves limit physical access to in-person visits to health care providers. Telehealth dramatically eases the burden of mobility impairment while preserving access to care.

Similarly, many patients in need of cognitive and psychological rehabilitation services have found that virtual services may be more accessible and even potentially more effective, with the potential to cut down on distractions associated with receiving care in an unfamiliar environment. We also note that the proliferation of telehealth may allow patients to receive more stable, continuing access to therapy and other important services, with telehealth visits occurring between intermittent in-person visits in order to maintain the level of care available to the patient. We support the expansion of telehealth past the expiration of the PHE to ensure that patients are able to benefit from advances in technology that make virtual care possible.

However, it is critical that expansion of telehealth services does not come at the expense of in-person care, especially when the services needed by the patient are more effectively and efficiently provided in-person. Beneficiaries with illnesses, injuries, disabilities, and chronic conditions often need the highest levels of medical care in order to maintain, regain, and/or improve their health and function. It is crucial that beneficiaries receiving rehabilitation care are able to access the most appropriate care in the most appropriate settings.

New regulations expanding telehealth must ensure that telehealth is utilized only when clinically appropriate and that beneficiaries who need in-person care do not face additional barriers to access as a result of telehealth adoption. When either virtual or in-person care is considered to be equivalently appropriate for the patient's clinical needs, Medicare regulations must not promote one over the other. The decision between virtual and in-person care should be made between the patient and their provider.

We encourage CMS to continue to work under the agency's current authority to ensure that patient-centered telehealth is available to as many patients as possible, in as many appropriate forms as possible, while ensuring that telehealth adds to existing forms of available care without replacing or supplanting these modalities.

Impact of Proposed Changes to Evaluation and Management Visit Reimbursement

Traditionally, CPR does not comment directly on provider reimbursement issues. However, the proposed reductions to the conversion factor and resulting estimated cuts to reimbursement for certain physician specialties and rehabilitation therapy providers have the potential to severely impact patient access to rehabilitation care. Therefore, we urge CMS to work to mitigate or eliminate the impact of these cuts in order to ensure that patients are able to access the medically necessary care they need in the most appropriate settings.

As outlined above, CMS proposes to reduce the Medicare conversion factor by nearly 11% in 2021, resulting in decreased fee schedule amounts for services across the board. While some specialties are expected to see an increase in their aggregate reimbursement due to increased payment for E/M services, many specialties will see significant net reductions. In particular, providers of certain services that comprise the foundation of medical rehabilitation, including

physical medicine and rehabilitation physician services, physical therapy, occupational therapy, audiology, and speech-language pathology, are estimated to see reductions ranging from 3-9% less than overall 2020 reimbursement. In addition, these estimates represent average projections across entire specialties, and the conversion factor cuts will have a variable impact on practitioners who treat patients with a diverse set of complex conditions. In fact, many providers may see their reimbursement drop significantly more than the CMS estimate.

Providers of rehabilitation care are already facing serious financial strain. Of course, the current public health emergency has significantly impacted the financial health of many providers, due to the cancellation and delay of "non-essential procedures," reduced patient volume, increases in costs associated with preventing further COVID-19 infection, and the general effects of the national economic downturn. Additionally, as we have stated in previous regulatory comments, changes in the payment models for many areas of post-acute care, including the Patient-Driven Groupings Model (PDGM) and the Patient-Driven Payment Model (PDPM) in the Medicare home health agency (HHA) and skilled nursing facility (SNF) prospective payment systems, respectively, have already resulted in decreased access to rehabilitation therapies.

CPR believes that implementation of the proposed cuts to therapy, physical medicine, and other rehabilitation services will decrease patients' access to care. Especially during the current public health emergency, the added financial pressure is likely to cause practitioners to close or limit their practices if these reductions are implemented, limiting patient choice and access to care. Patients in rural and underserved areas may be most at-risk if these cuts are finalized, as many of these patients already face barriers in accessing rehabilitation care. In addition, the cuts are likely to have ripple effects beyond the Medicare program, as many private payers and other federal health care programs link their reimbursement rates to Medicare payment levels or discount their rates off Medicare rates.

Assuming CMS proceeds with the proposal to finalize new valuations for E/M visits, we urge CMS to use all authorities available to the agency to ensure that patients are not adversely affected by the proposed reimbursement cuts and to protect the viability of rehabilitation physicians and therapists in 2021 and beyond.

Maintenance Therapy in Medicare Part B

As CPR has expressed in past regulatory comments, the coalition continues to be concerned about decreased access to rehabilitation services, especially therapy services, across Medicare payment systems. In addition to recent reductions in therapy access under the SNF and HHA payment systems for Medicare beneficiaries, we have also noted our concerns about the importance of "maintenance" therapy, which is covered by Medicare as affirmed under the *Jimmo v. Sebelius* class action settlement but is often at risk of being cut or eliminated entirely. "Maintenance" therapy assists a patient to maintain or prevent deterioration of their functional status, as opposed to improving their functional abilities.

As stated in the Proposed Rule, CMS has adopted on an interim basis during the PHE a policy allowing physical therapists (PTs) and occupational therapists (OTs) the discretion to delegate the performance of maintenance therapy services, as appropriate, to a PT or OT Assistant (PTAs

and OTAs). CMS now proposes to make this policy permanent. CPR generally supports this proposal, and we appreciate CMS's efforts to ensure that patients have access to these essential services. However, beneficiaries who require maintenance therapy should still have access to PTs and OTs when necessary to ensure they are achieving optimal outcomes. Expanding the types of providers that are authorized to perform this therapy under the Medicare Part B benefit would increase providers' ability to provide medically necessary maintenance therapy to patients in need of such services. We hope to see this provision implemented in the final rule, with clarifications that beneficiaries will continue to have access to PTs and OTs when necessary.

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We greatly appreciate your consideration of our comments on the CY 2021 Physician Fee Schedule Proposed Rule. Should you have any further questions regarding this information, please contact Peter Thomas or Joe Nahra, coordinators for CPR, by e-mailing Peter.Thomas@PowersLaw.com and Joseph.Nahra@PowersLaw.com or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association of People with Disabilities
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
The Arc of the United States
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Association of University Centers on Disabilities
Brain Injury Association of America
Center for Medicare Advocacy
Child Neurology Foundation
Christopher & Dana Reeve Foundation
Clinician Task Force
Disability Rights Education and Defense Fund
Epilepsy Foundation
Falling Forward Foundation
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics

National Association of State Head Injury Administrators
National Athletic Trainers' Association
National Disability Rights Network
National Multiple Sclerosis Society
Rehabilitation Engineering and Assistive Technology Society of North America
Spina Bifida Association
United Cerebral Palsy
United Spinal Association