September 27, 2019

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

RE: Medicare Program; CY 2020 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 [CMS-1715-P]

Dear Administrator Verma:
The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 13,900 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and development disabilities. Each day, our members provide essential housing and health care services to residents in over 1.07 million skilled nursing facility (SNF) beds and more than 253,000 assisted living beds.

With such a membership base, the Association represents the majority of SNFs and a rapidly growing number of assisted living communities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly, and individuals with disabilities who receive long term or post-acute care in our member facilities each day.

We appreciate the opportunity to comment on the Physician Fee Schedule Proposed Rule for calendar year (CY) 2020. SNF's furnish and bill Medicare Part B under the fee schedule for residents under a Part A stay for services excluded from consolidated billing requirements, as well as for physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services for beneficiaries who are either not eligible for or have exhausted Part A benefits. Additionally, SNFs provide short-term Medicare Part A post-acute services to beneficiaries who require skilled nursing and/or rehabilitation services on an inpatient basis. SNF residents have complex health care conditions, comorbidities, and functional deficits requiring ongoing interdisciplinary care. In addition to outpatient therapy payment rates and policies associated with services furnished by PT and OT assistants, our SNF members have a vested interest in assuring that other policies that impact care for SNF residents, including physician and telehealth provisions, provide adequate and timely access to these necessary services to improve care and reduce unnecessary hospitalizations for emergent conditions that could be better treated in place at a lower cost.

If you have questions about any of our comments, please contact Daniel Ciolek at (302)740-7888.

Sincerely,

Daniel E. Ciolek, PT, MS, PMP
Associate Vice President, Therapy Advocacy

Contents

September 24, 2019

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

Submitted electronically

RE: Medicare Program; CY 2020 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 [CMS-1715-P]

Dear Administrator Verma:

We are writing in response to the request for comments on the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2020 Revisions to Payment Policies under the Physician Fee Schedule (PFS) and Other Revisions to Medicare Part B proposed rule.

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 13,900 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and development disabilities. Each day, our members provide essential housing and health care services to residents in over 1.07 million skilled nursing facility (SNF) beds and more than 253,000 assisted living beds.

With such a membership base, the Association represents the majority of SNFs and a rapidly growing number of assisted living communities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly, and individuals with disabilities who receive long term or post-acute care in our member facilities each day.

I. AHCA General Comments

We appreciate the opportunity to comment on the Physician Fee Schedule Proposed Rule for CY 2020. SNF's furnish and bill Medicare Part B under the fee schedule for residents under a Part A stay for services excluded from consolidated billing requirements, as well as for physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services for beneficiaries who are either not eligible for or have exhausted Part A benefits. Additionally, SNFs provide short-term Medicare Part A post-acute services to beneficiaries who require skilled nursing and/or rehabilitation services on an inpatient basis. SNF residents have complex health care conditions, comorbidities, and functional deficits requiring ongoing interdisciplinary care. In

addition to outpatient therapy payment rates and policies associated with services furnished by PT and OT assistants, our SNF members have a vested interest in assuring that other policies that impact care for SNF residents, including physician and telehealth provisions, provide adequate and timely access to these necessary services to improve care and reduce unnecessary hospitalizations for emergent conditions that could be better treated in place at a lower cost.

With regard to the specific proposed policies, we are gravely concerned with CMS' proposed application of the CQ/CO modifier when outpatient physical therapy and occupational therapy services are furnished "in whole or in part" by a physical therapist assistant (PTA) or occupational therapy assistant (OTA) and how this policy, if finalized as proposed, will negatively affect Medicare beneficiary access and add administrative burden. If this proposal is finalized as proposed, the access to and safety of vital outpatient physical and occupational therapy services for the most vulnerable physically impaired beneficiaries will be compromised.

Additionally, we are concerned about proposed changes to physician evaluation and management (E&M) payments that would result in a negative eight percent adjustment to outpatient therapy payment rates beginning CY 2020.

Finally, with regards to telehealth policy, we request that the secretary consider revising existing obsolete SNF telehealth frequency limitations promulgated through prior rulemaking as well as consider approaches to improve telehealth access to currently excluded geographic locations and to rehabilitation services furnished by PT, OT, and SLP professionals.

Below is a summary list of our specific recommendations. Sections II-IV of this comment letter provides a detailed discussion related to these recommendations.

Provisions Related to therapy Services (NPRM section II.M)

AHCA Recommendations:
We ask the Secretary to not finalize these policies as proposed. Instead, we are requesting that CMS, in finalizing the therapy assistant adjustment provisions of Section 1834 of the BBA, implement the following policy:

1. **That for this policy CMS define the clinical scenario where a therapist and a therapy/therapist assistant are jointly furnishing services to a patient at the same time by using the term "in tandem" and not use the term "concurrent".**
2. **When a therapist and assistant are jointly furnishing services to a patient at the same time "in tandem", and the therapist is fully engaged in the service during that time, the service during that time period should be identified as a therapist's services and be allocated to the therapist.**
3. **That CMS define "in whole or in part" to mean skilled therapy service <u>unit</u> furnished by a PTA or an OTA that is furnished under the supervision of a therapist, but <u>independent</u> of any time the therapist is furnishing the service.**
4. **Consistent with the CY 2019 final rule CMS statements described above, that only those <u>units</u> of services provided "in whole or in part" by the assistant should be**

subject to the 10% de minimis standard, the CQ/CO modifier, and subsequently the 15% payment adjustment, not all units of the entire therapy service.

5. **That no new burdensome documentation requirements be added. At a maximum, sub regulatory guidance could be revised to include a statement such as *"The provider should have a mechanism in place to provide evidence whether a specific service was furnished independently by a therapist or an assistant, or was furnished "in part" by an assistant in sufficient detail to permit the determination of whether the "de minimis" threshold was met."***

Provisions Related to Proposed Adjustments to Outpatient Therapy CY 2021 Rates as Reflected in Table 111 (NPRM section VI.C.2.c)

AHCA Recommendations:
We ask the Secretary to not finalize the proposed E&M payment and coding policies in a manner that would result in the arbitrary across-the board eight percent cut to outpatient therapy service payments. Instead, we are requesting that:

1. **CMS defer any decision regarding CY 2021 pricing of procedures for services furnished by physical and occupational therapists and speech-language pathologists pending the completion of the following activities:**
    a. **That CMS follow established transparent policies, including involvement of the therapy professionals furnishing outpatient therapy services in validating that the proposed pricing of therapy service procedures adequately reflects the provider's costs for furnishing such services.**
    b. **That this pricing activity consider the adequacy of payment rates to at least cover costs based on the cumulative effects of other recent CMS cost-containment strategies that impact the pricing for these procedures including; 1) the ongoing 2 percent sequestration adjustment, 2) the 50% multiple procedure payment reduction (MPPR) policy, and 3) the national correct coding initiative (NCCI) edits.**
    c. **That this pricing activity consider the adequacy of payment rates to at least cover costs beginning in CY 2022 based on the implementation of the 15% cut to "services furnished in whole or in part" by a therapy/therapist assistant.**
2. **CMS consider alternative approaches to achieving budget neutrality by:**
    a. **Redistributing practice expense adjustments across health care services/providers that do not have demonstrable costs for equipment and supplies.**
    b. **Establishing a floor to the magnitude of negative adjustments so that no individual procedure is priced lower than the provider costs for furnishing such services that were established during the most recent CPT, RUC, and PE Subcommittee process.**
    c. **Phasing in any budget neutrality cuts across multiple years rather than applying a drastic cut in a single cycle.**

Provisions Related to Telehealth Services

AHCA Recommendations:

- **AHCA recommends that CMS standardizes the SNF telehealth visit limitations for SNF and PAC provider settings to "once every three days" so that they shall be identical across all PAC provider settings.**
- **AHCA recommends that CMS investigate opportunities to expand the access to telehealth services to providers that are currently ineligible to furnish these services due to current statutory rural and underserved areas limitations.**
- **AHCA recommends that CMS investigate opportunities to include physical therapists, occupational therapists, and speech-language pathologists as covered telehealth providers.**

II. Therapy Services (NPRM Section II.M.) 84 FR 40558

We understand that that Section 53107 of the Bipartisan Budget Act of 2018 (BBA), enacted on February 9, 2018, included pay-for provisions related to the repeal of the Medicare Part B payment cap for therapy services. These provisions describe administrative steps so that, starting in CY 2022, the Centers for Medicare and Medicaid Services (CMS) would apply a 15% adjustment to the outpatient physical and occupational therapy payment rates for services furnished "in whole or in part" by a therapy assistant.

In the proposed rule, CMS would define the meaning of "in whole or in part by a therapy assistant" in the context of documentation and claim coding requirements for CY 2020 that would permit the operationalization of the 15% therapy assistant adjustment beginning CY 2022. While it appears that that most of the CMS proposed provisions are consistent with the intent of the law, we believe that parts of the overall proposed approach discussed below are problematic and require changes before finalization. Most problematic are these parts defining whether a therapy service was furnished "in whole or in part" by the assistant which we believe overstep the legislative intent and improperly applies reduced payments for to therapist-furnished services.

We believe that the Congressional intent of the therapy assistant provisions was to better align payments with the cost for delivering therapy services since therapy assistant wages are typically lower than therapists wages. **We do not believe the Congressional intent was to apply an adjustment to therapy service <u>units</u> completely furnished by the therapist or when the therapy assistant was providing a "second set of hands" to the therapist for safety or effectiveness reasons.**

CMS is proposing that when a therapist is furnishing care and requires the help of a therapy assistant as a "second set of hands" for safety or effectiveness purposes, for payment purposes, the therapist's time is ignored, and this treatment time is instead attributed to the therapy assistant 15% payment discount policy. For example, if a therapist spent the entire 60 minute "service" providing direct care to a resident, but during that session they required the side-by-side assistance of a therapy assistant for 7 minutes, the entire hour of service would subject to the 15% therapy assistant adjustment.

CMS is using the confusing terms "concurrent" and "concurrently" to describe clinical scenarios where the PTA or OTA works alongside the respective PT or OT to provide a "second set of hands" for safety or effectiveness purposes when an alternative term such as "in tandem" would be appropriate and create less confusion. This usage describing a two-clinician 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.

CMS is also proposing to apply the 15% cut to individual time-based 15-minute service <u>units</u> completely and independently furnished by the therapist. For example, if a therapist independently furnished 30 minutes of a time-based service and an assistant independently furnished 15 minutes, all three 15-minute service units would be subject to the therapy assistant adjustment. We believe that those service units furnished completely by the therapist should be attributed to the therapist. The 15% therapy assistant adjustment should only apply to the individual service units that were independently furnished completely by the assistant or furnished "in part" by an assistant if more than 10% of that service unit was independently furnished by that assistant (per the "de minimis" threshold).

Additionally, we believe that CMS' proposed application of the 10% "de minimis" standard when the therapist assistant and the therapist each separately furnish portions of the same service is in *direct conflict* with CMS' response to comments in the 2019 PFS Final Rule (83 FR 59452) in which the agency outlined its policy regarding application of the modifier when the therapist and therapist assistant furnished portions of the same service.

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

Commenters on the 2019 PFS proposed rule "recommended that CMS allow for reporting of the same code, on the same day, for the same beneficiary on 2 different claim lines to distinguish between those code units furnished by a therapist and those furnished by an assistant in reference to the 15-minute timed intervention codes and the group therapy code (CPT code 97150)."[2] CMS responded, stating it wished to offer clarification to commenters' concerns and alternatives. CMS proceeded to explain that its claims processing system allows for the differentiation of the same procedure code on different line items and provided an example of how the CQ/CO modifier policy would apply when the same service was furnished separately by the therapist and assistant, noting that the units furnished by the therapist assistant for the procedure code would be billed on the claim line with the modifier for the therapist assistant's services, and the units furnished by the therapist for the same procedure code would be billed on another claim line without the therapist assistant modifier.

Specifically, CMS stated:

> We offer clarification on some of the commenters' concerns and alternatives, as follows… CMS claims processing systems already allow, when not constrained by other policies such as Medically Unlikely Edits (MUEs), the same procedure code to be reported on two different claim lines as long as there is a different modifier used to uniquely identify the service and prevent the service from being considered a duplicate. For example, if a therapy assistant furnished one unit (15 minutes) and the therapist furnished 2 units (30 minutes) of the same procedure code that is defined to be billable in 15-minute increments, one unit of the procedure code would be billed on the claim line with the modifier for the therapy assistant's services and two units of the procedure code would be billed on another claim line without the assistant modifier.[3]

It appears in this proposed rule that the agency is contradicting last year's Final Rule and is now proposing to require that the CQ/CO modifier apply when the minutes furnished by the assistant are greater than 10% of the total minutes—the sum of the minutes spent by the therapist and therapist assistant for that service, thereby *not* allowing for the same procedure code to be reported on 2 different claim lines.

We believe that the proposed policy do not make sense and will result in unintended consequences that will hurt beneficiaries. First, the proposed policy could create access barriers for beneficiaries with conditions such as morbid obesity, stroke, and post-surgical who require direct care from two therapy clinicians simultaneously. In addition, the proposed policy creates a perverse incentive for unsafe clinical practices if therapists are financially penalized for seeking to use assistants as a "second set of hands" to achieve optimal clinical outcomes or to assure patient safety during the treatment.

Our final major concern is related to administrative burden. **CMS is proposing that the outpatient therapy provider be required to add a statement in the medical record for *each* line of *every* claim to explain why the CQ/CO modifier was *used* or *not used*, even if the provider does not even employ therapy assistants.** We believe that the proposed documentation requirements conflict with the Agency's efforts to place "patients over paperwork". Current policies already require extensive documentation and further notation would be redundant to the application of the modifier itself (see Medicare Benefit Policy Manual

[2] CY 2019 PFS Final Rule p. 59659 https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf
[3] *Id.*

Chapter 15, Section 220.3, particularly subsection E). We believe that if a provider has a mechanism to provide evidence whether a specific service was furnished independently by a therapist or an assistant, or was furnished "in part" by an assistant in sufficient detail to permit an auditor to determine whether the "de minimis" threshold was met, the provider should not also be required to separately document this information in a narrative note.

Over the past year, AHCA along with numerous other stakeholders have worked diligently—through comment letters as well as numerous meetings with CMS staff—to advocate for application of the 10% *de minimis* standard in such a way that will continue to allow outpatient therapy providers to deliver high-quality care to their patients with minimal administrative and financial disruptions. **We do not believe that the proposed provisions related to the application of the CQ/CO modifier when outpatient physical therapy and occupational therapy services are furnished in whole or in part by a therapy assistant reflect appropriate consideration of stakeholders' concerns and recommendations.**

AHCA Recommendations:
We ask the Secretary to not finalize these policies as proposed. Instead, we are requesting that CMS, in finalizing the therapy assistant adjustment provisions of Section 1834 of the BBA, implement the following policy:

6. **That for this policy CMS define the clinical scenario where a therapist and a therapy/therapist assistant are jointly furnishing services to a patient at the same time by using the term "in tandem" and not use the term "concurrent".**
7. **When a therapist and assistant are jointly furnishing services to a patient at the same time "in tandem", and the therapist is fully engaged in the service during that time, the service during that time period should be identified as a therapist's services and be allocated to the therapist.**
8. **That CMS define "in whole or in part" to mean skilled therapy service <u>unit</u> furnished by a PTA or an OTA that is furnished under the supervision of a therapist, but <u>independent</u> of any time the therapist is furnishing the service.**
9. **Consistent with the CY 2019 final rule CMS statements described above, that only those <u>units</u> of services provided "in whole or in part" by the assistant should be subject to the 10% de minimis standard, the CQ/CO modifier, and subsequently the 15% payment adjustment, not all <u>units</u> of the entire therapy service.**
10. **That no new burdensome documentation requirements be added. At a maximum, sub regulatory guidance could be revised to include a statement such as "*The provider should have a mechanism in place to provide evidence whether a specific service was furnished independently by a therapist or an assistant, or was furnished "in part" by an assistant in sufficient detail to permit the determination of whether the "de minimis" threshold was met.*"**

III. Estimated Specialty Level Impacts of Proposed E&M Payment and Coding Policies if Implemented for CY 2021 - Table 111 (NPRM section VI.C.2.c) 84 FR 40886

We have serious concerns with the CMS proposal to impose significant arbitrary payment cuts for therapy services in 2021. **As reflected in Table 111 of the proposed rule, physical therapy and occupational therapy services would see a combined impact of negative eight percent in CY 2021. The cuts, if finalized, will cause a serious financial strain on outpatient therapy providers in all settings.**

Medicare margins for therapy services in all settings are already low and have challenged the sustainability of providers. For example, **a March 2019 Medicare Payment Advisory Commission Report to Congress indicated that the all-in margin for SNFs across all payers, including outpatient therapy services under the Part B benefit, was only 0.5 percent[4].** Absorbing an arbitrary eight percent cut to outpatient therapy services will only reduce these razor-thin margins further. **It is critical that CMS reimburse outpatient physical therapy providers at a level that will continue to allow them to deliver high-quality care to their patients.**

We acknowledge that CMS must maintain budget neutrality with the fee schedule. However, we do not believe CMS has thoroughly considered the work and practice expense (PE) requirements for outpatient therapy providers. In fact, **the proposed rule provided no detailed analysis whatsoever to justify that the proposed cuts would not result in payments that are lower than provider costs to furnish such services.**

Medicare outpatient therapy providers are already stretched to the limits. Between 2011 and 2020, CMS has put forward reimbursement changes for physical/occupational therapy that ranged between -5% to +4%, whereas, during that same time period, CMS put forward reimbursement changes for specific physician specialties, such as family practice and general practice, that ranged between 0% to +7%.

Specifically, the proposed drastic arbitrary and across the board payment cut, which, if implemented, would be in addition to the current 2% sequestration reduction, thereby amounting to a 10% cut in reimbursement. This 10% reduction is in addition to the recently implemented 50% multiple procedure payment reduction (MPPR) policy for the practice expense (PE) relative value units (RVUs) for "always therapy" services and national correct coding initiative (NCCI) edits that impose a significant penalty on code combinations that represent standard and necessary care.

For 2021, while CMS proposes to impose an eight percent payment cut for outpatient therapy services, physician services in general practice and family practice specialties will experience an 8% and 12% increase in reimbursement, respectively. Additionally, it is not apparent that CMS considered the impacts of the statutory therapy service reimbursement cuts already scheduled to

[4] Medicare Payment Advisory Commission; March 2019 Report to Congress: Medicare Payment Policy; Chapter 8: Skilled Nursing Facility Services, page 219. http://www.medpac.gov/docs/default-source/reports/mar19_medpac_ch8_sec.pdf?sfvrsn=0

be implemented in CY 2022 as part of the implementation of the therapy assistant 15% payment adjustment discussed in Section II.M of the proposed rule (and discussed in depth above in Section II of these comments).

Considering the magnitude of the cuts proposed in this rule for 2021, it is essential for CMS to ensure that the process it uses to develop policies is transparent and that decisions are based on accurate information. The information provided in the rule is very limited and does not provide enough information regarding the data and analysis used to determine the cuts to specialty providers. CMS is proposing these cuts to specialty providers, including physical and occupational therapists, without seeking the input of any health care professionals and providers who furnish outpatient therapy services. Further, CMS has offered no explanation regarding how the agency may redistribute the cuts across the code set used by therapy professionals.

Because the national associations representing the therapy professions, including the American Physical Therapy Association (APTA), American Occupational Therapy Association (AOTA), and American Speech-Language-Hearing Association (ASHA) are extensively involved in the establishment and valuation of most of the Current Procedural Terminology (CPT) codes billed by therapists through the CPT, RVS Update Committee (RUC), and Practice Expense (PE) Subcommittee process, and the fact that just recently CMS implemented revised pricing for therapy service procedures based on the formal transparent procedures established by CMS, we find it disturbing that CMS apparently ignored this recent code valuation and furthermore, did not contact these organizations to obtain further clarification regarding the provision therapy services and the current state of physical and occupational therapist and speech-language pathologist practice. **Given the absence of any input from health care professionals who furnish these therapy services, it is apparent that CMS may have made flawed assumptions regarding practice that impacted the results reported in Table 111 of the proposed rule.**

For example, PE values should align with current therapist practice. The RVUs for PE are based on the expenses that providers incur when they purchase/rent clinic space, buy supplies and equipment, and hire nonphysician clinical and administrative staff. Physical therapy providers must purchase numerous types of equipment, including treatment tables, body-weight-support systems, transfer slings, exercise bikes, and/or parallel bars, and treatment modalities including electric muscle stimulation and ultrasound. **We oppose the proposed arbitrary reductions to the PE value.**

We believe that in the long run, the proposed significant arbitrary reduction therapy service payment rates will result in a decreased workforce and an inability to meet the needs of the Medicare population. Resultant shortages in therapy clinician workforce would be problematic as the demographic trends indicate a significant growth in Medicare-eligible individuals seeking access to services.

AHCA Recommendations:
We ask the Secretary to not finalize the proposed E&M payment and coding policies in a manner that would result in the arbitrary across-the board eight percent cut to outpatient therapy service payments. Instead, we are requesting that:

3. **CMS defer any decision regarding CY 2021 pricing of procedures for services furnished by physical and occupational therapists and speech-language pathologists pending the completion of the following activities:**
    a. **That CMS follow established transparent policies, including involvement of the therapy professionals furnishing outpatient therapy services in validating that the proposed pricing of therapy service procedures adequately reflects the provider's costs for furnishing such services.**
    b. **That this pricing activity consider the adequacy of payment rates to at least cover costs based on the cumulative effects of other recent CMS cost-containment strategies that impact the pricing for these procedures including; 1) the ongoing two percent sequestration adjustment, 2) the 50% multiple procedure payment reduction (MPPR) policy, and 3) the national correct coding initiative (NCCI) edits.**
    c. **That this pricing activity consider the adequacy of payment rates to at least cover costs beginning in CY 2022 based on the implementation of the 15% cut to "services furnished in whole or in part" by a therapy/therapist assistant.**
4. **CMS consider alternative approaches to achieving budget neutrality by:**
    a. **Redistributing practice expense adjustments across health care services/providers that do not have demonstrable costs for equipment and supplies.**
    b. **Establishing a floor to the magnitude of negative adjustments so that no individual procedure is priced lower than the provider costs for furnishing such services that were established during the most recent CPT, RUC, and PE Subcommittee process.**
    c. **Phasing in any budget neutrality cuts across multiple years rather than applying a drastic cut in a single cycle.**

IV. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (Section II.F.) 84 FR 40517

AHCA appreciates the Secretary's continued focus on telehealth services in the Medicare program. However, we believe that the current telehealth policies, including those enhancements included in this proposed rule continue to overlook the opportunities to improve beneficiary access to cost-effective care and reduce overall Medicare expenditures by applying inconsistent access across PAC settings and in all geographic locations, as well as by not including PT, OT, and SLP rehabilitation professionals among the list of covered telehealth professionals.

Under Medicare, telehealth services have proven to be a beneficial treatment option for millions of Americans in their home and in facilities. Specifically, telehealth services offer broader patient access to address emergent and some ongoing health care needs in situations where a physician is unavailable to render face-to-face care. **With appropriate telehealth technology, remotely located physicians can assess and order treatment interventions that could stabilize or resolve a health issue, avoiding the disruption and costs associated with a preventable hospital admission.**

Section 149 of the MIPPA (P.L. 110-275) added SNFs as telehealth originating sites effective for services on or after January 1, 2009. **However, the CMS has promulgated regulations that have severely limited the potential benefit of telehealth services to SNF residents.** While Congress, through MIPPA and the IMPACT Act of 2014 (P.L. 113-185) seek to improve SNF telehealth access and standardize quality measurement across settings to facilitate innovative care delivery models, CMS continues to impose setting-specific regulatory barriers to achieving these results. The telehealth provisions authorized by §1834(m) of the Act are implemented in 42 CFR 410.78 and 414.65, and further detailed in the Medicare Claims Processing Manual, Chapter 12, Section 190.

Since the inception of the introduction of SNF telehealth coverage under the Medicare benefit effective calendar year 2011, beneficiary access to telehealth services for SNF residents has been arbitrarily and severely restricted by CMS regulations. Notably, in the CY 2011 Physician Fee Schedule Final Rule (75 FR 73317-73318 and 73615), CMS placed a "… limitation of one telehealth visit every 30 days by the patient's admitting physician …", while the limitation is only once every three days for inpatient hospitals and other post-acute care provider settings, including Inpatient Rehabilitation Facilities (IRF) and Long-Term Care Hospitals (LTCH) (see 75 FR 73317-73318 and 73615) . **This restriction on telehealth access to SNF residents is a barrier to aligning PAC care delivery and the success of several physician and SNF value-based payment (VBP) initiatives, including the recently implemented SNF VBP program that seeks to reduce avoidable hospital readmissions, as well as the various PAC Quality Reporting Programs (QRPs) implemented in response to the IMPACT Act.**

Aligning the physician telehealth frequency limitations across PAC settings, particularly in rural and underserved locations, would provide the physician and the SNF another valuable tool to evaluate a patient's status and make clinical decisions that could reduce the risk negative health outcomes. We note that a majority of SNF patients, particularly long-stay residents, present with multiple chronic conditions. **As recently as August 12, 2016, in a Report to Congress, the Secretary stated that "*Telehealth appears to hold particular promise for chronic disease management…Ensuring ready access to care for such individuals may help avert costly emergency room visits or hospital stays*[5]."**

Since the SNF telehealth limitations were first implemented in CY 2011, there have been dramatic improvements in available telehealth technology as well as availability of recent evidence-based research demonstrating improvement in care, including reductions in hospitalizations and healthcare costs associated with innovations in telehealth services to address emergent health conditions. **However, despite these points, CMS has not revisited the SNF telehealth limitations in fee schedule rulemaking since the CY 2014 Final Rule (78 FR 74399).** We believe the time to revisit this arbitrary regulatory limitation to access to telehealth services in SNF is long overdue.

It is within the CMS regulatory authority to standardizes the SNF telehealth visit limitations so that they shall be identical across all PAC provider settings. Such a provision would not eliminate mandatory SNF face-to-face visits, but instead would permit flexibility to

[5] Department of Health and Human Services, Office of Health Policy, Office of the Assistant Secretary for Planning and Evaluation (ASPE). *Report to Congress: E-Health and Telemedicine.* August 12, 2016.

address emergent situations when the physician/practitioner is not physically able to be in the SNF (e.g. nights/weekends/office hours).

Another notable and important barrier to the effective use of telemedicine to avoid hospitalizations involves the statutory restriction of the benefit to rural and underserved geographical areas. Most SNF residents are in facilities that do not qualify, even though the need and opportunity is enormous, particularly during nights and weekends.

Finally, while the current statutory list of covered telehealth providers does not include physical and occupational therapists as well as speech-language pathologists, we believe that recent enhancements in telehealth technology and therapist practice have demonstrated the benefits of these services in improving clinical outcomes and reducing preventable hospitalizations.

AHCA Recommendations Related to Telehealth

- **AHCA recommends that CMS standardizes the SNF telehealth visit limitations for SNF and PAC provider settings to "once every three days" so that they shall be identical across all PAC provider settings.**
- **AHCA recommends that CMS investigate opportunities to expand the access to telehealth services to providers that are currently ineligible to furnish these services due to current statutory rural and underserved areas limitations.**
- **AHCA recommends that CMS investigate opportunities to include physical therapists, occupational therapists, and speech-language pathologists as covered telehealth providers.**

Thank you for the opportunity to comment on the CY 2020 Medicare Physician Fee Schedule and proposed rule.

Sincerely,

Daniel E. Ciolek, PT, MS, PMP
Associate Vice President, Therapy Advocacy