September 6, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W. Room 445-G
Washington, DC 20201


Dear Mr. Slavitt:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) is the nation’s largest association of long term and post-acute care providers with more than 12,000 members who provide care to approximately 1.7 million residents and patients every year. We appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services’ (CMS) proposed rule to revise the CY 2017 physician fee schedule and other revisions to Part B.

Our comments begin on the following page and are organized according to sections as laid out in the proposed rule. We look forward to ongoing collaboration with CMS to implement thoughtful, common-sense policies that allow skilled nursing providers to continue delivering high-quality care to beneficiaries.

Should you have any questions regarding our comments, please contact Daniel E. Ciolek, Associate Vice President of Therapy Advocacy, at dciolek@ahca.org or 202-898-3174.

Sincerely,

Michael. W. Cheek
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A. Evaluative Procedures for Physical Therapy and Occupational Therapy (CPT Codes 97X61, 97X62, 97X63, 97X64, 97X65, 97X66, 97X67, 97X68) – pages 46256-46259

Background
As described in the proposed rule, effective January 1, 2017, the American Medical Association (AMA) Current Procedural Terminology (CPT) editorial panel deleted four CPT codes that described physical therapy (PT) and occupational therapy (OT) evaluations and re-evaluations (97001-97004) and created eight new CPT codes (97X61-97X68) to more precisely describe the evaluative procedures furnished for PT and OT. With the retirement of codes 97001-97004, it is necessary for CMS to identify codes that can be billed under Medicare Part B for PT and OT evaluations under the Medicare Physician Fee Schedule (MPFS) beginning January 1, 2017, as well as determine the values for such codes. In the proposed rule, CMS discusses the recommendations of the AMA Health Care Professional Advisory Committee (HCPAC) regarding the relative values that should be assigned to each of these new PT and OT evaluation and reevaluation codes so that they are work neutral and budget neutral.

In this NPRM, CMS is proposing the following:

1. **CMS proposes to adopt the new PT and OT evaluation CPT codes (97X61-97X68) for use in Medicare, effective January 1, 2017.** (p.46257)

   The CMS stated rationale for adopting the new CPT codes rather than creating Medicare G-codes to report PT and OT evaluations and re-evaluations is to preserve consistency in the code set across all payers and lessen the burden on providers.

   **AHCA Comment: AHCA supports the adoption of the new PT and OT evaluation CPT codes.**

   AHCA agrees that coding for PT and OT evaluations across all payers should be consistent. We agree that creating G-codes for PT and OT evaluations that have different definitions than CPT codes used for all other payers would be extremely burdensome for providers, and could result in avoidable billing errors.

2. **CMS proposes to reject the AMA HCPAC valuation recommendations, and instead price the services described by the stratified PT and OT evaluation codes as a group instead of individually.** (p.46257)

   The CMS stated rationale for rejecting tiered pricing for the three new PT and three new OT evaluation codes was that there is insufficient information available to adequately determine whether the assumed usage of each of the low-, moderate-, and high-complexity evaluation codes would be accurate. CMS states that the codes
would not be work neutral or budget neutral if actual utilization differs from that predicted by the HCPAC. Additionally, CMS voiced concerns that stratified pricing could also incentivize upcoding to a higher complexity level. CMS cited provisions of the Protecting Access to Medicare Act (PAMA) to justify this proposed approach. CMS also requested that stakeholders submit objective data to support stratified pricing.

**AHCA Comment:** AHCA believes that stratified evaluation pricing better reflects patient-centered needs is preferred over the proposed group pricing. However, if CMS proceeds with group pricing as proposed, AHCA strongly recommends that CMS implement this only as “temporary” group pricing for the new stratified PT and OT evaluation CPT codes, and only if CMS stipulates a plan to quickly transition to stratify the PT and OT evaluation pricing in future rulemaking.

AHCA is disappointed that CMS did not propose to adopt stratified pricing for the new PT and OT evaluation codes. AHCA strongly believes that a rapid transition to stratified pricing of PT and OT evaluations is necessary and consistent with the CMS triple aim and the concept of patient-centered care. While CMS voices concerns about potential incentives for upcoding, the proposed “one-size-fits-all” pricing creates a strong disincentive to provide necessary services to patients with complex care needs.

If CMS proceeds with the group pricing proposal, AHCA recommends that CMS identify this as a “temporary” pricing approach. AHCA recommends that CMS begin analyzing the usage patterns of these new codes as they begin to be submitted on Medicare claims on January 1, 2017 so that accurate real-world usage can be used to resolve the stated concerns surrounding the HCPAC assumptions impacting work and budget neutrality. We recommend that this analysis include patient sub-populations to identify characteristics of beneficiaries that are more likely to receive low or high complexity evaluations as well as the settings where these patients receive care. CMS should assure that the AMA HCPAC cost estimates are representative of all settings, including SNF, that furnish Medicare Part B PT and OT services under the MPFS. Results should be shared with stakeholders in a timely and transparent manner.

AHCA also recommends that CMS establish a specific process and target date to transition from the “temporary” group price to stratified pricing for the new PT and OT evaluation CPT codes, and that any AMA HCPAC recommendations and supporting data that is submitted to CMS under the recently revised “Process for Valuing New, Revised, and Potentially Misvalued Codes” is shared with the public for review prior to publication of the proposed rule. In addition, AHCA recommends that during this time, CMS meet stakeholders to identify approaches, including provider education, to address CMS concerns about potential upcoding incentives prior to the implementation of stratified evaluation pricing.

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1 80 Federal Register 70932.
3. CMS proposes to reject AMA HCPAC valuation recommendations, and instead maintain the same work values for PT and OT evaluations and re-evaluations.

CMS proposes to apply the same historical work Relative Value Unit (RVU) of 1.20 for both the new PT and OT evaluation groups of services, which is identical to the values of the PT and OT evaluation CPT codes 97001 and 97003 that are being retired in 2016. The historical RVU values being proposed were similar to the HCPAC recommended values for the new Moderate Complexity evaluation codes. CMS also proposes to apply the traditional PT and OT re-evaluation code RVU value of 0.60 that was used for the soon-to-be retired codes 97002 and 97004 to the new PT and OT re-evaluation CPT codes. CMS rejected the HCPAC recommendation to significantly increase the RVUs for PT and OT re-evaluations citing work neutrality concerns.

AHCA Comment: AHCA recommends that PT and OT evaluation and re-evaluation code values reflect the complexity of the work associated with patient-centered characteristics.

AHCA believes that that the historical value assigned to the complexity of the work necessary to perform PT and OT evaluations has not been distributed appropriately in a patient-centered manner, and that the and re-evaluation payments have been insufficient. Evaluations and re-evaluations play a necessary and important role in the outpatient therapy plan of care and the concept of work neutrality should not be held within the context of an individual therapy code, but would be better served within the context of all codes used to describe the scope of therapy services. Because we believe the AMA HCPAC code value development process has not been historically transparent, and may not adequately represent the delivery of Medicare Part B PT and OT services in facility-based providers including SNF, AHCA recommends that CMS share the AMA HCPAC recommendations and supporting data with the public for review as soon as possible prior to the publication of the proposed rule.

4. CMS requested comments on implementation issues related to the new PT and OT evaluation and re-evaluation codes.

AHCA Comment: AHCA recommends that CMS work with provider and beneficiary stakeholders as well as CMS payment contractors to update Medicare manuals, Local Coverage Decision (LCD) policy, billing and payment systems, and develop and disseminate educational resources related to how clinicians should use the new codes to report PT and OT evaluations and re-evaluations.

AHCA recognizes that the process of replacing the four current PT and OT evaluation and re-evaluation CPT codes (97001-97004) with eight newly established codes (97X61-97X68), effective January 1, 2017, represents a significant change. In particular, the introduction of International Classification of Functioning, Disability and Health (ICF) terminology within the new evaluation code definitions may create
confusion to therapists as such terminology has not seen widespread use to date in the Medicare program. A coordinated education effort will be essential for a successful implementation, and AHCA recommends the following.

First, AHCA recommends that CMS meet with the provider community representing all settings the furnish Part B PT and OT services under the Medicare Physician Fee Schedule as soon as possible to develop standardized educational materials disseminated through the CMS Medicare Learning Network (MLN), CMS Open Door Forums (ODF), Medicare Administrative Contractor (MAC) provider outreach web sites/publications, and beneficiary outreach vehicles including the [www.medicare.gov](http://www.medicare.gov) website and the 1-800-Medicare call center.

Second, AHCA recommends that CMS, through publicly available program transmittals, instruct the MACs to update their claim processing systems and LCDs affected by the transition to the new PT and OT evaluation and re-evaluation codes in a timely manner so that providers have clear direction regarding when and how to use these new codes.

Third, if CMS proceeds with the proposed group pricing approach for the PT and OT evaluations, AHCA recommends that CMS direct review contractors to allow payment for the new evaluation codes if the documentation supports payment for any evaluation code included in the PT or OT evaluation payment group.

B. Potentially Misvalued Therapy Codes – page 46259

**Background:**

In the proposed rule, CMS summarized the statutory and regulatory background of efforts at identifying potentially misvalued services and implementing corrective actions towards assuring that the relative value units (RVUs) of the procedure codes are updated in a transparent and timely manner. As required by law, CMS listed ten codes that account for the majority of therapy spending under the MPFS. These codes are: 97032, 97035, 97110, 97112, 97113, 97116, 97140, 97530, 97535, and G0283. CMS did not propose any specific changes to the code values at this time, and acknowledged that the therapy specialty organizations are pursuing the development of coding changes which may take several years.

1. In this NPRM, CMS has requested information regarding the appropriate valuation of the existing 10 therapy modality and procedure service codes.

**AHCA Comment:** AHCA continues to support CMS efforts at identifying appropriate valuation of services as long as the process is transparent and all stakeholders are adequately represented in the process.

Due to the ongoing AMA work with therapy specialty organizations on revising codes commonly used to describe outpatient therapy services, AHCA recommends that CMS defer consideration of revising the physician work and direct practice expense inputs components of the current procedures as they may be significantly
modified in the near future. Efforts to reprice existing codes that will soon be replaced would further delay the development process of the replacement codes that would better describe the service.

However, if CMS decides to pursue reviewing this list of common outpatient therapy codes for potential revaluation, AHCA recommends that the impact of the Multiple Procedure Payment Reduction (MPPR) policy is considered and mitigated so that rehabilitation service providers are not subject to a double-hit on practice expense (PE) PE cuts with any proposed revaluation. Because we believe the AMA procedure code and code value development processes have not been historically transparent, and may not adequately represent the delivery of Medicare Part B therapy services in facility-based providers including SNF, AHCA recommends that CMS share the AMA HCPAC code value recommendations and supporting data with the public for review as soon as possible prior to the publication of the proposed rule.

C. Medicare Telehealth Services – pages 46179-46184

Background:
In the proposed rule, CMS summarized the statutory and regulatory background of efforts regarding Medicare coverage of telehealth services and how services could be added to the list of covered telehealth services.

1. In this NPRM (p. 46184), CMS is rejecting a request to add a number of rehabilitation therapy service codes to the list of covered telehealth services.

CMS discusses requests received to add several procedure codes commonly used to describe PT, OT, and speech-language pathology (SLP) services to the list of covered telehealth services. These codes are: 92507, 92508, 92521, 92522, 92523, 92524, 92526, 92610, 97001, 97002, 97003, 97004, 97110, 97112, 97116, 97532, 97533, 97535, 97537, 97542, 97750, 97755, 97760, 97761, and 97762. CMS dismissed identifying these codes as covered telehealth services for two reasons; 1) the codes are most commonly furnished by PT, OT, and SLP practitioners, and 2) PTs, OTs, and SLPs are not explicitly included in the list of authorized telehealth practitioners under section 1834(m)(4)(e) of the Social Security Act, as defined in section 1842(b)(18)(c).

AHCA Comment: AHCA recommends that CMS establish a demonstration program to evaluate the clinical benefit of physical and occupational therapists and speech-language pathologists furnishing telehealth services to Medicare beneficiaries.

AHCA recognizes that current Medicare statute does not explicitly identify rehabilitation therapists from furnishing 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 in healthcare delivery models, including Medicare 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 rehabilitation therapy services, particularly in underserved areas, can potentially have a dramatic impact on improving care and reducing negative consequences and costs of care. In the SNF setting, telehealth therapy services in underserved areas may make the difference in preventing falls, functional decline, and costly emergency room visits, and hospital admissions/readmissions.

AHCA recommends that CMS use its authority under the Center for Medicare & Medicaid Innovation (CMMI) to conduct a demonstration to evaluate the clinical benefit of physical and occupational therapists and speech-language pathologists furnishing telehealth services to Medicare beneficiaries in all settings, including SNF – in those states that permit such services. The results of such a demonstration on the Medicare population would help inform policymakers considering whether to include PTs, OTs, and SLPs as authorized practitioners of telehealth services.

2. In this NPRM, CMS is silent about SNF telehealth frequency limitations.

AHCA Comment: AHCA strongly recommends that CMS reconsider a request to remove the arbitrary limitation of one telehealth subsequent nursing facility care visit every 30 days reported by CPT Codes 99307 through 99310.

AHCA believes that arbitrary restrictions of beneficiary access to necessary services are inappropriate, suppress innovative care models, and can lead to negative unintended health consequences to beneficiaries. In the CY 2014 Final Rule, CMS stated

"We are not persuaded by the information submitted...that it would be beneficial or advisable to remove the frequency limitation we established for SNF subsequent care when furnished via telehealth. Because we want to ensure that nursing facility patients with complex medical conditions have appropriately frequent, medically reasonable and necessary encounters with their admitting practitioner, we continue to believe that it is appropriate for some subsequent nursing facility care services to be furnished through telehealth. At the same time, because of the potential acuity and complexity of SNF inpatients, we remain committed to ensuring that these patients continue to receive in-person, hands-on visits as appropriate to manage their care. Therefore, we did not propose any changes to the limitations regarding SNF subsequent care services furnished via telehealth for CY 2014 (78 FR 74403),

However, AHCA contends that the clinical benefit has already been established with the adoption of SNF telehealth coverage in the CY 2011 Final Rule (75 FR 73317 through 73318), and the absence of any credible evidence of compromised care since the implementation has demonstrated that physicians and SNF providers have been judicious in the application of the regulation.

Furthermore, since CMS last reviewed this restriction in the CY 2014 rule, both physician and SNF accountability for quality of care has increased significantly through the implementation of various value-based purchasing (VBP) programs that provide
incentives/penalties for quality and resource use outcomes including rehospitalization rates, and Medicare spend per beneficiary. Other programs including the Bundled Payments for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR) bundled payment programs include similar incentives for physicians and SNFs to be innovative and to better coordinate care in a more cost-effective manner.

Eliminating SNF telehealth frequency limitations for admitting physicians, particularly in rural 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. In particular, we note that a majority of SNF patients, particularly long-stay NF 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”[1].

We assert that the current arbitrary limitation on telehealth frequency for subsequent SNF services is counterintuitive, and creates artificial administrative barriers to the successful implementation of such beneficiary-centered initiatives. Today, in many cases, SNFs with beneficiaries that do not have a physician immediately available for a face-to-face visit, may have no other recourse than to transfer the patient to a hospital for emergency evaluation or admission. A telehealth subsequent nursing facility care visit could result in effective care plan changes that would negate the need for the patient to be transferred for a hospital for observation care or an admission.

AHCA urges CMS to seriously reconsider prior decision, and instead either eliminate the SNF telehealth frequency limitation, or at least relax the limitation and study whether the revised policy negatively impacts care.

D. SNF 3-Day Rule Waiver Beneficiary Protections in the Medicare Shared Savings Program (MSSP) – pages 46437-46441

Background:
CMS is proposing two policies that aim to protect beneficiaries from unexpected out-of-pocket expenses under certain scenarios in which the CMS waiver of the SNF 3-day rule is being used by participants in Track 3 of the MSSP ACO program. The SNF 3-day waiver, for application in the MSSP model, was finalized in a June 2015 final rule (80 FR 32804-32806). Each proposal is addressed below:

1. CMS is proposing a 90-day grace period that functionally acts as an extension of beneficiary eligibility of the SNF 3-day waiver

Beneficiaries may only be assigned to a Track 3 MSSP ACO if they are enrolled in both Medicare Part A and Part B. CMS describes the relatively rare situation where a

beneficiary is prospectively assigned to a Track 3 MSSP ACO (through the track’s unique prospective assignment methodology rather than the more typical retroactive alignment), but who, for whatever reason, becomes dis-enrolled from Medicare Part B (usually for lack of payment of the monthly premium payment). In these rare instances, CMS is proposing a grace period of 90 days that would act as an extension of the beneficiary’s eligibility for the waiver even if they technically should fall out of alignment with the ACO. CMS is presuming this will allow them enough time to provide an updated list of waiver-eligible beneficiaries to the ACO.

AHCA Comment: AHCA supports CMS’ proposal for a 90-day grace period in these rare circumstances, so long as there is not a delay in regularly providing the ACO with an accurate list of beneficiaries who are enrolled in the ACO. A grace period would become ineffective if CMS/CMMI is unable to provide a timely, accurate Track 3 beneficiary lists to the ACOs.

2. CMS is proposing a rule that no payment be made to a SNF who, knowingly or unknowingly, admits an ACO beneficiary who does not have a 3-day qualifying inpatient stay, and who is also, for whatever reason, ineligible for the SNF 3-day waiver. In these instances, CMS would not allow the SNF to bill the patient directly for the non-covered services.

AHCA agrees with CMS that patients should not be subjected to unexpected, out-of-pocket medical bills for services that are widely presumed (by both the patient and the providers) to be covered under the Medicare benefit. AHCA also appreciates CMS’ continued and ongoing efforts to test waivers of the SNF 3-day rule that afford providers the flexibility to redesign care in a way that meets the goals of the triple aim, benefitting both patients and providers. However, we have very grave concerns over CMS’ proposal to hold a SNF solely accountable for a breach in communication with an ACO over which the SNF has absolutely no control.

As stated in this proposed rule, the SNF 3-day waiver will be available for use by ACOs to refer Track 3-assigned beneficiaries to a SNF for post-acute care without having a qualifying 3-day inpatient stay in a short-term acute care hospital. One of the requirements under this rule is that the SNF must have a “SNF Affiliate Agreement” with the ACO as codified in § 425.612(a)(1) of the Act. The ACO must apply for the waiver from CMS, and CMS must individually approve each ACO’s application. CMS will regularly provide to the ACO an up-to-date list of Track 3-assigned beneficiaries who are eligible to be admitted to a SNF under the 3-day waiver.

Under the current construct of the program, CMS determines which beneficiaries are eligible to use the waiver and provides a list of those beneficiaries to the ACO. So presumably, at any given time, both the ACO and CMS should know precisely which beneficiaries can be admitted to a SNF affiliate under the waiver. However, there is nothing outlined in current program rules and policies that would guarantee that SNF affiliates also have access to this same information. While the SNF may verify general Medicare coverage eligibility through the Common Working File, they must rely upon the good faith of the hospital of the ACO to provide accurate information regarding a
beneficiary’s eligibility to be admitted to the SNF affiliate under the waiver. Therefore, AHCA believes it makes little sense to hold the SNF solely accountable for the validity and accuracy of information to which they do not have independent access.

AHCA Comment: AHCA believes strongly that CMS should not withhold payments to SNFs for claims where a MSSP ACO Track 3 beneficiary was admitted under a 3-day waiver because of information received in good faith from an ACO referring hospital, but which the SNF cannot independently verify.

AHCA believes CMS should explore policies which would give SNF affiliates independent access to beneficiary waiver eligibility information that they could access prior to admission to verify if a beneficiary truly does meet eligibility requirements for the waiver. For example, CMS could make it a requirement in SNF affiliate agreements that the ACO provide all SNF affiliates with timely, accurate lists of Track 3 waiver eligible beneficiaries. Alternatively, CMS could integrate this information into the Common Working File so that SNFs may independently verify a beneficiary’s eligibility under the waiver. AHCA stands ready to work with CMS staff to develop sensible policies that do not unfairly penalize SNFs who are working in good faith with ACOs to achieve the program’s goals to lower Medicare cost growth while improving quality outcomes.

E. Release of MA Plan Bid Pricing Data and Medical Loss Ratio (MLR) Data – pages 46455-46456

Background:
Under the proposed rule, CMS would release on an annual basis Medicare Advantage (MA) and Part D data that has historically considered to be proprietary and confidential. Specifically, CMS proposes to release to the public Medicare Advantage (MA) bid pricing data and medical loss ratio (MLR) data. Bid pricing data includes the estimated revenue required by an MA plan for providing original Medicare benefits and mandatory supplemental benefits, plan pricing of enrollee cost-sharing for original Medicare benefits and mandatory supplemental benefits, actuarial bases for bid amounts, and projected enrollment. MLR data demonstrates the proportion of plan revenue used for patient care rather than for such other items as administrative expenses or profit. CMS indicates that making this data publicly available will help ensure accountability, and will assist public research/future policymaking, and will inform beneficiaries making enrollment decisions. The MA bid pricing data would be at least five years old and would exclude information treated as proprietary.

AHCA Comment: AHCA supports CMS’ proposal to release MA bid pricing data and MLR data, and we encourage CMS to narrow the window of the five-year delay to ensure that the data and analyses resulting from the data released are relevant and timely for purposes of policy development and evaluation.

F. Medicare Advantage Provider Enrollment – pages 46409-46412
Background
Under the proposed rule CMS would require providers and suppliers that contract with MA organizations to also be enrolled as approved Medicare providers and suppliers through the Provider Enrollment, Chain, and Ownership System (PECOS) as is currently required for Medicare fee-for-service (FFS) payment. In the proposed rule, CMS states “This proposal would create consistency with the provider and supplier enrollment requirements for all other Medicare (Part A, Part B, and Part D) programs” (p. 46411). The stated intent of the proposed rule would assist CMS efforts at preventing fraud, waste and abuse and protect Medicare enrollees.

AHCA Comment: AHCA requests clarification that the proposed MA organization provider and supplier enrollment requirement does not extend to employees and contracted services furnished through properly enrolled and approved Medicare providers of service, including skilled nursing facilities (SNFs).

AHCA supports CMS’ ongoing efforts at protecting Medicare beneficiaries and the Medicare program from fraud, waste and abuse. We support the intent of the proposed CMS requirements to hold MA organizations accountable to the same program integrity and quality accountability standards as are required in the Medicare FFS programs. However, we seek clarification to assure that the proposed requirements do not add MA provider enrollment burdens that extend beyond the current FFS enrollment process requirements.

In particular, under current Medicare FFS provider enrollment requirements, SNFs enroll and are identified as providers under the PECOS system. SNF Medicare FFS billing is subsequently submitted on behalf of all the covered services furnished by SNF employees (e.g. physical therapists) and/or through contractual arrangement (e.g. rehabilitation agencies). Under Medicare FFS consolidated billing requirements, all Part B therapy services furnished to SNF residents must be billed by the SNF.

Additionally, under FFS Medicare, there is no requirement that professional employees or contracted professionals/agencies of a properly enrolled provider of service such as a SNF must be independently enrolled in the PECOS system. Other Medicare FFS conditions/requirements of participation and payment policies require that the PECOS enrolled provider of service conduct the necessary screenings and background checks of employees or contracted professionals/agencies involved in the services being billed, to assure that they are qualified to furnish the services, and are not otherwise excluded from the Medicare program.

AHCA seeks clarification that employees or contracted service professionals or agencies of providers of service, including SNF, do not meet the definition of first-tier, downstream, and related entities (FDR) as described in the proposed rule.