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September 10, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1693–P
P.O. Box 8016
Baltimore, MD 21244–8016

Re: AHCA Response to Medicare Program; Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program. Federal Register, Vol. 83, No. 145, July 27, 2018. CMS-1693-P

Dear Administrator Verma:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 13,600 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 1.06 million skilled nursing facility (SNF) beds and more than 240,000 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) 2019. 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. In general, SNF residents have complex health care conditions, comorbidities, and functional deficits that require ongoing physician evaluation and management services. Therefore, in addition to outpatient therapy policy issues, our SNF members have a vested interest in assuring that physician payment policies are appropriate to assure an adequate workforce of physicians that furnish care to their residents, and that interoperability incentives and requirements are appropriate for SNF.

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

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A. THERAPY SERVICES – NPRM Section II.M

In this section of the notice of proposed rulemaking (NPRM), CMS describes specific actions the agency had taken to date to implement the repeal of the therapy caps provisions in Section 50202 of the Bipartisan Budget Act of 2018 (BBA of 2018), and those provisions of Section 53107 that are still required to be implemented. These applies to Medicare outpatient therapy services furnished by office and facility-based providers. The Section 53107 provisions proposed in this NPRM related to the payment for outpatient PT and OT services furnished by therapy assistants would not apply to those critical access hospitals that are not paid under the physician fee schedule.

A.1. NPRM Section II.M.2. Proposed Payment for Outpatient PT and OT Services Furnished by Therapy Assistants

AHCA General Comment: **For reasons discussed below, AHCA recommends that CMS only finalize for CY 2019 those requirements in Section 53107 of the BBA of 2018 that pertain to the establishment of claim procedure code modifiers to identify all outpatient physical therapy or occupational therapy services furnished in whole or in part by a therapy assistant. We believe that CMS should work with stakeholders prior to the promulgation of the CY 2020 proposed rule to address concerns regarding the definition of the phrase *"in whole or in part"* and other topics to better address the Congressional intent and to mitigate potential unintended consequences related to the proposed definition.**

A.1.1. Background

The BBA established the following provisions and timelines related to Medicare Physician Fee Schedule payment for outpatient physical therapy and occupational therapy services furnished by a therapy assistant that require CMS to establish regulations through notice and comment rulemaking.

Payment Year	Implementation Requirement
CY 2019	No later than January 1, 2019, CMS shall establish a claim procedure code modifier to identify all outpatient physical therapy or occupational therapy services furnished in whole or in part by a therapy assistant.
CY 2020	Beginning with services furnished on or after January 1, 2020, Medicare outpatient therapy claims containing services for physical therapy or outpatient occupational therapy services furnished in whole or in part by a therapy assistant, shall include the therapy assistant claim procedure code modifier, that was established in 2019, for each service furnished by the physical therapy or occupational therapy assistant.
CY 2022	Beginning with services furnished on or after January 1, 2022, the amount of payment for Medicare outpatient therapy claims lines for services (procedure codes) identified with the physical therapy or occupational therapy assistant modifiers shall be paid an amount equal to 85 percent of the amount of Medicare Physician Fee Schedule payment rate for that service HCPCS code.

To implement these statutory requirements CMS has proposed the following in this NPRM:

1. ***Establish two new claim line therapy discipline procedure code modifiers that separately identify PT and OT services when they are furnished in whole or in part by a physical therapy assistant (PTA) or an occupational therapy assistant (OTA). This will require the following conforming changes in policy:***

   CMS is proposing in Section II.M.2 of the NPRM to define *"therapy assistant"* as an individual who meets the personnel qualifications set forth at §484.4 of the regulations for a physical therapist assistant and an occupational therapy assistant (PTA and OTA, respectively).

   AHCA Comment: AHCA supports the adoption of the definition of *"therapy assistant"* as proposed by CMS effective for CY 2019.

   CMS is proposing in Section II.M.2 of the NPRM to define the new therapy modifiers for services furnished in whole or in part by physical therapy or occupational therapy assistants as follows:

   - New - PT Assistant services modifier (to be used instead of the GP modifier currently reported when a PTA furnishes services in whole or in part): Services furnished in whole or in part by a physical therapist assistant under an outpatient physical therapy plan of care;
   - New - OT Assistant services modifier (to be used instead of the GO modifier currently reported when an OTA furnishes services in whole or in part): Services furnished in whole or in part by occupational therapy assistant under an outpatient occupational therapy plan of care;

   AHCA Comment: AHCA supports the proposed adoption of the two new therapy modifiers to reflect the outpatient therapy services furnished in whole or in part by physical therapy or occupational therapy assistants, but <u>ONLY IF</u> CMS revises the proposed definition of the phrase *"in whole or in part"* prior to CY 2020 rulemaking to address the concerns we raise below.

   CMS is proposing in Section II.M.2 of the NPRM that the existing GP modifier *"Services delivered under an outpatient physical therapy plan of care"*, GO modifier *"Services delivered under an outpatient occupational therapy plan of care"*, and GN modifier *"Services delivered under an outpatient speech-language pathology plan of care"* be revised to read as follows:

   - Revised GP modifier: Services fully furnished by a physical therapist or by or incident to the services of another qualified clinician – that is, physician, nurse practitioner, certified clinical nurse specialist, or physician assistant − under an outpatient physical therapy plan of care;
   - Revised GO modifier: Services fully furnished by an occupational therapist or by or incident to the services of another qualified clinician – that is, physician, nurse practitioner, certified clinical nurse specialist, or physician assistant − under an outpatient occupational therapy plan of care; and
   - Revised GN modifier: Services fully furnished by a speech-language pathologist or by or incident to the services of another qualified clinician – that is, physician, nurse practitioner, certified clinical nurse specialist, or physician assistant − under an outpatient speech-language pathology plan of care.

   AHCA Comment: AHCA supports the proposed revision of the three new therapy modifiers to reflect the outpatient therapy services delivered and fully furnished by a therapist, physician or non-physician practitioner under an outpatient physical therapy, occupational therapy, or speech-language pathology plan of care, but <u>ONLY IF</u> CMS

revises the proposed definition of the phrase *"in whole or in part"* prior to CY 2020 rulemaking to address the concerns we raise below. We also believe that this will also require CMS to provide a definition of the term *"fully furnished"* as used in the proposed revised GP, GO, and GN modifier definitions prior to CY 2020 rulemaking as we also discuss below.

2. ***Define those services that would be considered to be furnished "in whole or in part" by a PTA or OTA, and that would be subject to the new therapy assistant modifiers starting January 1, 2020, and subject to the payment reduction to 85 percent of the Medicare physician fee schedule for outpatient therapy services furnished on or after January 1, 2022.***

In discussing a rationale for developing a definition to describe all services that are furnished *"in whole or in part"* by a PTA or OTA that would be subject to the use of the new therapy assistant modifiers, CMS states that they do not believe the provisions of section 1834(v) of the Act were intended to apply when a PTA or OTA performs portions of the service such as administrative tasks that are not related to their qualifications as a PTA or OTA. Rather, CMS states that they believe the provisions of section 1834(v) were meant to apply when a PTA or OTA is involved in providing some or all of the therapeutic portions of an outpatient therapy service.

CMS is proposing that all services that are furnished *"in whole or in part"* by a PTA or OTA are subject to the use of the new therapy modifiers

AHCA Comment: AHCA can only support the proposed requirement that all services that are furnished *"in whole or in part"* by a PTA or OTA are subject to the use of the new therapy modifiers if CMS revises the proposed definition of the phrase *"in whole or in part"* prior to CY 2020 rulemaking to address the concerns we raise below. We also believe that this will also require CMS to provide a definition of the term *"fully furnished"* as used in the proposed revised GP, GO, and GN modifier definitions prior to CY 2020 rulemaking as we also discuss below.

CMS is proposing to define *"in part"* for purposes of the proposed new therapy assistant modifiers to mean any minute of the outpatient therapy service that is therapeutic in nature, and that is provided by the PTA or OTA when acting as an extension of the therapist. Therefore, a service furnished *"in part"* by a therapy assistant would not include a service for which the PTA or OTA furnished only non-therapeutic services that others without the PTA's or OTA's training can do, such as scheduling the next appointment, greeting and gowning the patient, preparing or cleaning the room.

AHCA Comment: AHCA strongly opposes the proposed definition of *"in part"* for purposes of the new therapy assistant modifiers. We agree that non-therapeutic activities of the therapy assistant should not apply to this definition for the reasons CMS discussed in the NPRM, we also believe strongly that CMS must consider whether the procedure being billed was *"fully furnished"* by the therapist before considering whether the therapy assistant modifier would be applicable. As discussed below, we believe that CMS should work with stakeholders prior to the promulgation of the CY 2020 proposed rule to address concerns regarding the definition of the phrase *"in part"* as well as develop a clear definition of the phrase *"fully furnished"* to better address the Congressional intent and to mitigate potential unintended consequences related to the proposed definition.

A.1.2. AHCA Discussion

AHCA disagrees strongly with the CMS interpretation of Congressional intent with regards to the proposed definition of the definition of the phrase "*in part*" and we offer an alternative and more appropriate interpretation.

We anticipate numerous unintended consequences if the proposed definition is finalized, including reduced access to care and reduced patient safety, particularly for those beneficiaries with conditions that commonly require hands-on care simultaneously from more than one therapy clinician. In the real world, the interaction of the therapist and therapy assistant involves a collaborative effort to achieve the best patient outcomes. As we discuss below, this policy should not disincentivize clinically appropriate collaborative simultaneous care by the therapist and therapy assistant.

CMS must provide additional consideration of the Congressional intent and the potential unintended consequences on outpatient therapy clinical service delivery approaches, and revise the proposed definition of the phrase *"in part"*.

Congressional Intent

First – We believe that the Congressional intent in enacting the payment reduction for outpatient therapy services furnished by therapy assistants was the belief that the payment for services was relatively proportional to the costs to deliver such services. Given this, we believe that the definition of what constitutes whether therapy services were furnished *"in part"* by a therapy assistant should only be determined after it has been determined whether the service was *"fully furnished"* by the therapist – e.g. the therapist fulfilled the required elements that meet the billing code definition, regardless of whether the therapy assistant was involved in the treatment or not (See Scenarios 1 and 2 below).

We appreciate the challenge that CMS has in addressing Congressional intent as the Agency develops policy language associated with the statutory phrase *"in whole or in part"* as it applies to Section 53107 of the BBA of 2018. However, we also note that in those same statutory provisions, Congress also included the following statement *"Nothing in the preceding sentence shall be construed to change applicable requirements with respect to such modifiers."*

We believe that CMS can meet the Congressional intent and apply policy consistent with the statutory language if CMS describes a decision pathway that first identifies whether the service provided by the therapist, physician, or non-physician practitioner can be considered *"fully furnished"* according to the definition of the HCPCS code, and if not, then the second step would be to determine if the HCPCS code definition can be satisfied by the services furnished *"in whole or in part"* by a therapy assistant.

Second – CMS has not clarified in this proposed rule the definition of what constitutes a therapy "service" that the proposed definition of "in part" applies to. For example, it is unclear whether the term "service" describes

1) an individual HCPCS code service unit,
2) all the time-based service units associated with an individual HCPCS code (e.g. does three 15-minute units of code 97110 represent three separate 15 minute "services", or only one "service" of code 97110), or
3) all the different procedure codes and associated code service units associated with a therapy encounter (e.g. if three 15-minute units of a time-based code and one unit of an untimed code, is this considered to be a single "service" visit, or are each procedures and/or billed units considered separate "services).

It is common for multiple unique untimed and/or time-based HCPCS codes to be furnished and billed during a single treatment session (e.g. a time-based manual therapy code and an untimed vasopneumatic device therapy code). Additionally, it is common for multiple units of a single time-based code be furnished and billed during a single treatment session (e.g. three 15-minute units of therapeutic exercise to represent 45 total minutes of this procedure).

We believe that this policy should apply to the definition of each individual procedure unit billed and should not apply to the aggregated time applicable for multiple units of a single time-based procedure, nor across multiple procedures furnished during a single treatment session. The following scenarios describe real-world clinical situations that this policy should address appropriately to align with Congressional intent.

Scenario 1:
In most cases, the therapist conducts an evaluation independently and develops a plan of care. Depending on the complexity of the care, the follow-up interventions during any one treatment session may be done solely by the therapist, solely by the assistant, or there could be a hand-off during the treatment session where some of the services that are therapeutic in nature are furnished by the therapist, while others are furnished by the therapy assistant. In these cases, it may involve a relatively straightforward process or policy to differentiate the services furnished by the therapist and the therapy assistant, as the costs of the different clinicians delivering care do not overlap.

Scenario 2:
However, in other cases, the clinical needs of the patient necessitate the therapist utilize the services of the therapy assistant to essentially serve as a *"second set of hands"* to enable the safe and effective completion of the services. For example, a patient may present with morbid obesity, flaccid limbs resulting from a recent stroke, or have balance, strength, or endurance issues that prevent safe mobility training without the active engagement of more than one clinician in the assessment or delivery of rehabilitation services. In these cases, the therapist would be actively engaged with the performance of the evaluation and/or the performance of the therapeutic intervention throughout the delivery of the service as defined by the HCPCS code. In such cases, due to the patient clinical needs, the costs of the different clinicians delivering services overlap and result in higher care delivery costs than those described in Scenario 1 above. It appears that the proposed policy would essentially penalize providers that deliver care under Scenario 2, which could result in unintended consequences of reduced patient safety, reduced access to Part B therapy services for patients with complex care needs, or delays in recovery.

Proposed Solution

The HCPCS codes required to report outpatient therapy services represent evaluation and treatment services that could be either untimed or time-based. Each of these codes contains specific requirements that must be satisfied to bill the service. AHCA proposes that *"in whole or in part"* shall be defined in the context of whether any services that are therapeutic in nature could not have been billed otherwise without the involvement of the therapy assistant. In other words, if the evaluation or treatment service code could have been billed by the therapist, whether the therapist assistant was involved or not, then the service shall be billed as a therapist-delivered service. We note that in this NPRM, CMS is proposing to redefine the definition of the GN, GO, and GP therapy service modifiers to represent the therapy services furnished by therapists, physicians, and non-physician practitioners services *"fully furnished"* by such clinicians. However, CMS has not defined the phrase *"fully furnished"*.

We propose that CMS define the phrase *"fully furnished"* in a way to reflect that if the therapist, physician, or non-physician practitioner performed services that satisfied the requirements to bill the specific procedure code (or individual procedure code unit in the case of time-based codes), then the service unit would be billed with the applicable GN, GO, or GP claim service modifier. The therapy assistant modifier would not apply to the such specific code unit, even if the therapy assistant participated in furnishing the defined service unit. However, if the requirements to bill the defined service unit could not have been satisfied without the participation of the therapy assistant, then the GN, GO, or GP modifiers would not be appropriate as the qualifying services to satisfy billing requirements were furnished *"in part"* by the therapy assistant, and the available therapy assistant modifier would then be required.

Below we describe examples of billing scenarios applying the AHCA proposed solution for defining *"fully furnished"* as it applies to therapist, physician, and non-physician practitioner therapy services, and *"in part"* as it applies to the outpatient therapy assistant procedure modifier and eventual payment rate adjustment – at the individual procedure unit level:

Billing Example 1 – Untimed Services – Therapy assistant modifier does not apply

- The therapist, physician, or non-physician practitioner *"fully furnished"* the services that satisfied the requirements to bill the specific untimed evaluation or procedure code with no therapy assistant present.
- The therapist, physician, or non-physician practitioner *"fully furnished"* the services that satisfied the requirements to bill the specific untimed evaluation or procedure code, and a therapy assistant was present during part or all of the service delivery period to render support to the therapist.

Billing Example 2 – Untimed Services – Therapy assistant modifier does apply

- The therapist, physician, or non-physician practitioner is not present with the patient for the untimed procedure, and a therapy assistant furnished *"in whole"* all of the service defined by the untimed procedure code.
- The therapist, physician, or non-physician practitioner is present with the patient for the untimed evaluation or procedure and furnished only a part of the service described by the untimed evaluation or procedure, and a therapy assistant furnished *"in part"* the remainder of the service defined by the untimed evaluation or procedure code.

Billing Example 3 – Time-based Services – Therapy assistant modifier does not apply

- The therapist, physician, or non-physician practitioner *"fully furnished"* the services that satisfied the requirements to bill the specific time-based procedure code with no therapy assistant present.
- The therapist, physician, or non-physician practitioner *"fully furnished"* the services that satisfied the requirements to bill the specific time-based procedure, and a therapy assistant was present during part or all of the service delivery period to render support to the therapist.

Billing Example 4 – Time-based Services – Therapy assistant modifier does apply

- The therapist, physician, or non-physician practitioner is not present with the patient for the time-based procedure, and a therapy assistant furnished *"in whole"* all of the service defined by the time-based procedure code.
- The therapist, physician, or non-physician practitioner is present with the patient for the untimed procedure and furnished only a part of the service described by the time-based procedure, and a therapy assistant furnished *"in part"* the remainder of the service defined by the time-based procedure code.

Discussion Summary

We understand that there are additional details that may need to be addressed related to the above discussion pertaining to the definition of the phrases *"in whole or in part"*, *"in part"*, and *"fully furnished"* which we believe should be addressed before finalizing any of these definitions prior to promulgation of the CY 2020 payment rule to assure that the definitions comply with the statutory language, Congressional intent, and that does not disrupt access to care or patient safety. Some of these details include the following:

1) How would the current "8-minute rule" described in Chapter 5, Section 20.2.C of the Medicare Claims Processing Manual be applied related to the definitions of the phrases *"fully furnished"*, "in *whole"*, or *"in part"*?
2) How will the Multiple Procedure Payment Reduction (MPPR) policy described in Chapter 5, Section 10.7 of the Medicare Claims Processing Manual be applied to serviced furnished by therapists, physicians and non-physician practitioner using the GN, GO, and GP therapy service modifiers versus the two new PT and OT assistant therapy service modifiers when fully priced and therapy assistant modifier adjusted procedures are billed on the same date?
3) How will the claim allowed charges for the discounted therapy assistant payments beginning in CY 2022 be captured and applied for the purposes monitoring the targeted medical review program implemented as part of the repeal of the therapy caps provisions in Section 50202 of the BBA 2018?
4) How will the claim allowed charges for the discounted therapy assistant payments beginning in CY 2022 be captured and applied for the purposes of determining Medicare allowed amounts related to beneficiary liability?

We believe that these, and other unresolved issues could best be addressed by CMS working with therapy stakeholders through the development of regulatory and sub-regulatory policies prior to the promulgation of the CY 2020 physician fee schedule proposed rule next summer. This will provide sufficient time to identify and mitigate for unintended consequences, and still permit time for CMS to permit testing of the new therapy assistant claim therapy service modifiers prior to the Congressionally mandated CY 2020 reporting of the new modifiers.

A.2. NPRM Section II.M.2. Proposed Functional Reporting Modifications

CMS is proposing to end the requirements for the reporting and documentation of functional limitation G-codes (HCPCS codes G8978 through G8999 and G9158 through G9186) and severity modifiers (in the range CH through CN) for outpatient therapy claims with dates of service on and after January 1, 2019.

> **AHCA Comment: AHCA supports the proposed elimination of the reporting and documentation of functional limitation G-codes for outpatient therapy claims starting in FY 2019.**

We agree that the reporting requirements have been extremely burdensome and, due to the lack of standardization, has not generated useful information necessary for evaluating the effectiveness of the outpatient therapy services furnished.

We also believe that the measurement of function and outcomes associated with therapy service delivery are critically important for the advancement of value-based payment (VBP) models. However, the information collected and reported must be standardized and reflect meaningful measures of a patient's health care needs and functional outcomes. As we represent skilled nursing providers, we are also particularly sensitive to the need to develop meaningful outpatient therapy functional measures that do not

conflict with, or add to existing administrative burdens associated with existing program requirements including the Skilled Nursing Facility Quality Reporting Program (SNF QRP), and SNF 5-Star Quality Rating Program that rely, in part, on Medicare required Resident Assessment Instrument (RAI) health condition and functional measures, at admission and discharge from the SNF, as well as at regular intervals (no less often than quarterly). We look forward to working with CMS on the future development of meaningful standardized outcomes measures associated with outpatient physical and occupational therapy as well as speech-language pathology services.

B. NPRM Section II.D. Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

In this section of the NPRM CMS is proposing a broad array of policy changes that would enable physicians to expand the use to communication technology-based services to increase flexibilities and efficiencies in care delivery to improve care. A chief motivation for these policy changes is to reduce the rate of preventable hospitalizations or rehospitalizations.

In the preamble discussion within this section, CMS describes the statutory history of the application of *"telehealth"* policies since the enactment of the provisions contained within Section 1834(m) of the Act, and notes that there may be opportunities for Medicare to permit a broader use of communication technology-based services beyond those explicitly restricted under the Section 1834(m) provisions. Specifically, CMS states that *"We have come to believe that section 1834(m) of the Act does not apply to all kinds of physicians' services whereby a medical professional interacts with a patient via remote communication technology. Instead, we believe that section 1834(m) of the Act applies to a discrete set of physicians' services that ordinarily involve, and are defined, coded, and paid for as if they were furnished during an in-person encounter between a patient and a health care professional."* Essentially, CMS is proposing to increase access to such services be creating two separate classes of communication technology-based services.

1. Services defined under section 1834(m) of the Act that apply to a discrete set of physicians' services that ordinarily involve, and are defined, coded, and paid for as if they were furnished during an in-person encounter between a patient and a health care professional. These services would be subject to statutory *"telehealth"* limitations
2. Services that are routinely furnished via communication technology. These services would not be subject to the limitations on Medicare telehealth services in section 1834(m) of the Act because CMS does not consider them to be Medicare telehealth services; instead, they would be paid under the PFS like other physicians' services and would need to comply with any applicable privacy and security laws, including the HIPAA Privacy Rule.

AHCA Comment: AHCA supports the direction that CMS is taking to modernize Medicare physician fee schedule payment by recognizing that communication technology-based services include an array of services beyond those currently contained within the Medicare *"telehealth"* provisions contained in Section 1834(m) of the Act.

AHCA Comment: We additionally support the CMS proposal to define and pay for those communication technology-based services that are defined as routinely furnished via communication technology as falling outside of the Medicare *"telehealth"* provisions and are therefore not subject to the Section 1834(m) limitations.

In the following comments, we discuss key areas that we believe would most impact residents of post-acute care settings including SNF.

B.1. NPRM Section 2.D.1. Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code GVCI1)

CMS proposes to pay separately, beginning January 1, 2019, for a newly defined type of physician's service furnished using communication technology. This service would be billable when a physician or other qualified health care professional has a brief nonface-to-face check-in with a patient via communication technology, to assess whether the patient's condition necessitates an office visit.

CMS proposes that the following policies would apply to this code:

- The code would be described as GVCI1 (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion).
- In instances when the brief communication technology-based service originates from a related E/M service provided within the previous 7 days by the same physician or other qualified health care professional, that this service would be considered bundled into that previous E/M service and would not be separately billable, which is consistent with code descriptor language for CPT code 99441 (Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion) on which this service is partially modeled.
- In instances when the brief communication technology-based service leads to an E/M in-person service with the same physician or other qualified health care professional, this service would be considered bundled into the pre- or post- visit time of the associated E/M service, and therefore, would not be separately billable.
- Pricing this distinct service at a rate lower than existing E/M in-person visits to reflect the low work time and intensity and to account for the resource costs and efficiencies associated with the use of communication technology.
- This service can only be furnished for established patients because we believe that the practitioner needs to have an existing relationship with the patient, and therefore, basic knowledge of the patient's medical condition and needs, in order to perform this service.
- Not applying a frequency limit on the use of this code by the same practitioner with the same patient, but CMS wants to ensure that this code is appropriately utilized for circumstances when a patient needs a brief non-face-to-face check-in to assess whether an office visit is necessary.

  AHCA Comment: AHCA supports the CMS proposal to adopt this HCPCS code as representing a communication technology-based service not be subject to the limitations on Medicare telehealth services, and all the related detailed descriptions of how the codes should be used and priced related to established patients. However, we request that CMS clarify that this policy should not be restricted to a determination of the necessity for an office visit, but to also apply to the determination of whether a facility-visit is necessary to address an emergent issue. In other words, the policy should apply to both office-based and facility-based E&M codes.

We believe that given the reality that physicians cannot be available 24x7 to see an established patient in their office, or in a facility such as a SNF, there may be incredible value in using this service to determine whether a face-to-face visit, a change in the care plan, or an emergency room or hospital admission may be necessary. We do not believe frequency limitations are necessary given the proposed payment limitations tied to proximate E&M code billing or other bundling scenarios.

B.2. NPRM Section 2.D.2. Remote Evaluation of Pre-Recorded Patient Information (HCPCS code GRAS1)

CMS proposes to create specific coding that describes the remote professional evaluation of patient-transmitted information conducted via pre-recorded "store and forward" video or image technology. These services would not be subject to the Medicare telehealth restrictions in section 1834(m) of the Act, and the valuation would reflect the resource costs associated with furnishing services utilizing communication technology. CMS further states *"We believe that proposing payment for these interprofessional consultations performed via communications technology such as telephone or Internet is consistent with our ongoing efforts to recognize and reflect medical practice trends in primary care and patient-centered care management within the PFS."*

CMS proposes that the following policies would apply to this code:

- This remote service would be considered bundled into that office visit and therefore would not be separately billable.
- In instances when the remote service originates from a related E/M service provided within the previous 7 days by the same physician or qualified health care professional, that this service would be considered bundled into that previous E/M service and also would not be separately billable.
- This service to be a stand-alone service that could be separately billed to the extent that there is no resulting E/M office visit and there is no related E/M office visit within the previous 7 days of the remote service being furnished.
- Coding and separate payment for this service is consistent with the progression of technology and its impact on the practice of medicine in recent years and would result in increased access to services for Medicare beneficiaries.
- The code for this service would be described as GRAS1 (Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with verbal follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment).

AHCA Comment: AHCA supports the CMS proposal to adopt this HCPCS code as representing a communication technology-based service not be subject to the limitations on Medicare telehealth services, and all the related detailed descriptions of how the codes should be used. However, we request that the policy should apply to both office-based and facility-based E&M codes.

We believe that given the reality that physicians cannot be available 24x7 to see an established patient in their office, or in a facility such as a SNF, there may be incredible value in using this service to determine

whether a face-to-face visit, a change in the care plan, or an emergency room or hospital admission may be necessary. We do not believe frequency limitations are necessary given the proposed payment limitations tied to proximate E&M code billing or other bundling scenarios.

B.3. NPRM Section 2.D.3. Inter-professional Internet Consultation (CPT codes 994X6, 994X0, 99446, 99447, 99448, and 99449)

CMS proposes to pay for interprofessional consultations performed via communications technology such as telephone or Internet is consistent with our ongoing efforts to recognize and reflect medical practice trends in primary care and patient-centered care management within the PFS.

CMS proposes that the following policies would apply to these codes:

- Separate payment for these services, discussed in section II.H. Valuation of Specific Codes, of this proposed rule.
- Require the treating practitioner to obtain verbal beneficiary consent in advance of these services, which would be documented by the treating practitioner in the medical record, similar to the conditions of payment associated with the care management services under the PFS. Obtaining advance consent includes ensuring that the patient is aware of applicable cost sharing.

AHCA Comment: AHCA supports the CMS proposal to pay for these HCPCS codes as representing a communication technology-based service not be subject to the limitations on Medicare telehealth services, and all the related detailed descriptions of how the codes should be used. However, we request that the policy should apply to both office-based and facility-based consultations codes.

We believe that given the reality that for physicians in a facility such as a SNF, there may be incredible value in using this service to determine whether a face-to-face visit, a change in the care plan, or an emergency room or hospital admission may be necessary.

B.4. NPRM Section 2.D.4. Medicare Telehealth Services under Section 1834(m) of the Act

The following Section 2.D.4 subsection comments discuss a specific policy proposal related to specific procedures impacting SNF short- and long-stay residents that describe face-to-face encounters but are payable *"telehealth"* services under the restrictions of Section 1834(m) of the Act.

B.4.1. NPRM Section 2.D.4.c.(5) Subsequent Nursing Facility Care Services: CPT Codes CMS currently recognizes

CMS proposes no changes to current policy. CPT codes 99307-99310 (representing subsequent nursing facility care services E&M codes) as payable *"telehealth"* codes and they are currently on the list for billing as Medicare telehealth services if certain requirements are met. However, CMS has also placed a limitation on the SNF setting that is more restrictive than telehealth restrictions for subsequent care E&M codes that apply in similar PAC settings with similar patient populations. Specifically, SNF subsequent care E&M codes may only be billed via telehealth once every 30 days, while the limitation for other PAC settings is only once every three days.

AHCA Comment: 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),*

We are not arguing for any relaxation of current physician face-to-face encounter requirements in the SNF setting. These telehealth services would only be furnished when clinically necessary for emergent conditions outside of routine face-to-face encounters when it is not feasible for that resident's physician to be at the resident's SNF bedside (e.g. nights, weekends, office hours). Without telehealth flexibility for a resident's physician to address emergent conditions, is that the beneficiary could be subject to an avoidable and disruptive emergency department visit or hospital readmission.

AHCA contends that the clinical benefit SNF telehealth has already been established with the adoption of SNF telehealth coverage in the CY 2011 Final Rule (75 FR 73317). 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. Specifically, under the PAMA of 2014, beginning October 1, 2018, SNFs are subject to negative payment adjustments of up to two percent based on their risk-adjusted performance on the IMPACT Act compliant hospital readmission measure. 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.

With respect to consistency and fairness, in this proposed rule, Section.2.D.4.c.(4) Subsequent Hospital Care Services, CMS uses an identical argument for justifying a limit of one subsequent care telehealth visit every three days, instead of the once per 30 days restriction for SNF residents. We note that this means that CMS is applying an entirely different standard to telehealth frequency limitation for SNF than that applied to other post-acute care (PAC) provider settings such as long-term care hospitals (LTCH) and inpatient rehabilitation facilities (IRFs) that frequently treated beneficiaries with similar conditions and health needs. If CMS is to move toward standardizing policies across PAC settings to pave the way for a successful transition to a unified PAC payment model, as envisioned and described by the IMPACT Act, then SNF telehealth frequency limitations should also be standardized with the *"once every three days"* limits that apply to LTCH and IRF.

Reducing SNF telehealth frequency limitations for admitting physicians to align with other PAC providers, particularly in rural and underserved locations and time periods where the physician is not readily available for a face-to-face encounter with an established patient, 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 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 with a physician that is not familiar with the beneficiary's history or needs. 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.

We are not arguing for any relaxation of current physician face-to-face encounter requirements. However, CMS should recognize the potential benefits to improve care and avoid preventable rehospitalizations by affording the same telehealth flexibilities to SNF residents as those currently available in other PAC provider settings.

> **AHCA Recommendation: AHCA strongly recommends that CMS reconsider their proposal to maintain the status quo, but instead reduce the arbitrary limitation of one telehealth subsequent nursing facility care visit every 30 days reported by CPT Codes 99307 through 99310 to once every three days, so that the limitation is standardized across the SNF, LTCH, and IRF PAC inpatient settings.**

[1] 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.

C. NPRM Section II.I. Evaluation & Management (E/M) Visits

CMS is proposing to revise their policies associated with payment for office-based Evaluation and Management (E&M) procedure codes under the premise of streamlining physician documentation and reducing burden. Specifically, CMS is proposing to reduce some documentation requirements and also eliminate the payment differential between office-based E&M code levels 2 through 5. CMS is also proposing to create HCPCS G-code add-ons to recognize additional relative resource costs for E&M services provided to patients with more complex needs that may not be adequately accounted for by eliminating the payment differential between office-based E&M code levels 2 through 5.

> **AHCA Comment: While SNFs do not furnish or bill Medicare for office-based physician E&M codes, we believe that there are potential unintended negative impacts this proposed policy change may have on beneficiaries that reside in our member facilities. We offer the following comments from this context.**

First, we caution against CMS implementing policy changes that could discourage physicians from furnishing primary care E&M services to beneficiaries with complex care needs. Older adults and persons with disabilities commonly present with multiple conditions, comorbidities, and functional deficits that often require the complexity of physician services described by E&M code levels 3 through 5. As Table 21 of the NPRM demonstrates, specialties that are more likely to use these higher intensity E&M codes (geriatricians, rheumatologists, neurologists, etc.) reflect specialties commonly providing care to residents in SNFs and would be most negatively impacted by the proposed payment policy change. We are concerned that if physicians who commonly provide care to the types of beneficiaries that also often require SNF care, then fewer physicians may elect to serve such beneficiaries, which could result in a reduced SNF physician workforce at a time the population of aged adults is expected to expand rapidly.

Additionally, while we recognize that CMS is proposing to introduce new G-code modifiers to mitigate the projected payment reductions in part to those physicians that typically furnish care to the beneficiary population that also often require SNF care, as reflected in the revised impact analysis presented in Table 22 of NPRM, we are concerned that this may not be adequate. For example, we are aware of concerns voiced by physicians that the proposed payment policy change and new G-code adjustors may not result in adequate payments and could add to confusion and documentation errors if one set of document and coding policy applies for office-based E&M codes and another set applies for the unchanged facility-based E&M codes. Such documentation errors could indirectly impact SNF regulatory, quality, and payment policy as physician documentation is required as part of the SNF record for short- and long-stay residents.

> **AHCA Recommendation: We recommend that CMS consider the potential unintended consequences the proposed payment and documentation policy changes for office-based physician E&M codes may have on the workforce of physicians willing to furnish services to disabled and aged individuals with multiple conditions, comorbidities, and functional deficits. With dramatic demographic growth in the aging population, SNFs depend on policies that assure a growing and qualified physician workforce, and we recommend that CMS seriously consider recommendations offered by impacted physicians, particularly SNF medical directors, and physicians that furnish care to beneficiaries in both office and in SNF settings.**

D. NPRM Section III. H. CY 2019 Updates to the Quality Payment Program

NOTE: The below comments are updated but consistent with AHCA/NCAL comments submitted on June 27, 2016 in response to the CMS MIPS-APM Proposed Rule (CMS-5517-P).

D.1. Background

Function is a primary determinant of: 1) quality of life; 2) the need for increased healthcare resources, services and supports; 3) and the need for long-term facility-based care. Outpatient therapy services play a critical role in the restoration and/or maintenance of an individual's function and can help prevent the need for long-term facility-based care, as well as facilitate the return to community for individuals with acute health events. Additionally, outpatient therapy is a key component in the Administration's goal of focusing on value of services - not volume, and of focusing on better care, smarter spending, and healthier people.

Recent initiatives in quality and resource use measurement and incentive programs through Accountable Care Organizations (ACOs), the Comprehensive Care for Joint Replacement Model (CJM) program, and other quality and value-based payment (VBP) initiatives have resulted in an increased demand for lower-cost and high-quality outpatient therapy services. Additionally, evidence such as the recent report published by the National Institutes of Health on *The Role of Opioids in the Treatment of Chronic Pain*[1] suggesting that physical therapy should be considered as an initial non-pharmacologic alternative for pain treatment, could further increase the demand for outpatient therapy services. As a natural progression of these initiatives, the MIPS and APM programs could provide the necessary framework to assure that all aspects of a Medicare beneficiaries rehabilitation needs through the continuum of care are furnished by providers that are equally incentivized to furnish high-quality and cost-effective care.

> **AHCA Comment: We believe that this proposed rule falls short in addressing incentive programs necessary to address the quality and value of services furnished to the majority of Medicare beneficiaries that require and receive outpatient therapy services.**

Specifically, per a recent Medicare Payment and Advisory Commission (MedPAC) publication[2], over 5 million Medicare FFS beneficiaries received outpatient therapy services under the PFS totaling $7.2 billion in expenditures. Of this amount, only 2% of these expenditures are attributed to physician and non-physician practitioner outpatient therapy services which are included in the MIPS and APMs. While CMS has indicated in this proposed rule that PTs, OTs in private practice are being considered for inclusion in the MIPS and APM programs, they only collectively represent 36% of outpatient therapy expenditures.

In contrast, facility-based providers, including hospitals, skilled nursing facilities (SNFs), outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), and home

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[1] National Institutes of Health. The role of opiods in the treatment of chronic pain. Final Report. https://prevention.nih.gov/docs/programs/p2p/ODPPainPanelStatementFinal_10-02-14.pdf

[2] MedPAC Payment Basics: Outpatient therapy services payment system. October 2017. http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_17_opt_final06a411adfa9c665e80adff00009edf9c.pdf?sfvrsn=0

health agencies (HHAs), account for 62% of Medicare FFS outpatient therapy expenditures. In most facility-based outpatient therapy settings, beneficiaries are older, frailer, and have cognitive deficits and multiple chronic conditions that could result in more extensive health care expenditures if the beneficiaries' functional impairments are not addressed adequately. From our review of this proposed rule, and from listening to several recent CMS open door forum (ODF) calls, there does not appear to be a consideration by CMS to include facility-based outpatient therapy services in the MIPS or APM programs at any time.

We envision two significant unintended consequences if CMS does not address this issue through rulemaking. First, the well-documented large variation in outpatient therapy service delivery, quality, and outcomes could increase to an untenable level if nearly two-thirds of the PFS services delivered by facility-based PTs, OTs, and SLPs are not covered under the MIPS, APM, or any other value-based payment incentive program. Second, the unfair and unbalanced incentives between office-based and facility-based outpatient therapy PT, OT, and SLP providers through the currently envisioned MIPS and APM incentive models, could create an exodus of high performing facility-based therapists to office-based settings where they would have the opportunity to be rewarded for delivering high-value outpatient therapy services. As the MIPS incentive program is designed to be budget neutral, we do not believe there is a cost impact to our recommendations.

The following detailed comments highlight the two specific AHCA/NCAL recommendations pertaining to this issue, and the rationale we believe provides the necessary justification for CMS to develop a mechanism for facility-based providers that furnish outpatient therapy services under the PFS via eligible clinicians to be eligible for MIPS and/or APM performance-based annual PFS adjustments.

D.2. MIPS/APM Eligibility of Facility-Based Outpatient Therapy Providers

AHCA Recommendation: We recommend that CMS consider developing a mechanism under the Merit-Based Incentive Payment System (MIPS) and/or Alternative Payment Model (APM) to enable facility-based providers that furnish outpatient therapy services (physical therapy [PT], occupational therapy [OT], and Speech-Language Pathology [SLP]) and that submit claims through facility provider billing under the PFS via eligible clinicians, to be able to participate.

Outpatient therapy services are furnished to Medicare beneficiaries under the PFS in a variety of settings including: physician offices; private practice offices of PTs, OTs, and SLPs; hospital outpatient therapy departments, SNFs, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), and home health agencies (HHAs - when not under a HH plan of care). Under the proposed rule, it appears that only physicians and non-physician practitioners (year 1) and therapists in private practice would be eligible for MIPS or APM incentive adjustments.

In the MIPS-APM Proposed Rule (CMS-5517-P), CMS described the statutory and regulatory background of efforts by CMS to implement specific provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which was enacted on April 16, 2015. Section 101 of this law repealed the sustainable growth rate (SGR) formula for updating Medicare physician fee schedule (PFS) payment rates, substituted a series of specific annual update percentages through 2018, and replaced this payment methodology with a new methodology beginning in 2019 that ties annual PFS payment to value through a MIPS adjustment to baseline rates for eligible clinicians. In addition, Section 101 of MACRA also created an incentive program to encourage participation by eligible

clinicians in APMs.

Per the MIPS-APM Proposed Rule (CMS-5517-P), Section 1848(q)(1)(C) of Title XVIII of the Social Security Act (the Act) limits MIPS incentive payments for the first two years to physicians and certain non-physician practitioners. However, beginning with the third year of the program, and for succeeding years, MACRA gives the Secretary discretion to specify additional eligible clinicians as defined in Section 1848(k)(3)(B) of the Act. Specifically, section 1848(k)(3)(B)(iii) of the Act states that PTs, OTs, and SLPs are defined as "Eligible Professionals" under the quality reporting system. **This statutory definition does not distinguish the setting where the therapist furnishes outpatient therapy services.** As such, AHCA/NCAL contends that therapists furnishing outpatient therapy services in facility provider settings, including SNFs, should be eligible to participate in PFS quality reporting incentive programs.

However, although acknowledging that facility-based therapists are considered eligible professionals, CMS does not appear to have the intent to include them in the MIPS or APM programs being developed. For example, in the CMS *2016 Physician Quality Reporting System (PQRS) List of Eligible Professionals*[3], it lists PTs, OTs, and SLPs as eligible professionals, but also states:

> ***"Eligible But Not Able to Participate***
>
> *EPs who bill Medicare Part B services, but do not fall into the denominator for any measures are not able to report PQRS. Additionally, some EPs may not be able to participate due to their billing methodologies. Following are different scenarios in which an eligible EP is not able to participate in PQRS:*
>
> ***Scenario 2: Does not submit individual rendering National Provider Identifier (NPI) -*** *An EP who* ***does not*** *bill Medicare at an individual NPI level, where the rendering provider's individual NPI is entered on the professional or institutional form associated with specific line-item services, is not able to participate in PQRS."*

This is not a new barrier but can be overcome as the MIPS and APM programs are developed over the next several years. In the early days of PQRS in 2007 (formerly Physician Quality Reporting Initiative), CMS decided to exclude facility-based outpatient therapy providers from participation even though services were being furnished by eligible professionals[4]. The rationale provided at the time pointed to then existing technical limitations related to facility-based provider claim submissions. **Since that time, there have been numerous advances in technology that should allow CMS to work with facility-based outpatient therapy providers be able to either eliminate, or work-around those limitations so that the MIPS incentive payment could be expanded to include facility-based outpatient therapy service providers in the near future.**

[3] Centers for Medicare & Medicaid Services, 2016 Physician Quality Reporting System (PQRS) List of Eligible Professionals, *available at* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PQRS_List_of_EPs.pdf (last visited June 21, 2016).

[4] 72 Fed. Reg. 66222, 66337 (Nov. 27, 2007).

D.3. Identiufy MIPS/APM Measures for Facility-Based Outpatient Therapy Providers

AHCA Recommendation: We recommend that if CMS enables facility-based providers that furnish outpatient therapy services under the PFS via eligible clinicians to be eligible for MIPS and/or APM performance-based annual PFS adjustments, then CMS should work with facility-based outpatient therapy providers to identify the most appropriate setting-specific methodology for establishing composite performance scores for the four performance categories of; quality, resource use, clinical practice improvement activities (CPIAs), and meaningful use of certified EHR technology.

Facility-based outpatient therapy providers, particularly SNF, typically treat beneficiaries with more complex health conditions, cognitive deficits, and functional impairments than ambulatory care providers, and the current performance measures being used for ambulatory care quality programs may not necessarily be appropriate for such patients. For example, the CMS Developing Outpatient Therapy Payment Alternatives Project[5], completed in 2014, identified these differences and developed separate versions of the Continuity Assessment Record and Evaluation (CARE) assessment tool for community dwelling versus nursing facility and day rehabilitation program participants.

In addition, SNFs and other facility-based providers are already subject to a number of quality and value-based payment measures that could be potentially leveraged as a setting-specific substitute for an ambulatory care provider measure.

For example, CMS has recently promulgated rules and proposed rules for post-acute providers to submit quality data on a number of quality and resource use measures as part of the implementation of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. Of note was the inclusion of therapy-related measures for mobility and self-care that are based upon specific CARE assessment tool items. Consideration of leveraging such setting-specific substitute measures and/or measures in other performance categories (e.g. advancing care information) could include setting-specific performance benchmarks and also have the benefit of minimizing administrative burden on SNF and other facility-based provider eligible clinicians, while permitting more meaningful comparisons of outpatient therapy quality across similar patients and across similar providers.

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[5] Centers for Medicare & Medicaid Services, https://www.cms.gov/Medicare/Billing/TherapyServices/Studies-and-Reports-Items/DOTPA-Reports.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending (last visited June 21, 2016)

E. NPRM Section IV.A. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange Through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers

NOTE: *AHCA recognizes that this RFI is identical to that presented by CMS in the Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program, CMS-1696-P (83 FR 21089). The following AHCA comments, with minor updates, reflect the comments we submitted to CMS on June 25, 2008 in response to the prior SNF PPS rule solicitation.*

CMS notes that this interoperability section is a Request for Information and is not a formal proposal. The Agency also encourages respondents to provide complete but concise and organized responses. CMS also notes respondents are not required to address every issue or respond to every question.

AHCA agrees and supports this critical line of work, which greatly will enhance patient care as well as Medicare and Medicaid efficiency. And, at AHCA's recent Congressional Briefing, we appreciated Secretary Azar's comments on this topic. Below are the questions most pertinent to AHCA as well as AHCA's responses to questions we believe most germane to the profession. We also offer several possible courses of action to address interoperability challenges unique to long-term and post-acute care relative to acute care providers and settings.

1. CMS notes, "*We have received stakeholder input through recent CMS Listening Sessions on the need to address health IT adoption and interoperability among providers that were not eligible for the Medicare and Medicaid EHR Incentives program, including long-term and post-acute care providers, behavioral health providers, clinical laboratories and social service providers, and we would also welcome specific input on how to encourage adoption of certified health IT and interoperability among these types of providers and suppliers as well*."

   AHCA Recommendation: While we are supportive of the effort and welcome the opportunity to work with CMS and the U.S. Department of Health and Human Services Office of the National Coordinator, we believe the long-term and post-acute care space requires targeted analysis and planning to fully engage in this effort.

a. SNFs are struggling financially to operate, now, and cannot absorb new requirements.

Due to failure of Medicaid rates to keep pace with costs (i.e., most Medicaid rates do not cover costs) and the collapse of the longstanding Medicare-Medicaid hydraulic, SNFs are struggling to maintain operations. Regarding the latter point, SNFs have long relied on Medicare rates to offset Medicaid payment shortfalls. However, as Medicare Advantage (MA) penetration rates have increased and Alternative Payment Methods (APM) have proliferated, Medicare rates and lengths of stay have eroded. Specifically, 33% of all Medicare beneficiaries now are enrolled in MA plans that pay significantly less than Medicare fee-for-service (FFS). Of the remaining 67%, 22% are impacted by APMs, leaving 45% in traditional FFS without intensive third-party pressures to shorten lengths of stay as well as decrease utilization of higher cost services. While these outcomes are positive for

Medicare, beneficiary impacts are mixed and SNF total margins are at an all-time low. See ***Figure 1***, below.

Figure 1. Comparison of Median SNF Medicare Part A Fee-For-Service Margin, Non-Medicare Margin, and Total Margin, 2013-2018

Federal Fiscal Year	SNF Medicare Margin	Non-Medicare Margin	Total Margin
2013	13.1%	-1.9%	1.9%
2014	12.5%	-1.5%	1.9%
2015	12.6%	-2.0%	1.6%
2016	11.4%	-1.5%	1.9%
2017	10.6%	-2.0%	1.6%
2018 (Projected)	9%	-2.3%	0.7%

Source: MedPAC Data Summarized by the American Health Care Association.

AHCA Recommendation: CMS should explore two lines of financial support:

- **For Medicaid, the availability for Enhanced FMAP (EFMAP) to states to engage in comprehensive Health Information Exchange (HIE) efforts, which include long-term and post-acute providers. CMS has offered EFMAP to states for a variety of Administration efforts in the past, so precedence exists as well as models for such an approach; and**
- **Explore MAC-specific demos using CMMI's demonstration authority. CMMI's statutory demonstration authority requires its demonstration projects improve quality and result in program savings. We believe an interoperability demonstration would improve care and produce savings while addressing a serious gap in services.**

b. *Long-Term and Post-Acute Care providers cannot access HITECH Act or Anti-Stark Kick-Back Funds.*

As you know, Long-Term and Post-Acute Care providers were not included in Meaningful Use; the Anti-Stark Kick-Back provisions did not include our most common partners, hospitals; and very few APMs make use of the telehealth waiver provision. The result is we have virtually no easy approach to address the very serious issue discussed, above.

AHCA Recommendation: CMS should explore with providers strategies for upstream providers to support long-term and post-acute providers with interoperable systems.

c. *Existing platforms and tools are designed for acute care patients and services.*

Acute care services are designed to address a specific health care issue and are time-limited in nature. For example, a patient enters a hospital, undergoes a surgical procedure, and is discharged. Once discharged to a long-term or post-acute care setting, the patient needs and services are dramatically different: 1) care is focused on longer term recovery, not a short two- to three-day stay; 2) multiple comorbidities and/or degenerative conditions must be managed over the entire course of a longer length of stay; and 3) long-term and post-acute care providers either are focused upon maintaining

function or a return to the highest practicable level of function rather than the completion of a specific procedure or course of treatment.

Additionally, we do not believe there are sufficient existing HIT standards to support interoperable exchange of many of the potential data elements that would be beneficial for hospitals, physicians, or other upstream providers or beneficiaries to transfer to SNF, or vice versa. Our position is supported by information on current gaps specific to SNFs published in a recent Office of the National Coordinator for Health Information and Technology September 2017 report titled *Electronic Health Record Adoption and Interoperability among U.S. Skilled Nursing Facilities in 2016* https://www.healthit.gov/sites/default/files/electronic-health-record-adoption-and-interoperability-among-u.s.-skilled-nursing-facilities-in-2016.pdf. Despite a lack of government support comparable to that provided to hospitals and physicians, SNFs have been reducing the technology gap (only 31% do not have an EHR or HIO). However, per the ONC report, interoperability remains a huge barrier as "Nine percent of SNFs reported that their staff was able to easily integrate patient health information from outside sources into their EHR, that is, without scanning or manual entry. However, only 7% of the facilities reported the ability to engage in all four interoperability domains."

In addition, to meet the mandate of the IMPACT Act, CMS and its quality measure development contractors are struggling to address the domain: *"(E) Accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions— ''(i) from a hospital or critical access hospital to another applicable setting, including a PAC provider or the home of the individual; or ''(ii) from a PAC provider to another applicable setting, including a different PAC provider, a hospital, a critical access hospital, or the home of the individual."*

These gaps are substantial and justify judicious and an incremental approach to implementing mandatory SNF interoperability requirements.

AHCA Recommendation: CMS should convene a work group of IT vendors that specialize in long-term and post-acute care provider platforms and providers to:

- **Design platforms tailored to our populations and services;**
- **Develop a long-term and post-acute care definition of "medically necessary" information;**
- **Develop standardization while allowing for critical local and regional specificity (long-term and post-acute care delivery systems are highly localized relative to more standardized acute care); and**
- **Address alignment with IMPACT Act Quality Reporting Program provisions already in place.**

2. *CMS invites members of the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients. We are particularly interested in identifying fundamental barriers to interoperability and health information exchange, including those specific barriers that prevent patients from being able to access and control their medical records.*

As we noted above, long-term and post-acute care services are very different from acute care services and our patients' and residents' needs also are different. Most of our patients and residents have: 1)

less experience with technology and how to access, manage, and understand their medical records and information; 2) many are unable to undertake such activities due to cognitive impairment – often some form of dementia among older adults or developmental disabilities among persons with disabilities; and 3) due to item two, many patients and residents have a legal guardian or the provider plays such a role. We believe special attention would be required to address HIPAA privacy requirements. Additionally, many older adults prefer paper copies of materials. Education and a glide path to electronic resources likely will need to be designed.

> **AHCA Recommendation: Like the funding effort, a work group or technical expert panel composed of beneficiary groups, clinicians specializing in geriatric care or services to person disabilities, as well as providers should be convened to design an interoperable platform that will meet long-term and post-acute care provider needs, as well as interface with acute care platforms. And, this group also could consider how the IMPACT QRP data elements and measures could be used as building blocks.**

3. *What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future? Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements*?

a. *CMS and AHCA have been working together to remove certain information technology provisions from our Requirements for Participation.*

Already, long-term and post-acute care providers, in particular, SNFs, are the most heavily regulated providers in the health care space. Additional administrative requirements would have an array of serious implications. First, such requirements would exacerbate the financial crisis and, because SNFs have Requirements for Participation rather than conditions, many SNFs might be forced to close or withdraw from Medicare. Just at the time when the aging boom is unfolding, this would result in serious access problems. Second, AHCA appreciates CMS' work with AHCA to reduce the Requirements for Participation burden. And, one of the Association's top provisions for elimination is the Facility Assessment (FA). The FA would have required, *"(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations."* Adding such a requirement back would reverse months of work between CMS and AHCA as well as impose an untenable burden on SNFs.

> **AHCA Recommendation: CMS should not re-introduce burdensome government regulation oversight but instead turn to more positive incentive-based approaches (see below).**

b. *CMS has finalized rules to implement a new payment system for SNFs in FY 2020 called the Patient-Driven Payment Model (PDPM).*

PDPM will require several years of information technology transformation to support the new system and provider adaptation. Introducing new interoperability requirements at the same time as PDPM implementation and shake out would create serious operational challenges for IT vendors and providers.

AHCA Recommendation: CMS should not consider implementing interoperability requirements for SNFs until the new payment system has been launched and experience has been gained.

c. *CMS should focus on quality outcomes and related incentives to participate in any future interoperability effort and not fall back on government regulation and punitive oversight provisions.*

As noted, SNFs already are heavily regulated and subject to an array of government regulations and requirements. At the same time, the IMPACT Act QRPs are in place and could serve as the building block for a quality-based approach to encourage adaptation of interoperability capacity. Specifically, the IMPACT Act transfer of health information measures being developed are contemplating HIE not just between upstream and downstream providers, but also whether patients/families can access or receive health information via portals or other secure electronic means. The current challenge is the SNF IMPACT measures only can be applied to Part A stays while other PAC settings can use IMPACT Act measures for Medicaid, Medicare Advantage, and other payers.

AHCA Recommendation: CMS should consider, once the funding problem has been solved, adding an interoperability QRP or other element at Nursing Home Compare and allow market forces to drive implementation rather than regulation and penalties.