September 13, 2021

VIA Electronic Submission

Ms. Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: AHCA Response to Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements Federal Register, Vol. 86, No. 139, Friday, July 23, 2021. CMS–1751–P (RIN 0938–AU42)

Dear Administrator Brooks-LaSure:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 14,500 long term and post-acute care facilities, or 1.08 million skilled nursing facility (SNF) beds and nearly 280,000 assisted living beds. With such a membership base, the Association represents the majority of SNFs and a rapidly growing number of assisted living (AL) communities as well as residences for individuals with intellectual and developmental disabilities (ID/DD).

We appreciate the opportunity to comment on the Physician Fee Schedule Proposed Rule for calendar year (CY) 2022. SNFs serve a dual purpose. First, SNFs provide short-term Medicare Part A post-acute services to beneficiaries who require skilled nursing and/or rehabilitation services on an inpatient basis. Second, SNF's furnish and bill Medicare Part B under the PFS for long-stay and 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 in nursing facilities who are either not eligible for or have exhausted Part A benefits. Additionally, SNF providers often also furnish Part B therapy services to ambulatory outpatients and AL residents, often to provide follow-up care after a SNF stay.

Long- and short-term SNF, AL, and ID/DD residents have complex health care conditions, comorbidities, and functional deficits requiring ongoing interdisciplinary care. In addition to outpatient therapy payment rates and policies associated with services furnished by PT and OT assistants, our members have a vested interest in assuring that other Part B policies that impact care for residents, including physician, portable x-ray, clinical labs, and telehealth providers, provide adequate and timely access to these necessary services to improve care and reduce unnecessary hospitalizations for emergent conditions that could be better treated in place at a lower cost.

The Association appreciates the efforts of CMS in responding to the COVID-19 public health emergency (PHE) through the issuance of various waivers and other regulatory changes to permit more flexible, effective, and efficient care delivery during this crisis.

In this comment letter the Association would like to focus on the following key topics discussed in the proposed rule:

- Therapy Services (section II.H.)
- Practice Expense RVUs (section II.B.)
- Telehealth and Other Services Involving Communications Technology (section II.D.)
- Clinical Laboratory Fee Schedule (section III.M.)
- Provider/Supplier Medical Review Requirements (section III.N.2.)
- Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA–PD Plan (section 2003 of the SUPPORT Act) (section III.Q.)

If you have questions about any of our comments, please contact Daniel Ciolek at dciolek@ahca.org.

Sincerely,

Daniel E Ciolek
Associate Vice President, Therapy Advocacy

Detailed AHCA/NCAL Comments

A. Therapy Services (section II.H.) (86 FR 39213)

- **AHCA requests that CMS delay the implementation of the reduced payment for physical therapy and occupational therapy services furnished in whole or in part by physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) at 85 percent of the otherwise applicable Part B payment for the service, currently scheduled to begin on January 1, 2022, to:**

    1. **Permit time for adequate beneficiary, provider, Medicare Administrative Contractor (MAC), education about the significant policy revisions regarding attribution of PTA and OTA services that are proposed in this rule,**
    2. **Permit adequate time for claim medical record and software developers to update, test, deploy updated software as well as train providers on the updates necessary to address the revised PTA and OTA attributions policies proposed in this rule,**
    3. **Be able to develop and deploy educational materials to beneficiaries regarding the policy change and how it may impact their co-insurance liability as well as how therapy service costs are described on their Medicare Summary Notice (MSN).**
    4. **Allow time for CMS to address the claims processing hierarchy under the MPPR policies when the same service procedure code is reported on the same date by a therapist and assistant.**

Comment: In the proposed rule CMS indicates that in order to comply with section 1834(v)(1) of the Act, beginning January 1, 2022, therapy services furnished in whole or in part by a PTA or OTA identified based on the inclusion by the billing therapy services provider (whether a therapist in private practice or therapy provider) of the CQ or CO modifier, respectively, on claim lines for therapy services, and the payment for those services will be adjusted 15%. Additionally, the Agency states that per usual system update process, CMS plans plan to issue instructions in a change request to prepare the Agency's shared systems and Medicare Administrative Contractors (MACs) to pay the reduced amount for therapy services furnished in whole or in part by a PTA or OTA. CMS indicates the Agency will be accomplished by issuing an MLN article once the CR is released, after the CY 2022 PFS final rule is issued.

AHCA/NCAL members do not believe that it is reasonable for CMS to implement such payment cuts without adequate advance provider notice and educations. In the preamble of this section of the proposed rule (86 FR 39213) CMS stated the following statements about all statutory requirements related to this policy as follows:

> *We are implementing the third and final part of the amendments made by section 53107 of the Bipartisan Budget Act (BBA of 2018) (Pub. L. 115–123, February 9, 2018). The BBA of 2018 added a new section 1834(v) of the Act. Section 1834(v)(1) of the Act requires CMS to make a reduced payment for physical therapy and occupational therapy services furnished in whole or in part by physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) at 85 percent of the otherwise applicable Part B payment for the service, effective January 1, 2022.*
>
> *Section 1834(v)(2) of the Act requires that: (1) By January 1, 2019, CMS must establish a modifier to indicate that a therapy service was furnished in whole or in part by a PTA or OTA; and (2) beginning January 1, 2020, each claim for a therapy service furnished in whole or in part*

by a PTA or an OTA must include the modifier. Section 1834(v)(3) of the Act requires CMS to implement these amendments through notice and comment rulemaking.

We note and acknowledge that CMS did meet the January 1, 2019 requirement to establish necessary modifiers to indicate that a therapy service was furnished in whole or in part by a PTA or OTA, and that Beginning January 1, 2020 claims for therapy services furnished in whole or in part by a PTA or OTA were required to include the new modifiers per CMS guidance – without impacting payments. However, the specific policies and guidance related to when providers should use the modifiers on claims has changed significantly since the codes were first required to be submitted with claims beginning January 1, 2020. CMS describes extensively in the proposed rule how the initial coding requirements applicable for CY 2020 were revised for CY 2021 claims submissions as stakeholders identified flaws in the policy as well as sub regulatory guidance. In this rule CMS again is proposing substantive changes to the policies for how therapy services are to be attributed to the PTA or OTA versus when they are not. Each of these changes require substantial provider retraining and medical record and billing software updates so that providers can accurately code claims to comply with this policy.

While we acknowledge that the policy changes introduced in CY 2021 were necessary, and those that are proposed for CY 2022 will further improve the policy to align with the Congressional intent, we must note that the necessary changes for CY 2022 will again require substantive provider retraining and medical record and billing software updates. However, unlike CY 2020 and CY 2021, any coding errors beginning January 1, 2021 will impact payment rates and program integrity exposure unless the implementation is delayed permitting adequate preparation.

In a normal year, the Final Rule is published by November 2 permitting at least a 60-day notice prior to implementation which is challenging. In recent years, the Physician Fee Schedule Final Rule has been late, including last year's rule that was published on December 28, 2020. Additionally, most sub regulatory guidance associated with a Final Rule, or in this situation - therapy service minute attribution rules, algorithms, and associated documentation guidance - will be published to MACs via program transmittals and providers will be informed via MLN Matters articles after the publication of the Final Rule. This will further reduce the timeline for software developers to make necessary coding update and then deploy and train provider staff of the changes, and for providers to retrain staff regarding other building policies revised resulting from the additional changes in how therapy services will be attributed to comply with the revised regulatory requirements. Such updates require months to complete, not weeks. Failure to offer providers sufficient time to prepare for new coding requirements that significantly impact payment rates will result in unnecessary errors.

It is also unclear how beneficiaries will be adequately informed about the policy change in a timely manner – particularly how it will impact their coinsurance liability and how therapy service pricing is reflected on their Medicare Summary Notice (MSN). Failure to provide sufficient beneficiary education in advance will result in unnecessary confusion.

Finally, while this proposed rule addresses the specific therapy assistant policies, we are unaware if CMS has addressed how the implementation of the PTA and OTA adjustment policy will interact with Multiple Procedure Payment Reduction (MPPR) policies. As you know, the MPPR which reduces payments for the practice expense (PE) portion or units of service surpassing the edit threshold on a date of service. Full payment is made for the unit or procedure with the highest PE payment, and the PE of subsequent services are adjusted by 50%.

It is unclear to us how the MPPR edit hierarchy will be applied when multiple units or procedures subject to MPPR adjustments are billed on the same date of service in cases where the services are billed under separate lines by the PT and PTA or OT and OTA. Technically, services furnished by therapists and

assistants have the same base PE prior to application of the new therapy assistant adjustment which could create claims processing/payment problems. We believe that to be consistent with the intent of section 1834(v) of the Act, if an NCCI edit applies, on any date of service where procedures are billed by a therapist and assistant, the edit hierarchy for applying the new therapy assistant payment adjustment and how it interacts with the MPPR policy should not disadvantage a provider. We request that CMS provide clarification of the interaction of the new PTA and OTA payment adjustment policy with the MPPR policy prior to implementation.

- **AHCA supports the CMS proposal to amend the regulations at §§ 410.59(a)(4)(iii)(B) and 410.60(a)(4)(iii)(B) for outpatient occupational therapy and physical therapy services, respectively, and at § 410.105(d)(3)(ii) for CORF services to specify that CMS considers a service to be furnished in part by a PTA or an OTA when the PTA/OTA furnishes a portion of a service, or in the case of a 15-minute timed code, a portion of a unit of a service, separately from the portion of the service or unit of service furnished by the therapist such that the minutes for that portion of a service or a unit of a service furnished by the PTA/OTA exceed 10 percent of the total minutes for that service or unit of a service.**

Comment: AHCA/NCAL appreciates the CMS responsiveness to stakeholder concerns and is proposing this rational and fair regulatory change.

- **AHCA also supports the CMS proposal to amend the regulations to refine the de minimus policy, thereby creating a new "Midpoint Rule" at §§ 410.59(a)(4)(iv) and 410.60(a)(4)(iv) for outpatient occupational therapy and physical therapy services, respectively, and at § 410.105(d)(3)(iii) for CORF services to provide that, for the final 15-minute unit billed for a patient for a date of service, when the PT/OT provides more than the midpoint (at least 8 minutes) of a service such that they could bill for the service without any additional minutes being furnished by the PTA/OTA, the service may be billed without a CQ or CO modifier, and any remaining minutes of service furnished by the PTA/OTA are considered immaterial.**

Comment: AHCA/NCAL appreciates the CMS responsiveness to stakeholder concerns and is proposing this rational and fair regulatory change.

- **AHCA requests that CMS consider applying administrative discretion that when the therapy assistant adjustment is implemented, providers in rural and underserved locations will be exempt from the 15% adjustment.**

Comment: Medicare beneficiaries residing in AHCA/NCAL member nursing facilities, assisted living residences, and residences for individuals with intellectual and developmental disabilities (ID/DD) in rural and underserved locations require outpatient therapy services. Such therapy is essential to restore lost function after a recent health event, or to maintain function or delay functional decline for optimal quality of life. However, given declining reimbursement, including the nine percent cut to PT and OT services promulgated in the CY 2021 Physician Fee Schedule Final Rule to finance increased payments for physician office services, rural outpatient therapy providers and those in underserved areas are increasingly challenged to recruit and retrain physical and occupational professionals, and are increasingly and disproportionately reliant on the services of PTAs and OTAs. This additional rate cut targeting PTA and OTA services will make it even harder for providers to staff these locations. As such, unless exempted, the therapy assistant adjustment policy will impact beneficiaries in rural and underserved areas in an inequitable manner by reducing access to care.

B. Practice Expense RVUs (section II.B.) (86 FR 39106)

- **AHCA/NCAL supports the CMS proposed clinical labor pricing updates described in subsection (d) (86 FR 39118) as reflected in the percent change listed in Table 5 (86 FR 39120) and impact by specialty in Table 6 (86 FR 31922).**

Comment: Given the multiple and substantial financial pressures on Medicare outpatient therapy providers discussed elsewhere in our comments, we appreciate that CMS is recognizing the significant labor costs for physical therapy and speech-language pathology services that were not adequately accounted for in recent years. We support implementing the proposed updates that would increase the labor pricing for physical therapy aides by 39%, physical therapy assistants by 64%, and speech-language pathologists by 64%. This update will somewhat help mitigate the payment cuts implemented in CY 2021 to offset the costs incurred by the CMS decision to update physician officer procedures.

C. Telehealth and Other Services Involving Communications Technology (section II.D.) (86 FR 39130)

Requests to Add Services to the Medicare Telehealth Services List for CY 2022 (86 FR 39131)

- **AHCA/NCAL appreciates that CMS has demonstrated an openness to consider adding the range of services commonly furnished physical and occupational therapy procedures as well as speech-language pathology procedures requested to be added to the permanent telehealth services list presented in Table 8 once additional information becomes available.**

Comment: While AHCA/NCAL is disappointed that CMS is not considering adding the range of services commonly furnished physical and occupational therapy procedures as well as speech-language pathology procedures requested to be added to the permanent telehealth services list presented in Table 8 (86 FR 39132) at this time, we appreciate the opportunity to furnish the services as appropriate during the COVID-19 PHE, which should help provide the data necessary to support permanent adoption in future rulemaking.

Revised Timeframe for Consideration of Services Added to the Telehealth List on a Temporary Basis (86 FR 39136)

- **AHCA/NCAL supports the CMS proposal to retain all services added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023.**

Comment: Many of the Category 3 telehealth services have been very important for residents of skilled nursing facilities, assisted living residences, and AD/DD communities in accessing needed care and reducing the cost and stress of travelling to practitioner offices, while also reducing the risk of COVID-19 infection in this vulnerable population. We agree with the CMS arguments that retaining all services added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023 will allow the Agency time to collect more information regarding utilization of these services during the pandemic, and provide stakeholders the opportunity to continue to develop support for the permanent addition of appropriate services to the telehealth list through the regular consideration process, which includes notice-and-comment rulemaking. Keeping these services on the Medicare telehealth services list through CY 2023, will facilitate the submission of requests to add services permanently in the CY 2023 PFS rulemaking process and for consideration in the CY 2024 PFS rule.

- **AHCA/NCAL supports CMS adding to the Telehealth Category 3 List the following categories of services listed in Table 11 (86 FR 39138).**

    - **Speech, Language, and Audiology Services (27 codes),**
    - **Physical, Occupational, and Speech Therapy (3 codes), and**
    - **Nursing Facility Services (3 codes)**

Comment: Table 11 denotes services added to the Medicare Telehealth Services List for the duration of the PHE beneficial to AHCA/NCAL member residents, but which were not added to the telehealth list on a Category 3 basis. Like our comments above related to existing Category 3 telehealth services, these additional services permitted to be performed via telehealth for the duration of the PHE have been very important for residents of skilled nursing facilities, assisted living residences, and ID/DD communities in accessing needed care and reducing the cost and stress of travelling to practitioner offices, while also reducing the risk of COVID-19 infection in this vulnerable population. We note that many of these codes, particularly related to speech-language pathology services were not introduced until well into the PHE, and therefore there may not be sufficient data collected by the end of the PHE to be able to submit a request for permanent addition to the Medicare Telehealth List. In addition, with the rise of the Delta and other more aggressive COVID-19 variants, even when the PHE ends, there may be a justifiable reason for furnishing these services in a specific situation, particularly if the patient or provider become infected and the safest care delivery method for the service would be via telehealth. If CMS is extending the use of Category 3 telehealth services through the end for CY 2023, then these services listed in Table 11 (86 FR 39138) should also be included into Category 3 to permit an equitable analysis of the efficacy of the services for consideration to add to the permanent telehealth list.

Implementation of Provisions of the Consolidated Appropriations Act, 2021 (CAA) (86 FR 39145)

- **AHCA/NCAL supports the proposed approach to implement Section 123(a) of Division CC of the CAA which will permit the beneficiary's home to be an originating site for telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder.**

Comment: Medicare beneficiaries residing in AHCA/NCAL member facilities and residences often require services for the treatment of mental health disorders. During the COVID-19 PHE, many of these individuals accessed mental health services via telehealth and found that receiving care via this technology was much less disruptive than the often long and stressful process of leaving their residence to go to the mental health practitioner's office. In many cases, they were less likely to miss appointments and therefore were more likely to respond positively to consistent treatment. While this proposed rule would maintain a requirement of periodic face-to-face visits, it provides for much more flexibility and access to this essential service for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, which we support as proposed.

D. Clinical Laboratory Fee Schedule: Laboratory Specimen Collection and Travel Allowance for Clinical Diagnostic Laboratory Tests and Use of Electronic Travel Logs (section III.M.) (86 FR 39308)

- **AHCA/NCAL support revisions to clinical laboratory policies recommended by NASL that would improve access to these vital services for residents in facilities and their residences, particularly those located in rural locations.**

Comment: Residents in AHCA/NCAL member facilities and residences benefit from access to clinical laboratory services furnished at their bedsides or in their homes. This has been particularly important during the COVID-19 PHE. In recent years, even prior to the current pandemic, our members have described challenges in getting clinical laboratory services for their residents, particularly in rural locations – citing that clinical lab providers are often unwilling to service their location due to inadequate Medicare reimbursements. With the ongoing and evolving nature of the COVID-19 virus, highlighted by the current Delta variant surge, we have reached a "new normal" for the need of safe and timely clinical laboratory services, which will obviously be reflected in increased costs borne by the clinical laboratory service providers.

Our members support many of the improvements suggested by the National Association for the Support of Long-Term Care (NASL), who represent many clinical laboratory providers that furnish services to AHCA/NCAL member facilities and residences. Specific NASL suggested reforms that we support include:

1. Simplify the travel allowance by creating a single per-encounter flat-rate payment for travel,
2. Create a rural add on to a single per-encounter flat-rate payment for travel,
3. Recognize costs borne by the industry by permanently increasing the laboratory specimen collection fee, and
4. Extend the increased reimbursements post-pandemic to ensure our nation's most vulnerable have access to vital bedside medical services, including specific considerations to increase specimen collection fees related to non-COVID-19 CDLTs

E. Provider/Supplier Medical Review Requirements: Addition of Provider/Supplier Requirements related to Prepayment and Post-payment Reviews (section III.N.2.) (86 FR 39315)

- **AHCA/NCAL supports efforts at clarifying medical review policy definitions in regulation to improve provider understanding of the processes as well as improve audit consistency among contractors.**

Comment: We agree that it would be appropriate to standardize longstanding sub regulatory medical review definitions and timelines in regulation, particularly those that are inconsistent. We also appreciate that CMS is proposing to promulgate regulatory protections that would require contractors give the provider or supplier notice and time to respond to the additional documentation request, and that permit providers to submit additional documentation in response to requests beyond the response timeline for good cause.

F. Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA–PD Plan (section 2003 of the SUPPORT Act) (section III.Q.) (86 FR 39326)

- **AHCA/NCAL supports the CMS proposal to extend the compliance deadline for Part D controlled substance prescriptions written for beneficiaries in long-term care (LTC) facilities, excluding beneficiaries who are residents of nursing facilities and whose care is provided under Part A of the benefit, from January 1, 2022, to January 1, 2025.**

Comment: Section 2003 of the SUPPORT Act generally mandates that the prescribing of a Schedule II, III, IV, or V controlled substance under Medicare Part D be done electronically in accordance with an electronic prescription drug program beginning January 1, 2021, subject to exceptions, which the Secretary may specify. AHCA/NCAL appreciates the CMS administrative discretion applied in proposing to adjust compliance deadlines impacting our member nursing facilities.

Our members recognize that electronic prescribing of controlled substances provides multiple advantages over the traditional processing of paper prescriptions. However, as CMS has noted in the proposed rule, nursing facilities have and continue to face significant structural barriers in obtaining and implementing health information technology (HIT) and assuring adequate interoperability with other healthcare provider systems. Some of these barriers include:

- Skilled nursing facilities were excluded from HITECH Act funding to adopt interoperable HIT that was extended to hospitals and physicians and continue to be excluded from such funding,
- The NCPDP SCRIPT 2017071 standard is inadequate for SNF/LTC facility workflow, and as CMS notes, an adequate script may not be adopted until at least January 1, 2023.
- Many LTC/SNF facilities in rural locations continue to lack access to broadband service to provide secure interoperable connectivity need for compliance with this requirement.

We support the CMS proposal to revise § 423.160(a)(5) to extend the compliance deadline for Part D controlled substance prescriptions written for beneficiaries in long-term care (LTC) facilities, excluding beneficiaries who are residents of nursing facilities and whose care is provided under Part A of the benefit, from January 1, 2022, to January 1, 2025. However, we also request that CMS work diligently with LTC providers to expedite the removal of the longstanding barriers to implementing the interoperable HIT technology and workflows that will permit successful compliance of this electronic prescription requirement. We also request that CMS provide status updates as we move toward the revised January 1, 2025 compliance date to identify if further flexibilities are necessary.