

December 17, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-4185-P
PO Box 8013
Baltimore, MD 21244-8013

Submitted Electronically

Re: Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021 (CMS-4185-P)

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit the following comments on the Policy and Technical Changes to the Medicare Advantage (MA), Medicare Prescription Drug Benefit, Program of All-inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021 proposed rule. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

APTA supports the implementation of a new regulation to allow MA plans to offer additional telehealth benefits. Increasingly, providers, patients, and payers are seeking more effective and cost-efficient ways to deliver care. In 2015, of Kaiser Permanente's 110 million interactions between physicians and members, 56% were virtual, surpassing physical visits for the first time.

Consequently, Kaiser Permanente estimated the number of consumers using telehealth within their system would increase to roughly 7 million by 2018 (up from 350,000 in 2013).¹ Coverage of telehealth services is gradually becoming more widespread, particularly with commercial payers and state Medicaid programs; 30 states and the District of Columbia require that private insurers cover telehealth the same as they cover in-person services.² Many other insurers cover at least some telehealth service—and many more have expressed interest in expanding their telehealth coverage. Further, 49 states and the District of Columbia currently have some form of Medicaid reimbursement for telehealth.³ Proper application of telerehabilitation services, particularly in underserved regions, can dramatically improve care and patient outcomes and reduce costs by ensuring access to specialized services in isolated rural areas that face difficulties in maintaining and staffing full-service hospitals⁴ and attracting sufficient outpatient community-based providers.

APTA supports CMS's proposal to include additional telehealth benefits in the definition of basic benefits and to account for additional telehealth benefits in the basic benefit bid. Under this proposal, MA plans will be permitted to offer—as part of the basic benefit package—additional telehealth benefits beyond what is currently allowable under the original Medicare telehealth benefit. We request the agency consider our detailed comments below.

Recommendations

Finalize Proposed Definition of Additional Telehealth Benefits

APTA recommends that CMS finalize its proposal to define additional telehealth benefits as services that meet the following: (1) are furnished by an MA plan for which benefits are available under Medicare Part B but that are not payable under section 1834(m) of the Social Security Act (Act); and (2) have been identified by the MA plan for the applicable year as clinically appropriate to furnish through electronic exchange. Skilled services furnished by physical therapists are available under Medicare Part B but not payable under Section 1834(m) of the Act. As such, under the proposed definition, physical therapy services may qualify as additional telehealth benefits, should they be identified by the MA plan as clinically appropriate to furnish through electronic exchange.

The increased use of telehealth to deliver health care may require clinicians to practice across geographic boundaries. The Department of Veterans Affairs (VA), which operates the nation's largest health care system and is recognized as a world leader in the development and use of telehealth services, has achieved better results through telemedicine. According to the VA, telemedicine has increased access to high-quality health care services and has proven to be an

¹ Sangarapillai Manoharan M. Current Capabilities and Moving Forward With Telemedicine Treatment. Presentation at National Workers' Compensation and Disability Conference & Expo. 2017:9.

² American Telemedicine Association. Webpage. Q&A: About Telemedicine. <http://www.americantelemed.org/main/about/about-telemedicine/telemedicine-faqs>. Accessed December 7, 2018.

³ Center for Connected Health Policy. Webpage. Telehealth and State Medicaid Policy. https://www.cchpca.org/sites/default/files/2018-10/CCHP_50_State_Report_Fall_2018.pdf. Accessed November 18, 2018.

⁴ Medicare Payment Advisory Commission June 2016 Report to Congress, Chapter 8. <http://www.medpac.gov/docs/default-source/reports/chapter-8-telehealth-services-and-the-medicare-program-june-2016-report-.pdf?sfvrsn=0>. Accessed December 7, 2018.

effective and convenient way for patients to receive—and medical providers to provide—medical care.⁵ In an effort to improve licensure portability for physical therapists and physical therapist assistants, the Federation of State Boards for Physical Therapy, with support from APTA, recently developed an interstate licensure compact for physical therapy.⁶ The purpose of the Physical Therapy Licensure Compact is to increase consumer access to physical therapy services by reducing regulatory barriers to interstate mobility and cross-state practice. Under the compact, physical therapists and physical therapist assistants are able to apply for privileges to practice in participating states while maintaining licensure in their home state. This compact, currently adopted in 21 states, also allows physical therapists located in states that have signed onto the compact to use telehealth to expand their practices and enhance patient access. Ultimately, the expansion of coverage by MA plans for telehealth would be a cost- and life-saving solution to the critical access to care concerns that impact MA enrollees.

Coverage of additional telehealth benefits would facilitate patient-centered care by providing enrollees the needed discretion to determine when, where, and how they access benefits and seek specialized clinicians that can best address their condition. The implementation and expansion of telehealth availability also would greatly reduce the cost and burden of seeking care across urban and rural geographies. Further, APTA supports CMS’s proposal to continue to permit MA plans to offer supplemental benefits via remote access technologies and/or telemonitoring for services that do not meet the requirements for additional telehealth benefits.

Electronic Exchange

APTA supports CMS’s proposal to define *electronic exchange* as “electronic information and telecommunications technology.” Examples of electronic information and telecommunications technology (electronic exchange) may include, but are not limited to, the following: secure messaging, store-and-forward technologies, telephone, videoconferencing, other internet-enabled technologies, and other evolving technologies as appropriate for non-face-to-face communication. This broad and encompassing approach allows for technological advances that may develop in the future and avoids tying the authority in the proposed new regulation to specific information formats or technologies that permit non-face-to-face interactions for furnishing clinically appropriate services.

Clinically Appropriate

We appreciate that CMS is seeking feedback on whether to place limitations on the types of Part B items and services that can be included as additional telehealth benefits, and its approach to do so. APTA supports CMS’s proposal not to specify the Part B services that a MA plan may offer as additional telehealth benefits, but instead to allow MA plans to independently determine which services are clinically appropriate on an annual basis. MA plans are in the best position to identify which additional benefits are clinically appropriate to furnish through electronic exchange. Taking a broad approach will help to expand access to telehealth for individuals who suffer from chronic and/or complex conditions. Chronic conditions, such as diabetes mellitus or congestive heart failure, are well suited to telehealth. For example, researchers at Community

⁵ Department of Veterans Affairs—Office of Public Affairs. (n.d.). Fact Sheet - VA Telehealth Services. www.va.gov/COMMUNITYCARE/docs/news/VA_Telehealth_Services.pdf. Accessed December 7, 2018.

⁶ Physical Therapy Licensure Compact. Webpage. Federation of State Boards of Physical Therapy. <http://www.fsbpt.org/FreeResources/PhysicalTherapyLicensurecompact.aspx>. Accessed November 18, 2018.

Health Center and the University of Connecticut Health Center found that a telemedicine consult platform specific to cardiology cases saved almost \$500 per patient in Medicaid costs over in-person treatments. Although unique to cardiology, this supports the concept that telehealth offers cost savings opportunities for patients, providers, and payers.⁷ Such conditions require frequent appointments, often just to assess a patient's status; as such, access to these services via a telehealth medium could greatly reduce the burden of managing these conditions, consequently resulting in better patient outcomes and improved quality of life. Additionally, individuals who are homebound or have disabilities that make travel difficult would benefit from being able to access the provider in their own environment; access to telehealth also would allow oversight and encourage patients who are not activated and/or engaged with self-care instructions. We are hopeful the new policy will allow MA plans to focus on provider types that previously have been denied the opportunity to participate in telehealth opportunities.

For example, physical therapy often is overlooked in telehealth when it is actually well-suited to the medium. Physical therapists play a vital role in optimizing movement through patient education and empowerment. They observe how a person moves, employ coaching techniques, assess patient risk, and instruct patients in safe and efficient ways to improve daily activities. Physical therapists also utilize telehealth to assess the patients' environment and identify and mitigate risk to ensure a successful treatment outcome. Rather than simulating a patient's home, work, or school environment based on an oral account, physical therapists are able to observe those environments in real time, and witness the way a patient navigates and engages. The vast majority of physical therapist treatments include a home exercise component. Using telehealth to observe patients in their own environment ensures that exercises and functional activities are properly performed and allows the physical therapist to help patients avoid complications and further injury. This is particularly beneficial to persons with chronic conditions—a population that is at risk for falls and other serious and avoidable complications.

Telehealth therapy services have the potential to prevent falls, functional decline, costly emergency room visits, and hospital admissions and readmissions. Further, the very nature of physical therapy treatment, in that it generally requires multiple sessions per week, makes it well-suited to telehealth. For homebound patients, those who require assistance to attend medical appointments, those who need to travel long distances, or those with chronic conditions requiring ongoing treatment, the ability to replace or supplement some of the in-clinic sessions with those furnished via telehealth greatly reduces the burden on the patient and caregivers to access care. Access to services via telehealth would allow more patients to seek care at their convenience without having to miss work or school, and would also support greater engagement and access for caregivers who may be working to balance multiple responsibilities.

Telehealth furnished by physical therapists also has the potential to greatly enhance patient health and well-being. Proper application of telehealth rehabilitation therapy services potentially can have a dramatic impact on improving care, reducing negative consequences, and lowering costs by ensuring access to specialized care in geographic areas that face difficulties in

⁷ Is Telemedicine Actually Impacting Your Workers' Comp Claims? <http://riskandinsurance.com/telemedicine-impacting-workers-comp/>. Accessed December 7, 2018.

maintaining and staffing full-service hospitals⁸ or attracting sufficient community-based providers. Incentivizing the delivery of telehealth by physical therapists will lead to reduced health care expenditures, increased patient access, and improved management of chronic disease and quality of life, particularly in rural and underserved areas. Patient geography no longer will be a barrier to receiving timely, appropriate medical care with the most qualified provider. While rehabilitative services furnished via telehealth would not replace traditional clinical care, it would give physical therapists, and physical therapist assistants acting under the direction and supervision of physical therapists, the flexibility to provide care when and where it is most needed.

APTA requests that CMS clarify in final rulemaking that MA plans that choose to cover telehealth within their basic benefit package may include, if determined to be clinically appropriate to be furnished through electronic exchange, telehealth services furnished by a physical therapist. Physical therapists are qualified health care professionals under the definition put forth by the AMA. That is, a “physician or other qualified health care professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.”

Enrollee Access

MA enrollees should have access to high-quality providers in their communities, in both urban and rural areas. CMS states within the rule that an “enrollee has the right to request additional telehealth benefits through the organization determination process. If an enrollee is dissatisfied with the organization determination, then the enrollee has the right to appeal the decision.” Given CMS’s efforts to ensure enrollee access to medically necessary services, and as discussed in more detail below, we encourage CMS to closely examine MA plans’ adoption of prior authorization and utilization management for a broad range of medically necessary services. MA enrollees should have direct access to certain services covered under Part B, such as physical therapy, without being subject to prior authorization requirements.

Allowing MA enrollees direct access to physical therapist care, particularly for musculoskeletal problems, is a cost-effective alternative as it eliminates additional physician visits, reduces medication use including opioids, prevents more costly interventions such as hospitalization or surgery, and eliminates or reduces delays in care, thus improving health outcomes and reducing overall health care costs. At a minimum, we encourage CMS to require MA plans to furnish same-day authorizations. By doing so, MA plans would enhance patient access to timely, high-quality care that is appropriate for the patient’s condition, would avoid preventable adverse events, and would reduce the utilization of unnecessary and/or high risk services. We also encourage CMS to closely audit plan performance with respect to timeliness of treatment authorizations and impose penalties if unnecessary delays are identified.

⁸ Medicare Payment Advisory Commission June 2016 Report to Congress, Chapter 8. <http://www.medpac.gov/docs/default-source/reports/chapter-8-telehealth-services-and-the-medicare-program-june-2016-report-.pdf?sfvrsn=0>. Accessed November 18, 2018.

Other Recommendations

We appreciate that CMS is making revisions to MA and Medicare Part D program policies to reduce burden and increase beneficiary access. However, we are disappointed that CMS failed to incorporate any of our previous suggestions in our response to the agency's request for information and to the Contract Year 2019 MA proposed rule. APTA encourages the agency to consider our detailed recommendations below.

Develop Policies That Incentive MA Plans to Increase Enrollee Access to Preventive Services

Expanding the capacity of preventive services and increasing their availability to the MA population will have a powerful effect on the health of enrollees, their families, and communities. For example, to reduce the risk of functional decline, falls, and hospitalizations, we encourage CMS to invest in and promote preventive services, including an annual "wellness" visit by a physical therapist. Physical therapists have the necessary education, experience, and expertise to provide a broad health and functional screening and to track the patient's health and functional status over time. Such a screening may also lead to a referral for a physical therapist evaluation and treatment or to another health care professional for potential problems identified during the visit that could have escalated—requiring more costly treatment later—had they remained unchecked. Moreover, visiting a physical therapist annually promotes optimal health, wellness, and fitness, and slows the progression of impairments, functional limitations, and disabilities through early identification and management of risk. We encourage CMS to more closely evaluate the importance and cost effectiveness of preventive and risk-management services for MA enrollees and work with plans to expand access to such services across states and communities.

Accrued Amount of Therapy Services for Medicare Advantage Enrollees

APTA has concerns that MA payers that require therapy providers to affix the KX modifier for services above the outpatient therapy threshold to indicate medical necessity do not furnish providers with information related to each MA enrollee's utilization based on the outpatient therapy threshold. Per CMS's Therapy Services webpage:

Section 50202 of the Bipartisan Budget Act of 2018 (BBA of 2018) repealed application of the Medicare outpatient therapy caps and its exceptions process while adding limitations to ensure appropriate therapy. The new law, through section 50202 of the BBA of 2018, preserves the former therapy cap amounts as thresholds above which claims must include the KX modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record. Just as with the incurred expenses for the therapy cap amounts, there is one amount for PT and SLP services combined and a separate amount for OT services. This amount is indexed annually by the Medicare Economic Index (MEI). For CY 2018 this KX modifier threshold amount is:

- \$2,010 for PT and SLP services combined, and
- \$2,010 for OT services.⁹

⁹ Note: This amount is increased to \$2,040 for PT and SLP services combined and \$2,040 OT services in 2019.

Along with this KX modifier threshold, the new law retains the targeted medical review (MR) process (first established through Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)), but at a lower threshold amount of \$3,000. For CY 2018 (and each calendar year until 2028 at which time it's indexed annually by the MEI), the MR threshold is \$3,000 for PT and SLP services and \$3,000 for OT services. The targeted MR process means that not all claims exceeding the MR threshold amount are subject to review as they once were.¹⁰

Through Section 50202 of BBA of 2018, Congress essentially made permanent the exceptions process for outpatient therapy services. In Medicare fee-for-service, outpatient therapy providers are generally able to access the accrued amount of therapy services from the ELGA screen inquiries (now Medicare Health Insurance Portability and Accountability Act Eligibility Transaction System, or HETS) in the CWF, through the IVR, provider portal, etc. Suppliers who did not have access to these inquiries could call the contractor to obtain the amount accrued.

MA enrollees can receive outpatient therapy services from the offices of privately practicing therapists, physician offices, outpatient hospital departments, CAH outpatient departments, rehabilitation agencies, CORFs, skilled nursing facilities, and/or from home health providers. However, MA plans do not update the accrued amount of therapy services, requiring therapy providers furnishing care to MA enrollees to internally track total claim amounts for enrollees and apply the KX modifier to claims exceeding the threshold (\$2,040 for PT and SLP combined and \$2,040 in 2019) when appropriate.

By refusing to update the accrued amount of outpatient therapy services, MA plans render it extremely difficult, if not impossible, for outpatient therapy providers to determine when to affix the KX modifier to the claim to indicate that services over the threshold are medically necessary. Not providing such information is simply one more administrative and financial burden on outpatient therapy providers, which not only results in a loss of reimbursement for outpatient therapy providers but also forces providers to direct time, effort, and resources away from patient care to call MA plans and inquire as to the beneficiary eligibility. Moreover, such practices are contrary to CMS's goals to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience.

To continue to reduce burdens for therapy providers, improve the quality of care, decrease costs, and ensure that patients and their therapy providers are making the best health care choices possible, we strongly request that CMS direct MA plans to provide enrollee utilization of therapy services on an ongoing basis. To ensure that therapy providers are properly affixing the KX modifier to claims, it is imperative that they have access to real-time MA enrollee utilization data.

Prior Authorization for MA Plans

APTA strongly encourages CMS to develop additional policies that reduce unnecessary regulations and improve access to physical therapy within the MA program. Currently, MA enrollees must undergo a prolonged, burdensome process to obtain treatment authorization. A

¹⁰ Centers for Medicare and Medicaid Services. Medicare Billing: Therapy Services. <https://www.cms.gov/Medicare/Billing/TherapyServices/index.html>. Accessed November 28, 2018.

delay in authorization may severely hinder a patient's recovery, requiring physical therapists and other providers to decide between furnishing an uncovered service at their own expense or risk the patient's health and well-being by waiting for a plan to authorize medically necessary care. Additionally, the care authorized by the health plan often is often not consistent with the physical therapist and physician recommendations nor of the goals and values of the patient. While APTA supports appropriate utilization management to promote the delivery of value-based care, we contend that current prior authorization programs exponentially increase administrative burden while simultaneously adversely impacting patient access to medically necessary care and creating a systematic focus on volume of services.

In accordance with the health care triple aim, APTA understands and supports reasonable efforts to ensure appropriate utilization of physical therapy services that recognize the physical therapist's ability to render patient-centered care using evidence-based guidelines, clinical judgment and decision-making, full scope of licensure, timely patient access to medically necessary services, and streamlined administrative processes. However, current MA prior authorization programs are not consistent with these objectives. While many plans have instructions for obtaining prior approval for current and ongoing patients, they are unclear and burdensome. Moreover, because various system issues have proven overwhelming and require immediate attention, APTA is concerned about the long-term impact of these program structures and design. Prior authorization runs contrary to the precepts of a value-based model and does not facilitate professional judgment or clinical decision-making based on patient presentation or outcome.

We also question the problems Medicare Advantage Organizations (MAOs) are attempting to address through prior authorization. In light of the opioid epidemic and growing body of evidence, prior authorization programs—by not supporting early access to conservative, nonpharmacological management for musculoskeletal conditions including low back pain—further impede access, delay medically necessary services, increase use of medications, facilitate seeking of less-effective treatments, and likely increase downstream and total costs of care. Prior authorization substantially increases administrative burden and the possibility of inadvertent error and is in direct conflict with contemporary clinical practice.

To better align MAOs with CMS's Patients over Paperwork initiative, we urge CMS to require MAOs to take action toward a goal of reducing unnecessary burden, increasing efficiencies, and improving the customer experience by eliminating prior authorization or, at a minimum, requiring MAOs to furnish same-day authorizations. Alternatively, to ensure that beneficiaries continue to receive high-quality care and avoid stinting on medically necessary services, APTA suggests that CMS consider the following: exempting from prior authorization patient populations with certain conditions, and clinicians who participate in standardized data collection system and are willing to share outcomes; require the use of specific performance-based outcome measures; and/or require the collection of patient-reported outcome measures that have clinical utility and are meaningful to a diverse set of provider types.

By acting in the spirit of the Patient Protection and Affordable Care Act by protecting MA enrollees from arbitrary care denials and restrictions, CMS would help to better ensure patient access to timely, high-quality care that is appropriate for the patient's condition, avoids

preventable adverse events, and saves plans, providers, and patients from expending resources on unnecessary services.

Conclusion

APTA thanks CMS for the opportunity to comment on the Policy and Technical Changes to the MA, Medicare Prescription Drug Benefit, PACE, Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021 proposed rule. We look forward to working with CMS in making revisions to the policies proposed within this rulemaking to ensure that MA enrollees continue to have access to medically necessary physical therapy services. Should you have any questions or need additional information, please contact Kara Gainer, director of regulatory affairs, at karagainer@apta.org or 703/706-8547.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Sharon L. Dunn". The signature is written in a cursive, flowing style.

Sharon L. Dunn, PT, PhD
Board-Certified Orthopaedic Clinical Specialist
President

SLD: krg