

August 30, 2010

Secretary Kathleen Sebelius
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2480-NC
P.O. Box 8010
Baltimore, MD 21244-1850

Submitted Electronically

RE: CMS-2480-NC Medicaid Program; Request for Comments on Legislative Changes to Provide Quality of Care to Children

Dear Secretary Sebelius:

On behalf of the American Physical Therapy Association and our 74,000 physical therapists, physical therapist assistants, and students of physical therapy members, we respectfully submit this letter in response to the Centers for Medicare and Medicaid Services' (CMS) "Request for Comments on Legislative Changes to Provide Quality of Care to Children". Physical therapy is an essential service provided to children under the Medicaid and the Children's Health Insurance Program (CHIP). Therefore, we are very excited about the opportunity to provide legislative recommendations.

Therapy services are provided in a variety of settings, including home care, Intermediate Care Facilities for People with Mental Retardation (ICF/MR), hospitals, outpatient clinics or offices; inpatient rehabilitation facilities; skilled nursing, extended care, sub-acute facilities; patients' education or research centers, hospices and schools. Therapy helps a beneficiary gain the best possible function. Specifically, physical therapy services ensure the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health.

Medicaid has "mandatory" services that each state must offer and then each state is allowed the flexibility to cover additional "optional" services as it sees fit. Physical therapy falls into this category of "optional services", and is currently covered in approximately 37 states. When covered this benefit serves the most vulnerable Medicaid populations—children and individuals with disabilities. APTA is concerned that as the Medicaid system is

streamlined to become more efficient and cost-effective, optional services such as physical therapy will be marginalized.

It is our fear that beneficiaries who could greatly benefit from physical therapy will lose access to these services. Elimination of optional services, which in fact are essential services, could likely cost the State more when eliminated services result in institutionalized care, development of more severe health outcomes, or increased visits to hospitals.

In this solicitation, CMS requests public comments for legislative changes that can be recommended to the Secretary of Health and Human Services, including requirements for the process and content of quality reporting by the States. These recommendations should align with the quality of care provided under the Social Security Act for:

- *Preventative health care services;*
- *Health care for acute conditions;*
- *Chronic health care;*
- *Health services to ameliorate the effects of physical and mental conditions and to aid in the growth and development of infants, young children, school-age children, and adolescents with special health care needs.*
- *The quality of children’s health care under the Social Security Act, across various domains of quality, including:*
 - *Clinical quality,*
 - *Health care safety,*
 - *Family experience with health care,*
 - *Health care in the most integrated setting,*
 - *Elimination of racial, ethnic, and socio-economic disparities in health and health care.*

APTA asserts that the subsequent comments address the dimensions of quality and subject areas set forth in this solicitation. Accordingly, we strongly urge the Administration to consider the following recommendations for congressional and regulatory action.

Promulgating Physical Therapy as a “Mandatory Service” under the Medicaid and CHIP Programs

As stated previously, physical therapy currently falls under the category of “optional services” under the Medicaid program; meaning States may choose to offer these services under the State Medicaid plan. Physical therapy services are only mandatory when offered under the Early, Periodic Screening, Diagnostic, and Treatment program which is very narrow and limited in scope and duration. This denies a major portion of Medicaid beneficiaries’ access to medically necessary physical therapy services.

Under *Section 1302 of the Patient Protection and Affordable Care Act of 2010*, the Secretary is mandated to provide an essential health benefits package that has a

delineated rehabilitation benefit. APTA is very encouraged by the provision and strongly urges the Secretary to recommend that this provision clearly state in statute that it includes physical therapy and mandates that all state Medicaid and CHIP plans must offer physical therapy as an “essential health benefit” to all beneficiaries. Under Medicare, physical therapy services have their own benefit under *Section 1861(P) of the Social Security Act* and are covered when provided according to the standards and conditions of the benefit described in the Medicare regulations. We contend that it is wholly appropriate to establish such a benefit in the Medicaid program on the federal level.

Medicaid must embrace and recognize the team approach to the delivery of quality health care. Physical therapists are integral members of the rehabilitation treatment team and States, as well as the federal government, should make every effort to make unrestricted access to physical therapy available to all Medicaid beneficiaries during rehabilitation treatment.

Defining “Qualified Physical Therapist” and “Qualified Physical Therapist Assistant” under Medicaid and CHIP Programs

APTA strongly believes that physical therapy services should only be delivered by a qualified physical therapist and/or physical therapist assistant. This clarification will substantially improve the quality of care provided to Medicaid beneficiaries. To ensure patient safety and quality of care, it is critical that beneficiaries receive physical therapy services from health care professionals who are trained and educated in the specific discipline.

Physical therapists possess the specialized training to treat children with disabilities and other chronic conditions. APTA is very concerned about the delivery of physical therapy services by non-qualified providers under the Medicaid program. This has become especially apparent in the school-based setting where aides with insufficient training have been utilized to carry out physical therapy plans of care without appropriate supervision by licensed and qualified therapists. This practice is severely diminishing the level of care delivered to children in the school-based setting. As with all patients, these Medicaid beneficiaries deserve only the best quality of care. We strongly believe that access to quality care should not be compromised for any reason.

Therefore, APTA offers that the Secretary recommends that a definition of “qualified physical therapist” and “qualified physical therapist assistant” be mandated for the Medicaid and CHIP programs as delineated under the Medicare program.

At 42 *CFR Section 484.4*, “qualified physical therapist” is defined as,

A person who is licensed, if applicable, by the State in which practicing, unless licensure does not apply and meets one of the following requirements:

(a)(1) Graduated after successful completion of one of a physical therapist education program approved by one of the following:

- (i) The Commission on Accreditation in Physical Therapy Education (CAPTE).*
- (ii) Successor organizations of CAPTE.*
- (iii) An education program outside the United States determined to be substantially equivalent to physical therapist entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or an organization identified in 8 CFR 212.15(e) as it relates to physical therapists.*
- (2) Passed an examination for physical therapists approved by the State in which physical therapy services are provided.*
- (b) On or before December 31, 2009--*
 - (1) Graduated after successful completion of a physical therapy curriculum approved by the Commission on Accreditation in Physical Therapy Education (CAPTE); or*
 - (2) Meets both of the following:*
 - (i) Graduated after successful completion of an education program determined to be substantially equivalent to physical therapist entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified in 8 CFR 212.15(e) as it relates to physical therapists.*
 - (ii) Passed an examination for physical therapists approved by the State in which physical therapy services are provided.*
- (c) Before January 1, 2008--*
 - (1) Graduated from a physical therapy curriculum approved by one of the following:*
 - (i) The American Physical Therapy Association.*
 - (ii) The Committee on Allied Health Education and Accreditation of the American Medical Association.*
 - (iii) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association.*
- (d) On or before December 31, 1977. was licensed or qualified as a physical therapist and meets both of the following:*
 - (1) Has 2 years of appropriate experience as a physical therapist.*
 - (2) Has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.*
- (e) Before January 1, 1966--*
 - (1) Was admitted to membership by the American Physical Therapy Association;*
 - (2) Was admitted to registration by the American Registry of Physical Therapists; and*
 - (3) Graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education.*
- (f) Before January 1, 1966 was licensed or registered, and before January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy.*
- (g) If trained outside the United States before January 1, 2008, meets the following requirements:*
 - (1) Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy.*
 - (2) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.*

The definition of physical therapist assistant included in *section 484.4* is as follows:

A person who is licensed, registered or certified as a physical therapist assistant, if applicable, by the State in which practicing, unless licensure does not apply and meets one of the following requirements:

(a)(1)(i) Graduated from a physical therapist assistant curriculum approved by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association; or if educated outside the United States or trained in the United States military, graduated from an education program determined to be substantially equivalent to physical therapist assistant entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified at 8 CFR 212.15(e); and

(ii) Passed a national examination for physical therapist assistants.

(b) On or before December 31, 2009, meets one of the following:

(i) Is licensed, or otherwise regulated in the State in which practicing.

(ii) In States where licensure or other regulations do not apply, graduated before December 31, 2009, from a 2-year college-level program approved by the American Physical Therapy Association and after January 1, 2010, meets the requirements of paragraph (a) of this subsection.

(c) Before January 1, 2008, where licensure or other regulation does not apply, graduated from a 2-year college-level program approved by the American Physical Therapy Association.

(d) On or before December 31, 1977, was licensed or qualified as a physical therapist assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

We believe that implementation of the above provisions in the Medicare program have helped to ensure that beneficiaries receive the maximum quality of care by the most appropriate, competent and skilled providers. Therefore, we urge the Secretary to recommend the implementation of this definition of “qualified provider” for all physical therapy services billed under the Medicaid and CHIP program.

Establishing Minimum Documentation Standards

Because of the partnership between the federal and state entities and the shared responsibilities, providers are often confused as to proper documentation standards for the Medicaid and CHIP programs. Unlike the clearly articulated documentation standards¹ that have been created by the Center for Medicare & Medicaid Services (CMS) for Medicare, clinical documentation guidelines for Medicaid are often confusing or non-existent.

Therefore, we recommend that the Secretary include in legislative recommendations a proposal for minimum documentation standards for Medicaid and CHIP at the federal level. Minimum documentation guidelines will lead to better efficiency and improved

¹ As delineated in CMS Transmittal 52, June 30, 2006 (Medicare Benefits Policy Manual, Pub. 100-02)

delivery of healthcare. By creating uniform clinical documentation standards, states will be able to collect the data necessary to measure quality and performance and the valuable information needed to detect fraud and abuse. In addition, APTA offers its expertise to CMS in crafting the appropriate clinical documentation standards for physical therapy services.

Improving Access to Durable Medical Equipment

For people with a variety of physical disabilities such as spinal cord injuries, traumatic brain injuries, cerebral palsy, and amputations, Medicaid is often their only means of accessing durable medical equipment (DME) like wheelchairs, prosthetic devices, and assistive technologies, particularly in school-based settings.

Physical therapists provide orthotics, ambulatory aids, and mobility assistance devices to the patients they serve to help them improve their function. These items become an essential part of the treatment plan for the patients who need them. DME is provided by physical therapists as an integral part of their physical therapy plan of care. The clinical judgment and expertise of the physical therapist is critical in selecting a particular DME item for the patient and is based on the therapist's evaluation of the individual patient. The physical therapist ensures that the item is appropriate to achieve the patient's functional goals, is properly sized and fitted for the patient, and that the patient and/or caregiver is educated in the proper use of the item.

In order to ensure that Medicaid beneficiaries receive the proper DME for their condition and to maximize rehabilitation and overall function, federal and state governments must ensure that health providers such as physical therapists are at the center of decision-making and that adequate funds are appropriated for the furnishing of DME. Therefore, APTA strongly urges the Secretary to include in legislative recommendations a defined structure that delineates that the entire medical record, including documentation from physical therapists, must be considered when determining the DME needs for infants, children, and young adults under the Medicaid and CHIP programs, as well as, mandating that States must make the coverage of these DME items for infants, children and young adults a funding priority within their state Medicaid and CHIP programs.

Promoting Preventative Medicine

The Secretary should recommend that all state programs include prevention services and promote health, wellness, and fitness. Physical therapists are involved in prevention, promoting health, wellness, and fitness, and in performing screening activities. These initiatives decrease program costs by helping Medicaid patients: (1) achieve and restore optimal functional capacity; (2) minimize impairments, functional limitations and disabilities related to congenital and acquired conditions; (3) maintain health; and (4) create appropriate environmental adaptations to enhance independent function.

Private insurers have led the way in implementing prevention/wellness programs, using health information technology, and requiring a team approach in patient care. Medicaid

should not be any different from these private initiatives. Both entities aim to provide quality health care, efficiently and cost-effectively.

Under *Section 4108 of the Patient Protection and Affordable Care Act of 2010*, the Secretary is required to provide incentives for prevention of chronic diseases in Medicaid. The Secretary would award grants to States to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions.

APTA is very excited about the possibilities that this new provision presents and urges the Secretary to recommend that these programs, as a minimum, must include physical therapy services. Physical therapists are uniquely qualified to address all of the above conditions and would add a wealth of expertise and enhanced value to these grant programs. In addition, physical therapy would aid States in reducing costs for much more costly services in the future for chronic health conditions and co-morbidities.

Incorporating the Use of Health Information Technology

As the Secretary explores cost-savings and efficiency in the Medicaid and CHIP program, the APTA commends the Administration's and Congress' decision to include health information technology (health IT) in its discussions and rulemaking processes. Numerous studies show that significant positive changes can be achieved with the adoption of comprehensive health information technology and quality assessment in health care delivery.

Physical therapists recognize that health care providers must ensure that their interventions contribute to the function, health, and well-being of their patients—the health consumer. To this end, the APTA supports the adoption of health information technology and the concept of pay for performance. However, it is vitally important that the adoption of health IT is approached comprehensively, including patient assessment tools, clearly identified health outcomes, interventions based on sound science and evidence, recognition that individuals with the same medical condition often present differently, and a cross-section of health care providers in health IT adoption plans. Discussions surrounding health information technology should take a multi-disciplinary approach and focus on the ultimate goal which is better performance by the health care provider (pay for performance) and improved health outcomes.

The goal for adopting health IT and pay for performance is not only ensuring efficiency in health care delivery but more importantly improving and/or preventing a decline in individuals' health status. Following this principle, the APTA has developed a database containing current research evidence on the effectiveness of physical therapy interventions, an electronic medical record (EMR) system, and an instrument that provides the beginning of documentation of outcomes that identify the unique contributions of the physical therapist practice.

Therefore, we strongly encourage the Secretary to recommend the continued work of implementing electronic health records, registries, and personal health records into the Medicaid and CHIP program.

Conclusion

APTA thanks CMS for the opportunity to offer recommendations on legislative changes to provide quality of care to children under the Medicaid and CHIP programs, and we look forward to working with the agency to craft payment and regulatory policies that reflect quality health care for all Americans. If you have any questions regarding our comments, please contact Roshunda Drummond-Dye, Regulatory and Payment Counsel at (703) 706-8547 or roshundadrummond-dye@apta.org.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Scott Ward". The signature is fluid and cursive, with a large initial "R" and "S".

R. Scott Ward, PT, PhD
President