February 28, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2018-0154
Room 445-G, Hubert H. Humphrey Building
PO Box 8103
Baltimore, MD 21244-8013

Submitted Electronically


Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants (PTAs), and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit the following comments on the Centers for Medicare and Medicaid Services’ (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter. The mission of APTA is to further the profession’s role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of physical health and functional abilities of members of the public. 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 of all ages. While physical therapists are experts in rehabilitation and habilitation, they can also 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 strongly believes that MA enrollees should have affordable access to high-quality providers in their communities, in both urban and rural areas. APTA appreciates the
opportunity to provide feedback and requests that the agency consider our comments below.

**Potential Changes to Maximum Out-of-Pocket (MOOP) and Cost-Sharing Standards for CY 2021**

CMS requests comments and suggestions on its application and interpretation of MOOP and cost-sharing standards for CY 2021 and subsequent years.

While APTA appreciates that CMS set a MOOP limit for physical therapy services at $40 beginning in CY 2015, as stated in previous comments, APTA encourages the agency to be mindful of the frequency of visits for physical therapy services, and the financial implications of a $40 copay for each visit. While primary care providers and most health care specialists are seen at infrequent intervals, MA enrollees (and other consumers) typically require multiple physical therapy visits over an extended period of time to properly recover from an injury or alleviate symptoms related to an acute or chronic condition. High cost-sharing requirements create a significant financial burden for enrollees in need of multiple visits for a full recovery and may be a deterrent to accessing care. Copayments for physical therapy are cited as a reason that some consumers opt to reduce their frequency of care or forgo medically necessary care. Consequently, enrollees who fail to receive the rehabilitative care they need from a physical therapist are more likely to require higher-cost interventions to remain functional, potentially resulting in the development or recurrence of severe functional impairments and downstream costs including surgery, imaging, and pharmacy.

*Therefore, APTA recommends that for 2020 and beyond, CMS consider reducing the MOOP limit and/or adopting a different cost-sharing mechanism for physical therapy.*

For example, CMS could limit the copay for services provided by a licensed physical therapist to the amount charged for a primary care visit. Alternatively, CMS could mandate that enrollees pay only 1 copay during an episode of care. We advise CMS to be more mindful of copay increases imposed by MA insurers and place reasonable limits on copays for enrollees seeking therapy services.

**Nonopioid Pain Management Supplemental Benefits**

Within the Draft Call Letter, CMS encourages MA organizations to consider Part C benefit designs for supplemental benefits that address medically approved nonopioid pain management and complementary and integrative treatments. The nonopioid pain management item or service must treat or ameliorate the impact of an injury or illness (eg, pain, stiffness, loss of range of motion).

APTA appreciates CMS’s efforts to encourage MA organizations to consider Part C benefit designs for supplemental benefits that address medically approved nonopioid pain management and complementary and integrative treatments. However, we have concerns that CMS is not also promoting benefit designs that increase access to evidence-based, interdisciplinary treatment approaches for acute and chronic pain, including physical therapy and cognitive behavioral health.
Physical therapy is a dynamic profession with an established theoretical and scientific basis for therapeutic interventions capable of restoring, maintaining, and promoting optimal physical function. Physical therapists work both independently and as members of interdisciplinary health care teams to enhance the health, well-being, and quality of life of their patients, who present with a wide range of conditions including those that commonly cause pain. In 2017, there were 225,420 physical therapists and 90,170 PTAs employed in the United States.\(^1\) Physical therapists and PTAs work in a variety of settings, including physical therapist private practices, general medical and surgical hospitals, home health, physician offices and offices of other health care practitioners, rehabilitation agencies, schools, and skilled nursing facilities. APTA recognizes the destruction that opioid addiction has caused in communities throughout the United States and is committed to helping to fight this public health crisis in any way that we are able. We strive to educate policymakers, clinicians, consumers, and other stakeholders on pain management options that best suit patients’ needs, goals, and desires, which ultimately can play a major role in turning around our nation’s opioid epidemic. There is a role for opioids, but there also needs to be a focus on prevention of addiction. In addition, providers must understand—and convey to their patients—that the use of opioids comes with significant risks and that effective nonpharmacological solutions to pain management are available.

Furthermore, because pain can be so difficult to treat and presents differently in every individual, its prevention and management require an interdisciplinary effort that takes into consideration the many variables that contribute to it, including the underlying cause(s) of the pain and the anticipated course of that condition; the options that are available for pain prevention and treatment, and patient access to these options; and the patient’s personal goals, values, and expectations around health care. Pain management requires an integrated team approach that focuses on nonpharmacological interdisciplinary management and interventions for acute pain to decrease the potentially disabling effects of chronic pain. \textit{We believe that CMS should publicly support and promote such team approaches that focus on nonpharmacological interdisciplinary pain management. Integrated, comprehensive pain management treatment plans that evaluate and treat the different factors influencing the presence of pain, and the underlying causes of addiction, will enhance the effectiveness, efficiency, and safety of the care delivered.}

CMS’s endorsement of this approach is necessary given that a major roadblock to the broader implementation of interdisciplinary pain management is that many prescribing providers are unaware that such an approach even exists. The emphasis on treat-to-target has had a powerful impact on pharmacological management, but current outcome measures cannot capture the real need—treat-to-participation—that patients desire. A more holistic, comprehensive approach will promote greater patient engagement and educate both patients and providers on how to address pain through increased movement rather than through pain medication, which can avoid overuse and abuse. This approach could also have a positive impact on outcomes among patients who receive treatment for mental and behavioral health conditions.

In conjunction with limiting access to certain drugs, CMS must also develop and promote accompanying policies that increase access to nonpharmacological alternatives, including physical therapy. By doing so, CMS will ensure that enrollees have enough options to receive medically necessary, appropriate care. Moving forward, it is imperative that CMS acknowledge the important role that physical therapists and other nonphysician health care professionals play in the prevention and treatment of acute and chronic pain. The answer is not to solely limit access to drugs. Rather, CMS should adopt policies that incentivize MA plans to promote collaboration, assessment, and care coordination across multiple disciplines. Failing to do so will only be reinforcing the idea that pharmaceutical options are the only option—albeit one with significant potential harm.

We encourage CMS to ignite the much needed paradigm shift away from opioid overutilization and toward safe and effective nonpharmacological treatments, when appropriate. Such actions will not only move this nation forward in its efforts to improve pain management but also foster and promote safe opioid prescribing.

Interoperability and Prior Authorization Coordination
CMS states within the Advance Notice that it is working with partners in the private sector to promote interoperability. CMS encourages all payers, including but not limited to MA organizations and Part D plan sponsors, to follow CMS’s example and align with the Da Vinci Project’s Coverage Requirements and Documentation Rules Discovery work. By taking this step, MA organizations and Part D plan sponsors can join CMS in helping to build an ecosystem that will allow providers to connect their electronic health records (EHRs) or practice management systems and efficient work flows with up-to-date information on items and services that require prior authorization and the documentation requirements for items and services under that patient’s current plan enrollment.

APTA appreciates CMS’s comments and recommendations that MA insurers align their coverage requirements and documentation rules discovery work. As stated in our comments to the Office of National Coordinator for Health Information Technology (ONC) on its Draft Strategy to Reduce Regulatory and Administrative Burden Relating to Health Information Technology (IT) and EHRs, requiring standard formatting of clinical documentation data elements/claims that is adopted by providers and EHR vendors and accepted by payers with automated or streamlined transmission would help to eliminate the additional time and resources, as well as duplicative documentation, that is associated with the prior authorization process. Particularly significant is the provision of incentives to facilitate such adoption. We also support greater transparency; requiring prior authorization criteria to be available at the point of care would be beneficial and further contribute to burden reduction. Moreover, while APTA supports appropriate utilization management to promote the delivery of value-based care, we contend that current prior authorization programs used by MA plans exponentially increase administrative burden while simultaneously adversely impacting patient access to medically necessary services and creating a systematic focus on volume of services.
Patients often must undergo a prolonged, burdensome process to obtain treatment authorizations. This may hinder their recoveries, requiring physical therapists and other providers to decide between furnishing uncovered services at their own expense or risk the patients’ health and well-being by waiting for plans to authorize medically necessary care. Additionally, the care authorized by the MA insurer often conflicts with the health care professional’s recommendations. It is vital that future approaches to prior authorization recognize a clinician’s ability to render patient-centered care using evidence-based guidelines, clinical judgment and decision-making, and full scope of licensure. This would help ensure timely patient access to medically necessary services and streamlined administrative processes.

Accordingly, **APTA urges CMS to implement new requirements for MA plans’ prior authorization programs.** 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. **Specifically, APTA recommends that CMS incorporate standard language within its contracts that requires MA plans to:**

- Use the same standardized request form for prior authorization, developed by CMS;
- Accept prior authorization requests through the same submission mechanism, such as through a provider portal; and
- Adopt a required response period for prior authorization and repeat authorization requests.

Further, it is critical that CMS consider addressing the significant inconsistency between CMS and MA plans’ requirements when conducting medical review. For example, when submitting documentation in response to an Additional Documentation Request (ADR), providers have to use one process for Original Medicare, a different process for MA insurer #1, yet another process for MA insurer #2, and so forth. If the CMS contractor or MA insurer uses a website for electronic submission, the provider must log into a different portal for each payer. Making the process even more complex is the burden on the provider to locate the data submission location page for each MA insurer and CMS contractor. Even then, when on the submission page, the process is not consistent from one insurer to the next. **APTA recommends that CMS require each MA plan, as well as each CMS contractor (Medicare Administrative Contractor, Recovery Audit Contractor, Supplemental Medical Review Contractor, etc.) to use the same format, structure, and webpage layout for electronic records submissions and correspondence.** If providers are submitting in the same layout, file structure, and transport method, and with a similar webpage layout, then it is easier to share the information in a similar way with other health care providers, thereby increasing interoperability. **Additionally, we recommend CMS require MA plans adopt standardized template reporting for submission of prior authorization clinical data.**
APTA also advises CMS to require MA plans and subcontractors to use electronic portals to process prior authorization requests, denials, and appeals. Under such process, an MA insurer or subcontractor would be required to respond to an authorization or repeated requests for authorization within a set timeframe, such as 24 or 48 hours, allowing 72 hours for the provider to appeal, again through a similar electronic portal. If the insurer or subcontractor fails to reply within the timeframe, then the authorization would be granted. This type of process would allow the payer to use algorithms—to be reviewed by stakeholders, including professional associations—to identify the most blatant instances of abuse and would allow for proper, timely care to beneficiaries.

When prior authorization is universally imposed on a given service, it merely acts as a barrier to care and does not add value to the system. As such, APTA recommends that CMS require MA plans reserve prior authorization for outlier management when a risk adjusted condition-specific threshold is achieved. Additionally, prior authorizations should be limited to a specified number of visits and not units of service (15 minute increments). Often, MA plans restrict or limit the duration of each intervention at the unit level, without affording providers the opportunity to use their clinical judgment when making frequency of treatment decisions.

Further, to ensure that patients continue to receive high-quality care and avoid stinting on medically necessary services, APTA recommends that CMS consider instructing MA plans to exempt from prior authorization patient populations with certain conditions and clinicians who: 1) participate in standardized data collection system and are willing to share outcomes; 2) require the use of specific performance-based outcome measures; and/or 3) require the collection of patient-reported outcome measures that have clinical utility and importance that are meaningful to a diverse set of provider types.

APTA also recommends that to protect the rights of MA enrollees and guarantee access to medically necessary services, CMS should issue explicit instructions to MA plans requiring them to make coverage determinations using the same coverage criteria applicable to Medicare beneficiaries under the traditional Medicare program. Although CMS currently requires MA plans to comply with CMS’s National Coverage Determinations, general coverage guidelines included in original Medicare manuals and instructions, and Medicare Administrative Contractors’ Local Coverage Determinations,2 MA plans commonly use medical necessity language from their commercial products or improperly apply private, proprietary decision support tools to make coverage decisions, much to the detriment of the health of MA enrollees. Therefore, we strongly recommend that CMS modify the Call Letter and require MA plans to strictly comply with Medicare coverage regulations.

Finally, APTA recommends that CMS standardize the Medicare coverage, coding, and billing guidelines that an MA plan may adopt. MA plans often state that they follow

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2 42 CFR 422.101(b).
Medicare guidelines but then have confusing interpretations of these guidelines regarding the use of Correct Coding Initiative edits, the multiple procedure payment reduction, etc. The lack of standardized guidelines between Original Medicare and MA creates confusion among providers, leading to potential loss of documentation integrity, resulting in limited care coordination and collaboration among health care providers, and significantly increasing provider burden without improving the quality of care.

**Conclusion**

APTA thanks CMS for the opportunity to comment on the Advance Notice of Methodological Changes for 2020 for MA Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter. We look forward to working with CMS to ensure that MA enrollees continue to have access to high-quality 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,

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

SLD: krg