National Association for the Support of Long Term Care

October 5, 2020

Ms. Seema Verma
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

VIA Electronic Submission

Re: File Code CMS-1734-P: Medicare Program; CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Updates to the Quality Payment Program; Medicare Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Proposal to Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy Proposed Rule

Dear Administrator Verma:

The National Association for the Support of Long Term Care (NASL) is an advocacy organization representing suppliers of ancillary services and providers to the long term and post-acute care (LTPAC) sector. NASL members include rehabilitation therapy companies that employ physical therapists, occupational therapists, and speech-language pathologists who furnish rehabilitation therapy to hundreds of thousands of Medicare beneficiaries in nursing facilities as well as to beneficiaries in other long-term and post-acute care settings. NASL members also include both vendors of health information technology (IT) that develop and distribute clinical electronic medical records (EMRs), billing and point-of-care IT systems and other software solutions that serve the majority of LTPAC providers of assisted living as well as skilled nursing and ancillary services. In addition, NASL members include providers of clinical laboratory services, portable x-ray, and other specialized supplies for the LTPAC sector. NASL is a founding member of the Long Term and Post-Acute Care Health Information Technology Collaborative (LTPAC Health IT Collaborative), which was formed in 2005 to advance health IT issues by encouraging coordination among provider organizations, policymakers, vendors, payers and other stakeholders.

Nursing facilities have been 'ground zero' for the coronavirus because of nursing facility patient's unfortunate vulnerability to infection of COVID-19. NASL is very appreciative that CMS has taken rapid and repeated action to assist nursing facilities by authorizing various waivers and other policy flexibilities so that nursing facility (and other) providers can provide care more effectively and efficiently during the public health emergency.

NASL is pleased to submit these comments in response to the *Proposed Rule* noted above and published in the Federal Register on August 17, 2020. Our comments are focused on our deep concerns with the proposed change to the Conversion Factor, the importance of continuing telehealth services after the COVID-19 Public Health Emergency (PHE), as well as other issues.

Conversion Factor and E/M Policy

NASL vehemently opposes the proposed change to the Conversion Factor that would result in offsetting deep cuts in payment for a wide swath of provider types—including services provided to vulnerable nursing facility patients. This has significant potential to decrease access to services for the millions of patients. NASL acknowledges the value in supporting primary care which we understand to be one of the policy goals of the E/M proposal; however, CMS' continued pursuit of this goal and the offsetting cuts impact other providers and deeply undermine the existing health care system, risking reduced access for patients with the greatest needs.

Nursing facility patients are facing the greatest challenge our sector has ever experienced with the impact of COVID-19. Patients living in nursing facilities are among the most vulnerable patient populations at risk for COVID-19, due to both advanced age and likelihood of having other comorbidities. Nursing facility residents are older with weaker immune responses, and multiple co-morbid conditions, leading to frailty. Many of them are living with some form of cognitive decline including dementia. The herculean effort undertaken by nursing facility staff, rehabilitation therapists and other health care personnel to treat patients with COVID-19 and to prevent the spread of this virus is crucial to protecting our especially vulnerable patients from infection.

Because COVID -19 and the resulting public health emergency is the most significant challenge that nursing facility patients and their caregivers have faced, we are confounded to understand why CMS would move forward with significant cuts to essential services provided to nursing facility patients at this critical time. Nursing facility patients face significant cuts to physician and nurse practitioner services, rehabilitation therapy services, and diagnostic x-ray services. Nursing facility residents benefit from Medicare Part B rehabilitation services. They receive physical therapy in order to improve their functional ability as well as for mobility, strength, gait training for walking and neuro reeducation for balance. Occupational therapists provide therapeutic activities that help to improve patients' movement abilities, such as for balance retraining with carrying items for cooking and self-care and home management training to regain independence. Speech language pathologists treat a patient's communication challenges and disorders as well as life-threatening swallowing disorders. Attending physicians order x-ray

services performed at bedside that are critical to monitoring and diagnosing upper respiratory conditions (e.g., pneumonia, emphysema), cardiac conditions (e.g., heart failure), and falls (for early fracture detection). Nursing home residents undergo imaging, including chest radiographs and chest ultrasound, to allow the attending physician to determine their anticipated recovery from conditions that can be seen in a patient with COVID-19. Physicians monitor and treat nursing facility patients including those infected with and recovering from COVID-19. As CMS has encouraged more efficiency in care models over the years, there has been an expansion of nurse practitioners providing many of these physician services. NPs bill the same CPT codes yet at a lower cost due to the 15% differential. All of these services are essential to the care of nursing facility patients and they face significant cuts due to the E/M proposal. It is unconscionable that CMS would propose policies that slash reimbursement to nursing facilities at a time when providers face the greatest challenge and their expenses are higher than ever due to operational challenges brought on by the COVID-19 public health emergency (PHE).

As a result of the *Medicare Access and CHIP Reauthorization Act (MACRA)*, providers are not receiving a positive payment update overall. This is the first year of a 5 year period where MACRA provides for no positive payment update ostensibly to incentivize providers to participate in either MIPS or an Alternative Payment Model (APM). As we discuss later in our comments, CMS has precluded nursing facilities, rehab therapists practicing in nursing facilities, portable x-ray, and other providers from participating in these incentive programs. So, these providers cannot even strive for an increase that could perhaps begin to mitigate the reduction resulting from the E/M proposal. For these providers, CMS has closed any avenue of mitigating this significant reduction.

CMS' significant payment reduction for services provided to nursing facility patients for 2021 must not be viewed in a vacuum and should be considered among ongoing and future cuts providers who serve nursing facility patients are facing. These new reductions will only exacerbate the effects of these multiple cuts. A change of this magnitude will create unnecessary and mistimed disruption to long term care providers and the patients they serve. Contrary to the estimated 8% decrease noted in 2019, the rehab therapy provided to patients in nursing facilities will now see an estimated 9% payment reduction. Rehab services are already cut because the Practice Expense portion of reimbursement for the second service furnished to a patient on the same day under MPPR (Multiple Procedure Payment Reduction) is currently reduced 50%. In addition to the proposed 9% cut to rehab therapy CPT codes, rehab therapists are bracing for a 15% cut to services provided by occupational and physical therapy assistants beginning in 2022.

Diagnostic services including portable x-ray services are reduced in the proposed rule by an estimated 6%. Portable x-ray providers in 11 states are already facing reductions as high as 56% to the transportation portion of the reimbursement in addition to the 6% CPT code cut proposed for 2021.

Nurse practitioner services are already reduced by 15% if the NP is billing the CPT code rather than the physician. Combining CMS' proposed 8-10%[1] reduction for the physician services for nursing facility patients along with the existing rate reduction will severely restrict the ability of Nurse Practitioners to provide services in this setting. In the absence of the Nurse Practitioner specialty, the next level of care for patients in this setting will be Physicians for whom services will be rendered at the full rate allowed by Medicare, thereby adding costs to the system. Additionally, all Medicare providers will see services reduced by an additional 2% when sequestration begins again in January of 2021. At a minimum, all of the reductions detailed here will be extremely disruptive to patient care in the long-term care setting and could potentially result in a loss of access to this enhanced level of care. The chart below provides an illustration of the compounding cuts and the resulting net reductions. This loss can lead to an increase in the rate of rehospitalization which adds both trauma to the patient and increased costs to the healthcare system.

Year	Policy	Provider	Net Reduction
2011	MPPR	Rehab Therapy	-50% to the second and subsequent practice expense
2011	Sequestration	All providers	-2%
2013	Differential for Nurse Practitioners billing physician codes	Nurse Practitioners	-15%
2015	MACRA	All providers	0% increase x 5yrs
2015	MIPS- Unable to participate in quality bonus program	Rehab Therapy in Nursing Facilities, Portable x-ray	0% increase indefinitely
2020	Portable x-ray transportation reimbursement	Portable x-ray	Up to -56%
2021	PFS Proposed Rule	Rehab Therapy	-9%
2021	PFS Proposed Rule	Portable x-ray	-6%
2021	Physicians seeing nursing facility patients	Physicians/Nurse Practitioners	-8-10%
2022	Differential for Therapy Assistants	Rehab Therapy (OT & PT)	-15%

These cuts will impact patient care. To demonstrate the dramatic reduction in reimbursement for care due to CMS' E/M policies, NASL developed a patient scenario as an example of how the multiple cuts to Medicare Part B services are applied and impact reimbursement for the therapy services outlined in the following patient vignette:

> Ms. Carter, a 76-year-old female, was referred to physical therapy after a recent fall due to a loss of balance. The patient lives in a nursing facility and prior to her fall she was able to ambulate throughout the facility independently. Now, she requires moderate assistance with ambulation. She was referred to physical therapy with the goals to increase strength, balance and regain independence with

walking. After her physical therapy evaluation, the physical therapist recommended the following intervention: Therapeutic Exercise (CPT code 97110) for strengthening, Neuromuscular Re-education (CPT code 97112) for balance, Gait Training (CPT code 97116) for ambulation and Therapeutic Activities (CPT code 97530) for balance retraining with functional tasks such as lifting or carrying an object.

NASL calculated the reductions to the patient's care resulting from the current, proposed and future reductions. The data and calculations in the table below are based on rates in the CY20 Medicare Physician Fee Schedule as currently available on www.cms.gov. The data reflects an average treatment day for this patient, showing data for one unit for each CPT code listed. Evaluation codes are not part of these services. In our patient vignette, Ms. Carter is being treated in the Washington, DC, metropolitan area; so, the data used applies the Geographic Practice Cost Index (GPCI) for the Washington, DC, area (i.e., GPCI 1220201 DC + MD/VA Suburbs). Physical therapy assistants (PTAs) delivered care for 50% of the therapy services in this vignette so as to illustrate the anticipated impact of the therapy assistant cut scheduled to take effect on January 1, 2022. The rates captured in the table below build on the base rate found in the CY2020 Physician Fee Schedule. The Multiple Procedure Payment Reduction (MPPR) is applied to the practice expense component of the second and subsequent codes for services billed on the same day. For 2021 data, we extrapolate from the 2020 base rate by applying the CMS estimated 9% Evaluation and Management (E/M)-related cuts that are scheduled to take effect on January 1, 2021. The same base rate is used for 2022 calculations, which also include the cut when a therapy assistant provides the services. The percent decrease calculations that appear at the bottom of the table are included to show the layered effect and increasing impact that each cut has on the reimbursement for therapy services for Ms. Carter. The chart below shows the anticipated reimbursement for services for Ms. Carter with the cumulative reductions of all the cuts applied is an estimated reduction of 31.2%.

Patient Example – Ms. Carter

HCPCS Code & Description *CPT codes in patient vignette*	**2020 Current Rates** *GPCI 1220201 Applied*	**Multiple Procedure Payment Reduction (MPPR)**	**MPPR Effect**	**2020 Reimbursement** *MPPR + 2% Sequestration Cuts Applied*	**2021 Projected Rates** *2020 Rates Less 9% E/M Cut*	**~ MPPR Applied** *(-20.17%)*	**2021 Reimbursement** *9% E/M + MPPR + 2% Sequestration Cuts Applied*	**2022 Projected Rates** *2020 Rates Less 9% E/M Cut*	**15% Assistant Code Cut** **Cut Applied*	**~ MPPR Applied** *(-20.17%)*	**2022 Reimbursement** *9% E/M + MPPR + 15% Assistant Cut 2% Sequestration –All Cuts Applied–*
97116 Gait Training	$35.14	$26.55	($8.59)		$31.98			$31.98	$31.98		
97112 Neuromuscular Re-ed	$41.00	$41.00	($0.00)		$37.31			$37.31	$37.31		
97530 Therapeutic Activities	$46.66	$32.12	($14.54)		$42.46			$42.46	$42.46		
97110 Therapeutic Exercise	$35.58	$26.77	($8.81)		$32.38			$32.38	$27.52*		
	$158.38	**$126.44**	**($31.94)**	**$123.91**	**$144.13**	**$115.06**	**$112.75**	**$144.13**	$139.27	**$111.18**	**$108.96**
Decrease *Compared to 2020*		**(20.2%)**		**(21.8%)**	**(9.0%)**	**(27.4%)**	**(28.8%)**			**(29.8%)**	**(31.2%)**

NASL Recommendations

NASL knows CMS is working to keep vulnerable nursing facility patients safe during the PHE and our members appreciate CMS' efforts to support nursing facilities in these challenging times. **NASL urges CMS to exclude services provided to nursing facility patients from the reductions due to the proposed change to the Conversion Factor. In the alternative, NASL urges CMS to delay or phase in over multiple years its reform that forces the offsetting dramatic cuts to services for nursing facility patients at this time of a public health emergency.** Nursing facility patients are extremely vulnerable to COVID-19 and nursing facility staff are working diligently to contain the virus and prevent spread amid very difficult conditions. These reductions will be extremely disruptive to patient care and may result in changes that could impact and most likely decrease patient access to care.

For patients in nursing facilities and other long term care settings including in their home, who receive the services slated for deep cuts, the reductions will degrade the availability of therapy services and this is a shortsighted effort that will cause a cascade of negative ramifications in years to come. COVID-19 has created significant health challenges for seniors, beyond the immediate risk of illness and mortality. A decline in services for this chronically ill population with multiple morbidities will unleash a tsunami of frailty upon seniors under Medicare. Many Medicare beneficiaries are struggling with access to care amid the COVID-19 public health emergency, as well as with the effects of isolation. Reducing the availability of needed care will not do a thing to improve the health of this population.

Reductions of this magnitude are unconscionable at a time when long term care provider and supplier costs to provide care because of the pandemic have dramatically increased. Efforts to keep our patients safe means that providers can see fewer patients throughout the day, they experience higher costs from purchasing Personal Protective Equipment (PPE), and sometimes must step away from their work for a period of time if they are exposed to COVID-19, creating staffing shortages in some areas.

NASL believes that cutting payments while providers face an unprecedented increase in the cost of providing care is a recipe for disaster for preserving patient access to care. We are now moving into the 8th month of the impact of the public health emergency due to the COVID-19 pandemic. Providers in the long term care sector are shouldering higher ongoing costs for providing care. The CMS mandate for regular testing for nursing facility staff extends also to NASL members who are contractors and vendors to nursing facilities. Funds to reimburse for this testing have not been shared with our member companies who continue to bear this necessary yet additional cost. PPE is an ongoing challenge and an additional cost to providing care. Some providers can see fewer patients and visit fewer facilities because of ongoing screening restrictions. For these and other reasons including higher hazard pay and loss productivity because clinicians and staff are been exposed and cannot work, have all increased the cost of providing needed care. Many of these costs are borne by providers whether or not COVID-19 is present in the nursing facility.

In addition to the direct impact of COVID-19 on Medicare beneficiaries infected with this virus, the indirect impact to the vulnerable nursing facility population who has been isolated and sequestered from access to activities, socialization and, sometimes, treatment appears to have been disregarded. In many cases, our providers now have to address that patients have diminished skills. Nowhere in this *Proposed Rule* is there evidence of acknowledgment or empathy for these Medicare beneficiaries and the medically necessary care they so urgently need.

Reducing reimbursement for these providers during the most significant challenge our health care system has ever faced, may upset that delicate balance, pushing these providers underwater and making the provision of care in some areas economically unfeasible. That may mean providers in rural areas or those in high-cost urban areas can no longer continue seeing patients. Providers may be forced to withdraw from certain markets, retreating to sustainable areas, but those areas too will become challenging economically amid the cuts. The result of providers being forced to reduce services at facilities will be the disruption of the continuity of care for patients and is this is not in their best interest. Reducing payment for services in this way will also result in a reduction in the number of providers available to serve patients.

Amid the COVID-19 PHE, providers such as rehabilitation therapists who may have been able to provide services to multiple patients at once utilizing group therapy are no longer able to perform these types of services for the patients who benefit from them because of COVID-19 restrictions.

Patients being treated for COVID-19 or patients who are recovering from it present heightened challenges and increased costs that are different from the typical type of care providers generally furnish to patients in long term care facilities and other settings. These patients have additional costs from infection prevention, such as PPE requirements, as well as ensuring these patients' care needs are met while in isolation. As a result, the cost of care for these patients begins to look like the high level of resource utilization seen by patients affected by End Stage Renal Disease or HIV.

The reductions that CMS is making in the Physician Fee Schedule have a ripple effect with other payors both inside Medicare and outside. Medicare Advantage Plans generally pay a percentage of the Physician Fee Schedule for part B services and so they will most undoubtedly reflect these reductions. Private insurance that uses Medicare as a payment benchmark may take the opportunity to reduce reimbursement. The cascade of reductions both from various Medicare payors and non-Medicare payors including private insurance and Medicaid will be a disaster for patients and providers—all during a public health emergency.

We must recognize the ripple effect of these dramatic reductions in the Physician Fee Schedule that produce far reaching consequences into the future. As multiple payors reflect PFS reductions and costs to provide care increase, provider companies could potentially be unable to continue employing the same number of clinicians if these cuts move forward. Also, there will be a disincentive for students to choose the long term care setting as their career during a time when there is a shortage of clinicians in the long term care setting. This decrease in students will only

exacerbate the existing provider shortage in the coming years ahead as more Americans become eligible for Medicare and need long term care services.

CMS has not only not provided, but precluded providers from mitigating these disastrous cuts. CMS has precluded nursing facility and other institutional providers from earning payment incentives for their Part B services. CMS has continuously excluded therapists who practice in nursing facilities and other institutional settings from participating in Medicare's Merit-based Incentive Payment System (MIPS), which is part of the Quality Payment Program, under the *Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)*. Because of consolidated billing mandates, nursing facilities must include Part B rehab therapy services on their claims and CMS has not developed a pathway to allow nursing facilities to earn incentives (or penalties) under MIPS. CMS has stated its commitment to continuing to include more services under value based arrangements yet has precluded the setting that bills the majority of Part B outpatient therapy from earning performance-based incentives that could mitigate the cuts.[1] **NASL believes that CMS could and should make changes to allow nursing facilities to participate in MIPS, thus being eligible to earn a performance based increase that could help to mitigate the reductions.**

GPC1X Complexity Code

NASL also has significant concerns with the utilization assumptions CMS made in valuing the add-on GPC1X code. In the 2020 final rule, GPC1X is defined as visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. This definition does not provide enough guidance for providers to know when it is appropriate to add this code and is vague enough to invite speculation that it could be used for every visit. The only comparable CPT code is the psychiatric code for interactive complexity. Even though interactive complexity can be reported with multiple levels of service, CPT guidelines are explicit as to what circumstances must occur for the code to be added. CPT not only lists factors that are typically present, it goes on to specify which factors must be present for code use. This level of detail is essential for determination of the appropriateness of code usage and accurate utilization estimation. NASL believes that, without clarification, it is impossible to narrow down the types of patients that would be eligible for this service. It should also be noted that complex patients are seen by nonphysician practitioners that do not have access to bill evaluation and management services. If GPC1X is to be added, it or an equivalent add-on code should also be made available to any provider that sees a patient that meets said qualifications. **NASL urges CMS not to implement GPC1X until the code guidelines can be further defined and clear utilization estimates and patterns can be established.**

[1] MedPAC Medicare Payment Basics: Outpatient Therapy Services Payment System. Accessed on 10-1-20. http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_opt_final_sec.pdf?sfvrsn=0

CPT Code 99072

On September 8, 2020, the American Medical Association (AMA) released new CPT code 99072 for reporting the cost of additional personal protective equipment (PPE), cleaning supplies, and clinician or clinical staff time needed to safely provide in-person services during the public health emergency. The current CPT code definition for this code does not allow institutional providers to bill for this new code. Yet institutional billers are bearing much of the burden of treating COVID-19 patients and utilize PPE in significant amounts. **NASL supports the addition of this CPT code and encourages CMS to modify it to allow for it to be billed by all providers who bill Medicare, including institutional billers.**

Telehealth

Throughout the COVID-19 PHE, NASL member rehabilitation therapy companies, nursing facility companies, clinical labs, portable x-ray companies and information technology providers have adapted to meet the care needs of their patients. For some of our members, telehealth technology has been an avenue for patient's continued access to rehab therapy. For patients and rehab providers, this ability has been a lifeline to ensure they continue to receive needed care while protecting the health of the patient and the provider to reduce the transmission of COVID-19. **NASL is grateful to Congress and CMS in implementing and exercising waiver authorities contained in the CARES Act that allowed CMS to exercise a waiver to expand the use of telehealth to provider types including occupational and physical therapists and speech language pathologists.**

Telehealth and other tools such as virtual care and e-visits have become crucial tools during the public health emergency. While in person care is the absolute preference, the need to prevent spread of COVID-19 has provided many barriers to access to care. Providers have used telehealth and other virtual communication tools in a variety of ways to get around these barriers and further patient care. For example, providers have been able to perform therapy evaluations of the patient using telehealth; providers have been able to continue treatment for patients while maintaining isolation requirements to support infection control; and providers have used telehealth to meet the requirements of the mandatory 10th supervisory visit. Additionally, telehealth has also been a successful option for mitigating the challenges that have arisen during the COVID-19 public health emergency, such as from a provider unexpectedly being unable to work after exposure. Many therapists treat patients in multiple nursing facility buildings in a day. Screening requirements that only allow therapists into a facility if they have not visited patients in another facility with COVID can significantly narrow down the number of therapists available to treat, to evaluate and to supervise. Telehealth is used to extend the reach of a therapist who is outside the facility and can use the technology to communicate with a therapist who is inside the facility with the patient. To provide CMS further understanding of how some NASL members have utilized telehealth, we have included a number of successful clinician experiences with telehealth in Appendix A.

While some may think that services provided via telehealth are more efficient, meaning cheaper because the provider may have not borne as much cost compared to an in-person service– that is not necessarily true. Our experience utilizing telehealth to deliver some rehab therapy services shows that telehealth may not necessarily be a more cost effective option for providers. Depending on the service provided, the patient and other factors, delivering therapy via telehealth can involve two providers, one that is remote and one in-person assisting the patient. Sometimes this is efficient and sometimes it is not. The provision of telehealth from a provider point of view is not a one size fits all policy. Most importantly, the ability to utilize telehealth has been a critical tool for continuing patient access to therapy despite all the barriers that COVID-10 presents to patient care. During the PHE, our members have continued this access even when sometimes providing the service using telehealth exceeds the reimbursement. Telehealth should be thought of as continuing or expanding access to care, not necessarily as a way to deliver less costly care.

The experience of the past six months with providers demonstrating the value and proof of telehealth's potential has accomplished what would have taken years to demonstrate in a demonstration project. From the volume of telehealth claims received by CMS during the PHE, it is clear that telehealth works, patients want it as an option, and providers can offer more services through it than previously permitted under Medicare's rules. In a recent study, analysis shows that rehabilitation therapy delivered via telehealth can be as effective as in-person care.[2] The results from the study show that both telehealth and non-telehealth can be equally effective for improving functional status; and that patients were equally satisfied with their therapy care regardless of whether any care visits were administered using telehealth. The results are clear – telehealth is a viable tool in health care, and Medicare should embrace this change sought by patients and providers.

<u>Medicare coverage for telehealth services furnished by rehabilitation therapists is absolutely critical in order for beneficiaries in skilled nursing facilities to maintain access to medically necessary services during the COVID-19 pandemic and for the health and safety of the patient, the therapist and the staff in the nursing facility.</u> Rehabilitation therapists are critical members of the interdisciplinary care team. Rehab therapists are authorized by CMS to furnish services via telehealth technology in other settings where outpatient therapy is provided and, as such, are qualified to furnish services via telehealth to Medicare beneficiaries living in the SNF setting.

In this *Proposed Rule*, CMS lays out its intention to move in a variety of directions for various telehealth services that have been newly-offered during the public health emergency. While CMS has outlined its intention to keep some CPT codes on the telehealth list beyond the end of the public health emergency, some CPT codes, such as those used by rehabilitation therapists to deliver services via telehealth, are not set to remain available after the public health emergency ends.

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[2] "Overview of Telehealth and Outcomes in Rehabilitation," Mark Werneke, PT, MS, Dip. MDT, Daniel Deutscher, PT, PhD, Deanna Hayes, PT, DPT, MS, https://www.nethealth.com/ground-breaking-net-health-study-compares-telehealth-rehab-therapy-with-in-clinic-visits/ (Accessed 9/28/20).

NASL recognizes that there are two critical components for the continuation of these services after the public health emergency – CMS' role in ensuring these services remain on the telehealth list after the public health emergency, and Congress' role in modifying statutory restrictions on the types of providers that can perform telehealth services. CMS should fulfill its role in ensuring the availability of these services to patients while providers pursue statutory changes through advocacy with Congress.

Telehealth has helped further the goal of ensuring patients receive care when they need it and in the right setting. For example, patients in rural areas or who may live in areas affected by snowfall can still continue to be seen by their provider even if they cannot make it to the provider's location that day. Telehealth ensures access to care and timely delivery of that care in a patient-centered way.

NASL urges CMS to reconsider the decision to remove the rehab CPT codes following the end of the PHE and ensure that rehab CPT codes for services currently available remain so afterwards; the clinical evidence supports these services continuing to be available for the benefit of patients. NASL supports the permanent addition of rehabilitation therapists to the list of covered telehealth providers under Medicare and understands that this authority exists by waiver currently and would need Congressional action. Nevertheless, NASL supports the permanent addition of the 21 listed outpatient therapy service CPT codes from CMS's April 6th Interim Final Rule with Comment (IFC) (CMS-1744-IFC) to the Category 2 Medicare telehealth services list. CMS had previously added these outpatient therapy services CPT codes to the telehealth list prior to the waiver that authorized therapists as telehealth providers. In addition, we also request that CMS add select SLP codes associated with dysphagia evaluation (CPT code 92610) and treatment (CPT code 92526) to the list of telehealth CPT codes to ensure the safety of Medicare beneficiaries who might otherwise be at risk of choking, dehydration, malnutrition, and/or aspiration pneumonia.

The ability to furnish rehabilitation therapy and other services to patients via telehealth supports the limited access of staff members entering the facility and thus minimizing transmission risk and allowing therapists to continue providing clinical care safely and appropriately. Telehealth utilization also supports therapy assistants in the provision of care while navigating infection control restrictions for new and quarantined patients. As such, NASL urges CMS to make permanent the flexibilities it has granted during and for the duration of the public health emergency.

<u>Remote Physiologic Monitoring</u>

In the *Proposed Rule*, CMS seeks to provide clarification on certain CPT code descriptions and instructions associated with Remote Physiologic Monitoring (RPM), specifically related to CPT codes 99453, 99454, 99091, and 99457 (and the add-on code, 99458).

NASL is concerned that the proposed clarifications put forth in the *Proposed Rule* may be problematic because the clarifications may not be in sync with the CPT code descriptions.

Specifically, CPT codes 99091 and 99457 are incompatible according to the CPT descriptions; however, CMS appears to intend that these codes now be billed together, stating *"After analyzing and interpreting a patient's remotely collected physiologic data, the next step in the process of RPM is the development of a treatment plan that is informed by the analysis and interpretation of the patient's data" (emphasis added).* According to this statement by CMS, this progression of services (99091 then 99457) would be in violation of CPT guidance and instructions as articulated by the CPT Editorial Panel and written in the 2019 and 2020 Codebooks. **NASL believes that the CPT Editorial Panel clearly intended for 99091 and 99457 not to be reported in the same calendar month or in conjunction with each other. NASL requests that CMS make the appropriate corrections in the final rule**.

Additionally, NASL is concerned that CMS is clarifying that CPT code 99457 as requiring real time synchronous audio interaction. As a result, providers billing 99091 for 30 minutes for the collection and interpretation of data now have an additional 20 minutes required for reimbursement for 99457. This 50-minute time commitment is a significant increase in provider time when these two sets of codes formerly only required 20 minutes. Furthermore, CMS should reconsider its clarification that 99457 be a real time synchronous audio communication, as that is better encompassed by 99091, and not 99457, which should remain appropriately general.

Additionally, CMS clarifies in this *Proposed Rule* that when multiple medical devices are provided to a patient, the services (i.e., CPT codes 99453 and 99454) can be billed only once per patient per 30-day period. NASL believes that limitations on the frequency of how often a patient can be billed for setting up a new device (every 30 days) presents challenges for patients who are being treated by multiple providers who may rely on RPM technology to manage a patient's condition. CMS should address this issue by clarifying that the 30-day limitation is applicable per provider, per patient, per 30-day period so that patients being served by multiple providers for multiple conditions can have their needs adequately met.

Finally, CMS is clarifying that RPM services can be provided for both acute and chronic conditions. **NASL supports this clarification. However, NASL urges CMS to reconsider the 16-day minimum for data collection, as this may not be clinically appropriate or needed for acute patients.** For example, patients presenting with flu-like symptoms may benefit from a remote digital thermometer and digital pulse oximeter, but that data may only be needed for less than 16 days for monitoring a patient's condition. While CMS reduced this threshold to 2-days during the Public Health Emergency, CMS should find middle ground and amend this definition to 8 days of data to be collected over a 30-day period for CPT codes 99453 and 99454.

Therapy Assistants Performing Maintenance Therapy

NASL appreciates CMS allowing therapy assistants to perform maintenance therapy under the Medicare PFS. This change aligns the MPFS policy with CMS' policy for all other settings and assures consistency and continuity of care across Medicare programs for patients receiving rehabilitation therapy services. NASL agrees that it would be appropriate to allow assistants to perform maintenance therapy services under a maintenance program established by a qualified

therapist, if acting within the therapy scope of practice defined by state licensure laws and regulations. Medicare regulations require assistants to be licensed, registered, or certified in accordance with state laws. In states where such requirements do not apply, assistants must meet certain education and/or proficiency examination requirements in order for their services to be covered under Medicare. In addition, since the prevalence of dementias, such as Alzheimer's disease, is ever-growing among the Medicare population, this expansion to allow assistants supports increased access to therapy for these vulnerable beneficiaries. **Therefore, we believe that occupational therapy assistants and physical therapist assistants are qualified to provide maintenance therapy services when provided under the direction and supervision of a qualified therapist and when the qualified therapist is responsible for establishing the plan of care and assessing and reassessing the patient. NASL believes that the proposed change may also ensure better patient access to maintenance therapy, especially in areas where there are shortages of therapists.**

Retinal Imaging

Diabetic retinopathy is the leading cause of vision loss and blindness among adults between 20 and 74 years of age. According to the CDC, 30.2 million American adults (12.2%) had diabetes in 2015, with 1.7 million new cases per year. Among those ages 65 and up, 25.2% had diabetes. More than 80% of people living with diabetes will eventually develop diabetic retinopathy. However, with early detection, over 95% of vision loss cases can be prevented.

Consequently, NASL commends CMS for updating the descriptions of CPT Code 92228 and CPT Code 92227 to clarify the location where the retinal images are interpreted and the qualifications of the person performing the interpretation, thereby increasing access to this potentially vision saving exam in primary care settings. We also concur with CMS' proposal to activate CPT Code 92229 for automated point-of-care retinal imaging, and encourage CMS to valuate the code as recommended by the RUC. NASL believes it is vital that the reimbursement of this code reflects an appropriate value to encourage continued AI innovation and adoption.

However, we strongly disagree with the proposed valuation of CPT Code 92228 at $28.71. We believe it is equally vital that the reimbursement of this code reflects an appropriate value to continue to encourage the collaboration between the primary health care providers and ophthalmologist readers to make the investments necessary to close this critical care gap for patients living with diabetes. CPT Code 92228 should be equivalent to CPT Code 92250 and CPT Code 92229's proposed RUC valuation, at minimum.

Conclusion

On behalf of the members of NASL, I thank you for the opportunity to provide these comments. Please do not hesitate to be in contact should more information or detail be needed. If you have any questions regarding our comments, please contact cynthia@nasl.org or 202-213-0289.

Very sincerely,

Cynthia K. Morton, MPA
NASL Executive Vice President

NASL Appendix A

Rehabilitation Therapy Clinicians' Experience with Telehealth Under COVID-19

NASL is sharing a few experiences of how our NASL-member rehabilitation therapists have used the Medicare telehealth flexibilities during the COVID-19 pandemic to ensure that patients received the rehabilitation therapy services that they need in spite of the severe restrictions that infection prevention and control procedures have placed on clinical staff, including rehabilitation therapists. These clinicians' experiences offer insights into the logistical and procedural aspects of delivering care via telehealth, which we believe are important to consider as CMS develops future policy and initiatives.

What is most striking about the conversations that we have had with NASL members, who are serving on the frontlines of this pandemic, is the concern for their patients' well-being amid the isolation, angst, and sadness that COVID-19 has wrought. We are buoyed to know that NASL members strive to continue to provide access to quality care, whether in-person as most prefer or via telehealth, which has kept both patients and caregivers safe during this extraordinary time.

Clinicians' Experience with Telehealth #1

Throughout the pandemic, our care team has utilized their iPads with various platforms such as FaceTime, Google Duo and Skype to connect our residents with their loved ones. We also have utilized these apps to complete virtual family training, updates on patients' progress and virtual tours that helped us to ensure safe discharge planning and residents' transitions to next level of care. Using telehealth has eased the hardship that families encounter when unable to visit their loved ones often due to visitation restrictions imposed as part of infection prevention and control measures. We are proud of our care teams and of the many ways our therapists and staff have stepped up to provide the care our residents need. We appreciate the flexibilities that have allowed us to use technology in new ways to overcome the many challenges we have faced in caring for our seniors during these extremely difficult times.

Patient Scenario

Here is a specific example of how our team has used telehealth in caring for a 59-year old male who has COPD, hypertension, atrial fibrillation (AFIB), a heart valve disorder and a gastric sleeve. The patient was admitted to the hospital for management of bio-prosthetic aortic valve endocarditis due to a staph infection and was intubated. Prior to his hospitalization, he was independent in all mobility and walking with no assistive device. He lived with his wife and daughters in their two-story home, which had a bedroom and full bathroom on the first floor. Upon transfer to the facility, he was evaluated by both physical and occupational therapy staff, who determined that he needed moderate assistance for bed mobility and maximum assistance for transfers; he also was unable to ambulate. His treatment plan called for physical, occupational and speech language therapy to address functional decline and poor judgment and confusion

after being intubated in the hospital. The patient progressed well with his PT, OT and ST sessions and was preparing to be discharged from the facility.

Our team used FaceTime to provide virtual trainings for his daughter in preparation for his return home. We were able to see the entrance and other areas of their home, which enabled our team to offer training that was specific to the patient's discharge location. We were able to instruct the daughter on measuring door widths using the patient's walker. Since the patient often experiences shortness of breath even with short distances, we were able to recommend resting stations and clear pathways that he will be able to navigate in getting from bedroom to bathroom and common areas of the home. We also pointed out ways that the daughter could rearrange furniture and other items to improve the home's safety for her father.

Outcome

The patient was discharged home safely where he remains with his wife and daughter as a result of the pre-discharge virtual connection.

Clinicians' Experience with Telehealth #2

Our experience in using telehealth during the pandemic is somewhat limited since CMS did not extend telehealth flexibilities to therapy professionals until May with additional clarifications for those practicing in post-acute care settings a few weeks later. The use of telehealth was sparse during July, save for conducting a few evaluations as needed. We saw an increased volume in telehealth use during August in our more rural locations.

Our approach has been to use telehealth as a means for dealing with COVID-19-related disruptions in the patient's access to care, as we have maintained direct, face-to-face therapy services as the gold standard as long as circumstances have allowed us to do so. We also have provided on-site virtual visits where the therapist and patient were located at the same facility/location, but in different rooms.

Patient Scenario

Our rehabilitation company serves a relatively rural region. This patient scenario begins like so many others with a patient being admitted to a facility on a Friday afternoon. The patient is part of a Medicare managed care plan, which requires that therapy evaluations be done within 24 hours of admission. The physical therapist (PT) assigned to this nursing facility, which is located in a rural area, was in the middle of a 14-day quarantine due to exposure to COVID-19, and therefore unavailable that Friday. A second therapist who could conduct the patient evaluation would have to travel from another facility; however, only staff assigned to this facility were allowed entrance due to pandemic restrictions. Even though the facility did not have any patients

who tested positive for the virus, all new admissions were quarantined for two weeks upon admission.

The 91-year-old, medically complex, female patient was referred to therapy, presenting with multiple conditions and receiving narcotic pain medication. Prior to a 12-day hospitalization, the patient lived alone at home and was independent with bed mobility, transfers, and ambulation with a 4-wheeled walker. Upon evaluation, the patient required moderate assistance in mobility, transfers, and gait due to medically complex conditions resulting from a bowel obstruction. The patient was motivated to participate in therapy and said that her goal was to "get stronger so I can go back home." With the patient's written and verbal consent, the PT evaluation was completed using telehealth audio/visual technology.

The telehealth visit was scheduled by the physical therapist from a distant site, approximately 90 miles away from the originating site, which is the facility to which the patient had been admitted on Friday afternoon. Unfortunately, the internet connection from the distant site facility failed and the parties were unable to connect at the scheduled time. The PT assistant at the patient's facility remained "on standby" to assist the patient with the virtual visit.

After completing her scheduled treatments at the distant facility, the PT received approval to drive to a third facility about 20 miles away in hopes of completing the patient's therapy evaluation. Fortunately, connectivity from the second distant site facility was available and the therapist successfully completed her evaluation of the patient on the day she was admitted to the facility. Without the use of this telehealth option, the therapist would have had to travel 90 miles to provide the clinical services as required by the patient's Medicare managed plan. Without this option, the clinical services would have been delayed for one to three days.

Outcome

Despite the technical challenges, which the therapist was able to navigate, we were able to ensure the patient's access to the therapy evaluation directed by her physician and her treatment began without delay.

It is not unusual for therapy services such as evaluations to be delayed in rural areas where there are limited therapy providers. The ability to provide a telehealth visit allowed us to provide the best care for the patient, while respecting the facility's restrictions limiting the number of personnel from entering the facility, thereby minimizing transmission risk. While our focus is on the patient, we welcome the use of telehealth services in order to allow therapists to continue safely and appropriately delivering clinical care as well as support for the therapist assistant within the infection control guidelines for new and quarantined patients.

We ask each patient who receives a telehealth visit to complete a Telehealth Satisfaction Survey after the visit. This patient completed the survey and continues to receive her physical and occupational therapy treatments as she works toward her goal of returning home.

Though pandemic restrictions were an overriding consideration in this case, we believe that ensuring the patient has timely access to medically necessary skilled care through the use of telehealth is the most important factor when looking at this use of telehealth.

Clinicians' Experience with Telehealth #3

In early April, I was faced with a choice – either evaluate a new patient admitted to a skilled nursing facility (SNF) using an audio/visual synchronous platform to remotely evaluate the patient, or opt to not intervene, which would limit this patient's access to physical therapy services due to the COVID-19 public health emergency. The SNF where this patient was admitted is located in a rural area and the facility recently implemented infection control measures that limited travelling staff from entering the SNF in order to reduce the risk of cross-contamination.

Patient Scenario

The patient had a clear medical necessity for physical therapy services following a recent hospitalization after falling at her home; still, without remote intervention, this patient would not be able to receive the skilled physical therapy services that she needed. After reviewing her medical record and collaborating with the PT Assistant (PTA) who was on-site at the facility, I determined the best course of action was to evaluate the patient remotely using the PTA as my extender. This mode of treatment was new for me, but well within my scope of practice as a board-certified physical therapist (PT). At the time of this evaluation, Medicare had not yet made the decision to include PTs as authorized telehealth providers that could bill for rendered services, so this evaluation was not billable at the time it was performed.

Outcome

Here are some things that I learned from this process:

- I was pleasantly surprised at the success of the remote evaluation process. I was able to hear and see my patient clearly. Equally important, my patient was able to hear and see me and to ask questions as well.
- The process took about the same amount of time as an in-person evaluation. I had prepared for the assessment and consulted with the PTA prior to setting up telecommunications with the patient. We had all of the supplies that we needed for the assessment process and I was able to collect all of the objective measures that I would have captured in person.

- The ability to collaborate in real time with the PTA who would take over treating this patient after I developed the plan of care was great! It allowed us to brainstorm interventions together at the very beginning of treatment.
- Most importantly, the patient's outcomes were positive – she was discharged and returned to her home to live independently following 10 days in the SNF.

Clinicians' Experience with Telehealth #4

I am a director of rehabilitation at a skilled nursing facility (SNF). As you can imagine with the health care crisis right now, things in my field have been crazy to say the least. Remote visits have recently been utilized by rehab for the first time at our building and let us just say they have made the impossible possible!

We have been through the webinars and the conferences. We attended the trainings and meetings and we knew the protocol. We thought that we had a flawless game plan in case we were affected by COVID-19. Then, unfortunately, it happened – COVID-19 entered our building. We implemented everything that we had trained for, but we still ran into issues. As our designed COVID unit filled up with our beloved residents, we had to figure out how to get therapy services to them while still fully serving our regular unit. We had very limited options. The staff that we sent to the COVID unit had to stay there and not return to the regular unit without a 14-day quarantine period. Multiple staffing issues ensued, so we brainstormed among the sister communities on ways to serve everyone safely without using PRN staff. Then we learned that therapy could utilize remote visits. So, we decided to send one therapist from each discipline into the COVID unit and leave some therapy assistants and one evaluating therapist at our regular unit.

The only way that our facility and the communities near us were able to give every resident the services they so desperately needed and deserved was through remote evaluations and remote visits. Without that option, it would have been impossible. Our residents not only needed rehab for their physical well-being, especially as they weakened from fighting the virus, but they also were frightened and isolated. They did not have family by their side. So, having the ability to send a familiar face in their rooms every day to help them through this crisis, someone to laugh with them, to make them stronger and to give them hope was priceless. We could not have given these precious services to every single patient in our care without utilizing remote visits. With so much unknown in health care right now, we hope to have this tool available to continue to offer what I consider life-changing therapy to our seniors in our care!

Clinicians' Experience with Telehealth #5

I have the opportunity and privilege to work with patients who contracted COVID-19 in the COVID unit. I have seen the decline of function, condition and the series of signs and symptoms they suffered. Some of them recovered and some succumbed to the disease and passed away.

Through this time, I have witnessed and believed in the importance of early rehab interventions to assist patients with getting stronger through therapeutic interventions and to enhance or maintain their functional mobility independence. Rehab interventions could not be successful without the remote assessment by licensed therapists and implemented by the therapy assistants in the COVID unit.

I am hoping this remote therapy intervention program will continue for the betterment of our COVID-19 patients until this pandemic is under control.