August 9, 2019

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6082-NC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: RFI on Reducing Administrative Burden to Put Beneficiaries over Paperwork

Dear Sir or Madam:

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 80,000 physical therapists, occupational therapists and speech language pathologists through our member organizations which provide rehabilitation services throughout the United States. NARA's members provide therapy in all settings across the care continuum including inpatient hospital settings, skill nursing facilities, outpatient clinics and facilities, in patient's homes, and in retirement and assisted living communities. As a member-driven organization, NARA promotes accessible and high-quality physical therapy, occupational therapy, and speech-language pathology services through education, support, and advocacy. NARA's membership demographics give it a unique insight into the full breath of the continuum of care for beneficiaries and the types of administrative burden that has been created by rules, policies and procedures forcing clinicians' time and other resources to be spent on excessive documentation and cumbersome administrative process rather than providing high-quality care to restore beneficiaries' health and function and enhance quality of life.

NARA appreciates this opportunity to provide input to Centers for Medicare & Medicaid Services (CMS) on the Beneficiaries over Paperwork initiative.

Access to Care Challenges

NARA believes there are several administrative burdens which limit beneficiaries' access to rehabilitation care. CMS could help improve the access to care by standardizing and modernizing policy.

It is well noted that there is an increase in the number of beneficiaries who subscribe to Medicare Advantage plans over the past several years. While NARA understands and supports the choice of plans for beneficiaries, we have experienced a significantly increased administrative burden in the following ways.

- Many Medicare Advantage plans require prior authorization for numerous services including rehabilitation. While NARA understands the desire of these payers to ensure the appropriate level of care is provided to its subscribers, we have experienced some unnecessarily long and unpredictable delays in care while awaiting authorization. NARA recommends creating a standard requiring all Medicare Advantage payers to communicate authorization decisions with two (2) business days;
- CMS allows therapy providers to be certified as a Rehabilitation Agency or provide service as a Private Practice. There are advantages to being credentialed as a Rehab Agency over a Private Practice including billing as an institutional provider (on a CMS-UB-04 claim form) and not having to individually credential each physical, occupational, or speech language pathologist therapist providing care to its beneficiaries. However, many commercial payers with Medicare Advantage plans frequently process claims for Rehabilitation Agencies incorrectly or deny payment which requires the provider to waste resources to appeal a denial or complete a reconsideration process for incorrectly processed claims. NARA members have found that these commercial payers do not recognize a Rehabilitation Agency as an institutional provider and subject them to private practice requirements including individual credentialing of therapist and billing claims on a CMS-1500 claim form instead of the institutional provider practices established by Medicare. NARA recommends that CMS standardize the process and require commercial payers offering a Medicare Advantage plan to follow established CMS practices for claims, credentialing and reimbursement for all Medicare approved providers.

Some additional areas causing administrative burdens and creating impediments to access to care include:

- All 50 States and most commercial payers recognize some level of direct access to therapy services without a referral from a physician or non-physician practitioner (NPP). NARA finds this direct access has helped improve patient access to safe and appropriate care and reduce costs in several cases. However, Medicare beneficiaries are not permitted to utilize direct access for therapy services because of CMS's requirements of identifying a treating physician or NPP who certify the therapy plan of care, NARA recommends CMS implement policy allowing direct access to physical, occupational and speech therapy for its beneficiaries;
- Currently, Occupational Therapists are not permitted to open a home health case for Medicare beneficiaries. Occupational therapists have the necessary skills and competency to evaluate a patient and complete OASIS documentation to initiate home health services. NARA supports current legislation (S 1725/HR 3127) allowing occupational therapists to initiate (open) home health services for beneficiaries covered by Medicare Part A.
- Medicare requires a three (3) day hospital stay in order for a patient to be eligible for a skilled nursing facility (SNF) stay under Medicare Part A, With the recent expansion of

hospital admission vs. observational stay, some beneficiaries who are stable enough to leave the hospital but not able to safely return home could benefit from care in a SNF setting. These observation stays often do not meet the criterion of a three-day hospital admission. Some Medicare Advantage plans and CMS Comprehensive Care for Joint Replacement (CJR) programs allow for waivers of the required three day stay but beneficiaries with traditional Medicare do not allow for waivers. NARA recommends removing the 3-day hospital stay and allowing the physician to decide if the patient is appropriate for and likely to demonstrate better outcomes with a skilled nursing facility stay;

- Outpatient therapy providers who provide therapy services to a beneficiary with a previous skilled nursing facility stay often receive denials for an overlap of stay when a patient is not properly discharged from the facility setting due to the current consolidated billing requirements. In order for the therapy provider to receive payment, it must dedicate resources to determine which provider may be flagging the overlapping stay, contact that facility and collaborate with the facility's billing department to ensure the discharge claim is promptly and properly submitted indicating the patient's date of discharge. There is often confusion created when a patient lives on the facility's campus and is discharged from a SNF level of care which creates additional burden for the therapy provider in submitting a clean claim. Several NARA members have expressed an inability to get cooperation from some facilities resulting in the therapy provider being unable to collect payment from CMS for the services it provides even when they have contacted the MAC or CMS Regional Office for assistance in resolving this issue. NARA recommends CMS create a standardized acceptable timeframe for a facility to properly and promptly file its last claim to indicate the discharge date. Alternatively, CMS could create a standard arbitration process at the MAC level for providers to advocate for reimbursing for services rendered when there is an error in discharge dates or unknown overlap;
- Similarly, when beneficiaries transition from skilled homecare services under Medicare Part A through a home health provider, there is unnecessary administrative burden for outpatient therapy providers when claims are not closed promptly and properly. For example, if the home health provider leaves the beneficiaries case "open" later than an outpatient therapy provider begins care, the outpatient provider is likely to receive a denial of payment. At times beneficiaries and families are not aware of skilled home care services and do not disclose to outpatient providers when asked. NARA encourages CMS to work with stakeholders to determine timely reporting and billing guidelines when beneficiaries transition care settings so providers submitting clean claims do not receive denials based the timely processing of discharges from previous providers. Alternatively, CMS could create a standard arbitration process at the MAC level for providers to advocate for reimbursing for services rendered when there is an error in discharge dates or unknown overlap;
- Medicare requires the physician or non-physician practitioner, who is certifying a patient for home health services, to provide a face-to-face encounter within 90 days prior to the start

of home health care or within 30 days following the start of care. Confirming if this face-to-face encounter has occurred within the allowed timeframe creates burden for home health providers and creates risk of denial of reimbursement by the home health provider even if the completion of a face-to-face encounter may be out of its control. For example, if the patient chooses not to see a physician or NPP during the appropriate window of time or the physician or NPP is not available to see the patient or accessible to sign the attestation, the home health care provider would not be reimbursed for the services it has provided. The requirement for a face-to-face encounter within this timeframe to certify a home health episode is inconsistent with other care settings and unnecessary given the technology and telecommunication of today. Requiring a beneficiary who is homebound to attend a face-to-face encounter can create hardships and added expense for the beneficiary and for his or her caregivers. Additionally, some home health agencies may not initiate service until after a face-to-face encounter within the acceptable timeframe is confirmed. NARA recommends CMS revise the requirement to allow for certification of a home health episode without a face-to-face encounter.

CMS Processes for Issuing Regulations and Policies

NARA members also note various administrative burdens related to the regulations for a Rehabilitation Agency and Outpatient Physical Therapy (OPT). Some are cumbersome while others appear outdated given the changes in the industry and current health care practice and operations. In addition, there are challenges with the variability in which new policies are communicated and implemented. Some examples include:

- CMS requires that Outpatient Physical Therapy have at least two people on duty anytime rehabilitation treatment is being provided to a beneficiary per C.F.R 485.723(a)(6). However, in Section 485.711(C) of the State Operations Manual (SOM) states that the two persons must be employed by the clinic or rehabilitation agency. While NARA understands and agrees with the need for two persons to be on duty to ensure the safety of beneficiaries and staff, we feel that allowing an organization to utilize competent non-employed staff (e.g. via staff of a neighboring organization in an assistive living facility) or volunteers could satisfy the intent of the safety measure. This would reduce the burden to providers and therefore improve access of care for beneficiaries. NARA recommends CMS examine the ability to safely and effectively use non-employed persons to satisfy this requirement;
- CMS requires that OPT's to provide the modalities of heat, cold, water and electricity per section 485.713(a)(1)(i). While this may have been an appropriate requirement at one time, the therapy industry continues to evolve and providers continue to work toward best practice. A blanket requirement of these specific modalities is unnecessary for many patient populations or clinical practices and is not consistent with strives for evidence base or reimbursement practices. (e.g. CMS does not consider heat or cold treatment a skilled therapy and does not reimburse for these modalities). Many providers obtain equipment to satisfy this requirement that goes underutilized. For example, many providers obtain

buckets to provide contrast bath to meet the requirement of a water modality; however, this is not a current commonly accepted clinical practice frequently utilized in the therapy industry. NARA agrees with the need to ensure providers have the adequate equipment for the beneficiaries they serve, we recommend eliminating this requirement and maintain the language in sections 485.713 which states an organization must provide "an adequate number of qualified personnel and the equipment necessary to carry out its program and to fulfill its objectives";

- The newly added Emergency Preparedness Program (EPP) requirements have created a burden on health care providers, especially smaller providers. While NARA members promote safety and recognize the criticalness for comprehensive preparation and preparedness for emergency situation, there is concern about the cumbersomeness of the requirements. Rehabilitation Agencies and OPTs are subject to thirty-nine (39) separate requirements under the EPP section. Many of these requirements are redundant with the previously established Disaster Preparedness (section 485.727) which were not modified with the addition of the EPP requirements. NARA recommends the EPP and disaster preparedness standards be consolidated to allow for reasonable practice of ensuring safety of all individuals without excessive administrative burden.
- Medicare requires Rehabilitation Agencies to perform an annual statistical evaluation under section 485.729 (b). This evaluation must include specific components which may or may not be the most beneficial metrics for a provider depending on the patient population or organizational set up. In addition, most providers are reviewing key metrics impacting its patient care and business more frequently than the annual requirement. Some track and analyze these metrics on a quarterly, monthly or even on a daily basis. NARA recommends CMS modernize the standard of the statistical evaluation to require providers to collect and analyze the key metrics to allow for successful oversight of the business at least annual.

Additionally, NARA recommends CMS implement a standardized method by which to communicate changes and new policies for maximum effectiveness. Currently there is inconsistency in the way CMS communicates with its stakeholders. Sometimes, key changes are communicated in an "open door forum" call while other times they are shared in a Medicare Learning Network (MLN) articles or via a distributed power point presentation. A consistent method would help educate and communicate with all the appropriate stakeholders including organizations, providers, direct clinicians, as well as industry vendors (e.g. software vendors) that need time to implement the changes and facilitate successful implementation and compliance.

Provider Challenges Variance in Practice Settings

NARA members express challenges with the variation that exists in policy and payment among the various therapy settings. Navigating through the variances creates unnecessary burden for providers.

- Medicare recognizes physical therapy assistants (PTA's) and certified occupational therapy assistants (COTA's) and reimburses for services when its criteria including proper supervision is met. Currently there is variation in the level of supervision required for PTA's and COTA's to provide care to its beneficiaries. For all settings other than private practice, PTA's and COTA's can function under the general supervision of qualified physical therapist (PT) or occupational therapist (OT) respectively. When the supervising PT or OT is not present onsite, he or she must be available for telecommunication for guidance when a PTA or COTA is providing services. In a private practice setting, however, CMS requires direct supervision of a PTA by a PT or a COTA by an OT who must on the premise when beneficiaries are being treated. This variance in practice settings is inconsistent and creates an administrative burden for providers. NARA recommends that CMS standardize the supervision level of a PTA or COTA in a private practice setting to match that of other settings. With current technology and telecommunications advances, a PTA or COTA can maintain instant and appropriate communication with his or her supervising therapist allowing for safe and effective treatment to be provided with general vs. direct supervision;
- Medicare beneficiaries often benefit from maintenance therapy plans which help to maintain their function or prevent or slow decline. However, this benefit is only available for beneficiaries in skilled nursing facilities and was recently added to the proposed home health rule for CY 2020. NARA believes CMS should include this benefit for outpatient beneficiaries to be consistent across all care settings;
- As previously mentioned, Occupational Therapists are not permitted to open a home health case for Medicare beneficiaries. NARA supports legislation (S 1725/HR 3127) allowing occupational therapists to initiate (open) home health services under Medicare A. Occupational therapists have the necessary skills and competency to evaluate a patient and complete OASIS documentation and initiate home health services;
- Currently, hospitals are not required to provide patient diagnosis information to post-acute care (PAC) providers which makes it difficult for PAC providers to include that information in medical records. NARA encourages CMS to finalize the hospital discharge requirements and include the requirement for them to transfer patient diagnosis information to subsequent providers to be consistent with other post-acute providers. By doing so, the PAC providers would have decreased administrative burden by using resources more effectively in the admission process by standardizing how the patient diagnosis information is shared among providers. CMS could address this by including a checkbox on the MDS to indicate whether the information was received from the previous provider. Additionally, NARA encourages CMS to consider the increased burden and costs for EHR vendors, and indirectly providers, that lie in the multiple step process of ONC Health IT Certification process as related to this measure;
- Once upon a time, providers were required to submit Quarterly Credit Balance Reports to their MAC. When the provider did not timely submit the report, their payments were held. Most often these reports were a zero balance so there was no reason to submit these

reports. Some MACs have eliminated this requirement while others still require it. NARA recommends CMS removing this requirement in full for Rehabilitation Agencies.

Coding and Documentation Requirements for Medicaid and Medicare Payments

NARA supports the need for proper documentation and reporting for care delivered by qualified therapists. A therapist is required to have a signed prescription or order from a physician/NPP in order to provide treatment; however, most States and commercial payers do not require a physician/NPP order and beneficiaries have direct access to seek the care of a physical therapist, occupational therapist, and speech-language pathologists. Additionally, Per Chapter 15 of the Medicare Benefit Policy Manual[1], once the plan of care is established a therapist is required to obtain the prescribing physicians/NPPs signature within 30-days of establishing the plan. Obtaining a physician's signature timely can be a challenge when a physician's payment is not connected to approving the plan of care. The therapy provider's is in jeopardy when a physician for whatever reason is unable to sign paperwork even though the therapist has made several attempts to obtain the authorizing signature. While the policy manual provides some clarification and examples for reasonable delayed certification, if the therapist is not in the same practice location as the prescribing physician it can be difficult for the therapy provider's staff to obtain the signature. NARA recommends Medicare Administrative Contractors (MAC) accept the physician prescribing order as certification in lieu of a timely signature when the documentation supports the need for therapy.

Policies and Requirements for Dually Enrolled (i.e. Medicare and Medicaid) Beneficiaries

NARA encourages CMS to consider additional risk adjustments for providers based on the types of populations they serve. Since the inception of the Affordable Care Act, urban facilities are providing services to a significant population of underserved or Medicaid beneficiaries should be considered for a risk adjustment. They often deal with beneficiaries with multiple co-morbidities who have not had access to health care services or may not have a consistent or stable living environment causing a longer length of stay due to non-existent or very limited discharge options. They are at significant risk for monetary penalty under the quality payment program.

Beneficiary Enrollment and Eligibility Determination

NARA members have shared with us that the process for them to verify benefits of beneficiaries has been greatly improved over the years; however, there are still some situations which have proven to be burdensome to providers as demonstrated below.

[1] Medicare Benefits Policy Manual https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf pages 162 and 168 accessed on August 5, 2019

- While most claims with a secondary insurance are crossing over to the payer, providers would like to see an increase in the number of payers where the ability exists for the claim to crossover after processing by Medicare. We recommend CMS consider setting a standard process or creating an incentive to secondary payers to make this possible;
- Providers still find that beneficiaries' records are not being updated timely regarding coordination of benefits with third party liability claims or employer group plans. We realize this these updates can be difficult to obtain from the beneficiary but they cause unnecessary denials for providers. CMS could consider an automatic update terminating a liability open case after 6-12 months. CMS could also consider reaching out to beneficiaries twice a year requesting any updates or work with employer group plans to provide updates for Medicare eligible beneficiaries. These updates are vital for providers submitting clean claims getting processed timely and accurately;
- NARA members have reported extensive confusion from beneficiaries on insurance when they switch from traditional Medicare to a Medicare Advantage plan. NARA recommends requiring Medicare Advantage plans to provide verbal and printed reminders multiple times throughout the life of the plan that a beneficiary's traditional Medicare card is no longer valid for benefits. This can cause a delay in the beneficiary's assess to care while the provider tries to determine who their benefits are through when the beneficiary is adamant their Medicare card is their only coverage;
- When Medicare is the secondary payer, claims cannot be submitted electronically which creates unnecessary burden for therapy providers. NARA encourages Medicare to develop a system and work with clearinghouses in order for providers to successfully submit Medicare secondary claims.

Conclusion

NARA thanks you for this opportunity to share some of our insight and recommendations related to the Centers for Medicare & Medicaid Services (CMS) request for information on the Beneficiaries over Paperwork initiative. We again applaud CMS's effort to reduce unnecessary burden for providers to allow the focus and resources to remain on the beneficiaries we serve. Should you have any questions concerning these comments or NARA can be of further assistance, please contact George G. Olsen, Esq. of Williams & Jensen, PLLC at ggolsen@wms-jen.com.

Respectfully submitted,

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President
National Association of Rehabilitation Providers and Agencies