January 29, 2016

Chairman Orrin Hatch
Senate Finance Committee
104 Hart Office Bldg.
Washington, DC 20510

Ranking Member Ron Wyden
Senate Finance Committee
221 Dirksen Senate Office Bldg.
Washington, D.C., 20510

Senator Johnny Isakson
131 Russell Senate Office
Washington, DC 20510

Senator Mark Warner
475 Russell Senate Office Bldg.
Washington, DC 20510

Re: Bipartisan Chronic Care Working Group Policy Options Document

Dear Senators Hatch, Wyden, Isakson and Warner:

The National Association for the Support of Long Term Care (NASL) commends the Bipartisan Chronic Care Working Group for issuing a broad range of thoughtful policy options aimed at coordinating and improving the quality of care for individuals with chronic diseases and increasing efficiency in the Medicare program.

NASL is a trade association representing providers of ancillary services to long term and post-acute care (LTPAC) settings. NASL's members include rehabilitation therapy providers that employ physical therapists, occupational therapists and speech-language pathologists who provide therapy services to patients in skilled nursing facilities (SNFs), nursing homes (NHs), in their homes via home health and hospice care, and other long term and post-acute care (LTPAC) settings. In addition, NASL represents suppliers of durable medical equipment, suppliers of enteral nutrition and developers of health information technology (HIT) with full clinical and point-of-care IT systems and clinical labs and portable x-ray serving the long term care patient.

NASL's comments focus on the policy options in three areas, including (1) expanding access to telehealth services, (2) enhancing chronic care management services for certain Medicare beneficiaries and (3) functional measures.

Telehealth

NASL recommends that the Finance Committee expand Medicare beneficiaries' access to services furnished via telehealth, including physical therapy, occupational therapy and speech-language pathology services, in both the Medicare Advantage and the fee-for-service programs.

NASL supports policies that would expand the categories of services that may be furnished via telehealth as well as the healthcare providers who may furnish Medicare's telehealth services. Telehealth technology has become a clinically-effective, cost-effective mechanism for an array of health services that increases Medicare beneficiaries' access to needed services and providers. We believe that current Medicare policy related to telehealth services is far too limited, and as a result, unduly hinders beneficiaries' access to cost-effective, medically necessary services.

In particular, NASL supports policies that would expand Medicare coverage of telehealth services to include physical therapy, occupational therapy, and speech language pathology services. We believe that Congress should expand covered providers for the purposes of rehabilitation therapy telehealth services to include physical therapists (PTs), occupational therapists (OTs) and speech-language pathologists (SLPs), as well as physical therapist assistants (PTAs) and certified occupational therapy assistants (OTAs).

We agree with the Working Group that "telehealth technology is not necessarily an additional benefit, but rather an alternative mode of care delivery of mandatory benefits to an enrollee." There is strong evidence that telehealth technology has improved to the extent that it now is a viable addition to standard rehabilitation therapy practices. For example, in the previous comments we submitted to the Working Group, we highlighted an initiative in the State of Washington where telehealth successfully increased patient access to physical therapy services. NASL members collaborated with the State of Washington and a community-based therapy provider on a tele rehabilitation pilot project that was focused on reducing barriers to patients' timely access to physical therapy. The pilot demonstrated that telehealth can improve access to care, as it bridged a gap between limited workforce resources and patients' needs in rural areas. In addition, it resulted in improved clinical outcomes, which led to faster discharges from SNFs and fewer re-hospitalizations. The State has since amended the Washington Administrative Code to include the use of telehealth in the practice of physical therapy (WAC 246-915-187).

Thus, we support the Working Group's policy option that would permit MA plans to include certain telehealth services in their annual bid amount, and believe that the MA plans should be allowed to include rehabilitation therapy telehealth services furnished by PTs, OTs, SLPs, PTAs and OTAs. Similarly, we believe that MA plans should have the flexibility to offer additional supplemental benefits related to the treatment of chronic conditions and the prevention of chronic disease, including rehabilitation therapy telehealth services. In addition, we believe that the Medicare FFS beneficiaries also should have access to high-quality,

clinically-effective, efficient therapy services furnished via telehealth. Thus, we believe that both the MA program and the Medicare FFS program should provide coverage of rehabilitation therapy telehealth services, including both synchronous and asynchronous (store-and-forward, remote patient monitoring) services, furnished by PTs, OTs, SLPs, PTAs and OTAs.

Additionally, NASL supports the three policy options that would modify the originating site requirements applicable to telehealth services, including: (1) eliminating the originating site requirements for ACOs participating in the two-sided risk models or permitting these ACOs to waive the geographic component of the requirements; (2) eliminating the geographic component of the originating site requirements for the purposes of promptly identifying and diagnosing strokes; and (3) expanding Medicare's qualified originating site definition for the purpose of increasing access to home hemodialysis therapy. However, NASL believes that Congress should expand the originating site requirements beyond rural counties and health shortage areas in metropolitan areas for telehealth services furnished to MA and Medicare FFS beneficiaries. We believe that the Working Group should defer to guidelines related to the safe use of telehealth that are established by professional boards and societies, such as the Federation of State Medical Boards (FSMB), the Federation of State Boards of Physical Therapy (FSBPT) and the National Council of State Boards of Nursing (NCSBN)

We also recommend that the Senate Finance Committee create telehealth and remote patient monitoring services "bridge" demonstration waivers. This bridge program would help providers that are subject to alternative payment models required under the Medicare Access and CHIP Reauthorization Act (MACRA) transition or "bridge" to the new system. The demonstration waivers would allow applicants to use telehealth and RPM services without the following limitations that currently exist under section 1834(m) in the Social Security Act, which includes: originating site restrictions; geographic limitations; use of store-and-forward technologies; use of remote patient monitoring services; and, limitations on the type of health care providers who may furnish such services. The "bridge" demonstration could sunset at a pre-determined time, e.g., six months after implementation of MACRA.

Chronic Care

NASL recommends that the legislation produced by the Working Group should ensure that all Medicare beneficiaries have access to chronic care management services.

NASL supports the Working Group's proposals to expand chronic care management services, and believes that the policies should be clearly defined to account for all Medicare beneficiaries with chronic conditions. We support the development of a new high-severity chronic care management code, as well as a one-time visit code for clinicians after beneficiaries have received a diagnosis of a serious or life-threatening illness, but believe that these codes should be available for use by all providers who bill for Part B services, including providers who are required to use CMS' institutional claim forms.

We agree that managing the care of a beneficiary with multiple chronic conditions necessitates increased interactions between the patient and his or her provider outside of the typical in-person visit, which may include other members of a patient's care team (i.e., social worker, dietitian, nurse, behavioral health specialist). It is important to note that these increased interactions are required for beneficiaries with multiple chronic conditions regardless of their setting of care. It is for this reason that the Finance Committee should pursue legislation that would make these services available to beneficiaries in all settings, and that the availability of such services should not depend on the particular claims forms used by various Medicare providers.

Medicare beneficiaries residing in SNFs and NFs, as well as beneficiaries receiving rehabilitation services through a Medicare outpatient rehabilitation agency or CORF, are elderly and are frequently frail with multiple chronic conditions. We believe that the Working Group should ensure that a new high-severity chronic care management code does not inadvertently penalize these medically complex Medicare beneficiaries who are treated by providers mandated to use CMS' institutional claim forms.

For example, SNFs receive bundled payments for residents whose stays are covered by Medicare Part A. These payments are intended to encompass care coordination and chronic care management services during the period immediately following a hospitalization. However, some Medicare beneficiaries do not qualify for the Medicare A benefit in the SNF because they have not had the required 3-day hospital stay or they have entered a SNF due to the exacerbation of chronic diseases. Without the prior hospitalization, SNF stays are not covered under Medicare Part A.

For Medicare beneficiaries with chronic diseases who reside in NFs, Medicare Part B covers a number of services, primarily rehabilitation services (physical therapy, occupational therapy and speech-language pathology). The rehabilitation services covered by Medicare Part B are required to be billed on an "institutional claim" known as the UB-04. In contrast to Medicare Part A-covered stays, the facilities do not receive payment for care coordination or chronic care management for these patients, since CMS requires that the Part B services are to be provided and billed under the Medicare Physician Fee Schedule (using the CPT coding system).

NASL members have extensive and longstanding experience with the chronic care population; these patients are a high percentage of the beneficiaries we treat in skilled nursing and nursing facilities. We employ highly skilled professionals who have specialized in the care of this population. Medicare mandates that we give evidence of quality care and closely monitor both the services provided and the claims submitted for the services provided to these patients.

We believe that non-Part A SNF residents would be best served if the SNFs are responsible for the largest portion of complex chronic care management. SNFs clearly have the expertise and capability of furnishing complex chronic care management services for their residents and are best positioned to provide these services to beneficiaries truly needing residential care. We believe that the Working Group should adopt a policy that enables SNFs to submit claims for complex chronic care management services, using the CMS established coding system for these services on an "institutional claim. "

Similarly, SNFs clearly have experience caring for patients who are diagnosed with serious or life-threatening illnesses, including Alzheimer's/Dementia. Similar to Medicare beneficiaries outside of SNFs, residents in SNFs who are newly diagnosed with serious or life-threatening illnesses need to have discussions with clinicians regarding the progression of the disease, treatment options and available resources. To the extent that a resident's SNF stay is not covered by Medicare Part A, Congress should ensure that an institutional provider is able to submit a claim for the newly established one-time visit code after a beneficiary is diagnosed with a serious or life-threatening illness, such as Alzheimer's/dementia in addition to allowing capture of the chronic care management on the UB-04 claim.

In line with the "triple aim" of health care reform, NASL urges the Working Group to closely examine the role of all providers, including SNFs and NFs, in the management of CCM and to consider a program design and reimbursement structure that encourages and appropriately rewards coordinated efforts across the continuum of care.

Quality Measures for Chronic Conditions

The Working Group is considering requiring CMS to include in its quality measures plan, which is required by the MACRA, particular measures that focus on health care outcomes for individuals with chronic disease. The Working Group is considering measures related to: (1) patient and family engagement, including person-centered communication, care planning, and patient-reported measures; (2) shared decision-making; (3) care-coordination, including care transitions and shared accountability within a care team; (4) hospice and end-of-life care; (5) Alzheimer's and dementia, including measures for family caregivers, outcomes, affordability, and engagement within the healthcare system or other community support systems; and (6) community-level measures, in areas such as obesity, diabetes and smoking prevalence. In addition, the Working Group also is considering recommending that the Government Accountability Office conduct a report on community-level measures as they relate to chronic care management.

CMS is rapidly implementing the *Improving Medicare Post-Acute Care Act of 2014* (IMPACT Act) which includes quality measures in the domain areas of skin integrity, incidence of major falls, functional assessment, pressure ulcers, providing for the transfer of health

information and care preferences and others. The four post-acute care providers (SNF, home health, long term care hospitals and inpatient rehabilitation hospitals) must report data to satisfy these measures and data collection begins October 1, 2016. This is an extensive undertaking both for CMS to structure the data collection instrument and for providers to report the data. We will not know until significant data are collected and the results of these quality measures are evaluated whether these measures are fully accurate. This will take time. For that reason, NASL cautions against layering on additional measures, even if they relate to chronic care, for the post-acute care providers until we understand if the IMPACT Act quality measures actually work and produce useable results.

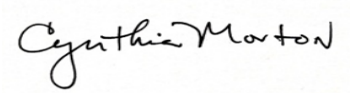
> **NASL recommends that the Working Group consider that post-acute providers are already required to submit data on quality measures that relate to chronic care in some fashion. NASL recommends that these measures be taken into consideration and Congress should ensure that any new requirements do not duplicate or contradict measures for post-acute care providers that have been implemented or are being implemented as a result of the IMPACT Act.**

Functional Status and Risk Adjustment

The Working Group is considering mandating a study to examine whether functional status, as measured by activities of daily living or other means, would improve the accuracy of risk-adjusted payments for Medicare Advantage plans. The study also could examine the potential challenges in providing and reporting functional status information by MA plans, providers and/or CMS. NASL would support such a study because we understand the importance of functional status as it relates to the ability of the patient to return or remain in the community. We recommend that the Working Group examine what has been conducted by CMS and its contractors with respect to functional status in preparation for standardized data collection of functional status and other domains required by the IMPACT Act.

NASL appreciates the opportunity to submit these views. For more information, I can be reached at 202 803-2385 or Cynthia@nasl.org

Sincerely,



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