American Physical Therapy Association

1111 North Fairfax Street
Alexandria, VA 22314-1488
703 684 2782
703 684 7343 fax
www.apta.org

June 29, 2011

Submitted Electronically

Secretary Kathleen Sebelius
Centers for Medicare and Medicaid services
Department of Health and Human Services
Attention: CMS -2328 – P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS 2328-P; RIN 0938-AQ54: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services

Dear Secretary Sebelius:

On behalf of our 78,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) appreciates the opportunity to submit comments to the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), in response to the notice and request for comments published in the *Federal Register* on May 6, 2011, for the "Medicaid Program; Methods for Assuring Access to Covered Medicaid Services" proposed rule.

APTA is committed to advancing the safety and quality of healthcare and we are eager to work with the CMS and the States in promoting access to appropriate health care services in the current environment of States' resource constraints. Physical therapy is an essential service provided to adults and children under Medicaid and CHIP. APTA supports the practitioner's ability to deliver individualized patient care that is medically necessary by providing a range of benefits to choose from to optimize health outcomes rather than reducing or eliminating benefits that are crucial to improving a beneficiaries' ability to function, participate in daily living, maintain productivity and improve the

quality of their health outcomes. In this current environment of practitioner shortages, it is imperative that this vulnerable population of beneficiaries be able to access the appropriate health care services - including physical therapy – and practitioners that they medically require.

APTA commends CMS in its utilization of the recommendations of The Medicaid and CHIP Payment and Access Commission (MACPAC) in this proposed rule and would like to take this opportunity to comment on particular areas of importance to physical therapists within these proposals.

Physical therapy services are provided in a variety of settings, including home care, Intermediate Care Facilities for People with Mental Retardation (ICF/MR), hospitals, outpatient clinics or offices; inpatient rehabilitation facilities; skilled nursing, extended care, sub-acute facilities; patients' education or research centers, hospices and schools. Physical therapy efficiently aids a beneficiary in gaining the best possible function within the context of their medical condition. These services ensure the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health. Often, physical therapy is an effective and less costly option than alternative treatments, such as surgery.[1] Costs associated with hospital readmissions after surgical procedures can often be reduced by utilizing physical therapy, where appropriate. Physical therapists are critical to ensuring patients attain an optimal level of mobility and safety in their environment. Physical therapists are uniquely qualified to provide functional training and educate the patient and caregivers on important factors such as prevention of further injury, illness and/or decline in functional status and the resulting effects of immobility. In addition, physical therapists are able to recognize subtle changes in a person's status that may require further evaluation or referral to other healthcare providers before the problems are exacerbated and require readmission.

Under Medicaid, physical therapy falls into the category of "optional services", and is currently covered in approximately 37 states. When covered, this benefit serves the most vulnerable Medicaid population – including children, individuals with disabilities and dual eligible beneficiaries. In the current fiscal environment, States are weighing all options to reduce costs, particularly benefits that are defined as "optional." APTA is concerned that as the Medicaid system is restructured by States that optional benefits will be discontinued and cautions CMS on issuing recommendations to States that may inadvertently encourage elimination of services, such as physical therapy, when their elimination could result in increased costs to States due to increased inpatient hospital admissions, development of more severe health conditions, or institutionalized care. APTA agrees with the MACPAC statement in examining access to care issues that "[o]ne of the key tests of the effectiveness of a health care coverage program is whether it **provides access to appropriate health care services** in a timely manner and whether those services promote health improvements."[2]

[1] Spine (Phila Pa 1976). 2008 Jul 15;33(16):1800-5.
[2] MACPAC, *Report to the Congress on Medicaid and CHIP*, March 2011, p. 125.

MACPAC-Recommended Framework

We support the adoption as part of the State-level review strategy of the MACPAC-recommended framework which considers (1) enrollee needs; (2) availability of care and providers; and (3) utilization of services, and the associated requirement of transparency in States' process design and implementation of this framework. Additionally, APTA agrees that it is imperative to identify problem areas and assess such factors as whether service delivery should be redesigned or provider enrollment and retention be improved. Currently, there is a primary care physician and physical therapist provider shortage and, in conjunction with the problem of provider non-participation in Medicaid, access to care is problematic.

APTA members on the frontline are encountering many occasions when they are unable to provide medically necessary services to Medicaid beneficiaries because of such variations as a States' elimination of the physical therapy benefit or a States' misinterpretation of who is considered a "qualified" physical therapist under 42 CFR § 440.110(a)(2)(i).[3] Although 37 states currently cover physical therapy as an "optional service," many of those States limit coverage for those services to specific settings, such as outpatient hospital departments. As a result, many Medicaid beneficiaries cannot access physical therapy services in private practice settings in their communities.

The proposed rule proposes that States conduct access reviews for subsets of services each calendar year and that States may choose the services they will review each year, and that each service must be reviewed at least once every 5 years. APTA urges CMS to require that optional benefits be included in this review to assess utilization rates and strongly recommends the issuance of a directive that allows serious impediments to accessing medically necessary care to be remedied in a timely and expeditious manner.

---

[3] On November 1, 2010, APTA sent correspondence to the CMS regional office in New York attempting to expedite the correction of a New York agency's recent misinterpretation of the federal definition of "qualified" physical therapist. The Code of Federal Regulations states that a "qualified physical therapist" is an individual who is "a graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association **or its equivalent** [emphasis added]; and licensed by the state." 42 CFR § 440.110(a)(2)(i). In the November 1, 2010, correspondence APTA wrote:

> "We are concerned that the standing interpretation being applied by the New York State OMIG will unintentionally result in many qualified physical therapists being rejected from validly billing for Medicaid services. This exclusion of otherwise qualified physical therapy providers would be detrimental to Medicaid recipients who have a crucial need for access to care. This misinterpretation should be corrected immediately so that those physical therapists – who became qualified under prior law and continue to be qualified practitioners - are not suddenly rejected from providing and being paid for Medicaid services. Therefore, we respectfully request that the Center for Medicaid and State Operations send official correspondence to the New York State Office of Health Insurance Programs with the correct interpretation of this law."

To date, the problem has not been rectified and numerous licensed and qualified physical therapists who have delivered Medicaid services (some exclusively) and have been practicing for many years have been terminated due to this misinterpretation. The New York State Office of Health Insurance Programs expressed equivalent concern in correspondence dated, October 14, 2010. To date, APTA has received no response from CMS.

Mandating only a 5 year review of each service could lead to access to care issues that languish for half a decade before they are corrected.

Under Medicaid, physical therapy services are only mandatory services when offered under the Early, Periodic Screening, Diagnostic, and Treatment program which is very narrow and limited in scope and duration. This denies a major portion of Medicaid beneficiaries' access to medically necessary physical therapy services. Under *Section 1302 of the Patient Protection and Affordable Care Act of 2010*, the Secretary is mandated to provide an essential health benefits package that has a delineated rehabilitation benefit. APTA strongly urges the Secretary to emphasize the cost savings to States of streamlining the mandatory physical therapy benefits under the Health Insurance Exchanges (HIE) benefits with their Medicaid and CHIP programs, especially due to potential administrative and cost burdens associated with "churning" beneficiaries.

Medicaid programs must develop more team approaches to the delivery of quality health care. Physical therapists are integral members of the rehabilitation treatment team and States, as well as the federal government, should make every effort to make unrestricted access to physical therapy available to all Medicaid beneficiaries as medically necessary.

For individuals with spinal cord injuries, traumatic brain injuries, cerebral palsy, amputations, and other conditions, Medicaid is often their only means of accessing durable medical equipment (DME) such as wheelchairs, prosthetic devices, and assistive technologies. Physical therapists provide orthotics, ambulatory aids, and mobility assistance devices to the patients they serve to help them improve their function. These items become an essential part of the treatment plan for patients who need them. The clinical judgment and expertise of the physical therapist is critical in selecting particular durable medical equipment items for the patient. The physical therapist evaluates the patient and ensures that the item is appropriate to achieve the patient's functional goals, is properly sized and fitted for that patient, and that the patient and/or caregiver is educated in the proper use of the item.

To ensure that Medicaid beneficiaries receive the appropriate DMEPOS items for their condition and to maximize rehabilitation and overall function, Federal and State governments must ensure that health care professionals, such as physical therapists, are involved in the selection of these items and that patients have access to and coverage for these items under Medicaid.

Standards and Methodologies Implementation

APTA further commends the implementation of MACPAC's first Congressionally-authorized expert recommendation on standards and methodologies for defining access to health care and health services, including utilization of analytic framework to determine the impact of any proposed Medicaid State Plan rate reductions on service access. However, we caution CMS that data element results may be skewed due to the variability of benefits offered under Medicaid State Plans. For example, the 3-part framework requires gathering information on utilization of services and the availability of care and providers. If certain benefit categories of care are excluded from measurement because they are either an "optional" or excluded benefit, then access to medically necessary

services and subsequent outcomes cannot be adequately measured. Furthermore, similar framework may be utilized to assess access to care for the required statutory test between Medicaid beneficiary access and access to medical services by the general population in the geographic area (as well as in the HIE), however, States would have to account for the inclusion or exclusion of services between the general population, the HIEs and Medicaid, which could be administratively burdensome and costly to States and lead to inaccuracies in access, quality of care and cost efficiency outcomes measures.

APTA supports the proposal of addressing potential issues in service access by requiring States to implement an ongoing mechanism that allows beneficiary feedback and to submit a corrective action plan to CMS to address any discovered access issues. APTA recommends that CMS also require an ongoing mechanism for **providers** to provide feedback on access issues to be included in the ongoing access reviews. Beneficiaries may not always be aware of services they are entitled to but do not receive, be able to effectively communicate care inaccessibility (as referenced in the proposed rule), or the patient and/or caregiver may simply not have time to fully explain all offered services. Providers on the frontlines often see immediate access to care problems and could provide valuable information to States.

Public Process to Involve Stakeholders

APTA strongly supports the proposal of requiring that States conduct a public process to receive stakeholder input prior to submitting a State Plan which proposes Medicaid provider payment rate reductions or changes to provider payment structures. APTA also supports inclusion of provider input when the State data collection and monitoring process uncovers an access issue, however, as previously stated, we recommend stakeholder feedback as part of the data collection and monitoring process as well. In fee-for-service States (which this proposed rule applies to), Medicaid provider payment rates are currently a percentage of that paid to providers under Medicare, which is one of the causes of a reduction in Medicaid provider participation. Inclusion of and collaboration with stakeholders in the payment model process has been shown to be highly beneficial to the State in ensuring continued participation by providers in the Medicaid program. Additionally, APTA supports the requirements of soliciting feedback from stakeholders in determining the oversight and monitoring procedures a State will implement to ensure access to care is sustained and remediated after payment rate reductions have been submitted and approved (although APTA does <u>not</u> support further rate reductions due to Medicaid's already reduced payment rate).

Defining "Significant" Changes in Payment Methods and Standards

APTA supports the CMS proposal of removing the "significance" reference in order to clarify to States that public notice is required for <u>any</u> change in payment methods or standards. APTA urges – in the public interest of promoting transparency – that CMS require States to also provide the public with any information on the resulting impact on service access that the proposed changes have once changes take effect. Additionally, we

support more stringent Federal oversight of State reviews when significant provider payment reductions are proposed or when access to care issues are evidenced.

Conclusion

In conclusion, it is vitally important that Medicaid beneficiaries, especially vulnerable populations such as children, the disabled and at-risk adults, are able to access care that is medically necessary for their health condition. The inability to obtain care or receive appropriate care results in a substantial cost to beneficiaries, States and the health care delivery system as a whole. APTA commends CMS for proposing the implementation of the MACPAC recommendations for providing a framework that will allow States to focus on increased access to services, better care delivery, improved health outcomes to the consumer, and improved cost efficiencies. We strongly urge CMS to encourage States to streamline benefits and methods in their data collection and monitoring activities which will result in more valuable data to measure care outcomes and reduce administrative burdens. Decreasing costs while allowing access to quality health services has been evidenced by innovative payment models such as medical and health homes and other integrated service models. These efforts will require increased participation and collaboration with all stakeholders.

APTA looks forward to working with CMS in its efforts to assist the States through the utilization of data collection, monitoring and analysis tools in lieu of simply cutting payment rates to providers. Historical data demonstrates that payment rate reductions are a poor tool to decrease States' health care costs. Thank you for your consideration of our comments. If you have any questions regarding our comments, please contact Deborah Crandall, Associate Director of Payment, Policy and Regulatory Affairs, at 703-706-3177 or deborahcrandall@apta.org.

Sincerely,

R. Scott Ward, PT, PhD
President