SUBMITTED VIA REGULATIONS.GOV

October 5, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: **CCD Health Task Force Comments on Rehabilitation Access under the CY 2021 Physician Fee Schedule Proposed Rule**

Dear Administrator Verma:

The undersigned members of the Consortium for Citizens with Disabilities (CCD) Health Task Force appreciate the opportunity to comment on the Calendar Year 2021 proposed rule for payment policies under the Physician Fee Schedule (the Proposed Rule). CCD is the largest coalition of national organizations advocating together for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society.

Our comments focus on the proposals to expand certain telehealth provisions under the Physician Fee Schedule (PFS) beyond the current Public Health Emergency (PHE) as well as the proposed changes to the PFS conversion factor and related impact on patient access to rehabilitation therapies.

Expansion of Telehealth under the Physician Fee Schedule

CMS proposes to permanently add several services to the Medicare telehealth services list and create a separate temporary list of services authorized for provision via telehealth through the calendar year in which the PHE ends. CMS also notes that certain services currently authorized during the PHE will not be extended, including physical therapy, occupational therapy, speech-language pathology, and other services predominantly furnished by therapists. The Health Task Force recognizes that these proposals are tied to the agency's current authority and that statutory changes will be required for certain telehealth expansions, including authorizing non-physician practitioners to provide telehealth services.

The Health Task Force recognizes that the health care system has rapidly adopted telehealth during the COVID-19 PHE, and that policymakers, including CMS and Congress, will be considering more permanent telehealth policies as the nation recovers. We urge CMS to ensure that telehealth polices improve health care services and access for people with disabilities and other populations facing health disparities, including people of color, people with limited English proficiency, and people with limited income and resources. In addition to the comments provided below, we have attached the Health Task Force's

telehealth principles, and encourage CMS to incorporate these concepts into this and future rulemaking impacting telehealth in the Medicare program.

We appreciate that the rapid expansion of telehealth has allowed many Medicare beneficiaries with disabilities and chronic conditions, to safely access medically necessary health care while protecting themselves from threat of infection with COVID-19. Especially for people with injuries, illnesses, disabilities, and chronic conditions, the ability to receive medical care virtually has been critical for improving health and function while limiting the risk of infection by abiding to social distancing protocols. As CMS reviews the regulations governing the use of telehealth, we strongly encourage the agency to ensure that patient access to care is the driving factor behind permanent expansions of telehealth, including telerehabilitation.

Many people with disabilities have seen a significant benefit in terms of access to care with the expanded availability of telehealth, even aside from the circumstances of the PHE. Beneficiaries with mobility impairments, for example, often face complications in accessing in-person visits, including with planning, transportation to and from their provider, and accessibility of facilities and equipment at the site of care. With telehealth, the burden of mobility impairment, especially for routine visits, can be dramatically eased while preserving timely access to care. Similarly, some people with cognitive disabilities have found that virtual services may be more accessible or in some cases, even more effective, with the potential to cut down on distractions associated with receiving care in an unfamiliar environment. The availability of telehealth may also provide an opportunity for more accessible, continuous care in between in-person visits.

In short, there are two major factors that must be considered when determining the permanent expansion of telehealth services: access and accessibility. Telehealth should be additive and supplemental to in-person care; access to the most medically appropriate services for an individual patient should not be decreased when telehealth is made more widely available. CMS must also ensure that telehealth is available and accessible to all patients – beneficiaries should not be excluded from being able to utilize virtual services due to inaccessible technology that an individual with a disability cannot utilize due to their disabling condition.

Further, while some beneficiaries will see additional utility in receiving medical care virtually, many individuals have complex conditions that are more appropriately treated in person, or may simply prefer in-person care for a variety of reasons. The expansion of telehealth must not come at the expense of in-person care, especially when the medical needs of a patient are more effectively and efficiently provided in person. Beneficiaries with disabilities and chronic conditions often need the highest levels of medical care in order to maintain or improve their health and function; it is critical that they are able to access the most appropriate care in the most appropriate settings for their individual needs. Medicare regulations must not promote one modality over another, and the decision between virtual and in-person care should be made between the patient and provider.

We support the expansion of telehealth as an option to expand the availability of care for beneficiaries, especially those with disabilities and chronic conditions, as long as telehealth is utilized only when clinically appropriate and does not present any additional barriers to accessing in-person care.

Additionally, the availability of telehealth services does not ensure that all beneficiaries will be able to access these services equitably. We appreciate the steps CMS has taken during the PHE to ensure that multiple modalities, including audio-only and other non-broadband based modalities, are covered and reimbursed appropriately. People with disabilities have a variety of needs that cannot be addressed by a "one-size-fits-all" approach to telehealth; CMS must protect accessibility by covering a variety of modalities and ensuring accessibility for all beneficiaries. For example, telehealth modalities must be compatible with screen reading software and other assistive technology, must ensure accessibility for those with disabilities and limited English proficiency through the use of interpreters and the provision of materials in alternative formats and non-English languages; and must meaningfully address the lack of or limited access to reliable broadband, technologies, and digital literacy training.

Given that the expansion of telehealth happened quickly and recently, there is still a lot to be learned about both the impact and effectiveness of telehealth across services and populations. Therefore, we also urge CMS to collect data on access to and utilization of telehealth, including disparities in access and outcomes faced by people with disabilities, racial and ethnic minorities, and other underserved populations.

We urge CMS to promulgate telehealth policies that ensure accessibility for all beneficiaries, including those with disabilities and those facing pre-existing health disparities.

Impact of Proposals to Address Budget Neutrality on Patient Access to Care

As indicated in last year's Physician Fee Schedule Final Rule, CMS is proposing to increase payment for in-office and outpatient evaluation and management (E/M) services on January 1, 2021 in order to shift incentives from specialty and surgical care toward the provision of primary care. Due to a statutory requirement that changes to the physician fee schedule remain budget neutral, CMS is also proposing to offset the cost of these changes by reducing the "conversion factor" for fee schedule services by nearly 11% across the board. The Health Task Force does not typically comment on reimbursement proposals that impact providers. But the magnitude of cuts imposed on rehabilitation therapy, physical medicine, and other critical health care services for individuals with disabilities included in the CY 2021 proposed physician fee schedule rule is very likely to have a detrimental impact on access to patient care. This is particularly true for beneficiaries with disabilities who already face significant barriers to receiving the care they need.

We recognize that budget neutrality is mandated by law; however, the impact of the decrease in the conversion factor has the potential to severely limit availability of care, especially for services frequently utilized by beneficiaries with disabilities, including physical therapy, occupational therapy, audiology, speech-language pathology, and rehabilitation physician services. These services have become ever more critical during the COVID-19 pandemic, especially as patients face long-term recoveries or even permanent disabilities as a result of COVID-19 infection. People with pre-existing disabilities already face significant health disparities, and these proposed cuts may further weaken the health care infrastructure to treat complex patients.

Especially during the current public health emergency, the added financial pressure associated with these cuts may cause practitioners to close or limit their practices, particularly threatening patients in rural and underserved areas. In addition, these cuts are likely to have ripple effects beyond the Medicare program, as many commercial insurers and other federal health care programs look to

Medicare as a precedent-setting payer or even explicitly tie their reimbursement rates to the Medicare physician fee schedule.

Therefore, as CMS moves forward with implementation of changes designed to enhance the availability of primary care, we urge CMS to consider all available authorities to ensure that patients are not adversely affected by the proposed reimbursement cuts and that access to care is protected during the current public health emergency and beyond.

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We appreciate your consideration of our comments. Please contact Peter Thomas at Peter.Thomas@PowersLaw.com with any questions or comments you may have. Thank you.

Sincerely,

The undersigned members of the CCD Health Task Force:

Allies for Independence
American Association on Health and Disability
American Academy of Physical Medicine and Rehabilitation
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Therapeutic Recreation Association
Autism Society of America
Brain Injury Association of America
Cure SMA
Easterseals
Epilepsy Foundation
Justice in Aging
National Association of State Head Injury Administrators
National Disability Rights Network
National Health Law Program
United Spinal Association

CONSORTIUM FOR CITIZENS WITH DISABILITIES

Health Task Force Telehealth Principles
July 2020

The Consortium for Citizens with Disabilities (CCD) is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

During the COVID-19 public health emergency, the health care system rapidly transitioned to providing many health care services through telehealth. As our nation recovers, policymakers will be determining a more permanent telehealth policy. Telehealth policies should improve health care services and access for people with disabilities and follow civil rights law.

Ensure Disability and Language Access
Telehealth coverage and access policies must ensure access for people with disabilities and limited English proficiency and comply with all existing civil rights laws. This includes the use of interpreters and provision of materials in alternative formats and non-English languages. Telehealth modalities must be compatible with screen reading software and other assistive technology, consistent with Web Content Accessibility Guidelines 2.0 (or latest version).

Ensure Multiple Access Modalities
To ensure equitable access to telehealth for people with disabilities, all payers must cover multiple access modalities, including audio-only and other non-broadband based modalities. The patient should have the right to choose among the available and appropriate modalities.

Ensure Privacy Protections
While many privacy requirements have been waived during the public health emergency to allow for rapid adoption of telehealth, going forward telehealth modalities must comply with patient privacy protections, including those of the Health Insurance Portability and Accountability Act (HIPAA).

Continue to Cover In-Person Services and Ensure Network Adequacy
Beneficiaries and enrollees from all payers must retain the right to receive health care in person and the availability of telehealth services should supplement, not supplant, the availability of in person services. Health plan policy or practice should not require the use of telehealth or discourage in-person visits, such as through higher copays for in person visits, additional prior authorization, or other utilization management requirements. Plans should continue to be required to meet network adequacy requirements based on in-person services.

Allow Providers to Deliver and Patients to Receive Services at Any Site
Payers should cover telehealth for patients located at any site, and providers at any originating site.

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Reimbursement should be provided for services delivered across state lines, subject to state law, including licensure and patient privacy laws.

Ensure Equitable Reimbursement
Telehealth services should be reimbursed at a rate sufficient to ensure provider participation.

Cover Electronic Prescribing and Ordering
Health care payers should cover prescriptions for medications and orders for durable medical equipment, home health, and other services made via telehealth, without requirement for a previous in-person visit. Electronic prescribing and prescribing following a telehealth visit should also be allowed for controlled substances.

Ensure Telehealth Promotes Equity
Care must be taken to ensure telehealth addresses health disparities among people with disabilities, including those that are due to systemic racism and other socio-economic injustices. This requires ensuring telehealth policies are culturally responsive, and meaningfully address lack of or limited access to reliable broadband, technologies, and digital literacy training.

Ensure Patients Can Make Informed Decisions
Patients and providers are equal parties in the decision-making process about whether to use telehealth. This equity in decision-making should apply not only to the decision about whether to use telehealth, but also the decision to continue using it during the course of treatment, based on patient preferences and clinical evidence and judgement.

Providers and payers must accurately disclose beneficiary cost-sharing obligations prior to service and connect beneficiaries and providers with the resources they need to understand their financial responsibilities.

Payers must maintain a directory of telehealth providers and/or include information about providers that are available via telehealth in their provider directory.

Payers and the federal government should also engage in an education campaign to ensure that the public understand telehealth opportunities and responsibilities.

Data collection
Data must be collected as telehealth becomes more common, including detailed demographic data on usage and outcomes by the following categories individually and in combination: race, ethnicity, age, disability status, preferred language, sex, sexual orientation, gender identity, socio-economic status, insurance coverage and geographic location. Data must be collected in accordance with patient privacy laws, with the opportunity for patients to opt-out of providing demographic data, and protocols for removing identifying characteristics of patients from the data.

Signatories:

ALS Association
American Academy of Physical Medicine & Rehabilitation
American Association on Health and Disability
American Council for the Blind

American Foundation for the Blind
American Network of Community Options and Resources
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Medical Rehabilitation Providers Association
Autistic Self Advocacy Network
Brain Injury Association of America
Center for Medicare Advocacy
Center for Public Representation
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Christopher & Dana Reeve Foundation
Disability Rights Education and Defense Fund (DREDF)
Epilepsy Foundation
Family Voices
Justice in Aging
Lutheran Services in America - Disability Network
National Alliance on Mental Illness
National Association of Councils on Developmental Disabilities
National Association of State Head Injury Administrators
National Center for Parent Leadership, Advocacy, and Community Empowerment (National PLACE)
National Disability Rights Network
National Down Syndrome Congress
National Health Law Program
The Arc of the United States