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September 2, 2014

Marilynn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS -1612-P
Mail Stop
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS- Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule

Dear Administrator Tavenner:

On behalf of our 88,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule regarding “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015,” published in the July 11, 2014 *Federal Register*. APTA’s goal is to foster advancements in physical therapy practice, research, and education. The mission of APTA is to further the profession’s role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the physical health and functional abilities of members of the public.

The physician fee schedule is currently the basis of payment for outpatient therapy services furnished by therapists in private practice as well as outpatient therapy services furnished by hospitals, outpatient rehabilitation facilities, public health agencies, clinics, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities (CORFs). Therefore, any changes to payments under the physician fee schedule for outpatient therapy services have a significant and direct effect on Medicare payments across the entire spectrum of the therapy delivery system.

These comments address: 1) the physician fee schedule update for 2015; 2) alternatives to the current process for valuing services; 3) misvalued codes; 4)

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the Medicare Shared Savings Program; 5) the extension and implementation of the Physician Quality Reporting System (PQRS) in 2015 and beyond; 6) the value-based modifier; and 7) locum tenens. Our comments on each of these provisions are discussed in further detail in the following paragraphs.

Physician Fee Schedule Update for CY 2015

In the proposed rule, CMS projects that due to the SGR formula there would be a 20.9 percent reduction in the Medicare physician fee schedule conversion factor beginning April 1, 2015. A cut of such magnitude would seriously hinder Medicare beneficiaries' access to physical therapy by making it virtually impossible for physical therapists in any setting to be able to provide care to these beneficiaries. While APTA realizes that such a sizable cut in Medicare payments is currently required by statute, we also recognize that Congress has been working to repeal the flawed SGR formula, to improve quality of care, and to transition to new payment models. We therefore, urge the Administration to continue to work with the Congress to prevent this drastic cut from occurring in April 2015 and to develop new payment models.

In the rule, CMS notes that the Protecting Access to Medicare Act of 2014 (PAMA) extended through March 31, 2015 the exceptions process for the outpatient therapy caps and the manual medical review process for therapy services exceeding \$3700. The APTA is pleased that Congress included a provision expanding the exceptions process. However, the exceptions process will expire on April 1, 2015 and therefore this Congressional action offers only a temporary solution to the problem.

The financial limitation has a detrimental impact on Medicare beneficiaries who need outpatient therapy services. In its June 2013 report to Congress, MedPAC indicated that in 2011, 19% of patients would exceed the physical therapy and speech therapy cap combined. Once exceeded, if there is no exceptions process in place, beneficiaries will not receive services that are medically necessary. As a result, the cap can be expected to have a significant harmful effect on beneficiaries needing rehabilitation services and could lead to complications, ultimately resulting in greater costs to the Medicare program. We recognize that it will take Congressional action to provide additional statutory authority and prevent the implementation of the therapy caps, and we continue to strongly urge Congress to take timely action to pass legislation that would repeal the therapy cap.

Alternatives to Current Process for Valuing Services

To respond to the request by stakeholders for more transparency and a more meaningful opportunity to participate in the valuation of CPT codes, CMS

proposes an alternative to the current process that would involve publishing values recommended by the RUC in the proposed rule, allowing for comment, and finalizing the values in the final rule. CMS would include proposed values for all codes for which CMS has a recommendation by January 15 of the preceding year. If finalized, this would mean that for the 2016 rule, CMS would include all codes for which they had proposed values from the RUC by January 15, 2015. For codes where CMS does not receive a RUC recommendation by January 15th of a year, CMS would delay revaluing the code for one year (or until they receive the RUC recommendation for the code) and include proposed values in the following year's rule. For codes that were revised or deleted as part of the annual CPT coding change and when the changes would affect the value of a code, CMS proposes to create temporary G-codes to describe the predecessor codes.

While APTA supports the transparency and the additional comment opportunity for the valuation of these services, we strongly urge CMS to implement the new timeline and procedures for the CPT 2017 cycle and the 2017 Medicare physician payment schedule instead of the proposed 2016 implementation date. The 2016 date would result in the delay in implementation of new and/or revised CPT codes that are currently underway by an additional year. The cycle for the CPT 2016 code set began in May 2014 and will conclude on February 7, 2015. Currently, a workgroup at CPT is discussing possible changes to the CPT codes pertaining to physical medicine and rehabilitation (97000 series). If finalized, the CMS timeline would make it impossible for implementation of these codes by 2016 given the proposal that values be sent to CMS by January 1, 2015. We believe that those who have already submitted coding changes should receive timely consideration and fair notice of the implementation date. If CMS were to announce a 2017 implementation date on November 1, 2014, it would provide appropriate notification to those submitting code change applications by the first CPT 2017 deadline of February 13, 2015.

We are supportive of the American Medical Association (AMA) proposal submitted to CMS that would accommodate publication of new, revised, and potentially misvalued CPT codes in the proposed year in the future. If CMS adopts the AMA proposal, there will be no need to create G codes describing predecessor codes that would be in effect for an interim period. We have major concerns with the CMS establishment of temporary G codes as proposed in this rule. Adoption of these temporary G codes would place a significant administrative burden on physicians, physical therapists, and other health care professionals who would need to learn and change systems to report these new codes for a short duration. In addition, it is likely that this would create a situation where providers would be reporting the new CPT codes to private payers for their services and the temporary G codes to

Medicare. It is likely that private payers would implement the new CPT codes as soon as they are published.

Refinement Panel Process

In the rule CMS proposes to eliminate the Refinement Panel process currently in effect that has been used by CMS to consider comments on interim relative value units. The Refinement Panel has consisted of members from primary care organizations, contractor medical directors, the specialty organizations who commented on the values, and specialty organizations related to the commenting specialty group. The Refinement Panel members voted and for many years CMS deferred to the vote of the Refinement Panel with regard to the values. More recently, CMS independently reviews each of the Refinement Panel's recommendations in deciding which CPT code values to finalize. In a number of cases, the Refinement Panel has supported the RUC recommended values and the commenters request, but CMS has still chosen to implement the original proposed value. We are seriously concerned with the elimination of the Refinement Panel because this would mean that CMS would no longer solicit the views of contractor medical directors, practicing physicians and physical therapists to determine if there is a need to modify proposed values. We recommend that CMS ensure that there is a fair and objective appeals process in effect for all organizations to appeal decisions by CMS with regard to values for specific CPT codes.

Misvalued Codes

The Affordable Care Act requires CMS to identify and review potentially misvalued codes and make appropriate adjustments to the relative values of those services identified as being misvalued. The PAMA amended the law to expand the categories of services that CMS is directed to examine for the purpose of identifying potentially misvalued codes to an additional 9 categories, in addition to the 7 categories that already existed.

In its identification of misvalued codes, CMS includes in the rule a list of 65 CPT codes for the RUC to review that fall into the category of "High Expenditure across Specialties with Medicare Allowed Charges of \$10,000,000 or more." In addition to an array of codes from other specialties, this list includes CPT code 97140 (manual therapy), 97530 (therapeutic activities), 97112 (neuromuscular reeducation), 97032 (electrical stimulation), 97035 (ultrasound therapy), 97110 (therapeutic exercises), 97113 (aquatic therapy), 97116 (gait training), and G0283 (electrical stimulation other than wound).

APTA agrees with the importance of ensuring that services are appropriately valued. However, APTA does not understand why charges greater than \$10 million should necessarily result in a code being potentially misvalued. CMS should provide the RUC with any data used that would explain why charges of greater than \$10 million would potentially translate into misvalued codes.

A workgroup at CPT is in the process of developing a new coding structure for the CPT codes in the 97000 series. We recommend that CMS allow the workgroup to continue to focus its efforts on the development of these new codes. With the development of these new codes already underway, it would not be a good use of resources for the RUC to spend time reexamining the values of the 9 CPT codes in the 97000 series identified by CMS in the rule. These new codes will ultimately be valued through the RUC process.

Conditions Regarding Permissible Practice Types for Therapists in Private Practice

Current Medicare regulations set forth special provisions for services furnished by therapists in private practice and include descriptions of the various practice types for therapists' private practice. CMS is concerned that the language in these provisions is not clear, particularly with regard to the relevance of whether a practice is incorporated. The regulations appear to make distinctions between unincorporated and incorporated practices, and some practice types are listed twice. Accordingly, CMS proposes changes to the regulatory language for clarification to remove unnecessary distinctions and redundancies within the regulations for OT, PT, and SLP. APTA is supportive of the improvements in the regulatory text to consistently specify the permissible practice types (a solo practice, partnership, or group practice, or as an employee of one of these).

Substitute Physician Billing Arrangements (Locum Tenens)

The Medicare statute generally allows for substitute physician billing arrangements where the services of the substitute physician are paid for on a per diem basis or according to the amount of time worked. Substitute physicians in the second type of arrangement are sometimes referred to as "locum tenens" physicians.

CMS is concerned about the operational and program integrity issues that result from the use of substitute physicians to fill staffing needs or to replace a physician who has permanently left a medical group or employer. CMS indicates a desire to require that a substitute physician be enrolled in the Medicare program and seeks comment regarding how to achieve transparency in the context of substitute billing arrangements for the identity of the

individual actually furnishing the service to a beneficiary. Overall, CMS is soliciting comments on the policy for substitute physician billing arrangements and whether there are any other approaches. This information would be taken into account for possible future rulemaking.

While we acknowledge that CMS's interpretation is that physical therapists currently do not have the statutory authority for locum tenens billing, ultimately APTA believes that physical therapists should be afforded the same opportunities as physicians for locum tenens billing. We are currently pursuing legislation in Congress to enable such billing in the future for physical therapists. In the interim, we would like to offer the following comments related to locum tenens billing.

APTA supports the reduction of fraud, abuse, and waste in the health care industry and increased transparency. At the same time, it is imperative that senior citizens and people with disabilities have timely access to medically necessary health care services. If a physician, physical therapist, or health care professional will be absent from their practice due to illness, pregnancy, continuing medical education or other issues, it is important for their patients to continue to receive the care that they need. Locum tenens has been a long-standing mechanism for enabling coverage for physicians in these circumstances on a temporary basis. It is particularly beneficial in rural areas where patients have no other options close by to receive their care. The inability of physical therapists to bill under locum tenens has limited patient access to physical therapy services, particularly in rural areas.

CMS asks in the rule whether they should require enrollment in the Medicare program of all physicians under locum tenens. We do not believe that enrollment is an approach that is workable in the context of substitute or locum tenens billing. The current Medicare enrollment process is inefficient, time consuming and burdensome, resulting in significant wait times before enrollment is finalized. We have received numerous reports of the enrollment process taking three months and sometimes even a year before completion. For physical therapists, delays in the enrollment process are further exacerbated by the requirement for a site visit prior to enrollment. Until CMS can expedite the enrollment process by increasing efficiency and reducing burden, requiring enrollment for temporary substitutes is not a feasible option. Such a requirement would result in delays in access to timely medically necessary care, potentially increasing the costs of care.

Instead of enrollment, the enhanced transparency the Agency seeks can be accomplished through a better tracking of the NPI and of the Q6 modifier that indicates the service was furnished by a locum tenens physician. CMS has developed the National Plan and Provider Enumeration System (NPPES) to

assign unique identifiers to physicians and other providers. If CMS requires that the NPI of the substitute physician rendering the service be placed on the claim form, CMS will be able to identify who provided the service. The practice submitting the bill for the care that was provided and the substitute physician identified by his/her NPI are ultimately responsible for providing high quality care to the Medicare beneficiary. More robust tracking of the Q6 modifier and reporting of the NPI number on the claim for the substitute physician should be sufficient to enable CMS to ensure that qualified individuals are furnishing the services without limiting beneficiary access to services. APTA would favor this same approach if and when physical therapists are formally accorded the locum tenens option.

Medicare Shared Savings Programs (Accountable Care Organizations)

APTA commends CMS for its continual checks and balances within the Medicare Shared Savings Program (MSSP) quality reporting structure. We believe that in order to ensure success and viability of Medicare ACOs, there must be a robust set of quality metrics that accurately reflect the totality of services provided to the Medicare beneficiary throughout the care continuum. Therefore, we were encouraged to read in the proposed rule that CMS shares this same belief. Physical therapists are essential in meeting this objective as they play a key role in prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the physical health and functional abilities. In the proposed rule, CMS examines changes to the MSSP ACO quality performance program and quality measures. CMS requests comments from stakeholders on future quality performance measures for ACOs.

With this in mind, we urge CMS to add measure(s) that address patient function (activity and participation). The patient's ability to function and participate in society is critical to obtaining positive outcomes. A growing percentage of the U.S. population has disabling conditions that limit their ability to carry out the major activities of their age group. As the number of older adults increases, their vulnerability to injury and limitations of their activities of daily living increases as well. This increase in vulnerability and decreased function results in an escalation of the utilization of health care resources. A focus on ensuring that individuals remain independent and functioning members of society throughout their lives will lessen the burden of disability on health care resources. For example, a physician may prescribe medication to a patient with a cardiac disease to manage his/her cholesterol and blood pressure, but if the patient is not active or participating in his/her regular activities of daily living (ADLs), he/she will become more dependent on medication and other costly medical treatments and require more health care resources.

The majority of quality measures that have been implemented into the MSSP are specific to physician practices. In exploring alternative payment models, CMS must take into account the importance of all interdisciplinary team members that make safe, high quality care possible. Providing comprehensive, interdisciplinary care requires a team of professionals. The MSSP discusses the use of teams, including inter-professional teams, but puts forth a quality structure that is based almost entirely on the performance of physicians. APTA believes that this is not consistent with the concept of patient care across the continuum and strongly urges CMS to put forth a proposal that accurately captures the impact of function on the MSSP patient population.

Physician Quality Reporting System

The Physician Quality Reporting System (PQRS) was initially implemented in 2007 as a result of section 101 of Division B of the Tax Relief and Health Care Act of 2006. Physical therapists are currently participating providers in PQRS and can report individual measures and measure groups. APTA supports the goal of improving quality of health care. Physical therapists are committed to providing high-quality, timely care and to the promotion of evidence-based practice and patient-centered practice. However, the APTA does have some concerns regarding provisions in the proposed rule regarding the PQRS program. These concerns are discussed below.

Physician Compare Website

Section 10331(a)(1) of the Affordable Care Act (42 U.S.C. 1395w-5 note) requires that CMS, by no later than January 1, 2011, develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program under section 1866(j) of the Act as well as information on other eligible professionals who participate in the Physician Quality Reporting System under section 1848 of the Act (42 U.S.C. 1395w-4). In addition, section 10331(a)(2) of the Affordable Care Act also requires that, no later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, CMS implement a plan for making information on physician performance publicly available through the Physician Compare Website. CMS did meet the initial requirements and now proposes to expand the data on the Physician Compare Website in this proposed rule for 2015 and 2016.

CMS proposes to expand public reporting of group-level measures by making all 2015 PQRS GPRO measures across all reporting mechanisms available for public reporting on Physician Compare in CY 2016 for groups of 2 or more eligible professionals (EPs). CMS also proposes to make all individual EP-level PQRS measures collected via registry, EHR, or claims available for

public reporting via Physician Compare in late CY2016, if feasible. Lastly, CMS proposes to make available on Physician Compare 2015 Qualified Clinical Data Registry (QCDR) measure data collected at the individual level or aggregated to a higher level of the QCDR's choosing, such as the group practice level, if technically feasible. CMS is proposing a minimum 20-patient sample for public reporting.

We strongly recommend that CMS continue to provide health care professionals the opportunity to preview data and measures in confidential formats and provide methods for feedback prior to posting the information on the site. We have concerns that CMS may be challenged in getting timely feedback reports to all providers to view prior to the public release of data on Physician Compare with the expansion of public reporting for all EPs and groups across all reporting formats. EPs should be allowed a reasonable period of time for review of reports in order to access and gather supporting information to correct errors, discrepancies, and other concerns.

Additionally, we strongly encourage CMS to consider an updated name for the Physician Compare website which includes data not only from physicians, but other EPs, such as physical therapists. We believe that as the website grows, the name of the website will not accurately reflect the inclusion of other providers and will only increase consumer confusion.

Satisfactory Reporting Requirements

CMS proposes to retain the claims-based, registry-based and EHR based reporting options. We support CMS's decision to retain multiple reporting options as we believe that this will encourage broader participation in the program. It is important to keep several options open so as not to require providers to incur additional costs when they may not be in a position to incur these costs. For example, while we certainly see value in registries, we do not believe it would be prudent at this time to assume that all practitioners are ready and able to use them.

CMS is proposing to increase the number of measures from 3 to 9 in CY 2015 in order for EPs to avoid the CY 2017 penalty. CMS proposes that eligible professionals, including physical therapists, who report on individual measures via the claims-based reporting option or registry option in 2015 must report on at least 9 measures covering at least 3 of the National Quality Strategy domains, at least 50% of the time. If less than 9 measures apply to the eligible professional, they must report 1-8 measures.

The increase from 3 to 9 measures for successful reporting is significant. APTA strongly urges CMS to consider a lower number of measures for

successful reporting in CY 2015. The proposed change in the number of measures will significantly increase provider burden in reporting. Anecdotally, we are aware that many of our providers still report via claims and have opted to report 3 measures in CY 2014, citing reporting burden as the main reason behind this decision. Additionally, as the focus of many measures in the PQRS program remains geared toward the general and family practice physician, many specialty professions will struggle to achieve these new thresholds resulting in a higher number of practitioners subject to the MAV process. Lowering the number of measures required for the reporting threshold will substantially increase the proportion of physical therapists, physicians and other health care professionals who will avoid for the PQRS penalty and will therefore encourage broader participation. Additionally, given the proposed expansion of the Value Modifier (VM) program in 2017, we believe it is premature to simultaneously expand the number of measures that must be reported to avoid the penalty under PQRS.

We have concerns about the continued low percentages of eligible professional participating in the reporting program given that in CY 2012 only 44.6% of MD/DO's and 24.4% of other eligible providers, including physical therapists, participated in PQRS. Many providers are still unaware of the impending changes to the structure from a payment incentive to a payment adjustment program. We urge CMS to continue to disseminate information about the PQRS program to increase awareness about the program and to recognize the efforts of providers who attempt to participate in the program even if they are unsuccessful.

Proposed Measures Individual & Group and Measure Specification Changes

CMS has proposed to make major changes to the available measures in the CY 2015 PQRS program. APTA is specifically concerned about the proposed change to eliminate the Back Pain measures group (#148-151) from the PQRS program in CY 2015. CMS proposes to eliminate this measures group as the measure steward is not intending on bringing this measures forward for re-endorsement and the measures "reflect clinical concepts that do not add clinical value to PQRS". Although the majority of our members report individual measures, in a recent survey, 10.1% of private practice members indicated that they are currently using the back pain measures group. With the removal of the back pain measures group, PTs will no longer be able to report measures groups, as this is the only measures group that applied to PT. As a result, their only option will be to meet the more administratively burdensome requirements for successfully reporting individual measures.

Feedback Reports

Section 1848(m)(5)(H) of the Act requires the Secretary to provide timely feedback to eligible professionals on their performance with respect to satisfactorily submitting PQRS data. In the past, these provider level reports have been issued annually and distributed about seven months after the reporting period has ended. Additionally, CMS is providing interim dashboard reports to eligible providers through QualityNet on a quarter basis, however, there have also been significant delays in these reports. The delay in the distribution of these reports has made it difficult for providers to make any changes to improve their reporting under the program. Additionally, our members have expressed confusion and frustration in the past about the registration process for these reports. As a large majority (approximately 75%) of our members who responded to a survey still report in PQRS via claims, they rely solely on QualityNet for feedback on their performance in the PQRS program. In a recent survey of our private practice section members, 76.5% of those who are participating in PQRS responded that they have never accessed a feedback report from QualityNet. More concerning, of those who responded to the survey, only 31% received a bonus payment, suggesting that a large percentage of those participating are not meeting the successful reporting threshold. APTA believes that performance feedback is an essential component of successful performance improvement, and increasing the availability of these reports, as well as providing more timely releases of such reports, would greatly assist providers in improving the quality of care they deliver. The ability to receive provider feedback in a timely fashion will become even more critical as non-physicians, including physical therapists, are included in the VM program.

Value-Based Payment Modifier

The requirement that CMS implement a value-based payment modifier (VM) for some physicians by January 1, 2015, and for all physicians by January 1, 2017 was established by Section 3007 of the Affordable Care Act. The proposed rule seeks to apply the VM to all physicians and groups of physicians and also non-physician eligible professionals and to increase the amount of payment at risk. This would have a significant and immediate impact on non-physician providers including physical therapists, with almost no time for preparation. We will discuss our concerns in detail below.

Timing of Implementation of Value-Based Modifier

In the rule, CMS proposes to apply the VM to all physicians and non-physician eligible professionals in groups with 2 or more eligible professionals and to solo practitioners starting in CY 2017. Under Section 3007 of the Affordable Care Act, CMS was required to add all physicians to

the program by CY 2017; however, CMS had discretion to add non-physicians to the program. As proposed, the inclusion of eligible non-physician professionals would result in full and immediate implementation of the program for non-physician providers which is a very different approach compared to previous years in which CMS phased in the VM program for physician groups, based on group size. The changes to the VM program in the rule would place practices comprised of 10 or more non-physician eligible professionals, such as PT's, immediately at risk for a downward adjustment in the first year of the program, placing these practices, particularly the smaller mid-sized practices, at a disadvantage that similarly-sized physician practices did not face as the VM was phased in. Our recent survey of private practice members indicates that nearly 15% of the respondents practice at facilities with 10 or more PT's. With the 2017 VM implementation date proposed by CMS, we are deeply concerned that physical therapists will not have ample time to prepare for this program prior to implementation.

CMS notes in the rule that all physician groups and solo practitioners will have adequate data to improve performance on the quality and cost measures that will be used to calculate the VM in CY 2017. Later this summer, CMS plans to disseminate Quality and Resource Use Reports (QRURs) based on CY 2013 data to all physicians that will contain performance information on the quality and cost measures used to calculate the composites of the VM. However, CMS acknowledges that these QRUR reports will not be available for non-physicians, such as physical therapists, until the summer of 2015. By not receiving their QRURs, physical therapists are at a significant disadvantage as they will have no information about their performance on measures that would be used to determine their payment under the VM program. Without this information, they do not have necessary data that would enable them to improve their performance on measures that would be used to calculate their VM score for 2017.

APTA has major concerns with the extension of the VM program to non-physicians at this time. If CMS decides to extend the VM program to non-physicians, APTA recommends that CMS consider a phase-in approach for non-physician providers similar to the approach that was used for physicians, especially in cases where the group in question includes only non-physician EPs. A phase-in approach would give non-physician providers more time to prepare for the VM program while also allowing CMS time to prepare and create QRUR reports or their equivalent for these groups. Again, as many of our providers are not accessing their PQRS reports, we believe that it is going to take time to educate and orient our providers to these new reports. Specifically, APTA recommends that CMS use a phase-in approach as they did with the physicians over three years: groups of 100 or more non-physicians in year one, groups of 10-99 non-physicians in year two, and lastly,

groups with 2 to 9 non-physicians and solo practitioners in year three. Using the phase-in approach would allow PT practices to have ample preparation time prior to the program implementation. We believe that this approach would reduce the number of physical therapists who need to be notified immediately about the VM program and would focus on implementation in practices that are more likely to have staff devoted to compliance with quality initiatives and other requirements.

Penalty and Value Matrix for the Value-Based Modifier

CMS proposes to make quality-tiering mandatory for groups and solo practitioners within Category 1 for the CY 2017 VM. Category 1 includes: (1) groups that meet the criteria for satisfactory reporting of data on PQRS quality measures via the group practice reporting option (GPRO) for the CY 2017 PQRS payment adjustment; (2) groups that do not register to participate in the PQRS as a group practice participating in the PQRS GPRO in CY 2015 and that have at least 50 percent of the group's eligible professionals meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the CY 2017 PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS-qualified clinical data registry for the CY 2017 PQRS payment adjustment; and (3) solo practitioners that meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the CY 2017 PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS qualified clinical data registry for the CY 2017 PQRS payment adjustment. However, groups with between 2 and 9 eligible professionals and solo practitioners would be subject only to any upward or neutral adjustment determined under the quality-tiering methodology, and groups with 10 or more eligible professionals would be subject to upward, neutral, or downward adjustments determined under the quality-tiering methodology.

Again APTA is especially concerned that the addition of all non-physician providers into the VM program immediately in CY 2017 would subject some groups to full quality tiering in year one of their VM participation if the group is composed of 10 or more eligible non-physician providers. Given the complex methodologies of the VM program and its measures, a phased in approach would allow non-physician providers some additional time to familiarize themselves with the program.

Although the law does not require CMS to do so, CMS proposes to increase the penalty under VM program from 2.0% in 2016 to 4.0% in 2017. This would mean that a provider that does not participate in PQRS in 2015 would be subject to a 6.0% reduction in payment in 2017. APTA has significant concerns with the increase of the VM penalty to 4.0%, particularly in

combination with the inclusion of all non-physician providers in the program. First, we do not see how it will be possible in a short two month time span after publication of the rule to make physical therapists aware that they will be subject to this significant penalty if they do not participate successfully in PQRS in 2015. The CY 2012 PQRS data demonstrates a 25.7% participation rate in PQRS for PT/OT's. We do anticipate that the number of participating eligible professionals in the PQRS program increased in the CY2013 national data, as CY 2013 participation is tied to the first PQRS penalty in 2015, however, that data is not yet available. We have concerns about the ability of CMS to close this participation gap in the 60 days between the release of this final rule and the beginning of the CY 2015 PQRS reporting year should the rule finalize as proposed. Implementation of the VM will require a massive education and outreach campaign from CMS and its contractors to ensure physical therapists are appropriately informed.

Moreover, physical therapists already face penalties under the PQRS program, the 2% sequester reduction, the multiple procedure payment reduction (MPPR), the therapy cap, and the projected 20.9% SGR cut. We urge CMS to take into account the magnitude of the impact of both the increased penalty and the inclusion of our providers, regardless of practice size, in the same VM program year. A cut of this magnitude in conjunction with all the other payment reductions would potentially result in closure of practices and limit access to services for Medicare beneficiaries.

Value-Based Payment Modifier Quality Measures

While APTA appreciates that CMS's goal is to utilize a comprehensive group of quality measures in the VM program to ensure that payment is reflective of both the quality and the cost of care, many of the measures in the program are focused on physician practice. Specifically, the condition-specific and readmission quality measures and the cost measures that are included in the VM program are specific to physician practice. CMS policy codified in §414.1270(b)(5) states that a group of physicians subject to the value-based payment modifier will receive a cost composite score that is classified as "average" under §414.1275(b)(2) if CMS is unable to attribute a sufficient number of beneficiaries to a group and thus is unable to calculate at least one cost measure with at least 20 cases. CMS proposes in this rule to apply this policy to solo practitioners under the VM program as well.

Based on this policy almost all groups composed of eligible physical therapists in the VM program will be scored as "average" for the specific cost measures. In addition, the four outcome measures identified under the VM program would not be applicable to physical therapists. This creates a situation where performance on PQRS measures is the sole or primary

determinant of the VM score for physical therapists. This suggests that the existing VM methodology could unfairly treat PTs. Further, APTA has three major concerns in this area that we have previously discussed: the low participation rate, the low number of participating PT's who have accessed their PQRS feedback reports, and the low rate of providers who have received a bonus payment. As we discussed above, in a recent survey of our private practice members, 76.5% of those who are participating in PQRS have not accessed a feedback report. Given the lag time of the PQRS feedback reports, APTA is concerned that our providers will not be able make the necessary adjustments in their PQRS reporting process to ensure that they achieve the highest possible quality score in the VM program. Lastly, we are concerned that our providers may not be meeting the successful reporting requirements given that in our recent survey only 31% of PT's who are participating in PQRS have received a bonus payment.

As many of the specific cost and quality measures in the VM program are geared towards primary care practice, APTA suggests that as CMS moves forward with the integration of non-physicians in the VM program that they consider engaging non-physician stakeholder groups to develop specific quality and cost measures that are meaningful to all providers in the patient care giver team including non-physicians. While we recognize that CMS will classify all physical therapists in the "average" cost category, we are concerned about the ability of CMS to construct a value based modifier in the future that is able to distinguish between physical therapists who have high costs due to their patient mix as compared to those who have high costs due to their practice and/or referral patterns. In order to develop adequate measures in the future, stakeholder engagement and input would be critical.

Claims-Based Data Collection of Functional Limitation Information

Section 3005(g) of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) requires CMS to implement, beginning on January 1, 2013, a claims-based data collection strategy that would be designed to collect data on patient function during the course of therapy services in order to better understand patient condition and outcomes. CMS finalized the data collection strategy to meet the above requirement in the final Physician Fee Schedule rule of CY2013.

Under the rule, nonpayable G-codes and modifiers would be included on the claim forms that would capture data on the beneficiary's functional limitations (a) at the outset of the therapy episode; (b) at specified points during treatment; and (c) at discharge. In addition, the therapist's projected goal for functional status at the end of treatment would be reported on the first claim

for services and periodically throughout the episode. Modifiers would indicate the extent of the severity of the functional limitation.

CMS has not included any planned changes to the data collection regulations in the CY 2015 proposed Physician Fee Schedule rule. Nonetheless, APTA would like to take this opportunity to provide feedback about the future evolution and possible changes to this claims-based data collection process.

General Concerns Regarding the Collection of Data on Functional Limitations

As CMS is aware, therapy providers faced numerous challenges with the implementation of the Functional Limitation Reporting (FLR) requirements. Currently, submission of FLR data is a condition of payment for therapy services provided under Medicare Part B. Early in the implementation of this program in 2013 and through the first half of 2014, due to problems with Medicare's claims processing systems, many providers were not paid for therapy services. As a result, physical therapy providers experienced significant financial hardship.

CMS staff implemented new system edits in early May 2014 which appear to have resolved a large majority of the claims processing issues related to the submission of FLR data. Unfortunately, due to the complicated nature of this reporting system and the limitations that are inherently involved with claims submission of this data, we are still experiencing claims processing issues. We are continuing to work with CMS staff to resolve these issues on a case by case basis.

APTA strongly supports the long term goal of improving the payment system for outpatient therapy services and using data collection to achieve this goal. To gather meaningful information that could be used to compare one provider to another regarding their patient care or one patient to another patient with respect to their condition, functional limitations, and outcome of care, would necessitate the use of one standardized data collection tool by all therapists. Unfortunately, at this time due to the variety of outpatient therapy settings and the wide diversity of patient conditions treated by therapists, no such standardized tool exists that could be used by all providers to report a patient's functional limitation.

In the absence of one standardized tool, we believe that the information reported on the claim form regarding the patient's functional limitations supported through the use of one or more tools could be useful in enabling CMS to more efficiently determine the impact of therapy services for an individual patient over the course of that individual's episode of care. This

data could provide CMS with easily obtainable information about the individual beneficiary's progress without requiring an in depth medical review and could assist CMS in identifying cases for potential medical review.

APTA recommends that therapy associations and organizations and CMS collaborate in the near future to develop a core data set or a finite list of measures that could be used in any tool to gather information about the patient function. We acknowledge that the current data collection is limited without the use of one standard measurement tool which hinders the ability of CMS to aggregate and analyze data on a national scale, but we are hopeful that this initial data collection may better inform decisions about future uniform data elements, whether they be single questions, or measurement tools, that can be applied more universally to beneficiaries receiving outpatient therapy services.

Suggestions Related to FLR Data Submission

CMS required the collection of the functional limitation data via the claims-based mechanism in the CY2013 final rule, however, APTA would recommend that CMS consider other forms of data submission in the future. Currently, outpatient private practice physical therapists are required to report in quality programs, such as PQRS, under Medicare. The PQRS program allows for the transmission of data to CMS via three mechanisms: claims, registry, qualified clinical data registry, and electronic health record data submission. Although not specifically designated as a "quality reporting program" APTA does believe that the functional limitation reporting requirements are in fact very similar to other Medicare quality reporting programs. To that end, we would suggest that CMS explore additional data submission mechanisms to decrease provider reporting burden in the future.

Conclusion

APTA appreciates the opportunity to comment on the CY 2015 Medicare Physician Fee Schedule proposed rule, and we look forward to working with the agency to craft patient-centered reimbursement policies that reflect quality health care for all Medicare beneficiaries. If there are any questions about our comments or additional information is needed, please contact Gayle Lee, Senior Director, Health Finance and Quality, at 703-706-8549 or

gaylelee@apta.org or Heather Smith, Director of Quality, at 703-706-3140 or heathersmith@apta.org.

Sincerely,

A handwritten signature in black ink that reads "Paul Rockar Jr." in a cursive script.

Paul A. Rockar, Jr, PT, DPT, MS
President

PAR: grl, hls