



September 8, 2015

Andy Slavitt, Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Attention: CMS-1631-P

Re: File Code-CMS-1631-P; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Proposed Rule

Dear Acting Administrator Slavitt:

On behalf of the over 4200 members of the Private Practice Section (PPS) of the 90,000 member American Physical Therapy Association (APTA), I write to offer comments on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule regarding “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for 2016” (CMS-1631-P), published in the July 15, 2015 *Federal Register*.

In this publication, CMS the proposes revisions to payment policies, updates quality provisions, and establishes 2016 payment rates for Medicare-billed services that take place in hospital and ambulatory surgery center settings. CMS is expected to publish a final rule by November 1, which will become effective January 1, 2016, for services furnished during calendar year 2016.

The physician fee schedule is 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.

PPS will share views and comments with CMS on the following topics that our relevant to our membership:

- Physician Quality Reporting System
- Merit-Based Incentive Payment System

- Value-Based Payment Modifier
- “Incident-to” Billing
- Self-Referral
- Opt-out Policy

### **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 have been participating providers in PQRS since 2007 and can report individual, group and registry measures. PPS 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 and patient-centered practice. However, PPS does have some concerns regarding provisions in the proposed rule regarding the PQRS program. These concerns are discussed below.

The proposed rule leaves reporting requirements for rehabilitation therapists participating in PQRS largely unchanged in CY2016. However, if an individual eligible professional (EP) or group practice does not satisfactorily report or satisfactorily participate while submitting data on PQRS quality measures during that year, a negative 2% payment adjustment would apply to covered professional services furnished by an individual EP or group practice during 2018. The 2018 PQRS payment adjustment is the last adjustment that will be issued under the PQRS as this program is set to expire in CY2018 when MIPS begins in CY2019.

#### *PPS Comment:*

##### 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 plans to expand the data on the Physician Compare Website in 2016.

PPS recommends 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. With the expansion of public reporting for all EPs and groups across all reporting formats, we have concerns that CMS may be challenged in providing timely feedback reports to all providers to view prior to the public release of data on Physician Compare. 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 alternative name for the Physician Compare website which now includes data not only from physicians, but other eligible professionals (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.

#### 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. CMS currently provides annual PQRS performance reports through Quality Net, as well as interim dashboard reports. Annual reports are typically available 8-9 months after the end of the calendar year, while the interim reports are delayed by roughly one to two quarters. The delay in the distribution of these reports has made it difficult for providers to make any changes to improve their reporting under the PQRS program. Providers are required to register through the Enterprise Identity Management (EDIM) service in order to create an account prior to accessing the PQRS reports. Our members have expressed confusion and frustration about the registration process for these reports. In a survey of PPS members in the summer of 2014, only 23.5% of those who reported participating in PQRS, had accessed a feedback report. PPS 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 we move towards value-based payment programs such as the Merit-Based Incentive System (MIPS).

#### Transition to MIPS

PPS supports the payment adjustments outlined in the proposed rule, including the negative payment adjustment for those eligible professionals who do not satisfactorily participate or report PQRS quality measures. However, PPS is unclear with respect to the type of quality reporting CMS will require for physical therapists in the two year gap between when MIPS begins in 2019 for some eligible professionals but will not include physical therapists until 2021 at the earliest. Will those eligible professionals not included in the 2019 MIPS still be required to submit data on PQRS quality measures to avoid future negative payment adjustments or will PQRS reporting requirements be suspended through 2021 for those eligible professionals not yet transitioned to MIPS? When does CMS expect to publish guidance for the portion of eligible professionals not included in MIPS in 2019? PPS urges CMS to provide appropriate guidance in the final rule to the affected eligible professionals who will be caught in this transition period.

#### **Implementation of Merit-Based Incentive Payment System**

Section 1848(q) of the Act, added by section 101(c) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), requires that CMS consolidate several existing programs, including Medicare and Medicaid EHR Incentive Programs, Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier (VM) into a single, more simplified program called the Merit-Based Incentive Payment system (MIPS), applicable

beginning with payments for items and services furnished on or after January 1, 2019. Through MIPS, annual payment updates will be provided based on their performance in four categories:

1. Quality (maximum 30 points)—determined by the Physician Quality Reporting System (PQRS) mandatory quality reporting requirement and the Value Based Modifier (VM) quality measures;
2. Resource use (maximum 30 points)—determined by the VM cost measures;
3. Meaningful use of an electronic health record (maximum 25 points)—for complying with Meaningful Use (MU) in the performance year; and
4. A new category of “clinical practice improvement” activities (maximum 15 points)—the criteria of which have yet to be determined. CMS is expected to post a request for information regarding the definition of clinical practice improvement before December 2015.

*PPS Comment:*

Expanding Application to Additional Non-Physician Providers

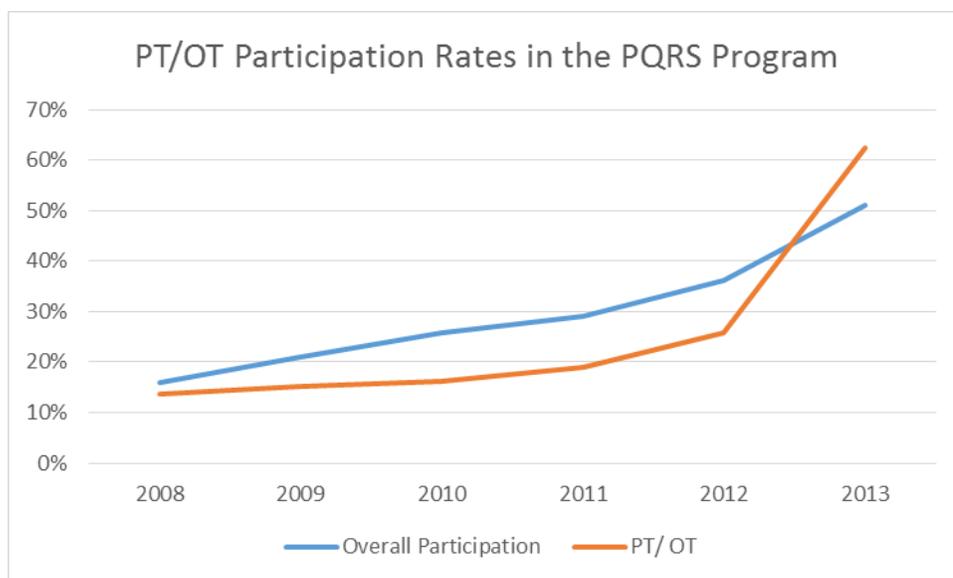
Given the legislative mandate the following table demonstrates the impact on physical therapists in private practice reporting under Medicare part B quality reporting programs.

<b>Quality Reporting for Physical therapists Under Medicare Part B</b>				
<b>Calendar/ Current Year (Data Year)</b>	<b>Year Penalty/ Payment Applied</b>	<b>PQRS Penalty</b>	<b>VM Incentive/ Penalty</b>	<b>MIPS Incentive/ Penalty</b>
<b>2015</b>	<b>2017</b>	<b>-2.0%</b>		
<b>2016</b>	<b>2018</b>	<b>-2.0%</b>	4.0x to -4.0% Includes specified non physician EPs (excludes PTs)*	
2017	2019			3.0x to -4.0% Includes MDs and other specified EPs*
2018	2020			3.0x to -5.0% Includes MDs and other specified EPs*
<b>2019</b>	<b>2021</b>			<b>3.0x to -7.0%</b> <b>CMS may add remaining EPs** (including PTs) to program</b>

<b>2020</b>	<b>2022</b>			<b>3.0x to -9.0% CMS may add remaining EPs** (including PTs) to program</b>
<p>* Last year of VM and initial years of MIPS will only apply to physicians, physician assistants, nurse practitioners, clinical nurse specialists, and nurse anesthetists  **Physical therapists, occupational therapists, speech language pathologists, clinical social worker, clinical psychologist, registered dietitian, nutrition professional, audiologists</p>				

PPS notes that under Section 2 of MACRA the PQRS program becomes voluntarily in 2019 (based on performance in 2017) and the MIPS program begins in 2019 for physicians, physicians’ assistants, nurse practitioners, clinical nurse specialists, and nurse anesthetists. Other non-physician eligible professionals to be added beginning in year 3 (2021) of the MIPS program under the discretion of the Secretary including physical therapists, occupational therapists, speech language pathologists, clinical social worker, clinical psychologist, registered dietitian, nutrition professional, and audiologists. However, the factors by which additional eligible professionals will be included by CMS at a later date are not known. PPS has concerns regarding these legislative changes to the quality reporting program, specifically with the lack of inclusion of several non-physician groups including physical therapists and therefore urges CMS to include in the final rule an amplification of the criteria to include non-physician professionals such as physical and occupational therapists in the MIPS beginning in 2021.

Physical therapists have been included in quality reporting under Medicare part B in the PQRS program since its inception in 2007. The PT/OT participation rate in PQRS in 2013 was 62.6%, which exceeded the overall eligible professional (EP) participation rate of 51.2% and the MD/DO participation rate of 59.1%. PPS has significant concerns that PT exclusion from the MIPS program in 2017 and 2018 will have a strong negative impact on the reporting rate of quality measure by physical therapists. Furthermore, PPS is concerned that PTs will struggle to return successfully into the quality reporting space in 2019 under the constructs of an entirely new program after this two year hiatus. PPS strongly encourages CMS to continue to incentivize participation in quality reporting programs (e.g. PQRS) for PTs and the other non-physician providers that are excluded from the initial group of EPs in MIPS. One example of incentivizing PTs to continue to reporting quality measures in the 2017 and 2018 reporting year would be to give providers credit towards their MIPS performance when they join that program in 2019. We would welcome the opportunity to work with CMS on developing mechanisms to incentivize physical therapists to continue to participate in PQRS.



Another concern PPS has is the gap in the reporting of public data that will occur on the Physician Compare website as result of the exclusion from the first two years of the MIPS program. As CMS continues to launch data on the Physician Compare website, PPS is concerned about the public perception of the absence of physical therapists during the 2017 and 2018 years when they are not participating in the MIPS program. We believe that a lack of data during these years may give the public an incorrect impression that physical therapists are choosing not to participate in the MIPS program when they are legislatively excluded. Again, we encourage CMS to develop mechanisms that will incentivize PTs and the other non-physician providers to continue reporting quality measures during these interim years (2017, 2018) in order to avoid these unintended consequences.

We are hopeful that exclusion from the MIPS program in its inception years will not impact our ability to participate and advocate for physical therapists. Given the changes that are simultaneously occurring in the post-acute care space with the implementation of the IMPACT Act, PPS believes that the next several years will be a critical period for the development and implementation of measures of that impact physical therapists in various quality programs across the continuum of care.

### **Value Based Payment Modifier**

As added by Section 3007 of the Patient Protection and Affordable Care Act of 2010, Section 1848(p) of the Social Security Act requires Medicare to establish a value-based payment modifier (VM) that provides for differential payment under the MPFS based upon the quality of care furnished compared to cost during a performance period. The VM was applied to all physicians and groups of physicians by January 1, 2017. Subsequently, CMS began by implementing VM requirements on groups of physicians with 100 or more eligible professionals and in each ensuing year has expanded the requirements so that now CY2018 payment-

adjustments will apply to non-physician EPs in groups with 2+ EPs and to non-physician EPs who are solo practitioners.

*PPS Comment:*

Closely tied to PQRS, the VM program uses PQRS data and other quality and cost metrics to determine an overall value score that will be used to determine Medicare payment. The 2015 proposed rule sought to apply the VM fully to all physicians and groups of physicians as well as non-physician eligible professionals including physical therapists (PTs) and to increase the amount of payment at risk.

PPS notes that in the 2016 MPFS proposed rule, CMS expands the VM program to additional allied health professionals but still has not included rehabilitation therapists. PPS urges CMS to expand the list of eligible professionals to include physical therapists; however, PPS believes that when CMS adopts VM metrics for PTs and other currently non-participating EPs, CMS should phase in the applicability of the VM for non-physician providers using a phasing-in approach similar to that which was used for physicians. For physicians, CMS phased in the program over three years applying the VM to groups of 100 or more physicians in year one, groups of 99-10 physicians in years two, and to solo practitioners and groups of two or more physicians in year three. CMS should do the same for non-physician providers. This approach would give non-physician provider groups needed time to prepare for the VM program. Non-physician groups are insufficiently familiar with the history of the VM and CMS activities to date and will need time to adapt to these significant policies; non-physician providers should be afforded the same time and consideration physicians received with respect to transitioning to the VM. This reasonable approach is essential, especially considering the proposed increase in the penalty associated with the VM.

Should VM be expanded to include rehabilitation therapies before 2021, PPS seeks clarification on the type of VM reporting CMS will require for rehabilitation therapy in the gap of two years between when MIPS begins in 2019 for some eligible professionals and 2021—the earliest date of inclusion for rehabilitation therapy in MIPS. Will those EPs not included in the 2019 MIPS be required to submit VM data in the interim to avoid negative payment adjustments or will VM reporting requirements be sustained through 2021 for those EPs not yet transitioned to MIPS? PPS urges CMS to provide reporting guidance to the 2021 portion of EPs in the in the final rule.

A communication put forth by CMS on December 2, 2014 via MLN Connects states, “CY 2018 payment-adjustments will apply to non-physician EPs in groups with 2+ EPs and to non-physician EPs who are solo practitioners based on performance during CY 2016.” PPS inquires whether this applies to all non-physician EPs or a discreet subset of EPs. Should rehabilitation therapists be included in these payment adjustment guidelines, EPs who fail to participate in both the PQRS and VM programs in 2016 would be subject to a 4.0% VM penalty and a PQRS penalty of 2.0%, for a cumulative 6.0% penalty. Consequently, PPS urges CMS to clarify the affected EPs in the final rule.

### **“Incident to” Billing**

CMS proposes to revise the “incident to” regulations to clarify that the physician who bills for the “incident to” service must also be the physician who furnishes the service or who directly supervises the service—it must be the physician upon whose professional service the “incident to” service is based. CMS proposes to explicitly prohibit auxiliary personnel who have either been excluded from Medicare, Medicaid and any other federally funded health care programs or who have had their enrollment revoked for any reason from providing any “incident to” services. CMS also invites comments about possible approaches to ensure services are provided by qualified individuals (e.g. mechanism for registration, the use of claim elements such as modifiers to identify who is providing the services, and post-payment audits).

#### *PPS Comment:*

PPS strongly supports the CMS proposal to ensure that the physician who bills for the “incident to” services is the supervising physician and that services billed “incident to” are performed by qualified individuals. This policy will contribute to ensuring quality of care to Medicare beneficiaries and reduce concerns of fraud, waste, and abuse. Currently, there is no mechanism for identifying the personnel who provided the services that are billed as “incident to” services. There is no requirement that the individuals providing the “incident to” services are enrolled in the Medicare program. We recommend at a minimum that CMS require a unique modifier on the claim form to denote who is providing the services that are billed as “incident to” services. PPS also recommends targeted audits and medical review, particularly of physicians billing for physical therapy services, to ensure compliance with Medicare rules and regulations.

### **Self-referral**

The physician self-referral statute (section 1877 of the Act) prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership interest or compensation arrangement), unless an exception applies. In this proposed rule, CMS discusses the history of the Act and of its implementation, including changes made under the ACA and more recently the MACRA. CMS proposes to update its regulations to accommodate delivery and payment system reform, to reduce burden, and to facilitate compliance. PPS will share its views on one of the two new exceptions proposed: assistance to employ a non-physician practitioner (Section 411.357(x)).

CMS proposes a new limited exception for hospitals, federally qualified health centers (FQHCs), and rural health clinics (RHCs) to provide remuneration to a physician to assist with the employment of a non-physician practitioner (NPP) in a geographic area served by the hospital, FQHC, or RHC (hereinafter referred to collectively as “hospital”). This proposed exception would protect both direct compensation arrangements between the hospital and an individual physician and indirect compensation arrangements between the hospital and a physician “standing in the shoes” of a physician organization to which the hospital provided remuneration. The new exception is intended to recognize the increased role NPPs play in meeting primary care

needs and in improving patient outcomes and reducing costs, and to expand access to primary care services, especially in rural areas.

The exception would apply for NPPs who furnish only primary care services (general family practice, general internal medicine, pediatrics, geriatrics and obstetrics, and gynecology); specialty care services (e.g., cardiology or surgical services) would not be protected. CMS seeks comment on whether more or fewer types of primary care services should be included and whether there is a compelling need for NPPs who furnish non-primary care services. PPS supports the concept of expanding access to primary care services. However, we have serious concerns with any policy that would allow recruitment assistance for physicians to employ non-physicians who provide other services, such as physical therapy.

*PPS Comment:*

There has been a long history of problems relating to physician-owned physical therapy arrangements. Studies have demonstrated that physician-owned physical therapy arrangements have a significant adverse economic impact on consumers, third-party payers, and physical therapists.<sup>1</sup> Specifically, a 2006 report by the Department of Health and Human Services' Office of the Inspector General (OIG)<sup>2</sup> showed that physical therapy billed directly by physicians represents a large and growing percentage of Medicare's total expenditures for these services. The OIG found that 91% of PT billed by physicians and allowed by Medicare did not meet Medicare guidelines which resulted in a significant amount of improper payments. In addition, Medicare claims from 2002 to 2004 were analyzed and aberrant patterns of billing and unusually high volumes of claims were identified. In a report issued in August 2009, the OIG examined physician "incident to" services billed in 2007 under the Medicare program, and found that 49 percent of rehabilitation therapy services (including primarily therapeutic exercise, massage therapy, ultrasound therapy, therapeutic activities, and electrical stimulation) performed by non-physicians were furnished by staff not trained as therapists that the OIG found to be unqualified. Therefore, we would have major concerns with any expansion of recruitment assistance to employ other non-physicians, such as physical therapists.

**Medicare-opt out**

Section 106(a) of MACRA requires that instead of a pro-active renewal, Medicare opt-out affidavits filed on or after June 15, 2015 automatically renew every two years unless the non-participating EP notifies CMS of their intent to re-enter the Medicare program at least 30 days prior to the start of their next two-year opt-out period.

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<sup>1</sup> Mitchell JM, Scott E. Physician ownership of physical therapy services: Effects on charges, utilization, profits, and service characteristics. *JAMA*. 1992; 268:19-23; Swedlow A, Johnson G, Smithline N, Milstein A. Increased costs and rates of use in the California Workers' Compensation System as a result of self-referral by physicians. *N Engl J Med*. 1992;327:1502-1506; Office of the Inspector General, Department of Health and Human Services. 1994.

<sup>2</sup> *Physical Therapy in Physician's Offices*, no. OEI-02-90-00590. Washington, DC: OIG and OIG, Physical Therapy Billed By Physicians (May 1, 2006).

*PPS Comment:*

While PPS applauds the reforms that have made it easier for those EPs opting-out of Medicare to maintain that status, this change provides a much-needed opportunity to point out where the opt-out provision could be further reformed to meet the needs of both Medicare beneficiaries and providers. Much to the dismay of PPS, physical therapists are still not included the list of EP Medicare providers able to use the opt-out provision. The *Medicare Patient Empowerment Act* (H.R.1650/S.1849) modernizes the Medicare statute by allowing a Medicare beneficiary to enter into a private contract with an eligible professional (regardless of whether the EP is a participating or non-participating physician or practitioner) for any item or service covered by Medicare. H.R.1650/S.1849 would not only include physical therapists in the list of eligible professionals, it would modify existing law to allow for one-to-one billing relationships between providers and Medicare beneficiaries instead of allowing for only a practice-wide opt out—empowering individual beneficiaries at no additional cost to the Medicare program. To protect against fraud or abuse, the *Medicare Patient Empowerment Act* prohibits entering into a contract at a time when the Medicare beneficiary is facing an emergency medical condition or urgent health care situation. PPS recognizes that adding PTs is beyond the existing authority of CMS without a change in law; however, we appreciate this opportunity to comment on the issue nonetheless.

**Conclusion**

PPS thanks CMS for the opportunity to provide these comments on the proposed rule for the 2016 Medicare Physician Fee Schedule. PPS is committed to meaningful and effective innovation in the Medicare program and pledges to continue its cooperation and collaboration with CMS. We look forward to more opportunities to partner with CMS in pursuit of meaningful and effective innovation in the Medicare program.

Sincerely,

A handwritten signature in black ink that reads "Terrence C. Brown". The signature is written in a cursive style with a long horizontal line extending from the end.

Terrence Brown, PT, DPT  
President, Private Practice Section of APTA