September 2, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1612–P,
P.O. Box 8013, Baltimore, MD 21244–8013

Re: AHCA Response to Proposed Rule, 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;, 79 Federal Register 40318, July 11, 2014, CMS 1612-P

Dear Ms. Tavenner,

The American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) represents over 12,245 skilled nursing facilities (SNFs), or 1.012 million beds, and 157,584 assisted living residence (ALR) beds. The Association represents the vast majority of SNFs and a rapidly growing number of ALRs. We appreciate the opportunity to comment on the Revisions to Payment Policies Under the Physician Fee Schedule for CY 2015. The submitted comments below are identified by section and page within the proposed rule.

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The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent more than 12,000 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and developmental disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member facilities each day.
AHCA Recommendations Summary

A. Section I.B.4 - Most Recent Changes to the Fee Schedule (p.40322)
   - AHCA recognizes that while CMS does not have the statutory authority to ignore the flawed SGR formula, we appreciate CMS’ support for necessary legislative reform to the formula that would otherwise result in an estimated -20.9 percent PFS update for CY 2015.
   - The three key therapy reform points AHCA supports are:
     o Repeal of the Part B (Outpatient) Therapy Caps
     o Reform Medical Review of Outpatient Therapy Services
     o Collect Standardized Data Elements for Outpatient Therapy Services
   - AHCA recommends that CMS provide a public statement to Congress in support of the three key therapy reform points above, similar to the Administrators statement in support for legislative SGR reform.
   - AHCA recommends that CMS implement several specific administrative reforms to the Part B therapy MMR not outlined by CMS in the February RAC ‘pause’ announcement:
   - AHCA recommends that CMS provide summary statistics of the FR trends to date, and, based upon these trends and the DOTPA study findings, a description of what improvements CMS proposes are necessary to improve the FR requirement so that useful data can be gathered to help improve the integrity of Part B therapy payments.

B. Section II.B - Potentially Misvalued Services Under the Physician Fee Schedule (p.40334)
   - AHCA supports CMS efforts at identifying appropriate valuation of services as long as the process is transparent and all stakeholders are adequately represented in the process.
   - AHCA recommends that if CMS decides to pursue reviewing common outpatient therapy codes, that the impact of the MPPR policy is considered and mitigated so that rehabilitation service providers are not subject to a double-hit on PE cuts with any proposed revaluation.
   - AHCA recommends that if CMS proceeds with adopting the nine outpatient therapy procedures listed in Table 10 of the proposed rule for revaluation analyses, then CMS shall instruct the two validation contractors to include input from SNF sector and other facility-based providers so that the PE valuation is adequately representative of facility expenses in addition to office-based practitioner costs.

C. Section II.F - Valuing New, Revised and Potentially Misvalued Codes (p.40359)
   - AHCA supports the CMS proposal to modify the process for valuing new, revised and potentially misvalued codes as it will enable a more transparent process where affected stakeholders, including SNF providers will have an opportunity to provide comment and evidence to CMS prior to the adoption of final values.
   - AHCA recommends that due to the nearly concurrent introduction of ICD-10 diagnosis coding requirement in October 2015, CMS consider placing a moratorium on the introduction of significant changes in procedure codes for CY 2016 unless such codes are essential to assure beneficiary access to necessary services.

D. Section III.E - Access to Identifiable Data for the Center for Medicare and Medicaid models (p.40376)
   - AHCA recommends that CMS consider the potential impacts on the administrative burden and costs to providers that participate in such Innovation Center evaluation projects, and that appropriate incentives are built into the participation agreements to adequately compensate providers for the study-related administrative costs.
AHCAPhysical therapy

A. Section I.B.4 - Most Recent Changes to the Fee Schedule (p.40322)

- Sustainable Growth Rate (SGR) (p.40322)

On the July 3, 2014 the Centers for Medicare and Medicaid Services (CMS) issued a fact sheet that accompanied the release of the proposed policy and payment changes to the Medicare Physician Fee Schedule for calendar year 2015. In the fact sheet, CMS stated “The Administration supports legislation to permanently change SGR to provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care.” AHCA recognizes that while CMS does not have the statutory authority to ignore the flawed SGR formula, we appreciate CMS’ support for necessary legislative reform to the formula that would otherwise result in an estimated -20.9 percent PFS update for CY 2015.

- Part B Outpatient Therapy Caps and Related Policies (p.40322)

AHCA maintains that beneficiary access to needed therapy services must not be limited by arbitrary caps in reimbursement. Medicare Part B physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services enable beneficiaries to restore or maintain their highest level of functional independence following an illness or injury, or recent decline resulting from a degenerative condition. These cost effective services help avoid costly hospital and post-acute admissions and readmissions, and often facilitate the return to community-based living for institutionalized beneficiaries.

Patient access is restricted by annual per-beneficiary benefit limits (therapy caps). We appreciate that Congress has recently enacted another temporary exceptions process to permit therapy services to be furnished above the cap limits through March 31, 2015. However, this process also includes mandatory manual medical review (MMR) arbitrarily set at $3,700 that is inefficient and disproportionately impacts patients with the greatest health care needs.

Beneficiaries and providers need the stability provided by permanent patient-centered improvements. Congress should build-upon the framework for Part B therapy improvements introduced during the recent debate to reform the sustainable growth rate (SGR) formula. The three key therapy reform points AHCA supports are:

1. Repeal of the Part B (Outpatient) Therapy Caps
   Therapy caps are bad policy. Arbitrary benefit threshold limits have the greatest impact on beneficiaries with the most complex needs. Limiting access to Part B therapy services increases the likelihood that more-costly hospital and post-acute services will be needed.

2. Reform Medical Review of Outpatient Therapy Services
   Medical review is an essential component to assuring prudent use of healthcare dollars. The current flawed medical review process must be reformed with a
process that is administratively efficient and better targets those claims most likely to reveal improper billing.

3. Collect Standardized Data Elements for Outpatient Therapy Services

The non-standardized functional reporting (FR) data currently being collected by the Centers for Medicare and Medicaid Services (CMS) is administratively complex, yet does not provide useful information. Future patient-centered quality and payment models first require the collection and analysis of standardized data elements.

AHCA recognizes that CMS requires Congressional action to repeal the therapy caps and implement necessary major medical review reform. However, AHCA recommends that CMS provide a public statement to Congress in support of the three key therapy reform points above, similar to the abovementioned Administrators statement in support for legislative SGR reform.

While legislative reforms are pending, AHCA believes that CMS has the authority and opportunity to implement some refinements in how the Part B therapy manual medical review (MMR) of all claims surpassing the annual per-beneficiary $3,700 threshold is conducted. The statutorily required therapy MMR review program has been implemented since October 2012, and although a pause in reviews was announced in February 2014 while CMS completes the procurement of new recovery audit contractors (RACs), CMS has indicated that it intends to review all MMR eligible claims that have been compiling once RAC reviews resume. AHCA is encouraged with many of the much needed improvements to the Recovery Audit program that were outlined by CMS in February. However, there is much uncertainty regarding the details of the enhancements and we encourage CMS to quickly share such details with providers regarding when and how RACs will resume conducting reviews, and what new accountability measures have been introduced that will assure that 1) providers are not overwhelmed, 2) the initial review decisions are appropriate, and 3) unnecessary appeals are prevented. Specific to therapy MMR, AHCA recommends that CMS implement the following specific administrative reforms not outlined by CMS in the February RAC ‘pause’ announcement:

- Conduct post-pay review only
- Implement additional development request (ADR) volume controls
- Streamline processes to reduce confusion, review time, and provider burden
- Utilize and disseminate MMR and appeals statistics gathered to date to provide necessary feedback and education to providers, and inform policymakers

During CY 2013, CMS implemented the statutorily required claims-based functional reporting (FR) which gathers data on beneficiaries’ functional limitations at periodic intervals during the therapy episode of care as reported by therapy providers and practitioners furnishing PT, OT and SLP services. However, the data submission process has been troubled with problems and unnecessary payment delays due to CMS and contractor systems problems. In addition, the data required to be submitted is not standardized and we believe is of limited usefulness for payment evaluation purposes. In
July 2014, CMS released the results of the seven-year Developing Outpatient Therapy Alternatives (DOTPA) project, conducted by RTI International, which described the development and testing of a standardized functional reporting tool for outpatient therapy services. **AHCA recommends that CMS provide summary statistics of the FR trends to date, and, based upon these trends and the DOTPA study findings, a description of what improvements CMS proposes are necessary to improve the FR requirement so that useful data can be gathered to help improve the integrity of Part B therapy payments.**
B. Potentially Misvalued Services Under the Physician Fee Schedule - II.B (p.40334)

In the proposed rule CMS describes the statutory and regulatory background of efforts at identifying potentially misvalued services and implementing corrective actions towards assuring that the relative value units (RVUs) of the procedure codes are updated in a transparent and timely manner. **AHCA supports CMS efforts at identifying appropriate valuation of services as long as the process is transparent and all stakeholders are adequately represented in the process.**

On Table 10 – *Proposed Potentially Misvalued Codes Identified Through High Expenditure Specialty Screen* (p. 40337), CMS lists nine Healthcare Common Procedure Coding System (HCPCS) codes that are commonly utilized for outpatient therapy services furnished by PT, OT, and SLP providers. These codes are: 97032 – electrical stimulation; 97035 – ultrasound therapy; 97110 – therapeutic exercises; 97112 – neuromuscular reeducation; 97113 – aquatic therapy/exercises; 97116 – gait training therapy; 97140 – manual therapy 1/> regions; 97530 – therapeutic activities; and G0283 – elec stim other than wounds.

On page 40337 of the proposed rule CMS states “We believe that a review of the codes in Table 10 is warranted to assess changes in physician work and to update direct practice expense (PE) inputs since these codes have not been reviewed since CY 2009 or earlier. Furthermore, since these codes have significant impact on PFS payment at the specialty level, a review of the relativity of the codes is essential to ensure that the work and PE RVUs are appropriately relative within the specialty and across specialties, as discussed previously.”

While it may be true that the PE inputs have not been reviewed since 2009 or earlier, AHCA would like to remind CMS that CMS and Congress have since taken two significant actions through the multiple procedure payment reduction (MPPR) policy cutting the PE component of the PFS payments for these procedure codes used to describe outpatient therapy services. Below is an excerpt of AHCAs comments to the CY 2014 PFS proposed rule summarizing the history:

“MPPR” refers to a Medicare policy that applies a reduction to payments for “practice expenses” associated with therapy services provided to the same patient, on the same day in “outpatient” settings (including outpatient clinics, hospital outpatient departments, and SNFs).

The rationale for the policy is that when therapy services are provided to the same patient, on the same day, in consecutive therapy sessions or in a single session, then the expense associated with those services is less than what the expense would be if therapy services were provided in different, non-consecutive, sessions. These expenses include “set up” costs and other activities that must be done as part of therapy treatments. In 2011, CMS applied a 25% reduction to facility payments for practice expenses based on this rationale and as of April 1, 2013, Congress increased the threshold to a 50% reduction for this purpose.
Our analysis of the Medicare Standard Analytic File 5% beneficiary sample projected to the 100% national estimate suggests that increasing the MPPR reduction to 50% will result in an additional an additional 9.75% reduction in total payments to providers on top of the initial similar cut observed when the initial 25% reduction was implemented.

The MPPR policy was originally developed for therapy delivered in “outpatient” settings on the assumption that it is common for Medicare beneficiaries to receive consecutive therapy sessions from multiple therapy disciplines or multiple therapy interventions in a single outpatient visit (Physical, Occupational and/or Speech Therapy).

In contrast, in the SNF setting, due to the clinical characteristics of the patients and the operational realities of delivering therapy services in SNFs, it is very uncommon for patients to receive consecutive therapy services or more than one therapy treatment in a single session. Instead, most SNF patients receive therapy services from different therapy disciplines at different times of the day because they are physically and cognitively unable to tolerate intensive therapy services delivered consecutively or in a single session. Some patients have a gap of at least 30 minutes between therapy sessions, and a great majority have a gap of 1 hour or more between sessions.

In addition, it is improper to apply the MPPR edits across the three therapy disciplines. These services represent distinct Medicare benefits and the application of the cross-discipline application of these edits created a disproportionate negative impact on nursing facilities and other providers that provide multi-disciplinary rehabilitation therapy services.

Lastly, when CMS proposed and finalized the MPPR payment reduction they did not use SNF therapy data to support the policy but instead relied on patient data from hospital and other outpatient settings. MedPAC’s recent report likewise did not include SNF data to support their MPPR policy recommendations. Although there may be minor overlap in practice expense of some time-based procedures furnished by PT or OT services furnished within a single session, the rationale for the MPPR policy is not appropriately applied when considering the unique patient-centered needs of nursing facility patients, and certainly does not justify a 50% reduction. CMS should study the issue further—including an analysis of data for therapy delivered in SNF settings—to better inform changes to the MPPR policy.

**AHCA recommends that if CMS decides to pursue reviewing this list of common outpatient therapy codes, that the impact of the MPPR policy is considered and mitigated so that rehabilitation service providers are not subject to a double-hit on PE cuts with any proposed revaluation.**

In addition to the above concerns, AHCA has reviewed the descriptions of the Urban Institute and RAND Corporation projects, as well as the Urban Institute interim report located at the web links CMS provided on page 40336 of the proposed rule. We are very concerned about the lack of descriptions regarding how CMS is instructing, or will instruct the contractors to perform validation of RVUs for potentially Misvalued outpatient therapy procedures. As we discuss in more detail in our comments below related to Section II.F of the proposed rule, AHCA is concerned with the current lack of SNF sector representation in the RUC process, and the RUC does not typically include
SNF in their valuation surveys, but instead focus on office-based specialty practitioners. AHCA recommends that if CMS proceeds with adopting the nine outpatient therapy procedures listed in Table 10 of the proposed rule for revaluation analyses, then CMS shall instruct the two validation contractors to include input from SNF sector and other facility-based providers so that the PE valuation is adequately representative of facility expenses in addition to office-based practitioner costs.

Finally, AHCA is concerned about the significant risks associated with any CMS efforts that would result in the introduction of new codes to replace potentially misvalued codes, or that would require significant changes to existing codes beginning in CY 2016, especially those related to outpatient therapy services. With the implementation of the ICD-10 diagnosis coding system in October 2015 there is already a significant risk that CMS, Medicare administrative contractor (MAC), and/or provider systems may have problems resulting in payment delays. An additional introduction of significant changes in procedure codes for a specific service or specialty in January of 2016 could compound such risks significantly. **AHCA recommends that due to the nearly concurrent introduction of ICD-10 diagnosis coding requirement in October 2015, CMS consider placing a moratorium on the introduction of significant changes in procedure codes for CY 2016 unless such codes are essential to assure beneficiary access to necessary services.**
C. Valuing New, Revised and Potentially Misvalued Codes – II.F (p. 40359)

In the proposed rule CMS discussed the current process for valuing new, revised and potentially misvalued codes and problems associated with the lack of transparency and incongruity between the PFS rulemaking cycle and the release of codes by the AMA CPT Editorial Panel and the RUC Review process. Specific stakeholder complaints regarding the process were described including:

- “…they have no opportunity to respond to the RUC recommendations before CMS considers them in adopting interim final values because the RUC actions and recommendations are not public (p.40360).”
- “…some types of suppliers that are paid under the PFS are not permitted to participate in the RUC process at all (p.40360).”

These issues are of a particular concern to AHCA members. While recent CMS and MedPAC reports have indicated that a plurality of Medicare Part B outpatient PT, OT, and SLP services are furnished in the SNF setting, the SNF sector is not represented in the RUC process, and the RUC does not typically include SNF in their valuation surveys, but instead focus on office-based specialty practitioners.

In the proposed rule CMS outlined the advantages and disadvantages of three potential alternatives to the current process. Ultimately, CMS proposed the option that would require the RUC recommendations to be submitted no later than January 15 of the year preceding the implementation, revision or revaluing of a code (e.g. January 15, 2015 for CY 2016 codes). CMS proposed the creation of temporary G-codes and other activities in cases where the RUC was not timely so that service delivery would not be interrupted while CMS completed a thorough evaluation of the codes and the public, including stakeholders not invited to the RUC process, had an appropriate opportunity to provide comment.

AHCA supports the CMS proposal to modify the process for valuing new, revised and potentially misvalued codes as it will enable a more transparent process where affected stakeholders, including SNF providers will have an opportunity to provide comment and evidence to CMS prior to the adoption of final values.

In addition, per the rationale regarding risks described in our comments pertaining to Section II.B of the proposed rule above, AHCA recommends that due to the nearly concurrent introduction of ICD-10 diagnosis coding requirement in October 2015, CMS consider placing a moratorium on the introduction of significant changes in procedure codes for CY 2016 unless such codes are essential to assure beneficiary access to necessary services.
D. Access to Identifiable Data for the Center for Medicare and Medicaid models – III.E (p.40376)

AHCA supports the efforts through the CMS Center for Medicare and Medicaid Innovation (Innovation Center) to test “…innovative payment and service delivery models that could reduce program expenditures while preserving and or enhancing the quality of care furnished to individuals…(p.40376)” However, the proper analysis of outcomes, clinical quality, patient experience, utilization/expenditures, and other factors often requires the consideration of the interrelationships of multiple public and private payers and payment models upon the individual. Such analysis will require the Innovation Center to have access to new sources of individually identifiable health information identified as necessary to conduct research authorized under statute.

For example, the construction of multi-payer quality measures would allow CMS and the states to evaluate innovative all-payer payment reform models, including dual eligible individuals under the State Innovation Model (SIM). Skilled nursing facilities (SNFs), nursing facilities (NFs), and assisted living residences (ALRs) provide a range of temporary or permanent residential-based care to dual-eligible individuals, or individuals covered under a variety of payers and payment models. Innovation Center efforts to streamline and standardize data required across payer types and payment models would not only facilitate the development of innovative patient centered payment reform models, but would significantly reduce provider burden and errors currently associated with complying with different requirements for different payers and payment models.

In this proposed rule, CMS has solicited an invitation for “…public comment on the proposal to mandate the production of individually identifiable information necessary to conduct the statutorily mandated research under section 1115A of the Act (p.40378)”. While AHCA supports the conceptual need for this mandate, we are concerned about how CMS intends to address the financial and administrative impact of the implementation of such a provision. For example, to date, our member facilities have been excluded from federal electronic health record (EHR) incentive programs that were offered to physicians and hospital based providers. Interoperable EHR technology may be a necessary keystone of Innovation Center evaluation programs. **AHCA recommends that CMS consider the potential impacts on the administrative burden and costs to providers that participate in such Innovation Center evaluation projects, and that appropriate incentives are built into the participation agreements to adequately compensate providers for the study-related administrative costs.**
Conclusion

AHCA appreciates the opportunity to comment on the 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.

There are quite a number of challenges for CMS to address that weigh statutory limitations with available administrative flexibility, including issues related to: the SGR, Part B outpatient therapy caps and related policies, potentially misvalued codes, and access to identifiable data for Innovation Center payment model evaluations.

AHCA welcomes the opportunity to work with CMS as part of the solution. Although the devil is in the details, we have offered what we believe are practical recommendations to move in the necessary direction and achieve the ultimate objective, and we pledge to offer our assistance to CMS to support necessary legislative changes, and facilitate the necessary provider engagement needed. Please feel free to contact me at 202.898.3174 or dciolek@ahca.org. We look forward to hearing from you on how we may assist CMS in Part B payment reform efforts.

Sincerely,

Daniel E. Ciolek
Senior Director, Therapy Advocacy

cc: Chava Sheffield
Jessica Bruton
Renee Mentnech
Pamela West