AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

August 29, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1612-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: 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, *Federal Register*. July 11, 2014. CMS-1612-P

Dear Administrator Tavenner:

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for more than 173,000 audiologists, speech-language pathologists, speech, language, and hearing scientists, audiology and speech-language pathology support personnel, and students. We appreciate the opportunity to comment on the proposed revisions to the Physician Fee Schedule (PFS) and other proposed revisions for calendar year (CY) 2015.

This letter includes ASHA's comments regarding the following topics in the order of their appearance in the July 11, 2014, *Federal Register*:

- RUC Recommendations for Migration from Film to Digital Practice Expense Inputs
- Using OPPS and ASC Rates in Developing PE RVUs
- Potentially Misvalued Codes: Review of High Expenditure Services Across Specialties with Medicare Allowed Charges of $10,000,000 or More
- Proposal to Modify the Process for Establishing Values for New, Revised, and Potentially Misvalued Codes
- Chronic Care Management
- Conditions Regarding Permissible Practice Types for Therapists in Private Practice
- Reports of Payment or Other Transfers of Value to Covered Recipients
- Physician Compare
- Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System
- Value-Based Payment Modifier and Physician Feedback Program

RUC Recommendations for Migration from Film to Digital Practice Expense Inputs (pg. 40329)
ASHA supports the RUC recommendation to remove the film supply and equipment items listed in Table 6 and agree with CMS that it is appropriate to use digital inputs as a proxy for services that may still use film. We appreciate the opportunity to comment on the appropriate proxy input for services listed in Table 7, which were excluded from the original RUC recommendation. **Specifically, ASHA agrees that the computer workstation (ED021) serves as an appropriate proxy for the film supply and equipment items currently included as direct practice expense in the services listed below, which are primarily billed by audiologists and speech-language pathologists.**

- 92521 Evaluation of speech fluency
- 92523 Evaluation of speech sound production and language comprehension
- 92524 Behavioral and qualitative analysis of voice
- 92601 Cochlear implant follow-up exam, <7 years
- 92603 Cochlear implant follow-up exam, 7/> years
- 92611 Motion fluoroscopy evaluation of swallowing function

Using OPPS and ASC Rates in Developing PE RVUs (pg. 40332)
ASHA understands CMS' ongoing efforts to improve the accuracy and reliability of the data used to establish Medicare payment rates. However, as noted in the proposed rule, collecting PE directly from providers poses challenges, both logistically and in ensuring data validity across a diverse range of providers. We believe that the AMA/Specialty Society RVS Update Committee (RUC) process for evaluating PE is a sufficiently rigorous methodology for assigning payment rates. Not only is the RUC process overseen and carefully vetted by its Practice Expense Subcommittee, it also involves the experience of experts in the relevant fields and is closely monitored by CMS representatives who attend the meetings.

Potentially Misvalued Codes: Review of High Expenditure Services Across Specialties with Medicare Allowed Charges of $10,000,000 or More (pg. 40337)
ASHA recognizes the need for ongoing efforts to identify, review, and adjust values for potentially misvalued codes. While we understand that specialty societies have the opportunity to participate in the review of identified codes through the RUC's Relativity Assessment Workgroup (RAW), we would like to also take this opportunity to comment on CPT code 92557 (comprehensive audiometry), which has been identified by CMS through a review of high expenditure services with allowed charges of $10 million or more. **ASHA does not believe that CPT code 92557 is misvalued for the reasons outlined below.**

CPT code 92557 is a binaural assessment of air conduction, bone conduction, and speech audiometry. The information obtained from this diagnostic procedure is the foundation for the identification and management of disorders of the auditory and vestibular systems. It plays an essential role in determining whether additional testing is needed, and can also inform intervention of hearing and vestibular disorders. Hearing loss is a very common occurrence for aging adults and we believe the increase in utilization of approximately 18% between 2003 and 2013 can be correlated to the number of eligible individuals entering the Medicare system. **As such, we contend that the identification of 92557 as a high expenditure service is not**

indicative of abuse or overutilization, but is a reflection of an aging population that is at heightened risk for hearing loss and balance disorders. ASHA looks forward to working with CMS, the RAW, and related specialty societies during the review of CPT code 92557 as a potentially misvalued code.

Proposal to Modify the Process for Establishing Values for New, Revised, and Potentially Misvalued Codes (pg. 40361)

ASHA appreciates CMS' willingness to increase transparency by considering alternatives to the current process for valuing new, revised, and potentially misvalued codes. We support the idea of modifying the process to allow recommended changes to RVUs to be published in the proposed rule. However, we are concerned that the CMS proposal—particularly the CY2016 timeline and the use of G-codes when recommendations for new and revised codes are not received in time for proposed rulemaking—will cause confusion and place an undue administrative burden on both CMS and Medicare providers.

As an alternative, we strongly urge CMS to adopt the timeline and process outlined by the American Medical Association (AMA) in its June 3, 2014, letter to Deputy Administrator Cavanaugh. The AMA's proposal is supported by ASHA and numerous other specialty societies, as expressed in the August 13, 2014, comment letter to Administrator Tavenner. We believe it is the most efficient way forward while still affording stakeholders sufficient opportunities to comment on changes to RVUs.

ASHA is also concerned with the CMS proposal to eliminate the refinement panel process, should a different approach to the current valuation process be adopted. While an alternative process may provide stakeholders additional opportunities to review and comment on proposed RVUs, we do not agree that it is a sufficient replacement for a fair and objective appeals process. Elimination of the refinement process implies that CMS will no longer take advantage of external input from medical experts regarding proposed values. **This perceived lack of an objective appeals process is worrisome and ASHA encourages CMS to implement a consistently managed appeals process that is open to any organization that has provided comment on a proposed value.**

Chronic Care Management (pg. 40364)

ASHA appreciates the CMS proposal to allow chronic care management (CCM) services billed "incident to" the physician services under general supervision. It is clear that many of the CCM services would be performed during off-duty hours or without the managing physician on-site.

It is unclear in the proposed language, and prior rules related to CCM, which provider types are able to bill incident to the physician for CCM. Several qualified health providers, such as audiologists and speech-language pathologists, perform many of the services for CCM. Specifically, speech-language pathologists work with Medicare beneficiaries with chronic, neurodegenerative conditions such as Parkinson's Disease, ALS, or multiple sclerosis that require close monitoring and treatment of swallowing and communication disorders. Speech-language pathologists collaborate with other qualified health providers on the development and revision of patient-centered plans of care; electronic health records maintenance; appointment availability; care transitions; and home and community-based clinical services coordination.

The proposed rule is clear that physicians are the primary provider and biller of CCM services. However, **ASHA requests that time spent on CCM services by other members of the interdisciplinary health care team are included in the physician's billing of CCM. Additionally, ASHA requests that clarification regarding the role of speech-language pathologists and other qualified health providers on the interdisciplinary team is clearly delineated in the final rule, including a list of providers who can directly bill for CCM, and a list of providers who are able to include their time under the general supervision of a physician.**

Conditions Regarding Permissible Practice Types for Therapists in Private Practice (pg. 40371)
ASHA agrees that the proposed changes to the regulations addressing practice types for therapy services do not change current policy and more accurately reflect the type of practices associated with speech-language pathologists.

Reports of Payment or Other Transfers of Value to Covered Recipients (pg. 40383)
ASHA supports and agrees with the CMS proposal to remove the language in regulations, section 403.904(g) in its entirety, and in particular, section 403.904(g)(i).

ASHA approves continuing education (CE) providers to offer CE courses and conferences for audiologists and speech-language pathologists to maintain the ASHA Certificate of Clinical Competence and state licensure renewal requirements. Although audiologists and speech-language pathologists are not held to the open payments reporting rules, often physicians are presenting sessions related to hearing, communication, and swallowing disorders at CE events where manufacturers of hearing and communication devices provide financial support. Limiting the exemption to the five organizations currently listed in the regulations does not adequately recognize organizations of equal importance and stature in the continuing education community, and it is unclear from previous rules the standard or process that was applied to exempt the organizations listed. The standards for ASHA-approved CE providers are equivalent to those offered by the five organizations currently listed.

ASHA agrees with the CMS assessment that: removal of the section of the regulation does not significantly change program policy due to the redundancy of the language in section 403.904(i)(1); it protects CMS from the perception of endorsing specific continuing education providers, and it prevents the need for additional resources to develop accreditation or certification standards and implement a verification, approval, and monitoring process to ensure compliance.

Physician Compare Website (pg. 40385)
ASHA has expressed concerns in previous rules, and continues to challenge the proposal to publicly report the Physician Quality Reporting System (PQRS) data on Physician Compare for the timeframe proposed. Due to the arduous process for measure development and endorsement, at this time audiologists and speech-language pathologists are limited to medication documentation, which is not a measure of clinical quality. ASHA is working with other stakeholders in audiology to develop clinically relevant measures that inform best practices for

audiologists that will be available in future years. Additionally, ASHA is investigating the possibility of the Qualified Clinical Data Registry (QCDR). Because the measures available for reporting do not accurately reflect the quality of services provided by an audiologist or speech-language pathologist, **ASHA requests that Westat contractors continue to work with professional societies in the development of Physician Compare.** ASHA intends to propose a timeframe that aligns with measure and registry development**.** ASHA is supportive of consideration of other measures that have been developed, collected, and approved by specialty societies, and will continue to work with CMS PQRS to ensure that audiology and speech-language pathology are participating in clinically appropriate quality and outcome measures.

ASHA appreciates the recognition that specialty societies are most familiar with measuring quality and outcomes for the professions they represent. The proposal to link Physician Compare with society websites to include non-PQRS measures is a good option to ensure consumers have pertinent and timely information to make their provider choice.

The most recent iteration of Physician Compare lacks detail for training, certification, and specialty board recognition many audiologists and speech-language pathologists possess. While we recognize that much of the provider information is populated by the PECOS system, **ASHA reiterates the request that like fields are reflected for allied health professionals that are currently only available for physicians.**

Physician Payment, Efficiency, Quality Improvements—Physician Quality Reporting System (pg. 40391)

ASHA has been an active proponent of quality and outcome measures for audiologists and speech-language pathologists. When the Physician Quality Reporting Initiative did not include audiologists as eligible providers, ASHA worked diligently with the audiology community to ensure that all members were able to participate in this landmark initiative, and has since continued to support audiology participation through convening the Audiology Quality Consortium (AQC). For speech-language pathologists, we ensured participation by enrolling an established data collection tool, the National Outcomes Measurement System (NOMS), as a CMS approved registry. NOMS, not originally designed to report quality measures, but rather collect benchmarking data on functional outcomes related to specific speech, language, and swallowing conditions, was modified in order to meet registry requirements and ensure burden-free PQRS participation for speech-language pathologists.

The comments below elaborate on the following recommended changes or considerations related to PQRS.

- PQRS application to critical access hospitals is not appropriate.
- The continuation of the claims-based reporting option and the Measures Applicability Validation (MAV) process is noted and appreciated.
- The proposal to increase outcome measures from one to three is appreciated, although ASHA has questions regarding the parameters for risk-adjusting such measures.
- ASHA requests reconsideration for the proposed deletion of PQRS measure #261: Referral for otologic evaluation.

Critical Access Hospitals

ASHA disagrees, and has expressed our opposition in previous rules, with the decision to classify critical access hospitals (CAHs) similar to private practice. It stands to reason that the original interpretation of the role of CAHs, aligning their services with those provided in outpatient hospital departments, was correct. CAHs are hospitals that have qualified by their location and the number of beds; Medicare pays for the same services provided in CAHs that are provided in acute care hospitals. Although the definition of outpatient services in section 1861 of the Act is broad enough to include those furnished by providers and other institutional and office settings, it is incorrect to assume that other institutional settings would include CAHs. The application of PQRS in CAHs creates an additional burden to a facility that was intended to offer medically necessary services where access was sparse. Those that qualify as CAHs already have reduced access to medical professionals and limited capabilities, and compounding the burden further limits the time available for services. **ASHA recommends the application of PQRS to CAHs be postponed until a new payment system is available for all providers**.

Claims-Based Reporting and Measures Applicability Validation (MAV) Process

ASHA is pleased that the claims-based reporting option will continue in 2015. At this time, the claims-based reporting option is the only option available for audiologists and speech-language pathologists to participate in PQRS. Audiologists and speech-language pathologists are not mandated electronic health record participants, and many in private and group practices do not have the resources available to participate in PQRS through any other method. The claims-based reporting option should continue to be an option until CMS can ensure all providers are able to participate with minimum burden and cost.

Additionally, it is critical for audiologists and speech-language pathologists that the Measures Applicability Validation (MAV) process remains intact until measures and/or a CMS approved registry is available for all provider types. The MAV process also protects those providers from reporting generalized measures that are not applicable due to state scope of practice laws. ASHA appreciates that the MAV process will continue to exist in order to protect those providers unable to report Medicare beneficiaries due to the limitations of measures and the patients that present to them.

Normalization of Outcome Measures

ASHA appreciates that CMS continues to move forward with encouraging outcome measures for reporting purposes. In previous comments, ASHA supports the combination of outcomes, process measures, care coordination, patient management, and patient satisfaction, to truly capture quality. Additionally, it is important to include more granular measures that provide precise estimates of a patient's status in relation to each of the impairments that are being treated as well as the associated gains that ostensibly result from the course of treatment.

ASHA believes that the requirements for measures should stem from programmatic needs and the need for the data to truly inform quality, with appropriate risk-adjustment and normalization. Ultimately, outcome measurements can only support quality. Quality Clinical Data Registries (QCDRs) need the ability to risk-adjust outcome

measures, and each measure should be normalized individually according to the population that has submitted the measure. Raw scores should never be compared. Additionally, there is a need to risk-adjust outcome measures in order to incentivize use. If a clinician is able to score a higher quality composite score by choosing a majority of process measures, they will continue to do so in order to avoid negative adjustments. Thus, it is important that the QCDRs, as the entities collecting the critical information about "case-mix" data (e.g., patient characteristics such as health conditions, severity, demographic information) and the nature of the services delivered (e.g., service delivery context, type, intensity, and dosage of treatment), also provide the appropriate methodology for normalization.

Proposed Deletion of Measure #261

ASHA opposes the deletion of Measure #261, and requests reconsideration for 2015. It has been understood that the audiology measures used by CMS did not meet NQF endorsement standards and would eventually be retired for use. We also agree that measures indicating a referral for further evaluation are not a robust measure of quality. However, we request reconsideration for 2015 to 1) ensure audiologists have a clinically relevant measure to report in 2015, 2) have a measure by which to train and educate, and 3) have an interim measure while audiology stakeholders develop and finalize six measures, currently in the testing phase of measure development.

Audiologists are among a small number of provider types who are limited in the number of measures available for reporting by virtue of the statutory definition that limits audiologists to diagnostic providers related to the exclusive areas of hearing and balance. Developing measures of quality and outcomes for a limited scope, and participating in interdisciplinary measures that require outcomes or treatment management of the patient has proven to be more than difficult. With this in mind, ASHA, along with the Audiology Quality Consortium (AQC), has worked on developing measures that are clinically relevant and will drive best practice. CMS and NQF have provided valuable guidance and feedback in the course of this process, and the measures are now undergoing the testing phase. Because it is our desire that audiologists participate in the PQRS program, we ask that the deletion of Measure #261 be postponed until the new measures are finalized and accepted into the PQRS system. Audiologists will be more motivated to participate in PQRS with a discipline-specific measure, and it allows additional opportunities for education and practice. Measure #261 is also included in the MAV process, which requires audiologists to meet benchmark requirements for #261 and the documentation of medication #130. Measure #130 alone is not adequate to assess quality or participation by the providers.

Value-Based Payment Modifier and Physician Feedback Program (pg. 40492)

ASHA appreciates the time CMS staff has offered to answer the questions of staff and our colleagues from other non-physician organizations. Based on that discussion and our analysis of the proposed rule, ASHA recommends the following.

- The Value-Based Payment Modifier (VM) should be postponed for non-physician eligible providers, including audiologists and speech-language pathologists, who are not attributed to the cost measure due to the inability to bill Evaluation and Management codes.

- A timeline for implementation should be proposed in the CY 2016 Medicare Physician Fee Schedule Proposed Rules for a phased-in implementation of the VM to non-physician eligible professionals.

Postpone Implementation

ASHA understands that the application of the value-based payment modifier (VM) to all eligible professionals, including audiologists and speech-language pathologists, is intended to promote shared accountability, system-based care, and collaboration between providers. However, we strongly disagree with the assumption that CMS has provided ***non-physician*** groups and solo practitioners with sufficient lead time to understand the VM. In a review of prior proposed rules, references to the value-based modifier implementation refer to the physicians and not eligible professionals (EPs). Additionally, the statute specifies that:

> (7) Application.—For purposes of the initial application of the payment modifier established under this subsection during the period beginning on January 1, 2015, and ending on December 31, 2016, the term "physician" has the meaning given such term in section 1861(r). On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary determines appropriate.

The inexplicit language in the statute, and the absence of references in prior rules, did not prepare ASHA for the proposal in the CY 2015 rule.

Arguably, providers were allowed time to learn a reporting system since the 2007 origin of PQRS. However, the annual changes to PQRS reporting options have hindered the capability and the motivation for participation. With the slow retirement of audiology measures available in PQRS, and the sweeping changes finalized last year that resulted in the disqualification of the speech-language pathology measures and registry, audiologists and speech-language pathologists have been forced to learn reporting requirements for documentation of medication in the medical record (Measure #130). At this time, Measure #130 is the only measure that is proposed to apply for both professions, and according to our initial analysis of other measures, the only reasonable one given the limitations of licensure laws. ASHA is investigating solutions for our members to participate, including re-evaluation of other available measures, measure development, and QCDR development. All of these solutions take significant time and the cycle of the proposed rule, measure development, and measure revisions does not lend to a realistic timeline for education and implementation.

As we established in our discussion with CMS, audiologists and speech-language pathologists are unable to bill Medicare for Evaluation and Management (E/M) codes. It is our understanding that these codes, along with four chronic clinical conditions, and hospital admission, are the mechanisms used for attributing the cost-measure. The four chronic conditions are not those typically cared for in private practice, and with group practice reporting option (GPRO) not being a possibility, it appears—as proposed—that audiologists and speech-language pathologists will not be attributed to a cost measure. The limited options for reporting (claims-based, Measure #130) presents with unique issues and questions regarding VM application to audiologists and

speech-language pathologists. The PQRS calculation at this time will only be based on Measure #130, which is not an indication of quality or value. Based on these facts, **ASHA requests that the implementation of the VM for practices comprised only of non-physician eligible providers is delayed until 2016, and a phased-in implementation similar to the physicians' is applied**.

Proposed Timeline

ASHA recommends the following timeline for consideration:

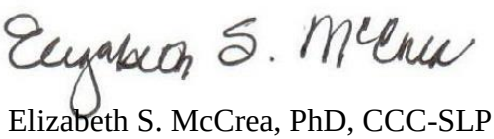
CY 2016	The implementation of the VM to all practices with 100 or more non-physician EPs, with no downward adjustment
CY 2017	The implementation of the VM to all practices with 10 or more non-physician EPs, with no downward adjustment for practices with 10-99 EPs
CY 2018	The implementation of the VM to all practices, including solo EP practices, with no downward adjustment for practices with 1-9 EPs
CY 2019	The implementation of the VM to all practices with the downward adjustment applicable regardless of practice size

The proposed timeline is consistent with the implementation to physician groups. **ASHA strongly recommends that the timeline is proposed in the CY 2016 Medicare Physician Fee Schedule in order to allow for comments and adjustments.**

Finally, ASHA recommends that a Technical Expert Panel of non-physician professionals representing the specialty societies be convened in order for CMS to develop policies and processes for continued participation in PQRS and VM. ASHA offers our assistance, and would like to meet with CMS further regarding quality reporting for audiologists and speech-language pathologists.

Thank you for the opportunity to provide comments on the 2015 proposed Medicare Physician Fee Schedule. Should you have any questions regarding relative values, rates, and coding, please contact Neela Swanson, ASHA's director of health care coding policy, at 301-296-5675 or by e-mail at nswanson@asha.org. For other issues addressed, please contact Lisa Satterfield, ASHA's director of health care regulatory advocacy, at 301-296-5671 or by e-mail at lsatterfield@asha.org.

Sincerely,



Elizabeth S. McCrea, PhD, CCC-SLP
2014 ASHA President