PRIVATE PRACTICE SECTION, APTA

American Physical Therapy Association

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June 27, 2016

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-2016-5517-P

Submitted Electronically

Re: File Code-CMS-5517-P; "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models"; Proposed Rule.

Dear Acting Administrator Slavitt:

On behalf of the over 4100 members of the Private Practice Section (PPS) of the 93,000 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; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models" (CMS-5571-P), published in the May 9, 2016 *Federal Register*.

This proposed rule for the implementation of the Merit-Based Incentive Payment System (MIPS), alternative payment models (APMs), and incentive payments for participation in physician-focused payment models will impact outpatient physical therapists in private practice as well as outpatient physical therapy services furnished in hospitals, outpatient rehabilitation facilities, public health agencies, clinics, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities. The implementation of these programs will have a substantial impact on rehabilitation therapy professionals for the foreseeable future.

In this publication, CMS proposes a flexible, rather than a one-size-fits-all quality measures program, which it argues reflects "how doctors and other clinicians deliver care and gives them the opportunity to participate in a way that is best for them, their practice, and their patients".[1]

PPS commends CMS for "laying the groundwork for expansion towards an innovative, outcome-focused, patient-centered, resource-effective health system"[2]*. Below, in italics, you will find PPS's comments on relevant aspects of the NPRM upon which we have standing, experience, and valuable comments to share.*

Implementation of the Merit-Based Incentive Payment System (MIPS)

As required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), beginning in 2019, CMS will 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). Through MIPS, annual payment updates will first be provided to a discreet list of eligible professionals. MIPS allows these Medicare clinicians to be paid for providing high value care based upon their performance in four categories: Quality, Advancing Care Information, Clinical Practice Improvement Activities, and Cost—which could be problematic for physical therapists who are not currently required to report or use all of the measurement mechanisms referenced.

1) Quality (50% of total score in year one, 45% in year two, and 30% in subsequent years[3]): For this category clinicians would choose to report six measures from among a range of options that accommodate differences among specialties and practices.
2) Advancing Care Information (25% of total score in year one): In this section clinicians would choose to report customizable measures that reflect how they use technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange. Unlike the existing reporting program (that physical and occupational therapists are not a part of), this category would not require all-or-nothing EHR measurement or redundant quality reporting.
3) Clinical Practice Improvement Activities (15% of total score in year one): This category would reward clinical practice improvements, such as activities focused on care coordination, beneficiary engagement, and patient safety. Clinicians may select activities that match their practices' goals from a list of more than ninety options.
4) Cost (10% of total score in year one, 15% in year two, and 30% in subsequent years[4]): For this category, the score would be based on submitted Medicare claims, meaning there will be no additional reporting requirements for clinicians. This category would use forty episode-specific measures to account for differences among specialties.

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[1] "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models", published May 9, 2016, *Federal Register Vol.81, No.89*, https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf, pp. 28166.
[2] *Ibid.* https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf, pp. 28166.
[3] *Ibid*. https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf, pp. 28185.
[4] *Ibid*. https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf, pp. 28185.

PPS Comment:
PPS thanks the Agency for a thorough and thoughtful proposal for how to implement MIPS and the APM elements of MACRA. At the same time, PPS would like to voice concern that the rule is largely focused on hospital-based providers as well as those practicing in large groups. Below please find detailed comments on specific elements of the proposed rule.

Expanding Application to Additional Non-Physician Providers

Section 1848(q) of the Act, added by section 101(c) of MACRA, implements the MIPS program in 2019, beginning with the inclusion of physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. Other non-physician eligible professionals may be added in year three of MIPS, under the discretion of the Secretary, including physical therapists, occupational therapists, and speech language pathologists.

PPS Comment:
While PPS applauds CMS for developing criteria based on value and quality while also considering resource utilization and providing flexibility to reporting clinicians, we are disappointed that, beginning in 2019, MIPS will only apply to physicians and the other designated providers but not yet to physical therapists as well as other non-physician professionals. PPS believes that such expansion is feasible and can incorporate functional limitation reporting measures as well as NQF-endorsed measures for physical therapists that have been recognized by CMS. Physical therapists have been included in quality reporting under Medicare part B in the PQRS program since its inception in 2007. After much effort, the PT participation rate in PQRS in 2014 was 72.2%, exceeding the overall eligible professional participation rate of 62.2%. PPS has significant concerns that the exclusion of physical therapists from the MIPS program in 2017 and 2018 will have a strong negative impact on the reporting rate of quality measures by physical therapists. Moreover, PPS is concerned that in 2019 physical therapists will struggle to successfully return to quality reporting under the constructs of a new program after a two year hiatus. Furthermore, 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.

Additionally, the factors by which additional eligible professionals will be included by CMS at a later date are not clear. PPS urges CMS to include in the final rule an amplification of the criteria to include non-physician professionals such as physical therapists in the third year of the MIPS program, beginning in 2021.

At the time of expansion, there should be sufficient activities and relevant measures applicable and available to suit the needs and types of eligible clinicians; if this is not the case, the weight for a given performance category should be modified or should not apply to that eligible clinician. The determination should be based on an eligible clinician's specialty and practice type.

Sunsetting Current Payment Adjustment Programs

Section 101(b) of the MACRA calls for the sunsetting of payment adjustments under three existing programs (PQRS, VM, and EHR Incentives) for Medicare enrolled physicians and other practitioners. CMS proposes to continue payment adjustments through 2018, as well as amend the regulation text at

§ 495.102(d) to remove references to the payment adjustment percentage for years after the 2018 payment adjustment year and add a terminal limit of the 2018 payment adjustment year.[5]

PPS Comment:
PPS commends CMS' sensitivity to the fact that should PQRS and the other payment adjustment programs sunset before their users were incorporated into MIPS, there would have been a gap in the payment adjustment for providers. However, PPS remains concerned that without further extensions through 2020, there will be a minimum two-year gap in the applicability of a quality reporting program for physical therapists. Should there be a gap, physical therapists would be prohibited from being recognized financially for their contributions to quality or outcomes because there will be no mechanism by which therapists can receive any kind of bonus or incentive payment. PPS raised this concern in response to last fall's Request for Information.

Voluntary Participation in MIPS
Section 1848(q)(1)(A) of the Act requires the Secretary to permit any eligible clinician who is not a MIPS eligible clinician the option to volunteer to report on applicable measures and activities under MIPS.[6]

PPS Comment:
PPS praises CMS's proposal to grant physical therapists the ability to voluntarily participate in MIPS in 2017 and subsequent years in order to gain reporting experience in the new program before being required to participate. However, without financial or other implications, the PT participation rate will be low given the lack of reporting incentive and the high burden of data collection. PPS encourages CMS to consider innovative ways to incentivize participation in quality reporting programs, for physical therapists and the other non-physician eligible clinicians excluded from the initial group of eligible clinicians in MIPS, such as giving eligible clinicians 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.

It is unclear how many clinicians will avail themselves of this opportunity; however we encourage CMS reach out to those that do and inquire how the MIPS parameters align with the measures that rehabilitation therapists are familiar with reporting under PQRS, as well as how applicable MIPS measures are to physical therapy. We suggest the therapy cap exceptions process should be automatically applied to the patients of private practice physical therapists who voluntarily participate in MIPS.

Low-Volume Threshold
Section 1848(q)(1)(C)(ii)(III) of the Act provides that the definition of a MIPS eligible clinician does not include MIPS eligible clinicians who are below the low-volume threshold selected by the Secretary under section 1848(q)(1)(C)(iv) of the Act for a given year. Section 1848(q)(1)(C)(iv) of the Act

[5] *Ibid*. https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf, pp. 28170.
[6] *Ibid*. https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf, pp. 28173.

requires the Secretary to select a low-volume threshold to apply for the purposes of this exclusion which may include one or more of the following [emphasis added]: (1) The minimum number of Part B-enrolled individuals who are treated by the MIPS eligible clinician for a particular performance period; (2) the minimum number of items and services furnish to Part B-enrolled individuals by the MIPS eligible clinician for a particular performance period; and (3) the minimum amount of allowed charges billed by the MIPS eligible clinician for a particular performance period. CMS proposes at § 414.1305 to define MIPS eligible clinicians or groups who do not exceed the low-volume threshold as an individual MIPS eligible clinician or group who, during the performance period, have Medicare billing charges less than or equal to $10,000 and [emphasis added] provides care for 100 or fewer Part B enrolled Medicare beneficiaries.[7]

PPS Comment:
Physical therapy for complicated patients can be very expensive; therefore (after they are included in MIPS) some private practice physical therapists could be denied the low-volume threshold after caring for only a few very expensive patients. This could introduce a perverse incentive for providers and result in limited access to care. PPS acknowledges the Secretary was given discretion to define the "low-volume threshold" within the parameters of the law which required only one of the three elements be met. However, citing the concerns above, PPS respectfully requests that the definition be changed to "an individual MIPS eligible clinician or group who, during the performance period, have Medicare billing charges less than or equal to $10,000 OR [emphasis added] and individual who provides care for 100 or fewer Part B enrolled Medicare beneficiaries".

Score adjustment for first few years of the program
In the proposed rule, two of the four measures are adjusted over time to allow for practice adjustment as well as clinician experience and learning curves. The quality measure decreases over time—worth half the total score in year one, forty-five percent in year two, and capped at thirty percent in subsequent years.[8] The cost measure becomes more significant over time: representing only ten percent of total score in year one, fifteen percent in year two, and topping out at thirty percent in subsequent years.[9]

PPS Comment:
When the time comes to include physical therapists in the MIPS program, PPS requests that they be granted the same stepped-down percentage of score for quality and stepped-up percentage of score for cost that are in place for those clinicians participating in MIPS in these first two years. Such an approach would give those eligible clinicians the same time and consideration doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists received during their transition to MIPS.

[7] *Ibid*. https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf, pp. 28178.
[8] *Ibid*. https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf, pp. 28185.
[9] *Ibid*. https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf, pp. 28185.

Outcome Measures

As directed by MACRA, this rule proposes measures, activities, reporting, and data submission standards across four performance categories. Under section 1848(q)(2)(C)(i) of the Act, the Secretary must, as feasible, emphasize the application of outcome-based measures in applying section 1848(q)(2)(B)(i) of the Act. Quality measures and activities vary by category and include outcome measures, performance measures, and global and population-based measures. The proposed rule would have the MIPS eligible clinician report at least six measures, with at least one being an outcome measure (if available).[10]

PPS Comment:

PPS commends the Agency for embracing and pursing outcome measures as a part of the overarching Administration strategy to change payment structures to improve quality and patient outcomes as a way to transform how health care is delivered. Additionally, PPS thanks CMS for responding to the comments provided to the request for information where PPS encouraged the reduction of the number of required measures and a focus instead on patient-centric outcome measures such as functional status. Section 3005(g) of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) required 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, otherwise known as Functional Limitation Reporting (FLR). As our member therapists are currently reporting FLR, it'd be a familiar, effective, and meaningful manner by which care can be delivered, improved, evaluated, and reimbursed in MIPS.

Physical therapists can also utilize and report on NQF-endorsed outcome measures for rehabilitation therapists. CMS should take these existing reporting pathways into account when determining the number of measures and the methods when including physical therapists in MIPS. PPS also suggests that patients of private practice physical therapists who collect and report outcomes measures should automatically be eligible for exception from the therapy cap.

Advancing Care Information

Under the proposed rule, Advancing Care Information (ACI) accounts for twenty-five percent of total score in year one. In order to receive an ACI score, clinicians would choose to report customizable measures that reflect how they use technology and electronic health records (EHR) in their day-to-day practice, with a particular emphasis on interoperability and information exchange.

CMS discusses that if there are not sufficient measures and activities applicable and available to each type of MIPS eligible clinician, the Secretary shall assign different scoring weights (including a weight of zero) for each performance category based on the extent to which the category is applicable to each type of MIPS eligible clinician, and for each measure and activity specified for each such category based on the extent to which the measure or activity is applicable and available to the type of MIPS eligible clinician. Many non-physician clinicians are not eligible to participate in the Medicare and/or

[10] *Ibid*. https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf, pp. 28186.

Medicaid EHR Incentive Program; there is little evidence as to whether there are sufficient measures applicable and available to these types of MIPS eligible clinicians. CMS proposes to assign a weight of zero to the advancing care information performance category if there are not sufficient measures applicable and available to nurse practitioners, physician assistants, certified registered nurse anesthetists, and clinical nurse specialists. CMS notes that they intend to use the first MIPS performance period to further evaluate the participation of these MIPS eligible clinicians in the advancing care information performance category and would consider for subsequent years whether the measures specified for this category are applicable and available to these MIPS eligible clinicians.

PPS Comment:
Under current law, physical therapists are not required, nor are they supported or incentivized, to have or use an electronic health record (EHR) system. PPS suggests that CMS should continue to work with rehabilitation therapists to determine if and when to include them in the ACI category. Non-physician groups such as rehabilitation therapists are insufficiently familiar with EHR systems and requirements, and therefore will need time to adapt to these policies. PPS thanks the Agency for its proposal to assign a weight of zero to the advancing care information performance category if there are not sufficient measures applicable for MIPS clinicians. If CMS wants to require this of physical therapists in the future, we would encourage the Agency to evaluate the availability of measures for non-physicians in the ACI category in the first several years of the program and as other clinicians are added. Upon identifying gaps, CMS should ensure appropriate and relevant measures and incentives are available for achieving Meaningful Use as well as a phased-in reporting requirement similar to that granted to physicians when the Meaningful Use program began. Such an approach would give non-physician provider groups needed time to prepare to use EHR, especially if the overall MIPS score for physical therapists intends to score the use of EHR.

Clinical Practice Improvement Activities
The implementation of MIPS includes a score for Clinical Practice Improvement Activities (CPIA). Section 1848(q)(2)(C)(v)(III) of the Act defines CPIA as an activity that relevant eligible clinician organizations and other relevant stakeholders identify as improving clinical practice or care delivery and is likely to result in improved outcomes. Clinicians may select activities that match their practices' goals from a list of more than ninety options. Additionally, CMS proposes that the following scoring would apply to MIPS eligible clinicians who are in a small practice (consisting of fifteen or fewer professionals), a practice located in a rural area, or practice in a geographic health professional shortage area (HPSA) or any combination thereof: reporting of one medium-weighted or high-weighted activity would result in fifty percent of the highest potential score, and reporting of two medium-weighted or high-weighted activities would result in one-hundred percent of the highest potential score.

PPS Comment:
PPS praises the Agency's emphasis on activities that have a proven association with improved health outcomes. We also appreciate that clinicians are able to choose among more than ninety options for activities that match their practice's goals and features. PPS supports the scoring approach to the CPIA category and appreciates the alternative scoring methods for providers in small practices that will impact the vast majority of our private practice physical therapists. PPS also suggests that fewer

measures, and those that are directly pertinent and applicable to the type of eligible clinician and practice focus, should be required rather than the number that are currently required by PQRS. Should the focus be on the quantity of measures, it runs the risk of being (a) an exercise in paper-pushing and box checking that is of little value to the patient and (b) for particular eligible clinicians (like physical therapists) that can only do the measures on one type of visit, such as an evaluation, the time spent on the measures during that visit vastly outweighs the potential bonus (or penalty) for that time spent, and thus, is not a practical incentive nor valuable use of patient time. For example, some of the information physical therapists are currently required to report is irrelevant, such as if the therapist followed up on vitamin D supplementation or how to approach an 80 year old with a BMI of 30+.

While there are many medium level activities that physical therapists might achieve on the initial CPIA list, there are only three high level activities that may typically apply to our providers. PPS anticipates many of our private practice providers will meet the small group exceptions for the CPIA category; however, we are concerned that are not enough CPIA measures that reflect activities that non-physician providers would engage in. PPS requests that CMS to continue to work with physical therapists to ensure that appropriate and relevant CPIAs are ready and sanctioned for their use when they are required to participate in MIPS. For example, the ongoing and continuous collection and reporting of functional status outcomes measures should be considered CPIAs.

Resource Use

The Act describes the resource use performance category under MIPS as ''the measurement of resource use for such period using a methodology specified in the Act as appropriate and, as feasible and applicable...'' Section 1848(r) of the Act (as added by section 101(f) of MACRA) specifies a series of steps and deliverables for the Secretary to develop ''care episode and patient condition groups and classification codes'' and ''patient relationship categories and codes'' for purposes of attribution of patients to practitioners, and provides for the use of these in a specified methodology for measurement of resource use. Under MIPS, the Secretary must evaluate costs based on a composite of appropriate measures of costs using the methodology for resource use analysis specified in section 1848(r)(5) of the Act that involves the use of certain codes and claims data and condition and episode groups, as appropriate. The agency does not propose any data submission requirements for the resource use performance category; scoring will be calculated using administrative claims data.[11]

PPS Comment:

PPS strongly believes that at this time therapists are not in a position to have their performance evaluated on the total cost of care. As physical therapists were not included in the VM program they have not received information on resource use measures; therefore, at this time our providers have little to no exposure to episode cost data. Presently, there are insufficient accurate available to implement such a concept. Numerous studies demonstrate the positive impact of early therapy intervention in reducing therapy utilization and improving outcomes, and in some cases, even decreasing the need for additional costly interventions such as imaging and surgery; however,

[11] *Ibid*. https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf, pp. 38181.

rehabilitation therapists have no control over when the patient sees the therapist in the course of their condition. Until they are able to initiate timely intervention, inclusion in the total cost of care calculation is premature. This is yet another reason why Medicare should facilitate physical therapists to be the entry point to care for Medicare beneficiaries with musculoskeletal conditions. Fundamentally, PPS wants to ensure that private practice physical therapists are not set up for failure by an inability to achieve the maximum number of points if they must be evaluated in each category (regardless of relevance).

Submission Mechanisms

After reviewing the comments to the Request for Information, CMS did not propose creating a new MIPS eligible clinician identifier. The Agency proposes to use a combination of billing TIN/NPI as the identifier to assess performance of an individual MIPS eligible clinician. Similar to PQRS, each unique TIN/NPI combination would be considered a different MIPS eligible clinician, and MIPS performance would be assessed separately for each TIN under which an individual bills.[12] Furthermore, CMS proposes multiple data submission mechanisms for MIPS to provide MIPS eligible clinicians with flexibility to submit their MIPS measures and activities in a manner that best accommodates the characteristics of their practice.[13] The individual reporting data submission mechanisms include claims, qualified clinical data registries (QCDRs), qualified registries, EHRs, and administrative claims (with no submission required).[14]

PPS Comment:
PPS supports the proposed rule's use of a combination of billing TIN/NPI as the identifier to assess performance of an individual MIPS eligible clinician. Claims-based reporting is highly utilized by physical therapists, and should be maintained. To make the submission process user-friendly, especially for small practices, more choices are better than fewer choices.

Timely Feedback

Under section 1848(q)(12)(A)(i) of the Act, as added by section 101(c)(1) of MACRA, CMS is required to provide MIPS eligible clinicians with timely (such as quarterly) confidential feedback on their performance under the quality and resource use performance categories beginning July 1, 2017. The law grants CMS discretion to provide such feedback regarding the advancing care information and CPIA performance categories. Within the quality and cost performance categories, CMS proposes to use fields similar to those currently available in the Quality and Resource Use Reports (QRURs). Because the first performance feedback, required in July 2017 would be based on historic data set(s) CMS proposes to provide performance feedback on an annual basis at first, taking a few years to work towards quarterly performance feedback.[15]

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[12] *Ibid*. https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf, pp. 38177.
[13] *Ibid*. https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf, pp. 28181- 28182.
[14] *Ibid*. https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf, pp. 28182.
[15] *Ibid*. https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf, pp. 28277.

PPS Comment:
While PPS appreciates CMS' goal of quarterly performance feedback and has long encouraged the Agency to develop timely, actionable feedback reports for providers. We encourage CMS to provide feedback reports to all clinicians reporting in MIPS, including those who are not formally included in the program. We also suggest that feedback reported on less than a quarterly basis is insufficiently timely for business, patient, and clinical management purposes. Historically, the feedback reports for claims-based reporting have been significantly delayed and this lag time must be shortened. Ideally, timely feedback would be given no later than six weeks from the last date for data submission for that time period. Without regular feedback, quality improvement cannot be achieved. As the goal of the MIPS program is to improve the quality of patient care, regular and timely feedback is an essential component of success.

Advanced Alternative Payment Model (APM)

Thanks to new tools created by the Affordable Care Act, increasing numbers of Medicare clinicians are participating in alternative payment models (APMs). Building on the ACA, the MACRA legislation created additional rewards for Medicare clinicians who participate to a sufficient extent in Advanced APMs. To be an Advanced APM, an APM through its payment entity must also meet all three MACRA criteria (section 1833(z) (3) (D) of the Act). The Advanced APM must: 1. Require participants to use certified electronic health record technology (CEHRT); 2. Provide for payment for covered professional services based on quality measures comparable to those in MIPS; and 3. Require that the participating APM entities bear more than nominal financial risk for monetary losses under the APM or that the APM be a medical home expanded under CMS Innovation Center authority (Section 1115A of the Act). Those clinicians would be exempt from MIPS reporting requirements and qualify for financial bonuses. Many clinicians who participate to some extent in APMs may not meet the law's requirements for sufficient participation in the most advanced models. The proposed rule is designed to provide these clinicians with financial rewards within MIPS, as well as to make it easy for clinicians to switch between the components of the Quality Payment Program based on what works best for them and their patients. CMS expects that the number of clinicians who qualify as participating in Advanced APMs will grow as the program matures.

Section 101(e)(1) of MACRA adds a new section 1868(c) to the Act which establishes the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and sets forth requirements for criteria and a process for stakeholders to propose physician-focused payment models (PFPMs) for review by the PTAC. This entity will have significant influence on the certification and creation of new APMs by CMS.

PPS Comment:
While PPS supports CMS' goal of providing flexibility to providers seeking new models through which to provide quality care, PPS has concerns that CMS has narrowly defined Advanced APMs in a manner that inhibits participation by specialty and non-physician providers to the point of effectively barring them from the program. Under the proposed rule, non-physician providers are not allowed to create an Advanced APM; they can participate only if an Advanced APM decides to contract with them. Additionally, the Advanced APM owners may have their own non-physician services (conflict of interest), and/or contract with a limited number of providers, thereby not allowing an opportunity for

the eligible clinician to participate in one or more Advanced APMs even if they desire to do so. As a result, non-physician providers, such as independent physical therapists, have very little or no control over whether they are part of an Advanced APM; therefore PPS urges CMS to create APM pathways under the Center for Medicare & Medicaid Innovation and through the Physician Focused Payment Model technical advisory committee that will allow physical therapy practices and other therapy providers to be the main conveners of an approved APM.

Additionally, PPS urges CMS to recognize the vital role that rehabilitation therapists can play in ensuring that APMs provide access to and deliver quality care to Medicare beneficiaries. While CMS has made progress by promulgating models under section 1115A, there are a number of models that require significant modifications if a seamless, integrated model of care is to be achieved. APMs should provide the appropriate safeguards and operational details that are needed to create a comprehensive program that is quality-driven, inclusive of all medically necessary services, fosters patient choice, substantially mitigates abusive and fraudulent behavior, and is transparent in its legal and organizational structure.

Likewise, PPS suggests CMS establish requirements for network adequacy that ensure the availability of sufficient type and location of health services to meet the needs of the patient population served by the APM. CMS should require APM to demonstrate that essential services such as physical, occupational, and speech language therapy are provided within the APM or that the APM has the appropriate referral relationships in place to enable patients to choose the provider of their choice and conveniently access these services—perhaps outside of the APM. APMs should be obligated to demonstrate compliance with this requirement prior to approval of the entity as an APM.

PPS remains concerned about the myopic focus on physician services. While we believe that physician care is an essential part of the APM model, it should not be the sole focus. PPS strongly encourages CMS to certify more existing models as Advanced APMs such as the Comprehensive Care for Joint Replacement Model (CJR) and Bundled Payments for Care Improvement Initiative (BPCI) that would allow for increased applicability and the participation of more types of providers. APMs should also assess and measure the quality and cost of non-physician services such as physical therapy. It is our sincere hope that the PTAC and CMS will not focus exclusively on physician and specialty physician APMs, but that the scope of models considered by the PTAC will also take the participation of non-physician providers such as physical therapists into consideration. Moreover, PPS urges the Agency to broaden its scope of APM criteria and to require specialty services such as rehabilitation services (physical, occupational and speech language therapies) within the APM.

While PPS encourages its members to adopt EHRs, the cost of acquisition, implementation, and maintenance of an EHR is a significant barrier to adoption—particularly for small, independent practices. Under current law, physical and occupational therapists are not required, supported nor incentivized, to have or use an EHR system. Echoing our concerns with regards to Advancing Care Information in the quality reporting measures, PPS encourages the Agency to revise the current criteria for Advanced APMs to waive of this requirement for providers who were not previously included under EHR Meaningful Use. Should CMS determine that it is necessary to have all Advanced APM participants use an EHR, PPS suggests that, prior to establishing such a requirement, the Agency

would provide appropriate resources and support to be furnished by the federal government for physical therapists to adopt interoperable EHRs that are necessary to communicate and coordinate care with other APM participants and professionals as well as the gradual phase-in of EHR requirements in a manner similar to that which was granted to physicians when the Meaningful Use program began. Non-physician groups such as rehabilitation therapists are insufficiently familiar with electronic health record systems and requirements, and therefore will need time to adapt to these policies; non-physician providers should be afforded the same time and consideration physicians received with respect to transitioning to EHR. Such an approach would give non-physician provider groups needed time to prepare to use EHR, especially in the context of participation in an Advanced APM.

Conclusion

PPS thanks CMS for the opportunity to provide these comments on the proposed rule for the implementation of MIPS and Advanced APMs. Private practice physical therapists are committed to providing care to Medicare beneficiaries while participating in quality improvement programs and APMs. PPS is committed to meaningful and effective innovation in the Medicare program and pledges to continue its cooperation and collaboration with CMS. If you have any questions regarding our comments, please contact Jerry Connolly at jerryconnolly@msn.com or Alpha Lillstrom Cheng at alpha@lillstrom.com. We look forward to more opportunities to partner with CMS in pursuit of these goals for the Medicare program. Thank you for your time and consideration.

Sincerely,

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