

November 17, 2015

Andrew Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
9500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-3321-NC

Dear Acting Administrator Slavitt:

The Private Practice Section (PPS) of the American Physical Therapy Association (APTA) respectfully submits these comments on CMS-3321-NC the CMS Request for Information regarding “Implementation of the Merit-based Incentive Payment System (MIPS), Promotion of Alternative Payment Models (APMs), and Incentive Payments for Participation in Eligible Alternative Payment Models”, published in the October 1, 2015 *Federal Register*.

The PPS is the Private Practice Section of the 90,000 member American Physical Therapy Association. Our 4,300 members are physical therapists who are primarily the owners or partners in independent private practice across the nation. Their patient-focused clinics are conveniently located throughout the community where therapists and patients form a bond over the course of treatment.

This request for information will influence the implementation of the merit-based incentive payment system, alternative payment models, and incentive payments for participation in eligible alternative payment models, which will impact outpatient physical therapists in private practice. Therefore, the implementation of these programs will have a substantial impact on rehabilitation therapy professionals well into the future.

Our comments (**shown throughout in bold**) pertain only to those issues or questions on which we have standing.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L.114-10) repeals the sustainable growth rate (SGR) formula for updating Medicare physician fee schedule (PFS) payment rates and establishes a new methodology that ties annual PFS payment adjustments to value through a Merit-Based Incentive Payment System (MIPS) for MIPS eligible professionals (MIPS EPs). MACRA also creates an incentive program to encourage participation by eligible professionals (EPs) in Alternative Payment Models (APMs).

MACRA requires establishment of the MIPS applicable beginning with payments for items and services furnished on or after January 1, 2019, under which the Secretary is required to: (1) Develop a methodology for assessing the total performance of each MIPS EP according to performance standards for a performance period for a year; (2) using the methodology, provide for a composite performance score for each MIPS EP for each performance period; and (3) use the composite performance score of the MIPS EP for a performance period for a year to determine and apply a MIPS adjustment factor (and, as applicable, an additional MIPS adjustment factor) to the MIPS EP for the year.

Under the Act, a MIPS EP's composite performance score is determined using four performance categories:

- Quality;
- resource use;
- clinical practice improvement activities; and
- meaningful use of certified EHR technology (CEHRT).

The Act defines a MIPS EP for the first 2 years as a physician (as defined in section 1861(r) of the Act), a physician assistant (PA), nurse practitioner (NP) and clinical nurse specialist (CNS) (as those are defined in section 1861(aa)(5) of the Act), a certified registered nurse anesthetist (CRNA) (as defined in section 1861(bb)(2) of the Act), and a group that includes such professionals. Beginning with the third year of the program and for succeeding years, the statute defines a MIPS EP to include all the types of professionals identified for the first 2 years. It also gives the Secretary discretion to specify additional EPs, as that term is defined in section 1848(k)(3)(B) of the Act, which could include a certified nurse midwife (as defined in section 1861(gg)(2) of the Act), a clinical social worker (as defined in section 1861(hh)(1) of the Act), a clinical psychologist (as defined by the Secretary for purposes of section 1861(ii) of the Act), a registered dietician or nutrition professional, a physical or occupational therapist, a qualified speech-language pathologist, or a qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

The Merit-Based Incentive Payment System (MIPS)

PPS Comment: PPS notes that there is a two-year gap in the applicability of the program to physical therapists and this inherently prohibits therapists from being incentivized or rewarded for their contributions to quality or outcomes. This means that, as the SGR formula is replaced, there is no mechanism, until year 3 at the earliest, by which physical therapists can receive any kind of bonus or incentive payment. PPS urges CMS to take every action possible, including supporting legislation if necessary, to remedy this fundamental unfairness.

CMS seeks comment on what specific identifier(s) should be used to appropriately identify MIPS EPs for purposes of determining eligibility, participation, and

performance under the MIPS performance categories. The questions on which they seek comment include:

RFI: Should we (CMS) use a MIPS EP's TIN, NPI or a combination thereof? Should we create a distinct MIPS Identifier?

PPS Comment: We believe a combination makes sense based on our answers below. There are already too many identifiers and PPS members do not want a new identifier to apply for and keep track of. The use of the individual NPI number and practice TIN, as used in PQRS, works well and a new identifier is not needed. Obtaining new numbers has been shown to cause delays in patient treatment. The only instance in which CMS should consider developing a new identifier is to track services delivered pursuant to the in-office ancillary services exception.

RFI: What are the advantages/disadvantages associated with using existing identifiers, either individually or in combination?

PPS Comment: An advantage to the individual NPI/TIN combination, as used in PQRS, is that a practice is not penalized for something that an EP did at a previous practice location.

RFI: What are the advantages/disadvantages associated with creating a distinct MIPS identifier?

PPS Comment: PPS strongly opposes additional burdens on our clinicians that distract from the primary purpose of delivering high-quality therapy care to their patients. Creating a distinct MIPS identifier is unnecessary.

RFI: Should a different identifier be used to reflect eligibility, participation, or performance as a group practice vs. as an individual MIPS EP?

PPS Comment: Using the group NPI number with or without the TIN is sufficient to identify the practice as opposed to the EP.

RFI: How should we calculate performance for MIPS EPs that practice under multiple TINs?

PPS Comment: Calculation should be done the same way it is done now for PQRS – by a combination of individual NPI number and TIN.

RFI: Should practitioners in a virtual group and virtual group practices have a unique virtual group identifier that is used in addition to the TIN?

PPS Comment: The RFI indicates that the virtual group is a combination of TINs, which we presume to mean the TINs of the various participants in the virtual group. That being the case, then the virtual group needs its own identifier while the practices can be identified by TIN and EPs identified by NPI.

RFI: How often should we require an EP or group practice to update any such identifier(s) within the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)? For example, should EPs be required to update their information in PECOS or a similar system that would pertain to the MIPS on an annual basis?

PPS Comment: Updates should only be required when changes warrant.

RFI: What safeguards should be in place to ensure that MIPS EPs do not switch identifiers if they are considered “poor- performing”?

PPS Comment: PPS doubts that this is an issue. If an EP (identified by NPI) is performing poorly in one practice/TIN, switching practices/TINs would either improve their performance because they went somewhere else with a better program, or it would have no impact on their performance because they just switched TINs and they’d still perform poorly. Thus, complicated safeguards do not seem necessary.

Virtual Groups

Section 1848(q)(5)(I) of the Act requires the Secretary to establish a process to allow an individual MIPS EP or a group practice of not more than 10 MIPS EPs to elect for a performance period for a year to be a virtual group with other such MIPS EPs or group practices. CMS quality programs, such as the PQRS, have used common identifiers such as a group practice’s TIN to assess individual EPs’ quality together as a group practice. The virtual group option under the MIPS allows a group’s performance to be tied together even if the EPs in the group do not share the same TIN. CMS seeks comment on what parameters should be established for these virtual groups.

The questions on which CMS seeks comment include:

RFI: How should eligibility, participation, and performance be assessed under the MIPS for voluntary virtual groups? Assuming that some, but not all, members of a TIN could elect to join a virtual group, how should remaining members of the TIN be treated under the MIPS, if we allow TINs to split? Should there be a maximum or a minimum size for virtual groups? For example, should there be limitations on the size of a virtual group, such as a minimum of 10 MIPS EPs, or no more than 100 MIPS EPs that can elect to be in a given virtual group? Should there be a limit placed on the number of virtual group elections that can be made for a particular performance period for a year as this provision is rolled out? We are considering limiting the number of voluntary virtual groups to no more than 100 for the first year this provision is implemented in order for CMS to gain experience with this new reporting configuration. Are there other criteria we should consider? Should we limit for virtual groups the mechanisms by which data can be reported under the quality performance category to specific methods such as QCDRs or utilizing the Web interface? If a limit is placed on the number of virtual group elections within a performance period, should this be done on a first-come, first-served basis? Should limits be placed on the size of virtual groups or the number of groups? Under the

voluntary virtual group election process, what type of information should be required in order to make the election for a performance period for a year? What other requirements would be appropriate for the voluntary virtual group election process?

PPS Comment: Full comprehension of the rationale and benefits of a virtual group is difficult. With that said, PPS believes that if there is an inherent advantage for a large group (over a small group), then yes, there should be a limit. PPS believes that since there is considerable unknown terrain as this program is initially implemented, it is prudent to begin with limits to allow for careful assessment of the virtual group concept. CMS should consider allowing a certain number of various sizes and placed a limit on the number of groups until the virtual group concept has been thoroughly evaluated.

RFI: Should there be limitations, such as that MIPS EPs electing a virtual group must be located within a specific 50 mile radius or within close proximity of each other and be part of the same specialty?

PPS Comment: Knowing that there may be major differences between (and in some cases, within) states, PPS believes a limit on distance is necessary. Moreover, in order to accurately evaluate a virtual group, at least initially, they must be comprised of the same specialty.

Quality Performance Category

The Act describes the measures and activities for the quality performance category under the MIPS. It requires the Secretary by November 1 of the year before the first day of each performance period (calendar year) under the MIPS, establish the list of quality measures from which MIPS EPs may choose for purposes of assessment for a performance period for a year. CMS' experience under other quality programs, namely the PQRS and the VM, will help shape processes and policies for this performance category.

Reporting Mechanisms Available for Quality Performance Category

There are two ways EPs can report under the PQRS, as either an individual EP or as part of a group practice, and for reporting periods that occur during 2015, there are collectively 7 available mechanisms to report data to CMS as an individual EP and as a group practice participating in the PQRS GPRO. They are:

- Claims-based reporting;
- Qualified registry reporting;
- QCDR reporting;
- Direct EHR products;
- EHR data submission vendor products;
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS;

- GPRO Web Interface.

Generally, to avoid the PQRs payment adjustment, EPs and group practices are required to report for the applicable reporting period on a specified number of measures covering a specified number of National Quality Strategy domains. If data are submitted on fewer measures than required, an EP is subject to a Measure Applicability Validation (MAV) process, which looks across an EP's services to determine if other quality measures could have been reported.

The questions to which CMS seeks comment include:

RFI: Should we maintain all PQRs reporting mechanisms noted above under MIPS? If so, what policies should be in place for determining which data should be used to calculate a MIPS EP's quality score if data are received via multiple methods of submission? What considerations should be made to ensure a patient's data are not counted multiple times? For example, if the same measure is reported through different reporting mechanisms, the same patient could be reported multiple times.

PPS Comment: Claims-based reporting is highly utilized by EPs, and should be maintained. However, the feedback reports for claims-based reporting are significantly delayed and this lag time must be shortened. Presumably the patients have a unique identifier or combination of identifiers that CMS is using now, or should be using now to address this issue under PQRs. It does not seem a new one is required. If one is not being used, then it would seem that if data are submitted for an EP through various methods, then patient identifiers need to be compared with the various methods. And, if this is not a problem with PQRs now, we don't see why would it be with MIPS? Reporting mechanisms should not be reduced unless one is not being used. To make the submission process user-friendly, especially for small practices, more choices are better than fewer choices. Otherwise, the bonus will be made less attractive by the cost of reporting and thus less of an incentive.

Seemingly, the data being reported would be accompanied by a specific patient number or identifier, this should allow a computerized cross referencing to ensure that data is not reported multiple times.

RFI: Should we maintain the same or similar reporting criteria under MIPS as under the PQRs? What is the appropriate number of measures on which a MIPS EP's performance should be based?

PPS Comment: Fewer measures, and those that are directly pertinent and applicable to the type of EP and practice focus, should be required rather than the number that are currently required by PQRs. Otherwise, it is (a) an exercise in paper-pushing and box checking that is of little value to the patient and (b) for particular EPs (like PTs) 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. In addition, some of the information PTs 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+.

RFI: Should we maintain the policy that measures cover a specified number of National Quality Strategy domains?

PPS Comment: PPS believes a more valuable focus would be on measures that are directly pertinent to the type of EP and practice, rather than NQS. Valid, reliable and responsive functional outcomes measures represent the most important domain and they are patient-centric and measure the effect of treatment.

RFI: Should we require that certain types of measures be reported? For example, should a minimum number of measures be outcomes-based? Should more weight be assigned to outcomes-based measures?

PPS Comment: We support the use of outcomes-based measures that are applicable to the EP and practice and we believe outcomes measures should be given more weight. Additionally, if these outcomes measures are used, we believe that a fewer number of measures should be required and/or that outcomes measures are sufficient by themselves. PTs are already participating in Functional Limitation Reporting (FLR), and CMS should take this into account when determining the number of measures and the methods for including PTs in MIPS.

RFI: How do we apply the quality performance category to MIPS EPs that are in specialties that may not have enough measures to meet our defined criteria? Should we maintain a Measure-Applicability Verification (MAV) Process?

PPS Comment: Yes, a Measure-Applicability Verification (MAV) Process should be maintained.

RFI: If we customize the performance requirements for certain types of MIPS EPs, how should we go about identifying the MIPS EPs to whom specific requirements apply?

PPS Comment: We believe the only way to identify the MIPS EPs to whom specific requirements apply is to ask the stakeholders.

Data Accuracy

RFI: CMS' experience under the PQRS has shown that data quality is related to the mechanism selected for reporting. Some potential data quality issues specific to reporting via a qualified registry, QCDR, and/or certified EHR technology include inaccurate TIN and/or NPI, inaccurate or incomplete calculations of quality measures, missing data elements, etc. Since accuracy of the data is critical to the accurate calculation of a MIPS composite score, CMS seeks comment on what additional data

integrity requirements should be in place for the reporting mechanisms referenced above. Specifically: If CMS determines that the MIPS EP (participating as an individual EP or as part of a group practice or virtual group) has used a data reporting mechanism that does not meet our data integrity standards, how should CMS assess the MIPS EP when calculating their quality performance category score? Should there be any consequences for the qualified registry, QCDR or EHR vendor in order to correct future practices? Should the qualified registry, QCDR or EHR vendor be disqualified or unable to participate in future performance periods? What consequences should there be for MIPS EPs?

PPS Comment: If CMS has approved the QCDR or EHR, there should be no penalties for the EPs as PPS believes that EPs should be able to rely on CMS' approval of registries and EHRs and take it as assurance that they can submit data correctly on behalf of the EP. The EPs should be notified as soon as CMS knows there is an issue, so the EP can find another submission mechanism if needed. Instead of focusing on penalties or consequences, PPS urges the Agency to explore an educational process that would help EPs comply with the complicated requirements.

Resource Use Performance Category

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, accounting for the cost of drugs under Part D.” Section 1848(p)(3) of the Act specifies that costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs for purposes of the VM under the PFS. Section 1848(r) of the Act (as added by section 101(f) of the 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 the 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. CMS' experience under the VM will help shape this performance category.

RFI: How should we apply the resource use category to MIPS EPs for whom there may not be applicable resource use measures?

PPS Comment: It should not be counted in the calculation, as it is in the PQRS MAV.

In addition, PPS strongly believes that at this time therapists are not in a position to have their performance evaluated on the total cost of care. Presently, sufficient accurate data are not available to implement such a concept. However, we do note that numerous studies do appear in

the literature that 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. PTs have no control over when the patient sees the therapist in the course of their condition. Until they do, inclusion in the total cost of care calculation is premature. The above is another reason why Medicare should facilitate physical therapists to be the entry point to care for Medicare beneficiaries with musculoskeletal conditions.

Clinical Practice Improvement Activities Performance Category

The Act specifies that the measures and activities for the clinical practice improvement activities performance category must include at least the following subcategories of activities:

- Expanded practice access;
- population management;
- care coordination;
- beneficiary engagement;
- patient safety and practice assessment; and
- participation in an APM.

RFI: CMS seeks comment on other potential clinical practice improvement (CPI) activities (and subcategories of activities), and on the criteria that should be applicable for all clinical practice improvement activities. The Agency also seeks comment on the following subcategories, in particular how measures or other demonstrations of activity may be validated and evaluated:

- A subcategory of Promoting Health Equity and Continuity, including:
 - (a) serving Medicaid beneficiaries, including individuals dually eligible for Medicaid and Medicare,
 - (b) accepting new Medicaid beneficiaries,
 - (c) participating in the network of plans in the Federally-facilitated Marketplace or state exchanges, and
 - (d) maintaining adequate equipment and other accommodations (for example, wheelchair access, accessible exam tables, lifts, scales, etc.) to provide comprehensive care for patients with disabilities.
- A subcategory of Social and Community Involvement, such as measuring completed referrals to community and social services or evidence of partnerships and collaboration with the community and social services.
- A subcategory of Achieving Health Equity, as its own category or as a multiplier where the achievement of high quality in traditional areas is rewarded at a more favorable rate for EPs that achieve high quality for underserved populations, including persons with behavioral health conditions, racial and ethnic minorities,

sexual and gender minorities, people with disabilities, and people living in rural areas, and people in HPSAs.

- A subcategory of emergency preparedness and response, such as measuring EP participation in the Medical Reserve Corps, measuring registration in the Emergency System for Advance Registration of Volunteer Health Professionals, measuring relevant reserve and active duty military EP activities, and measuring EP volunteer participation in humanitarian medical relief work.
- A subcategory of integration of primary care and behavioral health, such as measuring or evaluating such practices as: co-location of behavioral health and primary care services; shared/integrated behavioral health and primary care records; cross-training of EPs.

PPS Comment: PPS believes that the clinical practice improvement (CPI) categories and subcategories posited in the RFI are largely inapplicable as *improvement* activities for private practice physical therapists. For example, (1) because of circumstances and the locus of control beyond the influence of PTs in private practice, therapists may not be allowed to participate in the network of plans in the Federally-facilitated Marketplace or state exchanges; and (2) maintaining adequate equipment and other accommodations to provide comprehensive care for patients with disabilities is what our members do because that is the clientele we serve. Moreover, it is difficult to comprehend how “maintaining” something can be characterized as an “improvement.”

PPS also disagrees with a subcategory of Promoting Health Equity and Continuity that is characterized by serving Medicaid beneficiaries. The numerous and disparate state requirements for coverage of these patients, and the reimbursement that is below the cost of providing care for many therapy clinics, renders it a counterintuitive business decision to enroll/treat Medicaid patients.

For the above reasons (and several more can be cited), PPS urges CMS to engage physical therapist and other nonphysicians in developing appropriate and applicable clinical practice improvement activities for this sector and the corresponding benchmarks by which performance will be measured.

RFI: Should EPs be required to attest directly to CMS through a registration system, Web portal or other means that they have met the required activities and to specify which activities on the list they have met? Or alternatively, should qualified registries, QCDRs, EHRs, or other health IT systems be able to transmit results of the activities to CMS?

PPS Comment: Qualified registries, QCDRs, EHRs, or other health IT systems should transmit results of the activities to CMS. If for whatever reason this is not available through that mechanism, CMS should create a Web portal.

RFI: How often providers should report or attest that they have met the required activities?

PPS Comment: Once annually or biennially should be sufficient. But this could be less frequently (i.e., a longer period) if another certification or competency is the CPI activity accepted. For example, if maintenance of specialty board certification is recognized, then the frequency of reporting should coincide with the duration of the maintenance requirement. Likewise, if the EP achieves recognition or certification in a patient or practice related service, this, too, should be recognized in accordance with the requirements of such certification.

RFI: What threshold or quantity of activities should be established under the clinical practice improvement activities performance category? How should the clinical practice improvement activities performance category be applied to EPs practicing in these types of small practices or rural areas? Should a lower performance threshold or different measures be established that will better allow those EPs to reach the payment threshold?

PPS Comment: A lower performance threshold or different measures should be established that will better allow those EPs to reach the payment threshold.

Development of Performance Standards

RFI: The Act requires the Secretary, in establishing performance standards with respect to measures and activities for the MIPS performance categories, to consider: historical performance standards, improvement, and the opportunity for continued improvement. CMS seeks comment on the following questions:

PPS Comment: PPS believes that all EPs should be able to attain the standards. Moreover, standards should not be based on rankings that pit providers against one another as this creates “winners” and “losers.” Objective benchmarks should be used. If an EP is already performing at a high level, or attains a high level by meeting the benchmarks, the EP should not be disqualified from receiving bonus payments because they cease to “improve.” Conversely, EPs who don’t hit the benchmarks, but make significant improvement toward the benchmarks from where they started, should be rewarded. Benchmarks should take into account pertinent characteristics of EPs when they vary widely in practice settings. The correct answers to several specific questions in this section depend on what the standards/benchmarks are. In other words, benchmarks should be standard specific. Finally, when setting standards/benchmarks, severity and comorbidities should be taken into account.

RFI: Which specific historical performance standards should be used? For example, for the quality and resource use performance categories, how should CMS select quality and cost benchmarks? Should CMS use providers’ historical quality and cost performance benchmarks and/or thresholds from the most recent year feasible prior to the commencement of MIPS? Should performance standards be stratified by group size or

other criteria? Should we use a model similar to the performance standards established under the VM?

PPS Comment: Because of the rapid pace at which healthcare is changing, it is difficult to rely on historical data, especially for outpatient providers. A case in point is shorter hospital stays which result in patients presenting to outpatient PT clinics in more acute conditions thus requiring increased services.

RFI: How would different approaches to defining the baseline period for measuring improvement affect EPs' incentives to increase quality performance? Would periodically updating the baseline period penalize EPs who increase performance by holding them to a higher standard in future performance periods, thereby undermining the incentive to improve? Could assessing improvement relative to a fixed baseline period avoid this problem? If so, would this approach have other consequences CMS should consider?

PPS Comment: Baseline periods should only be updated when there is a compelling reason to do so. They should not be updated frequently, or just in the interest of change. PPS urges CMS to use caution when setting (and updating) baselines to avoid creating the effect that the reward is just always beyond achievement.

RFI: Should CMS consider improvement at the measure level, performance category level (that is, quality, clinical practice improvement activity, resource use, and meaningful use of certified EHR technology), or at the composite performance score level?

PPS Comment: Improvement should be measured at the category level and EPs who are not obligated under meaningful use for electronic health records should be exempt from that category.

RFI: Should improvements in health equity and the reductions of health disparities be considered in the definition of improvement? If so, how should CMS incorporate health equity into the formula?

PPS Comment: Improvements in health equity and the reductions of health disparities should NOT be considered in the definition of improvement.

Feedback Reports

The Act requires the Secretary, beginning July 1, 2017, to provide confidential feedback on performance to MIPS EPs. Specifically, CMS is required to make available timely confidential feedback to MIPS EPs on their performance in the quality and resource use performance categories, and CMS has discretion to make available confidential feedback to MIPS EPs on their performance in the clinical practice improvement activities and meaningful use of certified EHR technology performance categories. This feedback can be provided through various mechanisms, including the use of a Web-based portal or other mechanisms determined appropriate by the Secretary.

CMS poses the following questions for comment:

RFI: What types of information should we provide to EPs about their practice's performance within the feedback report? For example, what level of detail on performance within the performance categories will be beneficial to practices? Would it be beneficial for EPs to receive feedback information related to the clinical practice improvement activities and meaningful use of certified EHR technology performance categories? If so, what types of feedback?

PPS Comment: The lowest level of detail that CMS can provide will be the most useful, e.g., per EP, per measure. In addition to being useful (meaningful and easily understood) they must be sufficiently timely to enable EPs to make adjustments and improvements.

RFI: What other mechanisms should be leveraged to make feedback reports available? Currently, CMS provides feedback reports for the PQRS, VM, and the Physician Feedback Program through a Web-based portal. Should CMS continue to make feedback available through this portal?

PPS Comment: A Web-based portal is optimal. It must be easily accessed and meaningful information. The feedback reports must be *actionable*, that is clearly linked to standards in a real way that enables EPs to put the information to work to improve patient care.

RFI: How should CMS work with partners to enable feedback reporting to incorporate information from other payers, and what types of information should be incorporated? Who within the EP's practice should be able to access the reports? For example, currently under the VM, only the authorized group practice representative and/or their designees can access the feedback reports. Should other entities be able to access the feedback reports, such as an organization providing MIPS-focused technical assistance, another provider participating in the same virtual group, or a third party data intermediary who is submits data to CMS on behalf of the EP, group practice, or virtual group?

PPS Comment: All EPs should be able to access their own data. If the EP or group practice representative authorizes another party to examine the data, that party should be permitted to do so.

RFI: With what frequency is it beneficial for an EP to receive feedback? Currently, CMS provides Annual Quality and Resource Use Reports (QRUR), mid-year QRURs and supplemental QRURs. Should we continue to provide feedback to MIPS EPs on this cycle? Would there be value in receiving interim reports based on rolling performance periods to make illustrative calculations about the EP's performance? Are there certain performance categories on which it would be more important to receive interim feedback than others? What information that is currently contained within the QRURs should be included?

PPS Comment: Ideally feedback should be in real time if the patient care improvement (in efficiency and effectiveness) is to be achieved. Short of that, the

more frequent the feedback the better. In short, feedback that is reported less than on a quarterly basis is insufficiently timely for business, patient, and clinical management purposes. Moreover, feedback must be timely, that is, given no later than six weeks from the last date for data submission for that time period.

RFI: Should the reports include data that is stratified by race, ethnicity and gender to monitor trends and address gaps towards health equity? What types of information about items and services furnished to the EP's patients by other providers would be useful? In what format and with what frequency?

PPS Comment: PPS believes that real-time quality feedback reports are essential if an incentive program is to be meaningful and effective. It is our belief that CMS should provide feedback reports through a Web-based portal as is done presently for measures that are calculated using claims-based data. However, more detailed feedback reports are necessary for providers to determine the reasons for any deficits in their performance reporting.

Additionally, PPS urges CMS to work with registries and EHR vendors who will be providing feedback reports to EPs in the MIPS program in order to standardize and streamline feedback reports in the future.

Public Reporting

CMS also seeks comment on what should be the minimum threshold used for publicly reporting MIPS measures and activities for all of the MIPS performance categories on the Physician Compare Web site.

In the CY 2016 PFS proposed rule (80FR 41809), CMS indicated that it will continue using a minimum 20 patient threshold for public reporting through Physician Compare of quality measures (in addition to assessing the reliability, validity and accuracy of the measures). An alternative to a minimum patient threshold for public reporting would be to use a minimum reliability threshold. CMS seeks comment on both concepts in regard to public reporting of MIPS quality measures on the Physician Compare Web site as well as comment on the following:

RFI: Should CMS include individual EP and group practice-level quality measure data stratified by race, ethnicity and gender in public reporting (if statistically appropriate)?

PPS Comment: PPS supports the public reporting of participation of those providers that meet the successful reporting requirements as an initial step. And we join other stakeholders in recommending that CMS not publish MIPS data in the initial few years of the program. We believe that the reporting of performance data should follow in later years to allow for proper analysis and benchmarking in MIPS and to ensure its usability by consumers.

PPS supports the minimum threshold used for public reporting of MIPS measures. We also support the stratification of quality data when appropriate. But we caution that stratification could result in small sample sizes impacting the data's validity and statistical significance. For this reason, reporting stratified data publicly may be confusing to consumers.

Flexibility in Weighting Performance Categories

The Act requires the Secretary, if there are not sufficient measures and activities applicable and available to each type of EP, to assign different scoring weights (including a weight of zero) from those that apply generally under the MIPS. CMS seeks comment on the following questions:

RFI: Are there situations where certain EPs should not be assessed at all for purposes of a particular performance category?

PPS Comment: Yes

RFI: Should it be evenly distributed across the remaining performance categories?

PPS Comment: Yes

RFI: Generally, what methodologies should be used as we determine whether there are not sufficient measures and activities applicable and available to types of EPs such that the weight for a given performance category should be modified or should not apply to an EP? Should this be based on an EP's specialty?

PPS Comment: Yes, if there are not sufficient measures and activities applicable and available to types of EPs, the weight for a given performance category should be modified or should not apply to an EP. This should be based on an EP's specialty, and practice type.

RFI: Should this determination occur at the measure or activity level, or separately at the specialty level?

PPS Comment: It could occur at both as needed.

RFI: What case minimum threshold should CMS consider for the different performance categories?

PPS Comment: The EP should have at least 50 applicable cases per year to be measured on a category.

RFI: How should we assess performance on each of the 4 performance categories and combine the assessments to determine a composite performance score? For the quality and resource use performance categories, should we use a methodology (for example, equal weighting of quality and resource use measures across National Quality Strategy

domains) similar to what is currently used for the VM? How should we use the existing data on quality measures and resource use measures to translate the data into a performance threshold for the first two years of the program?

PPS Comment: Without knowing what measures are being utilized, it is difficult to answer these questions with any degree of certainty. Measure owner input on the thresholds for specific measures is required. PPS would object to any weighting that cannot be uniformly applied to all EPs. In other words, criteria that only apply to MDs, cannot be weighted more heavily than those that apply to nonphysicians.

RFI: What minimum case size thresholds should be utilized? For example, should we leverage all data that is reported even if the denominators are small? Or should we employ a minimum patient threshold, such as a minimum of 20 patients, for each measure?

PPS Comment: We believe CMS should use a minimum of 50 cases. This means that the EP is seeing at least one applicable patient per week, and this will minimize “cherry-picking.”

Payment Incentive for APM Participation

RFI: To help establish criteria and a process for determining whether an EP is a QP or partial QP, this RFI requests information on issues such as: How should CMS define “services furnished under this part through an EAPM entity”? What policies should the Secretary consider for calculating incentive payments for APM participation when the prior period payments were made to an EAPM entity rather than directly to a QP, for example, if payments were made to a physician group practice or an ACO? What are the advantages and disadvantages of those policies? What are the effects of those policies on different types of EPs (that is, those in physician-focused APMs versus hospital-focused APMs, etc.)? How should CMS consider payments made to EPs who participate in more than one APM? What policies should the Secretary consider related to estimating the aggregate payment amounts when payments are made on a basis other than fee-for-service (that is, if payments were made on a capitated basis)? What are the advantages and disadvantages of those policies? What are their effects on different types of EPs (that is, those in physician-focused APMs versus hospital-focused APMs, etc.)? What types of data and information can EPs submit to CMS for purposes of determining whether they meet the non-Medicare share of the Combination All-Payer and Medicare Payment Threshold, and how can they be securely shared with the federal government?

PPS Comment: Non-physician providers, such as independent physical therapists, have very little or no control over whether they are part of an EAPM. Under the criteria above, they are not allowed to create an EAPM, so they can participate only if an EAPM decides to contract with them. The EAPM 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 EP to participate in one or more EAPMs even if they desire to. Therefore, the non-physician EP should not be penalized here. CMS should exempt

non-physician providers from this requirement (we note that “physician” is in the name of this program, not “provider”).

In addition, PPS strongly urges CMS to recognize the vital role that rehabilitation therapists 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.

To this end, all providers participating in the APM should participate in the APM’s governance. Meaningful participation by each provider is critical to the overall success of the APM. CMS should prohibit APMs from limiting participation in APM leadership to physicians and hospitals as well as basing governing influence on the size of the organization. Group rehabilitation therapy practices, independent therapists, and rehabilitation agencies can and should be significant contributors to the proper functioning of the APM and therefore, should be adequately represented within the governing board of the APM. To strengthen the APM structure, PPS recommends that CMS establish a mechanism for providers to share information and/or voice concerns regarding unfair business practices or non-compliance with APM requirements directly to the Agency. In addition, CMS should ensure that providers are able to challenge the APM if and when termination from the APM occurs.

Likewise, PPS urges CMS to 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. It is important that APMs be required to demonstrate the availability of the requisite services to treat their assigned Medicare beneficiaries. That is, CMS should require APM to demonstrate that essential services such as PT, OT and SLP are provided within the APM or the APM has the appropriate referral relationships in place that enables patients to conveniently access these services. APMs should be obligated to demonstrate compliance with this requirement prior to approval of the entity as an APM.

Nominal Financial Risk

RFI: To help establish the appropriate type or types of “financial risk” to be considered an EAPM entity, CMS seeks responses to questions that include: What is the appropriate level of financial risk “in excess of a nominal amount” to be considered an EAPM entity? What is the appropriate level of “more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures” that should be required by a non-Medicare payer for purposes of the

Combination All-Payer and Medicare Payment? What are some points of reference that should be considered when establishing criteria for the appropriate type or level of financial risk, e.g., the MIPS or private-payer models?

PPS Comment: PPS joins other stakeholder organizations in urging CMS to ensure APMs achieve a true and meaningful commitment to clinical integration. Financial resources and human capital alone are not sufficient to show clinical integration. Real clinical integration is evidenced in patient coordination of care across health care settings, providers, and suppliers. Clinical integration is best shown when there is a structure in place that is patient-focused and where clinicians collaborate on best practices in an effort to furnish higher quality care that they likely would not achieve if working independently.

PPS urges the Agency to adopt realistic expectations with respect to the level of “meaningful commitment” that APM participants such as rehabilitation therapists, particularly those in solo or small practices, would be able to reasonably reach in a practical manner. Smaller practices can significantly contribute to the quality of care, improved functional outcomes and patient satisfaction achieved by an APM. But these practices have limited financial and human resources preventing deployment of substantial assets. PPS urges CMS to clearly define “nominal financial risk” in a manner that does not place undue and disproportionate administrative or financial burden on APM participants. Measures that safeguard against insolvency of these practices due to their participation in an APM are highly recommended.

Likewise, the startup costs for APMs are sure to be substantial. Smaller non-physician practices, such as physical therapists in private practice, are not prepared to assume a large a financial burden and PPS fears that APMs will look to their participating providers to bear some of the start-up costs in order to be a part of the APM. This could effectively be used to limit APM participation and we urge CMS to be vigilant for such developments. In addition, we encourage the Agency to provide grants and other funding to alleviate the burden of APM start-up costs to rehabilitation therapists and other small independent providers.

EAPM Entity Requirements

RFI: An EAPM entity is defined as an entity that (1) participates in an APM that requires participants to use certified EHR technology; and (2) bears financial risk for monetary losses under the APM that are in excess of a nominal amount or is a medical home expanded under section 1115A(c) of the Act.

PPS Comment: In order to meet the definition of an eligible alternative payment model (EAPM) the participant must use a certified electronic health record (EHR) technology. MACRA also provides for covered professional services to have meaningful participation in the submission of quality measures. PPS encourages its member clinics to adopt EHRs. However, the cost of acquisition, implementation and maintenance of an EHR is a significant barrier to adoption, particularly for small practices.

PPS urges CMS to re-state the definition of an EAPM to say that participants who were included in Meaningful Use (MU) (i.e., incentivized by CMS to utilize a Certified EHR), must use EHRs, but other participants such as non-physician providers who were included in MU are not affected by such a requirement.

PPS thanks the Agency for the opportunity to provide these comments on the request for information [CMS-3321-NC]. PPS is committed to continue its cooperation and collaboration with CMS and we look forward to more opportunities to partner with the agency in pursuit of meaningful and effective innovation in the Medicare program.

Sincerely,

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

Terence C. Brown, PT, DPT
President, PPS/APTA