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Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
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Submitted electronically

RE: Direct Provider Contracting Models – Request for Information

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit the following comments in response to the Centers for Medicare and Medicaid Services (CMS): Direct Provider Contracting (DPC) Models – Request for Information (RFI). The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for otherwise avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

The physical therapy profession is committed to the restoration, maintenance, and promotion of optimal physical function. Physical therapists are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status across all age populations. Physical therapists also help patients maintain health by preventing further

deterioration or future illness. Maintaining access to physical therapist services is integral to ensure patients' recovery and to prevent further deterioration of patients' conditions. Please find below our detailed comments responding to the agency's RFI.

Questions Related to Provider/State Participation

1. How can a DPC model be designed to attract a wide variety of practices, including small, independent practices and/or physicians? Specifically, is it feasible or desirable for practices to be able to participate independently or, instead, through a convening organization such as an ACO, physician network, or other arrangement?

Physical therapists are well-positioned to be rewarded based on the value of the care they provide to their patients. However, the existing Medicare alternative payment models (APMs) fail to promote collaboration with small and medium-sized physical therapy and other nonphysician practices, as these providers frequently are not viewed as foundational partners by larger providers, such as integrated health systems. Secretary Azar has expressed that the US Department of Health and Human Services (HHS) is committed to creating a "true competitive playing field" that rewards value. To achieve Secretary Azar's objective, CMS must take into greater consideration the differences between physical therapists and other providers, and account for those differences as it pursues the development of new APMs. Until CMS creates a more level playing field between these different types of providers, physical therapists will continue to be unable to meaningfully participate in Medicare and Medicaid APMs, despite their desire to do so, potentially impeding patient freedom of choice and access to the highest quality of care.

A convening organization is feasible, as long as it does not limit participation solely to its in-house partners. APTA strongly supports the inclusion of private practitioners as participants in current accountable care organizations (ACOs), patient-centered medical homes, and other arrangements. Private practices, particularly those in rural communities or that offer unique services such as pediatric, neurologic, and aquatic therapy, are essential to the success of these models and will be instrumental in achieving network adequacy. The decision on inclusion should be patient-centric and data driven, and should reflect the needs of the local community. However, to date, APM conveners have been very exclusive in their contracting. While health systems and large organized provider groups have leverage and market share, smaller providers do not. Further, if CMS were to require providers to participate through a convening organization, the agency would need to address the many interoperability issues that will arise. While large provider groups/health systems may be on a compatible electronic health record system, most independent practices use electronic health records (EHRs) that are not standardized.

To avoid amplifying this tension between small and large providers, APTA recommends that CMS permit practices to independently participate in the DPC model. However, if a physical therapist or other nonphysician provider is a DPC initiator, we recommend that CMS allow clinical outcomes that assess change in function and other measures, in conjunction with cost data, to guide value-based care decision making and iterative improvements. Additionally, we recommend that to remove participation barriers, CMS should make the program accessible and widely disseminate information on enrollment and offer provider education on the program

requirements. Further, because data and information technology requirements are a challenge both technically and financially for smaller practices, CMS should examine solutions that complement current systems. CMS also should encourage both DPC participants and nonparticipants to work collaboratively with physical therapists, in the determination of early and direct access to physical therapist services when appropriate, as well as promote physical therapist involvement in transition-in-care decision making and discretion in determining the need for referral without penalty.

Alternatively, CMS could design a DPC model that encourages large(r) physician and multi-specialty groups to better appreciate the value of physical therapist services and pursue opportunities for formal collaboration with independent physical therapists. The providers could form a network and agree to be at risk not only for their own financial performance but also for the performance of other providers in the network. To ensure that physical therapists are eligible to participate in such a model, CMS should mandate the inclusion of functional measure items within APMs that show the value of providers who traditionally have been excluded from APM participation. It is critical that new models, such as the DPC, include appropriate measures that address function and illustrate the value of each provider to the patient population included within the model. Moreover, this may be an opportunity for independent practices that are usually competitors to work together to address the needs of the community. If the model is developed with the intent of fostering collaboration and cooperation, then specific operational and clinical skills can be shared and leveraged.

2. What features should CMS require practices to demonstrate in order for practices to be able to participate in a DPC model (e.g., use of certified EHR technology, certain organizational structure requirements, certain safeguards to ensure beneficiaries receive high quality and necessary care, minimum percent of revenue in similar arrangements, experience with patient enrollment, staffing and staff competencies, level of risk assumption, repayment/reserve requirements)? Should these features or requirements vary for those practices that are already part of similar arrangements with other payers versus those that are new to such arrangements? If so, please provide specific examples of features or requirements CMS should include in a DPC model and, if applicable, for which practice types.

To ensure successful participation in the model, we recommend that CMS require practices to demonstrate the following basic and universal practice features:

- A strong infrastructure and leadership team that is innovative, progressive, and collaborative.
- Use of evidence-based best practices, thoroughly indoctrinating administrative and clinical staff.
- Use of standardized assessment tools that measure functional outcomes and data to demonstrate changes in practice based on those results.
- Collection and analysis of current data to effectively market to hospitals, physicians, and other health care organizations.
- Internal audit processes that address variations in practice and general performance deficits.

- If required by the model, effective integration of services across the continuum (sites, providers, diagnoses, etc.) and effective management of transitions in care (from acute hospital to home care, etc.).
- A robust health information infrastructure that contains an interoperable electronic health record.
- Engagement in continuous assessment of the health and disease demographic needs.
- A strong management team that not only addresses clinical issues but provides sound legal and financial advice.
- Effective contractual negotiation skills and solid business acumen to assess tolerance in risk-sharing

Newly participating providers who meet the basic criteria should be granted deference and added assistance. However, we believe that the degree of competency and proficiency with the above will increase as providers expand their participation in value-based contracting. Other participation criteria could include demonstrated data collection and analysis showing iterative changes to patient care, elimination of unnecessary service utilization, and improvement to the patient experience based on the application of data in practice.¹ Further, we acknowledge integrated technology plays a vital role in a practice's ability to function in a value-based care system. While we support requiring health care professionals and practices that participate in a DPC model to use certified EHR technology (CEHRT), physical therapists have been exempt from the Meaningful Use program (now termed Promoting Interoperability) and have not been afforded the same resources as physicians and hospitals for health information technology adoption. If lack of CEHRT bars health care providers from participating, they will be unable to succeed in a value-based care system going forward. Health care providers not included within Promoting Interoperability, but who are interested in participating in the DPC model, should not be required to use CEHRT until CEHRT standards for such providers have been adopted. CMS also must grant such providers a grace period during so they have an opportunity to adopt and implement the technology.

3. What support would physicians and/or practices need from CMS to participate in a DPC model (e.g., technical assistance around health IT implementation, administrative workflow support)? What types of data (e.g., claims data for items and services furnished by non-DPC practice providers and suppliers, financial feedback reports for DPC practices) would physicians and/or practices need and with what frequency, and to support which specific activities? What types of support would practices need to effectively understand and utilize this data? How should CMS consider and/or address the initial upfront investment that physicians and practices bear when joining a new initiative?

As stated above, APTA supports requiring providers within the DPC model to use EHR or CEHRT (when available). However, many providers, particularly small and rural practices, have faced barriers in the adoption of CEHRT. It is critically important that CMS offer assistance to physical therapists and other nonphysician providers, particularly small and rural providers, in

¹ APTA website. Comprehensive Care Joint Replacement Model Contracting Checklist. http://www.apta.org/uploadedFiles/APTAorg/Payment/Medicare/Alternative_Payment_Models/CJRContractingChecklist.pdf Accessed May 10, 2018.

the form of funding and technical support to assist them in preparing for and adopting the DPC model, as well as guidance on how to reduce administrative burden. We request that CMS provide appropriate resources and support, including implementation assistance and/or consultant support, to physical therapists and other nonphysician providers as they adopt certified EHRs, to better enable these practices to participate in these new models of care. Other types of support CMS should offer include education on risk sharing, guidance on interdisciplinary collaboration and data sharing, education on required data elements, education on data analysis and iterative practice changes based on results, physician and other referral source education on direct access to physical therapy for musculoskeletal conditions, and education on total cost of care and how to assess impacts on upstream and downstream costs.

Additionally, CMS should establish a policy that enables physical therapy EHR vendors to satisfy current CEHRT requirements. No physical therapy EHR vendors have CEHRT, as no standards currently exist, and CMS has not yet addressed how these vendors would meet the CEHRT requirements. While the Office of the National Coordinator of Health Information Technology (ONC) certification process has established standards and other criteria for structured data that EHRs must use, there is no standard certification criteria for EHRs for physical therapists and other nonphysician providers. APTA urges CMS and ONC to develop standardized such certification criteria. Moreover, we recommend that as CMS moves to establish guidance for CEHRT for physical therapists and other nonphysician providers, the agency implement a temporary waiver for such providers, so that these health care professionals can participate in the DPC model (and other APMs) without facing monetary penalties. CMS also should provide guidance and support to providers on interoperability.

It also is important for CMS to continue to support the development and success of professional registries as we move toward outcomes-based payment and advanced quality-reporting structures that will rely heavily on electronic data submission. Development of these registries has been spurred by the need to create meaningful quality measures to assist providers in the shift to value-based payment and models of care. These registries will be critical to the success of innovative payment models in the future, as they have the ability to deliver real-time data to providers for monitoring, assessing, and responding to new and dynamic models of care delivery.

Qualified Clinical Data Registries (QCDRs), such as APTA's [Physical Therapy Outcomes Registry](#), capture relevant data from EHRs and billing information, and transform this data into meaningful, intuitive, and actionable feedback for providers on the frontline of patient care. New models of care will require physical therapists to have access to real-time data so they can successfully identify and modify care design to maximize patient outcomes. The use of real-time data also allow for better coordination throughout the continuum of care and can be used to break down traditional silos of care. Therefore, we recommend that CMS provide financial support to small and rural physical therapy practices to facilitate their involvement in the Physical Therapy Outcomes Registry.

The agency asks within the RFI what types of data (e.g., claims data for items and services furnished by non-DPC practice providers and suppliers, financial feedback reports for DPC

practices) physicians and/or practices need, with what frequency, and to support which specific activities. To that end, APTA offers the following responses:

1. *Types of data CMS should provide to potential DPC practice providers:*
 - ICD-10 diagnoses and procedures.
 - Comorbidities.
 - Date of onset, and case severity or acuity, if available.
 - Age and sex.
 - Prior health care utilization for physical therapy as well as other services (CPT coding).
 - Surgical history.
 - Claims data (as a baseline).

2. *Types of data that providers need on an ongoing basis:*
 - Claims data—visits/services.
 - Care duration.
 - Outcomes data/result of standardized measures.
 - Total cost and services across all disciplines for the same episode of care.
 - New conditions and complications arising during care.
 - Patient-reported outcomes and satisfaction.
 - Transfers to other providers.
 - Admissions to the emergency department.
 - Readmissions to the hospital and post-acute care facilities.

APTA also recommends that CMS furnish providers with data at the 6-month and 1-year post-discharge limits, including exacerbations and recidivism, medical and pharmaceutical usage post-discharge, hospital readmissions, and adverse events. Moreover, we encourage CMS to develop algorithms that calculates actual cost against predicted cost for the entire episode and furnish that data to providers enrolled in the DPC model at the beginning of each calendar year.

Having access to the type of data listed above would help physical therapists assess patients' functional status and the value of physical therapist interventions, better understand the impact of the physical therapist on total cost of care, inform iterative clinical care improvements, identify dose specifics and reduce unwarranted variation in care, and recognize best practice and centers of excellence for specific conditions. This data also would help to educate treating providers and collaborative partners on best practice and benefit design as well as identify opportunities and elucidate areas for increased or changed collaboration with other disciplines; additionally, it would allow for the comparison of the value of interventions by different providers to determine what, when, and under what circumstances an intervention works best for a particular condition. For example, this could help payers and patients better understand the impact of conservative care on medication usage, specifically in regards to the use of opioids to manage pain. Moreover, this would help to support the shift away from traditional utilization management while also reducing administrative burden.

Questions Related to Beneficiary Participation

7. What support do practices need to conduct outreach to their patients and enroll them under a DPC model? How much time would practices need to “ramp up” and how can CMS best facilitate the process? How should beneficiaries be incentivized to enroll? Is active enrollment sufficient to ensure beneficiary engagement? Should beneficiaries who have chosen to enroll in a practice under a DPC model be required to enter into an agreement with their DPC-participating health care provider, and, if so, would this provide a useful or sufficient mechanism for active beneficiary engagement, or should DPC providers be permitted to use additional beneficiary engagement incentives (e.g., nominal cash incentives, gift cards)? What other tools would be helpful for beneficiaries to become more engaged and active consumers of health care services together with their family members and caregivers (e.g., tools to access to their health information, mechanisms to provide feedback on patient experience)?

We encourage CMS to require beneficiaries who choose to enroll in a practice under a DPC model to enter into a formal, written agreement with the provider that details the responsibility of the beneficiary to actively participate in his or her care.

8. The Medicare program, specifically Medicare Part B, has certain beneficiary cost-sharing requirements, including Part B premiums, a Part B deductible, and 20 percent coinsurance for most Part B services once the deductible is met. CMS understands that existing DPC arrangements outside the Medicare FFS program may include parameters such as no coinsurance or deductible for getting services from the DPC-participating practice or a fixed fee paid to the practice for primary care services. Given the existing structure of Medicare FFS, are these types of incentives necessary to test a DPC initiative? If so, how would they interact with Medicare supplemental (Medigap) or other supplemental coverage? Are there any other payment considerations or arrangements CMS should take into account?

A population that more closely adheres to treatment is likely to experience improved health and quality of life, resulting in fewer hospitalizations and emergency room visits. Unfortunately, Medicare beneficiaries, particularly Medicare Advantage enrollees, often are unwilling to or cannot receive care due to financial limitations, payer restrictions, time constraints, and/or lack of engagement. For example, patients are more likely to adhere to their treatment regimen when copays or coinsurance are eliminated or reduced. Thus, we encourage CMS to reduce cost-sharing for cost-effective care, such as physical therapy, for beneficiaries enrolled in the model who suffer from chronic conditions. Additionally, we recommend that CMS permit coverage of a physical therapy annual visit with no out-of-pocket cost to the beneficiary. Preventive screenings can reduce musculoskeletal-related downstream costs, facilitate appropriate education, identify at-risk individuals early, and reduce morbidity. Moreover, reducing or eliminating copays or coinsurance could provide financial relief to beneficiaries who elect to enter into private contracts with their health care professionals for services not covered by Medicare but that are medically necessary for their condition(s).

APTA also recommends that CMS promote a more accessible pain management model for Medicare Advantage enrollees, allowing a limited number of visits with no out-of-pocket cost. For example, CMS could consider adopting the maternity model for patients enrolled in a DPC practice, in which the patient pays only 1 copay at the initial visit, increasing the flexibility and opportunity for patients to access conservative care versus prescription drugs such as opioids. We also encourage CMS to allow DPC enrollees direct access to physical therapists for musculoskeletal conditions. Repeat studies demonstrate the effectiveness of conservative care, specifically physical therapy, in reducing total cost of care. Unfortunately, delays and barriers to such services, including onerous documentation requirements and regulations, such as the outpatient therapy plan of care certification requirement as well as utilization management, increase costs and adversely impact patient outcomes.² APTA recommends that CMS broaden its education to consumers to better facilitate patient decision-making in accessing the right provider at the right time, as this benefits patients and the health care system in its entirety. Alternatively, or in conjunction with the recommendations listed above, CMS could define the ICD-10 conditions eligible for lower cost-sharing and seek public comment on such conditions prior to implementation of the model.

Questions Related to Payment

9. To ensure a consistent and predictable cash flow mechanism to practices, CMS is considering paying a PBPM payment to practices participating in a potential DPC model test. Which currently covered Medicare services, supplies, tests or procedures should be included in the monthly PBPM payment? (CMS would appreciate specific Current Procedural Terminology (CPT®1)/Healthcare Common Procedure Coding System (HCPCS) codes as examples, as well as ICD-10-CM diagnosis codes and/or ICD-10-PCS procedure codes, if applicable.) Should items and services furnished by providers and suppliers other than the DPC-participating practice be included? Should monthly payments to DPC-participating practices be risk adjusted and/or geographically adjusted, and, if so, how? What adjustments, such as risk adjustment approaches for patient characteristics, should be considered for calculating the PBPM payment?

For physical therapists and physical therapist practices that choose to participate in the DPC model, APTA recommends that the per-beneficiary per-month (PBPM) payment include coverage of Medicare-covered physical therapy services, as well as several currently non-covered Medicare services, including screenings for risk and health promotion, an annual physical therapist visit, and telephonic and video-conferencing services. Additionally, for multi-specialty therapy practices participating in the DPC model, all rehabilitative therapy services—physical therapy, occupational therapy, and speech-language pathology—could be included under a single payment model.

We recommend the monthly PBPM payment includes but is not limited to the following CPT codes: 97161, 97162, 97163, 97164, 97010-97028, 97032-97039, 97110-97150, 97530-97546, 97597-97610, 97750, 97755, 97760-97763, 97799, 98960-98962, 98966, 98967, 98968, 98969, 99090, and 99091.

² APTA Website. Direct Access in Practice. <http://www.apta.org/DirectAccess/>. Accessed May 10, 2018.

We recommend the monthly PBPM payment includes but is not limited to the following ICD-10-CM codes: M00-M99, Z96.6 series, G00-G99, V00-W19, E08-E13, E65-E88, I60-I69, J40-J47, L89, and L97.

Additionally, APTA recommends that CMS geographically adjust and risk-adjust the PBPM payment. The location of the practice will determine the provider's staff and facility costs of doing business, which vary significantly across the country. In addition, risk and case-severity adjustments will help to disincentivize cherry picking or undertreating DPC enrollees. Appropriate patient characteristics on which to base a physical therapy risk-adjusted payment include but are not limited to: patient comorbidities/chronic diseases, prior hospitalizations in previous 12 months, average functional score, age, gender, environmental factors (including type of residence such as private or facility), societal factors, cognition, and number of medications.

We also recommend that CMS adjust for social risk factors. Lack of adjustment for social risk factors in outcome measures utilized in value-based payment models negatively impacts providers and facilities in geographic areas where the incidence of specific social risk factors are highest. However, we also acknowledge that implementing social risk factor adjustments may increase health disparities by essentially masking these factors. Currently, outcomes measures are not adjusted for social risk factors, which has led to reduced payments for providers and facilities caring for large numbers of disadvantaged patients. APTA is an active member of the National Quality Forum and has been following the social risk factor adjustment project; our organization has also reviewed the work performed by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine.

APTA supports the overarching strategies outlined in the ASPE report, which include measuring and reporting quality for beneficiaries with social risk factors, setting high, fair quality standards for all beneficiaries, and rewarding and supporting better outcomes for beneficiaries with social risk factors. As stated in previous comment letters, APTA encourages CMS to take immediate action on these recommendations. We support the testing of social risk factor adjustment models and the reporting of stratified outcomes measures to providers to enable them to better understand the effects of social risk factors on their performance. Once the risk-stratified data has been shared with providers, we recommend that CMS work with stakeholders to share this data with the public.

10. How could CMS structure the PBPM payment such that practices of varying sizes would be able to participate? What, if any, financial safeguards or protections should be offered to practices in cases where DPC-enrolled beneficiaries use a greater than anticipated intensity or volume of services either furnished by the practice itself or furnished by other health care providers?

APTA recommends that CMS consider varying the PBPM payment based on the provider's historical practice trends and the patient population they treat. The agency could identify these beneficiaries based on such measures as hospitalization rates, emergency room visits, primary care visits, and skilled nursing facility admissions. Based on previous utilization of services, CMS could then categorize patients into low-, medium-, and high-risk categories and stratify the

PBPM payment accordingly. This will help to protect providers who treat DPC-enrolled beneficiaries who require more services.

11. Should practices be at risk financially (“upside and downside risk”) for all or a portion of the total cost of care for Medicare beneficiaries enrolled in their practice, including for services beyond those covered under the monthly PBPM payment? If so, what services should be included and how should the level of risk be determined? What are the potential mechanisms for and amount of savings in total cost of care that practices anticipate in a DPC model? In addition, should a DPC model offer graduated levels of risk for smaller or newer practices?

APTA offers several different options for CMS’s consideration, including:

- To properly address the initial upfront investment that physicians and practices bear when joining a new initiative, allow providers the option of whether or not to take on risk for the first 12-24 months.
- Establish a mutually agreeable transition from fee for service (FFS) to a capitated payment so the individual practitioner or practice can accommodate its processes (for example: pay fee-for-service (FFS) for first 6-12 months and then transition to a PBPM model) and provide graded financial support or supplement to FFS/PBPM payment.
- Allow providers to take on downside financial risk but not mandate it as a participation requirement. We also recommend that any downside risk model(s) qualify as an Advanced APM under the Quality Payment Program.
- To incentivize providers to take on financial risk, we offer incentives to providers that are based on how well the practice performs on patient-reported outcome and performance-based measures.
- Afford graduated levels of risk based upon the size of the practice.
- Apply downside risk to Medicare-covered services within a confined period of time, such as 60 or 90 days “post-discharge.”

12. What additional payment structures could be used that would benefit both physicians and beneficiaries?

Additional payment structures for CMS’s consideration include episodic or per diem payment, as this would base payment on an episode of physical therapist or rehabilitation intervention.

Questions Related to General Model Design

15. What other DPC models should CMS consider? Are there other direct contracting arrangements in the commercial sector and/or with Medicare Advantage plans that CMS should consider testing in FFS Medicare and/or Medicaid? Are there particular considerations for Medicaid, or for dually eligible beneficiaries, that CMS should factor in to designing incentives for beneficiaries and health care providers, eligibility requirements, and/or payment structure? Are there ways in which CMS could restructure and/or modify any current initiatives to meet the objectives of a DPC model?

APTA proposes 3 types of models for consideration:

- For practices with more than 1 provider, individual providers can opt into the model but the full group is not required to participate.
- Providers enrolled in the DPC model may continue to bill Medicare under the fee schedule when furnishing reasonable and necessary Medicare-covered services to beneficiaries who elect to participate in the model. The PBPM payment would help the provider furnish enhanced services, better facilitate care, and comprehensively manage the patient. The model also could include performance-based payment incentives, similar to the Oncology Care Model.
- Providers enrolled in the DPC model would not bill Medicare and/or Medicaid under the fee schedule. The PBPM payment would be intended to cover Medicare-covered (and/or Medicaid) services. With this type of model, CMS would allow providers to enter into a private contract with the beneficiary to provide additional services not covered by Medicare; for example, services for wellness, health, and disease prevention.

Physical therapists and other health care professionals are not included in the group of providers who may “opt out” of the Medicare program. Allowing physical therapists and other certain health care professionals enrolled in the DPC model to enter into private contracts with beneficiaries may increase accessibility by incentivizing such providers to participate in the DPC model, as they will be permitted to earn compensation to counterbalance the lesser fees allowed under the fee schedule. This also may persuade more recent graduates to accept Medicare and Medicaid. However, CMS must ensure that Medicare and Medicaid beneficiaries continue to have access to providers who are not enrolled in the DPC model and who continue to accept Medicare and Medicaid’s fees based on the fee schedule. CMS also would need to implement certain parameters if the agency were to allow practitioners to directly contract with beneficiaries. For example:

- If CMS permits providers in the DPC model to enter into private contracts with beneficiaries, all providers should be required to use a contract that includes standardized, easy-to-read, and understandable language.
- Providers must be required to inform beneficiaries *prior to their enrollment in the practice* that the beneficiaries may be responsible for out-of-pocket costs.
- Providers who choose to enter into private contracts with beneficiaries must do so for all beneficiaries enrolled in the model and must do so for a defined set of services not covered by Medicare.
- The amount providers can charge the beneficiary out-of-pocket should be limited, either in percentage form or dollar amount. This amount can be updated on an annual basis.
- Providers should be prohibited from charging out-of-pocket costs from beneficiaries experiencing an emergent health care event or from individuals who are enrolled in the Qualified Medicare Beneficiary Program.

In addition to a DPC model that might encompass Medicare-covered services, APTA encourages CMS to examine the development of models that are focused on population-based preventive innovations around prevalent conditions or risks. To inform the development of such models, CMS would need to first solicit and collect feedback from the applicable provider and research communities on appropriate target areas. As an example, the physical therapist community might encourage condition-specific models that focus on low back pain, diabetes, and related

hypertension, obesity, and/or falls. Moving forward, we encourage CMS to consider and assess how to encourage provider participation in these more nontraditional alternative delivery models.

Questions Related to Program Integrity and Beneficiary Protections

16. CMS wants to ensure that beneficiaries receive necessary care of high quality in a DPC model and that stinting on needed care does not occur. What safeguards can be put in place to help ensure this? What monitoring methods can CMS employ to determine if beneficiaries are receiving the care that they need at the right time? What data or methods would be needed to support these efforts?

To ensure that beneficiaries continue to receive high-quality care and avoid stinting on medically necessary services, APTA suggests the following:

- Assess provider adherence to clinical practice guidelines.
- Require the completion of patient-reported satisfaction surveys.
- Require the collection of patient-reported outcome measures that have clinical utility and importance. Such measures should be meaningful to a diverse set of providers. For example, CMS could require physical therapists within the model to use the Patient-Reported Outcomes Measurement Information Systems (PROMIS).
- Require the use of specific performance-based (observation-based) outcome measures, such as the Timed Up and Go.

Additionally, CMS may encourage physical therapists who wish to participate in the DPC model to submit their data to the Physical Therapy Outcomes Registry. The APTA registry is the sole vehicle that permits standardized physical therapy data collection across all settings, diagnoses, and lifespan that is compatible with other registries, discipline data collection, and functional assessment tools. Moreover, registry participation will facilitate CMS data collection on functional measures at the start and conclusion of care. CMS could use registries and other mechanisms to track providers participating in the DPC model and take measured action based on the data. However, providers should be able first to remediate and use the data iteratively to improve practice patterns and patient communications. Additionally, quarterly performance reports that include benchmarks (once available) will reinforce and facilitate behavior change and practice improvements. To assist CMS in its efforts, APTA welcomes the opportunity to serve as a resource and share data results at the clinician, practice, and national levels for the measures included in APTA's QCDR.

Other ideas include the following:

- Providers and CMS should collect patient-reported outcomes and patient satisfaction surveys at the end of care. A patient follow-up mechanism should be established for complaints and compliments.
- CMS should track hospital readmission rates, transfers to other providers, adverse events, medical services, and pharmaceutical usage post-discharge.
- Follow-up data collection should be considered at 6-12 months post-discharge, as this would provide CMS another data point to assess long-term benefit and adherence.

Finally, we recommend that following implementation of the DPC model, CMS conduct quarterly provider-specific and patient-specific open-door forums, inviting stakeholders to provide feedback on the effects of implementation. In addition, CMS should develop an email box that allows the public to submit a question or provide feedback regarding the DPC model.

18. CMS wants to ensure that all beneficiaries have an equal opportunity to enroll with a practice participating in a DPC model. How can CMS ensure that a DPC-participating practice does not engage in activities that would attract primarily healthy beneficiaries (“cherry picking”) or discourage enrollment by beneficiaries that have complex medical needs or would otherwise be considered high risk (“lemon dropping”)? What additional beneficiary protections may be needed under a DPC model?

APTA acknowledges CMS’s concern that a practice may cherry pick patients or discourage enrollment of other beneficiaries. However, health care providers’ responsibilities are enshrined in professional codes of ethics that define what it means to be a health care professional. Values generally agreed upon across health care professions include the obligation to do no harm, work for the public good, and demonstrate respect for others. Physical therapists operate under the Code of Ethics for the Physical Therapist (Code of Ethics), which delineates the ethical obligations of all physical therapists, as determined by the House of Delegates, APTA’s policymaking body. Physical therapists have a duty to protect the intent of the Code of Ethics, practice in a manner that is consistent with the Code of Ethics, and ensure the best interests of the patient in all decisions and interactions.³

The APTA House of Delegates also has a nondiscrimination position that states: “Physical therapy practitioners shall provide quality, nonjudgmental care in accordance with their knowledge and expertise to all persons who need it, regardless of the nature of the health problem. When providing care to individuals with infectious disease, the American Physical Therapy Association advocates that members be guided in their actions by guidelines developed by the Centers for Disease Control and Prevention (CDC) and regulations set by the Occupational Safety and Health Administration (OSHA).”⁴

We anticipate that the majority of health care providers who adopt the DPC model will not cherry pick or discourage enrollment of beneficiaries with complex conditions. However, in an effort to prevent such actions, we recommend that CMS build into the DPC model a bonus or reward for providers who treat a larger percentage of the vulnerable population and achieve certain quality metrics. CMS should offer greater rewards to providers for providing better outcomes for patients with more complex conditions than for patients who are healthy and have relatively few issues. Additionally, as previously stated, CMS must risk adjust the monthly PBPM payment. There also may be a need for CMS to vary the risk adjustment for high-risk versus low-risk population, as some practices that serve more high-risk populations may need to offer more support services to beneficiaries, including home or community support.

³ APTA Code of Ethics. https://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/CodeofEthics.pdf Accessed May 10, 2018.

⁴ House of Delegates. Non-Discrimination in the Provision of Physical Therapy Services http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Health_Social_Environment/NonDiscriminationProvisionPTServices.pdf#search=%22non-discrimination%22 Accessed April 25, 2018.

19. Giving valuable incentives to beneficiaries to influence their enrollment with a particular DPC practice would raise quality of care, program cost, and competition concerns. Providers and suppliers may try to offset the cost of the incentives by providing medically unnecessary services or by substituting cheaper or lower quality services. Also, the ability to use incentives may favor larger health care providers with greater financial resources, putting smaller or rural providers at a competitive disadvantage. What safeguards should CMS put in place to ensure that any beneficiary incentives provided in a DPC model would not negatively impact quality of care, program costs, and competition?

This question emphasizes the importance of equally weighting cost and quality measures in the DPC model. Lower cost does not always equate to lower quality, and higher cost does not always equate to higher quality. It is important to evaluate service delivery based on a comparative analysis between results and cost. Results should include not only clinical and functional outcomes, but also the impact on other costs. For example, if a patient who is able to avoid a surgical procedure with equal or better outcomes through early and direct access to a physical therapist for rehabilitation, the “cost” of physical therapy should be equal to the physical therapy cost minus the surgery cost, which equates to an overall cost savings for an equal or better outcome. Narrowly focusing on the cost of a single service does not provide an accurate picture of the contribution of a particular service to functional outcomes or overall costs.

We also suggest that CMS consider initiating a pilot program to assess an array of financial incentives that are limited to a specified dollar amount on a sliding scale so as not to inadvertently disadvantage smaller practices. This would allow the agency to assess the impact on enrollment, retention, patient satisfaction, overall cost of care, and functional outcomes. Accordingly, incentives that derive a positive result could be replicated and supported on a larger scale.

Conclusion

APTA thanks CMS for the opportunity to provide feedback in response to the RFI on DPC models. We look forward to working with the agency to craft new models that improve the quality of patient care while also ensuring access to quality rehabilitation services is preserved. Should you have any questions regarding our comments, please contact Kara Gainer, director of regulatory affairs, at karagainer@apta.org or 703/706-8547. Thank you for your consideration.

Sincerely,



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SLD: krg