June 27, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1647-P
Room 445-G, Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically

RE: CMS-5517-P; Medicare Program – Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Acting Administrator Slavitt:

On behalf of the 93,000 physical therapist (PT), physical therapist assistant (PTA), and student of physical therapy members of the American Physical Therapy Association (APTA), I respectfully submit comments regarding the proposed Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models published in the Federal Register. APTA commends the Centers for Medicare & Medicaid Services (CMS) for taking an important step toward building an integrated care-delivery system that is interdisciplinary, patient-centered, and seeks to improve the quality of care for Medicare beneficiaries throughout the health care continuum. We look forward to working with the Agency to revise the proposed rule so that it meets its intended purpose.

This proposed rule will influence implementation of MIPS and incentive payments for participation in eligible APMs which will impact outpatient therapists in private practice, as well as outpatient therapy services furnished in hospitals, outpatient rehabilitation facilities, public health agencies, clinics, skilled nursing facilities (SNFs), home health agencies, and comprehensive outpatient rehabilitation facilities. Implementation of MIPS and APMs, therefore, will affect eligible clinicians across the entire spectrum of the therapy delivery system.
Introduction

The mission of APTA is to further the profession’s role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the public’s physical health and functional abilities. PTs practice in a wide variety of inpatient and outpatient settings, including hospitals, SNFs, home health agencies, rehabilitation agencies, and PT-owned private practice offices in which health care is delivered to Medicare beneficiaries.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was passed into law in an effort to repeal the Sustainable Growth Rate (SGR) used to calculate payment under the Medicare Physician Fee Schedule (MPFS) and replace it with a quality payment program with the following goals: “(1) Design a patient-centered approach to program development that leads to better, smarter, and healthier care; (2) develop a program that is meaningful, understandable, and flexible for participating clinicians; (3) design incentives that drive delivery system reform principles and participation in APMs; and (4) ensure close attention to CMS’ excellence in implementation, effective communication with stakeholders and operational feasibility.”

APTA stands firmly committed to the goals of MACRA, and the association has worked diligently over the past decade to ensure PTs are prepared to be meaningful participants in this new era of healthcare. Our commitment is evidenced by our current and past partnerships with CMS in such initiatives as the Physician Quality Reporting System (PQRS), Value-Based Purchasing Programs, Post-Acute Care Demonstration, and by our work with the National Quality Forum (NQF).

APTA has made significant efforts to provide health information technology (HIT) educational tools on the APTA website and to collaborate with internal and external stakeholders on HIT issues. Recognition of the need to capture rehabilitative services in electronic health records (EHRs) has led to substantial growth in the development of EHR systems in the rehabilitation sector. This data is crucial to the development of a robust registry such as APTA’s Physical Therapy Outcomes Registry. Also, APTA’s development of clinical practice guidelines and other important criteria has been the basis for the attributes of many existing HIT systems serving rehabilitative service providers.

The association is actively promoting the proliferation of innovative models throughout the country, as well. Through our Innovation Summit and Innovation 2.0 program, APTA has supported development of alternative payment models that show the impact physical therapy can have on improving the function and overall health of patient populations. Specifically, we have partnered with physicians in the Medicare Shared Savings Program (MSSP), created clinical care pathways for patients transitioning from acute to post-acute care, explored ways to impact child obesity in a patient-centered medical home, and worked with a commercial payer to develop a pay-for-performance program for patients with low back pain.

Our work in these projects teaches a central lesson—rehabilitation is key to providing high-quality care and lowering the growth of health care expenditures. While APTA is a
vested partner with the Department of Health and Human Services (HHS) in the objective of tying Medicare payment to quality (rather than quantity) through MIPS and APMs, we nevertheless are dismayed by the fact that participation of rehabilitation providers such as PTs are severely underrepresented in these initiatives. We strongly believe that the success of MIPS and APMs in improving the quality of care and decreasing costs depends on the collective efforts of all health care providers throughout the health care spectrum, including PTs, home health agencies, rehabilitation agencies, inpatient rehabilitation facilities, SNFs, and other provider types.

Recruitment and participation in MIPS, APMs, and other quality programs such as the Value-Based Modifier (VBM) and EHR Meaningful Use programs, has exclusively and disproportionately focused on physicians and hospitals. The true potential to reduce costs and improve the health of individuals and populations will not be fully realized until HHS takes meaningful steps to include PTs and other rehabilitation providers.

APTA strongly urges CMS to recognize the vital role PTs will play in ensuring that MIPS and APMs provide access and deliver quality care to Medicare beneficiaries. We believe that CMS has made progress through this proposed rulemaking, but significant modifications are needed to create a seamless, integrated model of care that is in the best interest of Medicare beneficiaries. In APTA’s view, the proposed rule lacks the appropriate safeguards and operational details needed to create a comprehensive program that is quality driven, is inclusive of all medically necessary services, substantially mitigates abusive and fraudulent behavior, and is transparent in its legal and organizational structure.

Summary of Recommendations

1) APTA supports the addition of PTs to the MIPS program in 2019. CMS should work with stakeholders within the rehabilitation community to ensure that we have appropriate and relevant measures to report under the program in all MIPS categories.

2) We believe PTs should be able to participate in MIPS in 2017 and beyond to gain reporting experience in the new program. We encourage CMS to incentivize PTs to continue reporting quality measures during these interim years.

3) We encourage CMS to ensure that all outpatient therapy providers, including facility based providers, can participate in MIPS.

4) We encourage CMS to develop timely, actionable feedback reports for MIPS providers.

5) We encourage CMS to certify more existing models, such as Comprehensive Care for Joint Replacement (CJR) and Bundle Payments for Care Improvement (BPCI), as Advanced APMs.

6) We believe CMS should revise the current criteria for Advanced APMs to include gradual phase-in of EHRs. This requirement should be waived for providers not previously included under EHR meaningful use.

7) We believe that clarification is needed on how Physician-Focused Payment Model (PFPM) and “other” APMs will qualify for credit under MIPS
categories—and specifically on whether participation in an APM should satisfy the CPIA category under MIPS.

8) We urge the adoption, in APM criteria, to also assess the inclusion of specialty services such as rehab services (PT, OT and SLP) within the APM.

9) We urge CMS to create APM pathways under the Center for Medicare and Medicaid Innovation (CMMI) and through the PFPM technical advisory committee that allow physical therapy practices, rehabilitation agencies, and other therapy providers to be the main conveners of an approved APM.

10) We advocate for strong safeguards to ensure that hospitals and physicians do not wield undue influence under APMs and bar PTs and other specialty and non-physician providers from participation.

11) We believe there should be strong measures in place to preserve beneficiary choice when it comes to receiving treatment from providers outside the APM.

**Merit-Based Incentive System: Specific Concerns for PTs**

Section 1848(q) of the Act, added by section 101(c) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), requires creation of the Merit-based Incentive Payment System (MIPS), applicable beginning with payments for items and services furnished on or after January 1, 2019. In the MACRA legislation, the MIPS program begins in the 2019 year with the inclusion of physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. Other non-physician eligible professionals are to be added beginning in 2021 under discretion of the Secretary, to include PTs, occupational therapists, speech language pathologists, clinical social workers, clinical psychologists, registered dieticians, nutrition professionals, and audiologists. As APTA has expressed previously, we are concerned by the lack of formal inclusion of PTs in MIPS’ inception years. Given the current health care payment environment, HHS’s goals, and the focus on outcome-based payment models, we believe that excluding PTs from MIPS in the initial years is a step backward that may have many unintended consequences.

PTs have been included in quality reporting under Medicare Part B since the inception of the PQRS program in 2007. As was the case among eligible professionals (EP) in all health care fields, reporting by PTs in the PQRS program was low in the early years of the program. APTA has expended significant effort and resources in member outreach and education to increase awareness and improve reporting rates. We amplified this push leading up to the 2013 reporting year, as this was the first year PQRS reporting was tied to penalties for EPs. The following table tracks the significant increase in the number of PTs reporting in PQRS (based on data included in annual PQRS Experience Reports).
PT participation in PQRS in 2014 was 72.2%, exceeding the overall EP participation rate of 62.2%. APTA is deeply concerned that excluding PTs from MIPS in 2017 and 2018 will have a strong negative impact on reporting of quality measure by PTs. The association also is concerned that PTs will struggle to return successfully to the quality reporting space in 2019 after the 2-year hiatus.

APTA does appreciate the fact that CMS is considering allowing PTs to report in the inception years of MIPS despite their formal exclusion. We are concerned, however, that, without financial or other incentives, the PT participation rate will drop. APTA encourages CMS to consider innovative ways to incentivize participation in quality reporting programs for PTs and the other non-physician eligible clinicians that were excluded from the initial group of eligible clinicians in MIPS. One example of incentivizing PTs to continue to reporting quality measures in the 2017 and 2018 reporting year would be to give eligible clinicians credit towards their MIPS performance when they join that program in 2019.

Another concern APTA has is the gap in the reporting of public data that will occur on the physician compare website as a result of the exclusion from the first two years of the MIPS program. As CMS continues to launch data on the physician compare website, APTA is concerned about the public perception of physical therapists during the 2017 and 2018 years when they are not participating in the MIPS program. We believe that a lack of data during these years may give the public an incorrect impression that physical therapists are choosing not to participate in the MIPS program when they are legislatively excluded. Again, we encourage CMS to develop mechanisms that will incentivize PTs and the other non-physician eligible clinicians to continue reporting quality measures during these interim years (2017 and 2018) in order to avoid these unintended consequences.

Given the changes occurring simultaneously in the post-acute care space with implementation of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, APTA believes the next several years will be critical ones for development and implementation of quality measures that will affect PTs across the continuum of care. We
hope that exclusion from MIPS in its inception years will not impede our ability to participate in this process and advocate for PTs. APTA is committed to continued involvement in organizations such as NQF and Physician Consortium for Performance Improvement (PCPI) in order to ensure that PTs are represented as quality measurement continues to evolve. The association has been an active member of these national organizations and has been represented on a variety of CMS convened technical expert panels dealing with quality measures across the continuum of care. We are hopeful that these opportunities to engage in the national quality dialogue will continue.

Facility Based PTs Billing Medicare Part B

As CMS staff is aware, PTs in private practice currently report and participate in PQRS. But a large number of PTs who work in facility based settings and bill Medicare Part B do not participate in the PQRS program. CMS has not mentioned future plans for these providers who practice in the facility based setting. We encourage CMS to consider adding these providers to MIPS in future years, and allowing providers in facility settings to participate in APMs and receive incentive payments. Excluding these providers from MIPS and APMs would leave a large number of providers outside these evolving value-based payment systems. We believe that PTs in the facility based setting could participate in MIPS by submitting data via electronic reporting (EHRs or registries).

Furthermore, we encourage CMS to consider allowing providers in facilities to report measures relevant to their respective settings. This may include measures reported under Part A. For example, providers billing Part B in SNFs may wish to report the same functional measures they report under the SNF quality reporting program (QRP). This is similar to CMS allowing physicians in the hospital setting to report hospital based measures for credit under MIPS. APTA welcomes the opportunity to work with CMS to determine how best to add facility based providers to MIPS and APM in future years.

Functional Limitation Reporting

In addition to Medicare quality reporting programs, PTs are also required to report functional limitation data to CMS. This requirement is separate and distinct from formal QRPs under Medicare. Section 3005(g) of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) required CMS to implement, beginning on January 1, 2013, a claims-based data collection strategy that would be designed to collect data on patient function during the course of therapy services in order to better understand patient condition and outcomes, otherwise known as Functional Limitation Reporting (FLR). CMS finalized the data collection strategy to meet the above requirement in the final Physician Fee Schedule rule of CY2013.

Currently, nonpayable G-codes and modifiers are included on the claim forms that capture data on the beneficiary’s functional limitations (a) at the outset of the therapy episode, (b) at specified points during treatment, and (c) at discharge. In addition, the therapist’s projected goal for functional status at the end of treatment is reported on the first claim for services and periodically throughout the episode. Modifiers indicate the
extent of the severity of the functional limitation. The tracking mechanism for this data differs from those of other quality programs under Medicare Part B, using 3 identifiers to track each episode of care—the beneficiary ID, the tax identification number (TIN) of the practice or facility, and the therapy modifier code.

The overall goal of FLR is to use the data collected to reform payment for outpatient therapy services in the future. To gather meaningful information that could be used to compare one provider to another (regarding patient care) or one patient to another patient (regarding condition, functional limitations, and care outcome), would necessitate the use of a single standardized data collection tool by all therapists. Unfortunately, given the wide variety of outpatient therapy settings and diversity of patient conditions treated by therapists at this time, no such standardized tool exists to report a patient’s functional limitation in the outpatient setting. We believe that data collection is limited by the lack of a standard measurement tool or standardized performance measure.

APTA sees the need to determine what role data collection may serve in the future while taking into account the many quality reporting changes occurring as both IMPACT and MACRA are implemented. Given the significant provider burden imposed by FLR and the lack of feedback to providers on the data, APTA would like to share how we envision FLR fitting into the Medicare quality reporting structure of the future.

One suggestion we have is to collect FLR data within MIPS, by developing a measure that captures functional change over the course of the episode of care. PTs would receive credit and get valuable feedback on their performance by collecting this data. APTA believes that gathering data on functional change over the course of the episode would be valuable to payers, including Medicare, as well to as patients and caregivers. Incorporating FLR data collection into MIPS would only capture data from PTs in private practice until therapists working in facility based settings, billing Medicare Part B, can participate in MIPS.

APTA strongly believes that measuring changes in patient function over the course of an episode of care is critically important, as such information is meaningful to all stakeholders. (CMS has included measures of patient function in the CJR model for this reason.) Additionally, there is a desire to incorporate more measures of patient function into the AHIP/CMS core measure sets and inclusion of these types of measures in the internal work of ICHOM. APTA welcomes the opportunity to work with CMS quality staff to examine how we can make this valuable data more meaningful in the future.

**MIPS Details**

**MIPS Eligible Clinicians, Clinician Identifiers, and Group Practices**

CMS proposes to allow eligible clinicians who are not MIPS eligible clinicians the option of voluntarily reporting measures and activities for MIPS to gain experience in the MIPS program. APTA appreciates the opportunity for PTs to report in the MIPS program in the 2017 and 2018 reporting years, however, APTA is concerned that without financial or
other implications, the PT participation rate will be low given the lack of reporting incentive and the high burden of data collection. APTA encourages CMS to consider innovative ways to incentivize participation in quality reporting programs for PTs and the other non-physician eligible clinicians that were excluded from the initial group of eligible clinicians in MIPS. One example of incentivizing PTs to continue to reporting quality measures in the 2017 and 2018 reporting year would be to give eligible clinicians credit toward their MIPS performance when they join the program in 2019. For example, successful participation in the 2018 reporting year would earn providers a specific number of bonus points toward the 2019 reporting year. We welcome the opportunity to work with CMS on developing such incentivizing mechanisms.

CMS proposes that a new Medicare-enrolled eligible clinician be defined as a professional who first becomes a Medicare-enrolled eligible clinician within the Provider Enrollment, Chain, and Ownership System (PECOS) during the performance period for a year and who has not previously submitted claims as a Medicare-enrolled eligible clinician either as an individual, an entity, or a part of a physician group or under a different billing number or tax identifier. These eligible clinicians will not be treated as a MIPS eligible clinician until the subsequent year and the performance period for such subsequent year. APTA supports the treatment of newly enrolled Medicare clinicians as non MIPS eligible clinicians in their first performance year of practice. Given the complexities of MIPS, we believe that this will allow new clinicians to become familiar with the program prior to becoming eligible.

CMS proposes to define MIPS eligible clinicians or groups who do not exceed the low-volume threshold as an individual MIPS eligible clinician or group who, during the performance period, have Medicare billing charges less than or equal to $10,000 and provide care to 100 or fewer Part B-enrolled Medicare beneficiaries. APTA supports this definition, as we believe it is important to identify and exclude from the program low-volume providers.

CMS proposes to eliminate a registration process for groups submitting data using third-party entities. When groups submit data utilizing third party entities, such as a qualified registry, health IT vendor, or QCDR, we are able to obtain group information from the third party entity and discern whether the data submitted represents group submission or individual submission once the data is submitted. APTA supports this proposal and believes that eliminating registration for groups submitting through a third party vendor will encourage more practices to submit as a group.

CMS proposes, based on the complexity of implementation, to implement virtual groups for the 2018 calendar year performance period and the agency intends to address the requirements for such virtual groups in future rulemakings. APTA encourages CMS to work with all stakeholders, including non-physicians, on this concept. We believe that specialty providers such as PTs will be interested in this reporting option under MIPS.

MIPS Performance Period
CMS proposes to retain the 1-year performance period for the MIPS program. Specifically, the agency CMS proposes that, for 2019 and subsequent years, the performance period under MIPS would be the calendar year (January 1 through December 31) 2 years prior to the year in which the MIPS adjustment is applied. For example, the performance period for the 2019 MIPS adjustment would be the full calendar year 2017—that is, January 1, 2017, through December 31, 2017. APTA supports the performance period as the calendar year, and encourages CMS to close the performance year to adjustment year gap to 1 year, if possible, in the future.

CMS proposes several strategies for dealing with claims data submission: include claims data processed by no later than 90 days after the end of the applicable performance period, include claims data processed by no later than 60 days after the end of the applicable performance period, use claims that are paid within 60 days after 2017 for performance assessment and MIPS payment adjustment application for 2019. APTA supports the 90-day window. If that is not feasible, we support a 60-day window.

CMS proposes that individual clinicians and group practices with less than 12 months of data be required to report all performance data available from the performance period. Specifically, MIPS eligible clinicians who report as individuals would report all partial-year performance data. Alternatively, for MIPS eligible clinicians who report with a group, the group would report all performance data available from the performance period, including partial-year performance data available for each individual clinician. APTA supports the submission of all performance data in the given reporting period for providers reporting as individuals or as a group.

MIPS Category Measures and Activities

CMS proposes the following data submission mechanisms for MIPS:

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<th>TABLE 1: Proposed Data Submission Mechanisms for MIPS Eligible Clinicians Reporting Individually as TIN/NPI</th>
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<td><strong>Performance Category/Submission Combinations Accepted</strong></td>
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CMS proposes allowing MIPS eligible clinicians and groups to submit information via multiple mechanisms but dictates that they use the same identifier for all performance categories and use only 1 submission mechanism per category. To decrease administrative burden, CMS encourages MIPS eligible clinicians to submit MIPS information for the CPIA and Advancing Care Information Performance categories through the same reporting mechanism that is used for quality reporting. Additionally, CMS notes that it has multiple policies encouraging the usage of QCDRs and certified electronic health record technology (CEHRT). CMS is promoting use of CEHRT by awarding bonus points in the quality scoring section for measures gathered and reported electronically via the QCDR, qualified registry, web interface, or CEHRT submission mechanisms.

While we recognize that claims based reporting is highly utilized by eligible clinicians, APTA recommends that CMS eliminate the claims based reporting mechanism in the future. APTA supports the use of electronic data reporting mechanisms, due to the complexity of the program we are concerned that using claims data submission specifically for the quality measures may place clinicians at a disadvantage due to the significant lag of feedback reports in the performance period. Without regular feedback, quality improvement cannot be achieved. As the goal of the MIPS program, or any quality reporting program, is to improve the quality of care, regular and timely feedback is an essential component of success. Reporting through electronic mechanisms has additional benefits including the ability to seamlessly capture data with decreased burden to the clinician, as CMS has acknowledged, if reporting is done through an EHR or through a registry that interfaces with an EHR.

CMS proposes MIPS quality criteria that focus on measures that are important to beneficiaries and maintain some of the flexibility from PQRS, while addressing several of the issues that concerned commenters.
To encourage meaningful measurement, CMS proposes to grant individual MIPS eligible clinicians and groups the flexibility to determine the most meaningful measures and reporting mechanisms for their practice.

To simplify the reporting criteria, CMS is aligning the submission criteria for several of the reporting mechanisms.

To reduce administrative burden and focus on measures that matter, CMS is lowering the expected number of measures for several of the reporting mechanisms, yet still are requiring that certain types of measures be reported.

To create alignment with other payers and reduce burden on MIPS eligible clinicians, CMS is incorporating measures that align with other national payers.

To create a more comprehensive picture of the practice’s performance, CMS is also proposing to use all-payer data where possible.

APTA appreciates these efforts and agrees with the overall goals of CMS for the program. CMS proposes to remove the requirement for measures to span multiple domains of the NQS. APTA supports this decision and agrees that, given the new categories under MIPS, providers likely will have measures that span multiple NQS domains. We believe that removing NQS reporting restrictions will further simplify reporting for providers.

**Quality Category**

CMS proposes that for payment years 2019 and 2020, 50% and 45%, respectively, of the MIPS composite performance score (CPS) will be based on performance in the quality performance category. For 2021 and beyond, 30% of the MIPS CPS will be based on performance in the quality performance category. APTA has concerns about this for clinicians being held out of the program until 2019.

Given that PTs have participated only in PQRS, they do not have cost/resource use measures, which would apply to them under MIPS. We are concerned that the quality category weighting would account for only 30% of their score when they would potentially enter MIPS in 2019. We believe this may put PTs at a significant disadvantage compared with other clinicians who will have 2 years of experience in the program.

The change in weighting of this category, combined with the increasing penalties under MIPS from 2017 to 2019, will place our providers in an unfair position upon entering the program. We ask that CMS make appropriate accommodations for clinicians who are added to MIPS at later dates, in order to provide them with equitable opportunities for success in this new reporting program.

CMS proposes that for the applicable 12-month performance period, the MIPS eligible clinician or group would report at least 6 measures, including 1 cross-cutting measure (if patient-facing) that includes at least 1 outcome measure. If an applicable outcome measure is not available, CMS proposes that the MIPS eligible clinician or group be
required to report 1 other high-priority measure (appropriate use, patient safety, efficiency, patient experience, care coordination) in lieu of an outcome measure. If fewer than 6 measures apply to the individual MIPS eligible clinician or group, CMS proposes that the clinician or group be required to report on each measure that is applicable.

CMS also proposes specialty-specific measure sets, designed with the American Board of Medical Specialties. Whatever the number of measures contained in a specialty-specific measure set, MIPS eligible clinicians would be required to report at least 1 cross-cutting measure and at least 1 outcome measure—or, if no outcome measures are available in that specialty specific measure set, to report another high-priority measure.

APTA supports this reporting criteria. We believe the lower threshold of measures for reporting is appropriate given the overall complexity of the program. APTA hopes that as the program matures, CMS will work with specialties that do not fall under the American Board of Medical Specialties’ rubric to develop similar sets for clinicians such as PTs. APTA believes that providers are looking for more guidance in measure selection, and that creation of these measure sets will help providers who are less familiar with the program report successfully. Additionally, APTA supports the flexibility of reporting either the specialty-specific measures set or the 6 measures. We believe this flexibility offers the most opportunity for success in reporting under MIPS.

Data Submission Criteria Proposals
CMS proposes the following data completeness criteria for individuals and groups:
APTA believes that increasing reporting requirements from 50% of all Medicare patients (under the current PQRS program) to 80% may be difficult for those reporting via claims. APTA also believes the data completeness reporting criteria for QCDR, registry, and EHR of 90% for all payers may be a difficult threshold, as many electronic reporting systems are set up to capture quality reporting data on Medicare patients only. This, therefore, will require workflow changes and additional programming to adjust for the data capture.

APTA supports the overall goal of moving toward reporting all payer data, but believes this may require a staged approach, using lower reporting thresholds in the beginning years of the program. Furthermore, should CMS choose to take a staged approach, we encourage CMS to provide clinicians with information on future reporting criteria to help...
all stakeholders, including EHR vendors, plan for future workflow changes. As CMS looks to collect all payer data, we suggest that new measures brought forward into the MIPS program cover the human lifespan to ensure that there are measures relevant to all patients.

Non-Patient-Facing MIPS eligible Clinicians

CMS proposes to apply the HHS secretary’s authority to reweight performance category scores to zero if there is no performance category score, or to lower the weight of the quality performance category score if there are not at least 3 scored measures. APTA supports the flexibility of reweighting categories.

Although PTs are not included in MIPS in its inception years, we do anticipate there will be challenges to ensure that PTs have adequate measures in all categories when they do enter the program. Reweighting the categories will allow CMS to work with specific stakeholders to ensure that unrepresented or underrepresented categories are reweighted appropriately for specific provider groups. For instance, PTs and other EPs who were not included in the Meaningful Use (MU) program continue to be challenged by CEHRT adoption. As PTs were not included in MU, overall EHR adoption in physical therapy facilities has been slow due to the cost and lack of funding to influence rapid adoption of CEHRT products. Additionally, as PTs were not part of MU, there are few CEHRT products in the market that include modules specific to them.

Selection of Quality Measures for Individual MIPS Eligible Clinicians and Groups

CMS will accept quality measures submissions at any time, but only measures submitted before June 1 of each year will be considered for inclusion in the annual list of quality measures for the performance period beginning 2 years after the measure is submitted. As is required by the Act, the Secretary must submit new measures for publication in applicable specialty-appropriate peer-reviewed journals. QDCRs will be exempt from this process, with QCDR measures undergoing a rigorous CMS approval process during the QCDR self-nomination period. APTA believes CMS should continue to work with stakeholders to make the process for selection of quality measures clear and well defined. We also encourage CMS to focus on getting new, relevant measures into the program within a shorter timeframe.

APTA believes that a 2-year submission to implementation interval will hinder introduction of new measures into MIPS through the traditional approach. We believe there will be growth in measures submitted to the program through QCDRs in the future.

Resource Use Performance Category

MACRA specifies a series of steps and activities to involve physicians, practitioners, and other stakeholder communities in enhancing the infrastructure for resource use measurement—including for the purposes of MIPS and APMs.
The Act requires the development of care episode and patient condition groups, and of classification codes for those groups. CMS proposes that the resource use performance category make up 10% of the CPS for the first MIPS payment year (CY 2019) and 15% of the CPS for the second MIPS payment year (CY 2020). As required by the Act, starting with the third MIPS payment year, the resource use performance category would make up 30% of the CPS. To ensure sufficient measure reliability for the resource use performance category in MIPS, CMS proposes to use a minimum of 20 cases for the total per capita cost measure.

CMS proposes to include in the resource use performance category several clinical conditions and treatment episode-based measures that have been reported in the Quality and Resource Use Report (QRUR) or were included in the list of the episode groups. Up to this point, PTs have not received information on resource use measures, as they were not included under the Value-Based Payment Modifier program. Furthermore, many of the resource use measures have been attributed to providers using rules surrounding the plurality of services of evaluation and management codes, and are primarily directed toward physicians and other primary care providers. Our providers have little to no exposure to episode cost data at this time. Additionally, PTs will not be eligible to participate in MIPS until reporting year 2019 at the earliest. For these reasons, APTA believes CMS should continue to work with non-physician professionals, such as PTs, on the episode groups to ensure that they make sense for non-physician professionals who are typically not primarily responsible for the ongoing care of these patients.

APTA recognizes that CMS is required to develop classification codes to identify patient relationship categories that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time service is provided. We support this approach, and believe that using relationship codes to determine attribution to providers of resource use measures may provide more meaningful data for nonphysician providers such as PTs than do the existing methodologies under the Value-Based Payment Modifier program. PTs typically furnish services to patients on a continuing basis during an episode of care, in coordination with the physician and other specialty providers.

APTA encourages CMS to work with stakeholders during the creation of these classification codes to determine the appropriate codes and methodologies for resources use attribution, particularly for the non-physician providers. APTA plans to submit comments later this summer regarding these codes. We believe that alternative methodologies for assigning resource use must be explored in order for non-physician providers such as PTs to create meaningful resource use measures for episode groups. For instance, in the case of PTs, resource use measures should reflect the costs associated with the specific provider’s service.

Clinical Practice Improvement Activity (CPIA) Category

CMS proposes that the CPIA performance category account for 15% of the CPS. CMS proposes to allow for submission of data for the CPIA performance category using the
qualified registry, EHR, QCDR, CMS Web Interface and attestation data submission mechanisms. CMS further proposes that in order to achieve the highest potential score of 100%, at three high-weighted CPIAs (20 points each) or six medium-weighted CPIAs (10 points each), or some combination of high and medium weighted CPIAs to achieve a total of 60 points for MIPS eligible clinicians participating as individuals or as groups. CMS proposes that an activity must be performed for at least 90 days during the performance period for CPIA credit.

CMS discusses the following exceptions for MIPS-eligible clinicians and groups:

- Small groups (≤ 15 clinicians), participants located in rural areas or geographic HPSAs, or non-patient-facing clinicians, are required to submit 2 CPIAs (either medium or high) to obtain a score of 100%.
- Those participating in an APM will receive 50% of the total CPIA score (30 points). To achieve 100% of the total CPIA score of 60 points, eligible clinicians or groups will need to select additional CPIAs.

While there are many medium-level activities that PTs might achieve on the initial CPIA list, there are only 3 high-level activities that may typically apply to our providers. APTA anticipates that many of our providers will meet the small-group exceptions for the CPIA category; however, we are concerned that not enough CPIA measures in this MIPS category that reflect the types of activities that non-physician providers would engage in.

CMS has proposed that in future years MIPS eligible clinicians or groups will have an opportunity to nominate additional subcategories, along with activities associated with each of those subcategories that are based on criteria specified for these activities, as discussed above. Additionally, CMS has proposed that in future years QCDRs will be allowed to define specific CPIAs for specialty and non-patient-facing MIPS eligible clinicians or groups through the already established QCDR approval process for measures and activities. APTA supports both proposals, as we believe it will allow specialty groups such as ours to bring forth other relevant CPIA activities.

**Advancing Care Information Performance Category**

CMS proposes to expand the reporting period for the advancing care information category to a 12-month reporting period to align with the overall reporting requirements of other MIPS categories. APTA supports aligning all category reporting periods to the 12-month calendar year. CMS proposes that the advancing care information performance category will constitute 25% of the MIPS eligible CPS for payment year 2019 and each year thereafter.

CMS points out that MIPS eligible clinicians will be evaluated under all four of the MIPS performance categories, including the advancing care information performance category, including MIPS eligible clinicians who were not previously eligible for the EHR Incentive, such as physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and hospital based EPs. CMS discusses that if there
are not sufficient measures and activities applicable and available to each type of MIPS eligible clinician, the Secretary shall assign different scoring weights (including a weight of zero) for each performance category based on the extent to which the category is applicable to each type of MIPS eligible clinician, and for each measure and activity specified for each such category based on the extent to which the measure or activity is applicable and available to the type of MIPS eligible clinician. CMS acknowledges that under the proposals for the advancing care information performance category of MIPS there may not be sufficient measures that are applicable and available to certain types of MIPS eligible clinicians, therefore, CMS proposes to assign a weight of zero to the advancing care information performance category for purposes of calculating a MIPS CPS for these MIPS eligible clinicians.

CMS goes on to state that as many of the non-physician clinicians are not eligible to participate in the Medicare and/or Medicaid EHR Incentive Program, there is little evidence as to whether there are sufficient measures applicable and available to these types of MIPS eligible clinicians. CMS proposes to assign a weight of zero to the advancing care information performance category if there are not sufficient measures applicable and available to NPs, PAs, CRNAs, and CNSs. CMS notes that they intend to use the first MIPS performance period to further evaluate the participation of these MIPS eligible clinicians in the advancing care information performance category and would consider for subsequent years whether the measures specified for this category are applicable and available to these clinicians. APTA supports the ability to assign a weight of zero to the advancing care information performance category if there are not sufficient applicable measures. APTA encourages CMS to evaluate the availability of measures for non-physicians in the advancing care information category in the first several years of the program and as other clinicians are added.

**Scoring of Quality Performance Category**

CMS proposes that for the quality performance category for first MIPS payment year (CY 2019 payment adjustments) the baseline period would be calendar year 2015, 2 years prior to the proposed calendar year 2017 performance period. CMS proposes that the quality performance category score would be the sum of all the points assigned for the scored measures required for the quality performance category plus the bonus points (subject to the cap) divided by the sum of total possible points. MIPS eligible clinicians would not receive zero points if they submitted the required measure and met the data completeness criteria, but are unable to be scored for any of the reasons listed in section II.E.6.a.2. (such as not meeting the required case minimum or using a measure that lacks a benchmark). CMS proposes to use for the quality performance category measures the case minimum requirements for the quality measures used in the 2018 VM: 20 cases for all quality measures, with the exception of the all-cause hospital readmissions measure, which has a minimum of 200 cases. To the fullest extent possible, MIPS eligible clinicians are encouraged to select measures that would have a required case minimum.

CMS proposes to create an incentive for MIPS eligible clinicians to voluntarily report additional high priority measures. CMS proposes to provide 2 bonus points for each
outcome and patient experience measure and 1 bonus point for other high priority measures reported in addition to the 1 high-priority measure (an outcome measure, unless no outcome measure is available, then another high priority measure) that would already be required under the proposed quality performance category criteria. CMS proposes to cap the bonus points for the high priority measures (outcome, appropriate use, patient safety, efficiency, patient experience, and care coordination measures) at 5% of the denominator of the quality performance category score. Additionally, CMS proposes to allow 1 bonus point under the quality performance category score if clinicians meet requirements referred to as “end-to-end electronic reporting.”

APTA appreciates the proposals related to scoring of the quality category. We do support the ability to report more than the required number of measures to allow clinicians to achieve the highest score possible. Additionally, we appreciate the ability for clinicians to earn bonus points as outlined for the quality category and believe this would be beneficial to our providers when they enter the program.

CMS recognizes that comparing all-payer performance with a benchmark that is built in part on Medicare data is a limitation, based on the fact that some PQRS reporting mechanisms have limited experience with all-payer data. Because of this issue CMS intends to monitor the benchmarks to see if there is a need to develop separate benchmarks. APTA supports the ongoing monitoring of the benchmarks for measures and would advocate for separate benchmarks where appropriate.

CMS proposes not to remove topped out measures at this time. CMS considered other alternatives such as limiting the number of topped out measures MIPS eligible clinicians may submit or reducing the weight of topped out measures. We support CMS decisions not to remove topped out measures at this time to allow clinicians to have adequate measures to choose from in the beginning years of the program. We ask CMS to consider that some provider groups may have multiple measures that have high performance rates that they must report due to measure availability. We have significant concerns about the removal of these measures in future years; of the 6 measures available for reporting by PTs via claims in 2016, 4 had performance rates of over 90% in 2014 (#130 documentation of medications, #131 pain assessment, #154 and #155 falls risk assessment and plan of care) and the other 2 had performance rates of 72% (#128 BMI screening) and 86% (#182 functional assessment). As other providers report some of these measures, we feel that we will be at risk of losing these topped out measures in future years and may find that we are entering the program in 2019 without an adequate number of measures. For this reason and other reasons discussed in our comments, APTA again urges CMS to make a decision regarding our inclusion in the 2019 MIPS program year that allows enough lead time to enable the excluded non-physician groups to prepare for MIPS participation.

CMS proposes that if a measure does not have baseline period information, or if the measure specifications for the baseline period differ substantially from the performance period, then CMS would determine the array of benchmarks based on performance on the measure in the performance period, breaking the actual performance on the measure into
deciles. CMS considered a variation on the scoring methodology that would provide a floor for a new MIPS measure. Under this variation, if a MIPS eligible clinician reports a new measure under the quality performance category, the MIPS eligible clinician would not score lower than 3 points for that measure. CMS believes that this would encourage reporting on new measures, but also prevent MIPS eligible clinicians from receiving the lowest scores for a new measure, while still measuring variable performance. CMS also considered lowering the weight of a new measure, so that new measures would contribute relatively less to the score compared to other measures.

APTA cautions CMS about incorporating methodologies that could cause unintentional scoring harm to providers who report new measures in the MIPS program. As we have outlined in our comments in this quality section, we are concerned about entering the program in 2019 without an adequate number of measures in the quality category given the number of topped out measures we currently report. It is possible that we may have many new measures in the early years of participation in MIPS. Given the lack of experience in value-based purchasing programs, we want to ensure that PTs are not set up for failure by an inability to achieve the maximum number of points if they must report new measures in the MIPS program.

CMS discusses options for improvement scoring methodologies to be incorporated into the MIPS program in future years. APTA believes that incorporating an improvement scoring methodology will be important moving forward, in particular when PTs enter the program in 2 years, as benchmarks may increase for our measures, potentially putting our providers at a disadvantage. We believe that the combination of achievement and improvement scoring would allow providers the best opportunity for success in the MIPS program.

Scoring of Resource Use Performance Category

CMS proposes to create benchmarks for the resource use measures based on the performance period. CMS considered an alternative to base the resource use performance category measure benchmarks on the baseline period rather than the performance period. This option would further align the resource use performance category benchmark methodology with the quality performance category benchmark methodology. This option would also allow CMS to publish the numerical benchmarks before the performance period ends; however, we believe the benefits of earlier published benchmarks are more limited for resource use measures. CMS believes the relative performance provided through the feedback reports would give MIPS eligible clinicians the information they need to track performance and to learn about their resource utilization. CMS believes that using benchmarks based in the performance period is a better approach than using benchmarks based in the baseline period because different payment policies could apply during the baseline period than during the performance period which could affect a MIPS’ eligible clinician’s resource use.

CMS proposes that if a MIPS eligible clinician is not attributed any resource use measures (for example, because the case minimum requirements have not been met for
any measure or there is not a sufficient number of MIPS eligible clinicians to create a benchmark for any measure), then a resource use performance category score would not be calculated.

APTA has concerns about the proposed benchmark period of the performance year, specifically the frequency through which feedback reports will be available to providers throughout the reporting year. Given the proposal for the frequency of feedback reports and the lag time between data collection and feedback reports, we are concerned that providers will not get sufficient feedback throughout the year on the resource use measures. For providers who have never received feedback on resource use measures, such as PTs, we are concerned that they will not be able to improve their performance in this category if their first feedback is 6 months into the performance period. For these reasons we encourage CMS to begin providing resource use feedback reports to the nonphysician groups at least 6 months prior to the date they enter into MIPS.

Scoring the CPIA Performance Category

CMS proposes to assign points for each reported activity within 2 categories: medium-weighted and high-weighted activities. Medium-weighted activities are worth 10 points. High-weighted activities are worth 20 points. CMS proposes the highest potential score to be 60 points for the CY 2017 performance period. CMS proposes that the following scoring would apply to MIPS eligible clinicians who are non-patient-facing professionals, part of a small practice (consisting of 15 or fewer professionals), a practice located in a rural area, or practicing in a geographic HPSA or any combination thereof:

- Reporting of 1 medium-weighted or high-weighted activity would result in 50% of the highest potential score.
- Reporting of 2 medium-weighted or high-weighted activities would result in 100% of the highest potential score.

APTA supports the scoring approach to the CPIA category and appreciates the alternative scoring methods for those in small practices, which will impact many of our providers.

Scoring the Advancing Care Information Performance Category

CMS proposes that to earn points toward the base score, a MIPS eligible clinician or group must report the numerator and denominator (or yes/no statement as applicable) for certain measures adopted by the EHR incentive programs in the 2015 EHR Incentive Programs Final Rule to achieve 50% of the total advancing care information performance category score. APTA is concerned, as we have expressed in several previous sections, that PTs will not have adequate measures to be assessed in this category and may be additionally hindered in meeting these measures by a lack of CEHRT vendors that offer products for PTs.

Calculating the Composite Performance Score (CPS)

CMS proposes the following equation for the CPS calculation:
CPS = [(quality performance category score x quality performance category weight) + (resource use performance category score x resource use performance category weight) + (CPIA performance category score x CPIA performance category weight) + (advancing care information performance category score x advancing care information performance category weight)] x 100.

CMS will closely examine the future report and recommendations on the issue of risk adjustment for socioeconomic status on quality measures and resource use to be issued by the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) and incorporate them as feasible and appropriate through future rulemaking. APTA supports the inclusion of risk adjustment for socioeconomic status on quality and resource use measures pending the recommendations of ASPE.

CMS provides a summary of the weights by performance category in the table below for the first 3 performance years of the MIPS program.

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>2019 MIPS Payment Year</th>
<th>2020 MIPS Payment Year</th>
<th>2021 MIPS Payment Year and beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Resource Use</td>
<td>10%</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>CPIA</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information*</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

*The weight for advancing care information could decrease (not below 15 percent) if the Secretary estimates that the proportion of physicians who are meaningful EHR users is 75 percent or greater. The remaining weight would then be reallocated to one or more of the other performance categories.

If there are not sufficient measures and activities applicable and available to each type of eligible clinician involved, the Secretary shall assign different scoring weights (including a weight of zero) for each performance category based on the extent to which the category is applicable and for each measure and activity based on the extent to which the measure or activity is applicable and available to the type of eligible clinician involved. CMS proposes to increase the weight of the quality performance category for MIPS eligible clinicians that are not scored on the resource use or advancing care information performance category. In CMS proposals, CPIA is the only performance category that would always have a performance category score. Therefore, CMS proposes that if a MIPS-eligible clinician receives a score for only 1 performance category, the clinician would receive a MIPS adjustment factor of 0% for the year.

APTA supports the reweighting proposal by CMS as outlined above. We believe that for providers who do not have performance scores in the resource use or advancing care information performance category, the provider should have the quality category weight increased.

MIPS Payment Adjustments
CMS proposes to use a single identifier, TIN/NPI, for all MIPS eligible clinicians, regardless of whether the TIN/NPI was measured as an individual, group or APM entity group. In other words, a TIN/NPI may receive a CPS based on individual, group, or APM entity group performance, but the payment adjustment would be applied at the TIN/NPI level. CMS proposes to use the CPS associated with the TIN/NPI combination in the performance period. For groups submitting data using the TIN identifier, CMS proposes to apply the group CPS to all the TIN/NPI combinations that bill under that TIN during the performance period. For individual clinicians submitting data using TIN/NPI, CMS proposes to use the CPS associated with the TIN/NPI that is used during the performance period. For clinicians in MIPS APMs, CMS proposes to assign the APM entity group’s CPS to all the APM entity participant identifiers that are associated with the APM entity on December 31 of the performance period.

In the case where a MIPS eligible clinician starts working in a new practice or otherwise establishes a new TIN that did not exist during the performance period, there would be no corresponding historical performance information or CPS for the new TIN/NPI. In these cases where there is no CPS associated with a TIN/NPI from the performance period, CMS proposes to use the NPI’s performance for the TIN(s) the NPI was billing under during the performance period. If the MIPS eligible clinician has only one CPS associated with the NPI from the performance period, then CMS proposes to use that CPS. This proposal ensures that MIPS eligible clinicians who qualify for a positive payment adjustment are able to keep it, even if they change practices. For those who have a negative payment adjustment, this proposal also ensures MIPS eligible clinicians are still accountable for their performance.

In scenarios where the clinician billed under more than 1 TIN during the performance period, and that clinician starts working in a new practice or otherwise establishes a new TIN that did not exist during the performance period, CMS proposes to use a weighted average CPS based on total allowed charges associated with the NPI from the performance period.

In some cases, a TIN/NPI could have more than one CPS associated with it from the performance period, if the eligible clinician submitted duplicative data sets. First, CMS proposes that if a MIPS eligible clinician is a participant in MIPS APM, then the APM Entity CPS would be used instead of any other CPS (such as a group TIN CPS or individual CPS). CMS proposes that if a MIPS eligible clinician has more than one APM Entity CPS for the same TIN (by participating in multiple MIPS APMs), we would apply the highest APM Entity CPS to the eligible clinician. Second, if a MIPS eligible clinician reports as a group and as an individual, CMS would calculate a CPS for the group and individual identifier and use the highest CPS for the TIN/NPI.

APTA supports the approaches outlined above by CMS for CPS score attribution. We believe that a weighted average CPS is a straightforward approach to handling providers who have changed practices mid-year. We appreciate that CMS needs to account for multiple scoring situations that may occur in the reporting period.
Review and Correction of MIPS Composite Performance Score

Beginning July 1, 2017, CMS proposes to include information on the quality and resource use performance categories in the performance feedback. CMS proposes to use fields similar (that is, quality and resource use) to those currently available in the QRURs. At a minimum for the first year, CMS proposes to provide performance feedback on an annual basis since the first performance feedback, required on July 1, 2017, would be based on historic data set(s). As the program evolves, CMS proposes to operationally assess/analyze the MIPS data, and may consider in future years providing performance feedback on a more frequent basis, such as quarterly. It is CMS’s goal to provide “timely” (such as quarterly) feedback as MIPS evolves. CMS proposes to initially make performance feedback available using a CMS designated system, such as a web-based portal; if technically feasible, perhaps an interactive dashboard. CMS is required to provide performance feedback for the quality and resource use performance categories only. CMS may consider including feedback on the performance categories of CPIA and advancing care information in future years.

CMS intends to explore the possibility of adding this feature to the CMS designated system, such as a portal, in future years. This feature could be a mechanism by which eligible clinicians can send their feedback (that is, if they are experiencing issues accessing their data, technical questions about their data, etc.) to CMS.

APTA supports use of a web-based portal to provide feedback reports. APTA feels that real-time feedback reports in quality reporting programs such as MIPS are an essential part of improving the quality of care for patients, and would encourage CMS to explore providing reports quarterly or more frequently throughout the year. APTA encourages CMS to provide feedback reports to all clinicians reporting in MIPS, including those who are not formally included in the program, as PTs who participate voluntarily will not see the value in data submission in MIPS without feedback reports. Additionally, APTA has concerns about the continued lack of awareness from providers on when and how to access these reports and encourages CMS to continue to explore ways to better communicate with providers regarding the feedback reports.

APTA encourages CMS to work with vendors (registry and EHR) who will be providing feedback reports to EPs in the MIPS program in order to standardize and streamline feedback reports in the future. APTA recommends that feedback reports be accessible to providers upon request, and that a threshold of quarterly feedback be a minimum requirement. APTA believes that clinically actionable data needs to be available to EPs throughout the year to support and drive quality improvement in clinical care. Last, APTA supports the idea of a feedback mechanism directly to CMS from the providers regarding the reports.

Performance Feedback Template

The performance feedback is meant to be meaningful and usable to eligible clinicians. In an effort to ensure these data are tailored to the needs of eligible clinicians, CMS solicited
comment through the MIPS and APMs RFI and received numerous comments regarding overall format of the performance feedback template. Suggestions were made on what this feedback should include for MIPS. CMS intends to collaborate with stakeholders outside of notice and comment rulemaking on how the performance feedback should look for MIPS, as well as what data elements would be useful for eligible clinicians. APTA supports the idea of a standardized feedback template. PTs were not included in the value-based payment program and did not receive QRURs, so at this time our providers do not have specific feedback regarding the template. We encourage CMS to engage with nonphysician providers to obtain feedback about the template.

Announcement of Result of Adjustments

Not later than 30 days prior to January 1 of the year involved, the MIPS adjustment factor (and, as applicable, the additional MIPS adjustment factor) is to be made available to MIPS eligible clinicians applicable to items and services furnished by the clinician for such year. If technically feasible, CMS proposes to include the MIPS adjustment factor in its performance feedback. If it is not technically feasible, CMS proposes to make it available through another mechanism as determined appropriate by the Office of the HHS Secretary (such as a portal or a CMS designated website). APTA recommends that CMS notify providers as soon as feasible regarding payment adjustments to allow practices to prepare for payment penalties. APTA would recommend that CMS consider providing the adjustment results via letter and through the feedback report if possible, especially in the beginning years of the program. Again, as we discussed above, many providers are still unaware of the timing of the release of the feedback reports and we would suggest that the payment adjust notice also go to the provider via letter or some other direct communication mechanism to ensure that the provider is aware of the adjustment as soon as possible. In the future, as providers are more aware of when and how to access their feedback reports, CMS may consider including the adjustment information in the feedback report.

CMS proposes to adopt a targeted review process under MIPS whereby a clinician may request that the agency review the calculation of the MIPS adjustment factor and, as applicable, the calculation of the additional MIPS adjustment factor applicable to that clinician for a year. CMS further proposes to adopt the following general process for targeted reviews: a MIPS eligible clinician electing to request a targeted review may submit their request within 60 days (or a longer period specified by CMS) after the close of the data submission period. All requests for targeted review must be submitted by July 31 after the close of the data submission period or by a later date that CMS specifies in guidance. APTA supports the targeted review process. Many of our providers submitted information PQRS review requests for the 2014 data year; they found the process extremely confusing and reported inconsistencies with the review process request submission. Based on our providers’ experiences, we encourage CMS to consider making this process as simple and transparent as possible.

Data submission via third party
Currently, the QCDR reporting mechanism provides a method to satisfy PQRS requirements based on satisfactory participation. CMS proposes that entities interested in becoming a QCDR for MIPS go through a qualification process. This includes the definition of a QCDR, self-nomination requirements, and the requirements of a QCDR, including the deadlines listed below. CMS proposes to expand QCDRs’ capabilities by allowing QCDRs to submit data on measures, activities, or objectives for any of the following MIPS performance categories:

- Quality
- CPIA
- Advancing care information, if the MIPS eligible clinician or group is using certified;
- EHR technology

CMS proposes to define a QCDR as a CMS-approved entity that has self-nominated and successfully completed a qualification process to determine whether the entity may collect medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. APTA is committed to improving the quality of care and believes that QCDRs offer a platform for quality improvement and collection of outcomes data. We are pleased to see the proposed regulations allow QCDRs to transmit data in all MIPS performance categories. We believe this will allow for streamlined data submission and more complete feedback to providers through QCDRs.

CMS proposes requirements for the establishment of a QCDR entity as follows: for an entity to become qualified for a given performance period as a QCDR, it must be in existence as of January 1 of that performance period (for example, January 1, 2017, for performance periods beginning in 2017). The QCDR must have at least 25 participants by January 1 of the performance period. These participants do not need to be using the QCDR to report MIPS data to CMS, but they need to be submitting data to the QCDR for quality improvement. APTA supports this proposal. Allowing QCDRs certification without requiring the submission of data to the MIPS program will allow registries hosted by nonphysician provider groups, such as APTA, to obtain QCDR certification despite lack of inclusion in MIPS in the inception years. APTA believes our registry is a vitally important resource for PTs to engage in quality improvement activities and to prepare for changing payment and delivery models, including participation in APMs. We believe it is important for CMS to continue to support the development and success of professional registries as we move toward outcomes-based payment and advance quality reporting structures, which will rely heavily on electronic data submission.

CMS proposes that for the 2017 performance period, the QCDR self-nomination period will be from November 15, 2016, until January 15, 2017. For future years, CMS proposes a self-nomination period from September 1 of the prior year until November 1 of the prior year. APTA supports this proposal; however, we encourage CMS staff to work with QCDR applicants to provide them feedback on measures that are submitted in the application process. APTA believes that getting feedback on potential measures during
the application process is critical for enabling QCDRs to make adjustments in order to get measures approved.

Public Reporting on Physician Compare

MACRA facilitates the phased approach to public reporting by requiring HHS to make available on the Physician Compare website, in an easily understandable format, individual MIPS eligible clinician and group performance information, including:

- The clinician’s CPS
- The clinician’s performance under each MIPS performance category (quality, resource use, CPIA, and advancing care information)
- Names of clinicians in Advanced APMs and, to the extent feasible, the names of these Advanced APMs and their performance
- Periodically posted aggregate information on the MIPS, including the overall range of composite scores for all clinicians as well as the range of their performance with respect to each performance category

Last, MACRA requires the Office of the HHS Secretary to annually make publicly available (beginning with 2015), in an easily understandable format, information with respect to physicians and other eligible clinicians on items and services furnished to Medicare beneficiaries.

CMS proposes that these data, to the extent that they meet the previously established public reporting standards, will be added to Physician Compare for each MIPS eligible clinician or group, either on the profile pages or in the downloadable database, as technically feasible. Statistical testing and consumer testing, as well as consultation of the Physician Compare Technical Expert Panel (TEP), will determine how and where these data are reported on Physician Compare. APTA supports the idea of a TEP to consult on the how and where the data be added to the physician compare website. We encourage CMS to ensure that there is appropriate and diverse representation on the TEP, including representation from nonphysician groups.

As we discussed in the beginning of this comment letter, APTA is concerned about the gap in the reporting of public data that will occur on the Physician Compare website because PTs excluded from the first 2 years of MIPS. We believe that a lack of data during these years may give the public an incorrect impression that PTs are choosing not to participate in the MIPS program when they are legislatively excluded. APTA encourages CMS to consider 2 potential solutions to this issue. First, we ask that CMS include a designation on Physician Compare that identifies providers who are not eligible for MIPS. Second, we encourage CMS to develop mechanisms that will incentivize PTs and the other nonphysician EPs to continue reporting quality measures during these interim years (2017, 2018) in order to avoid these unintended consequences.

Development of Alternative Payment Models

In the proposed rule, CMS lays out the core principles for APMs. They are:
1) To build a portfolio of APMs that collectively allows participation for a broad range of physicians and other practitioners.
2) Design the program such that the APM Incentive Payment is attainable by increasing numbers of practitioners over time, yet remains reserved for those eligible clinicians participating in organizations that are truly engaged in care transformation.
3) Maximize participation in both Advanced APMs and other APMs.
4) Create policies that allow for flexibility in future innovative Advanced APMs.
5) Support multi-payer models and participation in innovative models in Medicaid and commercial markets.
6) Recognize that the APM Incentive Payment added by the MACRA primarily incentivizes participation in Advanced APMs that involve covered professional services under Medicare Part B.
7) Minimize burden on organizations and professionals.

APTA supports these core principles and strongly urges CMS to use them as a litmus test for all APM activities, current and future. As stated earlier, many of the current APMs such as the MSSP and primary care initiatives have operated in isolation of nonphysician practitioners and specialty providers such as PTs. We believe that this not only diminishes the quality of care to Medicare beneficiaries and compromises collaborative care, but it also adds to the long-term growth of Medicare expenditures.

Advanced APMs

To be an Advanced APM, an APM through its payment entity must meet 3 MACRA criteria (section 1833(z) (3) (D)):

1) Require participants to use CEHRT
2) Provide for payment for covered professional services based on quality measures comparable to those in MIPS
3) Require that the participating APM entities bear more than nominal financial risk for monetary losses under the APM or that the APM be a medical home expanded under CMS’ Center for Medicare and Medicaid Innovation (CMMI) authority (Section 1115A of the Act)

Based on this criteria in the proposed rule, CMS has deemed that only 5 current APMs will qualify as Advanced APMs in 2017:

1) Shared Savings Program (Track 2 and 3)
2) Next Generation ACO Model
3) Comprehensive ESRD Care (CEC) (large dialysis organization arrangement)
4) Comprehensive Primary Care Plus (CPC+)
5) Oncology Care Model (OCM) (two-sided risk track available in 2018)
In the proposed rule, CMS acknowledges that this list is very limited. The agency encourages comments on expanding it; specifically, on how to make other programs under CMMI, such as CJR, qualify under the statutory requirements as an Advanced APM.

APTA believes that CMS' narrow definition of Advanced APMs bars participation by specialty and non-physician providers, but we remain hopeful that CMS will find ways to be more inclusive. As illustrated by the list above and throughout the current roster of projects under way by CMMI, rehabilitation has not been a focus, and, therefore, the participation of PTs in APMs has not been as robust as that of primary care physicians and hospitals.

This is due to several factors. One main factor is the organizational structure of the APMs. For example, for PTs in private practice to participate in the MSSP, the ACO entity must be willing to enter into a contractual arrangement with the physical therapy practice. Often, these entities are not willing to contract with providers outside of their networks or health systems. This is especially true in situations of physician-owned physical therapy services or large hospital systems that employ PTs. Therefore, we urge CMS to create APM pathways under CMMI and through the PFPM technical advisory committee that allow physical therapy practices, rehab agencies, and other therapy providers to be the main conveners of an approved APM.

By empowering these providers to originate APMs, CMS will meet the core principles laid out in the proposed rule while improving access to medically necessary rehabilitative care for Medicare beneficiaries. Numerous physical therapy practices and rehabilitation entities are at the forefront of innovation, and APTA strongly believes these entities should be able to become key players in health care transformation. APTA has undertaken the first steps to identify and support the work of these physical therapy innovators across the country and would be delighted to share this work with CMMI. Therefore, we strongly urge CMS to convene a summit where stakeholders such as APTA can present innovative models that focus on rehabilitation and care provided by nonphysicians and explore options for certifying these models as Advanced APMs and APMs.

Second, we urge CMS to consider including specialty services, such as rehabilitation (PT, OT, and SLP) in APM criteria. At a minimum, APMs should demonstrate that essential services such as physical therapy are provided within the APM or that the APM has the appropriate referral relationships in place to give patients access to these services. We recommend that CMS require all APMs to include this information on their application prior to approval of the entity as an Advanced APM or APM. In addition, CMS should also capture this information through patient surveys when inquiring about patient access to care, similar to the current methods employed in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program.

Third, we strongly encourage CMS to certify more existing models, such as CJR, as Advanced APMs. Currently, CJR is focused on elective primary hip and knee
replacement patients, from inpatient stay to post-discharge care 90 days after discharge. The program began on April 1, 2016, and is initially applicable for 5 years. Unlike other innovative models, CJR requires that all IPPS hospitals in the selected MSAs participate.

PTs are an essential member of the health care team; they provide evaluation and treatment for individuals following total hip and/or total knee arthroplasty (THA and/or TKA). In this capacity, PTs treat individuals in a variety of practice settings, including hospitals, SNFs, home health agencies, rehabilitation agencies, and private practice outpatient clinics. PTs integrate essential elements of evaluation and management with a person-centered focus based on the best available evidence to optimize outcomes. For individuals with THA and TKA, PTs provide various interventions with the goals of improving muscle performance, activity, and participation, and promoting physical activity to avoid subsequent impairments, activity limitations, and/or participation restrictions.

PT interventions are designed to restore and promote maximal physical function for patients following THA and TKA. The physical therapy model of practice as delineated in the Guide to Physical Therapist Practice is patient-centered, incorporating patients’ needs and goals across a continuum of care. PT interventions for people following THA and TKA aim to reduce pain; increase and maximize joint mobility, muscle strength, flexibility, and aerobic capacity; and prevent functional loss. Interventions may include therapeutic exercise; manual therapy; functional training in self-care, home management, and work; physical agent modalities; and use of orthotic, assistive, adaptive, protective, and supportive devices, combined with patient-related instruction and education.

APTA recommends that after the 5-year mandatory participation period, CJR become a voluntary program that allows providers who have been successful under the program to continue participation. We also recommend that CMS modify the program to allow multiple options for defining the episode. For example, CMS should enable conveners to have a bundled payment episode that excludes the inpatient stay, similar to that of model 3 within the BPCI. These modifications would encourage more participation in CJR while adding to the portfolio of APMs and the participation of providers within these APMs.

Fourth, APTA strongly urges CMS to ensure that there is a robust set of quality measures that apply to APMs, to reduce any financial incentives to decrease utilization and to ensure that APMs are meeting the goals of the program. In addition to the proposal that these programs meet the same standards as MIPS, we strongly recommend that CMS ensure that rehabilitation services such as physical therapy are integral components of APM quality programs. If strong measures are not in place, there is the potential for lack of beneficiary protection against underservice.

Use of Certified EHR Technology

An Advanced APM requires that its participants use CEHRT and makes payments under arrangements incorporating CEHRT. For Advanced APMs and Other Payer Advanced
APMs, CMS proposes to adopt the same definition of CEHRT as proposed for MIPS-eligible clinicians under section 414.3105, thereby aligning the MIPS and Advanced APM programs and facilitating transitions between MIPS and QP status. CMS seeks comment on the proposed CEHRT definition and whether it should be the same for Advanced APMs and Other Payer APMs. In addition, CMS seeks comments about other desirable HIT functionalities for APMs and about what new HIT standards and certification criteria are needed to encourage widespread interoperability.

APTA strongly believes that the participation of PTs in the adoption of HIT is vital to the success of APMs. The federal government will need to furnish appropriate resources and support for PTs to adopt interoperable EHRs that are necessary to communicate and coordinate care with other APM participants and professionals. As CMS is aware, PTs have been exempt from EHR meaningful use and have not been afforded the same resources as physicians and hospitals for HIT adoption. Therefore, we believe CMS should revise the current criteria for Advanced APMs to include gradual phase-in of CEHRTs. Initially, there should be a waiver of this requirement for providers who were not previously included under EHR meaningful use. PTs and other non-physician providers should be afforded the same opportunities as physicians to get up to speed with EHR adoption before punitive measures are imposed.

One critical step in supporting PTs’ adoption of CEHRT is the concerted effort to ensure that there are a sufficient number of certified EHRs that address rehabilitative care. Currently, only a limited number of EHRs certified through the Office of the National Coordinator (ONC) encompass the necessary components for the documentation and transmission of information regarding physical therapy services. Therefore, we urge CMS and ONC to work together to ensure that these products are certified accordingly. CMS and ONC should establish a designated work group of clinical experts and vendors for this specific purpose.

APTA strongly believes that EHR incentives and support need to be available both inside and outside of the APM, since a substantial number of private practice PTs will be administering care but may be outside the APM. We strongly believe that although operating outside of the APM, these health care providers will remain an important part of the health care continuum.

APTA believes EHRs will allow for improved patient and public health outcomes by providing access to real-time health information. For example, an EHR would allow an ACO participant or ACO provider/supplier to determine if a patient has specific drug or other allergies or what medications the patient is taking. In the instance of physical therapy, this information could help the PT determine the best method of treatment for the patient or understanding changes in the patient’s condition that will affect their progress toward the goals indicated in the plan of care.

For example, some medications affect balance and may limit what a PT can do with a patient. Or, knowing that a patient is on cardiac medication would help the PT determine which interventions to incorporate into a treatment program and how best to document
expected physiological responses to activity. In addition, it may be possible to conduct
disease tracking through HIT that could lead to early interventions to prevent or preclude
the worsening of a disease or condition.

Another method of clinical information data gathering and sharing that has been
employed with success is the Enterprise Data Warehouse (EDW). A data warehouse is a
single, complete, and integrated repository of data obtained from a variety of sources and
made available to providers and suppliers for reporting and data analysis. The EDW will
allow hospitals, physicians, PTs, and other rehabilitation providers to integrate data from
multiple source systems, enabling a complete view of care across multiple settings. The
EDW could potentially improve data quality by promoting the use of consistent codes,
descriptions, and nomenclature within the ACO. It is critical that APMs have a
comprehensive picture of clinical presentation and care of the patient in order to fix bad
practice patterns or the input of flawed data before major issues arise.

Therefore, APTA recommends that CMS encourage the use of new and innovative
methods for the collection of clinical data and require that APMs provide information
regarding quality performance to all eligible participants on, at a minimum, a quarterly
basis so that providers can adjust accordingly.

Monitoring and Program Integrity

CMS proposes to monitor Advanced APM Entities and eligible clinicians on an ongoing
basis for non-compliance with the conditions of participation for Medicare and the terms
of the relevant Advanced APMs in which they participate during the QP Performance
Period. CMS states that this will include vetting of applicants to Advanced APMs and
their compliance with the conditions of participation of Medicare and ongoing, periodic
assessments of Advanced APM Entities and eligible clinicians by APMs in conjunction
with the CMS Center for Program Integrity and other relevant federal government
departments and agencies.

CMS proposes that if an Advanced APM entity or eligible clinician is terminated from
the program during the QP performance period for program integrity reasons, or if the
Advanced APM entity or eligible clinician is out of compliance with program
requirements, CMS may reduce or deny the APM incentive payment to such eligible
clinicians. In addition, CMS states that if an eligible clinician is later terminated for
program integrity reasons arising during the QP performance period, CMS may recoup
all or a portion of any payment CMS made to the entity.

APTA supports this proposal, as we advocate for strong safeguards to ensure hospitals
and physicians do not exert undue influence under APMs that bar PTs and other
nonphysician providers from participation. In addition, there should be strong measures
in place that preserve beneficiary choice to receive treatment from providers outside of
the APM.
APTA strongly believes that the decision to include PTs and other non-physician providers in APMs should not be clouded by conflicts of interest and financial motivations. Therefore, we strongly urge CMS to monitor any negative effect hospital and physician market dominance may have, especially on small, independent nonphysician providers such as PTs in private practice. One potential concern we have with the ACO models is that a hospital may choose a larger physician group practice that provides physical therapy services to participate in the APM over a smaller PT private practice. This decision may be based on the larger physician group’s importance to the hospital as a referral source. Unlike physicians, PTs generally do not function as a primary referral source to the hospital. As a result, certain classes of providers, such as small PT private practices, could be excluded from ACO participation, and we believe that such exclusions could potentially impact quality of care.

Also, as a consequence of these joint ventures, hospitals and physicians may place undue pressure on nonphysician providers such as PTs to enter into questionable contractual arrangements that implicate the anti-kickback statute. These contractual agreements may include significantly lower proportions of shared savings distributed to nonphysician providers and compensation arrangements cloaked in the guise of rental or personal services agreements. We believe this issue also warrants scrutiny and the establishment of the appropriate safeguards under the anti-kickback statute, physician self-referral laws, and civil monetary penalty provisions.

As APMs form, and physicians and hospitals explore creative methods to encourage patients to stay within the APM network for their Medicare services, it may be all too convenient for APMs to employ current exceptions to the fraud and abuse laws in an abusive manner. Therefore, APTA requests that CMS ensure that APMs are prohibited from waiving copays, giving deep discounts, or offering other incentives such as free transportation and gym memberships to patients to incentivize them to receive services within the APM.

In addition, APTA requests that the federal government institute a system under which it continually (such as annually) assesses APM compliance with physician self-referral laws, anti-kickback statutes, and gainsharing civil monetary penalty provisions. We also request that the federal government provide guidance to providers, suppliers, and other stakeholders on methods in which the health care community can disclose or report potential violations of these anti-fraud and abuse laws.

**Physician-Focused Payment Models**

MACRA sets forth pathways for providers to participate in alternative payment models such as ACOs, bundled payment, and patient-centered medical homes that may offer incentive payments. Beginning in 2019, eligible clinicians who participate in Advanced APMs may become qualifying participants (QPs) and be excluded from the MIPS program. APM participants who are not QPs may receive a favorable scoring under MIPS.
Section 101(e)(1) of MACRA adds a new section 1868(c) to the Act that establishes the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and sets forth requirements for criteria and a process for stakeholders to propose PFPMs for review by the PTAC. This entity will have significant influence on the certification and creation of new APMs by CMS. CMS proposes to define a PFPM as an alternative payment model that has Medicare as a payer, includes APM entities (as in physician group practices or individual physicians) and targets the quality and costs of physician services.

More clarification is needed on how PFPM APMs and “other APMs” will qualify for credit under MIPS categories and, specifically, how participation in an APM will satisfy the CPIA category under MIPS. APTA urges CMS to provide significant flexibilities for providers in this area who are participating in an APM that does not meet the criteria of an Advanced APM.

As articulated previously, APTA remains concerned about the biased focus on physician services. While we believe that physician care is an essential part of the APM model, it should not be the sole focus. These models should also assess and measure the quality and cost of nonphysician services, such as physical therapy, on the APM.

It is our sincere hope that the PTAC and CMS will not focus solely on physician and specialty physician APMs but will take into consideration the participation of nonphysician providers such as PTs.

**Timeframe of Claims**

CMS notes that the statute directs CMS to make the APM incentive payment in a lump sum on an annual basis “as soon as practicable.” CMS states the importance of balancing the data accuracy with expedited payment.

CMS proposes to calculate the APM Incentive Payment based on data available 3 months after the end of the incentive payment base period, to allow time for claims to be processed. For example, for the 2019 payment year, CMS would capture claims submitted with dates of service from January 1, 2018, through December 31, 2018, and processing dates of January 1, 2018, through March 31, 2019. CMS believes that 3 months of claims run-out is sufficient to conduct the APM incentive payment calculations in an accurate and timely manner.

While APTA supports the proposal, we strongly encourage CMS to couple it with a detailed explanation of how CMS plans to ensure that information about beneficiary assignment, patient mix, condition, and diagnosis is transmitted to the APM and all providers associated with the APM in a timely manner. As providers who are allowed to participate in current APMs only as contracted parties with a hospital or physician practice, PTs in private practice, home health agencies, rehabilitation agencies, and SNFs often experience significant delays in receiving patient information. The failure to receive this information in a timely manner severely hinders rehabilitation providers from making critical infrastructure and clinical adjustments to ensure they are meeting the
quality metrics set forth by MACRA. Therefore, we recommend that CMS mandate that APMs transmit applicable patient information to all providers and eligible participants in the APM within 2 weeks after receipt of such information from CMS.

Along with providing timely patient information, CMS should mandate that APMs furnish providers and suppliers with timely information regarding their performance as eligible participants. With the advent of registries and other repositories for the collection of clinical data, it is imperative that providers have critical information about the quality metrics of the APM and how their care is contributing toward meeting these metrics.

We also recommend that CMS exercise its statutory authority by not only requiring APMs to provide a description in their application of how they plan to distribute shared savings among eligible participants and how these distributions will align with the mandates of MACRA, but also requiring that APMs in their applications demonstrate that savings will be distributed fairly and equitably to large and small practices. We believe this information should be closely monitored to guard against unfair business practices and to promote a fair and equitable distribution of incentive payments for all APM participants. CMS also should mandate that APMs distribute incentive payments to participants in a timely manner.

APTA strongly urges CMS to require that APMs, in good faith, make available to all participants financial and legal records in a timely manner before contractual agreements are finalized and throughout the duration of the contractual period. In addition, APMs should be required to provide clear and concise instructions to participants on compliance and quality-reporting requirements, including timely notification of when and how the APM has determined that a participant is in noncompliance with the stated terms of the agreement and/or the requirements of MIPS. This level of transparency is needed to ensure that participants are not susceptible to unfair business practices and that they are treated on a level playing field with the APM convener.

Considerations for Providers Operating Outside of an APM

As indicated within the rules of participation of most of the current APMs, participation is voluntary for professionals and patients. Beneficiaries may obtain Medicare-covered services from any Medicare provider or supplier regardless of their assignment to an APM. APTA strongly supports this provision. The decision to participate or not to participate in an APM should be solely decided by the patient and/or the provider/supplier, free of coercion or pressure from outside influences.

APTA strongly recommends that CMS clearly emphasize that any behavior that seeks to impede referrals or care by professionals who are not participating in the APM will be strictly monitored and penalized. CMS should not only collect and analyze claims data for APMs in a given area but also compare the claims data of the APM to that of nonparticipating Medicare-enrolled providers/suppliers in the same area during the same time period. These data should be analyzed not only for utilization comparisons and outcomes, but also to detect aberrant billing patterns that signal abusive or fraudulent
activities. In addition, CMS should ensure that beneficiary educational materials regarding APMs clearly inform beneficiaries that there are no barriers to their receiving care outside of an APM and that APMs are not allowed to impose any such barriers.

Second, CMS should reemphasize in its correspondence to APMs that patients have the right to receive care from providers and suppliers who are not a part of the APM. In this correspondence, we urge CMS to make it clear that APMs do not impede or restrict these providers and suppliers from obtaining access to medical records and other information that is needed to treat patients assigned to the APM in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 privacy and security laws.

Last, APTA recommends that all providers and suppliers, regardless of their involvement in an ACO, should be notified that an APM is forming in their area. This notification should explain in detail the APM requirements and contact information in case providers and suppliers have questions.

Conclusion

APTA thanks CMS for the opportunity to provide comments on the MIPS and APM incentive under the Physician Fee Schedule and Criteria for the PFPM proposed rule. As stated earlier, PTs are committed to providing care to Medicare beneficiaries through quality improvement programs and APMs. APTA looks forward to working with the Agency to ensure that MIPS and APMs are structured in a manner that is patient-centered, provides high-quality care, and seamlessly coordinates care throughout the health care continuum. If you have any questions regarding our comments, please contact Roshunda Drummond-Dye, Director Regulatory Affairs at (703) 706-8547 or roshundadrummond-dye@apta.org or Heather Smith, Director of Quality at 703-706-3140 or heathersmith@apta.org. Thank you for your time and consideration.

Sincerely,

Sharon L. Dunn, PT, PhD, OCS
President

SLD: rdd, hls