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August 16, 2017

Seema Verma, MPH  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Room 445-G  
Attn: CMS-5522-P  
Hubert Humphrey Building  
200 Independence Ave, SW  
Washington, DC 20201

*Submitted electronically*

**RE: CMS-5522-P; Medicare Program; CY 2018 Updates to the Quality Payment Program**

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) respectfully submits comments regarding the Medicare Program; Calendar Year (CY) 2018 Updates to the Quality Payment Program (QPP) proposed rule. APTA's goal is to foster advancements in physical therapist practice, research, and education. 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 physical health and functional abilities of members of the public. Physical therapy is an integral service provided to patients in a wide variety of inpatient and outpatient settings, including hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), rehabilitation agencies, and physical therapist-owned private practice offices in which health care is delivered to Medicare beneficiaries. We appreciate the opportunity to provide the following comments regarding the updates to the QPP for CY 2018.

This proposed rule will influence continued implementation of the Merit-based Incentive Payment System (MIPS) and incentive payments for participation in eligible alternative payment models (APMs). Its impact will reach outpatient therapists in private practice, as well as outpatient therapy services furnished in hospitals, outpatient rehabilitation facilities,

public health agencies, clinics, SNFs, HHAs, and comprehensive outpatient rehabilitation facilities. Continued implementation of MIPS and APMs, therefore, will affect eligible clinicians across the entire spectrum of the therapy delivery system.

APTA stands firmly committed to the goals of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and the association has worked diligently over the past decade to ensure that physical therapists are prepared to be meaningful participants in this new era of health care. 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, and post-acute care demonstration, and by our work with the National Quality Forum (NQF).

Rehabilitation is a critical element to delivering high-quality care and lowering the growth of health care expenditures. 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 providers throughout the health care spectrum, including physical therapists, HHAs, rehabilitation agencies, inpatient rehabilitation facilities, SNFs, and other provider types.

## **Summary of Recommendations**

### ***MIPS Program Recommendations:***

- 1) APTA strongly encourages CMS to add physical therapists to the MIPS program in 2021 (2019 data reporting year). Failure to include physical therapists in MIPS creates a fractured approach in moving all providers to value-based payment.
- 2) APTA encourages CMS to allow “pick your pace” in the initial year of participation for newly eligible professional groups added to the MIPS program.
- 3) APTA believes physical therapists should receive the same exceptions that other providers have received in MIPS for the advancing care information (ACI) category. This includes reweighting of the category when no sufficient measures are applicable or available to providers.
- 4) APTA encourages CMS to create a physical therapist specialty measure set for publication in the 2018 reporting year, as we believe that this would provide guidance for those who choose to participate in the selection of quality measures under MIPS.
- 5) APTA encourages CMS to ensure that all outpatient therapy providers, including facility-based providers, can participate in MIPS.
- 6) APTA urges CMS to waive the low-volume threshold exclusion for eligible professionals who elect to participate in a virtual group. The application of the low-volume threshold to virtual group participants prohibits solo practitioners and small practices from capitalizing on the opportunity to move to value-based payment. Additionally, APTA encourages CMS to allow providers who meet the low-volume threshold to have the ability to opt-in to MIPS in 2019.

### ***APM Recommendations:***

- 1) APTA strongly recommends that CMS address 2 barriers to the participation of physical therapists in APMs: (1) Certified Electronic Health Records Technology (CEHRT) and (2) the current Qualifying APM Participant (QP) threshold.

- 2) APTA encourages CMS to provide additional guidance, technical assistance, and other support to providers who have not previously participated in APMs.
- 3) APTA strongly recommends that CMS release its final determination of calculating the QP threshold for the Comprehensive Care Joint Replacement (CJR) model, as soon as feasible.
- 4) APTA urges CMS to release interpretive guidance that explicitly describes the payment and patient count information it anticipates APM Entities or eligible clinicians should submit in order for CMS to make a QP determination under the All-Payer Combination Option.
- 5) APTA strongly recommends that CMS reduce the record retention policy and require clinicians, APM Entities, and others to only maintain such records for a period of 5 years.
- 6) APTA urges CMS to create APM pathways under the Center for Medicare and Medicaid Innovation (CMMI) and through the Physician-Focused Payment Model Technical Advisory Committee (PTAC) that allow physical therapy providers to be the main conveners of an approved APM.

### **MIPS: Specific Concerns for Physical Therapists**

Section 1848(q) of the Act, added by Section 101(c) of MACRA, requires creation of the MIPS, applicable beginning with payments for items and services furnished on or after January 1, 2019 (with data reporting beginning in 2017). Physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists were included in the first year of the program. Under the discretion of the Secretary, other non-physician professionals are to become eligible in payment year 2021, including physical therapists, occupational therapists, speech language pathologists, clinical social workers, clinical psychologists, registered dietitians, nutrition professionals, and audiologists.

APTA strongly encourages the Secretary and CMS to formally add physical therapists to the QPP as eligible professionals beginning in 2021 (corresponding to the 2019 data reporting year). Physical therapists should be added to the program as they provide care to a large number of Medicare beneficiaries under the Part B benefit (4.3 million beneficiaries in 2011 per the Medicare Payment Advisory Commission Report to Congress) and act as integral members of the health care delivery team in outpatient settings. The Department of Health and Human Services has established goals to tie 50% of Medicare payments to quality or value through APMs and 90% percent of all Medicare fee-for-service (FFS) payments to quality or value by 2018. Failure to include physical therapists creates a fractured approach in moving all providers to value-based payment.

APTA believes that our members will face challenges, particularly in the first years of inclusion in the program, and we ask CMS to consider applying previous MIPS policies to physical therapists in their inception year in the program. We also request that CMS consider allowing “pick your pace” for newly eligible professional groups. Additionally, we encourage CMS to allow exceptions for our providers, as the agency has done for others in MIPS. APTA recognizes that physical therapists will be challenged in the ACI category of the MIPS program because they were not included in meaningful use and many of our

physical therapy-specific electronic health record (EHR) products today do not have CEHRT status. Moreover, many of the ACI measures may not apply to our providers. We ask the agency for the same consideration granted to nurse practitioners and physician assistants: exemptions for e-prescribing, hardship exemptions for small practices, and reweighting of the ACI category when measures are not applicable.

APTA appreciates the additional support that CMS has extended small practices with 15 or fewer clinicians, including those in rural locations, health professional shortage areas, and medically underserved areas, and we anticipate that a number of our small practices may benefit from this support once physical therapists become eligible professionals in MIPS.

One unique challenge APTA anticipates is decreased participation in quality reporting because of the gap between formal inclusion in the PQRS program that ended in 2017 and the pending formal inclusion in MIPS no earlier than 2019. In 2015, of the 52,458 eligible physical therapists, 79.8% reported under the PQRS program; this was 10% higher than the national average participation rate of 69.1% that year (2015 PQRS experience report appendix). As APTA has expressed in the past, we are grateful for the opportunity to voluntarily participate in the MIPS program in the 2017 and 2018 years. However, based on anecdotal information, we know that many of our providers have chosen not to voluntarily participate in the MIPS program in 2017 for a number of reasons.

We continue to encourage our members to stay involved in quality reporting through MIPS in 2017 and 2018 in order to gain experience in reporting under this new quality payment program. We believe it would be beneficial for physical therapists if CMS would create a specialty measure set for publication in the 2018 reporting year, as this would provide guidance for those who volunteer to participate in the selection of quality measures under MIPS. We welcome the opportunity to work with CMS on this measure set.

### **Facility-Based Physical Therapists Billing Medicare Part B**

As CMS is aware, physical therapists in private practice historically have participated in PQRS, but a large number of physical therapists who work in facility-based settings and bill Medicare Part B were unable to participate due to lack of independent billing in facility-based settings. We encourage CMS to consider adding these providers to MIPS in future years, and to allow providers in facility-based settings to participate in APMs and receive incentive payments. Excluding these providers from MIPS and APMs would leave a large number of providers outside of these evolving value-based payment systems. We believe that physical therapists in facility-based settings could participate in MIPS under the group reporting option.

Furthermore, we encourage CMS to consider allowing providers in facilities to report measures relevant to their respective settings, as CMS is exploring this same opportunity for eligible professionals in the hospital setting. For example, physical therapists billing Part B in SNFs may wish to report the same functional measures they report under the SNF quality reporting program (QRP). This would enable CMS to begin to align the new Improving Medicare Post-Acute Care Transformation (IMPACT) Act post-acute measures with the

MIPS program. APTA welcomes the opportunity to work with CMS to determine how best to add facility-based providers to the MIPS program, as well as to APMs, in future years.

### **Low-Volume Threshold**

CMS proposes to increase the low-volume threshold beginning in 2018 to \$90,000 or less for Medicare Part B charges, or for provision of care for 200 or fewer Part B beneficiaries. Additionally, CMS has proposed to allow individual MIPS eligible clinicians and groups in 2019 to opt-in to MIPS participation if they might otherwise be excluded under the low-volume threshold because they meet only one of the threshold determinations. APTA supports the change in the low-volume threshold; we agree with CMS that this change will reduce burden and mitigate some of the issues surrounding the confounding variables impacting performance under MIPS for small and rural practices. APTA supports CMS's proposal to move forward with an opt-in to the MIPS program to allow professionals to participate in 2019. However, we strongly encourage CMS to open MIPS participation to *any* eligible professional who wishes to opt-in to the program.

### **Virtual Groups**

CMS proposes to define a virtual group at §414.1305 as a combination of two or more Tax Identification Numbers (TINs) composed of a solo practitioner (a MIPS eligible clinician (as defined at §414.1305) who bills under a TIN with no other national provider identifier (NPI) billing under such TIN), or a group (as defined at §414.1305) with 10 or fewer eligible clinicians under the TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance period for a year. APTA supports this definition and believes that CMS should not limit the size of virtual groups at this time.

APTA strongly encourages CMS to waive the low-volume threshold exclusion for any participants that opt to form a virtual group. We believe this exclusion will arbitrarily limit the number of professionals who are eligible to form and receive payment adjustments through virtual groups. One of the primary benefits of having the virtual group option under MIPS is to allow eligible professionals who would not otherwise meet the low-volume threshold an opportunity to participate in the program, and receive payment adjustments, by forming a virtual group. We believe that professionals who put forth the effort to contract and apply to form a group would naturally exceed this threshold. Although physical therapists are not formally included in MIPS for 2018, we believe that many of our small practices would be detrimentally impacted in their ability to participate in future years if the low-volume threshold exclusion is applied to virtual group participants. Ultimately, the application of the low-volume threshold to virtual group participants prohibits solo practitioners and small practices from capitalizing on the opportunity to move to value-based payment.

### **Topped-Out Measures**

CMS proposes a 3-year timeline for identifying and proposing removal of topped-out measures—measures with benchmarks too high to allow meaningful metrics or room for improvement. After a measure has been identified as topped out for 3 consecutive years,

CMS may propose to remove the measure beginning in the 4th year. If removal is finalized through comment and rulemaking, the measure would no longer be available for reporting during the performance period. APTA supports this proposal, as we believe this allows eligible professions, societies, associations, vendors, and other key stakeholders to have sufficient time to prepare for the removal of a measure from the program.

### **Proposed Changes to the Qualified Clinical Data Registry (QCDR) Application Process**

CMS proposes beginning with the 2019 performance period a simplified process in which existing QCDRs in good standing may continue their participation in MIPS by attesting that the QCDR's approved data validation plan, cost, measures, activities, services, and performance categories offered in the previous year's performance period of MIPS have minimal or no changes and will be used for the upcoming performance period. CMS proposes that QCDRs with substantive changes to existing measure specifications or any new QCDR measures would have to be submitted for CMS review and approval by the close of the self-nomination period. APTA supports these changes and believes that decreasing the application burden for registries with minimal changes will enhance the capability of registry staff to assist their clients with quality improvement and data submission. Additionally, this may encourage registries to put forth many measure changes at one time versus submitting smaller changes annually, which should create a more efficient process for CMS staff in the review process.

### **APMs**

To ensure that physical therapists are well positioned to succeed in the QPP, we strongly recommend that CMS address two of the barriers to participation in APMs, specifically the CEHRT requirements and the current QP threshold. APTA encourages CMS to be mindful of providers who are not currently MIPS-eligible clinicians, but who would like to participate in APMs, specifically Advanced APMs. APTA strongly encourages CMS to provide significant flexibility to Advanced APM requirements for providers who need an opportunity to transition into a value-based payment models, much like the "pick your pace" transition period for MIPS-eligible clinicians. We strongly recommend that CMS relax the certified EHR requirements and modify the QP threshold.

#### **1. Certified Electronic Health Records Technology (CEHRT)**

The participation of physical therapists in the adoption of health information technology (HIT) is vital to the success of APMs. Recognition of the need to capture rehabilitative services in 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 QCDR. Additionally, 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 federal government, however, needs to furnish appropriate resources and support for physical therapists to adopt interoperable EHRs, which are necessary to communicate and coordinate care with other APM participants and professionals.

### *Phased in CEHRT Requirements*

Physical therapists have been exempt from EHR meaningful use and have not been afforded the same resources as physicians and hospitals for HIT adoption. No physical therapy EHR vendors have CEHRT and CMS has not yet addressed how these vendors would meet the CEHRT requirements. Further, while the Office of the National Coordination of Health Information Technology (ONC) certification process has established standards and other criteria for structured data that EHRs must use, there is no standard certification criteria for EHRs for physical therapists.

To ensure inclusion of physical therapists and other non-physician providers within Advanced APMs, there must be a sufficient number of certified EHRs that address rehabilitative care. Currently, only a limited number of EHRs certified through ONC encompass the necessary components for the documentation and transmission of information regarding physical therapy services. We urge CMS and ONC to work together to ensure that there are a sufficient number of certified products that have this capability. Moreover, it would be beneficial if ONC and CMS could provide implementation assistance and/or consultant support to physical therapists and other non-physician providers as they adopt certified EHRs.

Further, given that a substantial number of private practice physical therapists will be administering care to APM beneficiaries, but may themselves be outside of an APM, APTA strongly believes that EHR incentives and support must be available both inside and outside of an APM. Although these health care providers may be operating outside of the APM, they remain a significant part of the care continuum. Therefore, APTA urges CMS to revise the current criteria for Advanced APMs to include gradual phase-in of CEHRTs for providers, such as physical therapists, who have been exempt from meaningful use. CMS should consider implementing a waiver of this requirement for providers who were not previously included under EHR meaningful use. Physical therapists and other non-physician providers should be afforded the same opportunities as physicians to gradually phase into adoption of certified EHRs to ensure their successful participation in the QPP.

## **2. QP Threshold**

APTA recommends CMS consider the significant financial and administrative risk that physical therapists and other non-physician providers face when considering joining one or more Advanced APMs. For example, a physical therapist who fails to meet the QP threshold may be required to report under MIPS and unwittingly face a downward adjustment for the payment year. Alternatively, by choosing not to participate MIPS, and by not satisfying the QP threshold, the clinician is left without a Part B payment update or incentive payment. Clinicians determined to be Partial QPs agreed to take on significant risk when entering into agreements with APM entities, fully expecting to satisfy the QP threshold. Such clinicians proactively work to improve patient care. To that end, APTA recommends that CMS fully exclude from MIPS those clinicians determined to be Partial QPs; rather, going forward, Partial QPs should be allowed to earn a small bonus payment, such as 2%-3% of the estimated aggregate amounts paid for Medicare Part B services furnished by the Partial QP in

the preceding year. This will ensure that clinicians who have invested significant amounts of time and resources into ensuring the delivery of the highest-quality patient care are rewarded for taking on risk related to their patients' outcomes.

We do not believe MACRA prohibits Partial QPs from receiving an incentive payment that is less than the payment available for QPs.<sup>1</sup> In addition to the financial risk that the clinician or practice is required to take on, there are also legal, contracting, and technology fees associated with joining an APM. Participation in an APM requires significant resources and poses both a financial and administrative burden on the clinician or practice. Without offering a more significant reward, such as a small bonus, APTA believes that future APM participants who anticipate the possibility of missing the QP threshold by 1 or 2 percentage points may be significantly discouraged from participating in APMs.

Notwithstanding our recommendation above, APTA requests that within the final rule, CMS clarify that while an eligible clinician may not satisfy the QP or Partial QP thresholds, the clinician would continue to be held accountable for risk and also eligible to share in any APM savings.

### **Advanced APM Participation**

APTA asks that the agency carefully consider our additional comments as articulated below.

APTA has concerns that eligible clinicians who intend to participate in Advanced APMs in the future may not be adequately prepared for the complexities of APM contracting, the adoption of CEHRT, the collection and submission of data, and taking on risk. APTA encourages CMS to provide details on the method by which it intends to provide education and technical assistance to clinicians participating in Advanced APMs. We recommend that CMS provide additional education to provider types, such as physical therapists, who have not yet participated in APMs on a large-scale basis. Within the final rule, we encourage CMS to clarify how clinicians who intend to participate in an APM may request preliminary assessments that use historical data in order to anticipate likely threshold scores.

### **Medicare Advantage Health Plans**

Each year, physical therapists treat a significant number of Medicare Advantage patients. We appreciate that eligible clinicians who participate in Other Payer Advanced APMs, including those with Medicare Advantage, could receive credit through the All-Payer Combination Option beginning in 2021. Given the similarities of patients with Medicare Advantage and those with traditional Medicare, it is critical that CMS allow clinicians to use Medicare Advantage payments or patients to count toward the Medicare Option QP threshold. While the statute prohibits Medicare Advantage, Medicare-Medicaid plans, and the Programs of All Inclusive Care for the Elderly (PACE) in Medicare Option QP calculations, CMS has

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<sup>1</sup> MACRA states that in no case shall an eligible professional who is a partial qualifying APM participant, with respect to a year, be considered a qualifying APM participant for such year or be eligible for the *additional payment under paragraph (1)* for such year.

successfully used waivers of Medicare service rules and initiatives in other circumstances to assist APMs in improving care and engagement of patients.

Given that Medicare Advantage plans have saturated various markets across the country, APTA strongly recommends that, in an effort to improve the level of physical therapist participation in APMs, CMS permit eligible clinicians who participate in Advanced APMs that include Medicare Advantage to receive credit for that participation in QP determinations under the Medicare Option. To do so, we recommend using a waiver of authority—similar to the HHS Office of Inspector General and CMS waivers of certain fraud and abuse laws under the CJR model as well as the benefit enhancements afforded to Next Generation Accountable Care Organizations (ACOs)—which permits the waiver of certain Medicare service rules.

### **Determination of Other Payer Advanced APMs**

#### *Payer Initiated Other Payer Advanced APM Determination Process (Payer Initiated Process)*

CMS proposes to allow certain other payers, including payers with payment arrangements authorized under Title XIX, Medicare Health Plan payment arrangements, and payers with payment arrangements in CMS Multi-Payer Models to request that the agency determine whether their other payer arrangements are Other Payer Advanced APMs starting prior to the 2019 All-Payer QP Performance Period and each year thereafter.

APTA requests that CMS require payers that intend to submit a request to CMS for an Other Payer Advanced APM determination to notify in advance all APM Entities or eligible clinicians with whom it has contracted of its intent to submit the request. Such notification would help APM Entities or eligible clinicians avoid the burden and duplication of submitting their own such request, either prior to the All-Payer QP Performance Period or following the conclusion of the period. We suggest requiring payers to notify APM entities and eligible clinicians at least 60 days in advance of its intent to submit, given the time and resource-intensive process that would be required on the part of the APM Entities and eligible clinicians to compile all supporting documentation. Implementing such a requirement would also help CMS avoid having to review duplicative submission forms and accompanying documentation.

We support CMS's proposal to post on the CMS website a list of all other payer arrangements that are determined to be Other Payer Advanced APMs. APTA requests that in addition, CMS require payers to notify the participating APM Entities and eligible clinicians of CMS's determination as soon as practicable, so that eligible clinicians have a greater opportunity to assess whether they may satisfy the QP threshold or may be required to report under MIPS for the upcoming year.

#### *APM Entity or Eligible Clinician Initiated Other Payer Advanced APM Determination Process (Eligible Clinician Initiated Process)*

APTA requests CMS clarify the deadline for Other Payer Advanced APM determination requests *prior to the beginning of the All-Payer QP Performance Period* for other payer arrangements. As stated the CY 2018 proposed rule, CMS states that the Eligible Clinician

Initiated Process could be used to request determinations before the beginning of an All-Payer QP Performance Period for other payer arrangements, but would not be necessary for other payer arrangements that are already determined to be Other Payer Advanced APMs through the Payer Initiated Process.

CMS also proposes that if an APM Entity or eligible clinician submits incomplete information, CMS will notify them and allow the APM Entity or eligible clinician to submit additional information no later than 10 business days from the date of notification. APTA recommends that the incomplete submission notification from CMS be delivered electronically as well as in hard copy to the APM Entity and eligible clinicians to ensure the entity or clinician has the full 10 days to prepare and submit the required documentation. Moreover, we recommend that CMS's notification include the agency's rationale for its request. We also suggest that CMS accept the submission of supplemental documentation via mail, fax, e-mail, or other electronic methods as necessary.

Within the rule, CMS notes that APM entities and eligible clinicians may request Other Payer Advanced APM determinations using the Eligible Clinician-Initiated Process from August 1 through December 1 of the associated All-Payer QP Performance Period. Requests submitted by September 1 may allow Advanced APM determinations to be made before December 1. CMS intends to make the early notifications when possible, which APTA supports.

APTA has concerns, however, that CMS may not have the capacity to furnish an APM determination by December 31 for requests submitted in late October or November. A later determination, for example late January or February, would limit a clinician's window of opportunity to sufficiently collect and submit data under MIPS, should it be required. This could impact non-physician providers, such as physical therapists, in particular, as they may be new to the MIPS reporting process. We request that CMS establish an Advanced APM (Medicare Health Plan or Other Payer Arrangement) determination deadline by which clinicians can expect to receive a response from CMS based upon when the clinician's request is submitted. It is imperative that significant efforts be made to maximize the amount of time that MIPS-eligible clinicians have for data preparation and MIPS submission.

Moreover, APTA urges the agency to require that payers participating in Other Payer Advanced APMs provide clear and concise instructions to participants on compliance and quality-reporting requirements. CMS should mandate that all payers participating in APMs furnish APM Entities and eligible clinicians 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 receive critical information about the quality metrics of the APM and how their care is contributing toward meeting these metrics. Payer communication with APM Entities and eligible clinicians should also include timely notification of when and how the APM has determined that a participant is in noncompliance with the stated terms of their contractual agreement and/or MIPS requirements. 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.

Finally, APTA recommends that CMS require that all payers participating in APMs transmit information about beneficiary assignment, patient mix, condition, and diagnosis in a timely manner to APM Entities and eligible participants. As providers who are allowed to participate in current APMs only as contracted parties with a hospital or physician practice, physical therapists in private practice, HHAs, rehabilitation agencies, and SNFs often experience significant delays in receiving patient information. The failure to receive this information in an appropriate amount of time severely hinders rehabilitation providers from making critical infrastructure and clinical adjustments to ensure they are meeting the quality metrics under the QPP. Therefore, we recommend that CMS mandate that payers transmit applicable patient information to all APM entities and eligible clinicians within 2 weeks after receipt of such information from CMS.

### **Calculation of All-Payer Combination Option Threshold Scores and QP Determinations**

APTA supports CMS's proposal to create a 6-month All-Payer QP Performance Period of January 1 to June 30, as opposed to a 3- or 9-month period. As CMS acknowledges, limiting the performance period to 3 months would result in data that is not representative of the sample and likely would result in unintentional punishment for Advanced APMs with new collaborators. A 9-month performance period also would have complications, as such timeframe would significantly limit the amount of time clinicians have to collect and submit all necessary data to CMS, as well as prolong CMS's process to evaluate and render a QP determination.

APTA encourages CMS to maintain the QP determination submission deadline of December 1. While a later deadline may assist providers who need additional time to submit their Medicare and other payer data, it likely would not allow CMS sufficient time to complete the QP determinations and provide clinicians with QP and Partial QP status notifications in advance of the MIPS reporting deadline.

### **Use of Individual or APM Entity Group Information for Medicare Payment Amounts and Patient Count Calculations under the All-Payer Combination Option**

APTA strongly recommends that CMS release its final determination of calculating the QP threshold via the payment amount and patient count methods for the CJR model as soon as feasible. We understand that CMS is currently in the process of finalizing the numerator and denominator for the CJR model and that further guidance is forthcoming. Delaying publication of the CJR QP threshold numerator/denominator places those clinicians who require that information to ascertain whether their participation in the APM may satisfy the QP threshold at a severe disadvantage. Should CMS prefer to publish the final numerator and denominator for the CJR model in the final rule, any opportunity to identify and contract with hospitals participating in the CJR Advanced APM, as well as get up to speed with the adoption of certified EHRs prior to the start of the QP Performance Period, will be nonexistent. Accordingly, such clinicians will be forced to delay participation in the CJR Track 1-CEHRT for an additional year.

## **Information Submission for QP Determination**

APTA strongly urges CMS to release interpretive sub-regulatory guidance that explicitly describes the payment and patient count information it anticipates APM entities and eligible clinicians will need to collect and submit in order for CMS to make a QP determination under the All-Payer Combination Option, as well as the format and the submission mechanism (electronic, mail, fax, etc.). The proposed rule is vague on details, specifically in regards to what CMS expects the clinician to submit that outlines the payment and patient count information attributable to the eligible clinician through every Other Payer Advanced APM and for all other payments or patients, except from excluded payers, made or attributed to the eligible clinician during the All-Payer QP Performance Period. We request that CMS include in the final rule a calculation of the anticipated expense and time for clinicians to compile payment and patient count information.

## **Submission of Information for QP Determinations under the All-Payer Combination Option**

### *Required Information*

To facilitate and ease the burden for information submissions, CMS proposes to create a form that APM Entities or eligible clinicians would use to submit their payment amount and patient count information. We would greatly appreciate any clarification that CMS can provide regarding the method by which it anticipates payers and eligible clinicians should submit payment amount and patient count information in a way that allows CMS to distinguish January 1-March 31 information from January 1-June 30 information, so that the agency can make QP determinations based on the two snapshot dates.

## **Certification and Program Integrity**

CMS proposes that an eligible clinician or APM Entity submitting information with an All-Payer QP determination request must certify to the best of their knowledge that the submitted information is true, accurate, and complete. All documentation that would be needed to enable an audit of the determination (e.g., contracts, records) must be maintained for 10 years after submission or audit completion, whichever occurs later, and information and supporting documentation must be provided upon request to CMS.

Requiring APM entities and eligible clinicians to maintain all data submitted to CMS for a period of 10 years poses liability, storage, and cost issues, and places a significant burden on health care providers, including physical therapists, in small practices. It also places providers at greater risk of exposing health and other information. We encourage CMS to contemplate the statutes of limitation in enforcement, standards set by accreditation organizations, and state law record retention rules that require providers to retain records for 5 to 7 years. We recommend that CMS reduce the record retention policy to 5 years. There are numerous examples of the federal government implementing a record-retention requirement far less than 10 years. For example, CMS's 60-day overpayment reporting requirement calls for providers to retain records for 6 years, while the Occupational Health

and Safety Administration's recordkeeping requirement calls for employers to maintain the OSHA 300 log, privacy list, and other documents for 5 years.

### **Physician-Focused Payment Models (PFPMs)**

Within the proposed rule, CMS proposes to broaden the definition of PFPM to include payment arrangements that include Medicare or the Children's Health Insurance Program (CHIP) as a payer, even if Medicare is not included as a payer. CMS seeks comments on whether broadening the definition of PFPM would include potential PFPMs that could focus on areas not generally applicable to the Medicare population, and whether changing the definition of PFPM may engage more stakeholders in designing PFPMs that include more populations beyond Medicare FFS beneficiaries.

APTA appreciates CMS's proposal to broaden the definition of PFPM. We continue to have concerns, however, about the biased focus on physician services. While we support the development of PFPMs that include patient populations beyond Medicare beneficiaries, and believe that physician care is an essential part of the APM model, it should not be the sole focus. These models should also concentrate on, assess, and measure the quality and cost of non-physician provider services, such as physical therapy. It is our sincere hope that PTAC, as well as CMS, will begin to apply significantly more time and resources toward the development of rehabilitation-focused APMs. It is imperative that greater action be taken to integrate rehabilitation services into future payment models. As the development of future APMs continues onward and APM engagement grows, we strongly recommend that CMS provide additional guidance, technical assistance, and other support to providers who have not yet participated in APMs.

### **Inclusion of Physical Therapy in Future APMs**

As stated in our previous comments, APTA believes that CMS's narrow definition of Advanced APMs continues to bar participation by specialty and non-physician providers. We remain hopeful, however, that CMS will find ways to be more inclusive. Unfortunately, rehabilitation has not been an area of focus for the agency, and, therefore, specific guidance for physical therapists who wish to participate in APMs has not been as robust as that of primary care physicians and hospitals.

#### *APM Measure Set*

APTA strongly recommends that the agency ensure that the APM measure set, if similar to MIPS measures, qualifies for MIPS reporting. To that end, we seek clarification on MIPS reporting for instances in which the eligible clinician fails to meet the QP threshold. When eligible clinicians fail to satisfy the QP threshold (and/or Partial QP threshold), and thus are required to report under MIPS, does the agency intend to allow the eligible clinician's APM measure set to be counted for MIPS participation? Clinicians determined to be Partial QPs or those who fail to satisfy either the QP or Partial QP thresholds must be able to easily report their data under MIPS. To ensure that APM participation does not create unintentional administrative and financial burdens, APTA recommends that CMS view an APM measure

set in the same manner the agency currently treats specialty sets, and permit the clinician to use the APM measure set for required participation in MIPS.

APTA also requests that CMS clarify and provide guidance in the final rule on how it intends to treat clinicians who fail to see the minimum number of patients for a measure, and encourages CMS to exempt those clinicians from reporting on the measure. Additionally, we request clarification and guidance on whether CMS may compile a small set of cross-cutting measures for instances in which clinicians believe they may not satisfy the QP or Partial QP threshold, and as such, could be reporting on those measures throughout the year.

#### *Lack of Inclusion of Rehabilitation and Non-physician Care in APMs*

Lack of inclusion is due to several factors. The first factor is the organizational structure of the APMs. For example, under the Medicare Shared Savings Program, ACOs must enter into a contractual arrangement with a physical therapy practice in order for physical therapists to participate in these organizations. 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 physical therapists.

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. We strongly urge CMS to work with APTA and other stakeholders in developing innovative models that focus on rehabilitation and care provided by non-physicians and explore options for certifying these models as Advanced APMs.

#### *Inclusion of Specialty Services in APM Criteria*

We urge CMS to consider including specialty services, such as rehabilitation (physical therapy, occupational therapy, and speech-language pathology) 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.

We greatly appreciate that CMS has developed a track within CJR that satisfies the definition of Advanced APM. Physical therapists 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, physical therapists treat individuals in a variety of practice settings, including hospitals, SNFs, HHAs, rehabilitation agencies, and private practice outpatient clinics. Physical therapists integrate essential elements of evaluation and management with a patient-centered focus based on the best available evidence to optimize outcomes. For individuals with THA and TKA, physical therapists 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.

APTA recommends that once the 5-year mandatory participation period ends, 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 Bundled Payment Care Initiative (BPCI). These modifications would encourage more participation in CJR while adding to the portfolio of APMs and the participation of providers within these APMs.

Additionally, APTA encourages 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. Additionally, it is imperative 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 potential for lack of beneficiary protection against underservice.

#### *Monitoring and Program Integrity*

CMS proposes to consolidate its policy on reducing and denying APM incentive payments for non-compliance with all Medicare conditions of participation or the terms of the relevant Advanced APM in which they participate during the QP performance period and revise the new paragraph to discuss when CMS may reduce or deny an APM incentive payment to an eligible clinician.

While we support CMS's proposal, we strongly urge the agency to continue to monitor any negative effect that hospital and physician market dominance may have on small, independent non-physician providers, such as physical therapists in private practice. One potential concern we have in 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 physical therapist private practice. This decision may be based on the larger physician group's importance to the hospital as a referral source. Unlike physicians, physical therapists generally do not function as a primary referral source to the hospital. As a result, certain classes of providers, such as small physical therapist private practices, could be excluded from ACO participation, potentially impacting the quality of care delivered to patients.

Moreover, as a consequence of these joint ventures, hospitals and physicians may place undue pressure on physical therapists and other non-physician providers 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 non-physician 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. 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.

APTA also recommends that the federal government institute a system to periodically (e.g., 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.

#### *Considerations for Providers Operating Outside of an APM*

APTA strongly recommends that CMS definitively 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 non-participating 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.

#### *APM Payment Distribution*

APTA recommends 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.

### **Conclusion**

For the agency's reference, our requests for clarification regarding the QPP proposed rule are summarized below:

- **Calculation of QP Threshold for EPMs**
  - APTA requests that CMS clarify the calculation of the QP threshold for the CJR model.
- **Participation in Multiple Advanced APMs**
  - APTA requests that CMS clarify how and when eligible clinicians, including those on affiliated practitioner lists, may request from the agency preliminary

assessments that use historical data to anticipate likely Advanced APM threshold scores. (82 Fed Reg. 30176)

- **APM Entity or Eligible Clinician Initiated Other Payer Advanced APM Determination Process (Eligible Clinician Initiated Process)**
  - APTA requests clarification of the deadline for requesting an Other Payer Advanced APM determination *prior to the beginning* of the All-Payer QP Performance Period for other payer arrangements and whether CMS anticipates it will require eligible clinicians to submit a different form. It would be helpful to know more information about this process. (82 Fed. Reg. 30184)
  
- **Submission of Information for QP Determinations Under the All-Payer Combination Option**
  - APTA requests that CMS clarify how it anticipates APM Entities and eligible clinicians should submit payment and patient count information in a way that allows CMS to distinguish January 1-March 31 information from January 1-June 30 information, so that the agency can make QP determinations based on the two snapshot dates.
  
  - We also seek clarification on the type of payment and patient count information CMS anticipates APM Entities and eligible clinicians will need to submit in order for the agency to make a QP determination. APTA greatly appreciates any guidance that CMS can provide in sub-regulatory materials and/or the final rule.
  
- **APM Measure Set**
  - APTA seeks clarification from CMS on instances in which an eligible clinician fails to meet the QP threshold and is required to report under MIPS. In such instance, will the agency allow the eligible clinician's APM measure set to be counted for MIPS participation? Clinicians considered to be Partial QPs or who fail to satisfy either the QP or Partial QP thresholds must be able to easily report their data under MIPS. To ensure that APM participants do not face significant administrative and financial burdens, APTA recommends that CMS view an APM measure set in the same manner the agency currently treats specialty sets, and permit the APM measure set to count toward participation in MIPS.
  
  - We seek clarification on whether CMS would compile a small set of cross-cutting measures for instances in which clinicians believe they may not satisfy the QP or Partial QP threshold, and thus could report on such measures throughout the year.
  
  - APTA also requests that CMS clarify whether or not clinicians who fail to see the minimum number of patients for a measure would be exempt from reporting the measure.

APTA thanks CMS for the opportunity to provide comments on the QPP proposed rule for CY 2018. As stated earlier, physical therapists 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 Kara Gainer, Director of Regulatory Affairs at (703) 706-8547 or [karagainer@apta.org](mailto:karagainer@apta.org) or Heather Smith, Director of Quality at (703) 706-3140 or [heathersmith@apta.org](mailto:heathersmith@apta.org). Thank you for your time and consideration.

Sincerely,

A handwritten signature in black ink that reads "Sharon L. Dunn". The signature is written in a cursive, flowing style.

Sharon L. Dunn, PT, PhD  
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy  
President

SLD: krg, hls