



May 25, 2018

Adam Boehler
Deputy Administrator and Director
Center for Medicare & Medicaid Innovation
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Submitted electronically to DPC@cms.hhs.gov

RE: CMMI RFI re: Direct Provider Contracting Models

Dear Deputy Administrator and Director Boehler:

On behalf of the nearly 4,300 members of the Private Practice Section (PPS) of the 100,000 member American Physical Therapy Association (APTA), I write to provide input and feedback on the request for information (RFI) on the Direct Provider Contracting (DPC) model concept put out by the Center for Medicare & Medicaid Innovation (CMMI) on May 23, 2018.

PPS is an organization of physical therapists in private practice who use their expertise to restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities in patients with injury or disease. The rehabilitative and habilitative care they provide restores, maintains, and promotes overall fitness and health and is considered an Essential Health Benefit which is required to be offered as part of a qualified insurance plan as defined by the Patient Protection and Affordable Care Act. As small business owners, we are interested in policies that will allow for access to affordable quality care for our patients who are Medicare beneficiaries. PPS strongly urges CMMI to consider the following recommendations when utilizing stakeholder input to formulate a DPC model.

Questions Related to Provider Participation

The RFI put out by CMMI clearly has physicians in mind. While that is understandable, PPS encourages CMMI to consider designing a model that could be made available and accessible to other providers and suppliers as well. Direct provider contracting (DPC) should not be solely available to physician practices but should be open to other Medicare enrolled providers and suppliers as well, including physical therapists and occupational therapists. With a model design that is not too challenging to implement and whose regulations are not overly burdensome, it could not only be feasible but desirable for independent, private physical therapy practices to participate in a DPC model.

One idea to consider would be to allow for the use and recognition of Management Service Organizations (MSO). An MSO enables independent therapy practices to enter into tightly organized networks for many purposes, including contracting with payers. Every practice participating in the MSO would be on the same billing, practice management, and outcomes platform for reporting purposes. Under an MSO, the independent therapy practices would all bill under the single tax ID of that MSO. This creates efficiencies for the payer in that it provides for single source contracting and payment which makes value-based contracts easier to implement and manage as well as increases accountability and consistency in the delivery of care.

The RFI inquired as to what features it should require practices to demonstrate in order for specific practice types to be eligible to participate in a DPC model. PPS asserts that CMMI could use features and quality reporting that CMS already requires for private practice physical and occupational therapies. First, a primary care provider must sign off on the therapist's plan of care as well as a required tenth visit plan of care update. Additionally, since July 1, 2013 physical, occupational, and speech therapists are required to submit functional limitation reporting for all Medicare Part B patients. Furthermore, when the Bipartisan Budget Act of 2018 (Public Law 115-123) was signed into law on February 9, 2018, it repealed the former hard cap on rehabilitation therapy spending per beneficiary and replaced it with a new therapy policy which does not have a maximum benefit, but instead will manage therapy spending that is incurred in any Medicare Part B outpatient facility by requiring that the KX modifier indicating services are medically necessary must be included once physical therapy/speech-language therapy or occupational therapy spending reaches a specified amount (i.e. \$2010 in 2018). Once spending for a beneficiary reaches \$3000 (adjusted annually beginning in 2028) in a year, there is the potential for targeted medical review, triggered by factors such as being a new Medicare-enrolled provider, aberrant billing as compared to peer providers with similar scope of practice, or if the provider belongs to a practice whose partners have been flagged for aberrant billing.

After qualifying to use a DPC model, providers would need clear and specific implementation instructions and easy access to education and technical assistance in order to participate. Ideally, the model's infrastructure would support technical specialists for specific practice types. More specifically, PPS requests that those who will provide support for rehabilitation therapists have a firm understanding of the workings of small private practice physical therapy practices. For example, it would be insufficient to have someone who understands physician practices be assigned to assist a small outpatient physical therapy practice if they are not also intimately familiar with the nuances of small outpatient rehabilitation therapy practices. Finally, we appreciate the fact that the RFI mentions offering financial feedback reports, ideally those would be offered on a quarterly basis.

Questions Related to Beneficiary Participation

Medicare fee-for-service (FFS) beneficiaries have freedom of choice of any Medicare provider or supplier, including under all current CMMI models. CMS asked if there should be limits under a DPC model on when a beneficiary can enroll or disenroll with a practice for the purposes of the model and how frequently beneficiaries would be able to change practices for the purposes of adjusting per-beneficiary per-month (PBPM) payments under the DPC model. In the case of standard physical and occupational therapy, it must be very flexible as generally a patient is not

able to anticipate when or if they will need rehabilitation therapy over the course of a year. Except for cases of rehabilitation following a planned surgery, patients generally would not know in January that they are going to have an accident, fall, or a stroke and need physical therapy sometime that year. Individuals who have chronic or degenerative physical conditions such as Parkinson's or Multiple Sclerosis are a discreet subset of our patients who seek regular and continuous habilitative therapy treatment—these patients would be best suited for participation in a longer term PBPM payment arrangement.

For all other physical therapy patients, their care would be of limited duration and therefore they would need to be allowed to enroll and disenroll at any time. Additionally, the enrollment and disenrollment process must be nimble in order to enable a patient to enroll and receive care immediately when the need arises. Delays in rehabilitation therapy can lead to poorer outcomes; it would be intolerable to implement a system which would impose obstacles which would result in care being postponed.

Questions Related to Payment

PPS is extremely cautious of the use of PBPM arrangements for rehabilitation therapy. In physical therapy it would be difficult to tie a PBPM payment to a provider unless there were a fixed number of beneficiaries that could be assigned to the provider for care. Furthermore, if Medicare beneficiaries were assigned to or chose to be treated in a small outpatient clinic, that small-volume clinic would be much more vulnerable to the variables of complex medical needs and have a much greater challenge weathering the number of visits needed to address the necessary range of utilization. One of PPS' gravest concerns is how small-volume outpatient physical therapy clinics could participate without risking the financial well-being of their business; a low-volume exemption might be in order.

Capitation models have been tried in the commercial insurance market and were difficult to manage for physical therapy; many providers experienced losses and opted out. After attempting to use a capitation model, physical therapy providers determined that a PBPM payment was only workable and financially feasible if they treated that patient no more than six times per month. As a result, a perverse incentive was created where providers would provide care as infrequently as possible, which hampered patient care and depressed favorable outcomes. At that time, the PBPM model paid a single provider for the patient evaluation. In cases where the patient didn't like their initial clinic and went to an alternative clinic, the second provider was not paid because the model only allocated funding to pay for a single evaluation—which had occurred at the initial, unsatisfactory clinic. As a result, both the patients seeking their choice of provider and the clinicians they eventually chose to care for them were unhappy with the program.

It is important to learn from this lesson and avoid these pitfalls in any future PBPM model. Firstly, rehabilitation therapy evaluations should be covered for each new clinic that a patient chooses. So as to be responsive to changing therapeutic needs and progress, a beneficiary should be able to change practices or providers on a monthly basis for physical and occupational therapy services. Secondly, in order to address the real factor of the financial feasibility of participation for all outpatient therapy clinics, the participating DPC model provider should be able to utilize healthcare extenders to assist with the portions of care that are less technical. In this model, the

use of telehealth and the utilization of therapy assistants and other extenders would be valuable resources for overall improved outcomes at a set expenditure. A PBPM model created for use in rehabilitation therapy must grant the provider some latitude in how and by whom the care is provided; functional outcome and beneficiary satisfaction should be used as the key indicators of quality and success. PPS also suggests that prevention, patient education, and establishing maintenance programs should be included in the types of physical therapy services paid for under a PBPM model. All of these factors would need to be considered as current regulatory restrictions are reviewed and a PBPM model is designed.

Medicare beneficiaries are likely to use a therapy benefit more frequently than the general population. One method to reduce the high risk on providers participating in a PBPM system would be to establish corridors of care. In such a model a provider who treats a beneficiary requiring excessive levels of care would fall out of the PBPM reimbursement framework. In these types of cases the provider could be reimbursed using traditional FFS for those treatments that appear to be outliers based on standard care paths for a specific diagnosis and patients with similar co-morbidities.

Finally, we are encouraged that CMMI is willing to think of additional new payment structures through which Medicare beneficiaries can receive care from Medicare enrolled providers. CMS can achieve quality care by increasing the flexibility of the Medicare program. PPS encourages CMMI, to the fullest extent of its regulatory authority, to incorporate and adopt the policy changes laid out in the *Medicare Patient Empowerment Act (H.R.4133)*. The bill would allow Medicare enrolled providers (including physical therapists) to contract directly with their patients who are Medicare beneficiaries—on a case-by-case basis. The decision to opt-out would not affect the entire practice, only the billing relationship between that patient and therapist and could be entered into without delay.

Questions Related to General Model Design

The RFI states that CMS is committed to reducing burdensome requirements. This is much appreciated; from the private practice physical therapist perspective, the reporting requirements on outpatient therapy practices are already burdensome. PPS suggests that CMS retrieve the necessary data from what is already being submitted. For example, the CMS-1500 contains diagnostic treatment codes for each visit which indicate the time spent, as well as functional limitation reporting at the initial as well as the tenth visit. In order to keep additional reporting to a minimum, a provider could simply include a modifier that indicates the patient is participating in the DPC model. This would not only avoid providers having to submit more information than they already do, but it would also prevent them from having to make significant software changes in order to submit additional data. For many PPS members who own and operate small outpatient clinics, significant technology and electronic health record investments could be a cost prohibitive barrier for participation.

Another option would be for CMS to use its Common Working File data to study injuries by diagnosis and payment by Employer Identification Numbers. While data mining can be flawed, one thing that could positively impact Medicare's bottom line would be the ability to sort average costs of treating types of injuries. This should be less challenging to achieve with ICD-

10 in place. For example, using a diagnosis like Lumbago-M54.15, data could be mined by market areas. Using statistical data, CMS could determine a bell-shaped curve for how many visits were used during an episode of care and the total cost of treatment. If a particular therapy provider is able to demonstrate the ability to achieve consistent results at a lower cost than the average, CMS could identify them as a “preferred provider” and contract with that provider based upon an episodic rate rather than a FFS rate. Medicare could then grant its beneficiaries free choice to receive their care where they see fit but could simultaneously induce a patient to choose treatment with “preferred providers” by reducing or eliminating the beneficiary’s coinsurance, deductible, and copay amounts. This would provide patients with incentive to use a provider that is demonstrating care that is consistently cost effective and of high quality. Additionally, the program could elect to remove (from the program) or scrutinize providers that are consistently performing well below these episodic averages.

The providers highlighted as “preferred” would be those which are saving taxpayer money, providing positive outcomes and, reducing avoidable readmissions. CMS would publish the information, but not mandate that patients receive care at one of the highlighted clinics. This kind of transparency would increase the quality of information by which a patient could make an educated choice about where to seek care. An additional benefit would be that if other facilities notice that their number of Medicare beneficiary patients was dropping, it would encourage them to learn why and take action to change their care in a positive way.

Questions Related to Program Integrity and Beneficiary Protections

PPS appreciates that CMS wants to ensure that beneficiaries in a DPC model receive necessary care that is of high quality and that stinting on needed care does not occur. PPS agrees with the importance of identifying value but wants to make sure that new safeguards are not overly burdensome. As stated above in the General Model Design section, PPS suggests that CMS retrieve the necessary quality reporting data from what is already being submitted by providers.

As small business owners of outpatient therapy clinics who rely upon our reputation for providing high quality care in order to insure a thriving business, PPS appreciates that CMS is concerned about the risk of undue influence impacting patients choosing one DPC practice over another. If CMS were to use the above suggestion of using the Common Working File to identify high performing providers who have demonstrated superior outcomes and cost savings, they should then publish a list of “preferred providers” online. Beneficiaries would then have the opportunity to search for and learn why these clinics are receiving a “preferred provider” certification from CMS.

Furthermore, CMS could also make this information available to providers so that they may research their competition. For example, if treatment costs are varying significantly in a particular market area, providers might target growth into those areas where they think they can beat the competition by providing a better service at a lower cost. Providers would assess their competitive advantages and disadvantages and continually evaluate their businesses; they would learn, develop, grow, and improve in order to maintain or improve market share. This would be the case in rural, suburban, and urban communities.

PPS also strongly suggests that steps be taken to ensure patients are fully aware of both the limitations and benefits they will have agreed to upon choosing to participate in the DPC model. As providers we have regularly encountered patients who are not aware of the limitations (e.g. restrictions upon the number of therapy visits) they have agreed to when signing up for a program outside of traditional Medicare. Therefore, we suggest that CMS create a standard disclosure form, written in plain language, that is fully explained to the beneficiary before enrollment. To ensure unbiased information is presented, enrollment should be managed by a third party, not the chosen DPC provider. Once the patient agrees and is enrolled in a DPC model, they must be given a copy and it should remain part of the medical record; this agreement must be submitted if requested in an audit or in the case of a patient complaint.

In the case of rehabilitation therapy, the patient generally seeks care at the time they need the service. Additionally, physical therapists provide a wide range of services to address varied patient needs; therefore, it will necessary to have a system that will factor in a therapist's specialization and scope of practice. For example, in an orthopedic clinic it would be inappropriate for the provider to treat a beneficiary who had needs that extend beyond the provider's scope of practice—a patient who had an acute stroke should be seen by a physical therapist who specializes in neurological cases. Any model that CMS would develop to monitor “cherry picking” and “lemon dropping” must include an understanding of the physical therapy practice model which includes specialization and scope of practice limitations.

PPS has grave concerns with a model which would allow companies, hospitals, or clinics to incentivize potential patients to enroll in a DPC model with their providers. PPS believes it is paramount that providers not be allowed to offer incentives to beneficiaries that can induce patients to obtain their rehabilitation therapy from a participant practice or other specific suppliers and providers. An entities' ability to provide incentives would reflect their ability to spend money to increase patient volume but would not necessarily have any correlation with the quality of care the patients would receive. Furthermore, were incentives to be allowed it would certainly favor larger companies and practices over smaller or independent providers who don't have the extra funds available for incentives such as nominal cash incentives or gift cards.

Instead, CMS should be the entity which would provide incentives for patients to choose high quality care that is provided at a lower cost. Patient incentives could be in the form of reduced or waived deductibles, coinsurance, and copays when they obtain care from those facilities who have demonstrated the ability to provide quality care at a lower cost. However, should the DPC model provide beneficiary incentives in the form of reduced financial obligations, it would need to simultaneously ensure that participating providers were provided with an assured income stream that would not result in a net loss. Without that assurance, it would be difficult to find providers willing to participate. Finally, participation by patients as well as providers would likely increase if the enrollment process and participation requirements were simple and straightforward.

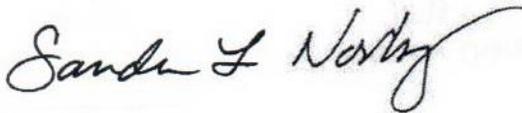
Conclusion

The DPC model should indeed be considered for physical therapy as it will be for PCPs and Family Practice Medicine. However, the restrictions that have evolved over time to prevent

fraud and over utilization may limit patients' outcomes and providers' ability to manage care. The success of such as models will require a paradigm shift in thinking and in regulating care under the Medicare rules.

PPS appreciates the opportunity to share our insight and perspective with the Department of Health and Human Services' Center for Medicare & Medicaid Innovation's request for information about direct provider contracting models. While CMMI might not have been considering how the DPC model might apply to rehabilitation therapy, we hope that our comments and feedback above were able to help the Innovation Center imagine how the model could be applied to our members and their outpatient physical therapy clinics. We look forward to future conversations about how a DPC model could be made available to private practice physical therapists and their patients.

Sincerely,

A handwritten signature in black ink that reads "Sandra L. Norby". The signature is written in a cursive style with a large, sweeping initial "S".

Sandra Norby, PT, DPT
President, Private Practice Section of APTA