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September 10, 2018

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

Attention: CMS–1693-P

Submitted electronically

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and other Revisions to Part B for CY 2019 and Quality Payment Programs

Dear Administrator Verma:

On behalf of the over 4,100 members of the Private Practice Section (PPS) of the 100,000 member American Physical Therapy Association (APTA), I write to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule regarding Revisions to Payment Policies Under the Physician Fee Schedule and other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Programs; and Medicaid Promoting Interoperability Program (CMS 1693-P) that was published in the July 27, 2018 *Federal Register*.

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. Representing independent, small business owners, we are interested in policies that will support the continued growth of our patient-centered care models.

In addition to the standard discussion of rates and policies surrounding payment, with the release of the 2019 the Medicare Physician Fee Schedule (MPFS) proposed rule, the Centers for Medicare & Medicaid Services (CMS) discussed how it intended to conduct the Quality Payment Program (QPP) for year three (reporting year 2019 which will impact payment for 2021). This proposed rule effects physical therapists in private practice who provide outpatient care as well as outpatient physical therapy services furnished in hospitals, outpatient rehabilitation facilities, public health agencies, clinics, skilled nursing facilities, home health agencies, and

comprehensive outpatient rehabilitation facilities and will have a substantial impact on rehabilitation therapy professionals for the foreseeable future.

PPS urges CMS to consider our views and comments on the following topics that are relevant to our membership and the Medicare beneficiaries we serve:

- Quality Payment Program
  - Eligible Providers
  - Merit-Based Incentive Payment System (MIPS) Determination Period
  - Low-Volume Threshold
  - Group Reporting
  - Quality Payment Program Performance Categories
- Medicare Physician Fee Schedule
  - Discontinuance of Functional Limitation Reporting
  - Reduction in Reimbursement for Services Furnished by Physical Therapy Assistants
  - Telehealth Services

Proposed Quality Payment Program Policy Changes

Eligible Providers

Restricted by statute, only physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists were MIPS-eligible clinicians for the first two years of the QPP. The Secretary of Health and Human Services (HHS) was given statutory authority to expand the program to additional providers in year three of the program. CMS assessed the list of possible clinicians to add and chose to include those providers who it considered to have a sufficient number of applicable quality measures and improvement activities available for reporting. As a result, this proposed rule seeks to add physical therapists, occupational therapists, clinical social workers, and clinical psychologists to the QPP, which includes MIPS.

While the program now includes physical therapists, not all will be required to participate. Providers can use the QPP website to determine if they are required to participate in MIPS. The website requires a clinician to provide their NPI, then CMS will inform the practitioner if they must participate in MIPS.

PPS Comment:
After two years of requesting inclusion in the QPP, PPS is pleased that the Agency has proposed to include physical therapy in the list of providers eligible to participate in MIPS.

MIPS Determination Period

In the proposed rule, the first 12-month segment of the MIPS determination period would take place October 1, 2017 through September 30, 2018 and be used to determine eligibility for MIPS. The second 12-month segment lasting from October 1, 2018 and September 30, 2019 would be used to verify provider eligibility through efforts such as rechecking group size as well as identifying groups that have disbanded or are no longer required to participate. Those

individual clinicians or groups evaluated and exempt from participation in MIPS during the first assessment period would retain that exemption for the applicable MIPS payment year, regardless of how they would be categorized in the second segment.[1] At the same time, should a provider be required to participate under the first assessment, but then dropped below the triggering threshold in the second assessment, that provider or group would then be determined to be exempt from participating in MIPS for that reporting year.[2]

PPS Comment:
PPS appreciates that the Agency is being careful not to compel the participation of providers who are not clearly and sustainably required to do so under the law. PPS recommends that CMS finalize, as proposed, the eligibility determination time periods as well as the time periods under which a provider is evaluated for participation.

Low-Volume Threshold
As in years past, CMS recognizes that low-volume providers of all types will have difficulty participating in MIPS and therefore have made an exception for certain small providers. CMS is proposing to use the same thresholds as last year; clinicians or groups are to be excluded from MIPS if they have ≤ $90,000 in Part B allowed charges for covered professional services OR provide care to ≤ 200 beneficiaries during the determination period.[3] New for year three, clinicians or groups may also be excluded from MIPS participation if they provide ≤ 200 covered professional services under the MPFS.[4] A professional service is considered to be a single billed unit of service. It will be easy for a practicing Medicare-eligible provider to exceed this lowest bar.

If an individual physical therapist exceeds the low volume threshold he/she must participate in MIPS or be subject to a penalty. If a group exceeds the low volume threshold (but none of the physical therapists in the group individually meet or surpass the threshold) the group may choose whether to participate or not in the program—but they are not required to do so. CMS will look at both the individual's national provider identifier (NPI)/tax identification number (TIN) and the group's TIN to determine whether or not the threshold has been exceeded, but can only apply a penalty to the group if the group actively chose to participate but then fell short of the measures required by MIPS.

PPS Comment:
PPS supports CMS maintaining the low-volume thresholds under which a provider is exempt from participating in MIPS, but because there is confusion in terms of whether or not the provider needs to meet all of the criteria described OR just one of the thresholds described, PPS requests that in the final rule CMS reframe the definition and also describe the scenario from the perspective of when the provider is compelled to participate in MIPS. For example, we are asking the Agency to please clarify if a physical therapist in private practice treats at least 200 unique beneficiaries and exceeds $90,000 in Part B allowed charges during the determination

[1] CMS 1693-P, pp 35886.
[2] CMS 1693-P, pp 35886.
[3] CMS 1693-P, pp 35886-35887.
[4] CMS 1693-P, pp 35887.

period, would this situation require the therapist to participate in MIPS or are they meeting the intent of the low volume threshold and therefore would not be required to participate in MIPS?

PPS also supports CMS' idea to expand the low-volume threshold criteria to include those who provide "more than 200 covered professional services" as it would establish a mechanism through which interested eligible providers may opt-in to MIPS. Based on CMS' 2016 professional services notation, under this criterion 96 percent of private practice physical therapists would qualify to opt in.[5] *In order to prevent providers or groups from accidentally opting-in, PPS appreciates that providers must clearly signal their intent to opt-in or voluntarily report to CMS by doing so via the QPP portal. PPS appreciates all of the agency's efforts to explain the criteria for participation in MIPS and would encourage the Agency to continue to provide such resources in the future. This support allows clinicians to make educated choices about the value of participating in the QPP which includes the best (and possibly only) chance for increased reimbursement between now and 2026.*

Group Reporting

A group is defined as "an entire single TIN"[6] with 2 or more clinicians (at least one clinician within the group must be MIPS-eligible) as identified by their NPI, who have reassigned their Medicare billing rights to a single TIN and choose to participate in MIPS at the group level. Some members of a group may also be on a participant list of a MIPS APM and may receive a MIPS payment adjustment based on the APM scoring standard.[7] Additionally, CMS is exploring a possibility of "sub-groups" in year four of the program so that the sub-group can report on measures and activities that are more applicable to that sub-group.

PPS Comment:
PPS seeks to clarify whether or not a group is required to participate if they meet the low-volume threshold but fail to report to Medicare that they are working as a group. For example, it is our understanding that if there are four physical therapists in a practice and those physical therapists don't exceed the threshold as individuals, but the group as a unit passes the threshold, then those individual providers have the freedom to decide whether or not to participate in MIPS. If this is accurate, then the group status gives the group the eligibility to participate, but doesn't obligate them to do so, furthermore the providers in a group must proactively decide which status to choose; the only people who would be penalized for not participating are those individuals who exceed the threshold and must participate in MIPS but do not do so.

Quality Payment Program Performance Categories

Seeking to improve the value of Medicare's quality-based payments and increase clinician flexibility, the proposed rule allows clinicians to choose measures and activities appropriate to the type of care they provide. MIPS allows Medicare clinicians to be paid for providing high value care based upon their performance in four categories: Quality, Promoting Interoperability,

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[5] See https://data.cms.gov/Medicare-Physician-Supplier/Medicare-Physician-and-Other-Supplier-National-Pro/85jw-maq9
[6] CMS 1693-P, pp 35891.
[7] CMS 1693-P, pp 35891.

Improvement Activities, and Cost. In this proposed rule, newly added clinicians—including PTs—are only required to report in two of the categories—Quality and Improvement Activities.

Quality performance category (worth 45% of total score):[8]
For this category, clinicians and groups must submit data on at least 6 measures including at least one outcome measure, if available.[9] In the proposed rule CMS designates seven functional status change outcome measures for physical therapists to use for reporting.[10] CMS proposes that if fewer than 6 measures apply to the clinician or group, then they must report on each measure that is applicable in order to get full credit.[11] Individual eligible clinicians in year three will be able to submit a single measure via multiple collection types, and will be scored on the data submission with the greatest number of measure achievement points. Reporting for the Quality category must cover the entire year and data must be submitted on at least 60 percent of the MIPS eligible clinician or group's relevant patients.[12]

PPS Comment:
As Quality Performance is the cornerstone of the goals of the QPP, PPS is pleased that the proposed rule not only provides clear mechanisms through which to report, but also provides physical therapy clinicians with seven outcome measures which reflect current clinical guidelines.

Improvement Activities performance category (15% of total score):[13]
This category will reward clinical practice improvements, such as activities focused on care coordination, beneficiary engagement, and patient safety which the Agency expects to result in improved outcomes. In order to get a good score for this category, providers need to attest to having engaged in these activities for 90 days. If clinicians are concerned that there are not enough relevant activities to choose from, CMS is actively soliciting improvement activity nominations in its Annual Call for Activities process.

PPS Comment:
PPS is pleased that the proposed rule allows clinicians to select activities that match their practices' goals and have a proven association with improved health outcomes. The list includes some which would be easily incorporated by physical therapists such as the use of a satisfaction survey to make improvements, providing education opportunities for new clinicians, integration of patient coaching practices between visits, engaging patients and families to guide improvement in the system of care, as well as developing a plan of care. Additionally, PPS plans on submitting additional relevant improvement activity nominations through CMS' Annual Call for Activities process.

Promoting Interoperability (PI) performance category (25% of total score):[14]

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[8] CMS 1693-P, pp 35896.
[9] CMS 1693-P, pp 35897.
[10] CMS 1693-P, pp 36351-36357, measures for patients with functional Impairments (217-223).
[11] CMS 1693-P, pp 35897.
[12] CMS 1693-P, pp 35897. See tables 31 and 32 on pp. 35898 for a detailed break-down.
[13] CMS 1693-P, pp 35905.
[14] CMS 1693-P, pp 35913.

The proposed rule exempts physical therapists from this part of MIPS in which eligible clinicians must use 2015 edition Certified Electronic Health Record Technology (CEHRT).[15] Performance-based scoring would take place at the individual-measure level.[16] The scores for each of the individual measures would be added together to calculate the score of up to 100 possible points for each MIPS eligible clinician.[17] "If a MIPS eligible clinician fails to report on a required measure or claims an exclusion for a required measure if applicable, the clinician would receive a total score of zero for the Promoting Interoperability performance category."[18]

PPS Comment:
It is appropriate that physical therapists are exempt from this category because the four included objectives are e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange.[19] These objectives have either minimal relevance to the physical therapy or heavy reliance upon electronic health records (EHR) technology.

Under current law physical therapists are not required to participate in meaningful use [known as the PI category in MIPS] and have not had access to the resources available to physicians and hospitals for implementing and using health information technology; therefore, it would be inappropriate to require use of CEHRT in the first year of MIPS participation. While the Office of the National Coordinator of Health Information Technology (ONC) certification process has established standards and other criteria for structured data that EHRs must use, there is no standard certification criteria for EHRs for physical therapists. As a result, only a limited number of CEHRTs encompass the necessary components for the documentation and transmission of information regarding physical therapy services. EHR vendors as well as providers need guidance, time, and financial resources to build and obtain rehabilitation-specific 2015 edition CEHRT.

<u>Cost performance category</u> (15% of total score):[20]
The proposed rule exempts physical therapists from this part of MIPS. For this category, the score would be based on submitted Medicare claims, meaning there will be no additional reporting requirements for clinicians. While CMS recognizes that many clinicians are still developing a familiarity with cost measures, it plans to increase the weight of the cost performance category by 5 percentage points each year until it reaches the statutorily required 30 percent weight for the 2024 MIPS payment year.[21]

PPS Comment:
As we represent a provider type who is certainly unfamiliar with cost measures, PPS requests that when physical therapists are required to report in the cost performance category that robust educational resources and training are made available to providers. Additionally, PPS suggests

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[15] CMS 1693-P, pp 35882, 35912.
[16] CMS 1693-P, pp 35915.
[17] CMS 1693-P, pp 35915.
[18] CMS 1693-P, pp 35915.
[19] CMS 1693-P, pp 35914.
[20] CMS 1693-P, pp 35901.
[21] CMS 1693-P, pp 35901.

that the weight of the category be lower for provider types who entered eligibility in year three versus those types of providers who were eligible to participate in MIPS from the outset.

Final Scoring:[22]
CMS proposes that if there are not sufficient measures and activities applicable and available to each type of MIPS-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 to that type of clinician. Further, CMS proposes that the small practice bonus would be added to the Quality performance category score, rather than added into the MIPS final score calculation.[23] CMS also proposes to adjust the final score by continuing a bonus of up to 5 points to address patient complexity for the 2021 MIPS payment year.[24]

When a MIPS eligible clinician joins an existing practice (TIN) in the final three months of the performance period year and the practice is not participating in MIPS as a group; or, when the practice is a newly formed TIN in the final three months of the performance period year, CMS proposes to assign a weight of 0 percent to each of the four performance categories and a final score equal to the performance threshold.[25]

PPS Comment:
As physical therapists are not required to report on two of the four categories, the proposed rule suggests that the weights of the two categories not required will be zeroed out and the weights of the quality portion (at 45 percent) and performance activities (at 15 percent) will be redistributed. PPS appreciates that CMS proposed to either weight the quality performance category at 85 percent and the improvement activities category at 15 percent or 70 percent for quality and 30 percent for improvement. While PPS strongly supports the focus on quality performance, we point out that providers should also be incentivized to focus on adequately measuring meaningful improvement in the delivery of care; increasing the weight of the improving activities category to 30 percent will ensure that an important balance is met through which providers can not only work towards the goal (through the improvement category) but achieve that goal (in the quality category). Therefore, PPS recommends the seventy-thirty weighting distribution as it will better enable private practice physical therapists to earn credit for their valuable improvement activities and achieve overall scores that reflect overall quality of care they provide.

PPS agrees that that the small practice bonus should be applied to the Quality performance category score and supports the proposal to do so rather than have the bonus applied only in the MIPS final score calculation. Furthermore, as providers who care for a wide range of patients, PPS appreciates CMS' proposal to continuing the bonus of up to 5 points to address patient complexity for the 2021 MIPS payment year.

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[22] CMS 1693-P, pp 35946.
[23] CMS 1693-P, pp 35950.
[24] CMS 1693-P, pp 35964-65.
[25] CMS 1693-P, pp 35966.

In order to protect newly formed NPI/TIN combinations from being obligated to participate when they would not be able to accurately estimate the volume of their new clinic, PPS requests that if the NPI/TIN did not exist in the first determination period, then instead of assigning a weight of 0 percent to each performance category, CMS would not require that new clinician to participate in MIPS in the first year in which that particular NPI/TIN combination exists, regardless of whether or not they would otherwise been obligated to participate. Alternatively, PPS suggests that this newly formed NPI/TIN combination should be treated as voluntarily reporting for the first year it was required to participate—affording the clinicians the opportunity to receive feedback form the Agency but not be at risk financially.

Performance Threshold / Payment Adjustment

The proposed rule seeks to set the performance threshold to which MIPS-eligible clinicians are compared for purposes of determining the MIPS payment adjustment factors at 30 points.[26] For those providers who score in the 25th percentile of the range of possible final scores above the 30-point performance threshold, a threshold of 80 points is proposed for exceptional performance in the 2021 MIPS payment year.[27] As required by statute, the maximum negative payment adjustment is -7 percent.[28] For those who score above 30 points, positive MIPS payment adjustments can be up to 7%, on a linear sliding scale.[29]

PPS Comment:

In year one of MIPS, the physicians' performance threshold was set at 3 points. The year three threshold is 30—ten times that of year one. PPS requests that those providers added in year three be granted the same lower performance threshold that was in place for those clinicians participating in MIPS in the first two years. Such an approach would give those eligible clinicians the same time and considerations to meet a threshold which will allow them to be eligible for positive payment adjustments that were granted to doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists during their introduction to MIPS.

Advanced Alternative Payment Model (APM)

Building on the Affordable Care Act (ACA), the MACRA legislation created additional rewards for Medicare clinicians who participate to a sufficient extent in Advanced alternative payment models (APMs). Those clinicians who participate in an Advanced APM are exempt from MIPS reporting requirements and qualify for financial bonuses. Many clinicians who participate to some extent in APMs may not meet the law's requirements for sufficient participation in the most advanced models. The proposed rule is designed to provide these clinicians with financial rewards within MIPS, as well as to make it easy for clinicians to switch between the components of the Quality Payment Program based on what works best for them and their patients. CMS expects that the number of clinicians who qualify as participating in Advanced APMs will grow as the program matures.

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[26] CMS 1693-P, pp 35972.
[27] CMS 1693-P, pp 35973.
[28] CMS 1693-P, pp 35976.
[29] CMS 1693-P, pp 35979, see Table 53.

PPS Comment:
Currently, physical therapists and other nonphysician providers are effectively barred from participating in Advanced APMs due to the lack of applicable CEHRT. While many providers are interested in participating in a value-based care system going forward, it is very difficult due to the lack of access to CEHRT which contains components necessary for the documentation and transmission of information regarding physical therapy services. Therefore, to better promote physical therapist participation in Advanced APMs, PPS recommends that the Agency consider modifying the CEHRT requirement for Advanced APMs to better accommodate participation by physical therapists. Additionally, PPS requests that physical therapists and other specialty providers are offered financial and technical assistance including implementation assistance and/or consultant support to physical therapists as they adopt CEHRTs, to better enable these practices to prepare for and participate in Advanced APMs.

Additionally, PPS requests that CMS take into account the significant financial and administrative risk that physical therapists and other nonphysician providers face when joining one or more Advanced APMs. For example, a physical therapist who fails to meet the threshold for being a Qualifying APM Participant (QP) may be required to report under MIPS and unwittingly face a downward adjustment for the payment year. Alternatively, a clinician who has chosen not to participate in MIPS, and cannot satisfy the QP threshold to participate in an Advanced APM is left without access to a Part B payment update or incentive payment, regardless of the high quality and value of the care they provide. Clinicians determined to be Partial QPs have agreed to take on significant risk when entering into agreements with APM entities, fully expecting to satisfy the QP threshold, and are proactively working to improve patient care. PPS encourages CMS to consider the obstacles and risks faced by physical therapists and how those may differ from other providers.

Medicare Physician Fee Schedule Proposed Changes

Discontinue Functional Status Reporting Requirements for Outpatient Therapy

The *Middle Class Tax Relief and Jobs Creation Act of 2012* required all providers of outpatient therapy services to include functional status information on claims for therapy services. Due to the repeal of the therapy cap in the *Bipartisan Budget Act of 2018*, CMS decided that functional status reporting data is no longer needed and has proposed to discontinue the "requirements for the reporting and documentation of functional limitation G-codes (HCPCS cods G8978 through G8999 and G9158 through G9186) and the severity modifiers (in the range CH through CN) for outpatient therapy claims" for services furnished on or after January 1, 2019.[30]

PPS Comment:
PPS appreciates that the Agency is following through with its commitment to a "Patients over Paperwork" initiative by focusing on improving patient outcomes and reducing regulatory burden. Therefore, PPS strongly recommends that CMS finalize its proposal to discontinue functional limitation reporting requirements, but suggests that the reporting requirement suspension be effective on the date of the final rule's publication instead of extending this unnecessary administrative burden to include services furnished between that date and January 1, 2019.

[30] CMS 1693-P, pp 35853.

Reduction in Reimbursement for Services Furnished by Therapy Assistants
The *Bipartisan Budget Act of 2018* requires that payment for services furnished in whole or in part by a therapy assistant be 85 percent of the applicable Part B payment amount for the service, effective January 1, 2022.[31] In order to implement this payment reduction, the proposed rule seeks to establish two new therapy modifiers – one for physical therapy assistants (PTA) and another for occupational therapy assistants (OTA).[32] The proposed rule defines, "in part" to mean any minute of outpatient therapy service that is therapeutic nature when the PTA or OTA is acting as an extension of the therapist.[33]

PPS Comment:
When considering the proposed differential of payment as described in the proposed rule, PPS encourages CMS to consider the manner in which physical therapy services are typically provided when both a physical therapist and a physical therapist assistant are involved in all or part of the patients care. It is not uncommon for a PTA to act as a second pair of hands for the physical therapist where both are involved in the delivery of a service, or alternatively the PTA can become the primary caregiver during the delivery of the service while the physical therapist provides supervision. Additionally, supervision requirements of the PTA by the physical therapist differ depending on the setting in which the services are provided. PPS suggests that the differential payment be applied only when the physical therapist is acting as a supervisor in a setting that requires direct onsite supervision and not in settings that allow for general or offsite supervision where the physical therapist is not directly involved in the delivery of the service by the PTA. Alternatively, PPS requests that if a payment differential were to be applied to all care provided by a PTA, that at the same time PTA supervision requirements in all settings should be changed to general supervision. The current in-office supervision requirements for physical therapists in private practice is hurting patients; for example, in small clinics in which only one physical therapist and one PTA are providing care, Medicare patients are impacted negatively when the physical therapist is on vacation or out sick.

Requiring the modifier to be applied when any minute of outpatient therapy is delivered by the PTA has serious implications for beneficiary access to care. Therefore, PPS recommends that CMS hold off and not finalize the definition of "in part" until CY 2020 rulemaking. This will allow CMS additional time to engage in an extensive discussion with the health care and rehabilitation industries, including the American Physical Therapy Association, the American Occupational Therapy Association, Part B therapy providers, and health information technology vendors in order to more precisely and accurately define the therapy assistant modifier and develop a differential policy which specifically reflects the circumstances under which the care is provided. Moreover, a delay in the defining of "in part" until CY 2020 proposed rulemaking will enable providers to get used to the process by voluntarily reporting the modifier during the latter half of 2019 based on the definition of "in part" as put forth in the 2020 proposed rule as

[31] CMS 1693-P, pp 35850.
[32] CMS 1693-P, pp 35850.
[33] CMS 1693-P, pp 35852.

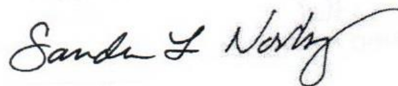
well as provide CMS data upon which to base a more specific policy that reflects when, where, and under what supervision requirements PTAs provide care.

Telehealth Services
The expansion of Medicare coverage for telehealth services is a cost- and life-saving solution to the critical concerns about access to care that impact the Medicare population. Proper application of telehealth rehabilitation therapy services, particularly in underserved areas and for the most vulnerable of Medicare beneficiaries, can dramatically improve care while reducing both program and beneficiary costs while more efficiently using both patient and provider time.

PPS Comment:
The appropriate use of telehealth rehabilitation therapy services (telerehab) could greatly improve the access and efficiency in delivery of select physical therapy services while reducing costs. PPS strongly encourages CMS, through its Center for Medicare and Medicaid Innovation (CMMI), to implement a pilot or demonstration program to evaluate the clinical benefit of rehabilitation therapists furnishing telehealth services to Medicare beneficiaries in those states in which telehealth services are permitted. The results of this demonstration would not only have the potential to improve beneficiary access to therapy services, but would also help to inform policymakers as they consider whether to recognize such healthcare professionals as authorized providers of telehealth under the Social Security Act. PPS also requests that the Agency support Congress in its efforts to expand the list of providers to be reimbursed for care provided via telehealth.

Conclusion
Private practice physical therapists are dedicated healthcare professionals, providing quality care to Medicare beneficiaries and are committed to participating in meaningful and effective innovation in the Medicare program. PPS thanks CMS for the opportunity to comment upon this proposed rule for the Medicare Physician Fee Schedule and the implementation of the Quality Payment Program. If you have any questions regarding our comments, please contact Alpha Lillstrom Cheng at alpha@lillstrom.com. We look forward to more opportunities to partner with CMS in pursuit of these goals for the Medicare program. Thank you for your time and consideration.

Sincerely,



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