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October 5, 2020

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Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1734-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-1734-P Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Verma:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), we appreciate the opportunity to submit comments in response to the Centers for Medicare and Medicaid Services (CMS) Medicare Physician Fee Schedule proposed rule. AAPM&R is the national medical specialty organization representing physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

VIII. Regulatory Impact Analysis

C. Changes in Relative Value Unit (RVU) Impacts

CMS proposes a 2021 conversion factor of \$32.26, which reflects a budget neutrality adjustment of -10.6 percent relative to the 2020 conversion factor of \$36.0896. While we continue to support the coding and valuation changes to the office and outpatient evaluation and management (E/M) codes that are largely contributing to this adjustment, as discussed further below, a reduction of this magnitude could have harmful impacts on physicians' and other clinicians' ability to sustain their practices, particularly for those practices that do not perform a large proportion of office and outpatient E/M visits. For example, many PM&R physicians focus on furnishing care in inpatient rehabilitation settings and therefore would disproportionately experience the



impact of the reduction in the conversion factor. Likewise, our physical therapy, occupational therapy, and speech language pathology colleagues – who perform vital services to support patients’ rehabilitation goals – are projected to face net payment reductions of 9 percent in 2021 under the PFS. We also note that payment impacts would extend beyond the Medicare program, as many other public and private payers, including the Department of Veterans Affairs and the TRICARE program, set payment rates based on rates in the Medicare program, thereby further exacerbating the effects of the PFS payment reductions.

While the projected reductions would be concerning at any time, we note that they would be even more devastating in 2021 given the impact the ongoing COVID-19 pandemic is having on clinical practice. Psychiatrists have played a unique and critical role in response to the pandemic, ensuring that patients experiencing severe complications from the virus are able to restore function and optimal health. However, psychiatry practices have had to implement many changes that have placed significant strain on our members. Many elective procedures were halted during the COVID-19 outbreak, which significantly impacted the financial health of psychiatry practices nationwide. While many practices have been able to offer more in-person services over time, they have continued to face financial and operational challenges as they have undertaken additional safety precautions, implemented social distancing in their practices, and faced shortages of personal protective equipment. Further, some patients remain hesitant or unable to leave their homes for medical services. For these reasons, overall volume has not yet returned to pre-pandemic rates. The American Medical Association has documented the impacts of halted elective procedures and slow reopening in its recent COVID-19 Financial Impact Survey¹.

The negative impact of the proposed conversion factor on practices already in a precarious financial position may be catastrophic, potentially pushing psychiatrists and other practitioners who support the essential health care needs of Medicare beneficiaries out of practice. Such an outcome would place patients at risk for not being able to obtain the care they need during and after the pandemic.

¹ AMA, COVID-19 Financial Impact Survey; [Fair Health, Healthcare Professionals and the Impact of COVID-19](#); [MGMA, COVID-19 Financial Impact on Medical Practices](#); [AMGA, Surveys of Financial Impact of COVID-19](#); [Primary Care Collaborative, Primary Care & COVID-19: Surveys](#).

For all of these reasons, AAPM&R urges CMS/HHS to use its authority under the public health emergency (PHE) to waive budget neutrality requirements for the new Medicare office visit payment policy.

II. Provisions of the Proposed Rule for the PFS

D. Telehealth and Other Services Involving Communications Technology

6. Comment Solicitation on Continuation of Payment for Audio-only Visits

AAPM&R strongly urges CMS to continue payment for audio-only services at least through the end of the calendar year in which the COVID-19 PHE ends and preferably at least through 2022. COVID-19 has highlighted the strengths of telehealth as it has allowed patients to access much needed care in a safe way. It has also highlighted the instances in which restricting coverage to audio-visual technology creates a barrier to care for certain patient populations and circumstances. For certain beneficiaries, audio-visual technology is simply not an option. For example, this may be due to lack of access or technological agility. Furthermore, some encounters simply do not require face-to-face contact. The Academy strongly supports the current level of access and reimbursement for audio-only services over the next two years.

7. Comment Solicitation on Coding and Payment for Virtual Services

AAPM&R urges CMS to continue to work with the AMA CPT to identify and define virtual services. During the PHE, physicians have found ways to continue to treat patients through new and innovative uses of technology. As new services are defined and added to CPT, we encourage CMS to find ways to adequately reimburse for them.

E. Care Management Services and Remote Physiologic Monitoring Services

AAPM&R appreciates the opportunity to submit comments regarding coverage for remote physiologic monitoring (RPM). We recognize that the current RPM code set is somewhat restrictive. We encourage CMS to work closely with the AMA CPT Editorial Panel to ensure that this code set is more inclusive of data capturing the patient's pain, functional status, and adherence to therapy. Furthermore, we urge CMS to ensure that all physicians, including physiatrists, can receive reimbursement to remotely monitor patients when it is appropriate and beneficial.

F. Refinements to values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits and Promote Payment Stability during the COVID-19 Pandemic

AAPM&R supports the January 1, 2021 implementation of the new office and outpatient E/M code descriptors and work RVU values recommended by the CPT Editorial Panel and AMA RUC and previously finalized. However, we recognize that the resulting physician payment cuts required to maintain budget neutrality will be unsustainable for the many physiatrists caring for Medicare beneficiaries, and as noted above we urge CMS to rely on all authorities available to mitigate this impact.

c. Comment Solicitation on the Definition of HCPCS code GPC1X

The code descriptor for GPC1X is different throughout various sections of the proposed rule. The comments outlined below are reflective of the following code descriptor, which we believe is the intended code descriptor, based on clarification provided by CMS and as articulated in the CY 2020 MPFS final rule:

GPC1X: Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient’s single, serious or complex chronic condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)

AAPM&R asserts that as described above, this code is highly relevant for many physiatry practices. Physiatrists treat patients with complex chronic conditions associated with medical comorbidities and high care needs. For example, many of our members are treating patients with stroke, traumatic brain injury, and neuromuscular disease. Evaluation, diagnosis and development of a treatment and management plan for chronic pain – which regularly accompanies the above conditions – is complicated and time consuming. *AAPM&R recommends that guidelines finalized for the use of code GPC1X are not restrictive based on the specialty of the physician in such a way that would restrict the code’s use by physiatry.*

AAPM&R is concerned that the utilization assumptions for code GPC1X identified in the proposed rule are significantly overstated. CMS assumes the code would be applied to 75% of all office visit claims. This estimate results

in a 3.5 percent decrease to the 2021 Medicare Conversion Factor. Based on the code descriptor, this estimate seems extremely unrealistic.

If CMS chooses to implement code GPC1X in 2021, AAPM&R urges CMS to re-examine and lower its 2021 utilization assumption.

G. Scope of Practice and Related Issues

In this section of the proposed rule, CMS contemplates or proposes several policies consistent with the President’s Executive Order 13890 on “Protecting and Improving Medicare for Our Nation’s Seniors” to modify supervision and other requirements of the Medicare program that limit healthcare professionals from practicing at the top of their license. Below we have included our response to provisions in each subsection.

1.b. Supervision of Residents in Teaching Settings Through Audio/Visual Real-Time Communications Technology

In the March and May Interim Final Rules with Comment Period (IFCs), CMS adopted policy on an interim basis during the COVID-19 PHE to allow the presence of a teaching physician during key portions of the service furnished with the involvement of a resident to be met using audio/visual real-time communications technology. CMS also adopted policy on an interim basis to allow PFS payment for the interpretation of diagnostic radiology and other diagnostic tests, if the interpretation is performed by a resident when the teaching physician is present via audio/visual real-time communications technology, given the teaching physician still reviews the resident’s interpretation. ***AAPM&R does not believe that these two policies should be made permanent but supports extension of the policies on a temporary basis until the end of the calendar year in which the PHE ends.*** We agree that this flexibility is an appropriate response to the current health care needs and helps limit potential exposure to both physicians and patients. This policy may also increase the capacity of teaching settings to respond to COVID-19. The risk of fraud, misuse, or abuse of the policy flexibilities are outweighed by the increased access and availability of residents and their supervising attendings to deliver healthcare via these technologies during the PHE.

AAPM&R shares CMS’ apprehensions that making these policies permanent, absent concerns due to COVID-19, could set a precedent that would impact patient care, particularly for high-risk patient populations (elderly, individuals with physical or cognitive disabilities, or other complex patients). PM&R attendings and residents have both expressed that the in-person teaching physician presence, not just "virtual presence," is necessary to provide

oversight and ensure the safety of Medicare beneficiaries. Permanently establishing this policy may also cause an increase in undue burden for the trainee and detract from the bedside teaching that is inherent in most residencies. Outside of the PHE, residents should be supervised in person, especially for testing, injections, surgery, reading radiologic studies, and other key training. At the same time, we support temporary continuation of these policies through the end of the calendar year in which the PHE ends in order to provide continuity for practitioners over the course of a full calendar year, and to account for potential lingering effects of the PHE, including norms around social distancing, potential ongoing risk of COVID-19 transmission, and ongoing challenges procuring personal protective equipment.

1.c. Virtual Teaching Physician Presence During Medicare Telehealth Services

In the March IFC, CMS adopted policy on an interim basis during the COVID-19 PHE to allow Medicare to make payment under the PFS for teaching physician services when a resident furnishes Medicare telehealth services to beneficiaries while a teaching physician is present using audio/video real-time communications technology. *AAPM&R supports extension of this policy on a temporary basis until the end of the calendar year in which the PHE ends.* AAPM&R shares concerns expressed by CMS and believes that these concerns are appropriate for care provided virtually in any circumstance, rather than only instances where the supervision is performed virtually. The supervising physician’s documentation of “teaching addendum” via virtual supervision should be considered equivalent to the pre-COVID-19 “teaching addendum” documentation.

1.d. Resident Moonlighting in the Inpatient Setting

In the March IFC, CMS amended policy during the COVID-19 PHE to state that “the services of residents that are not related to their approved GME programs and are furnished to inpatients of a hospital in which they have their training program are separately billable physicians’ services for which payment can be made under the PFS provided that the services are identifiable physicians’ services and meet the conditions for payment of physicians’ services to beneficiaries in providers, the resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the state in which the services are performed, and the services can be separately identified from those services that are required as part of the approved GME program.” *AAPM&R does not believe that these policies should be made permanent but supports extension of the policies on a temporary basis until the end of the calendar*

year in which the PHE ends. While resident moonlighting in the inpatient setting can help address workforce concerns and lessen the burden on physicians, particularly if another physician contracts the virus, there is a risk of overextending the trainee. Absent a PHE, potentially working over 80 hours, when including residency hours and moonlighting hours combined, can result in overexertion yielding substandard patient care. In any circumstance, we believe that moonlighting in the inpatient setting should comply with Accreditation Council for Graduate Medical Education (ACGME) standards. This includes adhering to an 80-hour per week duty hour requirement (including moonlighting hours), not allowing first-year residents to moonlight, and ensuring that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program or with the resident's fitness for work and does not compromise patient safety.

1.e. Primary Care Exception Policies

In the May IFC, CMS expanded the list of services included in the primary care exception to allow Medicare PFS payments to certain teaching hospital primary care centers for certain services of lower and mid-level complexity furnished by a resident without the physical presence of a teaching physician. This expanded list of services included CPT 99441 - 99443, 99445, 99446, 99421-99423, 99452, and G2012 and G2010. ***AAPM&R does not believe that these policies should be made permanent but supports extension of the policies on a temporary basis until the end of the calendar year in which the PHE ends.*** We appreciate that these flexibilities may lessen the burden on physicians for routine patient care appointments, such as refilling medications or preventive vaccines and screening. However, absent a PHE, there is a risk of undue burden on the trainee and substandard patient care if the teaching physician is not immediately available to assist the trainee (i.e. providing care for another patient concurrently while resident is seeing a low complexity patient). In addition, if trainees are spending substantial time caring for low complexity patients while the teaching physicians is caring for high complexity patients, this could begin to interfere with resident teaching and learning. There is also risk of insufficient oversight in patient care in cases where a resident may not yet be appropriately trained to notice certain nuisances of diseases that are worsening or require medication adjustments, specialist referrals, etc. CMS also seeks comment on whether to add CPT 99204, 99205, 99214, and 99215 to the expanded list of services included in the primary care exception policy. ***AAPM&R does not believe that these policies should be made permanent but supports adding these higher-level office and outpatient E/M services to the primary care exception policy on a***

temporary basis until the end of the calendar year in which the PHE ends in response to the current health care needs due to COVID-19.

Though not addressed in this current rule-making period, AAPM&R would like to reiterate comments we have submitted previously regarding services that may be performed by residents. We learned from AAPM&R members across the country that CMS requirements are resulting in greater restrictions on the activities that residents may perform in inpatient rehabilitation facilities (IRFs) compared to other settings. We are concerned that if these activities cannot be performed by residents working in IRFs, they will be limited in their ability to gain training and expertise in the critical elements of rehabilitation care. IRF regulations (42 CFR 412.622) currently require a rehabilitation physician complete certain tasks including:

- Face-to face visits
- Developing patients' individual overall plan of care

As a result, some IRFs are prohibiting residents from engaging in these activities and documenting information in patient medical records. Due to the lack of clarity in current regulations and guidance, the responsibility of completing these activities and associated documentation falls entirely to the rehabilitation physician and decreases the opportunity for residents to learn and practice these critical skills. This is inconsistent with the flexibility residents working under the supervision of teaching physicians in other inpatient and outpatient settings have. For example, residents generally may perform evaluation and management visits; surgical procedures and other complex procedures when a teaching physician is present during the critical or key portions. Likewise, they can complete documentation for teaching physician services if the teaching physician signs the notes and the documentation meets specified requirements regarding content and teaching physician participation. ***AAPM&R asks that CMS update its regulations and/or guidance to clarify that residents in IRFs may perform the bulleted services that must, as specified in IRF regulations, currently be performed by a rehabilitation physician.***

2. Supervision of Diagnostic Tests by Certain NPPs

In the May IFC, CMS adopted policy on an interim basis during the COVID-19 PHE, to allow Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Physician Assistants (PAs) or Certified Nurse Midwives (CNMs) (hereafter referred to as certain NPPs) to supervise diagnostic tests on a

permanent basis as allowed by state law and scope of practice. CMS is now proposing to amend its regulations to allow these certain NPPs to supervise diagnostic tests, including diagnostic psychological and neuropsychological testing services, on a permanent basis as allowed by state law and scope of practice. CMS also proposes to amend on a permanent basis, regulations that specify that diagnostic tests performed by a PA in accordance with their scope of practice and state law do not require the specified level of supervision assigned to individual tests, because the relationship of PAs with physicians under § 410.74 would continue to apply. ***As in AAPM&R's response to the IFC, we continue to request that CMS re-instate the physician supervision requirements of diagnostic tests after the PHE.*** AAPM&R appreciates the need to increase flexibility in scope of practice during the PHE to provide the necessary care for patients related to COVID-19, especially for lab testing and COVID-19 related orders. We also appreciate that this provision is subject to state law and note that conflicting state and federal provisions may result if this proposed rule were to be implemented. For example, some states do not allow non-physician practitioners to order select diagnostic procedures; as such, non-physician practitioners should not be allowed a blanket provision to supervise these diagnostic procedures. Performing diagnostic tests forms the foundation for diagnostic interpretation and should only be performed by individuals who possess appropriate clinical education and training, under the supervision of licensed physicians (MD/DO). Inaccurate execution of diagnostic testing can prohibit the proper and timely diagnosis of a disease, resulting in potential patient harm.

We also have concerns that this provision to allow more diagnostic testing without physician oversight would not intrinsically improve patient care and could increase the improper and inefficient utilization of already limited healthcare resources, as studies have shown that advanced practice clinicians tend to order more laboratory and diagnostic tests than physicians.² Nurse practitioners and physician assistants are integral members of the care team, but the skills and acumen obtained by physicians throughout their extensive education and training make them uniquely qualified to oversee and supervise patient care and diagnostic exams. Physician-led, team-based care has a proven track record of success in improving the quality of patient care and reducing health care costs.

² D.R. Hughes, et al., "A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits." *JAMA Internal Med.* 2014;175(1):101-07.

4. Provisions of Maintenance Therapy by Therapy Assistants

In the May IFC, CMS adopted policy on an interim basis during the COVID-19 PHE, to allow the physical therapist (PT) or occupational therapist (OT) who established the maintenance program to assign the duties to a PTA or OTA, as clinically appropriate, to perform maintenance therapy services. CMS explicitly stated that the maintenance therapy services furnished by therapist-supervised OTAs and PTAs will be paid in the same manner as rehabilitative therapy services. *AAPM&R supports permanent extension of this policy for PTs or OTs who establish maintenance programs to assign the duties to a PTA or OTA, as clinically appropriate, to perform maintenance therapy services in outpatient settings.* CMS also asserts that there is little difference between the rehabilitative therapy services furnished to improve a patient's functional status and maintenance therapy services, other than the goals set by the therapist in the therapy plan that are aimed to maintain, slow or prevent further decline of a patient's condition. AAPM&R would like to highlight that rehabilitative therapy plans are modified frequently to improve functional status and address the patient's evolving needs. While the PT or OT evaluates the patient and develops an initial plan that can be implemented by the PTA or OTA, the PT or OT must maintain its role of reevaluating the patient and adjusting the plan regularly. Team-based care should be maintained between all providers working together to provide patient care.

I. Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

2. Definition of OUD Treatment Services

In the CY 2020 PFS final rule, CMS finalized a definition of "OUD treatment services" to include oral, injected, and implanted opioid agonist and antagonist treatment medications approved by the Food and Drug Administration (FDA) under section 505 of the Federal Food, Drug, and Cosmetic Act (FFDCA) for use in the treatment of OUD. *AAPM&R supports CMS' proposal to amend the definition of OUD treatment services at § 410.67(b) by adding § 410.67(b)(8) to include opioid antagonist medications approved by FDA for the emergency treatment of known or suspected opioid overdose.* AAPM&R also agrees that the definition of OUD treatments should be further revised to include overdose education and that CMS should consider establishing an add-on payment for Opioid Treatment Programs (OTPs) to provide education related to overdose prevention. For CY 2021, CMS is proposing that in order for OTPs to bill for periodic assessments using HCPCS code G2077, a face-to-

face medical exam or biopsychosocial assessment would need to have been performed. Accordingly, the definition of periodic assessment would be amended to provide that the definition is limited to a face-to-face encounter. However, based on policies CMS finalized for the PHE, CMS proposes to revise § 410.67(b)(7) to allow periodic assessments to be furnished via two-way interactive audio-video communication technology, provided all other applicable requirements are met. AAPM&R does not believe use of virtual communication for periodic assessments should be made permanent but supports CMS' current interim policy that allows such activity on a temporary basis until the end of the calendar year in which the PHE ends.

K. Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D drug under a Prescription Drug Plan or an MA-PD plan

In this CY 2021 PFS proposed rule, CMS proposes to require all prescribers to conduct electronic prescribing of Schedule II, III, IV, and V controlled substances using the current NCPCP SCRIPT 2017071 standard by January 1, 2022, except in circumstances in which the Secretary waives the requirement. AAPM&R supports modernizing e-prescribing to improve patient safety and prescription accuracy and create workflow efficiencies for healthcare providers and pharmacies. We believe that an implementation date of January 1, 2022 is reasonable and appreciate the additional time for practices to transition, given many practices are still addressing ongoing concerns related to the current PHE. AAPM&R would like to highlight that though the implementation date is delayed, as with any EHR, not all practices or providers are currently using or planning to use this technology due to practice style, size, resources, capability and willingness to adopt new technology. We believe that if modernization is required, alternative options should be available, or assistance should be provided to ease the burden of cost and implementation.

IV. Quality Payment Program (QPP)

AAPM&R is concerned that CMS has not made detailed data on specialty participation in QPP tracks publicly available. For example, CMS' 2018 QPP Experience Report lacks key details about specialists' specific engagement in the MIPS and Advanced APM (A-APM) tracks of the QPP. There are several elements that specialties, including physiatry, need to know in order to understand participation trends, to craft meaningful educational materials for members, and to respond effectively to the policy proposals presented in this and other rules. These include specialty-specific MIPS data on: performance

category scores, total MIPS scores, and payment adjustments (including exceptional performance); participation trends such as group vs. individual-level reporting; reporting mechanisms used; measures most often reported; Qualifying APM Participant (QP) determinations; and model-specific participation for both MIPS APMs and A-APMs.

AAPM&R recommends that CMS publicly release data on specialty engagement in the QPP in order to further enhance our understanding of the impacts of future proposals to physiatrists and to improve our ability to draft comments on proposals that could significantly impact the field of physiatry.

3. MIPS Program Details

a. Transforming MIPS Value Pathways

AAPM&R supports the CMS delay in transitioning to the MVP framework until at least the 2022 performance year due to the PHE. As indicated in last year's comments on the RFI for the MVP policy development framework, AAPM&R supports the concept of a more cohesive and simplified participation experience by connecting activities and measures from the four MIPS performance categories relevant to a specialty, medical condition, or a particular population being cared for. While MVPs are intended to improve value, reduce burden, and better inform patient choice in selecting clinicians, we continue to be concerned about the ability of the current and emerging framework to meet these goals.

We offer the following comments on the revised Guiding Principles and Development Criteria:

Guiding Principles:

- *MVPs should consist of limited, connected complementary sets of measures and activities that are meaningful to clinicians, which will reduce clinician burden, align scoring, and lead to sufficient comparative data.*
- *MVPs should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers in evaluating clinician performance and making choices about their care; MVPs will enhance this comparative performance data as they allow subgroup reporting that comprehensively reflects the services provided by multispecialty groups.*

- *MVPs should include measures selected using the Meaningful Measures approach (and, wherever possible, the patient voice must be included, to encourage performance improvements in high priority areas.*

AAPM&R continues to agree that the MVPs offer the potential to move away from siloed activities and measures, but also recognizes the complexities of many common chronic conditions and the teams of health professionals that manage such populations. Conditions such as stroke, low back pain, arthritis and others are often comorbid conditions, and patients and providers have competing priorities in managing multiple chronic conditions simultaneously. Continuing with condition-focused pathways or measurement sets may not benefit patients seen by multiple specialists based on their specific diagnoses. AAPM&R also is pleased to see the patient voice incorporated into the MVP Guiding Principles, and we hope that the Agency will provide greater clarity on its expectations for how that will be accomplished. Furthermore, we offer the following on the proposed revisions to the MVP Guiding Principles:

1. We support the addition of “connected and complementary” sets of measures and activities that are meaningful to clinicians. We suggest that measures and activities should also be meaningful to patients to further promote the need for alignment with the CMS Meaningful Measures initiative and movement toward patient centricity. In addition, it will be difficult for developers and CMS to meet the second guiding principle of providing valuable information to patients and caregivers if the MVP components are not meaningful to patients and caregivers.
2. As noted above, we applaud CMS’ intent to add “the patient voice” to the third guiding principle but question the qualifier of “wherever possible.” AAPM&R believes that with appropriate guidance from CMS, and integration of patient engagement practices proliferating across the healthcare industry, the inclusion of the patient voice should be mandatory.

We note that CMS has also included “Incorporates the patient voice” as a new MVP Development Criterion. We encourage the Agency to be clear on expectations and offer tools, resources, and transparent guidance for MVP developers on how to best accomplish this patient inclusion. Engaging patients, families, and caregivers in the MVP definition and development process is essential. ***We strongly urge CMS to require that multiple patients***

with varying experiences and viewpoints be involved in any technical expert panels or other input opportunities. The voice of a single patient on any advisory panel provides limited input from the important patient community, and we believe it is not sufficient representation if CMS is truly interested in promoting a program that is understandable and usable by patients.

AAPM&R participates in numerous quality and measure collaborative groups that share information and work together to build expertise and knowledge. Collectively the groups we work with are expressing the following concerns about the MVP development process:

1. A need for more transparency and standardization in the MVP vetting process, and also the need for more innovative thinking and willingness to test new ideas. There is frustration over CMS rejecting more innovative proposals, which gives the impression that it is interested in little more than reshuffling the current program.
2. A need for clarity on the role of QCDR measures in MVPs (e.g., can they provide clinicians with multi-category credit, if applicable?).
3. A need for clarity on benchmarking and scoring:
 - a. Will participants in a single MVP only be compared to others reporting that MVP or to the broader MIPS eligible clinician population reporting on measures within that MVP?
 - b. How will CMS use MVPs to promote subgroup reporting if there is currently no mechanism to report that way under MIPS?
 - c. The proposed criteria that seems to suggest that CMS would expect all measures/activities in an MVP have the same denominator (e.g., CMS proposes to emphasize that “MVPs should consist of limited, connected complementary sets of measures and activities that are meaningful to clinicians...” CMS goes on to propose criteria related to the selection of MVPs that consider whether “quality measure denominators [have] been evaluated to ensure the eligible population is consistent across the measures and activities within the MVP”). We oppose measure collection and reporting in such a way; this would not be feasible for many specialties due to nuances unique to each measure that result in certain populations being included or excluded.
4. A need for resolution and improvement in the development of relevant cost measures, flaws in the existing total per capita cost measures and how the ongoing lack of cost measures for certain specialties will impact the MVP implementation process. We urge CMS to

accommodate more out-of-the-box thinking when it comes to cost measures since the current Acumen process to develop episode-based cost measures is lengthy and restricted to claims data.

AAPM&R supports a transparent and inclusive process to establish and implement MVPs into the QPP. We have noted our concerns about lack of clear guidance on the inclusion of the patient voice above. We support a standardized process for the co-development, solicitation, and evaluation of candidate MVPs; however, we are not confident there is an existing organization well positioned and capable to serve in these roles. ***We encourage CMS to work with the medical specialty societies to assist in the development of tools/resources for MVP development in order to be responsive to our needs and our desire to best represent our clinical members.***

On numerous occasions CMS has stated that clinicians are confused and overwhelmed by the number of measures and options that MIPS presents. AAPM&R believes that is a misconception. Our clinicians are confused by complex and varying scoring policies, program exceptions and differing thresholds in each category. ***We would urge CMS to focus on revising these more foundational program policies before attempting to add yet another pathway that layers on its own unique set of complex reporting and scoring rules.***

c. MIPS Performance Categories

(1) Quality Performance Category

(d) Selection of MIPS Quality Measures

As a specialty society with broad patient populations, we continue to stress the importance of identifying cross-cutting measures and improvement activities that reflect the care provided by a multi-specialty team AND drive our health system to patient-centered outcomes. As we have commented previously, we are concerned about CMS' direction in accomplishing limited, connected complementary sets of measures and activities meaningful to physiatry and rehabilitative (PM&R) care practices. We continue to develop our expertise in the development of measures, collection of essential data, and support of our members in moving toward value-based care. We would welcome the opportunity to work with CMS as an expert, stakeholder, and collaborator in developing specialty measure sets and eventually MVPs that will meet the needs of our members. In the past we have offered the following on existing PM&R measure sets and opportunities to participate in MIPS:

- a. ***AAPM&R urges CMS to remove or collaborate with us on revising the Physical Medicine Specialty Measure Set***; the Physical Medicine Measure Set is one that any physiatrist should find helpful when seeking quality measures to report or reflect current practice. However, we know that the measure set has limited value because:
- i. Although the measures could be applicable to some PM&R physicians, this set is not applicable to ALL PM&R physicians. We recognize the need to assist physicians and steer them to appropriate measures based on their specialized area of practice, but the sets are initially much better suited as educational materials. Many of the sets are categorized by general specialty and not broken down by sub-specialization.
 - ii. Many measures in the set do not reflect areas of care for which PM&R physicians are accountable for the intended outcomes. CMS is forcing providers to choose measures that do not reflect their specialty and do not reflect nor harmonize with the outcomes patients are seeking when working with a particular specialist.
 - iii. The lack of measures appropriate for and available to physiatrists will limit the development and implementation of MVPs. As CMS indicates: “MVPs should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers in evaluating clinician performance and making choices about their care.” If CMS intends to use the existing Specialty Measure Sets and existing Improvement Activities to guide the development of MVPs, this goal of providing information valuable to patients and caregivers will not be met and will be misleading, causing unintended consequences for patients and their caregivers.

In 2018, and throughout 2019, CMS and contracting partner HSAG convened Measure Development technical expert panels to tackle gaps in measures for prioritized specialties. Physical Medicine and Rehabilitation was one of those prioritized areas, yet to date, we are not aware of advancements in filling those gaps. We feel it is disingenuous to promote an arbitrary specialty measure set when measure concepts have been identified that would be more cohesive and simplified and more meaningful to both physiatrists and their patient populations. ***AAPM&R continues to urge CMS to remove or revise in collaboration with AAPM&R the Physical Medicine Specialty Measure Set and work with AAPM&R on identifying better measures for our specialty as you move toward the implementation of MVPs.*** The list of measure concepts

identified by this TEP follows,³ and we urge CMS to explore opportunities to engage AAPM&R to collaborate to fill these gaps.

Physical Medicine and Rehabilitation	
Meaningful Measure Area/ • Subtopic(s) Prioritized as Gaps	n = 24, or 49% of 49 total subtopics
Preventive Care	
<ul style="list-style-type: none"> • Diagnosis-specific primary prevention • Diagnosis-specific primary prevention: Traumatic brain injury • Diagnosis-specific primary prevention: Ultrasounds in spinal cord injuries • Interventions to prevent falls • Patient/caregiver interventions to prevent complications related to disability 	
Management of Chronic Conditions	
<ul style="list-style-type: none"> • Complex conditions • Symptom management: Pain 	
Care Is Personalized and Aligned With Patient's Goals	
<ul style="list-style-type: none"> • Family/caregiver education • Family/caregiver training • Treatment tailored to patient goals • Patient goal attainment • Patient self-efficacy/barriers to completion • Patient self-efficacy/barriers to completion: Pain in gaining function 	
Patient-Reported Functional Outcomes	
<ul style="list-style-type: none"> • Multiple chronic conditions • Symptom assessment • Symptom assessment: Pain • Health-related quality of life: General 	
Equity of Care	
<ul style="list-style-type: none"> • Cultural competency 	
Patient-Focused Episode of Care	
<ul style="list-style-type: none"> • Episode of care based on specific diagnosis • Episode of care based on specific diagnosis: Amputation • Episode of care based on specific diagnosis: Spinal cord injury • Episode of care based on specific diagnosis: Spine care • Episode of care based on specific diagnosis: Stroke • Episode of care based on specific diagnosis: Traumatic brain injury 	

AAPM&R also publicly supports the following comments, which align with comments submitted by the American Medical Association:

- AAPM&R appreciates CMS' proposal to reduce the previously-finalized 2021 MIPS performance threshold from 60 to 50 points in light of the COVID-19 pandemic. However, we urge CMS to consider maintaining the threshold at 45 points and to similarly reduce the exceptional performance threshold to incentivize ongoing participation in MIPS.

³ Centers for Medicare & Medicaid Services, Health Services Advisory Group. 2018 CMS Quality Measure Development Plan Environmental Scan and Gap Analysis Report. Baltimore, MD: Centers for Medicare & Medicaid Services; 2018. <https://www.cms.gov/Medicare/Quality-Payment-Program/MeasureDevelopment/Measure-development.html>

- We reiterate our strong support for collaboration between CMS and specialty societies to develop MVPs and urge the agency to finalize changes that will allow MVPs to be more innovative, flexible, less burdensome, and meaningful to patients.
- The AAPM&R strongly urges CMS to maintain the weight of the cost category at 15 percent and the quality category at 45 percent of the final MIPS score for the 2021 performance year in light of the unknown impact of the COVID-19 PHE on the cost measures, frontline physicians' focus on continuing to care for patients during this pandemic, and to provide physicians more time to familiarize themselves about their resource use.
- The AAPM&R urges CMS to maintain topped out measures that have a linkage to cost measures or MVPs, and to revise the existing quality measure benchmark methodology to incorporate more of a manual+data driven approach.
- The AAPM&R strongly urges CMS to extend the extreme and uncontrollable circumstances hardship exception flexibilities due to the COVID-19 PHE through at least 2021
- The AAPM&R supports CMS' proposal to use performance period quality measure benchmarks for the CY 2021 MIPS performance period rather than baseline period historic data, agreeing with CMS' concerns that 2019 performance data may not be a representative sample of historic data. We also urge CMS to consider the impact COVID-19 will have on 2020 and 2021 data and setting future benchmarks.
- The AAPM&R is concerned with CMS' proposal to truncate the performance reporting period as it relates to scoring flexibility for changes that impact quality measures. We urge CMS to work with measure stewards and relevant specialties to evaluate the data to determine whether a cut-off of nine months skews performance.

G. Third Party Intermediaries

Qualified Clinical Data Registries (QCDRs)


AAPM&R fully supports all statements made in the Physician Clinical Registry Coalition's comment letter in regard to the proposed changes for QCDRs in the proposed rule. We are extremely worried that many of the proposed changes would place significant and unreasonable burden on QCDRs and run counter to Congress' intention to encourage the use of QCDRs.

In fact, AAPM&R made the very difficult decision to *not* apply for QCDR status in 2020 and again for 2021 because of the increasing level of burden

imposed on QCDRs by CMS. *Until AAPM&R has confidence that our investment in the QCDR process will be valued by CMS and translated into policies that encourage and support QCDR use, rather than create obstacles, we have opted to shift our energy on more meaningful and impactful data collection.*

Thank you for the opportunity to comment on this important proposed rule. If the Academy can be of further assistance to you on this or any other rule, please contact Carolyn Millett at 847-737-6024 or by email at cmillett@aapmr.org for further information.

Sincerely,

A handwritten signature in black ink that reads "Annie D. Purcell, D.O." with a stylized flourish at the end.

Annie Davidson Purcell, D.O.

Chair

Reimbursement and Policy Review Committee