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August 17, 2023

The Honorable Chiquita Brooks-LaSure  
Administrator of the Centers for Medicare & Medicaid Services  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-5540-NC  
7500 Security Boulevard, Mail Stop C4-26-05  
Baltimore, MD 21244-1850

Re: CMS-5540-NC. Request for Information; Episode-Based Payment Model  
*Submitted Electronically via regulations.gov*

Dear Administrator Brooks-LaSure:

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) appreciates the opportunity to respond to the Centers for Medicare and Medicaid Services' (CMS) Request for Information (RFI) titled "Episode-Based Payment Model." AAPM&R is the national medical specialty organization representing more than 9,000 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 disabilities, 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. We appreciate the CMS Innovation Center's effort to strengthen its portfolio by engaging stakeholders to ensure new episode-based payment models focus on accountability for quality and cost, health equity, and specialty integration.

Over the past few years, our Academy – and the field of PM&R more broadly – has engaged to advance a new vision for our field that places physiatry earlier and throughout the care continuum, and that contemplates new practice models and opportunities for physiatry in promoting value-based transformation. AAPM&R has been grateful for the opportunity to meet with members of the CMS Innovation Center team in recent years to discuss improvements in model development and implementation, particularly as it relates to bundled-payment models. We were also pleased to support the Innovation Center Strategy Refresh for advancing system transformation when it was first released in late 2021, as it greatly aligns with our own priorities. We greatly appreciate your efforts to gather perspectives and insight from stakeholders when evaluating CMS' performance to date and considering future episode-based payment models that focus on the Innovation Center's five



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strategic objectives in driving accountability, equity, innovation, affordability, and transformation.

When discussing opportunities to improve episode-based payment models, AAPM&R believes there is an increasing need to ensure that models are designed to support outcomes of highest priority to patients, families, and caregivers. AAPM&R's Principles for Alternative Payment Models, which can be found attached to this letter, outline key elements necessary to achieve such a goal. The Academy encourages CMS to consider AAPM&R's principles when developing, recommending, implementing, and evaluating episode-based payment models. We would like to take this opportunity to use our principles as a framework to respond to select questions presented in this RFI.

### **Care Delivery and Incentive Structure Alignment**

#### *Care Coordination*

As addressed in **principle #1 – Collaboration and Coordination**, the Academy believes an alternative payment model must prioritize and incentivize collaborative and coordinated care. Collaborative and coordinated care should include medical specialties, nursing, behavioral health, and allied health professionals as necessary across the care continuum, including inpatient and outpatient settings. Additionally, coordination of care must ensure continuity and attention as patients transition from one care setting to another or to the home.

CMS must focus on improving care coordination between settings and providers when discussing model development and implementation. Psychiatrists are uniquely trained to help oversee a patient's care trajectory, navigate patients through their recovery, and help patients become as independent as possible, as quickly as possible. Psychiatrists not only identify the rehabilitation potential of a patient, but ensure the patient is triaged to the most appropriate setting of care to receive the most medically appropriate level of services in a coordinated manner that relies on open and ongoing communication with other members of the multidisciplinary care team. As such, we believe that access to specific specialists, such as psychiatrists, should be a key consideration when evaluating quality of care for certain patient populations. We encourage CMS to work with AAPM&R to identify ways to measure the clinical touch point of psychiatrists as they apply their clinical expertise to guide patients through their care journey in an episode.

#### *Specialty Integration*

In reference to **principle #6 – Incorporation of Psychiatry**, AAPM&R believes an alternative payment model must consider the role of psychiatrists when the model incorporates or benefits from rehabilitation care. Psychiatrists must play a leading role in addressing function and optimizing quality of life, which are prime metrics

in alternative payment models and patient-centered care. We believe that physiatrists must be involved in model development to provide expertise and analysis that is unique to the PM&R specialty.

The Academy urges CMS to develop new models or tweak existing models so that specialists play a more prominent role. Private payors have been successful in implementing models regionally in which specialists have played a key role. There have been studies over the past decade with evidence to support physiatry-led payment models. One in particular demonstrates the role of PM&R had in decreasing utilization and increasing patient satisfaction.<sup>1</sup> These could serve as examples for future CMS efforts. We remind CMS that there have been very limited opportunities for specialists to participate meaningfully in APMs. Most existing models are primary care or population focused and provide no material role for physiatrists.

#### *Leveraging Data*

Consistent with **principle #9 – Data Driven**, AAPM&R believes an alternative payment model must be data driven. Data must be made available and accessible to all participants on a regular and timely basis. The Academy believes that data analysis and/or access to customized analytical assistance (e.g., clinical data registries) must be made available to model participants to support process improvement and optimization of care delivery. In addition, alternative payment models must promote interoperability to ensure appropriate communication, relationships, and quality measurements of care through day-to-day operations and to support transitions of care.

AAPM&R encourages CMS to leverage data from EHRs as much as is feasible. However, this will first require the development and implementation of information technology standards and consistent guidance across federal programs for the capture, use, and exchange of such data. We recognize and appreciate the federal government's recent efforts to move in this direction but remind CMS that more work needs to be done before collection of such data is fully and seamlessly integrated into practice. It would be extremely helpful for physician organizations that want to enroll in these episode-based models to be able to have a constructive dialogue with the CMS Innovation Center and receive data and feedback from the agency on the models being developed and how to succeed under such model as a participant. At the same time, CMS must work with stakeholders to ensure that the collection of such data does not create additional burden on clinicians or patients and does not further erode the clinician-patient relationship.

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<sup>1</sup> Fox J et al, The Effect of Required Physiatrist Consultation on Surgery Rates for Back Pain, Spine 38(3):p E178-E184)

## **Health Equity**

As specified in **principle #2 – Patient-Centered Care**, AAPM&R believes an alternative payment model must emphasize patient-centered care and prioritize the needs of the patient to optimize health outcomes. To optimize health outcomes, care must be accessible and affordable for all patients including those with chronic injury, illness, and activity limitations. Moreover, we feel strongly that recognizing and accounting for social determinants of health must be a priority in all points of care and improvements in patient function and quality of life must be the foundation for a successful model. Additionally, patient-centered care must take into account patient priorities, including circumstances related to availability of caregivers and other assistance.

### *Managing Disparities*

Embedding health equity in all models is critical to reduce disparities in our health care system and communities. However, an important aspect of health care equity that has not received adequate attention is care for the disabled population. Physiatrists play an essential role in caring for patients with disabling conditions during initial rehabilitation and throughout their lifetimes. Many of these patients are often dually eligible for both Medicare and Medicaid or come from underserved communities that have not been sufficiently represented in models to date. Targeted interventions based on data collection and analysis, specifically for patients with complex needs and serious illness, can improve beneficiary health outcomes and reduce spending. For physicians to truly understand their patients' needs and conditions, we ask CMS to devise a concrete plan for making data readily available and accessible for model participants and that prioritizes social determinants of health (SDOH) and disability status measurement.

AAPM&R believes that measuring health equity and better quantifying healthcare disparities could help providers and policymakers develop more innovative and targeted interventions for disadvantaged groups and could provide beneficiaries with more transparent and meaningful data for healthcare decision making. At the same time, these efforts must account for the fact that many contributors to health inequities and related disparities are outside the control of the physician and the healthcare system, in general. Thus, it is critical that CMS approach these initiatives carefully, methodically, thoughtfully, and with ongoing stakeholder engagement to best understand structural and socioeconomic barriers to health, to ensure accuracy of analyses, to pursue potential solutions, and to monitor for unintended consequences.

### *Access to Care*

AAPM&R is also concerned that too many of the approaches considered to date evaluate whether a patient received appropriate care only once they had access to

care, but they do not seem to address whether the patient even had access to care in the first place. To ensure more equitable care for Medicare beneficiaries across settings, it is imperative that CMS not only evaluate social risk factors and other demographic data among patients who access care, but also varying degrees of access to care based on social determinants, as measured by factors such as insurance coverage, healthcare benefits and the types of specialties and settings of care available to a patient.

#### *Increasing Resources to Participate in Models*

In reference to **principle #8 – Availability of Resources**, AAPM&R believes an alternative payment model must ensure that participants are equipped with the resources they need to provide high-value care. Payment must be sufficient to ensure the delivery of high-quality, high-value care, and small practices must be supported to allow for model participation. Participants must be offered training and support in meeting the requirements of alternative payment models, and resources such as IT capability or provider network management should be made available to model participants as necessary.

We urge CMS to provide adequate resources to help practices achieve better health outcomes for high-risk patient populations when participating in these new episode-based models. All patients with Medicare coverage do not have equal opportunities to achieve good health outcomes, so one-size-fits-all models are more likely to widen than reduce disparities. APM payments and performance measures should account for risk factors such as lack of access to food, housing, and/or transportation that affect patients' ability to adhere to treatment plans. APM payment methodologies should be designed to support and encourage practices to address patients' social needs, including by providing care management services and coordinating services across interprofessional teams.

#### **Quality Measures and Multi-Payer Alignment**

As noted in **principle #3 – High-Value Care**, AAPM&R believes that an alternative payment model must prioritize the delivery of high-quality, high-value care. Physicians should coordinate care across the care continuum to best serve the patient. The care provided must be based on the best available evidence. Accountability for quality of care must include patient reported outcome measures focused on function and quality of life, given that process and utilization metrics alone are not sufficient to assess patient outcomes. Furthermore, models should reward high-quality care through payment incentives, and cost evaluation in models for demonstrating value must account for cost savings across the system, not just in certain silos of care.

Physiatrists are distinguished from other medical specialists in that our treatment is not focused on a specific disease or body system, but rather primarily focused on

patient function and longer-term outcomes across diseases and body systems. We appreciate CMS' recent efforts to incorporate more innovative measures into its models, including patient experience and rehabilitation referral measures, as well as patient-reported outcomes (PROs) in the Comprehensive Care for Joint Replacement Model (CJR). However, the use of PROs has been limited and remains optional. We encourage CMS to consider the broader use of patient-reported measures, particularly those that address function and health-related quality of life as part of the performance measure strategy. When compared to traditional quality measures, these measures can be far more indicative of patients' wellbeing and future health and health care utilization. As we shared with the Innovation Center team in early 2021, AAPM&R developed and maintains a registry focused on collection of essential data in psychiatric care. Specifically, the registry uses PROMIS-29, a validated patient reported outcome tool which features eight measurement domains including physical function. We encourage CMS to have a whole-person approach through all models of care with an emphasis on creating measures that truly prioritize patients' needs and long-term goals.

#### **Payment Methodology and Structure**

In reference to **principle #4 – Accountability**, AAPM&R believes that an alternative payment model must hold model participants accountable only for outcomes over which they have control. Quality and cost metrics used to determine performance must reflect the scope of services furnished by model participants. Alternative payment models must include accurate risk adjustment to ensure that model participants are not penalized for providing care to high-risk patients.

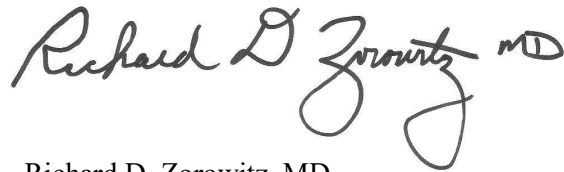
Risk adjustment, in particular, is vital to fully account for all factors that attribute to variances in cost, utilization, and outcomes. Psychiatrists treat patients with complex medical needs, whose total cost of care could increase dramatically through no fault of the physician. We see a grave threat to quality and efficiency if physicians are reducing or providing inadequate services to patients to avoid further financial penalties. To that end, AAPM&R urges CMS to re-examine existing models that place physicians at financial risk for outcomes and costs that they cannot control. We believe physicians should only be held accountable for controllable outcomes.

As noted in **principle #7 – Reasonable Risk**, AAPM&R believes that mandatory alternative payment models must allow for meaningful participation by providers with varying capacity to take on downside risk. To ensure flexibility, it must be recognized that some model participants may not have the population size to assume downside risk appropriately for the costs of care. In addition, considerations must be made for model participants with a large proportion of high-risk patients that may not have the capacity to assume downside risk for the costs of care. We urge CMS to provide more upfront dollars as part of these models so that physicians can make the investments needed to properly manage a population or condition.

This includes funding to support data analytics, the hiring of care managers, training, and other practice changes needed to improve care delivery and facilitate successful APM participation. We also urge that APMs be designed with “on-ramps” that give participants time as well as resources to transform their practices before being expected to take on downside risk. Physician practices, particularly small and rural practices and those serving marginalized patients, do not have financial reserves available to fund practice changes in advance of shared savings payments or to pay large penalties to CMS if their patients need expensive care. Physicians have been contending with years of payment cuts under the Physician Fee Schedule – in the face of historically high inflation – and the nominal payment updates authorized under MACRA will perpetuate this problem. Failure to provide adequate funding not only poses a barrier to participation by small and medium practices, but it will likely contribute to greater industry consolidation.

Thank you for the opportunity to respond to this RFI and for the Innovation Center’s continued drive to progress towards a widespread deployment and refinement of episode-based payment models. Please feel free to contact Megan Roop at (847) 737-6018 or [mroop@aapmr.org](mailto:mroop@aapmr.org) to arrange a meeting or address any questions you may have.

Sincerely,



Richard D. Zorowitz, MD  
Chair, AAPM&R Innovative Payment and Practice Models Committee