American Academy of Physical Medicine and Rehabilitation

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November 17, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-3321-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; Request for Information Regarding Implementation of the Merit Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

Dear Mr. Slavitt:

On behalf of the more than 8,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAMP&R), we appreciate the opportunity to submit comments to the request for information: *Medicare Program; Request for Information Regarding Implementation of the Merit Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models* that was published in the Federal Register. Physiatrists are specialists in the field of physical medicine and rehabilitation (physiatry) and treat adults and children with acute and chronic pain, persons who have experienced catastrophic events resulting in paraplegia, quadriplegia, traumatic brain injury, spinal cord injury, limb amputations, rheumatologic conditions, musculoskeletal injuries, and persons with neurologic disorders or any other disease process that results in impairment and/or disability.

Beginning with payments for items and services furnished on or after January 1, 2019, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), establishes a new methodology that ties annual physician fee schedule payment adjustments to value through a Merit-Based Incentive Payment System (MIPS) for MIPS eligible professionals (EPs). MACRA also creates an incentive program to encourage participation by eligible professionals (EPs) in Alternative Payment Models (APMs). The AAPM&R supports the development of methodologies that promote and support quality improvement in health care. In the comments below are the AAPM&R recommendations on how CMS should go about planning and implementing MIPS.

The Merit-based Incentive Payment System (MIPS)

MIPS EP Identifier and Exclusions

CMS currently uses a variety of identifiers to associate an EP under different programs. Requiring an additional identifier for MIPS would create an unnecessary burden on both EPs and CMS. AAPM&R believes that the best approach is to maintain identification by each EP's Tax Identification Numbers (TIN)/ National Provider Identifier (NPI) combination that is in place for the current physician quality programs.

- For individual EPs reporting a combination of a TIN and NPI should be used to assess eligibility and participation. This approach maintains the current identification combination that place EPs in the current physician quality programs.
- For groups reporting under MIPS the Academy recommends that eligibility should be assessed at the TIN level, and participation on the NPI, requiring that the group submit each participating NPI under the TIN. This allows individual EP's freedom to designate (or not participate) under the group's MIPS election. For many EPs, there may be more relevant reporting options than the larger group's election.
- It may be appropriate to create a new MIPS identifier for virtual groups because they will consist of separate practices with separate NPIs, TINs, and likely separate ownership structures. Virtual groups will have to work out a coordinated structure in order to comply with the program, so creating a distinct identifier could be part of the natural progression of entering into such an arrangement.

It is important for CMS to be aware that circumstances may occur that need to be addressed as the MIPS implementation moves forward.

Virtual Groups

The goal of the virtual group option under the MIPS intends to allow a group's performance to be tied together even if the EPs in the group do not share the same TIN. The implementation of virtual groups should be given maximum flexibility for physicians, small practices, and other EPs as MIPS implementation moves forward.

- There should be no initial, annual, or other limits placed on the maximum number of virtual groups approved each year. Limiting the establishment of virtual groups, including maximum number of allowed groups, minimum or maximum group size, geographic proximity, or particular specialty, will discourage EPs from pursuing this option, thereby limiting MIPS participation of practices with limited resources and administrative support.
- As health care continues to evolve telemedicine technologies allow health care to be provided at a distance. Telemedicine eliminates distance barriers and can improve access to medical services that would often not be consistently

available in distant rural communities. Thus, it would not be appropriate to set arbitrary geographic limitations, including a 50-mile radius.

- Limiting virtual groups to the same specialty or sub-specialty restricts the development of virtual groups and does not mirror current medical practices. Thus, there should be no requirement that all EPs within a virtual group are within the same specialty.

Quality Performance Category

AAPM&R recommends that CMS take advantage of the repeal of the sustainable growth rate and replacement with consolidated MIPS as an opportunity to fix the issues with the current quality reporting programs. Additionally, we urge CMS to make this a seamless and non-disruptive implementation.

Reporting Mechanisms Available for Quality Performance Category

- Given that not all providers have adopted an electronic health record (EHR) or participate in a registry, the Academy recommends, that at a minimum, CMS maintain all of the current PQRS reporting mechanisms to ensure flexibility for physicians with different needs.
- AAPM&R supports the continuation of reporting measures across 3 of the National Quality Strategy Domains. However, we urge CMS to reconsider the current PQRS requirement of 9 measures across the 3 domains. The Academy continues to believe that 9 measures is an arbitrary, high standard that provides limited, if any, value. Additionally, maintaining the 9 measure reporting requirement would also fail to recognize that the MIPS increases the total reporting burden of physicians with the addition of the new category of Clinical Practice Improvement (CPI) activities. For some specialties, some or all of the activities captured though CPI may be a more meaningful and accurate representation of quality than the current set of PQRS quality metrics.

Quality Measure Types and Weighting

- Valid and reliable outcome, functional, and structure status measures could potentially lead to more direct measures of quality and their development by medical specialties should be encouraged and funded.

Data Stratification

- Disparities represent a significant quality problem; and current data collection efforts are inadequate to identify and address disparities; quality performance measures should be stratified by demographic factors such as race, ethnicity, education, and gender. Data

stratification is important because adjustment for demographic factors should be considered to reflect the known effects on morbidity and mortality and to ensure equivalent quality and access to care among diverse patient populations.

- AAPM&R also recommends that data should have the ability to be stratified based on disability.
- CMS should consider directly providing QCDR entities with more open access to CMS claims and EHR data so they can easily gather this information. As it is, many EPs and health entities are hesitant to participate in clinical data registries, even for quality improvement, due to fears of breaching the security or privacy of protected patient health data.

EPs in Specialties with Few Quality Measures

- For specialties that may not have enough measures, CMS should use its authority to re-adjust the weights of the other MIPS categories.
- Due to serious flaws in the current Meaningful Use (MU) and Value Modifier programs, we caution against automatically adding weight to the MU or Resource Use categories.
- The CPI category may provide the most flexibility for many physicians to receive recognition for the quality improvement activities that are most relevant to their practice. This category was also given the least amount of weight under MACRA. Therefore, we believe that when a specialty does not have enough measures, CMS should give more weight to a properly constructed CPI category, developed in cooperation with the affected specialties and sub-specialties.
- Alternatively, CMS should allow specialties to select which other category(ies) they would like to allot a higher weight. We recommend that CMS customize the performance requirements for those EPs and work with the affected specialty and the related specialty society to set requirements that are appropriate for the unique nature of that particular specialty.
- Rather than taking a one-size-fits-all approach as it has with the current MU program, CMS must consider the varying practice patterns of specialties and sub-specialties, as well as the site-of-service in which a physician practices.

Barriers to Successful Quality Performance

- The greatest barriers to success for many physicians are not having a sufficient set of relevant measures to choose from, or having too few patients to meet minimum standards for a statistically significant sample. While QCDRs have allowed for the development of more diverse measures, this reporting mechanism is not yet accessible to everyone.
- CMS must continue to address measurement gaps and to improve the existing set of measures. We reiterate our concern that CMS has not yet allocated MACRA-authorized funding toward this effort, and we urge the agency to do so as expeditiously as possible. We also remind CMS of the importance of ensuring that measure development is evidence-based and clinician-led.

Resource Use Performance Category

Current Measures

- The RFI implies that CMS may keep all the current Value-based Modifier (VM) cost measures and then expand upon them. The current measures have no clinical relevance for many physicians. Some have no costs attributed to them. Others are tagged with costs for services they haveno opportunity to control. As can be seen in CMS' QRURs (Quality and Resource Use Reports) and VM experience reports, the current cost and outcome measures also discriminate against physicians with high numbers of chronically ill and high risk patients.
- There are many reasons for this, including an inadequate risk adjuster and cost of care measures that punish physicians repeatedly for the same high cost patients with multiple chronic conditions. Many of the measures were developed for hospitals and are inappropriate for physician practices, which do not have Medicare patient populations that are large enough or heterogeneous enough to produce an accurate picture of their resource use.

Peer Groups

- Due to the diversity of physician practices even within the same specialty, making accurate comparisons of their performance will require far more detailed delineation—of specialty, sub-specialty, area(s) of expertise and/or site(s) of practice—than is currently conducted by either Medicare or private payers. While we appreciate CMS' efforts to adjust for a physician's specialty in the VM program, more work is needed.
- A means of recognizing sub-specialization, either due to training, services provided, or site of service, will need to be developed and implemented.

- Site of service should also be used to make adjustments for physicians whose practices focus on hospital or nursing home patients, whose care is typically more complex and more costly than patients outside a facility.

Clinical Practice Improvement (CPI) Activities Performance Category

CPI is defined as an activity that relevant eligible professional organizations and other stakeholders identify as improving clinical practice or care delivery and when effectively executed is likely to result in improved outcomes. Therefore, AAPM&R recommends that CMS allow for the broadest interpretation of CPI activities possible. The selection of activities should be optional. No category should be mandatory. Physicians and other eligible professionals should be given credit for CPI activities in which they are currently engaged, including those that are mandated or encouraged by Medicare and other government programs. This would include a long list of activities such as: Participation in a Qualified Clinical Data Registry and in registries run by other government agencies such as FDA or private entities such as a hospital, or medical specialty.

Types of Qualifying Activities

- Other activities associated with the six CPI categories Congress specifically called for in the MACRA include the following types of activities:
  - Expanded practice access: Same day appointments for urgent needs; after-hours clinician advice – using secured messaging, patients can ask questions of their provider that are well documented in the patient record; remote monitoring of chronic conditions; establishing policy allowing patients with emergencies to walk-in during certain established hours; Saturday and expanded hours for clinics to increase access; use of satellite offices to bring services to patients; and serving on call in an emergency department.
  - Care coordination: Timely communication of test results; ability of a practice to receive and act upon fax or email from a referring doctor; ability to provide patients with printed copies of test results; and billing chronic care management or transitional care management codes.
  - Beneficiary engagement: Practices providing patients with the option to download or have mailed medical history forms to fill out prior to a first appointment; training of patients in appropriate administration of medications and proper use and maintenance of durable medical equipment and various remote monitoring devices and home testing products; use of

decision trees and questionnaires to engage patients in shared decision making on their medical care; patient flyers for specific conditions; and nutritional counseling.
    - AAPM&R also recommends including subcategories in Social and Community involvement. Measures of Social and Community involvement should include referrals to local community disability services.
- Various activities of organizations representing physicians and medical groups should also be recognized as practice improvement. This would include accredited continuing medical education, board-certification-related activities, and other initiatives aimed at improving clinical practice, such as opioid prescriber training and the provision of medication-assisted treatment of opioid use disorders.
- Administration of CAHPS or other patient experience and satisfaction surveys should be considered as a CPI activity rather than a quality measure.
- Physicians and other EPs should have the freedom to choose the CPI activities that are most beneficial and appropriate for their type of practice and patient population, regardless of subcategory domain. Subcategories should only serve as a guide for defining CPI activities.

Attestation and Reporting of CPI Activities

- Physicians should be able to demonstrate their performance of CPI activities through a simple attestation process. Attestation should occur annually.
- The attestation process would be best facilitated through a web portal that is simple to access and use.
- Transmission of CPI activity results also should be permitted but not required through EHRs and QCDRs, when and where the capabilities exist.
- Where applicable, there should be an option of having participation in a CPI activity reported by the certifying agency rather than individual physicians. An APM Entity should be allowed to provide participation rates for physicians in the APM.

Thresholds and Quantifying Activities

- CPI activity performance should be based on completion or ongoing participation in a specified number of clinical improvement activities, rather than hours.

- CPI activities should include those in which an individual physician or other EP can participate or complete, or activities in which participation or completion occurs at the group practice level.

Small and Rural Practices

- Allowing for the broadest definition of CPI activities and least burdensome requirements will be needed to ensure that physicians and other EPs in small or rural practices are able to participate. Ensuring that there are options which are free or low cost will also be crucial.

Meaningful Use of Certified EHR Technology Performance Category

Since Meaningful Use (MU) is one component of the MIPS program, it is extremely important that, prior to its implementation, CMS make changes to the program that will ensure that MU is achievable and meaningful for all physicians, including specialists. Thus, AAPM&R recommends that CMS reopen Stage 3 Meaningful Use to realign the program and take time to evaluate whether providers are successful under the Stage 2 Modifications rule. Incorporating Stage 3 – as finalized by CMS into the MIPS program– will prohibit physicians from being successful, and therefore, jeopardize their ultimate MIPS composite score.

Redesigning Stage 3

- CMS should return to the statutory intent and focus Stage 3 on the three categories outlined in the law: 1) electronic prescribing; 2) information exchange; and 3) quality reporting.
- MU measures should be redesigned to focus on outcomes and use cases rather than processes and data entry. Rather than emphasizing counting and thresholds, measures should focus on whether data is accessible and usable.
- CMS should collaborate with national specialty societies to develop health IT-enabled alternatives or pilots that could be optionally used to satisfy the MU component of the composite score. Physiatry, for example, should be given the option to participate in MU Stage 3 or satisfy an alternative pathway that could be comprised of elements of MU, such as clinical data registry participation, data security/HIPAA checks and updates, and implementing clinical decision support functionality. In addition, those looking to move to alternative payment models could pilot alternatives to the MU program that assist in moving to new payment and delivery models.
- CMS could also implement additional health IT-enabled activities outside the scope of the current MU requirements such as imaging data-sharing, structured reporting, enabling electronic orders, etc. The

ONC could readily establish health IT certification criteria for other IT functionality that supports these alternative actions. However, CMS and ONC would need to work closely with the national specialty societies to appropriately plan and implement these alternative pathways.

Partial Credit for Meaningful Use Attestation

- If providers are attesting for MU and meet a certain percentage of the measures, there should be an option for them to get credit for the percentage they were able to complete. It should not be an all or nothing system. Thus, AAPM&R recommends that CMS eliminate the pass/fail approach.
- We strongly disagree with the tiered approach. Using a performance-based/tiered methodology for the MU component of the composite score would unfairly penalize certain participants based on circumstances largely outside their control—such as subspecialty/scope of practice, location/setting, health information exchange (HIE) network availability, business environment/competition, and patient population, among others.

Hardship Exceptions

- There should be significant flexibility in the type of hardship exceptions that are offered for Meaningful Use. Many physicians face unique situations that may not fall into an established hardship exception category, but cause the provider to be unable to meet Meaningful Use.
- If a provider chooses to file a hardship exception, they should not be penalized in the MU performance category and should have options on how to reweight the other MIPS categories.
- Many physicians are forced to take a hardship exemption through no fault of their own, e.g., their EHR vendor had delayed updates, inaccurate information, faulty software, etc. These providers should not be penalized for the inability of their EHR software to complete Meaningful Use, and therefore, this should not affect their MIPS composite score.
- Hardship exceptions should not be capped at five years, since many practices simply cannot participate due to their specialty or patient population.

Development of Performance Standards

AAPM&R strongly urges CMS to make every effort to reduce the gap between the performance period and the payment year. To prioritize outreach and education to empower providers and groups to operate with clarity in MIPS. Additionally, performance standards should not change periodically, as CMS suggests in the RFI. Rather, the standards for one performance year should remain the standards throughout the entire performance year.

Public Reporting

Minimum Threshold

- MIPS is essentially an opportunity to press the reset button and to learn from mistakes made in the past, including rushed implementation of certain policies. We would suggest that CMS first work on carefully designing the MIPS system; accrue a minimum foundation of data using the new system (e.g., at least 2 years of data); confidentially share that data with practicing physicians via clear, easy to understand feedback reports; and simultaneously conduct research into what information and reporting formats are most valuable to consumers and physicians. Only after this work is complete should CMS transition to the public reporting of physician performance data.
- Similar to current programs, such as the Physician Quality Reporting System (PQRS), the early years of the MIPS could include the public reporting of data which indicates whether an EP satisfied the reporting requirements for the multiple components of MIPS. But we believe that attempting to accurately calculate and showcase performance data for public consumption is an unrealistic goal for the initial years of this new program. There are currently too many unresolved problems related to risk adjustment, attribution, appropriate sample sizes, and even the ongoing lack of relevant measures for certain specialties. The public reporting of performance data, in many instances, would be premature.

Feedback Reports

- AAPM&R recommends that EPs have the ability to designate as many people/entities as deemed necessary, access to the feedback reports.
- The Academy recommends CMS provide ongoing, real-time feedback on performance and should consult stakeholder groups continuously to determine the best presentation and most meaningful format for sharing ongoing, actionable performance feedback information with physicians and practices.
- CMS must be forthcoming in any feedback reports in regard to the methodologies used to comprise any benchmarks or attribute patients for a

particular measure. This information must be clearly identified and easy to interpret.

Alternative Payment Models

Payment Incentive for APM Participation

A fundamental principle of all APMs is that they will advance teamwork among those involved in providing health care to a patient population. The methods that an APM Entity uses to distribute APM revenues to the physicians and other health professionals participating in the APM should foster collaboration among the team, not present a barrier to it. Proposals that are submitted for qualified APMs should explain how revenues will be distributed instead of CMS establishing requirements.

- In most cases, it seems likely that payments under an alternative payment model (APM) will be made to an entity rather than directly to an eligible physician. In order to ensure that the physicians participating in the APM are able to influence the governance policies of the APM Entity, AAPM&R recommends that CMS require such entities to provide for meaningful participation in governance by physicians whether or not the APM Entity is a physician-owned organization. If the organization is a hospital or other entity that is not physician-owned, then it should be required to provide a means for physicians to influence the governing policies of the organization, such as through significant practicing physician representation on the governing board. This is important because by empowering clinicians to help make policies that have a material impact on the care patients receive, they are incentivized to lower cost and improve outcomes.
- Another key issue for APM Entities will be determining the methods for establishing that physicians participating in an APM have or have not met the MACRA participation thresholds to qualify for the lump sum incentive payments. These methodologies should be left to the discretion of the APM Entities, but they should be required to describe the method they will use when they submit an APM proposal. As noted above, an APM that involves revenues for physician and professional services only will use a different method for determining revenue thresholds for the participating physicians than would an APM that involves revenues for hospital and post-acute care services.
- APMs should continue to be required to get an APM identification and NPIs of participating EPs should be required to be submitted with the APM ID. The Academy recommends that this should be required to be updated annually or when an EP retires or leaves an APM for any reason. Medicare then makes payments to an APM ID involving multiple physicians, the APM Entity should

be allowed to take responsibility for providing information to CMS on the revenue shares attributed to each EP identified as a participant of the APM.

Patient Approach

- APMs may be designed around higher-cost conditions; as a result, some physicians may be more likely to meet the MACRA thresholds using the revenue approach. However, reporting the proportion of patients who are being managed within an APM may be a more patient-centered approach than summing up revenues from the services physicians provide..
- A related issue is what the minimum threshold of involvement in a patient's care should be in order for an APM physician to include a patient in their count. The attribution method used in the Medicare Shared Savings Program assigns patients to physicians if they have provided at least one primary service to the patient. Physicians in an APM could be contributing to the patient's care and meeting the goals of the APM in other ways, however, besides face-to-face visits and procedures for patients. Physiatrist, neurologists and other specialists could be consulting with primary care physicians on how to manage patients with substance use disorders, depression, Alzheimer's or diabetes, for example, without seeing the patients themselves. Radiologists and pathologists could help achieve correct diagnoses for patients and emergency physicians could help prevent hospital admissions. Diagnosis, treatment, and management for many patients in the population served by an APM may involve multiple physicians, each of whom could potentially legitimately count the patient as their patient. CMS should require those proposing qualifying APMs to describe how patients would be counted for purposes of establishing whether physicians are qualifying or partially qualifying APM participants.

Nominal Financial Risk

- There are many financial risks that can be more than nominal that the typical CMS approach overlooks, including start-up expenses, new positions hired (e.g. care manager), new equipment needed, data analysis expenses, loss of revenue from fee-for-service patients.
- AAPM&R recommends that anything higher than cost of living adjustments should be considered substantial. The risks should be the same for either pathway regardless of whether it would be in the context of MIPS or an APM. The lower the initial risk, the better to get maximum participation. It may be more of an incentive if a ladder approach was used – perhaps defining nominal risk as 2% the first year and 4% thereafter. Also, it is important that CMS allow sufficient time to achieve savings goals and not expect them to be reached in year one.

Physician-Focused Payment Models

- The RFI notes that PFPMs proposed to the PTAC and recommended to HHS need not meet the same criteria that MACRA establishes for APMs, but CMS encourages proposals that will allow physicians to earn incentive payments available to participants in qualified APMs. AAPM&R strongly agrees with this view.
- AAPM&R supports the proposed criteria outlined in the RFI under "context of model within delivery system."
- It is critical that the MACRA regulations establish a clear pathway for models to be proposed to the PTAC and for those models that are recommended by the PTAC to HHS to be implemented by CMS as qualified APMs. Additionally, CMS must be willing to give serious consideration to proposed PFPMs that come through the PTAC and support their implementation.
- AAPM&R recommends that APMs approved by the PTAC and Secretary that do not involve EAPM also be eligible for incentive payment.
- PFPMs should support innovative approaches that give physicians the flexibility to deliver different services than they can within current payment systems. They should also ensure that the PFPM does not have so many administrative requirements that additional payments are all spent on administrative costs rather than helping patients.
- National medical specialty societies, including the AAPM&R, have been working to develop PFPM proposals that would qualify as APMs under MACRA. There is increasing interest in APMs in the physician community since the passage of MACRA, and the AAPM&R has formed an Innovative Payment and Practice Models Workgroup that has been mapping a pathway forward for physiatrists. A significant concern of all specialties is whether or not CMS will implement the payment models they develop.
- Much of the focus on physician payment reform to date has been on three kinds of models: accountable care organizations, bundled payments for hospital-based episodes, and patient-centered primary care medical homes. But there are a number of other APMs that could improve patient care and reduce health care costs beyond these three. New PFPM proposals need to be developed by identifying opportunities to improve care for patients that will also reduce spending.

Criteria Model Design Factors

AAPM&R recommends the following criteria that would be potentially uniquely meaningful for Physiatrists. The criteria is both drawn from the RFI and from the criteria used to evaluate models for CMMI.

Criterion - Number and/or percentage of beneficiaries and practitioners included in the model–what is the scale of the model?

- Patients with disabilities are not necessarily representative of all beneficiaries, nor is their number large in scale, but it is important that their unique needs are recognized in models of care.

Criterion - Probability of model success – What are the nature and magnitude of risks/barriers to model success?

- "Disability" is not simply a medical term described by the diagnosis. It is caused by the interplay of physical, psychological, environmental, and social factors. Therefore, helping a patient reach their optimal functional state and ability to interact effectively within society is dependent on many factors outside the health care system. For example, rehabilitation may help a new paraplegic patient learn to maneuver in various settings in a wheelchair, but unless the community installs curb cuts and there is accessible public transportation, or funds to equip a car with hand controls, he will not be easily able to get to work and social events.

Criterion - Economic impact – What is the likely yield that CMS will see for its time and resource investments in the model?

- The economic impact of models for people with disabilities could be substantial, but it will be measured in terms of life-long rather than episodic determinants. For example, if services provided could adequately prevent and/or treat the many complications that occur with some disabilities, it would prevent many acute care hospital admissions over the patient's lifetime.

Criterion - Overlap with current and anticipated models – To what degree is the intervention in the proposed model unique in design from that in other models?

- Overlap with current and anticipated models should not be a significant issue for two reasons. First, two demonstrations may be working with different populations – e.g. a primary care medical home open to all would be different than a medical home structured for people with disabilities. Second, even if the demonstrations are working with the same population, one party may be better able to implement the

design effectively. If you only test the model with the ineffective owner of the project, you may conclude that the model does not work rather than that it was ineffectively implemented.

Criterion - Consistent with Innovation Center and CMS capacity - CMS has dedicated resources and authority to support innovation, but resources are finite.

- People with disabilities are a small segment of society. However, APMs built based on the needs of this select population should not be disqualified as an innovative model, simply because of size.

Use of Electronic Health Record Technology

- The construct and use of certified health IT in APMs should follow a functional outcomes approach, rather than one that is exclusively tied to process measures and "counting clicks" to meet thresholds.
- To date, the intent of CEHRT has been to accommodate the needs of the Meaningful Use (MU) program. Throughout Stage 1 and 2, ONC regulation established the definition of what constituted CEHRT. While MU is a component of MIPS, its structure is primarily based on process measures and threshold achievement. Current generation EHRs are built on the prescriptive requirements established by ONC to reflect the needs of the MU program.
- ONC's newly established 2015 Edition certification program removes the direct tie to MU and has established a list of criteria from which health IT products can be built from. These criteria still mirror the basic functions of MU, however, ONC no longer establishes the definition of CEHRT—that is now the responsibility of CMS.

Quality Measures for MIPS and APMs

- It is important that quality measure reporting for an APM be no more burdensome than under MIPS. It is also important to focus on harmonizing measures so that there are not different ways of measuring the same thing that must be used for MIPS vs. APMs and Medicare vs. other payers.

- Experience to date with APMs, such as a joint replacement model in Wisconsin, has found that APM measures are more likely to be based on outcomes, such as complication, readmission, and reoperation rates, instead of typical PQRS measures. We support this approach.

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We appreciate the opportunity to comment on this request for information. The AAPM&R looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Jenny Jackson, Manager of Finance and Reimbursement in the AAPM&R Division of Health Policy and Practice Services. She may be reached at jjackson@aapmr.org or at (847)737-6024.

Sincerely,

Phillip Bryant, DO
Chair
Reimbursement and Policy Review Committee
American Academy of Physical Medicine and Rehabilitation