American Academy of Physical Medicine and Rehabilitation

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Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-FC
P.O. Box 8016
Baltimore, MD 21244-8013

RE: CY 2018 Proposed Updates to the Quality Payment Program (QPP)

Dear Administrator Verma,

On behalf of the more than 10,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), we appreciate the opportunity to submit comments to the final rule: CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year published in the *Federal Register* on November 16, 2017.

Physical medicine and rehabilitation (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. Many provisions in the proposed rule will impact physiatrists nationwide. We therefore appreciate your consideration of the following comments.

Qualified Clinical Data Registry (QCDR)

One of the biggest unresolved challenges of the year was the QCDR submission and review process.

AAPM&R believes that CMS needs to overhaul and improve its current QCDR submission and approval process. In the final rule CMS stated the following:

> We understand the commenters concerns, but would like to note we have been working to implement process improvements and develop additional standardization for the 2018 performance period self-nomination and QCDR measure review, in which consistent feedback is communicated to vendors, additional time is given to vendors to respond to requests for information, and more detailed rationales are provided for rejected QCDR measures. Furthermore, through our

review, we intend to communicate the timeframe in which a decision reexamination can be requested should we reject QCDR measures. In order to improve predictability and avoid delays or misunderstandings, we have made updates to the self-nomination form to outline all of the information needed during the review process.

CMS also noted it intent to assign specific personnel to communicate self-nomination and QCDR decisions as appropriate and will continue to use their internal decision tracker to track all decisions made on QCDRs and their QCDR measures, as they did during review of the 2017 self-nomination and QCDR measures. CMS also stated that they are currently working through efforts to standardize a review process and timelines.

Unfortunately, none of this was apparent during the submission and review process. In fact, the 2018 submission process and approval process was quite hectic. CMS had over 1600 measures to review and approve, which is a huge undertaking. This led to a chaotic few weeks of back and forth emails, phone calls and prompt updates for QCDR and measure approval. Our own registry spoke with 9 different contractors over the entire 6-week submission and approval window. Those 9 contractors sent conflicting approvals, denials, and requests on the same measures. The JIRA system was also overwhelmed with requests which meant emails were not always received and deadlines were missed. Deadlines were also an issue during the 2018 submission and approval process. At one point, we had only 51 minutes to respond to CMS.

Below are AAPM&R's suggestions to improve the QCDR submission and approval response:

- AAPM&R believes CMS should select 1 or perhaps 2 contractors to work with each individual registry throughout the process to avoid confusion.
- AAPM&R suggests that these contractors should send out ALL measure approvals, denials, or change requests at one time rather than piecemeal.
- AAPM&R asks that CMS use an online call scheduling request system that is automatically sent out to all QCDRs once reviews are final.
- Further, AAPM&R believes all calls should be at least 60-90 minutes. This will ensure that the CMS/PIMMS team and the QCDR team can get through all the measures and make recommended changes in a timely manner. It will also allow a buffer for those that may be late to the call.
- Finally, AAPM&R believes that all requests that come from the CMS/PIMMS team to the QCDR should be given a 24-hour turnaround time at the very least. Most QCDR staff are busy with other aspects of the job including

helping physicians report for the current MIPS year. To have to drop everything to comply with a 51-minute deadline is unquestionably unreasonable.

In addition to the persistent difficulties with the submission and approval process, **AAPM&R still advocates for the multi-year QCDR approval process.** Multi-year approval would allow the CMS/PIMMS team and the QCDR to have ongoing dialogue regarding the registry and their measures. If a QCDR was working with 1 contractor throughout the approval years, there would be less confusion on what the CMS/PIMMS team wants and expects from the QCDR year after year. The QCDR would feel that they have a consistent contact who understands the evolution of the measures. Periodic conference calls between the contractor and QCDR could take place to ensure that CMS is able to monitor the success of the QCDR and measures. CMS could also revoke the QCDR approval if the QCDR was not living up to the standards that CMS puts in place, however periodic calls could get in front of any and all issues.

In addition to our above comments, as a member of the Physician Clinical Registry Coalition (The Coalition), we fully support the comments in The Coalition's final rule comment letter regarding QCDRs.

Quality Performance Category

AAPM&R appreciates CMS finally adding PM&R codes to QPP measure 182, Functional Outcomes Assessment. This measure has been in our specialty measure set; however, our physicians have never been able to use it until now.

Cost Performance Category

Total Per Capita Costs and MSPB Measures: AAPM&R supports removal of general cost measures

AAPM&R continues to be concerned about the cost measures being used in MIPS; specifically, the total per capita cost and Medicare spending per beneficiary (MSPB) measures and continues to recommend that CMS discontinue use of the total per capita cost and MSPB measures. AAPM&R believes it is inappropriate to use broad measures such as total per capita costs and MSPB to evaluate the resource use of individual physicians. Many Medicare beneficiaries have multiple health problems, and in most cases, those different health problems are treated by multiple physicians and other providers. QRURs consistently show that the services delivered by an

individual physician represent a tiny fraction of the total cost of care for their patients. Moreover, under Medicare rules, beneficiaries have the freedom to see any physicians they wish in order to obtain treatment for their health problems. Even if each of the individual physicians who a patient sees are "efficient" in the services they deliver and order, the overall spending on the patient's care may be higher than for other patients because of the number and types of physicians and other providers the patient chooses to use. As such, we continue to urge CMS to remove these measures for assessment under MIPS, particularly as CMS adopts new episode-based costs measures that are more tailored to measured clinicians' performance.

AAPM&R supports development of new episode-based cost measures

At the same time, we recommend that CMS continue development of episode-based cost measures with great care. While we are extremely supportive of the episode-based cost measure development process, and we have representatives currently participating in the episode-based cost measure development process led by Acumen, we also have several concerns.

The new episode-based cost measures are being developed in a short timeline and still require testing to ensure their appropriateness. Additionally, as noted in our comments provided in response to the field testing of episode-based cost measures, we believe that there are limitations regarding the application of such measures to physiatrists that should be addressed, that risk adjustment methodologies need to be refined, and that additional education for providers is needed about the implications of cost measurement.

Cost Measures with Risk Adjustment: AAPM&R supports use of cost measures which are adjusted for social risk factors

As noted in our comments to the proposed rule, AAPM&R also strongly believes that cost measures should be risk adjusted for sociodemographic factors such as socioeconomic status of the individual/family, the resources available in the community in which the patient resides, and work status. The Academy does not believe that risk-adjusting for sociodemographic status holds clinicians to different standards. Risk-adjustment helps ensure that clinicians are not financially penalized for serving vulnerable populations which can further reduce resource availability and worsen care disparities. AAPM&R recognizes that the complex patient bonus may help alleviate the potential negative impact of penalties associated with caring for more challenging patients. However, we still believe that risk adjustment on a per-measure basis is a more directed, precise way to address this issue.

CMS notes that adoption of the new episode-based measures will be proposed in future rulemaking. We urge CMS to take our comments into consideration prior to proposing these measures, and we will appreciate the opportunity to comment on future proposals for implementation of the new measures when that opportunity is made available.

AAPM&R supports postponing accountability for cost measures under MIPS

Finally, AAPM&R is aware that the American Medical Association (AMA) is currently pursuing legislation that would extend MACRA's two-year cost transition period to five years. We support these efforts to postpone cost measurement to allow for additional time to refine episode-based measures. We also support the AMA's recommendation to award bonuses to those clinicians who agree to pilot test episode-based measures and/or patient relationship categories.

Improvement Activities (IA) Performance Category

IA Inventory

In the Final Rule, CMS clarified that for PSPA_2, participation in the ASA Simulation Education Network fulfills the requirement for this Improvement Activity. We thank CMS for this clarification. AAPM&R has endorsed the PSH model, and we are members of the PSH Steering Committee and Learning Collaborative. We have members that are delivering care in health care systems that have implemented the PSH, and, as such, are hopeful that they will be eligible for these improvement activities. AAPM&R thanks the agency for finalizing its proposal to implement CC_15, the PSH (Perioperative Surgical Home) Care Coordination Improvement Activity, for the QPP Year 2 and Future Years.

Facility-Based Measures Scoring Option for the 2020 MIPS Payment Year for the Quality and Cost Performance Categories

CMS finalized the availability of facility-based measurement for the cost and quality performance categories starting with the 2019 MIPS performance year for clinicians practicing in inpatient hospital settings and finalized that facility-based measurement would rely on the cost and quality measures adopted under the value-based purchasing program of a facility program for a specified year.

AAPM&R continues to support facility-based measurement to consider clinician performance for the cost and quality performance categories as a voluntary option. This policy holds the potential to create greater flexibility for clinicians who may have limited quality measures available to them, like many AAPM&R members who

perform a limited set of services in a limited set of settings. At the same time, AAPM&R believes that limiting facility-based measurement to clinicians practicing in the inpatient hospital setting will not allow this option to fulfill its promise, as it will not be available to clinicians who predominantly practice in other facility (even Part A) settings.

As such, AAPM&R reiterates our request for CMS to consider further developing this policy in upcoming years to include measures adopted under the inpatient rehabilitation facilities (IRF) and skilled nursing facilities (SNF) quality reporting programs. While we recognize that such programs are not pay-for-performance, we believe that the need to increase reporting options for clinicians who largely practice in such settings should take priority, and that the addition of facility-based measurement to MIPS using these programs achieves similar goals as those that exist with pay-for-performance programs. As such, AAPM&R requests that CMS reverse its policy to limit facility-based measurement to measures adopted under only value-based-purchasing programs. AAPM&R welcomes the opportunity to discuss this issue with CMS to further develop this policy.

Bearing Financial Risk for Monetary Loss – Nominal Amount Standard for Small and Rural Practices

In response to a comment solicitation, CMS received many comments in favor of lower risk standards for small and rural practices, as well as some comments in opposition. CMS noted that it may address the topic of a different, potentially lower revenue-based nominal amount standard for small or rural practices in future rulemaking and welcomed further comment on this issue.

AAPM&R continues to believe that small and rural practices would benefit from a lower nominal risk standard and, in many cases, would only be able to participate in Advanced APMs if such APMs require lower amounts of risk. As noted in our response to the Innovation Center New Direction request for information, clinicians who treat smaller populations of patients with significant medical, functional, and cost concerns – like our members – in particular face significant challenges accepting risk. To begin, significant upfront investments are required to build the infrastructure and capacity to successfully manage risk, yet the patient populations treated by these clinicians are not dense enough to require the large provider groups or integrated care systems that would be able to make the necessary investments. Additionally, it is difficult to get the patient uniformity and population size necessary to spread actuarial risk, which can lead to catastrophic outcomes for small practices given the high cost of care for the significantly impaired individuals they treat, such as those with a spinal

cord injury, stroke, or neuromuscular disease. And while CMS has created an alternative standard for medical home models that would be available for smaller practices, this standard is only available for medical home models that have a primary care focus, meaning specialists who deliver care consistent with medical home practices (such as patient empanelment, risk stratified care management, and care coordination across the medical neighborhood) cannot access the lower risk requirements. ***To address these challenges, we continue to urge CMS to reduce risk requirements necessary for models to qualify as Advanced APMs, particularly by providing separate, more attainable standards for small practices, and by expanding the medical home financial standards to apply to specialty-focused medical homes.***

We appreciate the opportunity to comment on this proposed rule. AAPM&R looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Beth Radtke, Manager of Quality and Research Initiatives in the AAPM&R Division of Health Policy and Practice Services. She may be reached at bradtke@aapmr.org or at (847)737-6088.

Sincerely,

Scott Laker, MD
Chair
Quality, Policy, Practice and Research Committee
American Academy of Physical Medicine and Rehabilitation