American Academy of Physical Medicine and Rehabilitation

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June 22, 2018

Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1694-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: CMS-1694-P Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates

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 Fiscal Year (FY) 2019 Hospital Inpatient Prospective Payment Systems 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. Several of the provisions in the proposed rule will impact physiatrists nationwide. We therefore appreciate your consideration of the following comments.

IV. Other Decisions and Proposed Changes to the IPPS for Operating System

I.2 Hospital Value-Based Purchasing (VBP) Program: Proposed Policy Changes

In line with its Patients Over Paperwork and Meaningful Measures Initiatives, CMS proposes to eliminate a total of 19 measures (and decrease duplication for an additional 21 measures) that acute care hospitals are currently required to report across the 5 hospital quality and value-based purchasing programs, while still maintaining meaningful measures of hospital quality and patient safety.

Overall, AAPM&R supports this effort to eliminate duplication of effort and administrative burden. At the same time, in preparation for the physician fee schedule, AAPM&R recommends that CMS similarly aim to reduce reporting burden for clinicians under MIPS, while maintaining flexibility and preserving a sufficient number of specialty-specific measures. Further, AAPM&R asks CMS to collaborate with relevant clinical and patient stakeholders when making decisions related to the removal of measures, rather than making these decisions independently since what CMS might consider a costly measure might be important to a clinician or patient.

I.2.b Proposed Measure Removal Factors for the Hospital VBP Program
Across its hospital programs, CMS proposes to continue to rely on existing removal factors when considering whether to remove measures. CMS proposes a new removal factor: "Factor 8: The costs associated with a measure outweigh the benefit of its continued use in the program." In some instances when this factor is used as a justification for proposing to remove a measure, it may not necessarily due to the "cost" imposed on the provider, but the cost imposed on the entity that developed the measure. AAPM&R suggests this removal factor may be problematic if CMS proposes to remove a measure that clinicians or patients feel is important, but may be too costly to administer. AAPM&R requests that CMS adopt a more inclusive process, that accounts for the perspective of both patients and clinicians, when making measure removal determinations.

I.3 Accounting for Social Risk Factors in the Hospital Readmissions Reduction Program
Accounting for Social Risk Factors in the Hospital Readmissions Reduction Program (p. 901)
CMS is considering options to improve health disparities among patient groups within and across hospitals by increasing the transparency of disparities as shown by quality measures. It also is considering how this work applies to other CMS quality programs in the future. CMS plans to continue working with ASPE, the public, and other key stakeholders to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences. AAPM&R supports CMS's consideration to expand efforts to provide stratified data in hospital confidential feedback reports for other measures, and including other social risk factors beyond dual-eligible status in hospital confidential feedback reports.

M. Proposed Revision of Hospital Inpatient Admission Orders Documentation Requirements Under Medicare Part A

AAPM&R truly appreciates CMS' flexibility in removing the presence of an admission order as a Condition of Medicare Part A payment. As CMS points out, some contractors have been denying entire stays based on that missing order, even when the stay was medically necessary, and the physician's intent to admit the patient to inpatient status could be ascertained through other documentation. And, again as CMS points out, the requirement that there be an admitting order still exists under the Medicare Conditions of Participation. AAPM&R supports the change in this rule since it simply removes it from being used to indiscriminately deny payment for medically necessary care and allows some flexibility in how and when the admission order is written into the chart.

VIII. Quality Data Reporting Requirements for Specific Providers and Suppliers

A.5.b(7) Clinical Episode-Based Payment Measures

CMS proposes to remove 6 of these measures from the IQR Program since associated costs outweigh the benefit of their continued use (factor #8) and because they are not tied directly to other quality measures that could provide a picture of overall clinical effectiveness and efficiency. CMS also believes these measure data are already captured within the overall hospital MSPB measure, which will be retained in the Hospital VBP Program. While AAPM&R understands the lack of relevant quality measures is a reasonable reason not to use these, it is very concerning that CMS and other clinical stakeholders invested in the development of these more specific episode-based measures and now CMS is proposing to remove them and go back to simply using the MSPB measure, which is too broad of a measure to tie to specific existing quality metrics and too general to be meaningful to clinicians.

A.9.b Potential Future Inclusion of the Hospital Harm-Opioid-Related Adverse Events Electronic Clinical Quality Measure (eCQM)

This outcome measure assesses, by hospital, the proportion of patients who had an opioid-related adverse event. The measure uses the administration of naloxone, an opioid reversal agent, as an indicator of opioid-related adverse respiratory events (i.e., as a proxy for patient harm/adverse event). The aim is not to identify preventability of an individual harm instance or whether each instance of harm was an error, but rather to assess the overall rate of the harm within a hospital. CMS believes that reduction of adverse events may be

enhanced by measuring the rates of these events at each hospital in a systematic, comparable way.

AAPM&R encourages CMS to not include this measure in the Hospital IQR and PI Program until areas of concern by the Measures Application Partnership (MAP) are addressed. The MAP recommended that this measure be refined and resubmitted for consideration. It recommended adjusting the numerator to consider the impact on chronic opioid users. There was also concern the measure might discourage administration of naloxone in favor of taking other measures, like intubation. Further, there is no risk adjustment/exclusion around opioid sensitivity. Additional testing by the measure developer is underway and should be completed prior to inclusion in the program.

We appreciate the opportunity to comment on this proposed rule. If you have any questions about our comments, please contact Carolyn Winter-Rosenberg, Manager of Reimbursement and Regulatory Affairs in the AAPM&R Division of Health Policy and Practice Services. She may be reached at cwinterrosenberg@aapmr.org or at (847)737-6024.

Sincerely,

Annie Davidson Purcell, D.O.
Chair
Reimbursement and Policy Review Committee