American Academy of Physical Medicine and Rehabilitation

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September 27, 2019

Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1715-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-1715-P Medicare Program; CY 2020 Revisions to 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 to the 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.

AAPM&R previously submitted comments on the proposed rule earlier this month in an effort to make our recommendations available to CMS as soon as possible. We appreciate your consideration of the following comments on the rule as well.

II. Provisions of the Proposed Rule for PFS

I. Physician Supervision of Physician Assistant (PA) Services
CMS proposes to redefine its physician supervision requirement for PA services such that CMS would rely on state law and state scope of practice rules regarding physician supervision, or in states without laws governing physician supervision of PAs, CMS would rely on documentation in the medical record of the PA's "approach to working with physicians in furnishing their services."

AAPM&R objects to this proposal, which we believe would not be in the best interest of patient care, would not provide for sufficient oversight of PAs, and in states without physician supervision laws, would not meet statutory physician supervision requirements for Medicare to cover PA services.

While AAPM&R considers PAs and other advance practice practitioners (APPs) to be a vital part of the caregiving team, we strongly oppose the independent practice of APPs in the provision of rehabilitation care, and we are concerned that the proposal would move PAs one step closer towards independent practice. There is a significant disparity in the education and training that exist between physicians and PAs, with many physicians spending over 11 years in medical training in order to ensure they are properly trained and educated to diagnose and treat patients. The skills, knowledge, and abilities of PAs and physicians are not equivalent, and it is the recognition of this difference that underlies the statutory requirement for physician supervision. Indeed, appropriate physician oversight is necessary to promote high quality patient care and safety.

We are concerned that CMS' proposal would not allow for appropriate physician oversight, or create a uniform standard for physician supervision of PAs across the Medicare program. While we understand that CMS seeks to align regulatory requirements for PA physician oversight with current regulatory requirements that apply to nurse practitioners (NPs) and clinical nurse specialists (CNSs), as CMS itself notes in the preamble, statutory requirements for NPs and CNSs require "collaboration" with physicians, whereas the statutory requirements for PAs explicitly require "supervision." We believe this distinction is meaningful, and the collaboration framework CMS is proposing is not appropriate for PAs. Furthermore, we note that CMS' proposal for allowing PAs to document their "approach to working with physicians" does not include any threshold requirement for physician oversight or supervision of any nature. We therefore do not believe that this meets the statutory requirement for PA services to be provided under the supervision of a physician.

III. Other Provisions of the Proposed Regulations

K. CY 2020 Updates to the Quality Payment Program

3. MIPS Program Details
a. Transforming MIPS: MIPS Value Pathways Request for Information

AAPM&R appreciates that CMS is looking towards the future when it comes to MIPS by attempting to align the 4 categories to be more cohesive and simplified, however we strongly believe the MIPS Value Pathways (MVPs), as laid out in the RFI within the proposed rule, will not achieve that goal.

On numerous occasions CMS has stated that clinicians are confused 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 look at changing those program policies, rather than adding a new, more confusing way to report via MVPs.** It is our opinion that MVPs, as described within the RFI, would keep the disjointed, complex scoring and reporting requirements that are confusing to physicians. AAPM&R also believes the reason measures are confusing to clinicians is because of the lack of a CPT code to relevant measures. Many clinicians spend time looking through the 300+ measures available in the MIPS program to find which of their CPT codes match applicable QPP measures. Once their CPT codes are applied they often have less than the required 6. **We believe that is a fundamental flaw in the program that CMS needs to address.** CMS should not only invest in more user friendly tools for physicians, but spend time themselves sorting through the measures and codes to understand the frustration of physicians.

AAPM&R firmly supports The American Medical Association in their thoughts, feedback and recommendations on the MVPs as listed below:

Recommendations:
While we are appreciative of CMS' efforts to develop a high-level MVP framework and recognize it is a first step in the right direction, we recommend that several policies included in the MVP framework outlined in the proposed rule be changed. Specifically, CMS must ensure that participation in the MVP is voluntary; focus on measures that are meaningful to physicians rather than administrative claims/population health measures; ensure that the MVP option provides a more holistic track for physicians including revising the PI category and moving to attestation; and ensure there are appropriate incentives for physicians to report on new measures and an option for multispecialty practices to participate in MVP.

MVP Assignment

- CMS contemplates assigning clinicians to MVPs to reduce the physician administrative burdens that can be associated with having to choose from among the various measures and reporting options in the MIPS program**. AAPM&R appreciates CMS' intent, but we recommend a different approach that can lessen the burden without mandating how physicians participate in MIPS.**
- CMS should adopt an opt-in policy, which allows physicians to opt-in to CMS' suggested MVP, or to choose an alternative MVP, or to continue to report measures through the traditional MIPS pathway.

Population Health Measures

- **AAPM&R opposes CMS' proposal to incorporate population health/administrative claims-based measures into MVPs.**
- Many of the existing administrative claims measures have not been tested at the physician level and do not provide granular enough information for physicians to make improvements in practice. **CMS also prohibits specialty societies from developing and proposing administrative claims measures. AAPM&R strongly encourages CMS to change this policy if MVPs move forward.**
- Physicians treat patients at the individual level, not the population health level, so measuring them on population health measures often holds them accountable for things outside of their control.
- **AAPM&R continues to believe that the measures that should be included in MVPs are those that have been developed by physician-led organizations, such as specialty societies, to ensure they are meaningful to a physician's particular practice and patients and measure aspects of care that a physician can actually control.**

Holistic Program

- CMS' current MVP framework groups measures together into bundles in a specific clinical area, but still requires physicians to report in each performance category and maintains the status quo with Promoting Interoperability (PI) and Improvement Activities (IA) categories. **Instead, CMS' MVP proposal should eliminate the need for physicians to report in four separate performance categories.** For example, instead of a physician having to attest to IAs, the developer of each MVP should note to CMS which IAs are inherent in a particular MVP, and IA credit should be automatic. This is similar to how MIPS

APMs and recognized PCMHs are currently scored in the IA performance category.

- A physician should also be able to attest that they (or at least 75% of the eligible clinicians in their group) are using CEHRT or health IT that interacts with CEHRT, rather than reporting on individual Promoting Interoperability measures. When reporting on quality measures through the EHR or a registry, practices should get credit towards satisfying Promoting Interoperability requirements.
- This reduced reporting will create a hybrid approach between MIPS and Advanced APMs and greatly reduce the reporting burden, as well as better help physicians prepare to participate in APMs. Of note, CMS provides a great deal of flexibility in how they require Advanced APMs to document and communicate clinical care; physicians preparing to become Advanced APMs should be given the same consideration. They will still need to attest that they are not information blocking and will be subject to ONC's information blocking regulation.

<u>Incentives</u>

- Rather than mandate that physicians or groups report certain MVPs, CMS should incentivize physicians to report MVPs to ensure thorough testing of this new model. Possible incentives include more timely data and data analysis and reporting on a smaller set of patients during the transition to MVPs.
- Additionally, physicians should be incentivized to report on new quality measures and to report new MVPs to encourage the development of new, more meaningful reporting opportunities.
- CMS' proposal to remove a large percentage of the existing quality measures and to remove measures without benchmarks after only two years in the program may cause stakeholders to determine it is not worth their time to develop MVPs if they will soon be removed without adequate opportunity to report on measures.
- If CMS wants to truly improve quality across the healthcare system and have an impact on patients treated by a range of specialties, then it needs to incentivize pathways for specialists to more meaningfully engage in MIPS
- **CMS should also incentivize specialty societies, who have devoted limited resources toward developing measures, QCDRs, and APMs, to develop and propose MVPs.** For example, CMS should provide specialty societies with more QPP and claims data to help them

understand and target opportunities for a more cohesive, clinically relevant MIPS participation experience via an MVP.

- **In addition, CMS should provide preference to MVP proposals that incorporate electronic clinical quality measures or QCDR measures.** Relatedly, practices participating in MVP that submit their quality data electronically using a QCDR could receive full credit for the PI performance category if they also have a certified EHR to enable e-prescribing, as long as the practice attests to e-prescribing for at least one patient (unless an exception applies). This would incentivize specialists to continue participating in QCDRs while easing the reporting burden associated with PI.

CMS specifically requests comments on how QCDR measures could be used in MVPs and then states in the QCDR section that all QCDRs need to tie their measures to MVPs, cost measures, or improvement activities. Requiring something of a QCDR that is still at this point an idea is confusing and problematic. It would likely be impossible to establish a link between an MVP and a QCDR measure given that CMS states that it does not intend to have an MVP for each specialty, let alone subspecialty. **If CMS wants MVPs to work, they must engage with specialty society QCDRs.**

Finally, AAPM&R believes CMS should view the first few years of MVP implementation as a pilot period. It will take time to develop, refine, and educate physicians on this new framework for MIPS reporting. Specific features of the MVP approach should be refined and improved over time as physicians gain experience with the MVP option.

c. MIPS Performance Category Measures and Activities
(1) Quality Performance Category
(ii) Data Completeness Criteria

CMS proposes to increase the data completeness threshold when reporting on a quality measure from 60% of denominator eligible patients to 70% of denominator eligible patients. **AAPM&R believes the increased reporting requirement is counter to the Administration's Patients Over Paperwork initiative and would recommend maintaining the data completeness threshold at 60% for all data collection types.**

While CMS highlights that the average data completeness for reporting on a quality measures is 70% of denominator eligible patients, it does not take into consideration the following factors:

- Yearly program changes increase administrative burden and complexity of the MIPS program and are not in line with the goals of the Patients Over Paperwork initiative. Practices need stability to focus on improvement and reduced burden to transition to MVPs in 2021.

- Such a high threshold assumes physicians either provide care at a single site or that data move fluidly between sites, neither of which is the case. Some clinicians provide services across multiple sites using the same TIN/NPI combination; however, not all sites (including across sites of service) may (1) participate in MIPS or (2) use the same registry or EHR that the physician uses for MIPS reporting. When thinking about getting data from an EHR vendor into a registry or QCDR, each EHR vendor has a different approach to pulling data, which requires mapping of each practice individually because there is a lack of standardization in data elements and how data is captured across EHRs. Therefore, until physicians and other eligible clinicians can work within an environment where data and care is integrated seamlessly across settings and providers, it is premature to continue to increase data completeness and encourage reporting through a registry or EHR.

- It takes significant time to implement new measures or updates to measures into practice workflows or the registry or EHR, which further discourages practices from reporting on new measures. Vendors often do not complete updating measure specifications until after the beginning of the performance period. CMS also does not release measure specifications and educational materials in a timely manner, often releasing this critical information in the middle of the performance period (after Jan. 1).

- If vendors are cherry-picking cases on which to report, then CMS should implement corrective action plans with these specific vendors, rather than increase reporting burdens for all MIPS-eligible clinicians. Alternatively, CMS could institute requirements around randomized sampling of patients to guard against cherry picking. All physicians in MIPS should not be penalized and face unrealistic requirements for a bad actor.

(iv) Removal of Quality Measures
CMS proposes to remove 55 quality measures in 2020, which results in a 21% decrease in the total number of available MIPS quality measures. Over the last two years, CMS has removed approximately 32% of MIPS traditional quality measures. CMS also proposes to add an additional removal factor: *remove MIPS quality measures that do not meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance periods*.

AAPM&R recommends maintaining the existing MIPS quality measures to ensure consistency with program requirements, reduce the additional burden of forcing physicians to find new measures come January, provide additional opportunities to accrue data for more accurate benchmarking, and ensure a diverse inventory of measures to form the basis of MVPs. We also recommend that CMS not finalize the new measure removal factor, which will discourage measure stewards from developing new measures that are clinically meaningful.

As stated in our previous comment letter, dated September 2, 2019, we oppose the removal of Measure #131: Pain Assessment and Follow-Up. We believe **measure # 131 is a clinically appropriate and critically important tool for encouraging high quality pain assessment and management practices across multiple specialties, which makes it potentially appropriate for multiple future MVP(s), and that it should remain in MIPS for 2020 and beyond.**

(2) Cost Performance Category
(a) Weight in the Final Score
CMS proposes to increase the weight of the Cost performance category from 15 percent in 2019 to 20 percent in 2020, 25 percent in 2021, and 30 percent in 2022. CMS also proposes significant changes to the cost category in 2020, including adding 10 new episode-based cost measures and revising the existing total per capita cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measures.

AAPM&R urges CMS to maintain the weight of the cost category at 15 percent of the final MIPS score for at least the 2020 performance period because of ongoing, unaddressed concerns with the cost measures and the need to provide physicians with better feedback about their resource use. Our additional concerns are outlined below.

While AAPM&R has been supportive of the development of episode-based cost measures, which have the potential to more accurately evaluate physicians' resource use, we are concerned about the reliability and actionability of these measures. There is little variability between the highest and lowest costs for several of the episode measures, and we have yet to see data about what cost drivers will distinguish "high" and "low" performers.

We also need greater clarification about how episode-based cost measures will be maintained and updated. For instance, how should specialty societies work with CMS to address updates to the cost measures when Medicare changes payment policies, such as changes to the ASC-payable list for procedures, and when new drugs come to market?

Physicians continue to familiarize themselves with the cost measures, but have only received detailed feedback for one year – 2018. AAPM&R appreciates that the 2018 feedback reports include demographic and clinical characteristics for attributed beneficiaries, costs related to services billed by the clinician, and utilization of hospital and post-acute care. However, the feedback does not provide comparison information to help physicians determine the extent to which unwarranted variation in spending exists and to understand their own patterns of care. In addition, the feedback is based on measures that CMS is proposing to revise beyond recognition in 2020. Furthermore, physicians have not received actual performance feedback regarding any of the episode-based cost measures, the first wave of which went into effect in 2019.

Although CMS and Acumen made feedback available to physicians who were attributed episode measures during field testing, there was limited outreach and education, few physicians could access them, and the reports are no longer available for physicians to retroactively review. We have heard from physicians who were able to access their reports that the information was complex and difficult to interpret. We recognize the challenge of balancing the goal of providing as much data as possible with the goal of simplicity and enhanced usability. We also appreciate Acumen's effort to provide more granular data, while also providing upfront summaries, appendices and links to supplemental information. However, **we continue to urge CMS to present cost measure data in more digestible terms so that clinicians can easily understand what they are being measured on, how they are performing relative to other similar clinicians, and what they are supposed to be doing with this data to improve overall value.**

(v) Revised Cost Measures

As AAPM&R has stated in previous comment letters, we remain concerned about the use of the TPCC and MSPB and urge CMS to remove them from the MIPS program.

While we appreciate the efforts of CMS to improve cost measures, we believe the revised measures have some of the same flaws as the current measure, as well as new problems, that make them inappropriate for MIPS. If the agency does not remove TPCC and MSPB, CMS must address attribution, equity, double counting, and validity concerns, including:

- **Attribution** – The revised TPCC would eliminate the problem of attributing costs that occurred before the physician ever saw the patient; AAPM&R agrees that physicians should not be held responsible for such services. However, the new attribution methodology assumes that a primary care relationship exists if two things happen within three days or three months, and not otherwise. The new approach does not identify the end of a clinician's primary care responsibility for a patient. AAPM&R does not believe physicians should be held responsible for costs that occurred long after they saw the patient and after the patient has moved to another city or state. We also have concerns about holding multiple physicians in different practices accountable for the same costs.

- **Measure exclusions** – Measure exclusion should also be made at the service level in the revised TPCC. While certain specialties would be excluded from this measure, the services they provide would not be excluded. A practice comprised of measure-excluded specialists might still be subject to the measure if it also uses a physician assistant or nurse practitioner who provides an E/M visit and another primary care service. This situation will make it hard to determine which practices are likely to be subject to the TPCC measure. Moreover, primary care physicians will be held responsible for the costs of measure-excluded specialists that the primary care physicians do not provide and cannot control. If this revised measure is adopted, we urge CMS to develop exclusions based on service.

- **Double counting of costs** – TPCC and MSPB double count costs, a problem that is further exacerbated when physicians are also measured on episode-based cost measures. CMS does not believe costs are double

counted because each measure is compared to expected costs for its own beneficiaries or episodes. However, the observed costs are still being counted multiple times within different frameworks and with different benchmarks and comparison groups. We request CMS elaborate on how different comparison groups and benchmarks under different measures address this issue of overlap. We continue to believe that if CMS continues to use the revised TPCC and MSPB measures, along with the episode measures, it can potentially result in a clinician being held accountable multiple times for the same costs.

G. Third Party Intermediaries

(3) 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 because of the current burden and lack of investment for QCDRs from 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,

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