American Academy of Physical Medicine and Rehabilitation

aaPM&R

9700 W. Bryn Mawr Ave., Suite 200
Rosemont, Illinois 60018
www.aapmr.org

phone 847/737.6000
fax 847/754.4368
info@aapmr.org

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Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via: https://www.surveymonkey.com/r/macra-cost-measures-field-testing

RE: MACRA Episode-Based Cost Measures Field Testing

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 in response to CMS' MACRA Episode-Based Cost Measures Field Testing. 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.

AAPM&R has been fortunate to have two of our members serve on the MACRA Episode-Based Cost Measures Clinical Subcommittee for Musculoskeletal Non-Spine. Several AAPM&R member physicians have also engaged in the field testing process and provided us with feedback. Below, please find our comments and concerns regarding the episode-based cost measure program and field testing reports.

AAPM&R encourages CMS to consider the limitations of episode-based cost measurement for specialties involved in long term care. Improvement in patient function, measured over time, is one of the key ways in which the benefits of physiatrists' care is measured. Episode-based cost measures focus on a specific window in time to assess the cost of care provided to the patient. While this gives a snapshot of the care our members provide, it regularly does not capture the full picture. For example, our members can be involved with

knee arthroplasty patients in several ways. Prior to the procedure, physiatrists may be involved in other types of therapy and interventions which prevent a patient from needing a knee arthroplasty. If the procedure is necessary, physiatrists are involved following the procedure, directing the therapy a patient receives to regain strength and use of their knee, and they can remain involved in this care long after the designated 60-day episode window following the procedure. We remind CMS that – as this example illustrates – episodes like the ones currently undergoing field testing do not capture the important, high-quality care provided by many specialists.

Further, we note that the inclusion of post-acute care services provided and overseen by physiatrists may contribute to significant costs over the short time frame specified for the draft episode-based cost measures. However, high-quality post-acute care services can contribute to longer-term savings and improved outcomes, which are not visible under the current episode-based measurement framework. We believe this is a limitation that should be addressed.

Lastly, we have concerns that episode measures that focus on cost measurement without any linkage to quality performance would further lead to inaccurate assessment of the value that physiatrists provide, as well as potentially create incentives to limit referrals to our members. That is because attributed clinicians are not held accountable for quality outcomes – and often such outcomes would appear long after the draft episodes end – yet the attributed clinicians are held accountable for costs. As such, we recommend that CMS ensure that cost measures are tied to proper quality metrics to assess overall value before assessing clinicians' performance on these measures, and that such linkage to quality metrics consider long-term outcomes related to rehabilitation, function, return to work, and quality of life.

AAPM&R recommends that CMS strengthen the risk adjustment methodologies used to predict costs for the episode-based measures. A proper risk adjustment methodology is critical for accurately predicting expected costs for episode-based measures, as well as for ensuring that treating providers treat high-risk patients and provide or prescribe services that could otherwise disproportionately increase actual episode costs relative to predicted costs. However, we have concerns with the methodologies that CMS has proposed and believe that adjustments are needed. Specifically, we recommend that, rather than relying primarily on claims-based data, CMS expand the scope of data used to predict costs to include data on cognition and functional status,

which CMS can obtain from post-acute care quality reporting. Additionally, we recommend that CMS revisit the 120-day timeframe prior to each episode trigger for identifying risk adjustment variables. It is not clear how CMS selected this timeframe, and we have concerns that all relevant and applicable risk adjustors may not be captured in this short window.

AAPM&R requests additional transparency related to the implementation of episode-based cost measurement and patient attribution within the cost category of MIPS.

- With the recent announcement of the 10% weighting of the cost category in MIPS 2018, we are particularly interested in knowing how the cost category will expand in coming years to include episode-based cost measures. Additionally, we would appreciate the opportunity to review and comment on how episode-based cost measure performance will be used to determine a physician's MIPS cost category scoring. For example, information is provided on relative performance within risk brackets, but it is not clear whether or how these risk brackets will be incorporated into scoring.
- Furthermore, CMS recently finalized that reporting of patient relationship categories will be voluntary in 2018. Given the lack of tested, reliable data on patient relationship categories and how they inform attribution, we question the appropriateness of the attribution methodologies proposed for these draft measures. Once such data are available, we encourage CMS to offer a separate comment period associated with the application of patient relationship categories for the purposes of episode-based measure attribution. Additionally, we request clarity on attribution when multiple clinicians exceed the attribution threshold for the acute inpatient medical condition episode groups for the same episode and request that CMS ensure only clinicians who maintain primary responsibility for the episode are attributed.

AAPM&R urges CMS to consider mechanisms for streamlining and simplifying education and reporting related to episode-based cost measurement. Having participated in one of the clinical subcommittees AAPM&R is aware of the complexities of cost measurement. However, we urge CMS to consider the capacity of physicians participating in MIPS who have not been as engaged but who are being inundated with program information. For the average, busy physiatrist, the materials provided in the field reports and associated measure description files are far too lengthy and

complex. Further, we believe that these materials will be provided in addition to already burdensome reports modeled on QRURs that physicians are reviewing to determine their quality score, as well as information associated with the advancing care information and clinical practice improvement activity components of MIPS. AAPM&R has several suggestions for ways in which the cost measure materials can be streamlined to help direct physicians in their understanding of the reports.

- ***AAPM&R recommends that improvements be made to the mock report.*** We appreciate the use of a mock report to identify opportunities for improving the way episode-based cost measure data are reported to physicians. However, our members struggled with the reports, finding them incredibly confusing and difficult to understand. As such, we encourage CMS to further refine the report to make it more reader-friendly. Specifically, we encourage you to expand Appendix C to provide clearer definitions for each section of the Results and Appendix A tabs. We also recommend adding links to any headings and terms used within the report that may be new to a reader. The links could direct the reader to definitions or an expanded version of Appendix C so the reader doesn't have to keep switching back and forth.
- ***AAPM&R recommends use of a one-page fact sheet associated with each cost measure***. The field testing report included links to downloadable information about each measure. However, these files were far too lengthy and are likely to be ignored by the average physician. A one-page fact sheet on each measure, in addition to the more detailed information already provided, could improve the chances of the average physician understanding the measure(s) relevant to them. These fact sheets could include some of the key measure details such as the episode duration, trigger code, etc.
- ***AAPM&R recommends expanding the mock report to include mock data in Appendix B***. While the mock data in the summary tab, report tabs, and Appendix A tabs are beneficial, it would be helpful to also include mock data in Appendix B to help the reader understand how episode-level data would appear and how they would contribute to report results.

Thank you again for the opportunity to comment on the episode-based cost measure program and field testing reports. AAPM&R looks forward to continuing dialogue with CMS and Acumen on these important issues. 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 Purcell, DO
Chair
Reimbursement and Policy Review Committee
American Academy of Physical Medicine and Rehabilitation