American Academy of Physical Medicine and Rehabilitation

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October 16, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS–5524–P
P.O. Box 8013
Baltimore, MD 21244–1850

Sent electronically via http://www.regulations.gov/

RE: File code CMS–5524–P

Dear Administrator Verma:

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) is the national medical specialty organization representing more than 10,000 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 appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on the proposed rule, entitled, "Medicare Program; Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model (CMS–5524–P)". Overall, AAPM&R appreciates CMS' proposals to relieve some of the burdens placed upon medical providers through previous rulemaking on these Center for Medicare and Medicaid Innovation (Innovation Center) initiatives.

Mandatory Model Participation

The Academy supports CMS' proposals to cancel the new Episode Payment Models (EPMs), which require mandatory participation of those hospitals selected for participation, as well as to ease some of the requirements under the currently active mandatory Comprehensive Care for Joint Replacement Payment (CJR) Model. In general, AAPM&R has significant concerns with models that require mandatory participation, and therefore we support CMS' efforts to limit mandatory participation across all models. Many of our concerns with mandatory models align with those raised in response to

previous rulemaking on the EPMs, as detailed in Section IIIA of this proposed rule, including risk of:

- Potential harm to patients before CMS understands how models affect access to care, quality, and outcomes under model parameters; and

- Lack of readiness of hospitals and medical practices to undertake proposed reforms (for example, lack of proper staffing or infrastructure to support care redesign efforts), which could potentially lead to improper care or financial failure.

In addition to the concerns mentioned above, AAPM&R is particularly concerned with how any mandatory participation rules may impact many of the patients our members serve – patients with acute and chronic disabilities and functional limitations. In general, these patients do not fit well within the "one size fits all" approach of treatment models that are most likely to be targeted under mandatory models, because their needs are often different and the numbers for any specific kind of disability may be too small to make reliable generalizations. These difficulties may perhaps be exemplified by the *Jimmo vs. Sebelius* case, in which CMS contractors did not seem to understand that medically necessary skilled therapy could include maintenance therapy for certain kinds of patients/problems/disabilities. While the belief that maintenance therapy does not constitute medically necessary services may well be correct for many cases, it does not hold true for many of the patients our members treat. For them, maintenance therapy may mean the difference between being able to continue independently transferring safely to and from their wheelchair and losing enough function that they require assistance. However, it is not clear that mandatory models will take specific circumstances such as these into account when establishing design parameters or cost targets, for example. Without allowing clinicians, including physiatrists, the ability to opt in to participation in a model after assessing such considerations, the risks to patient safety and quality of care are likely to increase, and the chances of success under such a model for clinicians would be diminished.

Finally, we also have concerns specific to the parameters of the EPMs, which further bolster our support for CMS' proposed cancellation of these mandatory models. Specifically, the EPMs include numerous problems, as identified by comments, including problems with the adequacy of the quality measurement set, episode length, beneficiary notification requirements, and plans for progressively incorporating regional data into EPM target prices. Additionally, we share concerns about the inclusion of unrelated services in the EPM episodes' actual expenditure calculations, rather than just services that are related to the underlying MS-DRGs that triggered the episode. We believe that by holding the hospitals that have been forced into the program responsible for costs that will, in many cases, be unrelated to the underlying episode (a concern we hold even with the finalized listed of exclusions), CMS risks creating incentives that will undermine patient safety and quality of care.

For all the above reasons, AAPM&R supports CMS' proposal to limit mandatory participation in models through the cancellation of the mandatory EPMs, as well as through the easing of mandatory participation requirements under the Comprehensive Joint Care model. We also urge CMS to ensure that future Innovation Center models be implemented on a voluntary basis only, to protect against the risks outlined above.

Cardiac Rehabilitation Incentive Payment Model

While AAPM&R supports the proposed changes to the EPMs and CJR model given our concerns about mandatory model participation, the same concerns do not apply to the Cardiac Rehabilitation Incentive Payment Model, which allows for voluntary participation. This component of cardiac care can have significant advantages in terms of maintaining function and reducing medical risk for appropriate patients. It would seem preferable to leave this as a voluntary incentive payment for those that can incorporate it into their delivery systems. Given the potential for cardiac rehabilitation to improve the value of care, it would be unfortunate and likely counter-productive to eliminate it. That does not mean we would recommend leaving it structured as it currently is; as your proposed rule acknowledges, there are certain problems or issues (such as supervision requirements) that would be better resolved prior to implementation.

Clinician Engagement List

AAPM&R supports CMS' proposal to establish Clinician Engagement Lists for the CJR model for physicians, nonphysician practitioners, and therapists who are not CJR collaborators but who do have a contractual relationship with CJR participants based at least in part on supporting the participant's quality or cost goals under the model during the performance period. Likewise, we support CMS' companion proposal to consider the Clinician Engagement List an Affiliated Practitioner List, which would allow clinicians included on such list to be assessed for the Advanced Alternative Payment Model (APM) track of the Quality Payment Program based their support of the CJR model. Given the current menu of Advanced APMs, which provide little opportunity for specialists to participate, AAPM&R believes the addition of new avenues for Advanced APM participation is critical, and we encourage CMS to continue to explore similar structures – as well as additional options – as CMS rolls out new models.

Conclusion

In summary, although AAPM&R recognizes the need to improve the delivery of medical care, particularly focusing on value, we remain very concerned that many proposed changes to reimbursement, especially those that encourage the elimination of outliers and medically complex patients from care, may have negative effects on vulnerable populations like those we serve. New models should be tested in a manner mindful of the needs of those with significant disabilities, and it is important to keep care available for those individuals as models are tested and refined. AAPM&R urges CMS to proceed with

the development of new models of payment while maintaining an awareness of the needs of all of the citizens that it serves, including those with chronic injury, illness, and disability. As an organization focused on the care of these individuals, we are always happy to assist or offer perspective on the needs of our patient population.

If you have any questions, please contact M. Kate Stinneford, our Health Policy Manager, who can be reached at e-mail address: kstinneford@aapmr.org or 847-737-6022. Thank you for your consideration of these comments.

Sincerely,

Christopher J. Standaert, MD
Chair
Innovative Payment and Policy Models Committee
American Academy of Physical Medicine and Rehabilitation