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Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-P
P.O. Box 8013
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 proposed rule: CY 2018 Proposed Updates to the Quality Payment Program (QPP) that was published in the Federal Register on June 30, 2017 and implements provisions under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). 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.

II. Provisions of the Proposed Regulations and Analysis of and Responses to Comments.

C.1.a Definition of a MIPS Eligible Clinician

AAPM&R was concerned to learn that per the rule, "For Part B items and services furnished by a MIPS eligible clinician such as purchasing and administering Part B drugs that are billed by the MIPS eligible clinician, such items and services may be subject to MIPS adjustment…" We have serious concerns with this policy, which could disproportionately harm many of our members who regularly provide services such as injections of Part B drugs. We understand that CMS is applying this policy – which diverges from policies applied under previous incentive programs for eligible professionals such as the Physician Quality Reporting System (PQRS) or the Value-based Payment Modifier (VM) where adjustments were only applied to covered professional services – based on its interpretation of statute. However, we urge CMS to consider alternative interpretations of statute that would exclude Part B drugs

and durable medical equipment from MIPS payment adjustments, particularly since we believe that including these Part B expenditures is counter to the statutory intent of MACRA to reward value rather than volume. We also urge CMS to work with Congress to clarify statute to ensure that clinicians are not penalized or rewarded on the volume and cost of medically necessary drugs they supply in their offices.

C.1.c. Small Practices

AAPM&R recommends CMS consider the option to expand the proposed small practice size determination period to 24 months with two 12-month segments of data analysis when determining small practice size.
AAPM&R understands CMS now has operational reasons to account for small practice size in advance of a performance period, such as assessing and scoring IA performance, determining hardship exemptions for small practices, calculating the small practice bonus for the final score, and identifying small practices eligible for technical assistance. AAPM&R thanks CMS for recognizing that there may be circumstances in which the small practice size determinations made by CMS do not reflect the real-time size of such practices. CMS considered two options related to determining small practice size. While neither option is ideal for small practices, we support the first option of expanding the determination period to 24 months with two 12-month segments of data analysis (before and during the performance period), in which CMS would conduct a second analysis of claims data during the performance period. This options is less burdensome for clinicians and will provide more accurate data to practices. AAPM&R continues to be in favor of any option that does not require manual attestation on behalf of clinicians, as this leads to many issues related to lack of knowledge and education to fulfill a manual attestation requirement.

C.2.c. Low Volume Threshold

AAPM&R supports the low volume threshold exception criteria defined as ≤ $90,000 in Part B allowed charges OR ≤ 200 Part B beneficiaries for the 2018 reporting year.
AAPM&R agrees with the proposal to change the defined criteria for the low volume threshold exemption in the QPP regulations to those eligible clinicians who bill ≤ $90,000 in Part B allowed charges or see ≤ 200 Part B beneficiaries. While we agree to this change, we encourage CMS maintain a consistent threshold for at least two years to minimize confusion and ensure more consistency in terms of benchmarks and to provide consistent and frequent communications to clinicians stating their eligibility and requirements.

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C.4.e. Virtual Groups Election Process

AAPM&R urges CMS to expand the virtual group election process beyond December 1, 2017 to December 31, 2017 during its first year of implementation and provide special scoring accommodations for virtual groups for the first year.

While CMS recognizes that for the first year of virtual group formation prior to the start of the 2018 performance period, the timeframe for virtual groups to make an election would be relatively short since the final rule will not be issued until toward the end of 2017. CMS proposes it intends for this election process to be available as early as mid-September of 2017 and will publicize the specific opening date via sub-regulatory guidance. Thus, virtual groups would have from mid-September to December 1, 2017 to make an election for the 2018 performance year. AAPM&R has significant concerns about this short timeframe for the virtual group election process for two reasons. One, many clinicians will still be working towards meeting 2017 requirements during this timeframe making the virtual groups election process overly burdensome to meet by December 1, 2017. Second, and more significantly, education must be provided to clinicians to understand the entire virtual groups process CMS is proposing before clinicians can make an educated decision on whether to elect to participate in this process. Based on previous years, clinicians are consistently confused between the current reporting year and preparing for the next reporting year. AAPM&R believes many of its members will want to take advantage of the virtual groups option but will require extensive education on the process. *CMS must provide continuous and consistent education to clinicians on the virtual groups process for it to be a viable option.*

To address some of these concerns, we recommend that CMS extend the virtual group election process to December 31, 2017, to provide as much time as possible for eligible solo practitioners and groups to make an election. Even with this extended deadline, potential virtual group participants will have had limited time to process and understand requirements for virtual groups that are included in the final rule. Further, given the numerous challenges we expect virtual groups to face in their first year, for example, investments in electronic health records and other infrastructure to aggregate and streamline reporting across the virtual group participants, we expect that virtual groups will experience some difficulty performing at their maximum potential for the first year, if not longer. As such, AAPM&R recommends that CMS provide special scoring accommodations for virtual groups, for example similar to those provided to small practices even if the size of the virtual group, in total, exceeds the small practice definition. This would acknowledge the accelerated timeline and multiple challenges virtual groups are expected to face in the first year, as

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well as provide a smoother transition for virtual groups that did not have the benefit of CMS' "Pick Your Pace" policies in their first year of operations. Additionally, we recommend that CMS maintain virtual group requirements unchanged for several years to ensure that interested clinicians and groups have time to learn and understand the program in order to make informed virtual group participation decisions.

C.5. MIPS Performance Period

AAPM&R urges CMS to reduce the quality performance period to a minimum 90-day period within the CY 2018 and up to and including the full CY 2018.

The transition from reporting one measure on one patient to reporting a full calendar year will be overly burdensome for many clinicians. While AAPM&R understands CMS has implemented gradual transitions in the proposed 2018 rule, requiring one full year of quality reporting will be difficult, especially given the new option of virtual groups. AAPM&R believes many physiatrists will consider the virtual groups option but will need time to fully set up their virtual groups before they are ready to report on quality measures. Many clinicians are still implementing workflow changes within their practices and will not be able to meet the full reporting year requirement. Instead of requiring all clinicians to report a full year, CMS should reduce the quality performance period to a minimum 90-day window within the CY 2018 and allow clinicians to opt to report more data than the minimum.

AAPM&R is supportive of the performance period for the improvement activities and advancing care information performance categories to be a minimum of a 90-day period within the CY 2018 and up to and including the full CY 2018.

C.6.a. Performance Category Measures and Reporting

AAPM&R encourages CMS to reconsider multiple data submissions for all categories, especially the quality category, to only one data submission mechanism.

In the 2018 proposed rule, CMS proposes to allow individual MIPS eligible clinicians and groups to submit data on measures and activities, as applicable, via multiple data submission mechanisms for a single performance category. CMS states it strives to minimize complexity and administrative burden on clinicians. This proposal for increased flexibility also increases complexity and in some instances additional costs for clinicians as they may need to establish relationships with additional data submission mechanism vendors to report additional measures and/or activities for any given performance category,

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particularly if CMS proposes to apply a measure validation process that looks across multiple data submission mechanisms and multiple qualified registries to determine if applicable measures are available. Use of multiple data submission mechanisms also might limit CMS' ability to provide real-time feedback.

For virtual groups, CMS is proposing they would be able to use a different submission mechanism for each performance category and would be able to utilize multiple submission mechanisms for the quality performance category, beginning with performance periods occurring in 2018. However, virtual groups would be required to utilize the same submission mechanism for the improvement activities and the advancing care information performance categories. Different requirements for virtual groups will only cause more confusion for clinicians trying to adhere to the QPP requirements.

AAPM&R strongly encourages CMS to reconsider multiple data submissions due to the complexity it will place on clinicians and have the same rule for virtual groups. **AAPM&R also strongly supports the American Medical Association (AMA) comments on this issue.**

C.6.c. Selection of MIPS Quality Measures for Individual MIPS Eligible Clinicians and Groups Under the Annual List of Quality Measures Available for MIPS Assessment

AAPM&R supports the proposed substantive changes to the Closing the Referral Loop: Receipt of Specialist Report measure. AAPM&R appreciates CMS listening to our concerns regarding the reporting limitations of this measure in the 2017 year and supports the proposed substantive change to offer this measure as a registry measure for the 2018 performance period.

MIPS Quality Measure 182, Functional Outcome Assessment is a measure that is relevant to and should be reportable by physiatrists. However, based on the codes attached to the denominator, this measure is intended for Physical Therapists, Occupational Therapists, and Chiropractors; NOT Physical Medicine and Rehabilitation physicians**. AAPM&R continues to urge CMS to add codes such as 99201-5 and 99211-5 to this measure to be reportable by physical medicine physicians. If CMS cannot do this in time for the 2018 performance period, then it should remove this measure from the Physical Medicine Specialty Measure Set since it is currently not reportable by members of our specialty.**

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Lastly, assuming that CMS does not finalize its proposal to hold clinicians accountable for satisfying the quality measure requirement by reporting across multiple data submission mechanisms, AAPM&R asks CMS to clarify how a clinician would be treated if a Specialty Set only includes less than 6 measures reportable via a specific mechanism (e.g., a specialty set that includes 10 measures, but only includes 4 claims-based measures). Under CMS's data validation process, if the clinician reported on those 4 claims-based measures, would he/she be expected to look for 2 other claims-based measures outside of the specialty set to satisfy the 6 measure requirement or would reporting on the 4 measures suffice and still make the clinician eligible to earn the maximum score in the quality category? CMS has not yet released details for the 2017 reporting year related to the Eligible Measure Applicability (EMA) process making this a concern for the 2018 reporting year as well.

C.6.d. Cost Performance Category

Cost Category Weighting: AAPM&R supports weighting the cost category at 0% for the 2018 reporting year

AAPM&R agrees with the proposal to change the weight of the cost category from 10% to 0% for performance year 2018. While we recognize that the jump from 0% in 2018 to 30% in 2019 will be significant, we believe clinicians require additional education about cost measurement prior to it impacting their payment adjustments. We echo CMS's concerns about the level of familiarity and understanding of cost measures among clinicians. While we continue to provide education to our members, we urge CMS to continue its educational efforts with respect to cost measurement and clinician assessment under new episode-based measures as they are developed, including confidential feedback on those measures.

Furthermore, as we indicate below, 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. We believe CMS is not prepared to measure cost in a relevant and appropriately risk adjusted way. We urge CMS to seek the ability to delay cost measurement until evidence-based measures have been developed to accurately capture cost.

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

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clinicians who agree to pilot test episode-based measures and/or patient relationship categories.

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

As stated in our 2016 comment letter, we 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 to obtain treatment for their health problems. Even if each of the individual physicians whom a patient sees is "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 urge CMS to remove these measures for assessment under MIPS.

Episode-Based Measures: AAPM&R supports removal of the ten episode-based cost measures adopted for 2017 reporting

AAPM&R agrees with the proposal to remove the ten episode-based cost measures for the 2018 reporting year. We agree that retaining these ten measures would be confusing for clinicians as CMS is working to develop new episode-based measures.

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

AAPM&R is currently participating in the episode-based cost measure development process led by Acumen. Two of our members are currently serving on the subcommittee to develop an episode measure for musculoskeletal non-spine services. We appreciate that CMS has opened this process to expert participation. The process of measure development to-date has included several lengthy conference calls in addition to a full-day meeting in Washington, D.C. Our members have volunteered extensive time to this important process because we anticipate that CMS will thoughtfully consider the subcommittee's recommendations. We urge CMS to take all subcommittee recommendations seriously as they are reflective of a cross-specialty collaborative process.

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While we are extremely supportive of the episode-based cost measure development process, we urge caution in implementing episode-based measures that have not been thoroughly tested. The new episode-based cost measures are being developed in a short timeline and still require testing to ensure their appropriateness. The rule notes that adoption of the new episode-based measures will be proposed in future rulemaking. We will appreciate the opportunity to comment on future proposals for implementation of the new measures when that opportunity is made available.

Cost Measures with Risk Adjustment: AAPM&R supports use of cost measures which are adjusted for social risk factors
The AAPM&R 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 comprehensive way to address this issue.

C.6.e. Improvement Activity Criteria
AAPM&R supports the inclusion of language in the 2018 QPP proposed rule to explicitly recognize Continuing Medical Education (CME) as an Improvement Activity within the Merit-Based Incentive Payment System (MIPS). As a member of the Council of Medical Specialty Societies (CMSS), we refer CMS to their letter of support for this specific Improvement Activity.

C.6.f. Advancing Care Information (ACI) Performance Category

AAPM&R appreciates that CMS has not proposed to increase any of the reporting/performance thresholds under this category; however, this category still falls short of its intention due to its continued reliance on the rigid structure of the EHR Incentive Program. For example, clinicians must at least satisfy the base requirements to receive a score in the Advancing Care Information category, which is no different than the all-or-nothing approach from the initial EHR Incentive Program. The metrics under this category are borrowed from Stage 2 and 3 of the legacy program and continue to focus more on EHR

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functionality than providing physicians with the flexibility to demonstrate meaningful use in a manner that is most relevant to their practices. **AAPM&R urges CMS to offer clinicians the broadest selection of measures to choose from for purposes of both the base and performance Advancing Care Information score and to not require the use of any single measure to receive a score in this category**.

AAPM&R urges CMS to recognize the value that clinical data registries bring to health care and promote their use by establishing an alternative pathway that recognizes physicians utilizing an EHR to participate in a clinical data registry as satisfactorily achieving full credit for the Advancing Care Information category (regardless of whether the EHR has a direct interface with the clinical registry). This would not only further incentivize EHR adoption and participation in clinical data registries, but recognize the value of registries in facilitating a culture of performance improvement that benefits patient care and patient outcomes. We believe CMS has the statutory authority to modify the ACI requirements in this manner since the statute defining "meaningful use" specifies that the meaningful use of certified EHR technology includes the electronic exchange of health information to improve the quality of health care, and reporting on quality measures. Both can be achieved by using CEHRT to participate in a registry. The third requirement is that Meaningful Use "shall include the use of electronic prescribing as determined to be appropriate by the Secretary," which we interpret to mean that CMS has the authority to waive application of e-prescribing requirements as appropriate. The other statutory requirements for meaningful use, including health information exchange and quality reporting, can be achieved by electronically participating in a registry. For other measures that CMS deems important or necessary, such as the security risk assessment measure, we believe that these measures still could be fulfilled through an attestation to a QCDR. Finally, MACRA also provides CMS with substantial discretion to modify meaningful use requirements for incorporation into the ACI component of MIPS to ensure that the application of the MU requirements is "consistent with the provisions of" MIPS.

If CMS believes it needs to maintain the existing structure of this category, then **we at least urge CMS to modify the scoring policies in a way that gives more weight to clinicians who invest in the meaningful use of clinical data registries to improve patient care**. As currently proposed, this category seriously undervalues the critical contribution of clinical data registries to higher quality care. For example, if a clinician fulfills the Immunization Registry Reporting measure in this category, he/she would earn 10 percentage

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points towards the performance score. If a clinician cannot meet the Immunization Registry Reporting measure because it is not relevant to his/her practice, the clinician can earn only five percentage points in the performance score for each "other" registry that he/she reports to, up to a maximum of 10 percentage points. While we appreciate that reporting to an immunization registry is not a requirement, this proposal significantly diminishes the value of reporting to specialized or clinical data registries by only awarding five percentage points for each. **AAPM&R strongly believes that clinicians who do not have access to an immunization registry should, at the very least, be able to earn the full 10 percentage points for reporting to another registry, such as a specialized or clinical data registry**.

Reweighting of the ACI Category: AAPM&R urges CMS to automatically reweight the ACI performance category for clinicians who predominantly practice in settings such as Comprehensive Inpatient Rehabilitation Facility (IRF; POS 61) and Skilled Nursing Facility (SNF: POS 31).

AAPM&R represents some physiatrists who practice in one setting, like IRFs and SNFs, who struggle to meet ACI requirements much like inpatient hospital-based eligible clinicians. For example, they may not have control over the decisions that the facilities make regarding the use of health IT and CEHRT, and requirements under the Protect Patient Health Information objective to conduct a security risk analysis would rely on the actions of the facilities, rather than the actions of the MIPS eligible clinicians. AAPM&R requests that CMS implement policies that would allow for automatic reweighting of the ACI category for such clinicians. For example, CMS could include services provided in these facilities in the hospital-based MIPS eligible clinicians' definition. Alternatively, CMS could establish a special hardship exemption that would automatically be applied to those clinicians who perform 75 percent or more of their services combined in IRF, SNF, or hospital settings.

C.7. MIPS Final Score Methodology

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

CMS proposes that the quality and cost measures that may be used for facility-based measurement are those adopted under the value-based purchasing program of a specified facility program for the year specified. For the 2020 MIPS payment year, CMS proposes to include all the measures adopted for the FY 2019 Hospital Value-Based Purchasing (VBP) Program on the MIPS list of quality measures and cost measures. AAPM&R supports the availability of

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facility-based measurement to consider clinician performance for the cost and quality performance categories, as a voluntary option. We believe this option creates greater flexibility for clinicians, particularly those that 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.

CMS also requests comments on what other programs, if any, CMS should consider including for purposes of facility-based measurement under MIPS in future program years. AAPM&R asks 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 achieve similar goals as those that exist with pay-for-performance programs. AAPM&R welcomes the opportunity to discuss this issue with CMS to further develop this policy.

C.7.b. Calculating the Final Score

Complex Patient Bonus: AAPM&R encourages CMS to increase the complex patient bonus to the same amount (5 points) or a higher bonus than proposed for small practices.

AAPM&R is supportive of a complex patient bonus to account for the added changes of providing care to medically complex patients. However, we recommend that CMS establish a bonus that would provide clinicians meaningful opportunities to achieve up to 5 points or more, rather than limiting this bonus to 3 points, in order to establish comparability with the small practice bonus. We believe that allowing the complex patient bonus to at least equal (if not exceed) the small patient bonus is appropriate given that we expect patient complexity to have a greater impact in determining performance across the MIPS categories than small practice size. Additionally, if CMS finalizes its proposal to base the complex patient bonus on the average HCC score, we believe a scaling factor will be necessary as CMS' data show that average HCC scores are not likely to exceed 3 points.

Small Practice Bonus: AAPM&R supports the proposal to add the small practice bonus of 5 points to the final score of those clinicians and groups who meet the small practice criteria.

AAPM&R thanks CMS for proposing an adjustment to the final score for MIPS eligible clinicians in small practices. AAPM&R supports a bonus of 5 points to

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acknowledge the challenges small practices face in participating in MIPS and to help them achieve the proposed performance threshold. AAPM&R is also supportive of a rural bonus in the future comparable to the bonus for small practices.

C.8. MIPS Payment Adjustments

Establishing the Performance Threshold: AAPM&R supports maintaining a low performance threshold of 3 for performance year 2018

CMS seeks comment on whether to finalize its proposal to set the performance threshold at 15 points for performance year 2018, or whether alternatives of 6 points or 33 points are more appropriate. AAPM&R urges CMS to maintain as low a threshold as possible for 2018 and recommends a performance threshold of 3. Given the complexity of the MIPS program requirements and that 2018 is still, largely, a transition year, we believe clinicians would benefit from additional opportunity to understand and prepare for full participation in MIPS. Additionally, in order to limit the increase in the performance threshold from performance year 2018 to 2019, when CMS must set the performance threshold at the mean or median composite performance score from a prior period, we recommend that CMS adopt the lower of the mean or mean for 2019 performance.

C.10. Third Party Data Submission

AAPM&R supports and refers CMS to the comments of the Physician Clinical Registry Coalition related to QCDRs.

C.11. Public Reporting on Physician Compare

While AAPM&R supports public reporting of physician data when it is valid, reliable, and meaningful to both consumers and physicians, we have a few concerns regarding the plans CMS lays out in the proposed rule:

1) Expand the preview period: Physicians need at least 90 days to review and ensure accuracy of their information. **AAPM&R urges CMS to extend the current 30-day period to 90 days.**
2) Increase public reporting gradually. There have been previous issues with the accuracy of published data. Since MIPS is still a new program, **we encourage CMS to be cautious and thoughtful before expanding information included on the physician compare website.**
3) Limit public reporting to composite score and performance category participation. In the proposed rule, CMS proposes to publicly report not only the composite score and performance category of each physician, but also performance on all quality and resource use measures. We have concerns that many of the resource use and ACI measures have not yet

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been tested. Given MIPS is a new program for both CMS and physicians, we believe CMS should not publicly report physicians' performance on any specific measures within any of the performance categories at this early time. **Instead, AAPM&R recommends that CMS indicate whether a physician satisfied the reporting requirements for each of the performance categories with a green check mark, as it has done previously for the EHR Incentive Program.**

Stratification by Social Risk Factors: AAPM&R urges CMS to not publicly report based upon social risk factors on Physician Compare until research on risk adjustment has been vigorously tested and validated. AAPM&R agrees with CMS that stratifying data by risk factors is appropriate; however, risk adjustment methodologies have not been fully tested. AAPM&R is willing to consider confidential reporting of stratified rates using social risk factor indicators in lieu of publicly reporting of stratified rates for quality and cost on Physician Compare.

D.4. Overview of the APM Incentive

Advanced APMs: AAPM&R requests that CMS provide more clarity on how it will calculate the revenue of participants in an APM entity and a clearer description of its plan to average revenues to arrive at a determination of whether the APM meets the financial risk criterion. AAPM&R appreciates that CMS is maintaining the revenue-based nominal amount standard at 8 percent of the average estimated total Medicare Parts A and B revenue of providers and suppliers in participating APM Entities, although we do note that a lower amount may hasten CMS' goal of encouraging more clinicians to participate in an APM. It is simply too soon to know what the ideal risk standard is, but we appreciate that CMS did not raise it further. We also appreciate CMS's efforts to reduce the ambiguity of whether the nominal amount is intended to be based on a percentage of payments to all providers and suppliers in an APM Entity or only payments directly to the APM Entity itself. However, we are still somewhat confused by clarifying language that the nominal amount would be based on a "percentage of the average estimated total Medicare Parts A and B revenue of providers and suppliers in participating APM Entities. We request that CMS provide additional clarity on what it means to "average" the revenues of the participants in the APM entity. AAPM&R is concerned that because the revenue-based standard takes into account all revenue and is not focused just on the revenue that is subject to the risk mechanism of the model that it could discourage

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practices from taking part in these potential payment arrangements. For this reason, we request that CMS provide more clarity on how it will calculate the revenue of participants in an APM entity under the Revenue-based Standard and a clearer description of its plan to average revenues to arrive at a determination of whether the APM meets the financial risk criterion.

AAPM&R also agrees with CMS that consideration should be given to lowering the nominal amount risk standard for those in small practices and those in rural areas. Such practices already face challenges just trying to stay in existence, and lowering their potential risk may allow them to participate in an APM that would otherwise have been too risky.

AAPM&R recommends that CMS remove the requirement that a medical home must be limited to the list of specialties provided. AAPM&R questions CMS's decision to maintain medical homes as primary care based only. There are instances in which a Medicare beneficiary would be better served by a medical home geared towards a particular specialty. For example, people with disabling conditions might be better served in a medical home which is run by a physiatrist (perhaps in conjunction with a primary care provider.) Such a specialist would be more attuned to issues related to the patient's disability (e.g. spasticity in someone who has suffered a stroke) and better able to treat it. A physiatrist would also be more likely (based on training) to recognize and address functional issues which are (perhaps unnecessarily) interfering with a patient's ability to function at home and in the community. We recommend that CMS remove the requirement that a medical home must be limited to the list of specialties provided. In addition, to ensure that patients receive the care that is contemplated by the medical home concept, we recommend that CMS make the currently optional element a requirement: "Coordination of care across the medical neighborhood"

D.5. Qualifying APM Participant (QP) and Partial QP Determination
Advanced APMs Starting or Ending During a Medicare QP Performance Period: AAPM&R appreciates CMS's recognition of the disadvantage an APM entity or individual would face upon joining an APM during a Medicare QP Performance Period, without adjustments to the parameters used in calculating threshold scores. As such, we agree with CMS' proposal to make the Denominator and the Numerator correspond with the same dates rather than having one longer than the other. The requirement that the APM entity must be able to participate in the Advanced APM for 60 or more continuous days during the Medicare QP Performance Period makes sense in that it ensures that the

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APM entity has been involved in the APM for a sufficiently long period of time to reflect meaningful participation.

Participation in Multiple Advanced APMs: AAPM&R appreciates CMS's intent to clarify that if an eligible clinician is determined to be a QP based on participation in multiple Advanced APMs, and if any of the APM Entities in which the eligible clinician participates, voluntarily or involuntarily terminates from the Advanced APM before the end of the Medicare QP Performance Period, the eligible clinician is not a QP. We have concerns that this approach will disadvantage such clinicians, however, particularly considering that the eligible clinician likely has little influence in whether one of the Advanced APMs he participates in terminates before the end of the Medicare QP Performance period. If CMS finalizes this proposal largely unchanged, we recommend that CMS clarify that that it would continue to assess whether the eligible clinician would meet QP thresholds based on participation in the remaining Advanced APMs.

D.6. All-Payer Combination Option

AAPM&R appreciates CMS' inclusion of QP Determination Trees and the tables listing QP Patient Count Thresholds- All-Payer Combination Option and Payment Amount Method - All-Payer Combination Option by year. The table and tree design makes it much easier to determine whether an eligible clinician will qualify as a QP or possibly as a partial QP under the combined All-Payer Combination Option.

D.6.b. Other Payer Advanced APM Criteria

Financial Risk for Monetary Losses: AAPM&R recommends aligning Other Payer Advanced APM risk requirements with that of Medicare Advanced APMs

It is not clear why CMS feels that Other-Payer Advanced APMs require a more complicated method for ascertaining risk. The fact that Marginal risk, Minimum loss rate, and Total risk are all required makes it that much more difficult for physicians to join and demonstrate participation in Other Payer Advanced APM, especially under the proposed clinician-initiated process for Other Payer Advanced APM determinations. We believe that aligning requirements across all payers will reduce burden, reduce complexity, and increase the likelihood of participation in models across multiple payers.

D.6.c. Determination of Other Payer Advanced APMs

AAPM&R recommends that CMS increase the availability of the Payer-Initiated Process and strengthen requirements for payer submission of data

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While the process for Other Payer Advanced APMs is complex, the sheer number of differing rules becomes quite confusing. For instance, each of the eleven lettered subcategories within the first five numbered categories above has a set of unnumbered sub-subcategories such as Guidance and Submission Form, Submission Period, CMS Determination, CMS Notification, and CMS Posting of Other Payer Advanced APMs. Is there some way to simplify the process? Anything that takes 14 full pages in the Federal Register to explain is not going to be easily useable by physicians.

Under the Payer Initiated Process, we ask CMS to move up the date at which private payers can begin submitting payment arrangements for Other Payer Advanced APM determinations. To exclude private payers from submitting models next year (for 2019 participation) could undermine awareness of the existence of many innovations in the private sector. Additionally, it would decrease the burden on physicians if the use of Eligible Clinician or APM entity Initiated Process were kept to a backup mechanism only. To the extent feasible, payors should be required to submit the necessary information to CMS. The chances of all paperwork being submitted promptly and completely is much greater when the responsibility is put on the party who has control over those documents – the payor.

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 Kavitha Neerukonda, Director of Quality and Research Initiatives in the AAPM&R Division of Health Policy and Practice Services. She may be reached at kneerukonda@aapmr.org or at (847)737-6082.

Sincerely,

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

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