

November 16, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Angela Tejada
Assistant Secretary for Planning and Evaluation, Office of Health Policy
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: The Patient-Centered Headache Care Payment Model

Dear Ms Tejada:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit the following comments to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) regarding the Patient-Centered Headache Care Payment Alternative Payment Model (APM) submitted by the American Academy of Neurology (AAN). APTA supports AAN's proposed APM and the inclusion of physical therapists within the model's Headache Care Team. To better support the inclusion of physical therapists and other nonphysician clinicians in this model, APTA recommends that PTAC and AAN consider quality measurements that can be specifically attributed to physical therapists and other participating nonphysicians. Currently, even when physical therapists are involved in the patient's continuum of care, quality outcome measures are not attributed to the physical therapists who deliver necessary therapy services to patients under the model. We hope that PTAC and AAN can explore methods by which patient outcomes achieved under the model can be attributed to every individual clinician who delivers care to a patient.

Background

APTA's goal is to foster advancements in physical therapist practice, research, and education. The mission of APTA is to further the profession's role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the physical health and functional abilities of members of the public.

The physical therapy model of practice as delineated in the *Guide to Physical Therapist Practice* is patient-centered, incorporating patients' needs and goals across a continuum of care. Physical therapists serve an important role in patient safety and patient care transitions, and can help reduce readmissions by providing recommendations for the most appropriate level of care to the

health care team prior to and during care transitions. They also integrate essential elements of evaluation and management with a patient-centered focus based on the best available evidence to optimize outcomes. Physical therapists provide various interventions with the goals of improving muscle performance, activity, and participation, and promoting physical activity to avoid subsequent impairments, activity limitations, and/or participation restrictions.

For these reasons, we strongly believe that the success of APMs in improving the quality of care and decreasing costs depends on the collective efforts of all health care providers throughout the health care spectrum, including physical therapists, home health agencies, rehabilitation agencies, inpatient rehabilitation facilities, skilled nursing facilities, and other provider types. The true potential to reduce costs and improve the health of individuals and populations will not be fully realized until HHS takes meaningful steps to include physical therapists and other rehabilitation providers within APMs.

The Centers for Medicare and Medicaid Services (CMS), together with PTAC, is leading the transition from fee-for-service to value-based care. To truly accelerate the adoption and use of Medicare (and Medicaid) APMs, CMS, as well as PTAC members, must continue to promote payment models that are accessible to all providers, including physical therapists. Therefore, we strongly recommend that PTAC use its influence to encourage the development of APMs that incorporate providers who do not currently have access to an APM, including physical therapists, occupational therapists, and speech-language pathologists.

AAN's Proposal

The academy has proposed an APM designed to give neurologists, primary care providers, and other clinicians with expertise in treating headaches the accountability, resources, and flexibility needed to effectively diagnose and treat patients under the model. The key to AAN's proposal is incorporating a variety of specialists to assess patients with headache pain and expediting patient referrals to the appropriate experts based upon a patient's symptoms and characteristics.

Overall, APTA supports AAN's proposed APM, and we are pleased to find that the academy includes physical therapists among other nonphysician specialists on the model's Headache Care Team. We agree with the academy that a coordinated care approach can more efficiently diagnose and treat patients suffering from headaches, and reduce unnecessary emergency room visits and hospitalizations and the associated costs. We also agree that physical therapists can play an integral role in evaluating patients under this model and, with the other team members, develop individual plans of care to address the underlying cause of patient headaches.

APTA Recommendations

While APTA supports of the coordinated care approach proposed by AAN's payment model, APTA is concerned that the model does not effectively tie patient outcomes to the skilled care provided by nonphysicians such as physical therapists.

Quality Measures Specific to Each Provider Across the Continuum of Care

The academy's proposed payment methodology considers the variety of clinicians and services that may be required to diagnose and treat patients under the model. However, it is unclear how this model will attribute patient outcomes and quality metrics to each provider involved in a patient's care. Therefore, APTA urges AAN to reevaluate its quality metrics and ensure that patient outcomes can be attributed individually to each provider who treats patients under the model. Without this specific attribution, AAN will be unable to identify which interventions were most effective in addressing and treating patient conditions and subsequently reducing the costs associated with headache patients. Further, participating providers may not have sufficient incentives to deliver care under this model if their performance cannot be adequately attributed to patient outcomes under the model.

Quality and Outcome Measures Key to APM Success

Rehabilitation services such as physical therapy are integral components of APMs. Unfortunately, many of the metrics that have been developed to assess progress are exclusive of nonphysician specialties, including physical therapy. Additionally, some metrics are not attributed to nonphysician specialties due to the measure attribution methodologies; this includes cost metrics and metrics for readmissions at the provider level. APTA believes that both team-based metrics and specialty-specific metrics are important to the delivery of high-quality care.

As PTAC proceeds to evaluate and recommend new APMs to CMS, APTA urges the committee to encourage the development of models that incorporate quantitative and qualitative metrics, including meaningful performance-based and patient-reported outcome measures, by which CMS can ensure that coordinated, patient-specific, outcome-based care is being delivered safely to patients by properly qualified professionals. The variety of measures included within APMs must include measures applicable to multiple types of clinicians. Specialty sets should be developed and adopted for nonphysician providers, including physical therapists, speech-language pathologists, and occupational therapists. Such measures should contribute to coordinated care, be correlated to positive health outcomes, and not impose an undue burden on providers. The types of measures that we recommend CMS develop and adopt are measures that monitor and track patient outcomes, provider performance, and changes in utilization of services. Including a robust set of quality measures within APMs will help to show the positive effects of nonphysician providers' interventions on patient outcomes.

To ensure APMs are multidisciplinary, we recommend that CMS mandate the inclusion of functional measure items within APMs that show the value of providers who have traditionally been excluded from APM participation. It is critical that new models include appropriate measures that address function and illustrate the value of each provider to the APM patient population. To assist PTAC in its efforts, APTA welcomes the opportunity to serve as a resource to PTAC and CMS, to share data results at the clinician, practice, and national levels for the measures included in APTA's Qualified Clinical Data Registry (QCDR).

Conclusion

APTA strongly believes that CMS should incentivize the inclusion of additional practitioners within APMs, as proposed in the AAN payment model. However, we urge CMS and PTAC to

better promote the inclusion of practice-specific quality measures to better monitor the effectiveness of services provided by individual physicians and nonphysicians and to create more comprehensive data to match payment with quality care. While we support the academy's proposed payment model, we encourage AAN to revisit its quality metrics and identify more specific measures for the various providers involved.

Once again, we thank PTAC for the opportunity to comment on the proposed Patient-Centered Headache Care Payment Alternative Payment Model. Should you have any questions regarding our comments, please contact APTA Director of Regulatory Affairs Kara Gainer, at karagainer@apta.org or 703/706-8547.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Sharon L. Dunn". The signature is written in a cursive, flowing style.

Sharon L. Dunn PT, PhD
Board-Certified Orthopaedic Clinical Specialist
President

SLD: krg



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November 20, 2017

Jeffrey Bailet, MD
Committee Chairperson
Physician-Focused Payment Model
Technical Advisory Committee
Office of the Assistant Secretary for
Planning and Evaluation
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Bailet:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide our strong support for the Patient-Centered Headache Care Payment (PCHCP) proposal currently being reviewed by the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

Neurologists who treat headaches have identified several barriers in the current payment system that make it difficult to deliver comprehensive, high quality care to patients with complex and severe headaches. These barriers include inadequate payment for complete diagnostic workups, treatment planning, patient education and counseling, telephone support to patients, collaboration between primary care physicians and neurologists, and support services such as physical therapy and nutritional counseling. In addition, the process of screening and referring headache patients to neurologists needs to be improved so that only the patients who need specialist care are referred and their waiting times to schedule an appointment are reduced. The PCHCP model would address these barriers by providing a one-time payment to a neurologist or headache team to support a comprehensive evaluation and assessment of patients with undiagnosed, difficult to diagnose or poorly controlled headache disorders, education on headache prevention and management, appropriate testing, development of an initial treatment plan, and the first few months of treatment. Then, the neurologist or headache team would receive monthly payments, instead of evaluation and management payments, for patients who continue to have frequent, severe, and/or disabling headaches. The AMA believes this model could address current barriers in the fee schedule for physicians treating patients with headaches, allow physicians to take accountability for reducing avoidable spending and improving quality of care for patients with severe headaches, and reduce use of opioids for headache-related pain.

The AMA also supports the flexibility for physicians in the PCHCP model and the ability for physicians to gradually increase the amount of financial risk they choose to accept. Instead of a monthly payment that is designed only to cover the clinical services directly delivered by the physician managing the patient's care, physicians or practices could instead choose to receive larger bundled payments which would include the funds to pay for some or all other headache services. These bundled payments would

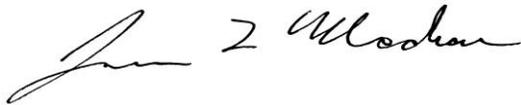
provide greater flexibility in how the physician delivers care, but would also require the physician to take greater accountability for managing utilization and spending. The AMA supports the flexibility of this model that can be designed for small practices that do not have the ability to take on significant risk, as well as more sophisticated practices that may be ready to move to a higher risk model.

The PCHCP model also emphasizes coordination of care between neurologists, primary care physicians, and other physicians with expertise in headache care. In addition, the model encourages physicians to leverage advanced practice professionals to perform tasks such as monitoring patient-reported data between visits (in collaboration with the specialists) to identify irregularities and needed interventions.

The PCHCP requires a face-to-face visit, but allows the use of teleneurology for subsequent visits once a patient is in stable condition. This would allow patients to be seen remotely via phone or video to review headache diaries and treatment questions. The AMA supports the use of delivery system innovations such as teleneurology, which enables improved access for patients who may live in rural areas or have difficulty traveling to appointments.

The AMA urges the PTAC to recommend the PCHCP model to the Secretary, and to work with the Center for Medicare and Medicaid Innovation to get a test of the model implemented. We thank the Committee for the opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with a large initial "J" and "M".

James L. Madara, MD