American Academy of Physical Medicine and Rehabilitation

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May 10, 2016

Mr. Scott M. Smith,
Office of Health Policy
Assistant Secretary for Planning and Evaluation
DHHA
200 Independence Ave., SW
Washington, D.C. 20201
Comments sent electronically to PTAC@hhs.gov

RE: Draft Review Process for PFPM Proposals

Dear Mr. Smith,

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) appreciates the opportunity to provide feedback on the draft review process for PTAC members to review proposed APMs sent to them. AAPM&R is the national medical specialty organization representing more than 9,000 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.

Our comments are grouped under the three key areas you state in your proposed process, although there is some overlap, and sometimes the comment does not fit ideally within the category.

Content of Proposals

- Please make the application process as simple as possible. Some of the application processes for past demonstration models have involved very lengthy and detailed information gathering and submission.

- Since the review proposal states that Committee recommendations will be incorporated into the final document, whether they are minority or majority opinions, there should be some way to note whether they are minority or majority in the document. Otherwise, unfair weighting may be given to an opinion which is not in accordance with that of the other members.

- Consider not requiring details of how the model will be implemented – submitted model plans, particularly those from medical associations, may have a conceptual model that has not yet been "test-driven" by physician members. There may be multiple ways to put a plan into action. To require detailed information about exactly how it will be implemented will limit opportunities for tweaking the model according to the needs or wishes of the physician willing to try it out. While the desire to have every last detail spelled out is understandable, it becomes a chicken and egg problem. If CMS requires strict adherence to a mapped out plan in order to qualify the model, it will need to be tested in order to ensure that the method selected for implementation is the best possible. At the same time, if CMS is unwilling to call a model an Advanced APM, what incentive is there for a physician to try it out? On balance, the burden for experimenting with a new payment model is heavier for the entity implementing it than it is for the entity approving it. One way to equalize things would be for the model to at least have a guarantee that it will not be disqualified due to some technicality after the physician has already invested time and money in implementing it.

- Will PTAC have the discretionary authority to approve a plan for CMS review even if it does not meet all criteria but has an adequate explanation as to why it does not meet criteria and possible substitute criteria?

- Because of the very tight timeframe, the chances of a model being ready to roll and to be approved as an Advanced APM prior to January 1, 2017 are very small. PTAC should have an alternative for recommending APMs that will perhaps not meet the criteria for an Advanced APM but will meet standards for Practice Improvement under MIPS. The application could have a section for the submitter to explain how the APM at least meets MIPS criteria, even if it does not meet all the criteria for an Advanced APM. The application should be clear on whether it is requesting Advanced APM status but will take MIPS satisfaction as an alternative. Also, CMS should consider not basing bonuses or penalties in 2019 on information generated during 2017.

- At the time for full Committee review, there should be an opportunity for the submitter to be part of the discussion in order to clarify or correct any possible misinterpretations by the Committee. This can be as simple as a phone conference line.

Technical Assistance

- Rather than returning incomplete or non-adherent proposals back to the submitter, perhaps it could be optional in the cases where there are only 1 or 2 unresolved issues for the PTAC team to contact the submitter by phone to discuss exactly why the proposal is considered insufficient and identify ways to rectify the problem (this could be considered a form of Technical Assistance.) The submitter could then revise the proposal in accordance with the discussion and resubmit it directly to the PTAC member who discussed it with him or her, rather than restarting the process from the bottom up. There could be a short timeframe for the submitter to make the revisions and send the revised copy to the PTAC in order to have closure for the PTAC member within a reasonable time period. For example, the submitter may be advised that the revised document must be received by PTAC within a specified time frame from the phone call or it will automatically lose its special status and return to the pile of unreviewed proposals.

- Please define "external technical experts." Can they be anyone the PTAC reviewer wishes to consult or is there some sort of preapproved list?

- Will submitters have access to the scoring methodology as well as the criteria before submitting proposals? Exactly how will scores be used in evaluating an APM?

Timeline for Review

- If the Committee decides not to recommend referral to CMS but to instead encourage revision and resubmission, the procedure and timeline should mirror that described above for submissions that were initially thought to have some relatively small problems. (The PTAC team should have the option to contact the submitter by phone to discuss exactly why the proposal is considered insufficient and identify ways to rectify the problem. There could be a short timeframe for the submitter to make the revisions and send the revised copy to the PTAC in order to have closure for the PTAC member within a reasonable time period. For example, the submitter may be advised that the revised document must be received by PTAC within a specified time frame from the phone call

or it will automatically lose its special status and return to the pile of unreviewed proposals, where it will start the process from the beginning.

- How will the situation be handled if PTAC receives a large number of proposed models at one time? Is there any risk that some submissions will not be reviewed, even if they were submitted by the deadline?

- The rule should identify whether this will be a continuing process for submitting new models or, if not, what the subsequent procedure will be.

While we understand that comments on PFPM criteria should not be submitted to PTAC, and we eagerly await their release by CMS, it is quite possible that some of the criteria may have an element that could have been included with these comments about the review process. For example, there may be some criteria in which we would wish to comment on how the PTAC can ensure that the criteria was met. We hope to have the opportunity to comment on those processes as well as the content of the criteria, once they are released.

If you have any questions, please contact AAPM&R's Health Policy Manager, M. Kate Stinneford at kstinneford@aapmr.org.

Thank you for your time and consideration in reviewing our comments.

Regards,

Peter, Esselman, M.D.
Co-Chair
Innovative Policy and Practice Models (IPPM) Committee
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