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March 13, 2020

Jeffrey Bailet, MD

Chair, Physician-Focused Payment Model Technical Advisory Committee

Office of the Assistant Secretary for Planning and Evaluation

U.S. Department of Health & Human Services

Hubert Humphrey Building

200 Independence Avenue, SW

Washington, DC 20201

Dear Dr. Bailet,

On behalf of the more than 36,000 neurologists and clinical neuroscience professionals, the American Academy of Neurology (AAN) is pleased to support the Medical Neighborhood Model proposal submitted by the American College of Physicians (ACP) and the National Committee for Quality Assurance (NCQA).

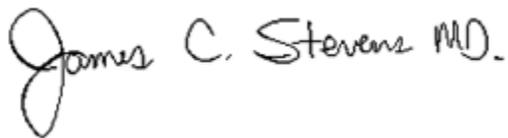
The Alternative Payment Model (APM) landscape, while growing, still lacks substantive APM options for many specialties, including neurology. At present, the only CMMI initiative targeted at the services neurologists provide is the voluntary Bundled Payment for Care Improvement – Advanced (BPCI-A). The BPCI-A model includes many inpatient episodes including episodes for acute ischemic stroke and intracranial hemorrhage and only a few surgically oriented outpatient episodes, none of which apply to neurology. This is not a very useful path for neurologists, as they are usually consultants rather than primary admitting physicians in these cases, and because most costs are determined by hospital and skilled nursing facility charges and by the cost of transport between care facilities. Moreover, the BCPI-A model does not apply to the many neurologists that practice in the outpatient setting. The ACP and NCQA Medical Neighborhood Model offers a great opportunity for neurology practices that collaborate and refer patients to primary care practices to participate in a value-based care model that monitors care coordination, quality outcomes, resource utilization and patient experience for patients that require advanced support from neurologists.

While the Medical Neighborhood Model has many strengths, the opportunity for scalability and accommodation of a variety of specialties, including neurology is paramount. This model builds on the strengths and inherently supports the Comprehensive Primary Care Plus (CPC+) and Primary Care First (PCF) models, which offers a great opportunity to avoid

duplication and instead build off and connect current structures that improve care. Two important elements of the Medical Neighborhood Model are its pre-screening process and optional e-consultation to resolve cases that do not require an appointment with a specialist. These elements not only enhance communication and consultation with the primary care and specialty practices, but values patients' time, reduces unnecessary delay to treatment and waiting times and allows for more urgent cases to be seen faster.

The AAN urges the PTAC to recommend the Medical Neighborhood Model proposal to the Secretary of Health and Human Services for implementation. We appreciate the opportunity to share our comments. Please contact Leslie Kociemba, AAN Care Delivery Program Manager at lkociemba@aan.com with questions or requests for additional information.

Sincerely,

A handwritten signature in black ink that reads "James C. Stevens MD." The signature is written in a cursive style with a large, looped initial "J".

James C. Stevens, MD, FAAN
President, American Academy of Neurology



JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

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March 19, 2020

Jeffrey Bailet, MD
Chair
Physician-Focused Payment Model
Technical Advisory Committee
Office of the Assistant Secretary for
Planning and Evaluation
U.S. Department of Health and 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 offer our strong support for the Medical Neighborhood Advanced Alternative Payment Model proposal from the American College of Physicians and the National Committee for Quality Assurance. It is critically important for well-designed payment models to be developed and implemented to improve teamwork and coordination between specialists and primary care physicians.

The proposal cites data from multiple sources indicating the magnitude of the problem with poor coordination between specialists and primary care physicians today. It notes that up to 50 percent of referring physicians have no idea if their patients ever actually see the specialist to whom they are referred. Although primary care physicians report sending referral information to specialists almost 70 percent of the time, specialists report receiving it for only 35 percent of referred patients. These gaps in communication lead to delays in care, inappropriate care, and errors, all of which could be prevented with the type of well-coordinated medical neighborhood approach described in this proposal.

The Medical Neighborhood model is scalable and can accommodate a variety of specialties. It builds on the strengths and inherently supports the success of the Comprehensive Primary Care Plus and the new Primary Care First models. Our current experience responding to the novel coronavirus strongly reinforces the advantages of the type of pre-screening process and (optional) e-consultations that are included in the model. These elements can help resolve certain cases that do not ultimately require an appointment with a particular specialist. In this manner, both patients' and physicians' time can be allocated more effectively, treatment delays due to

Jeffrey Bailet, MD

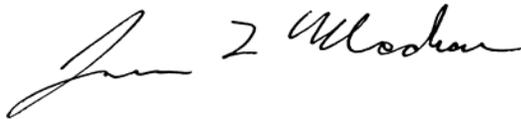
March 19, 2020

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waiting to see the wrong specialist can be avoided, wait times can be reduced, and more urgent cases can be seen more quickly.

Among the chief criticisms of the Medicare fee-for-service payment system is that it promotes fragmentation in care. The Medical Neighborhood model can repair this fragmented system. Patients tell us that what they want most is for their entire treatment team to collaborate on and implement their treatment plan seamlessly. The Medical Neighborhood model would be a great step forward in advancing this type of teamwork and the AMA urges the Physician-focused Payment Model Technical Advisory Committee to recommend it to the Secretary of Health and Human Services for implementation. Thank you for considering our views.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is written in a cursive style with a large, sweeping initial "J".

James L. Madara, MD



Jean Antonucci MD
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March 19 2020

To the committee members,

Thank you for the opportunity to comment on this proposal.

There are several reasons why this proposal should not go forward.

My background is that I am the author of a PTAC- approved proposal ,and I am a solo PCP NCQA level III primary care physician in rural Maine.

After 33 yrs of being crushed in primary care, I now speak bluntly, no longer the shy thing I once was.

PTAC is been made up of bright, interested people who seem to have their hearts in the right place though unable to get much done given the current political theatre. All I can do is speak.

This proposal suggests a payment for specialists to improve the process of care coordination. The notion of paying specialists more gets this proposal off on the wrong foot. Obviously procedural specialists make more than non-procedural specialists, but we are long past the time when we should have equalized pay among physicians(with perhaps a financial reward for those who must come in at midnight).

The proposal calls for improving communication -which they call care coordination. The proposal discusses some other details of care coordination around medication reconciliation and so forth, but the fact is, this is about communication.

This issue has been around for as long as I have practiced medicine. Primary care physicians claim they don't hear back from specialists and specialists claim they don't hear from primary care doctors.

In the first version of the NCQA PCMH (a dreadful tortuous project in which docs had to pull out reports from the EMR on how many patients had a phone number recorded!),practices in primary care had to produce reports on what percent of referrals were completed. This is a good and true end, but forcing measurement only tied one more hand of already overloaded primary care doctors.

Paying for communication doesn't make any sense to primary care nor should we be paying specialists more. There are several other interrelated comments--

For one thing, this proposal excludes a huge swath of primary care clinicians in this country. Certainly it would exclude me, because small practices and practices in certain regions have been excluded from CPC and CPC plus, either because of size or because not all regions were eligible, therefore this restricts once again which practices could be eligible.

However since the proposal is not about paying primary care, that may not matter very much. Before I even get to the crux of the problem, I point out a few more things -one is that this is a

typical bureaucratic approach in which now specialists sign agreements with primary care doctors. A meaningless "one more thing to do" burden .

I had to do that to get PCMH level III and the specialists were annoyed and insulted.

This is somewhat like posting signs in the office to tell people things-- just doesn't work/ sounds so good/ just doesn't work ,and in this case adds to everybody's time sucking administrative burdens.

In addition, once again ,NCQA and ACP want to resurrect the CAHPS surveys, a mediocre tool.I think there's a conflict of interest if you look deep enough into CAHPS and NCQA . CAHPS does not give results for six months and doesn't provide a practice with anything actionable and should not be on anybody's list any more of tools.

Having had your gracious courtesy to read this far here is the real crux of the issue: I wonder if anyone in ACP or NCQA has any idea what goes on here out on the ground?? I am very blunt and direct spoken because I've been at this for a long time and it is almost impossible as a quality working physician in this country to have a voice.NCQA is this so-called nonprofit whose founder makes about five times what I can possibly make,leading a country desperate for quality down a path of programs and measures that are incredibly burdensome to primary care.

Most of us were taught a long time ago to view the problem not the person and so I cross the line here when I talk about NCQA and ACP but I'm going to cross that line because it needs to be crossed. Neither group has the respect of any physician I've met .

I think this proposal is outrageous --to ask this country to pay specialists more to do some meaningless paperwork This is a rude and despicable proposal.

Here's where the problem really is --for many years some primary care doctors have not communicated well with specialists. The answer to that is for the specialist to pick up the phone just the way primary care has worked at relationships with specialists for years. Specialists need to have relationships with primary care; yet every specialist I've ever talked to responds to conversations for primary care with "here's what we need"" here's what we need to do." Never does the specialty practice say" how can I help you in primary care, what do you need?"

Primary care physicians should be sending appropriate information to specialists. Why they don't is a long list of reasons -most of which can be solved by specialist picking up the phone. Occasionally a specialist calls me and wants additional information and tells me why, now that is collegiality.

But there's more and what is there that is more is called EMR. One specialist told me he thinks EMR s are making it harder to send referrals. My first EMR was difficult about this- I could only easily send what was in the EMR ; outside labs an images took ages to gather up and send. They might go separately. Then they got lost

And

You must know that faxes often do not go through. I cannot reliably fax my own biller also in Lewiston Maine, 45min away-I have to mail her paper.

It is actually outrageous to me that we would waste money to have a ACP and NCQA- highly profitable organizations -torture primary care and specialists with this bureaucratic trivia of signing off with each other and pay specialists more for a problem that has to do with how we talk to each other.

What is the answer ? The answer is we should all be on one EMR where everyone can see the notes. Additionally I would comment on the fact that every doctor I've ever met Is a human being; some of

them just don't get it but if we were all in one EMR imagine, just imagine, if epic and other vendors weren't sucking up our money and time.

This proposal is worthless and should not be advanced

it will not solve any problem

it won't help any patients

It's beyond me that an outcome measure here would be to measure hospital readmissions because specialist and primary care talk to each other. It's not a very direct outcome of communication. This project is not about communication or it would have an entirely different focus. This proposal is contrived and dares to suggest we pay specialists more!

Here's the real problem it's the EMR and it's faxing and its people. I can't tell you how many specialists tell me they don't get what I sent . I have software that shows me I faxed papers but if someone says it did not go through I cannot prove that wrong.

At the VA where I once worked there was a gi -normous fax printer copier. ALL papers whether being copied printed or coming in as fax landed in the same tray. Hence a fax coming in about Joe Smith in the middle of a copy job ended up unseen and lost forever in the copy job.

I spoke up about this and was glared at.

Out here on the ground we know what the problems are. We need help. Monies from a stupid contrived proposal like this should come to those of us who are practical hard workers who can barely get through the day- but who know where the problems are.

I'm in rural Maine and maybe that's different from the rest of the country but I bet not that much,
Thanks for listening.

Jean Antonucci MD



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Via Electronic Submission

March 20, 2020

Jeffrey Bailet, MD

Committee Chair

Physician-Focused Payment Model Technical Advisory Committee

C/o US DHHS Assistant Secretary for Planning and Evaluation, Office of Health Policy

200 Independence Avenue, SW

Washington, DC 20201

Re: Comments regarding The “Medical Neighborhood” Advanced Alternative Payment Model Proposal

Dear Dr. Bailet and Members of the Committee:

On behalf of the American Society of Clinical Oncology (ASCO), I thank the Committee for the opportunity to submit comments on The “Medical Neighborhood” Advanced Alternative Payment Model Proposal submitted by The American College of Physicians (ACP) and The National Committee for Quality Assurance (NCQA).

The ACP and NCQA have submitted a proposal that is well-aligned to the criteria for physician-focused payment models. Similar to ASCO’s own Patient-Centered Oncology Payment Model (PCOP), the Medical Neighborhood Model (MNM) builds on the success of Comprehensive Primary Care Plus (CPC+) in transforming primary care within its participating communities. If implemented in conjunction with CPC+ and Primary Care First, it is likely that MNM will improve the quality and coordination of care for patients served by Cardiology, Neurology, and Infectious Disease.

Below is our feedback to the model’s authors and your committee in order to clarify or improve upon the proposal.

Certification Requirements

Within the proposal, MNM participants are required to participate in NCQA’s Patient-Centered Specialty Practice (PCSP) recognition program. We are concerned that requirements to participate in PCSP will add administrative burden to MNM participants and may conflict with specialty-specific programs which are more clinically relevant to the MNM participants. It is important to note that many professional societies have developed accreditation programs currently recognized as the “gold standard” for their specialty, including the American College of Cardiology’s

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Financial Risk

Track 2 of the MNM includes Comprehensive Specialty Care Payments (CSCP), equaling “25% of anticipated fee-for-service revenue at 110% of Physician Fee Schedule rates.” It is unclear whether CSCP is limited to professional services only or includes all billed items and services. We recommend that the proposal be clarified to include only professional services in CSCP.

The proposal also includes a Performance-Based Payment Adjustment (PBPA), to which MNM participants may have their payments recouped up to 10% of the total cost of care benchmark. We feel the inclusion of the PBPA is unnecessary given the financial risk already included in the model. Within CSCP, MNM participants are financially responsible for 25% of all performed services beyond those covered in the quarterly prospective lump sum payments, without any stop-loss or cap on potential losses. In its proposed rule for the Medicare Program; Specialty Care Models To Improve Quality of Care and Reduce Expenditures (CMS-5527-P), the Center for Medicare and Medicaid Services makes clear that such arrangements meet the Advanced Alternative Payment Model's criteria under 42 CFR 414.1415(c)(3)(i)(B). Inclusion of the PBPA is unnecessary and places MNM participants under additional financial risk.

Patient Choice

In order to bill for the MNM's Care Coordination Fee, the specialist must be an MNM participant and be designated in the Care Coordination Agreement as a principal co-manager or primary care manager for the referred condition. We are concerned as to how the latter requirement may impact patient choice under the model. Multi-specialty physician practices and integrated health systems have a financial incentive to refer to their own employed specialists. While page 17 of the proposal addresses a situation by which a patient chooses a non-MNM specialist, it does not address a situation by which a patient chooses an MNM specialist different from their primary care practice's preferred provider. In order to protect patient choice, it should be explicitly stated that primary care practices shall respect patient choice in their Care Coordination Agreements.

Thank you for the opportunity to comment on the MNM proposal. If you would like additional feedback or clarification on our comments, please contact me at Stephen.Grubbs@asco.org.

Respectfully,



Stephen S. Grubbs, MD, FASCO
Vice President, Clinical Affairs