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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

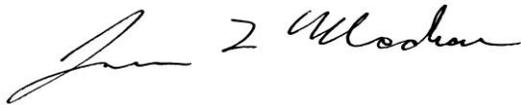
provide greater flexibility in how the physician delivers care, but would also require the physician to take greater accountability for managing utilization and spending. The AMA supports the flexibility of this model that can be designed for small practices that do not have the ability to take on significant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