



November 15, 2016

The Honorable Orrin Hatch
Chairman, Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Johnny Isakson
Co-Chairman, Chronic Care Working Group
Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Mark Warner
Co-Chairman, Chronic Care Working Group
Finance Committee
U.S. Senate
Washington, DC 20510

Dear Senators Hatch, Wyden, Isakson, and Warner:

On behalf of the American College of Physicians (ACP), I would like to take this opportunity to provide our feedback and suggestions on draft legislation, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2016, as released on October 27th. We applaud and appreciate the approach you have taken in seeking out the guidance and input of stakeholders when considering policy options to improve the care and services for patients with chronic care conditions. While this discussion draft is noticeably more narrow in scope than the policy options document released by the Chronic Care Working Group in December 2015, we believe it represents a positive first step in the effort to lower cost and improve care for these patients. Our comments will be focused on those provisions where ACP has existing policy, not only in terms of where we agree but also in those areas where we believe improvements could be made.

ACP is the largest medical specialty organization and the second largest physician group in the United States. ACP members include 148,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP-SUPPORTED PROVISIONS

We would like to highlight several important provisions in the discussion draft that are consistent with ACP policy and thank the committee for having included, in some cases, specific ACP recommendations from prior communications.

- **Section 101- Extending the Independence at Home Model of Care**

The Independence at Home Model of Care is a demonstration project under Medicare to test a payment incentive and service delivery model that uses physician and nurse practitioner-directed home-based primary care teams for Medicare beneficiaries with multiple chronic illness. This section would extend this demonstration for an additional two years. ACP is supportive of this model of care and supports expanding this demonstration project if results continue to be positive.

- **Section 303- Increasing Convenience for Medicare Advantage Enrollees Through Telehealth**

This section would allow a Medicare Advantage plan to offer additional, clinically appropriate, telehealth benefits in its annual bid amount beyond the services that currently receive payment under Part B. ACP is supportive of this policy as it would expand the role of telemedicine as a method of health care delivery that may enhance patient care.

- **Section 305- Expanding Use of Telehealth for Individuals with Stroke**

This section would expand the ability of Medicare beneficiaries presenting with stroke symptoms to receive a timely consultation via telehealth to determine the best course of treatment, beginning in 2018. ACP is supportive of this policy as we support lifting the geographic restriction for the purposes of identifying and diagnosing strokes through telehealth.

- **Section 402- Providing Flexibility for Beneficiaries to Be Part of an Accountable Care Organization**

This section would give Accountable Care Organizations (ACOs) in the Medicare Shared Savings Plan the choice to have their beneficiaries assigned prospectively at the beginning of a performance year. ACP is supportive of this section as we encourage giving ACOs the choice to have retrospective or prospective assignment of beneficiaries and allowing beneficiaries to voluntarily align with their main doctor for ACO assignment.

ACP RECOMMENDATIONS FOR IMPROVEMENT

In the interest of providing constructive feedback, ACP would also like to comment, as follows, on several provisions of the discussion draft where we offer technical changes, but also urge inclusion of several policies absent from the discussion draft that we feel are critically important.

Eliminating Barriers to Care Coordination under Accountable Care Organizations

The discussion draft establishes the ACO Beneficiary Incentive Program. This new program would create a process that allows ACOs to make incentive payments to all assigned beneficiaries that receive qualifying primary care services. ACOs would be allowed to offer a flat payment, of up to \$20 per qualifying service, directly to the beneficiary. This program is voluntary. Eligible ACOs would not be provided additional Medicare reimbursement to cover the primary care incentive payment costs. Permitting this option under a two-sided risk model would give ACOs an additional tool to achieve better health outcomes for beneficiaries- as well as produce cost savings for both the ACO and the Medicare program.

ACP supports the establishment of an Accountable Care Organization (ACO) Beneficiary Incentive Program as authorized by this Section 501 of the discussion draft. We believe that providing beneficiaries incentives to access care at the primary care level has the potential to reduce costs by keeping patients out of more costly settings such as hospitals.

ACP Recommendation

In an effort to incentivize ACOs as a beneficiary choice, we urge providing greater flexibility to ACO's in this program in so far as the \$20 cap on incentive payments for qualifying services, which seems arbitrary. Without understanding the rationale behind such a cap, we would urge elimination of the cap so ACOs would have flexibility to set their own incentive payment.

Technical Modification

Page 54, line 19, strike "up to \$20," and all that follows through the end of line 25 and insert "determined appropriate by the ACO;".

Proposed section 1899(m)(1)(A) of the Social Security Act, as proposed to be amended by paragraph 1. supra, would read as follows [new material shown in italic font]:

" (i) in an amount determined appropriate by the ACO; up to \$20, with such maximum amount updated annually by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12 month period ending with June of the previous year;

Providing Accountable Care Organizations the Ability to Expand Use of Telehealth

The discussion draft would apply the Next Generation ACO telehealth waiver criterion to the Medicare Shared Savings Program (MSSP) Track II (only if an ACO chooses prospective attribution and remains at two-sided risk), MSSP Track III, and the Pioneer ACO program. This provision would (1) eliminate the geographic component of the originating site requirement, (2) allow beneficiaries assigned to the approved MSSP and ACO programs to receive currently allowable telehealth services in the home, and (3) ensure that MSSP and ACO providers are only

allowed to furnish telehealth services as currently specified under Medicare’s physician fee schedule, with limited exceptions.

ACP supports the policy in Section 304 of the discussion draft but believes it does not go far enough in its expansion of telehealth services with respect to ACOs.

ACP Recommendation

We further urge the Committee to broaden this waiver authority to allow all MSSP tracks (including those with one-sided risk) to receive a waiver for the removal of the geographic restriction and originating site requirement for the use of telehealth services. We support the expanded role of telemedicine as a method of health care delivery that may enhance patient–physician collaborations, improve health outcomes, increase access to care and members of a patient's health care team, and reduce medical costs when used as a component of a patient's longitudinal care.

Technical Modification

Page 40, line 20, strike “a prospective assignment method” and all that follows through the end of line 21 and insert “any assignment method.”.

Proposed section 1899(I)(2)(A) of the Social Security Act, as proposed to be amended by paragraph 1. *supra*, would read as follows [new material shown in italic font]:

“(ii) for which Medicare fee-for-service beneficiaries are assigned to the ACO using *any assignment method.* ~~a prospective assignment method, as determined appropriate by the Secretary.~~”

Improving Care Management Codes for Individuals with Multiple Chronic Conditions

The discussion draft did not address the issue of new chronic care management codes, as was initially referenced in the Chronic Care Working Group Options Document. While we acknowledge this was likely due to the fact that CMS did address it in the FY 2017 Final Rule on the Physician Fee Schedule, we believe this warrants attention by the committee within legislation because there is a 40 minute time gap not recognized by CCM codes, either existing or in the final rule, for chronic care management services.

As you are aware, the recently-released Medicare Physician Fee Schedule Final rule established a new Complex Chronic Care Management code for doctors that provide Complex Chronic Care Management services to patients that last at least 60 minutes in length and for each additional 30 minutes thereafter, which ACP supports. CMS currently provides a code for Chronic Care Management services that last at least 20 minutes but has failed to initiate any new codes for these services that last between 20-40 and 40-60 minutes. ACP remains concerned that the fee schedule fails to adequately value chronic care services between 20-60 minutes, which could lead to more barriers to care for chronic care patients.

ACP Recommendation

We urge the Committee to include a section on Improving Care Management for Individuals with Multiple Chronic Conditions that would require CMS to establish two new codes (perhaps initially as G codes) that would recognize the value of care for clinicians who treat patients with chronic care conditions between 20-40 minutes and 40-60 minutes.

Encouraging Beneficiary Use of Chronic Care Management Services

ACP is disappointed that the discussion draft did not address the issue of beneficiary cost-sharing, as was initially referenced in the Chronic Care Working Group Options Document. This proposed policy would waive the beneficiary co-payment associated with the current chronic care management code as well as the complex chronic care management code that was recently approved by CMS. We believe waiving this beneficiary co-payment is critical in the effort to improve care to individuals with chronic conditions and it would require a legislative remedy to do it, as explained by CMS.

Waiving beneficiary cost-sharing, both the co-insurance and deductible, will incentivize beneficiaries to receive these CCM services. Currently, physicians are required to get authorization from patients to initiate CCM services—this is a means of ensuring that these patients are aware of these services and remain engaged partners. As a part of the discussion around this authorization, physicians notify patients that they will be responsible for the co-payment amount associated with CCM. At the time of this discussion, the physician is likely unaware of any supplemental coverage that the patient may have so they must inform the patient that he or she may be required to pay the copayment amount. If the discussion of a co-payment were no longer required because of the elimination of beneficiary cost-sharing, physicians would be more likely to have the discussion with beneficiaries about providing the CCM services that the patient needs. Further, waiving cost-sharing would eliminate any unintended discriminatory impact on beneficiaries of modest means, who more likely will not have any supplemental coverage.

ACP Recommendation

We urge the Committee to include a section that would move chronic care management services to the preventive services category under Medicare FFS to eliminate any beneficiary cost sharing associated with these services. Alternatively, you could insert a provision in this bill that would allow CMS to give physicians the option of routinely waiving the copay for chronic care management codes for patients with chronic conditions.

In conclusion, ACP appreciates your continued effort to improve care for patients with chronic conditions and stands ready to work with the committee to further develop this discussion draft or provide any additional feedback, as requested. Should you have any questions regarding this letter, please do not hesitate to contact Brian Buckley on our staff at bbuckley@acponline.org or by phone at 202-261-4543.

Sincerely,

A handwritten signature in black ink that reads "Nitin Damle". The signature is written in a cursive style with a prominent upward stroke on the letter 'N'.

Nitin S. Damle, MD, MS, MACP
President