January 26, 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 Chairman Hatch, Ranking Member Wyden, and Co-Chairmen Isakson and Warner:

On behalf of the American College of Physicians (ACP), I appreciate the opportunity to provide our comments on the Senate Finance Committee's Bipartisan Chronic Care Working Group Policy Options document, as released on Dec. 18, 2015, that summarizes key policies under consideration by the Committee to improve the care of patients with chronic diseases. We applaud your efforts and appreciate your recognition of the value of stakeholder input when considering these options that will aid the Committee in crafting policy that can be introduced as legislation later this year.

ACP is the largest medical specialty organization and the second largest physician group in the United States. ACP members include 143,000 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.

I. Summary of ACP's Key Recommendations

ACP wishes to highlight the following key recommendations that have been excerpted from our more detailed comments. The College's complete, detailed comments, including additional recommendations, can be found in the body of the letter.

Improving Care Management Code for Individuals with Multiple Chronic Conditions

- ACP supports requiring the Centers for Medicare and Medicaid Services (CMS) to establish reimbursement and coverage of additional codes for chronic care

management (CCM) services for patients who require more complex medical decision-making and additional non-face-to-face time beyond what is currently covered. The College urges Congress to require CMS to:

- Establish new codes (perhaps initially as G codes, then using the G codes as models for a CPT code that would be developed) for additional increments of time (beyond the current 20 minutes/month) for CCM services.
- Establish reimbursement for two complex chronic care management codes (CPT codes 99487 and 99489) for patients who have more complex diseases or require a higher level of medical decision-making.
- Create codes to provide reimbursement for diabetic care management and e-consultations.

Encouraging Beneficiary Use of Chronic Care Management Services

- The College strongly supports moving chronic care management services to the preventive services category under Medicare fee-for-service (FFS) to eliminate any beneficiary cost-sharing associated with the services.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

- The College strongly supports efforts to better integrate care for behavioral health conditions into the primary care setting.

Developing Quality Measures for Chronic Conditions

- The College is strongly supportive of filling gaps in quality measurement, including electronic specification of these measures; obtaining stakeholder input into the measures development process; and focusing on needed process and outcome measures, patient and family experience measures, care coordination measures, and measures of population health and prevention.

Maintaining Accountable Care Organizations' (ACO) Flexibility to Provide Supplemental Services

- ACP supports allowing ACOs to have as much flexibility as is necessary through waivers of Medicare fee-for-service policies to enable them to design a package of services to best meet the unique needs of their patient population.

Eliminating Barriers to Care Coordination under Accountable Care Organizations

- ACP supports providing flexibility for participating ACO programs to support patient engagement through positively incentivizing beneficiary in-network care through lower copayments, the removal of copayments for primary care, self-management activities, and the encouragement of treatment decisions reflecting high value.

Providing Flexibility for Beneficiaries to Be Part of an Accountable Care Organization

- The College supports allowing ACOs in the Medicare Shared Savings Program (MSSP) Track One to choose whether to have their beneficiaries assigned prospectively or retrospectively.

Providing ACOs the Ability to Expand Use of Telehealth

- ACP supports the policy of modifying the requirements for telehealth services to allow the Secretary to establish a process for ACOs in two-sided risk models to receive a waiver of the geographic component of the originating site requirement as a condition of payment for telehealth services. 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.

Ensuring Accurate Payment for Chronically Ill Individuals

- The College supports the use of risk adjustment and agrees that efforts to improve the accuracy of risk adjustment approaches being employed are needed.

Expanding Use of Telehealth for Individuals with Stroke

- The College supports lifting the originating site geographic restriction for the purposes of identifying and diagnosing strokes through telehealth.

Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations (SNPs)

- The College supports the Medicare Payment Advisory Commission's (MedPAC) recommendation to expand the flexibility of Medicare Advantage (MA) plans to tailor their offerings/benefits to meet the specific health care needs of the beneficiary. In effect, this approach folds into the general MA program aspects of current Chronic Condition Special Need Plans (C-SNP).

Expanding Access to Digital Coaching

- The College supports the working group's proposal to require CMS to provide medically-related information and educational tools on its website to help beneficiaries learn more about their health conditions and self-management of them as long as the tools have a strong evidence base.

Additional ACP Recommendations on Chronic Care Policy

- The College recommends that the Finance Committee consider the expansion of the Patient-Centered Medical Home (PCMH) Model as a primary resource that is uniquely suited to meet the needs to improve care for patients with chronic illness.
- The College strongly recommends that Congress enact legislation to reauthorize the Medicare Primary Care Incentive Payment (PCIP) program.
- The College strongly encourages Congress to extend the Medicaid pay parity program by passing S. 737, the Ensuring Access to Primary Care for Women and Children Act.

II. Detailed ACP Comments on Finance Committee Policy Options Document

Improving Care Management Code for Individuals with Multiple Chronic Conditions

Finance Committee Policy Options Document

The chronic care working group is considering establishing a new high-severity chronic care management code that clinicians could bill under the Physician Fee Schedule. A new code would reimburse clinicians for coordinating care outside of a face-to-face encounter for Medicare's most complex beneficiaries living with multiple chronic conditions. Managing multiple chronic conditions requires increased levels of patient and provider interaction beyond the typical in-person visit that often includes practice team members such as social workers, dieticians, nurses, and behavioral health specialists. The current chronic care management code covers a portion of that labor-intensive cost, the proposed new high-severity code payment would be higher to compensate providers who require more than the typical allotted time per month.

ACP Response/Recommendation

ACP supports requiring CMS to establish reimbursement and coverage of additional codes for CCM services for patients who require more complex medical decision-making and additional non-face-to-face time beyond what is currently covered. The College believes that several different codes are necessary to adequately allow for services for patients with varying complexity and severity of chronic conditions.

ACP urges Congress to require CMS to establish new codes (perhaps initially as G codes, then using the G codes as models for a CPT code that would be developed) for additional increments of time (beyond the current 20 minutes/month) for CCM services. Currently, CMS only covers CPT code 99490:

> Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health professional, per calendar month, with the following required elements:
>
> - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
> - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
> - Comprehensive care plan established, implemented, revised, or monitored.

The current chronic care management code time restriction of only 20 minutes hinders the physician caring for the patient. This limitation may not allow for reimbursement for the additional time and difficult work required for a physician to treat patients with multiple chronic conditions and complex conditions such as dementia. Developing one add-on code for CCM for up to two additional 20-minute CCM increments (e.g., 21-40 min; 41-60 min), not to exceed 60 minutes of time including the 99490 code would allow physicians to spend the time needed to deliver the appropriate level of care based on the beneficiaries' condition.

Additionally, **for patients who have more complex diseases or require a higher level of medical decision-making, ACP urges Congress to require CMS to establish reimbursement for two complex chronic care management codes (CPT codes 99487 and 99489).** According to the CPT code descriptions below, these codes are intended for patients with two or more chronic conditions who require "moderate or high complexity medical decision making" and at least 60 minutes of clinical staff time in a month. Establishing coverage and reimbursement for these additional complex CCM codes would address the chronic care working group's goal of establishing reimbursement for CCM services for patients with higher severity conditions that require additional clinical staff time each month.

> 99487: complex chronic care management services, with the following required elements:
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> - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
> - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
> - Establishment or substantial revision of a comprehensive care plan;
> - Moderate or high complexity medical decision making;
> - 60 or more minutes of clinical staff time directed by a physician or other qualified health professional, per calendar month.
>
> 99489: Complex chronic care management services – each additional 30 minutes of clinical staff time directed by a physician or other qualified health professional, per calendar month (List separately in addition to code for primary procedure).

The College also encourages Congress to push CMS to explore bundling of codes for certain chronic diseases. **ACP recommends that the creation of a code bundle for Diabetic Care Management (DCM) be developed to emphasize better care coordination, communication, and integration of the care team aimed at a better overall outcome cost of care for the Medicare beneficiary. ACP also recommends that Congress call on Medicare to cover evidence-based lifestyle modification programs under the traditional Medicare benefit, such as the Diabetes Prevention Program[1] or the Stanford Chronic Disease Management Program.**[2]

[1] http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61457-4/fulltext
[2] http://patienteducation.stanford.edu/programs/cdsmp.html

The College further recommends that Congress include in legislation a requirement for CMS to provide reimbursement for e-consultations both between hospitalists and primary care physicians and specialists and primary care physicians. This could be accomplished by CMS adopting the currently available and valued CPT codes 99446 (interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review), 99447 (11-20 minutes of medical consultative discussion and review), 99448 (21-30 minutes of medical consultative discussion and review), and 99449 (31 minutes or more of medical consultative discussion and review). In the changing environment of patient care, patients are being admitted to hospitals that are likely unaware of the patient's history. Because some hospitals and insurance companies have chosen to exclude the primary care physicians from admitting patients to the hospital, there can be a deficiency in communication between hospitals, hospitalists, and the patient's primary care physician, which may lead to unnecessary or ineffective services (e.g., unnecessary testing, medications prescribed that the patient previously used without success, etc.). This then leads to poorer outcomes and unnecessary costs that could be avoided if the primary care physician was consulted.

When a hospitalist does ask the patient's primary care physician to consult on the patient's care (most often via e-consultation/telephone), the primary care physician's service must be viewed as medically necessary concurrent care, especially when the hospitalist and primary care physician are of the same specialty. We feel that recognizing the value that the patient's primary care physician brings to the hospital in these situations is invaluable. The creation and recognition of an e-consultation code would align with the agency's broader payment reform efforts to decrease unnecessary testing, numerous specialty consultations, and prolonged hospitalizations, thus leading to decreased costs of hospitalizations. Further, evidence suggests there are benefits to primary care physicians being involved with patient care in a hospital setting in terms of both improved outcomes and cost savings to the health system. Gorroll and Hunt make the case for this model in the January 22, 2015, issue of the New England Journal of Medicine. [3]

Patients with chronic conditions often also require consultations and care from specialty/subspecialty physicians. Recent studies[4] reflect that many of these specialist/subspecialist visits can be avoided and care effectively provided through the use of e-consultations between the primary care and referred to specialty/subspecialty physician. This approach speeds up the delivery of care (long waiting-list time is avoided), allows the patient to obtain needed care without unnecessarily taking off from work or other responsibilities, and is a cost savings to the payer.

[3] Allan H. Goroll, M.D., and Daniel P. Hunt, M.D. "Bridging the Hospitalist–Primary Care Divide through Collaborative Care." N Engl J Med 2015; 372:308-309. http://www.nejm.org/doi/full/10.1056/NEJMp1411416

[4] A.. Chen and H. Yee. Improving Primary Care–Specialty Care Communication ARCH INTERN MED/VOL 171 (NO. 1), JAN 10, 2011. http://archinte.jamanetwork.com/article.aspx?articleid=226311&resultClick=3

Question 1: The working group is soliciting feedback as to the patient criteria for this potential new code. For example, beneficiaries that could be eligible could be those with five or more chronic conditions, one chronic condition in conjunction with Alzheimer's or a related dementia, or a chronic condition combined with impaired functional status.

Question 1 response: ACP does not recommend any arbitrary restrictions as to the number of conditions required or condition of diagnosis outside the two or more chronic conditions threshold that currently exists in CCM and complex CCM codes. Patients with these multiple chronic conditions may need more than one hour per month of care by a physician, and reimbursement for the new add-on code for the current CCM services and additional codes for complex CCM services described earlier would allow the physician to spend more time treating these complex patients.

Question 2: The working group is seeking input on the types of providers who should be eligible to bill the new high severity chronic care code. Clinicians who could be eligible to receive advanced care coordination payments are those who offer comprehensive, ongoing care to a Medicare beneficiary over a sustained period of time.

Question 2 response: We recommend that in order to determine what type of clinicians should be eligible to bill chronic care management codes the Committee specify that eligible clinicians be inclusive of physicians in specialties that "manage, participate, and meaningfully contribute to the provision of the services, in addition to providing a minimum direct supervision." This description of eligible clinicians mimics the language describing who can bill for advance care planning visits under Medicare. Like advance care planning, it is critical that chronic care management services are provided by clinicians with a longitudinal relationship with the Medicare beneficiary.

Question 3: The working group is requesting input on methodologies to measure the impact, effectiveness, and compliance in relation to this new payment construct.

Question 3 response: The College recommends that Congress call for a study that could be conducted by the GAO on the impact that CCM and transitional care management (TCM) have had on emergency room visits and hospital readmission rates for the population of patients receiving these services. This study could then provide guidance and recommendations to Congress and CMS on additional changes to policy.

Question 4: The working group is also soliciting feedback as to whether the new code should be (1) made permanent, (2) temporarily mandated until CMS has sufficient time and data to analyze the effectiveness of the current CCM code as well as the proposed higher severity code and provide a report to Congress, or (3) temporarily instituted while giving the Secretary of the Department of Health and Human Services authority to continue, discontinue, or modify the code based on effectiveness, clinician and patient feedback, utilization of the code, and other factors

Question 4 response: ACP recommends that Congress mandate that coverage of the new add-on code for CCM and the existing complex CCM codes be made permanent. This approach will provide a needed stability and set of expectations for the physicians and other clinicians who will be billing for these codes, as they need to make changes within their practices to workflows, team member roles, etc. in order to provide these services effectively. While we believe that coverage of such services should be permanent, we support a process that would allow for improvement and modifications, as appropriate, in the coverage policy and the specific codes for the coverage services based on the effectiveness of the new codes. Any such modifications should go through a rule-making process to allow for public comment.

Encouraging Beneficiary Use of Chronic Care Management Services

Finance Committee Policy Options Document

The chronic care working group is considering waiving the beneficiary co-payment associated with the current chronic care management code as well as the proposed high severity chronic care code described above.

ACP Response/Recommendation

The College strongly supports moving chronic care management services to the preventive services category under Medicare FFS to eliminate any beneficiary cost-sharing associated with the services. By making CCM a preventive service, all beneficiary cost-sharing would be waived and CMS would reimburse physicians for the full allowable amount under the fee schedule. We believe CCM is an important preventive service that allows for better management of patients with chronic conditions to avoid additional more costly office visits and hospitalizations. While cost-sharing can help to ensure that patients are aware of these services and make them engaged partners in management of their chronic diseases, the existing patient agreement is a better means of ensuring that these patients will continue to be aware and engaged partners.

Additionally, ACP recommends that complex coordination functions required for chronic care management should not be included within the certification requirements for EHR systems. Practices are just now beginning to experiment with a broad range of technologies and techniques aimed at improving chronic care management and care coordination. What we have learned thus far is that our current EHR systems are not capable of delivering needed functionality, and that these functions might be better managed through third-party tools. We have also learned that we do not yet know the best ways to use technology to deliver these complex services. It is too early in the process for standards or certification criteria to be imposed on this moving target. Practices should be permitted to implement separate care coordination systems that work with their EHR systems to best meet their needs.

Along the same lines, ACP also recommends that meaningful use should not be expanded to include activities involved in the coordination of the care of patients with chronic conditions until there is better evidence about the best ways to use health IT to perform that coordination.

Question 1: The working group is soliciting input on the extent that waiving cost sharing would incentivize beneficiaries to receive these services, especially considering that many Medicare beneficiaries have supplemental Medigap policies or elect employer retiree coverage that provides supplemental coverage?

Question 1 response: ACP believes that 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. Currently, 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 co-payment 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 and acquire signed authorization to provide 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.

Question 2: The working group is soliciting feedback as to whether waiving cost sharing addresses the concern that beneficiaries may question CCM services that appear on summary of benefit notices because they do not involve a face-to-face physician encounter?

Question 2 response: We believe that waiving this cost sharing for the chronic care management code would help alleviate the strain between the patient and the physician that may arise when a physician office seeks copay for this service outside of a visit. Even with a signed authorization, many patients may still not understand why they are required to pay a copay for this service during the months that they do not interact with the physician in a face-to-face visit. The elimination of this cost sharing would eliminate this burden. We further believe that waiving the copay, but maintaining a signed authorization, will help avoid the confusion of beneficiaries who do not understand why CCM appears on their explanation of benefits (EOB) when there was no face-to-face interaction with a physician.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

Finance Committee Policy Options Document

The working group is considering developing policies that improve the integration of care for individuals with a chronic disease combined with a behavioral health disorder. Policies would encourage care integration whether the beneficiary elects enrollment in traditional Medicare FFS, a Medicare FFS Alternative Payment Model, or a MA plan. The working group is soliciting specific policy proposals to meet the goals stated above.

ACP Response/Recommendation

The College strongly supports efforts to better integrate care for behavioral health conditions into the primary care setting. It is estimated that by 2020, mental health and substance use disorders alone will surpass all physical diseases as a major cause of disability worldwide. Most chronically ill patients with non-serious behavioral health needs access the health system through their primary care physician/clinician presenting an opportunity for behavioral health screening, referral, and possibly treatment in the primary care medical setting. The College strongly supports the concept of team-based care, and supports efforts to remove barriers that impede collaboration among primary care physicians, other health professionals and behavioral health professionals. Such impediments include payment silos that prevent adequate reimbursement for team-based care, workforce shortages, and information transfer problems. Regarding the latter issue, the College supports efforts to facilitate communication among primary care physicians and other health professionals and behavioral health clinicians; however, state and federal privacy protection and confidentiality laws may complicate the sharing of behavioral health information. For example, federal drug and alcohol abuse treatment regulations (Part 2 regulations) require the patient's formal consent to share records from federally-funded substance use treatment facilities. The College further recommends that Congress provide funding for grant programs to support efforts to integrate primary care and behavioral health and improve the availability of an appropriately trained workforce.

ACP recently published a position paper in the *Annals of Internal Medicine* entitled "The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care."[5] The College reiterates the recommendations from this paper as the Senate Finance Committee considers proposals toward its stated goal:

1. The ACP supports the integration of behavioral health care into primary care and encourages its members to address behavioral health issues within the limits of their competencies and resources.
2. The ACP recommends that public and private health insurance payers, policymakers, and primary care and behavioral health care professionals work toward removing payment barriers that impede behavioral health and primary care integration. Stakeholders should also ensure the availability of adequate financial resources to support the practice infrastructure required to effectively provide such care.
3. The ACP recommends that federal and state governments, insurance regulators, payers, and other stakeholders address behavioral health insurance coverage gaps that are barriers to integrated care. This includes strengthening and enforcing relevant nondiscrimination laws, removal of the 190-day limit for inpatient psychiatric care under Medicare, and reducing barriers to payment for use of telehealth to provide mental health treatment and consultations.

[5] Crowley RA, Kirschner N, for the Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: Executive Summary of an American College of Physicians Position Paper. Ann Intern Med. 2015;163:298-299. doi:10.7326/M15-0510. Accessed at: http://annals.org/article.aspx?articleid=2362310.

4. The ACP supports increased research to define the most effective and efficient approaches to integrate behavioral health care in the primary care setting.
5. The ACP encourages efforts by federal and state governments, relevant training programs, and continuing education providers to ensure an adequate workforce to provide for integrated behavioral health care in the primary care setting.
6. The ACP recommends that all relevant stakeholders initiate programs to reduce the stigma associated with behavioral health. These programs need to address negative perceptions held by the general population and by many physicians and other health care professionals.

The College also believes that requiring CMS to establish and reimburse for e-consultations between primary care physicians and behavioral health specialists (as referenced in our comments above on the improving CCM for patients with multiple chronic conditions) would be helpful in allowing for better integration between the two. Additionally, ACP encourages Congress to recommend that Center for Medicare and Medicaid Innovation (CMMI) include behavioral health integration as a milestone in the Comprehensive Primary Care (CPC) initiative.

Developing Quality Measures for Chronic Conditions

Finance Committee Policy Options Document
The chronic care working group is considering requiring that Centers for Medicare & Medicaid Services (CMS) include in its quality measures plan the development of measures that focus on the health care outcomes for individuals with chronic disease. Topic areas related to chronic conditions that the working group is specifically considering include:

- Patient and family engagement, including person-centered communication, care planning, and patient-reported measures;
- Shared decision-making;
- Care coordination, including care transitions and shared accountability within a care team;
- Hospice and end-of-life care, including the process of eliciting and documenting individuals' goals, preferences, and values, quality of life, receipt of appropriate level of care, and family/caregiver experience of care;
- Alzheimer's and dementia, including measures for family caregivers, outcomes, affordability, and engagement with the healthcare system or other community support systems;
- Community-level measures, in areas such as obesity, diabetes and smoking prevalence.

The working group is also considering recommending that Government Accountability Office (GAO) conduct a report on community-level measures as they relate to chronic care management. The report would discuss appropriate measures in this domain and provide recommendations for holding providers accountable to community-level measures, linking provider payment to these measures, and encouraging the use of these measures.

ACP Response/Recommendation
ACP believes that patients, families, and the relationship of patients and families with their physicians should be at the forefront of CMS's thinking in the development and implementation of the measurement plan.

The College is strongly supportive of filling gaps in quality measurement, including electronic specification of these measures; obtaining stakeholder input into the measures development process; and focusing on needed process and outcome measures, patient and family experience measures, care coordination measures, and measures of population health and prevention. Focusing on these areas as the current Medicare FFS program evolves into one that incentivizes value will better ensure that patients with chronic conditions will receive the coordinated, patient-centered care that they deserve. The College stressed these same areas be a focus in the responses submitted to CMS for the Medicare Access and CHIP Reauthorization Act (MACRA) request for information (RFI).[6]

As part of that response to CMS, ACP has recommended that in the short term, CMS consider adopting a core set of measures that are methodologically sound and Measure Applications Partnership (MAP) endorsed for use in the new Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) programs. CMS should consider utilizing the core set of measures identified through the America's Health Insurance Plans (AHIP) coalition pending approval by the organizations involved, which includes both physician and consumer organizations and CMS. Over the longer term, it will be critically important for CMS to continue to improve the measures and reporting systems to be used in Medicare to ensure that they measure the right things, move toward clinical outcomes and patient experience, and do not create unintended adverse consequences. For instance, it is critically important that the data collection and reporting burden related to the quality measurement be minimized. Additionally, it is important that feedback reports to clinicians that outline their performance on quality and resource use measures be not only timely, but also include patient-level data in an easily accessible manner.

The College further recommends that the term "patient experience" be thoughtfully considered by Congress in the context of chronic care or other potential legislation, as well as by CMS. It is a term that often appears in conjunction with the phrase "patient- and family-centered care." The Beryl Institute describes patient experience as "the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care."[7] Other terms that are often used interchangeably with patient experience or patient- and family-centered are patient engagement and patient empowerment. Patient engagement is defined by the Center for Advancing Health as "actions individuals must take to obtain the greatest benefit from the health care services available to them."[8] Anderson and Funnell define patient empowerment as helping patients enhance and use their own innate ability to manage chronic

[6] https://www.acponline.org/acp_policy/letters/acp_comment_letter_macra_rfi_2015.pdf
[7] http://www.theberylinstitute.org/?page=Mission
[8] Center for Advancing Health. "A New Definition of Patient Engagement: What Is Engagement and Why Is It Important?" 2010. Accessed at: http://www.cfah.org/pdfs/CFAH_Engagement_Behavior_Framework_current.pdf.

conditions.[9] Finally, related to all of these terms, but not typically used as interchangeably is "patient reported outcomes." The confusion over these terms has therefore made it difficult for stakeholders to agree upon what patient- and family-centeredness truly is.

These differing terms also have an impact on performance measurement. Patient engagement, for example, could be measured by how often patients access a practice's portal; however, this unfairly places accountability on the physician, without necessarily providing true benefit to the patient. Patient empowerment could be measured by a patient feeling ready to participate in a weight loss program—and this too could unfairly penalize a physician as this readiness is not fully under his/her control. Patient experience is typically measured by patient satisfaction (e.g. whether a patient liked the care they received), which is largely where the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is focused. Often, all of the components cited above are included when one talks about patient experience performance measures. All of these issues are important, but greater clarity is needed in terms of what and how each component is captured and used, with a strong eye toward identifying any unintended consequences that are not aligned with improving quality within a learning health care system.

The College further recommends that Congress develop legislation that supports and expands upon the current efforts of CMS to make transparent the quality and cost of services provided within the Medicare program—both hospital and office based, including beneficiary out-of-pocket charges—as this will be of significant benefit to patients with chronic disease.

This includes supporting research by the Agency for Healthcare Research and Quality (AHRQ) on the types of information that are most useful to beneficiaries and how best to deliver it. This legislation should also require that Medicaid plans provide cost and quality information at the state level, such as by expanding on H.R. 1326, the Health Care Price Transparency Promotion Act of 2013.

Maintaining ACO Flexibility to Provide Supplemental Services

Finance Committee Policy Options Document

The chronic care working group is considering clarifying that ACOs participating in the MSSP may furnish a social service or transportation service for which payment is not made under fee-for-service Medicare.

The chronic care working group is also considering clarifying that ACOs participating in the MSSP may furnish a remote patient monitoring service for which payment is not made under fee-for-service Medicare.

[9] *Funnell MM, Anderson RM, Arnold MS, Barr PA, Donnelly M, Johnson PD, Taylor-Moon D, White NH.* "Empowerment: an idea whose time has come in diabetes education." *Diabetes Educ. 1991 Jan-Feb; 17(1):37-41.*

ACP Response/Recommendation

ACP supports allowing ACOs to have as much flexibility as is necessary through waivers of Medicare fee-for-service policies to enable them to design a package of services to best meet the unique needs of their patient population. This includes providing transportation to medically underserved populations when necessary and providing remote patient monitoring services that are not currently covered under Medicare FFS. To that end, we are encouraged that CMMI recently announced the Accountable Health Communities Model[10] to test how identifying and addressing the health-related social needs of beneficiaries impacts total health care costs, quality, and outcomes. This model will operate through clinical-community linkages to help reduce the risk of developing chronic conditions and increase patients' ability to manage chronic conditions.

Eliminating Barriers to Care Coordination under Accountable Care Organizations

Finance Committee Policy Options Document

The chronic care working group is considering allowing ACOs in two-sided risk models to waive beneficiary cost sharing, such as co-payments, for items/services that treat a chronic condition or prevent the progression of a chronic disease.

The working group is specifically soliciting feedback on:

- Whether the items/services eligible for reduction should be defined through rulemaking or be left to the discretion of the ACO.
- The type of cost sharing that could be waived, such as copays, coinsurance, or deductibles.
- The extent that waiving cost sharing would incentivize beneficiaries to receive these services, especially considering that many Medicare beneficiaries have supplemental Medigap policies or elect employer retiree coverage that provide supplemental coverage.

ACP Response/Recommendation

ACP supports providing flexibility for participating ACO programs to support patient engagement through positively incentivizing beneficiary in-network care through lower copayments, the removal of copayments for primary care, self-management activities, and the encouragement of treatment decisions reflecting high value. We would like to reiterate the College's support for allowing primary care copay waivers as outlined in the joint comment letter from the ACO Working Group and co-signed by the American College of Physicians, American Medical Association, American Medical Group Association, Medical Group Management Association, National Association of ACOs, and the Premier healthcare alliance[11]:

> We believe there is opportunity for several additional waivers that would both help MSSP ACOs improve care delivery and encourage beneficiary health-seeking behavior. Our strongest recommendation is waiving certain primary care copays for all ACO tracks. We offer this proposal for four reasons. First, by waiving the

[10] https://innovation.cms.gov/initiatives/ahcm/

[11] https://www.acponline.org/acp_policy/letters/aco_working_group_response_sfc_chronic_care_policy_2016.pdf

copays for primary care services, the ACO can encourage patients to get the most appropriate and time-sensitive care. The waiver offers the possibility of further engaging beneficiaries in their health and their healthcare by helping ensure necessary preventative screenings are provided, chronic conditions are kept from unduly progressing, and preventing new conditions or exacerbations of existing conditions.

Second, unstable beneficiary assignment is a well-recognized MSSP problem. Michael McWilliams and his colleagues found in a 2014 *JAMA Internal Medicine* study that unstable assignment was as high as 33% and that "much of the outpatient specialty care for patients assigned to ACOs, particularly higher-cost patients with more office visits and chronic conditions, was provided by specialists outside of patients' assigned organizations, even among more specialty-oriented ACOs." CMS noted in its December 2014 proposed ACO rule that unstable assignment or "churn rate" is 24% on average. We believe a copay waiver would reduce unstable assignment and "leakage," or where ACO-assigned patients' office visits occur outside their ACO.

Third, because we propose to limit the copay waiver to five specific primary care (CPT) Evaluation and Management codes (99211-99215), Transitional Care Management codes (99495 and 99496) and the Chronic Care Management (CCM) CPT code 99490, we believe this will produce the greatest benefit for the least amount cost to the ACO. Without an out-of-pocket (OOP) cost, the ACO patient can seek care without having to decide presumptively whether care is essential or not. For the ACO provider, the waiver will, again, help reduce year-over-year assignment instability and leakage. The copay waiver would also serve the ACO provider and patient equally well since more timely appointments and greater adherence to care would minimize the possibility of greater downstream costs due to higher intensity care. The waiver would both motivate and reinforce beneficiary-provider attestation (offered in the Pioneer ACO model and discussed in the working group's policy options document).

Lastly, we recognize the concern that waiving OOP costs can drive over- or unnecessary utilization, i.e., the concern over the "offset effect." To address that concern, we recommend limiting the waiver to a discrete number of primary care codes delivered by primary care providers upon which ACO beneficiary assignment is based. The waiver would also only benefit a discrete number of ACO patients since about 25% of Medicare beneficiaries have Medigap insurance and a much larger percentage have supplemental coverage via employer-sponsored plans and other polices that typically provide first dollar coverage. We also know beneficiaries without secondary coverage are poorer in health, lower in income, have higher out-of-pocket costs and stint on care. Finally, we know that waiving the primary care copays will result in lower revenue for the ACO physicians and we recommend that the waiver be optional to an ACO, and in order to implement it, the ACO would need to have advanced consent of all

primary care providers through their ACO participant agreements. We further recommend that the ACO be able to reimburse the physicians for the forgone revenue associated with waiver of the copays.

In sum, we believe waiving a discrete list of primary care service copays for all three ACO tracks would encourage the use of primary care services, improve patient outcomes over time and further patient centered care. This recommendation is consistent with MedPAC's 2010 technical panel's finding that lowering cost sharing services for preventive services is a way to encourage the use of high-value, high-quality health care.

Providing Flexibility for Beneficiaries to Be Part of an Accountable Care Organization

Finance Committee Policy Options Document

The chronic care working group is considering recommending that ACOs in MSSP Track One be given the choice as to whether their beneficiaries be assigned prospectively or retrospectively. Also, the Chronic Care Working Group is considering recommending that Medicare fee-for-service beneficiaries have the ability to voluntarily elect to be assigned to the ACO in which their main provider is participating. The Secretary would be required to establish a process by which beneficiaries could voluntarily elect to be assigned to a MSSP ACO while still retaining their freedom of choice to see any provider.

The working group is soliciting feedback on whether:

- A beneficiary who voluntarily elects to be assigned to an ACO should be allowed to receive services from providers that are not participating in the ACO.
- ACOs that are assigned beneficiaries prospectively should receive an upfront, collective payment for all services provided to the beneficiaries in the ACO.

ACOs that provide services to beneficiaries who voluntarily elect to enroll in the ACO should receive an upfront collective payment for all services provided to these beneficiaries.

ACP Response/Recommendation

The College supports allowing ACOs in MSSP Track One to choose whether to have their beneficiaries assigned prospectively or retrospectively. They should also be permitted to choose to switch between prospective and retrospective assignment with each recertification. We would also like to reiterate the College's support for allowing flexibility in beneficiary assignment within MSSP ACOs as outlined in the joint comment letter[12] from the ACO Working Group:

> We support allowing ACOs to select using either retrospective or prospective beneficiary assignment. A retrospective assignment model can be beneficial for some ACOs. For example, a small ACO may be worried about dropping below the 5,000 beneficiary minimum and thus prefer a model where it could add beneficiaries throughout the year. Under the prospective model as currently

[12] https://www.acponline.org/acp_policy/letters/aco_working_group_response_sfc_chronic_care_policy_2016.pdf

defined by CMS, the ACO will only lose beneficiaries. However, by the time an experienced ACO selects a more advanced model design, a prospective model would most likely be preferred. With substantial risk required under this track, an ACO would want a very stable beneficiary population to avoid unexpected changes in its benchmark. Moreover, these more advanced ACOs would want to employ data analysis and beneficiary engagement techniques from the start of the performance period on a population for whom they know they are responsible.

We also support the working group's proposal to allow beneficiaries to voluntarily elect to be assigned to the ACO in which their main provider is participating. We recommend this beneficiary attestation process be available for all MSSP ACOs, regardless of track. This process would allow beneficiaries to attest that they consider a particular provider responsible for coordinating their overall care. An attesting beneficiary would be attributed to the ACO with whom that provider is affiliated. Although CMS would retain its current stepwise attribution process, beneficiary attestation would take precedence over that process when considering to which ACO a beneficiary should be attributed. Furthermore, the beneficiary would remain attributed to that ACO until the beneficiary enrolled in Medicare Advantage, moved out of the ACO's service area, attested to a provider affiliated with another ACO, or the beneficiary otherwise indicates that they receive their care elsewhere.

Providing ACOs the Ability to Expand Use of Telehealth

Finance Committee Policy Options Document

The chronic care working group is considering modifying the requirements for reimbursement for telehealth services provided by ACOs in the Medicare Shared Savings Program (MSSP). The HHS Secretary would be required to establish a process by which ACOs participating in MSSP two-sided risk models may receive a waiver of the geographic component of the originating site requirements as a condition of payment for telehealth services.

The working group is soliciting feedback on whether to lift the originating site requirement entirely or to specify additional originating sites. For example, if the originating site is the beneficiary's home, what safeguards would be needed to ensure that proper clinical equipment is readily available?

ACP Response/Recommendation

ACP supports the policy of modifying the requirements for telehealth services to allow the Secretary to establish a process for ACOs in two-sided risk models to receive a waiver of the geographic component of the originating site requirement as a condition of payment for telehealth services. 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.

Additionally, to ensure the appropriate use of telehealth services, an ACO should be required to: outline a plan on how it will use telehealth services particularly to improve chronic care management; have a mechanism in place to electronically transmit a record of the telehealth encounter to the patient's primary care provider if the eligible telehealth provider is not the patient's primary care provider; and, publicly post their use/approval of the waiver. We also recommend allowing CMS to deny or revoke a waiver as well as monitor an ACO's billing under the payment waiver to reduce possible abuse. The joint comment letter[13] from the ACO Working Group features further comments on this subject.

The College would also like to point the Committee to ACP's recommendations on telemedicine in our recent position paper in the *Annals of Internal Medicine*[14] for consideration in developing policy on telehealth:

1. ACP supports 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.
    a. ACP believes that telemedicine can be most efficient and beneficial between a patient and physician with an established, ongoing relationship.
    b. ACP believes that telemedicine is a reasonable alternative for patients who lack regular access to relevant medical expertise in their geographic area.
    c. ACP believes that episodic, direct-to-patient telemedicine services should be used only as an intermittent alternative to a patient's primary care physician when necessary to meet the patient's immediate acute care needs.
2. ACP believes that a valid patient–physician relationship must be established for a professionally responsible telemedicine service to take place. A telemedicine encounter itself can establish a patient–physician relationship through real-time audiovisual technology. A physician using telemedicine who has no direct previous contact or existing relationship with a patient must do the following:
    a. Take appropriate steps to establish a relationship based on the standard of care required for an in-person visit, or
    b. Consult with another physician who does have a relationship with the patient and oversees his or her care.
3. ACP recommends that telehealth activities address the needs of all patients without disenfranchising financially disadvantaged populations or those with low

[13] https://www.acponline.org/acp_policy/letters/aco_working_group_response_sfc_chronic_care_policy_2016.pdf
[14] Daniel H, Sulmasy LS, for the Health and Public Policy Committee of the American College of Physicians. Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings: An American College of Physicians Position Paper. Ann Intern Med. 2015;163:787-789. doi:10.7326/M15-0498. Accessed at: http://annals.org/article.aspx?articleid=2434625.

literacy or low technologic literacy. In particular, telehealth activities need to consider the following:

   a. The literacy level of all materials (including written, printed, and spoken words) provided to patients or families.
   b. Affordability and availability of hardware and Internet access.
   c. Ease of use, which includes accessible interface design and language.

4. ACP supports the ongoing commitment of federal funds to support the broadband infrastructure needed to support telehealth activities.
5. ACP believes that physicians should use their professional judgment about whether the use of telemedicine is appropriate for a patient. Physicians should not compromise their ethical obligation to deliver clinically appropriate care for the sake of new technology adoption.
   a. If an in-person physical examination or other direct face-to-face encounter is essential to privacy or maintaining the continuity of care between the patient's physician or medical home, telemedicine may not be appropriate.
6. ACP recommends that physicians ensure that their use of telemedicine is secure and compliant with federal and state security and privacy regulations.
7. ACP recommends that telemedicine be held to the same standards of practice as if the physician were seeing the patient in person.
   a. ACP believes that there is a need to develop evidence-based guidelines and clinical guidance for physicians and other clinicians on appropriate use of telemedicine to improve patient outcomes.
8. ACP recommends that physicians who use telemedicine should be proactive in protecting themselves against liabilities and ensure that their medical liability coverage includes provision of telemedicine services.
9. ACP supports the ongoing commitment of federal funds to establish an evidence base on the safety, efficacy, and cost of telemedicine technologies.
10. ACP supports a streamlined process to obtaining several medical licenses that would facilitate the ability of physicians and other clinicians to provide telemedicine services across state lines while allowing states to retain individual licensing and regulatory authority.
11. ACP supports the ability of hospitals and critical access hospitals to “privilege by proxy” in accordance with the 2011 Centers for Medicare & Medicaid Services final rule allowing a hospital receiving telemedicine services (distant site) to rely on information from hospitals facilitating telemedicine services (originating site) in providing medical credentialing and privileging to medical professionals providing those services.
12. ACP supports lifting geographic site restrictions that limit reimbursement of telemedicine and telehealth services by Medicare to those that originate outside of metropolitan statistical areas or for patients who live in or receive service in health professional shortage areas.
13. ACP supports reimbursement for appropriately structured telemedicine communications, whether synchronous or asynchronous and whether solely text-based or supplemented with voice, video, or device feeds in public and

private health plans, because this form of communication may be a clinically appropriate service similar to a face-to-face encounter.

Authorize Study on Medication Synchronization

Finance Committee Policy Options Document
The chronic care working group is considering requiring a study to determine, in order to improve medication adherence, how Part D prescription drug plans (PDPs) could coordinate the dispensing of prescription drugs so that, to the extent feasible, multiple prescriptions can be dispensed to a beneficiary on the same day, providing greater opportunity for the beneficiary to receive comprehensive counseling from a pharmacist. The study could look at current barriers to coordination and best practices used by commercial drug plans, with an assessment of the feasibility of such medication synchronization programs in Medicare.

ACP Response/Recommendation
ACP could support a study on how Part D prescription drug plans could coordinate the dispensing of prescription drugs to improve medication adherence. However, if such a study is implemented, we also recommend that it incorporate the following components:

- Reducing or removing the cost-sharing requirement for a defined set of evidence–based common chronic condition/medication pairings (e.g., high cholesterol/statin).
- Examining the effect of increasing prices and costs associated with prescription drugs and the potential negative effects on a patient's access to necessary medications, medication adherence, and potential solutions to the ongoing problem of high drug pricing and cost.

Ensuring Accurate Payment for Chronically Ill Individuals

Finance Committee Policy Options Document
The Chronic Care Working Group is considering making changes to the CMS-HCC Risk Adjustment Model. Specifically these changes to the CMS-HCC Model would take into account the following:

- Any changes in predicted costs associated with the total number of conditions of an individual beneficiary, including any cumulative impact of a large number of conditions;
- Any changes in predicted costs associated with the interaction between behavioral/mental health conditions with physical health conditions;
- The differences in costs associated with beneficiaries who are dually eligible for both Medicare and Medicaid through different eligibility pathways; and
- The use of more than one year of data to establish a beneficiary's risk score.

The Chronic Care Working Group is also considering a study to examine whether the use of functional status, as measured by activities of daily living or by other means, would improve the accuracy of risk-adjustment payments. The study could also examine the challenges in providing and reporting functional status information by MA plans, providers and/or by the CMS.

ACP Response/Recommendation

The College supports the use of risk adjustment and agrees that efforts to improve the accuracy of risk adjustment approaches being employed are needed. Current CMS policies for ACOs only allow an increase in risk adjustment based on demographic changes (i.e., aging) and not on changes in patient acuity, while the methodology allows for reductions in risk adjustment based on both demographic changes and changes in HCC scores. Risk adjustment methodologies for all three MSSP ACO tracks should be modified so that organizations are not disadvantaged by taking on the sickest populations. As a first step, we support the proposed study and further reiterate the comments outlined in the joint comment letter from the ACO Working Group.[15]

Expanding Use of Telehealth for Individuals with Stroke

Finance Committee Policy Options Document

The working group is considering eliminating the originating site geographic restriction for the narrow purpose of promptly identifying and diagnosing strokes. This would provide every Medicare beneficiary the ability to receive an evaluation critical to diagnosis of an acute stroke via telehealth from a neurologist not on-site. Specifically, this would allow for individuals in urban areas to receive this form of care delivery.

ACP Response/Recommendation

The College supports lifting the originating site geographic restriction for the purposes of identifying and diagnosing strokes through telehealth. There is a strong evidence base behind the use of telestroke programs, as discussed in ACP's recent position paper in the *Annals of Internal Medicine* on telemedicine:[16]

> Benefits from the use of telemedicine in subspecialties are also seen in telestroke services. The Mayo Clinic telestroke program uses a "hub-and-spoke" system that allows stroke patients to remain in their home communities, considered a "spoke" site, while a team of physicians, neurologists, and health professionals consult from a larger medical center that serves as the "hub" site.[17] A study on this program found that a patient treated in a telestroke network, consisting of 1 hub hospital and 7 spoke hospitals, reduced costs by $1436 and gained 0.02 years of quality-adjusted life-years over a lifetime compared with a patient receiving care at a rural community hospital.[18] A study funded by the Patient-Centered Outcomes Research Institute is enrolling patients with

[15] https://www.acponline.org/acp_policy/letters/aco_working_group_response_sfc_chronic_care_policy_2016.pdf

[16] Daniel H, Sulmasy LS, for the Health and Public Policy Committee of the American College of Physicians. Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings: An American College of Physicians Position Paper. Ann Intern Med. 2015;163:787-789. doi:10.7326/M15-0498. http://annals.org/article.aspx?articleid=2434625.

[17] Mayo Clinic . Tests and Procedures: Stroke telemedicine (telestroke). Accessed at*www.mayoclinic.org/tests-procedures/stroke-telemedicine/basics/definition/prc-20021080* on 5 May 2015.

[18] Demaerschalk BM, Switzer JA, Xie J, Fan L, Villa KF, Wu EQ. Cost utility of hub-and-spoke telestroke networks from societal perspective. Am J Manag Care. 2013; 19:976-85. PubMed

Parkinson disease to measure their ability to connect with neurologists through telemedicine. Research shows that although these patients do better under the treatment of a neurologist, fewer than one half of Medicare patients with the disease see a neurologist due to lack of access.[19] The Patient-Centered Outcomes Research Institute study will test the feasibility of patients being treated in their homes, whether telemedicine reduces caregiver burden, and whether it improves the quality of care and overall patient satisfaction.[20]

Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations (SNPs)

Finance Committee Policy Options Document

The chronic care working group is considering either a long term extension or a permanent authorization of the SNPs, including SNPs that enroll beneficiaries in need of institutional level of care (I-SNPs), SNPs that enroll beneficiaries eligible for both Medicare and Medicaid (D-SNPs), and SNPs that enroll beneficiaries with certain chronic diseases (C-SNPs). The chronic care working group is also considering requiring D-SNPs to offer fully integrated Medicare and Medicaid services to their enrollees.

- The working group is soliciting feedback on what modifications should be made to C-SNPs should another policy be implemented that would allow general Medicare Advantage plans greater flexibility in their benefit design to treat chronically ill beneficiaries (see "Adapting Benefits to Meet the Needs Chronically Ill Medicare Advantage Enrollees").

The working group is soliciting feedback on how much time is needed for states and D-SNPs to successfully integrate all Medicare and Medicaid services.

ACP Response/Recommendation

More than two-thirds of Medicare beneficiaries have two or more chronic conditions, and beneficiaries with multiple chronic conditions account for a disproportionate amount of healthcare utilization including office visits, hospitalizations (and readmissions), emergency room visits, and post-acute care admissions. Medicare currently allows beneficiaries to enroll in Chronic Condition Special Needs Plans (C-SNP), which provide specialized plans for specific chronic conditions. While C-SNP plans are available in the Medicare Advantage (MA) benefit for certain chronic conditions, only about 300,000 beneficiaries were enrolled in them as of April 2015, representing only 2 percent of total MA enrollment.[21] Of the beneficiaries in C-SNP plans, about 90 percent were in special plans for diabetes.

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[19] Burke JF, Albin RL. Do neurologists make a difference in Parkinson disease care? Neurology. 2011; 77:e52-3. PubMed CrossRef

[20] Patient-Centered Outcomes Research Institute. Can Virtual House Calls Provide More Patients with High-Quality Parkinson Disease Care? Accessed at *www.pcori.org/funding-opportunities/pfa-awards/pilot-projects/notes-from-the-field-can-virtual-house-calls-provide-more-patients-with-high-quality-parkinson-disease-care-2* on 26 June 2015.

[21] http://medpac.gov/documents/congressional-testimony/testimony-improving-care-for-beneficiaries-with-chronic-conditions-%28senate-finance%29.pdf?sfvrsn=0

Addressing the fact that the majority of Medicare beneficiaries have multiple chronic conditions, **the College supports the Medicare Payment Advisory Commission's (MedPAC) recommendation[22] to expand the flexibility of MA plans to tailor their offerings/benefits to meet the specific health care needs of the beneficiary. In effect, this approach folds into the general MA program aspects of current C-SNP.**

Expanding Access to Digital Coaching

Finance Committee Policy Options Document
The working group is considering requiring the Centers for Medicare & Medicaid Services (CMS) to provide medically-related information and educational tools on its website to help beneficiaries learn more about their health conditions and help them in the self-management of their own health. There would need to be a mechanism to ensure the information is valid and up-to-date.

The working group is soliciting feedback on what type of information would be most beneficial for beneficiaries.

ACP Response/Recommendation
The College supports the working group's proposal to require CMS to provide medically-related information and educational tools on its website to help beneficiaries learn more about their health conditions and self-management of them as long as the tools have a strong evidence base. CMS should partner with physician organizations and other stakeholders for the development and dissemination of any tools to ensure that information is valid and up-to-date.

ACP has produced a series of self-management guides for diabetes, rheumatoid arthritis, weight loss, COPD, and heart disease to support patients in managing their chronic conditions that would fit within this proposal. The guides are developed by a multidisciplinary development team of experts, including physicians, behavioral scientists, educators, nurses, pharmacists, health educators, and design experts, who spend months working with patients and clinicians to integrate critical medical, behavioral, and educational content into the guides. The end result is a tool that successfully communicates with patients both visually and through words. The guides have been praised by both patients and clinicians alike. Programs and tools like these could be supported by Medicare payment policies by: (1) reimbursing physicians appropriately for spending time with patients to engage them in shared decision-making based on the recommendations from those programs and similar efforts by other specialty societies and (2) developing a way to recognize, with higher payment updates perhaps within the new MIPS program, physicians who can demonstrate that they are incorporating such programs into their practices and engaging with their patients.

[22] Medicare Payment Advisory Commission Improving Care for Medicare Beneficiaries with Chronic Conditions. http://www.medpac.gov/documents/congressional-testimony/testimony-improving-care-for-beneficiaries-with-chronic-conditions-%28senate-finance%29.pdf?sfvrsn=0

Additional ACP Recommendations on Chronic Care Policy

ACP also recommends that as the Committee develops policies to improve the delivery of chronic care, it should advance the following recommendations (that were not included in the policy options document) to improve the delivery of primary care and strengthen the primary care physician workforce since these professionals treat a large percentage of patients with chronic illness. ACP asks the committee to expand the use of the patient-centered medical home and approve legislation that will reauthorize the Medicare Primary Care Incentive Payment Program and Medicaid Pay Parity Program.

Expand the Use of the Patient-Centered Medical Home

Finance Committee Policy Options Document
Although this policy was not included in the Finance Committee policy options document, ACP recommends that the Committee incorporate the expansion of the Patient-Centered Medical Home as it develops policy options to improve chronic care.

ACP Recommendation
The College recommends that the Finance Committee consider the expansion of the Patient-Centered Medical Home (PCMH) Model as a primary resource that is uniquely suited to meet the needs to improve care for patients with chronic illness, and we are encouraged that Congress explicitly supported their implementation under the MIPS and APM options established by MACRA. ACP was very impressed with the positive data tied to the early results of the Comprehensive Primary Care initiative (CPCi), which are consistent with the existing literature on the effectiveness and efficiency of the PCMH concept. According to data released by CMS in October of last year:[23]

- Over 90 percent of CPC practices successfully met quality targets on patient experience (as determined by the Consumer Assessment of Healthcare Providers and Systems (CAHPS surveys) and utilization (hospital rates and readmissions) measures, indicating quality scores that matched or exceeded national comparisons.
- All regions had lower than targeted hospital readmission rates. Readmissions can be burdensome to patients and caregivers and costly to the healthcare system. Lower readmissions indicate better coordination of care during transitions and patient support during the post discharge period.

Therefore, ACP strongly recommends that the Secretary exercise her existing authority to expand the CPCi (or PCMH model) if the evaluation results continue to be positive. Given that the current CPCi project is set to expire on October 1, 2016 (4 years after it was initiated), CMMI needs to initiate plans for this expansion now so that the currently participating practices, as well as new practices that are interested in joining, can be assured of ongoing consistency in their payment amounts and support services and have adequate time to prepare

[23] http://blog.cms.gov/2015/10/07/primary-care-makes-strides-in-improving-quality-and-costs/

for any potential changes that the program may undergo based on lessons learned. These plans will also ensure that the patients of the participating practices can have consistency in the care they are receiving.

The College also recommends a demonstration project through CMMI to determine the effectiveness of providing monthly care-coordination bonus payments to these practices to support such services as enhanced collaboration and coordination with the referring clinician, the provision of non-face-to-face consultative services, the maintenance of rapid scheduling for defined urgent patients, the timely delivery of the results of a consultation, and enhanced patient engagement.

Approve Legislation That Will Reauthorize the Medicare Primary Care Incentive Payment Program

Finance Committee Policy Options Document
Although this legislation was not included in the Finance Committee policy options document, we believe the inclusion of this policy will maintain and increase the physician workforce that will treat patients with chronic conditions

ACP Recommendation
As we mentioned in our previous letter to the Finance Committee last year, **the College strongly recommends that Congress enact legislation to reauthorize the Medicare Primary Care Incentive Payment (PCIP) program.** These professionals provide care to the large majority of patients with chronic illness and are likely to do so for the foreseeable future. The PCIP was established in recognition of the importance of a strong primary care workforce to our healthcare system, the current undervaluation of primary care services within the Medicare Physician Fee Schedule, and the trend for medical students to choose a career other than in primary care. MedPAC has called on Congress to continue this program given its importance to supporting primary care services and has provided recommendations for how the program could be restructured to continue to meet this goal.[24]

Reauthorize Legislation to Reinstate the Medicaid Primary Care Pay Parity Program

Finance Committee Policy Options Document
This policy was not incorporated in the Finance Committee policy options document, but ACP recommends its inclusion since evidence has shown that the parity program has increased access to primary care services

ACP Recommendation
The College strongly encourages Congress to extend the Medicaid pay parity program by passing S. 737, the Ensuring Access to Primary Care for Women and Children Act. In 2013 and 2014, physicians and other eligible health professionals in the Medicaid program were reimbursed at Medicare rates for evaluation and management services, the core of services

[24] http://www.medpac.gov/blog/may-2015/may-2015/2015/05/11/march-report-highlight-medpac-recommends-per-beneficiary-payment-for-primary-care. May 2015.

provided by primary care clinicians. Medicaid has historically struggled to attract physicians to the program in part because of insufficient reimbursement rates. As state Medicaid programs surge with new enrollees, more primary care physicians will be needed to meet patient demand, and enhanced payments may encourage more physicians to join or remain in the program. Additionally, as noted earlier, one of the key elements of MACRA is the stabilization of payment rates, with modest positive updates, during the transition period to the new MIPS and APM pathways—therefore, having Medicaid rates drop, particularly for the dual eligible population(discussed further below)is extremely problematic.

Early evidence shows that the Medicaid pay parity program has had its intended impact. A study released in January 2015 found that appointment availability for Medicaid-participating primary care clinicians increased by 7.7% during the period that pay parity was in effect, demonstrating that higher reimbursements are related to improved access for Medicaid patients. If pay parity is not renewed, these gains in patient access may be reversed and patients will have more difficulty getting the care they need. Medicaid pay parity is especially important as the federal government and state Medicaid programs work together to coordinate care for dual-eligibles.

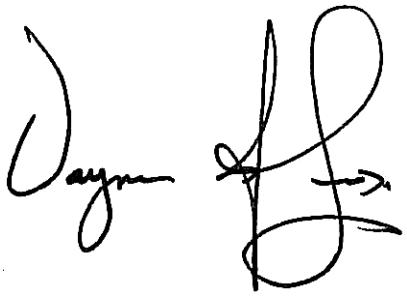
Conclusion

In summary, ACP is supportive of many of the recommendations in the Senate Finance Committee's Chronic Care Working Group policy options document, including the recommendations to improve access to chronic care and ensure appropriate reimbursement for complex chronic care management; eliminate beneficiary cost sharing for chronic care management services; integrate care for behavioral health conditions in a primary care setting; improve the process for development of quality measures for chronic conditions, including filling critical measure gaps; and allow increased flexibility for ACOs to better design packages of services for patients with chronic conditions, support patient engagement, choose the best approach for patient attribution to meet their needs, and expand the use of telehealth to treat their patients with chronic conditions.

We also look forward to working with you to implement our recommendations that were not included in the chronic care policy options document including the following requests to: create a new chronic care code bundle for diabetic care management; provide reimbursement for e-consultations between hospitalists and primary care physicians and specialists and primary care physicians; expand the implementation of the patient-centered medical home as a means of improving care for patients with chronic illness; reauthorize the Medicare Primary Care Incentive Payment program; reauthorize the Medicaid pay parity program; and not expand Meaningful Use to include activities involved in the coordination of the care of patients with chronic conditions until there is better evidence about the best ways to use health IT to perform that coordination.

ACP appreciates the opportunity to work with the Finance Committee and provide our recommendations to improve chronic care. If you have any questions, please do not hesitate to contact Brian Buckley at 202-261-4543 or bbuckley@acponline.org.

Sincerely,



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