



June 19, 2015

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 respond to your request for recommendations and policies that will improve care for patients with chronic diseases. We applaud you for your leadership in addressing chronic diseases to advance a solution with input from physicians, physician organizations, patient advocates, and other stakeholders.

ACP is the largest medical specialty organization and the second largest physician group in the United States. ACP members include 141,000 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.

The College has a number of specific recommendations for the Committee to consider in response to the policy categories posed in your letter dated May 22, 2015. These recommendations and supporting evidence and implementation details are described below.

ACP's key recommendations are that Congress:

- **Expand the flexibility of Medicare Advantage plans to tailor benefits;**
- **Make improvements to the Medicare Shared Savings Program;**
- **Consider expanding the Comprehensive Primary Care Initiative nationally;**
- **Reauthorize the Medicare Primary Care Incentive Payment program;**
- **Extend the Medicaid pay parity program;**
- **Improve the functionality of electronic health records;**

- Eliminate the copayment requirement for chronic care management and create codes to provide reimbursement for diabetic care management and e-consultations;
- Create Medicare reimbursement for advance care planning discussions;
- Achieve neutrality in payment rates based on site of service;
- Ensure that quality measurement targets remain patient-centered and reflect potential differences in benefits/harms for specific populations;
- Consider ways to significantly reduce or remove the cost-sharing requirement for a defined set of evidence-based common chronic condition/medication pairings;
- Engage representatives of the pharmaceutical industry, health plans, patients, physicians, and other stakeholders in ongoing discussions about the increasing prices and costs associated with prescription drugs;
- Support the ongoing commitment of federal funds into research on the safety, efficacy, and cost-effectiveness of telehealth activities;
- Require a study on the impact that flat or reduced payment rates to rural health centers has on health care access for Medicare beneficiaries, in particular those with chronic conditions;
- Support and expand upon the current efforts of CMS to make transparent the quality and cost of services provided within the Medicare program;
- Encourage Medicare to support approaches that allow for true shared-decision making and patient self-management;
- Support studying the effectiveness of reimbursement for Patient-Centered Specialty Practices that actively engage in collaboration and coordination with the referring clinicians; and
- Integrate care for behavioral health conditions into the primary care setting.

We ask that the Committee consider all of our recommendations, detailed below in response to the specific policy categories outlined by the Committee, in the context of the recently enacted Medicare Access and Chip Reauthorization Act of 2015 (MACRA), which creates incentives and payment structures that will lead overall to improvements in care for patients with chronic diseases, particularly the Patient-Centered Medical Home (PCMH) provisions under the newly established Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) pathways.

**1. *Improvements to Medicare Advantage for patients living with multiple chronic conditions;***

**Medicare Advantage**

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.<sup>1</sup> 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

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<sup>1</sup> Chronic Conditions Among Medicare Beneficiaries <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>

total MA enrollment.<sup>2</sup> Of the beneficiaries in C-SNP plans, about 90 percent were in special plans for diabetes.

Addressing the fact that the majority of Medicare beneficiaries have multiple chronic conditions, **the College supports the Medicare Payment Advisory Commission’s (MedPAC) recommendation<sup>3</sup> 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.

- 2. *Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures;***

### **Accountable Care Organizations**

The Medicare Accountable Care Organization (ACO) programs reflect positive trends as indicated by the continued interest in program participation—more than 400 organizations currently participating—and the early performance results for both the Pioneer ACO and Medicare Shared Savings Program (MSSP) indicate improved quality and cost savings.<sup>4</sup> CMS has recently released a final rule<sup>5</sup> containing the second iteration of regulations regarding the MSSP. The College has provided multiple recommendations to CMS as part of a larger collaborative effort to improve the MSSP.<sup>6</sup> The College believes that the MSSP and similar Medicare ACO programs promote the elements of care necessary to effectively treat the large number of Medicare beneficiaries with chronic conditions. These include increased accountability for quality and cost, patient engagement (centeredness) activities, care coordination and transition efforts, team-based care provision; and population management approaches. The College commends CMS for making changes in the program through the recently released final rule that will encourage increased physician involvement in the MSSP program, continue to establish a transitional roadmap toward the acceptance of increased risk, increase program design flexibility, and decrease unnecessary administrative burden. We were particularly pleased with the decision to continue to allow ACOs currently under the Track 1 (one-sided risk) option to sign on to an additional 3-year agreement without being penalized by a reduction in shared savings rate. It is through this option that many of our members can develop the skills necessary to succeed under two-sided risk models in the future. These improvements in the

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<sup>2</sup> <http://medpac.gov/documents/congressional-testimony/testimony-improving-care-for-beneficiaries-with-chronic-conditions-%28senate-finance%29.pdf?sfvrsn=0>

<sup>3</sup> 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>

<sup>4</sup> CMS Medicare ACOs continue to succeed in improving care, lowering cost growth <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-11-10.html>

<sup>5</sup> <http://www.gpo.gov/fdsys/pkg/FR-2015-06-09/pdf/2015-14005.pdf>. 32692 Federal Register / Vol. 80, No. 110/ Tuesday, June 9, 2015/

<sup>6</sup> [https://www.acponline.org/acp\\_policy/letters/mssp-aco\\_collaborative\\_2015.pdf](https://www.acponline.org/acp_policy/letters/mssp-aco_collaborative_2015.pdf)

program are particularly important as Medicare moves toward the implementation of the APM pathway as established by MACRA, which is where most ACO programs are expected to go.

**The College requests that the Committee, either through legislation or Congressional guidance, facilitate the expansion of the recently finalized regulations to further increase:**

- **Flexibility in attribution methodology allowed including direct beneficiary enrollment (self-attestation) and prospective and retrospective methodologies.**
- **The use of exceptions (waivers) to current Medicare fee-for service program requirements (e.g., waiver of the skilled nursing facility 3-day hospital stay rule, post-acute care referral limitations, home health, and telehealth requirements).**
- **Flexibility for participating 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.**
- **Flexibility in benchmark methodology so that organizations that have a history of providing high quality/low cost care or are located in a historically low-cost region are not inappropriately, negatively affected.**
- **Availability in a timely manner of data related to the utilization of clinical services by attributed beneficiaries—including mental health and substance abuse-related services.**

**The College also strongly recommends that organizations that are participating within the MSSP one-sided risk option be considered (at least for a defined period of time) as meeting the MACRA requirement of bearing “more than nominal financial risk” to qualify for the APM program.** The start-up costs alone for an MSSP, estimated to average around \$2 million,<sup>7</sup> reflect ample risk for participating physicians.

**The College also supports the evaluation of additional ACO models focused on addressing the specific substantial chronic care needs of many beneficiaries—an example of this would be the program proposed under Senators Wyden and Isakson’s Better Care, Lower Cost Act, S. 1932, which was introduced in the previous Congress. This bill both focuses on the specific needs of beneficiaries with chronic illness and combines design features found to be successful in the Medicare Advantage and ACO programs. ACP further recommends the evaluation of these models through the Center for Medicare and Medicaid Innovation (CMMI), which allows the Secretary to rapidly expand programs that meet defined quality and efficiency criteria within the Medicare program.**

#### **Patient-Centered Medical Home/Comprehensive Primary Care Initiative**

The College, along with many other national membership organizations representing physicians and other clinicians, as well as thousands of business, consumer, and payer groups represented in the Patient-Centered Primary Care Collaborative (PCPCC), has championed the PCMH and PCMH–Neighborhood (i.e., Patient-Centered Specialty Practice) concepts over the past several years. The

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<sup>7</sup> National Association of Accountable Care Associations. National ACO Survey, November 2013.  
<https://www.naacos.com/pdf/ACOSurveyFinal012114.pdf>

PCMH is an approach to providing comprehensive primary care in a setting that focuses on the relationships between patients, their primary care physician, and other health professionals involved in their care. Key attributes of the PCMH promote health care delivery for all patients, including those with chronic conditions, though all stages of life. Of note, the PCMH approach is modeled largely after the Chronic Care Model, which identifies the essential elements of a health care system that encourage high-quality chronic disease care.<sup>8</sup> These elements include: the community, the health system, self-management support, delivery system design, decision support, and clinical information systems. The Chronic Care Model was initially developed in the mid-1990s and has since been further refined through additional research and testing by national experts. It is widely viewed as an evidence-based approach to achieve improved health of patients, greater satisfaction for clinicians, and increased cost savings.

The PCMH model is a key element in the newly enacted MACRA law, as it is specifically included as part of both the MIPS and the APM pathways. Within MIPS, practices that are determined to be PCMHs will receive the highest possible score within the Clinical Practice Improvement Activities performance category. And within the APM pathway, practices that are advanced PCMHs can qualify as an APM without having to take on two-sided risk arrangements.

One critical program of the CMMI is the Comprehensive Primary Care Initiative (CPCi). Largely modeled on the PCMH approach, CPCi is collaboration between private and public payers and primary care practices to support patient-centered primary care. Practice selection was based on a number of criteria, which favored practices that were meaningful users of electronic health records (EHRs), had PCMH recognition, and were experienced in quality improvement initiatives. Ultimately, 502 practices in 7 regions were chosen to participate. Together with 31 unique other payers (3 to 9 per region), CMMI provides non-visit based, risk adjusted, monthly care management fees in addition to traditional payments for practices to invest in redesigning and transforming care. In addition to this enhanced payment, practices are supported with data feedback, learning activities, and technical assistance (TA). The five functions of CPCi practices are: (1) access and continuity, (2) planned chronic and preventive care, (3) risk-stratified care management, (4) patient and caregiver engagement, and (5) coordination of care across the medical neighborhood.

Findings on the early effects of CPCi on service utilization and costs for attributed Medicare fee-for-service (FFS) beneficiaries through September 2013 are promising and more favorable than might be expected for the first 12 months of the initiative. Across all seven regions in the first year, these results suggest that CPCi has generated enough savings in Medicare health care expenditures to nearly cover the CPCi care management fees paid by CMS for attributed Medicare FFS beneficiaries, although not yet enough to generate net savings. CPCi also generated reductions in hospitalizations, outpatient emergency department visits, primary care physician visits, and specialist visits. As for effects on quality, there was a sizable (4 percent) CPCi-wide decline in unplanned 30-day readmissions. Evaluators anticipate that it may take 18 months to 3 years for practices to fully transform and to see the full effects on cost, service use, and quality. Some statistically significant effects on quality-of-care process measures were observed only for high-risk beneficiaries.

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<sup>8</sup> [http://www.improvingchroniccare.org/index.php?p=The\\_Chronic\\_Care\\_Model&s=2](http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2).

Specifically, the likelihood of a beneficiary receiving all four diabetes services (i.e., tests of HbA1c, lipid, and urine protein and an eye exam) increased by 3 percentage points (up to 10 percent) for the high-risk group. Patients with chronic conditions would likely fall into this high-risk group.<sup>9</sup> **ACP recommends that further study on the specific experience and outcomes for patients with chronic conditions be carried out in order to better determine the impact of this program (and the PCMH model more broadly) on this patient population.**

The College was very impressed with the positive data tied to the early results of the CPCi, which are consistent with the existing literature on the effectiveness and efficiency of the PCMH concept.<sup>10</sup> The medical home is uniquely suited to meet the needs of patients with chronic conditions, and we are encouraged that Congress explicitly supported their implementation under the MIPS and APM options established by MACRA. **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 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.

### **Bundled Payment for Primary Care Services**

The College also is supportive of testing a bundled payment approach for in-office primary care services with adequate risk adjustment, such as the Advanced Primary Care payment model that was outlined in the recent Request for Information (RFI) from CMMI, but this should be done independent of the CPCi. While conceptually a viable model that could potentially facilitate better care for those with chronic conditions, ACP has concerns regarding the readiness of most practices at this time to succeed in this model without substantial practice support and protection from downside risk.<sup>11</sup>

### ***3. Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions;***

The FFS payment system will remain a chief component of Medicare physician payment for some time. With the creation of new alternative payment models, even within the new programs created by MACRA, FFS still remains the underlying basis on which these APMs are built. Therefore, the College recommends that Congress and CMS continue to focus on ways to improve the accuracy and the function of Medicare FFS. Any payments related to quality and efficiency must align with Medicare's broader payment reform goals of providing more support for physicians that are providing better, more efficient care. Additionally, ACP strongly believes that all public and private

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<sup>9</sup> <http://innovation.cms.gov/Files/reports/CPCI-EvalRpt1.pdf>

<sup>10</sup> Nielsen, M., Gibson, L., Buelt, L., Grundy, P., & Grumbach, K. (2015). The Patient-Centered Medical Home's Impact on Cost and Quality, Review of Evidence, 2013-2014. - See more at: <https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality#sthash.vhoTelhi.dpuf>

<sup>11</sup> [http://www.acponline.org/acp\\_policy/letters/acp\\_comments\\_cms\\_rfi\\_advanced\\_primary\\_care\\_payment\\_2015.pdf](http://www.acponline.org/acp_policy/letters/acp_comments_cms_rfi_advanced_primary_care_payment_2015.pdf)

payers should transition their payment systems to support innovative alternative payment and delivery models linked to the value of the care provided.

### **Reauthorization of the Primary Care Incentive Payment Program**

**The College strongly recommends that Congress enact legislation to reauthorize the Medicare Primary Care Incentive Payment (PCIP) program.** This program, which began in 2011 and is scheduled to sunset at the end of 2015, pays eligible internal medicine specialists, family physicians, pediatricians, and geriatricians a 10 percent bonus on top of the FFS payment for designated primary care services. 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,<sup>12</sup> 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, in its March 2015 Report to Congress,<sup>13</sup> reaffirmed the importance of maintaining the PCIP for the above stated reasons. Furthermore, 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, a significant reduction in payment to primary care at this time will make it more difficult for these clinicians to make the transformations required to successfully transition towards the value-based payment models (e.g., PCMHs, ACOs, bundled payments) incentivized under the recently passed MACRA law. **Therefore, we urge introduction of legislation to continue the Medicare PCIP in its current form—paying eligible internal medicine specialists, family physicians, pediatricians, and geriatricians a 10 percent bonus on top of the FFS payment for designated primary care services.** We also urge that reauthorization of this program be funded in the same way it is currently funded—directly by the Medicare program. We recognize that MedPAC has recommended that such payments instead be made on a per-beneficiary basis, and the College is open to further consideration of this approach, if attribution and risk-adjustment issues can be effectively addressed. However, development of a per-beneficiary payment structure that addresses such concerns may not be achievable before the current program expires on January 1, 2016, which would necessitate that Congress act prior to then to reauthorize the existing 10 percent bonus payments.

### **Extend Medicaid Pay Parity**

**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 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

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<sup>12</sup> American College of Physicians. How is the Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care. Available at [http://www.acponline.org/advocacy/current\\_policy\\_papers/assets/primary\\_shortage.pdf](http://www.acponline.org/advocacy/current_policy_papers/assets/primary_shortage.pdf)

<sup>13</sup> Medicare Payment Advisory Commission. March 2015, Report to Congress. Available at [www.medpac.gov/documents/reports/march-2015-report-to-the-congress-medicare-payment-policy.pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/march-2015-report-to-the-congress-medicare-payment-policy.pdf?sfvrsn=0)

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. An ACP member survey found that of the respondents who indicated they had enrolled in the pay parity program via their state Medicaid program, 46 percent would accept fewer Medicaid patients in 2015 (40 percent) or drop out of Medicaid entirely in 2015 (6 percent) if the program was allowed to expire.<sup>14</sup>

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.<sup>15</sup> 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. Between 2006 and 2013, the total number of Medicare-Medicaid enrollees increased by 24 percent, from 8.6 million to 10.7 million. As a result, Medicare-Medicaid enrollees make up a slightly larger percent of the total Medicare population in 2013 (19.4 percent in 2013 versus 19.0 percent in 2006).<sup>16</sup>

The prevalence of chronic diseases in the Medicaid population is high, and many beneficiaries have multiple chronic conditions. According to a 2012 analysis by the Kaiser Family Foundation, in the nonelderly Medicaid population 10 percent had diabetes, 23 percent had respiratory disease, 28 percent had cardiovascular disease, and 35 percent had a diagnosed mental illness. A majority of the Medicaid beneficiaries with each of these four conditions also had an additional physical chronic condition, ranging from 61 to 82 percent.<sup>17</sup> The Senate can help improve access to primary care for Medicaid patients by enacting S. 737 to ensure that Medicaid payments for designated services by primary physicians are reimbursed at no less than what Medicare pays for the same services. The College urges the Senate Finance Committee to consider and approve this legislation so that patients can access the physicians they know and trust.

### **Electronic Health Records and Meaningful Use**

Electronic health records can be useful to clinicians in providing access to clinical information and decision-support associated with improved patient outcomes for patients with chronic diseases; however, the principal focus by regulators, legislators, and other stakeholders should be on improving the functionality and usability of EHRs, as typically used by physicians in practice.

**Therefore, ACP recommends that complex coordination functions required for chronic care**

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<sup>14</sup> [http://www.acponline.org/acp\\_policy/policies/national\\_pay\\_parity\\_report\\_2014.pdf](http://www.acponline.org/acp_policy/policies/national_pay_parity_report_2014.pdf)

<sup>15</sup> Daniel Polsky, Ph.D., Michael Richards, M.D., Ph.D., Simon Basseyn, B.A., Douglas Wissoker, Ph.D., Genevieve M. Kenney, Ph.D., Stephen Zuckerman, Ph.D., and Karin V. Rhodes, M.D. Appointment Availability after Increases in Medicaid Payments for Primary Care. *N Engl J Med* 2015; 372:537-545. February 5, 2015. <http://www.nejm.org/doi/full/10.1056/NEJMSa1413299>

<sup>16</sup> Medicare-Medicaid Coordination Office. Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2013. December 2014.

<sup>17</sup> Kaiser Family Foundation. The Role of Medicaid for Adults with Chronic Illnesses. November 2012. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383.pdf>



**management not be included within the certification requirements for EHR systems.** Instead, practices should be permitted to implement separate care coordination systems that work with their EHR systems to best meet their needs. Care must be taken to avoid imposing more requirements upon certified EHR systems, including well-intentioned functions relating to chronic care management, which will make EHRs even less useful to practicing clinicians and their patients than they are today.

**Along the same lines, ACP also recommends that meaningful use 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 perform that coordination.** At that point, appropriate health IT data standards can be developed, which should be followed by the implementation in health information technology (IT) systems, and then by the measurement of these recommended care activities. It is critically important that both certification and meaningful use be approached thoughtfully, particularly as the meaningful use program will be incorporated into the MIPS pathway being initiated by MACRA.

### **Chronic Care Management**

**ACP recommends including in legislation an elimination of the beneficiary copayment for key care management services including Chronic Care Management (CCM; CPT 99490).** CCM is a positive development for improving care for patients—and paying for that care—much of which cannot be provided within traditional face-to-face encounters, and this policy aligns with the agency’s broader payment reform efforts. However, holding beneficiaries responsible for copayments on these services is a deterrent to their acceptance. This can cause undue strain on a doctor-patient relationship because patients are not accustomed to paying for a service when they do not see the doctor face-to-face, so it is often difficult to convince patients that their copayment is worth the service. Additionally, Transitional Care Management (TCM; CPT 99495, 99496), like CCM, is a positive development for improving care for patients and paying for that care. A review of the TCM codes usage in 2014 shows a substantial increase from 2013 with a decrease in the usage of the initial and subsequent hospital codes, which may suggest a positive impact in decreasing patient readmissions.<sup>18</sup> Like the Initial Preventive Physician Exam (Welcome to Medicare Prevention Visit) and Annual Wellness Exam, which are covered under Medicare as preventive services with no copayment or deductibles, CCM should similarly be treated as a preventive service with the copayment and deductible waived.

The College also recommends that copayments for all vaccinations recommended by the Centers for Disease Control’s (CDC) Advisory Committee on Immunization Practices (ACIP) be waived for Medicare beneficiaries. This would parallel the waiver of copayments for services with recommendations with a grade of A or B from the U.S. Preventive Services Task Force. Currently, only a limited number of vaccinations, covered under Part B, are relieved of a required co-payment. There is no exemption for recommended vaccination copayments under Part D coverage. The removal of barriers from disease prevention services is particularly important for the vulnerable chronic care population.

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<sup>18</sup> American Medical Association. Economic and Health Policy Research, April 2015.

### **Diabetic Care Management**

The College encourages Congress push CMS to use payment approaches that are aligned with the goal of moving payments away from volume to value-based care such as by exploring 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 Medicare cover evidence-based lifestyle modification programs under the traditional Medicare benefit, such as the Diabetes Prevention Program<sup>19</sup> or the Stanford Chronic Disease Management Program.<sup>20</sup>**

### **E-consultation Codes**

**The College recommends that Congress include in legislation a requirement for CMS to create a code and provide reimbursement for e-consultations both between hospitalists and primary care physicians and specialists and primary care physicians.** 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 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 in 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*.<sup>21</sup>

Patients with chronic conditions often also require consultations and care from specialty/subspecialty physicians. Recent studies<sup>22</sup> 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

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<sup>19</sup> [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(09\)61457-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61457-4/fulltext)

<sup>20</sup> <http://patienteducation.stanford.edu/programs/cdsmp.html>

<sup>21</sup> Allan H. Gorroll, 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>

<sup>22</sup> 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>

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.

### **Advance Care Planning**

**ACP supports legislation that would create Medicare reimbursement for advance care planning discussions between doctors, patients, and their families.** This includes bills such as S. 1549, the Care Planning Act of 2015, which was introduced by Sens. Isakson and Warner. The College has been a longstanding supporter of Medicare coverage for voluntary conversations between doctors and patients to create an end-of-life care plan that advances the needs of the patient. ACP encourages doctors to routinely raise the topic of advance care planning with adult patients with decision-making capacity and encourages them to review their values and preferences with their surrogates and family members. We believe that these conversations should take place in an outpatient setting before an acute crisis so that there is sufficient time for a patient to address their end-of-life care plans with a physician. Advance care planning is a critical service that should be available and covered for all Medicare patients, but especially those with chronic conditions.

A significant body of evidence exists that shows that advance planning consultations will significantly improve care at the end of life for patients. According to a report recently issued by the Institute of Medicine, “a committee of experts finds that improving the quality and availability of medical and social services for patients and their families could not only enhance quality of life through the end of life, but may also contribute to a more sustainable care system.”<sup>23</sup> The report emphasizes the importance of physician-patient communication and notes that although advance directive documents are useful, they cannot take the place of open, continuous conversations among doctors, patients, and families. ACP also believes that Medicare should adequately reimburse physicians for these consultations due to the significant amount of time and documentation involved in developing an end-of-life plan.

### **Site-neutral Payments**

**ACP recommends developing legislation that eliminates disparities in payments for the same clinical services when they are provided in different healthcare settings, when that care is not dependent on the hospital facility and its associated technologies, thus promoting site-neutrality.** Rather, in line with the College’s high value care initiative, ACP supports delivery of care in the most efficient setting, while maintaining quality of care. MedPAC has recommended this change in Medicare payment for the past few years—expanding the concept to cover outpatient, hospital in- and outpatient, and post-acute care settings.<sup>24</sup> The College, as a member of the Alliance for Site-

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<sup>23</sup> Institute of Medicine. Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. September 17, 2014. <http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx>

<sup>24</sup> Medicare Payment Advisory Commission. Assessing payment adequacy and updating payments in fee-for-service Medicare. March 2015 Report to Congress. <http://www.medpac.gov/documents/reports/chapter-2-assessing-payment-adequacy-and-updating-payments-in-fee-for-service-medicare-%28march-2015-report%29.pdf?sfvrsn=0>

Neutral Payment Reform, recently sent a letter<sup>25</sup> to Senate leadership highlighting the importance of this issue and its potential for substantial savings both to the Medicare program and patients. For instance, according to a recent study, in 2014, Medicare paid the hospital outpatient departments twice as much as a physician office for the same drug administration service.<sup>26</sup> These payment differentials also negatively impact patients, and they can be particularly impactful on patients with multiple chronic conditions who must interact regularly with the health care system in multiple settings. The data show that these disparities drive up patient costs through additional or increased copayments, which can therefore limit patient access and choice.

### **Skilled Nursing Facility 3-day Stay Rule**

The College recommends that Congress enact legislation to eliminate the requirement that patients have a 3-day inpatient hospital stay to qualify for Medicare coverage in a Skilled Nursing Facility (SNF). Any beneficiary who has stayed in the inpatient facility under inpatient or observation status should be considered as fulfilling the SNF coverage requirement. According to the June 2015 MedPAC report, beneficiaries with chronic conditions are more likely to experience a skilled nursing facility (SNF) stay.<sup>27</sup> This 3-day requirement provides an unnecessary risk to beneficiaries, and it precludes patients from SNF placement who only require short hospital stays as a result of the high uncovered cost.

### **Improvements to Quality Measurement**

The new MACRA law takes significant strides toward the alignment of quality measurement programs within Medicare, as well as with private payers, through the new MIPS program. It also clearly acknowledges that there is more work to be done, as it outlines the need for a measure development plan, funding for that measure development, and greater stakeholder input into the process. ACP 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.

Additionally, it is essential that this new approach to measure development not result in specialty specific, siloed efforts but rather be part of a national strategy for quality improvement. In January 2015, a report from the Brookings Institute recommended that:

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<sup>25</sup> Available at:

[http://www.acponline.org/advocacy/where\\_we\\_stand/assets/alliance\\_site\\_neutral\\_payment\\_reform\\_senate\\_2015.pdf](http://www.acponline.org/advocacy/where_we_stand/assets/alliance_site_neutral_payment_reform_senate_2015.pdf)

<sup>26</sup>

<http://www.imshealth.com/portal/site/imshealth/menuitem.762a961826aad98f53c753c71ad8c22a/?vgnextoid=3f140a4331e8c410VgnVCM1000000e2e2ca2RCRD&vgnnextchannel=736de5fda6370410VgnVCM10000076192ca2RCRD&vgnnextfmt=default>

<sup>27</sup> Medicare Payment Advisory Commission. Assessing payment adequacy and updating payments in fee-for-service Medicare. June 2015 Report to Congress: <http://medpac.gov/documents/reports/chapter-8-next-steps-in-measuring-quality-of-care-in-medicare-%28june-2015-report%29.pdf?sfvrsn=0>

CMS should prioritize the development of measures in MIPS and APMs for the top 20 conditions/clinical areas based on high cost, high volume, variation, and opportunities for care improvement. For each of these, high priority should be placed on measures of clinical outcomes, patient-reported outcomes (e.g., Patient Reported Outcomes Measurement Information System), patient experience, appropriateness and total cost of care. CMS should aim for these measures to be available for use in the top 20 clinical areas by 2018.<sup>28</sup>

This approach could be a reasonable way to achieve the goals outlined above. However, it is important to note that the development, validation, selection, refinement, and integration of performance measures should be a multilevel process that takes advantage of the most recent scientific evidence on quality measurement and has broad inclusiveness and consensus among stakeholders in the medical and professional communities. This entire process should be transparent to the medical community. Measures should be field-tested to the extent possible prior to adoption. **The College also recommends that Congress ensure that the measurement targets remain patient-centered and reflect potential differences in benefits/harms for specific populations.**

Further, the College continues to recommend that all measures, whether developed by a specialty society, federal agency, or other experts, go through a multi-stakeholder evaluation process, a role that currently is performed by the National Quality Forum (NQF). The MACRA law is also supportive of the development and implementation of patient registries. Qualified clinical data registries (QCDRs) involve a systematized method for collecting patient-based data that are often used to help clinicians understand and improve their practice, as well as improve the care they provide to those with chronic conditions—some physician societies have already implemented extensive and robust registry programs while others are still in the development phase. **Congress should continue to support the development and implementation of QCDRs to improve health care for those with chronic conditions.**

#### **4. *The effective use, coordination, and cost of prescription drugs;***

##### **Part D**

**The College recommends legislation that significantly reduces or removes the cost-sharing requirement for a defined set of evidence-based common chronic condition/medication pairings.** A recent Congressional Budget Office (CBO) report<sup>29</sup> reflects that there is a substantial body of evidence indicating that people respond to changes in cost-sharing by changing their consumption of prescription drugs. Furthermore, the increased utilization of these medications improves health and decreases overall medical spending. This evidence has led to a policy change within the CBO that

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<sup>28</sup> <http://www.brookings.edu/~media/research/files/papers/2015/01/012715-medicare-physician-payment-refom-web.pdf>.

<sup>29</sup> Congressional Budget Office “Offsetting Effects of Prescription Drug Use on Medicare’s Spending for Medical Services” (November 2012). Available at <https://www.cbo.gov/sites/default/files/43741-MedicalOffsets-11-29-12.pdf>

recognizes the medical cost offset from altering the cost-sharing structure of the Part D program to decrease or remove the amount of beneficiary contribution.

Research also reflects that lack of prescription drug adherence and polypharmacy contribute substantially to high spending within the Medicare population; particularly for beneficiaries with multiple chronic conditions.<sup>30</sup> Approaches such as medication therapy management with medication reviews, chronic disease self-management, and medication synchronization have been found successful in addressing these issues. **The College recommends legislation calling for MedPAC to evaluate and make recommendations to Congress regarding changes within the Medicare program to promote increased adherence to prescribed medications and decreased polypharmacy.**

### **Prescription Drug Pricing**

Additionally, the College is very concerned about rising prices of prescription drugs including specialty drugs, which include many drugs for chronic conditions, and generic drugs, some of which have experienced hundred fold increases. Some of these drugs, such as Imatinib (Gleevec) for the treatment of chronic myeloid leukemia must be taken for the rest of the patient's life and can cost tens of thousands or hundreds of thousands of dollars per year. Therefore, the College has joined the Campaign for Sustainable Rx Pricing,<sup>31</sup> a project of the National Coalition on Health Care, whose primary goal is to foster a national dialogue on the pricing of new high cost drug therapies. **The College recommends that Congress engage representatives of the pharmaceutical industry, health plans, patients, physicians, and other stakeholders in ongoing discussions about the 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.**

**Finally, the College continues to recommend that the Medicare program be able to negotiate volume discounts on prescription drug prices and pursue prescription drug bulk purchasing agreements, just as is done by the Veterans Administration.**

### ***5. Ideas to effectively use or improve the use of telehealth and remote monitoring technology;***

### **Telehealth**

Telehealth technologies have been shown to hold great potential in improving the efficiency and providing cost savings to the health care system. The use of telehealth for chronic care is an especially promising model. A 2014 review of available literature on the use of telemedicine interventions in the management of three chronic health conditions found benefits to this model including reduced hospital admissions or readmissions, reduced length of hospital stay, and decline in emergency room

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<sup>30</sup> IMS Institute for Healthcare Informatics, "Avoidable Costs in U.S. Healthcare: The \$200 Billion Opportunity from Using Medicines More Responsibly," June 2013. Available online at <http://www.imshealth.com/portal/site/imshealth/menuitem.c76283e8bf81e98f53c753c71ad8c22a/?vgnnextoid=12531cf4cc75f310VgnVCM10000076192ca2RCRD>

<sup>31</sup> <http://www.csrpx.org/>

visits.<sup>32</sup> However, the research is not entirely consistent. A systematic review of studies on telemedicine including all e-health interventions found 21 reviews reporting telemedicine as effective but 18 that found the evidence on telemedicine is “promising but incomplete.”<sup>33</sup> **The College supports the ongoing commitment of federal funds into research on the safety, efficacy, and cost-effectiveness of telehealth activities, including the use of remote monitoring technology and the use of telehealth generally in the management of chronic conditions.** A strong evidence base on the use of telehealth in various settings for various conditions will help to inform the development of best practices and the most efficient use of telehealth services.

Reimbursement is one of the most significant barriers to the adoption of telehealth, particularly in Medicare. Traditionally, Medicare has narrowly confined telehealth reimbursement to real-time interactive audio/visual communications at an approved originating site by approved physicians for certain services. The limited and sometimes complex reimbursement policies for telehealth services have fostered reluctance among some physicians to adopt or use these technologies for their patients. The College supports reimbursement for appropriately structured synchronous and asynchronous telehealth as it may be a clinically appropriate comparable service alternative to a face-to-face encounter. The College applauds efforts that have been made recently to expand Medicare coverage for telehealth services such as the provision in CMS’s 2015 Physician Fee Schedule allowing for coverage of remote chronic care management that had not been previously reimbursed, including remote patient monitoring.

#### **6. *Strategies to increase chronic care coordination in rural and frontier areas;***

##### **Rural Hospitals**

Efforts have been made by Congress over the years to address the economic discrepancies that exist in rural health care. However, despite these efforts, 53 rural hospitals have closed in the past 5 years, creating barriers to health care access for individuals who live in those communities.<sup>34</sup> **The College recommends that Congress require a study on the impact that flat or reduced payment rates to rural health centers, particularly sole community hospitals and critical access hospitals, has on health care access for Medicare beneficiaries, in particular those with chronic conditions. The College also recommends that any study into these complex financial issues also includes an evaluation of how rural hospitals utilize telehealth technology and how telehealth may affect the economic sustainability of these hospitals.**

#### **7. *Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers; and***

##### **Transparency**

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<sup>32</sup> Bashur RL, Shannon GW, Smith BR. The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management. *Telemed J E Health*. 2014 Sep; 20(9): 769-800. doi 10.1089/tmj.2014.9981.

<sup>33</sup> Ekeland AG, Bowes A, Flottorp S. Effectiveness of telemedicine: a systematic review of reviews. *Int J Med Inform*. 2010 Nov; 79(11): 736-71.

<sup>34</sup> <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>.

Given the high degree of healthcare utilization by Medicare beneficiaries with chronic conditions, it is important that the quality and cost of services provided are transparent to ensure that beneficiaries are obtaining good value from their health care decisions. **The College 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.** 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. Qualified Health Plans in the state and federal insurance exchanges should also be required to provide cost data that reflects both in-network and out-of-network costs as part of this legislation.

### **Shared Decision-Making and Patient Self-Management**

**The College strongly encourages Medicare to support approaches that allow for true shared decision-making and patient self-management, particularly for those with chronic illnesses.** There are a number of tools available today to help. For instance, ACP and the Alliance for Academic Internal Medicine (AAIM) provide a high-value, cost-conscious care curriculum to help train internal medicine residents about how to avoid overuse and misuse of tests and treatments that do not improve outcomes and may cause harm. The free curriculum, available at [www.highvaluecarecurriculum.org](http://www.highvaluecarecurriculum.org), is designed to engage internal medicine residents and faculty in small group activities organized around actual patient cases that require careful analysis of the benefits, harms, costs, and use of evidence-based, shared decision-making.

Additionally, 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. 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.

- 8. *Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.***



### **Specialty Practice (Medical Neighborhood) Recognition**

The benefits of the PCMH model that were outlined earlier should also be enhanced through supporting the other clinicians in the medical neighborhood that are providing patient-centered coordinated care, particularly for those with chronic conditions. Therefore, ACP is appreciative that MACRA does recognize the value of patient-centered specialty practices within the MIPS program, by providing such practices maximum points within the Clinical Practice Improvement Activities performance category. This approach reflects the value of non-primary care specialty/ subspecialty practices in delivering care with a patient-centered, integrated/coordinated, and high quality focus. **The College therefore 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.** The College has also developed a toolkit for specialty practices to promote high-value care coordination that may be of help in implementing such a demonstration project.<sup>35</sup>

### **Integration of Behavioral Health into Primary Care**

**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 and substance use disorders alone will surpass all physical diseases as a major cause of disability worldwide.<sup>36</sup> Behavioral health and medical comorbidity is a widespread problem—one estimate determined that 34 million American adults had mental health and medical conditions in a 12-month period.<sup>37</sup> Comorbidity presents a barrier that affects treatment adherence, outcomes, and health costs. It also impacts patient mortality as patients with behavioral health problems die at an earlier age than those without. Despite these issues, many chronically ill patients do not receive care for behavioral health conditions. For example, only about one-third of diabetes patients with mental and physical comorbidities receive diagnosis and treatment for their mental condition.<sup>38</sup>

Most chronically ill patients with non-serious behavioral health needs access the health care 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 and 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

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<sup>35</sup> [https://hvc.acponline.org/physres\\_care\\_coordination.html](https://hvc.acponline.org/physres_care_coordination.html)

<sup>36</sup> Substance Abuse and Mental Health Administration. Increasing Collaboration, Cultural Competence and Quality of Care. October, 2012. <http://www.samhsa.gov/sites/default/files/collaboration-cultural-comp-qoc.pdf>

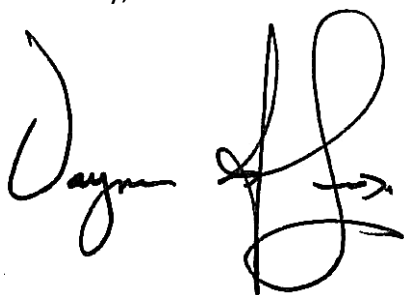
<sup>37</sup> Druss BG and Walker ER. Mental disorders and medical comorbidity. Robert Wood Johnson Foundation. Research Synthesis Report, No. 11. February 2011. Accessed at <http://www.rwjf.org/content/dam/farm/legacy-parents/mental-disorders-and-medical-comorbidity>

<sup>38</sup> Ducat L, Philipson LH, Anderson BJ. The Mental Health Comorbidities of Diabetes. *JAMA*. 2014;312(7):691-692.

and confidentiality laws may complicate the sharing of behavioral health information.<sup>39</sup> 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.

The College appreciates this opportunity to share its recommendations with the Senate Finance Committee for how to improve the Medicare program for patients with chronic conditions. Please contact Brian Buckley, [bbuckley@acponline.org](mailto:bbuckley@acponline.org), if you have any questions or would like additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Wayne J. Riley". The signature is fluid and cursive, with the first name "Wayne" written in a larger, more prominent script than the last name "Riley".

Wayne J. Riley, MD, MPH, MBA, MACP  
President  
American College of Physicians

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<sup>39</sup> [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2014/rwjf409991](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409991)