ACP
American College of Physicians
Internal Medicine | Doctors for Adults®

December 7, 2011

Jonathan Blum
Deputy Administrator and Director, Center for Medicare
Centers for Medicare and Medicaid Services
200 Independence Avenue, S.W.
Washington, D. C. 20201

Re: Payment for Chronic Care Coordination and Transition of Care

Dear Mr. Blum:

The American College of Physicians (ACP) is writing to follow up on our meeting with you and Jeffrey Kellman on August 26, 2011 at which we discussed the Centers for Medicare and Medicaid Services (CMS) proposal to have the RUC review all Evaluation and Management (E/M) Services. ACP represents 132,000 internal medicine physicians and medical student members. Internists specialize in primary and comprehensive care of adolescents and adults. During the August meeting we articulated our concerns about such a review and are grateful that you understood those concerns and that CMS withdrew its proposal. We also understand that CMS is interested in addressing what it has heard about inadequate payments to primary care physicians and that CMS is interested in looking at ways to make appropriate payment for chronic care provided to Medicare beneficiaries with multiple chronic conditions.

We realize that CMS is looking at many options for improving care by implementing new models of care delivery and payment systems. However, it may be a number of years before those programs have a widespread impact on Medicare beneficiaries and it is unclear whether they will replace or supplement the fee-for-service program. Given that the vast majority of Medicare beneficiaries currently receive care through the fee-for-service program, ACP recommends that CMS take steps to improve chronic care delivery and care coordination for those patients as soon as possible (i.e., in the proposed rule for CY 2013). ACP acknowledges that taking the steps we recommend in this letter will not solve all the payment policy issues facing internal medicine physicians and other primary care physicians, or completely address the unmet medical needs of Medicare beneficiaries with multiple chronic conditions. However, implementing our recommendations would provide immediate benefits to vulnerable Medicare beneficiaries and would be an important start from which lessons will be learned that can inform additional improvements, both within the fee-for-service program and in new payment

models, including patient-centered medical homes (PCMHs) and accountable care organizations (ACOs).

Therefore, we are writing to make two specific coding and payment recommendations for CMS to consider including in its proposed rule for CY 2013, based on a number of concepts that we discussed during our meeting. As described below, the recommended codes would provide additional payment for providing chronic care to frail, vulnerable patients who are functionally impaired and require the ongoing assistance of a caregiver, and to physicians who are responsible for transitioning care of a patient from an inpatient site of care to a home, domiciliary, or other similar site of care.

The care described by these proposed codes is typically delivered by internal medicine physicians, or other primary care physicians, to patients who are prone to readmissions to an acute care hospital or visits to the emergency department, which can potentially be avoided through appropriate chronic care or properly managed transitions from hospital care to home care.

Appropriate payment to primary care physicians caring for frail patients with functional impairment and for those transitioning to home care is important for a number of reasons:

- It sends a strong signal that CMS is committed to improving the care of these vulnerable patients.
- It would help CMS achieve its goal of reducing unnecessary readmissions and further align hospital and physician incentives in this regard. Until now CMS has focused largely on the hospitals role in arranging for follow up care but the reality is that the patient's primary care physician is frequently the individual who is responsible for the transition and who does most of the work.
- It would allow CMS to more easily track transitions of care, better understand how care during transitions is being delivered, by whom it is being delivered, and whether it is successful in avoiding readmissions.
- It is also a first step toward the goal of appropriately reimbursing primary care providers who use a team approach to care for frail vulnerable patients—in the fee-for-service environment, as well as in ACOs as they track care and internally allocate resources for the care of these patients.
- The physician and clinical staff work described in the two codes we propose below is not included in any current evaluation and management (E/M) service. Specifically, the work described in our proposed codes is not included in the pre-, intra-, or post-service work of any existing E/M code. We would be pleased to discuss this with you, as we have heard that there may be some disagreement over this issue. The history of these codes, dating back to the origination of the RBRVS, supports our contention.

ACP is also committed to participating in the Current Procedural Terminology/Relative Value Update Committee (CPT/RUC) workgroup process, which is intended to result in the submission of recommendations to CMS for codes and relative value units that describe a variety of chronic care services provided by primary care physicians. However, it is unlikely that those recommendations will be developed in the near future

and certainly not in time for the proposed rule for CY 2013. ACP does not think that it is necessary to wait for the CPT/RUC workgroup to complete its work before taking any action in this area.

Chronic Care Code

CMS should establish the following HCPCS code:

> Chronic care management of a patient with functional impairment severe enough to require one or more caregiver to provide, on an ongoing basis, at minimum, the following: patient history, physical assistance, ongoing support for activities of daily living and, where authorized, decision-making for the patient; includes all non face-to-face care (e.g., coordination of care, telephone calls, on-line communications, refills) provided directly by or under the supervision of a physician; per 30 days, minimum of 30 minutes contact with the patient and/or caregiver

This will be a code intended for use by primary care physicians only and should only be billed by one primary care physician per month (at the conclusion of the 30 day period during which this care was furnished).

We understand that there will be implementation issues regarding payment for this service and we would be pleased to work with you to address them. For example: is this a completely stand-alone code or should payment vary based on whether there was a face-to-face service was provided during the month? What documentation requirements should be required? Should the code be billed if the only physician involvement is supervision? Should other codes such as those for home health or hospice certification be billed in the same month as the proposed chronic care management code? If the patient has more than one physician who qualifies as a primary care physician, what process, if any, needs to be established to assure that the correct primary care physician reports the service?

Transition of Care Code

CMS should establish the following HCPCS code:

> Transition care management for a patient transitioning from an inpatient site of care (e.g., acute care hospital, SNF) to an outpatient site of care (e.g., home, domiciliary) including review of the discharge note and plan of care, medication reconciliation, interaction with other health professionals (including the physician(s) responsible for care at the inpatient site) and caregivers, implementing the intended plan of care and arranging follow-up; per 30 days after discharge from inpatient care.

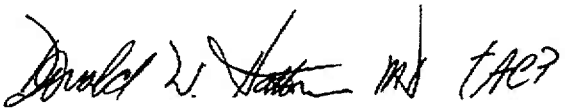
Our intent is for the patient's primary care physician to bill for this service. As with the chronic care code, we realize there are a number of implementation issues. For example:

should this code include one post discharge visit? Should the code include 30 days of care? How can CMS identify the physician who should bill for this service? Should non-primary care physicians be allowed to bill for this service?

We would like to schedule a meeting at your earliest convenience to discuss these proposals and any further steps that are appropriate to take. Again we thank you for the time and attention you have paid to this issue and we look forward to working on this important initiative to attain our common goal of improving care for Medicare beneficiaries and all patients with functional impairment.

Thank you for considering the ACP comments. Please contact Shari Erickson, Director, Regulatory and Insurer Affairs, by phone at (202) 261-4551 or e-mail to serickson@acponline.org if you have questions or need additional information.

Sincerely,



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