AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

RESPONSE TO THE POLICY OPTIONS DOCUMENT

THE SENATE FINANCE COMMITTEE'S WORKING GROUP ON CHRONIC CARE

JANUARY 27, 2016

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1. **Providing Medicare Advantage (MA) Enrollees with Hospice Care**
MA plans are not required to assume financial risk of their enrollees' hospice care. Rather, MA plans receive a reduced risk-adjusted capitated amount for health care items and services not related to the enrollees' terminal illness while Medicare Part A provides payment for each enrollee's hospice care.

The Working Group proposes to require MA plans to offer a hospice benefit. To do so would require changes in the quality measures for health outcomes and appropriate level of care.

The Working Group's Questions: What are specific plan-level measures that could be used to ensure MA hospice patients are receiving appropriate and high-quality care? What other safeguards that should be in place to ensure MA enrollees have access to high quality hospice services?

AAFP Response: The AAFP policy on hospice care defines hospice in terms of what it does rather than in what institution it occurs or how it is financed.

In general, the AAFP is supportive of the proposal to require MA plans to offer the hospice benefit, since they are otherwise required to provide all other benefits to which beneficiaries are entitled under Medicare. Requiring MA plans to offer the hospice benefit would have the advantage of maintaining continuity of care at a critical stage of the patient's life.

Continuity of care is essential to improved quality of care over time and is the process by which the patient and the care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost-effective medical care. The current separation of hospice care from MA represents a potential disruption of this continuity of care for MA beneficiaries who elect hospice.

Continuity of care is facilitated by an approach to health care that is based on a physician-led team. It reduces fragmentation of care and thus improves patient safety and the quality of care. Thus, the AAFP supports the role of family physicians in providing continuity of care to their patients in all settings, both directly and by coordination with other physicians and health care professionals. Ensuring that hospice care is facilitated by a physician-led health care team is one of the safeguards for ensuring MA enrollees have access to high quality hospice care.

Other steps toward that same goal include:

- Control of pain and other symptoms through medication, environmental adjustment and education
- Psycho-social support for both the patient and family, including all phases from diagnosis through bereavement
- Medicare services commensurate with the needs of the patient
- Physician-led interdisciplinary team approaches (which include clergy, social workers, nurses, counselors, therapists and others) to patient and family support and education
- Integration into existing facilities
- Specially trained personnel with expertise in care of the dying and their families
- Education regarding the use of hospice early in the diagnosis of the terminal illness to assist the patient and family as early as possible
- Promotion among beneficiaries and families of the fact that hospice does not involve hastening or prolonging the dying process

2. Improving Care Management Services for Individuals with Multiple Chronic Conditions
The Centers for Medicare and Medicaid Services (CMS) has begun to pay for Chronic Care Management (CCM) services using CPT code 99490 under specific circumstances. The payment for this code averages $42, which also requires from the patient a copayment of about $8.

The Working Group has offered a suggestion that a new high-severity chronic care management code be available in the Medicare physician fee schedule.

The Working Group's Questions: What should be the criteria for determining that a patient is eligible for the designation of having multiple-chronic conditions for purposes of charging services to this code? What providers should be eligible to bill for it? Who are the providers who offer "comprehensive, ongoing care to a Medicare beneficiary over a sustained period of time"? How should the impact, effectiveness and compliance related to the services offered by those who bill this code be measured? Should this be a permanent code, a temporary one that CMS has to evaluate over time, or a temporary code that can be extended and broadened by the Secretary of HHS based on specific criteria?

The AAFP Response: The AAFP strongly supports the inclusion (by CMS regulation and by authorization in the *Medicare Access and CHIP Reauthorization Act*, or MACRA) of the Chronic Care Management (CCM) services using CPT code 99490 in the Medicare physician fee schedule. The AAFP believes that Medicare coverage and payment for this code represents a step in the right direction toward paying for care management on a per-patient per-month basis using a risk-adjusted care management fee. Physicians and other health care professionals can use code 99490 for non-face-to-face services provided to beneficiaries with two or more chronic conditions who require at least 20 minutes of clinical staff time of chronic care management in a given calendar month.

Unfortunately, the current payment policy related to code 99490 represents a one-size-fits-all approach that ignores the fact that different patients will require different levels or intensities of chronic care management and thus will consume variable amounts of physician work and practice expenses. With this in mind, the AAFP supports the concept of paying for additional chronic care management codes.

Specifically, the AAFP supports Medicare payment for CPT codes 99487 and 99489. These codes describe complex chronic care management services. Like code 99490, these codes are for services provided to patients with two or more chronic conditions that are expected to last at least 12 months or until the death of the patient, and which place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline. Unlike code 99490, they require a more intense level of chronic care management, since code 99487 involves 60 minutes of clinical staff time and 99489 involves an additional 30 minutes beyond that.

The AAFP believes that primary care physicians are the most appropriate providers of chronic care management, since they are specifically trained for and skilled in comprehensive, first-contact and continuing care for persons with any undiagnosed sign, symptom or health concern (i.e., the "undifferentiated patient") not limited by problem origin (biological, behavioral or social), organ system or diagnosis. The primary care specialties include family medicine, geriatric medicine, general internal medicine, and general pediatric medicine.

Family physicians and other primary care physicians provide their patients with comprehensive and ongoing care over a sustained period of time. We believe that chronic care management services

are part of a broader payment strategy that recognizes and pays primary care physicians for the care management and coordination services they provide to their patients and the health care system in this context of comprehensive and ongoing care.

Impact and effectiveness are best measured through a practice's performance on the relevant measures for the eligible chronic conditions contained in the Core Measures Collaborative PCMH/ACO/Primary Care Core Measure set.

In a fee-for-service environment, compliance with Medicare payment policy for these services will need to be measured in ways similar to the way compliance is measured for other services: automated claims review where possible and targeted medical chart review for suspected outliers. For instance, CMS should be able to determine from diagnosis codes on a patient's claims whether or not he or she has two or more chronic conditions.

In any case, it typically takes several years for practices to adopt and use new codes; thus, the impact and effectiveness of the code must be measured over several years. Studies should examine patient experience as well as resource use and quality outcomes.

Given the complexities inherent in CCM service codes, the AAFP sees it as indicative that care management is not well suited for a fee-for-service payment structure. Thus, as noted, the AAFP urges CMS and other payers to move as soon as possible to a risk-adjusted, capitated, monthly payment for primary care management services. We believe it would be simpler and more efficient to pay for care management on a risk-adjusted, per-member per-month basis, as is done under the Comprehensive Primary Care (CPC) Initiative.

Like the chronic care management service (99490) for which Medicare now pays, the other service codes, 99487 and 99489, will require several years for practices to incorporate into their practice. Accordingly, Medicare should view those codes as something more than just temporary. At the same time, the AAFP hopes that these codes will not be permanent and that Medicare will move towards paying care management on a risk-adjusted, capitated basis in time which is not dependent on CPT coding.

3. Increasing Convenience for Medicare Advantage Enrollees through Telehealth

Medicare beneficiaries may receive telehealth services in only limited circumstances. Medicare offers payment for these services only to (1) physicians at a site distant from the patient and (2) the facility to which the patient must travel. MA plans have some additional flexibility in offering telehealth services at their own discretion, but Medicare does not pay for them separately or provide any incentives for their use.

The Working Group would like to consider whether MA plans should be allowed to include certain telehealth services in their annual bid amount.

The Working Group's Questions: Should MA plans' telehealth services be limited to those allowed under traditional Medicare? What additional telehealth services should Medicare provide?

AAFP Response: Regarding eligibility for payment, it should not matter whether a patient service is rendered in person or through telemedicine. If it is a valid service, it should be paid whether it was performed face-to-face or virtually. This should hold true for traditional Medicare, Medicare Advantage, and Medicare ACOs. Thus, MA plans' telehealth services should not be limited to those currently allowed under traditional Medicare, and traditional Medicare should expand its coverage of

telehealth services in such a way that it focuses on the service provided and not the means by which it is provided. In other words, if traditional Medicare covers a service when provided in-person, it should cover the same service provided by means of telehealth, assuming the service otherwise meets Medicare coverage requirements.

4. Providing ACOs the Ability to Expand Use of Telehealth

Like MA plans, ACOs do not receive any separate payment for providing telehealth services.

The Working Group is considering whether Medicare should be allowed to waive the geographic component of the originating site requirements for ACOs in the Medicare Shared Savings Program as a condition for payment.

The Working Group's Questions: Should the originating site requirement be eliminated entirely or should Medicare just specify additional sites? How can Medicare require proper clinical equipment for additional originating sites?

AAFP Response: Telehealth can provide effective care for patients as well as provide improved access and convenience. It does not make sense to limit these valuable and cost saving services to specific geographies. The restrictions should be lifted. The capital equipment costs for an originating site have plummeted since the enactment of the policies limiting originating sites based on geography. Telehealth is a particular benefit for rural physicians and other practitioners since it would help them deliver care to their patients, especially to those who have travel barriers.

In sum, payment should be made for physician services that are reasonable and necessary, safe and effective, medically appropriate, and provided in accordance with accepted standards of medical practice. The technology used to deliver the services should not be the primary consideration; the critical test is whether the service is medically reasonable and necessary. Care provided via telemedicine should be paid as other physician services.

5. Expanding Use of Telehealth for Individuals with Stroke

Stroke victims may be treated by telehealth if the originating site, where the patient is located, is in a rural Health Professional Shortage Area (HPSA) or a county outside an MSA.

The Working Groups is proposing that the restrictions on the originating site be eliminated for the narrow purpose of promptly identifying and diagnosing strokes.

The Working Group's Question: Should these restrictions be eliminated for this one purpose and be retained otherwise?

AAFP Response: The AAFP recognizes that the prompt diagnosis and treatment of strokes can save lives and decrease costs to Medicare and its beneficiaries over time. Consequently, the AAFP supports eliminating the restrictions on the originating site related to diagnosis and treatment of strokes by telehealth.

Further, the AAFP recognizes that telehealth can provide effective care and improved access and convenience for more than just stroke patients. From our perspective, it does not make sense to limit these valuable and cost saving services to specific conditions or geographies. Thus, we do not see the clinical reasoning to limit this policy change to stroke patients only. Instead, the restrictions

in question should be eliminated for more than just the diagnosis and treatment of stroke and should not be retained for other conditions.

6. Ensuring Accurate Payment for Chronically Ill Individuals

Payments to MA plans are risk-adjusted using the CMS Hierarchical Conditions Category (HCC) Risk Adjustment Model. It takes into account factors such as demography, enrollees' health history and severity of illness, among others.

The Working Group considered suggesting that the HCC model should take into account changes in predicted costs associated with the total number of conditions and with the interaction between behavioral/mental health conditions and physical conditions. Furthermore, it should include differences in cost associated with beneficiaries who are dually eligible for both Medicare and Medicaid; and it should use more than one year of data to establish a beneficiary's risk score.

The Working Group's Questions: What other potential changes to the HCC model should be applied? Should there be any differences in the risk adjustments for different payment models, like MA and ACO?

AAFP Response: In addition to the factors already identified regarding dual eligibility and behavioral health, when assigned, enrollees also need to be risk-stratified by race, ethnicity, gender, and other demographic variables to enable physicians to identify and reduce disparities among vulnerable populations. For example, how far a patient is located from safe "green space" or a local grocery store could impact the patient's health outcomes. With physicians participating in multiple payment models and patients moving in and out of various plans, the adjustments made should be applied uniformly across all payment models.

7. Providing Flexibility for Beneficiaries to Be Part of an ACO

Under specific conditions, Medicare beneficiaries are assigned to an ACO.

The Working Group looked at allowing beneficiaries to choose assignment to an ACO in which their main provider is participating. Beneficiaries would retain their freedom of choice to see any provider if assigned to an MSSP ACO.

The Working Group's Questions: Should beneficiaries who voluntarily choose assignment to an ACO still be allowed to receive services from providers outside the ACO?

Should ACOs that are assigned beneficiaries prospectively receive an upfront payment for all services provided to those beneficiaries?

Should ACOs that provide services to beneficiaries who voluntarily choose assignment to that ACO receive an upfront payment for these services?

The AAFP Response: The voluntary choice by a patient of a primary care physician is necessary in achieving the goal of patient-centeredness. The AAFP has maintained that prospective and voluntary assignment to ACOs is preferable to retrospective assignment, since prospective attribution increases patient engagement with a usual source of primary care and does not impinge on patient choice. In addition, providing physicians with a prospective list of patients for whom they are responsible facilitates proactive population management, which leads to improved outcomes. In contrast, retrospective attribution methodologies are particularly burdensome to physicians,

because it is challenging for physicians to engage in effective population health management if they do not know which patients are to be targeted for delivery, management, and coordination of care.

CMS has reported that of the 477 Medicare ACOs across the four different models—Pioneer, Shared Savings, Next Generation, and Comprehensive End-Stage Renal Disease Care—64 are risk bearing. This is part of the effort to make the ACO accountable for health care costs while maintaining needed medical services.

Therefore, given the accountability required of ACOs, beneficiaries may have to be encouraged to use services from providers inside the ACO, unless access is an issue or there are other exceptional circumstances. Essentially, an ACO is a network of providers, and if a beneficiary seeks care outside the ACO, then out-of-pocket costs should apply. This is not to say patient choice of providers should be reduced. However, patients seeking care outside of an ACO (if the ACO provides the services) can undermine the ACO's effectiveness. The mechanism and structure of an ACO are designed to manage population health, through enhanced coordination and management among a defined provider group, with clinical, cost, and outcomes data shared among providers. Integrating physicians and providers, facilities, and EHRs to manage and coordinate care seamlessly for a defined population is a herculean task. When a patient goes outside the ACO to receive services that the ACO offers, the patient diminishes the ability of that ACO to accomplish its goals of better patient care and improved outcomes at lower costs.

Physician and patient participation in an ACO should be voluntary, and the benefit structure should encourage patients in an ACO to select a primary care physician. For example, ACOs should be allowed to encourage patients who voluntarily enroll in an ACO to choose to receive primary care within the ACO through incentives such as lower copayments and coinsurance.

The AAFP calls for payments for primary care services to be made on a per-patient basis through the combination of a prospective global payment for direct patient care services and a global care management fee. The global payment for primary care services would capture the "core primary care" services, a majority of which are provided by family physicians. Any services provided by the family physician that fall outside the core primary care set of services would be paid for on a fee-for-service basis, through an appropriate bundle, or via another global payment structure. The global care management fee would capture those services performed by the physician or practice that contribute to the continuity and coordination of care, promote compliance and adherence, and facilitate appropriate use of health care resources.

8. Developing Quality Measures for Chronic Conditions

The 2015 *Medicare Access and CHIP Reauthorization Act* (MACRA) that attempts to restructure Medicare physician payment to be value-based requires HHS to propose a plan for the development of the quality measures that will be used in the new payment models.

The Working Groups is considering whether HHS should include in its quality measures plan the development of measures that focus on the health outcomes of those with chronic disease.

The Working Group's Questions: Should the Quality Measures Plan include measures for patient and family engagement, shared decision making, care coordination, hospice and end-of-life care, and Alzheimer's and dementia?

Should the plan include community-level measures in areas like obesity, smoking prevalence and diabetes?

The AAFP Response: The AAFP strongly recommends that the Working Group advocate for the use of the the multi-stakeholder Core Measures Collaborative's Core Quality Measures Set to ensure alignment, harmonization, and the avoidance of competing quality measures among payers. These sets contain a variety of measure targeting different services related to chronic conditions, prevention, and over/underuse.

Key stakeholders of this Collaborative include the CMS, America's Health Insurance Plans (AHIP), individual health plans, and provider, consumer, and employer groups. This important effort uses a multi-stakeholder process to define core measure sets and thus promotes alignment and harmonization of measure use and data collection across public and private payers. This process recognizes high-value, high-impact, evidence-based measures that promote better patient health outcomes. It also provides useful information for clinical improvements, decision-making, and payment.

Additionally, this measure-development process aims to reduce the burden of measurement and volume of measures by eliminating low-value metrics, redundancies, and inconsistencies in measure specifications and reporting requirements across payers. The Collaborative uses an iterative process that always seeks to include better and more desirable measures. The latest and most-updated version of the PCMH/ACO/Primary Care Core Set should always be used in this model.

Regarding patient engagement, the Core Set includes use of the Clinician and Groups Consumer Assessment of Healthcare Providers and Systems (CAHPS) to evaluate patient experience. However, this assessment comes with great expense and is resource intensive, especially for smaller practices; therefore, the Core Quality Measures Collaborative effort suggests that payers provide the CAHPS survey to physician offices and their patients free of charge through an online process. This approach would remove the financial burden associated with CAHPS implementation to assess patient experience. The AAFP supports this approach.

If new measures are considered, there should be a sustained effort to be sure they are focused and harmonized across public and private payers.

9. Encouraging Beneficiary Use of Chronic Care Management Services

Medicare pays for Chronic Care Management (CCM) services that are not provided face to face under specific conditions. However, patients are responsible for a 20-percent co-payment (approximately $8) for these services. Since billing physicians must collect these co-payments from patients who are confused about the service provided, physicians have been reluctant to use this code.

Because of the value of the CCM services, the Working Group is studying the option of stipulating that the beneficiary co-payment associated with the CCM code be waived. To be consistent, if Medicare establishes a high-severity chronic care code (see option #2), the Working Group would consider further stipulating that the co-payment for this code should be waived, as well.

The Working Group's Questions: To what extent would waiving this co-payment encourage beneficiaries to use these services, especially since many have supplemental Medigap policies that would cover these co-payments?

Would eliminating the co-payment for these non-face-to-face services alleviate beneficiary concerns that their summary of benefit notices include services that they did not receive, since they were provided outside of the office visit?

Would eliminating the co-payment encourage more physicians to offer these services, given that the burden of collecting the small co-payment from confused patients is removed?

The AAFP Response: To improve utilization of these services, the AAFP strongly recommends the elimination of the beneficiary's cost sharing (i.e., deductible and coinsurance) for all chronic care management services. These services do not currently fall under the Medicare preventive services umbrella, even though care management also serves to prevent chronic conditions from worsening and, thus, prevents the utilization of other, more costly services, such as inpatient hospital and emergency room care. Given the early results of CMS's Comprehensive Primary Care Initiative, we believe the costs to the Medicare program would be minimized by reductions in avoidable expenditures on other services.

Under the CCM code, absent supplemental coverage, the beneficiary is responsible for co-payment of about $8 a month, whether or not the patient sees the doctor in a separate face-to-face encounter. This has led to beneficiary confusion and to the administrative difficulty of collecting the beneficiary's share of the payment. Some beneficiaries also are unable or unwilling to enroll in a recurring monthly service that carries an additional patient charge. Given the high value of this service, the AAFP believes that chronic-care management should be available without beneficiary cost sharing.

Beyond removing the burden of collecting small copayments, as well as the financial burden on Medicare beneficiaries—half of whom live on incomes of about $25,000 or less—eliminating the copayment will encourage more family physicians to offer these services, because it will make the necessary conversation between the beneficiary and the practice required to get beneficiary's consent an easier conversation.

We would anticipate that eliminating the copayment would help reduce, to a large degree, the concerns of Medicare beneficiaries. The billing for the services will still appear on the Medicare summary of benefits notice even if there is no financial responsibility. While there may still be some confusion, to the extent that there is no financial responsibility, the concern attached to that confusion on the beneficiary's part should be mitigated.

10. Establishing a One-Time Visit Code for Post Initial Diagnosis of Alzheimer's Disease or Dementia or Other Serious or Life-Threatening Illness

Medicare does not pay for an office visit in which a physician may discuss with a patient the issues associated with a diagnosis of long-term, serious or life-threatening illnesses, like Alzheimer's disease or dementia.

The Working Group may propose that CMS implement a one-time payment to clinicians to recognize the additional time needed to have conversations with beneficiaries who are diagnosed with serious, long-term and life-threatening illnesses.

The Working Group's Questions: What is the scope of diseases that would be eligible for such a Medicare-covered office visit? Is the nature of certain illnesses more conducive to dedicated, covered planning visits upon diagnosis than other serious, chronic conditions? Who should be

eligible to bill for this service? Should the discussion requirements be different for different illnesses? Will these specific requirements be manageable for visits with patients who have multiple eligible conditions? How will this code interact with the CCM code and a possible new high-severity CCM code to prevent duplicate payments?

AAFP's Response: Unfortunately, creating an additional series of disease-specific codes, each with its own discussion and documentation requirements, will not help foster the discussions for which the Working Group is looking. In fact, such E/M codes will compound the problem and be a nightmare, particularly for primary care physicians who offer comprehensive care covering multiple serious and life-threatening conditions, which often occur simultaneously in the patient. Patients are not simply a collection of conditions or diseases. Rather, they benefit from a whole-person orientation to their care. That orientation is one of the hallmarks of primary care in general and family medicine in particular. The most direct path to improved care for Medicare patients who are diagnosed with serious or life-threatening illnesses is better support for primary care.

To that end, the AAFP would encourage the Working Group to consider proposals that move payment for primary care away from the fee-for-service model with its dysfunctional and undervalued E/M codes and associated documentation guidelines to a model in which primary care is paid globally. Until that occurs, we need to revalue current fee-for-service payment for primary care. Medicare does pay for an office visit in which a physician discusses with a patient the issues associated with the diagnosis of long-term, serious, or life-threatening illnesses. Physicians typically report such visits using office visit evaluation and management (E/M) codes 99201-99215 based on time, assuming that counseling and coordination of care consume more than half of the face-to-face time with the physician. Time spent in such visits extending beyond the typical time of the upper level codes (99205 and 99215) would be reported using prolonged services codes 99354 and 99355.

To the extent that the Working Group believes it is imperative that a discussion between the patient and the physician occurs upon diagnosis, consider a close examination of the current E/M codes, their payment levels, and the associated documentation guidelines. The Medicare fee-for-service system rewards physicians for doing things to patients (procedures, tests, etc.) rather than for talking with and listening to their patients (E/M services). Thus, the discussions the Working Group envisions are undervalued in the current fee schedule. Revaluing existing codes, then, is preferable to creating new ones.

Before revaluing the E/M codes, we must be sure that they appropriately describe and capture the range of work done in physician offices. Some evidence suggests that the 10 E/M office visit codes mask a much larger range of services. That evidence also suggests that office visits in a primary care setting are quantitatively and qualitatively different from those in other specialty settings. The current E/M codes do not capture those differences. If Medicare is going to more appropriately pay for E/M services, CMS must first re-examine how office-visit E/M codes are defined and described.

Whether or not Medicare redefines or revalues existing E/M codes, it must re-examine the documentation guidelines that it applies to those codes. The E/M documentation guidelines are about 20 years old. They were written at a time when electronic health records (EHRs) were not commonly used and at a time when office visits were primarily physician-driven. Today, EHRs are typical in physician offices, and E/M services are team-based and patient-centered. In short, the way E/M services are delivered has changed but the E/M documentation guidelines have not. An overhaul is long overdue. At a minimum, the Working Group should ask the Government Accountability Office to study the impact of the E/M documentation guidelines on both clinical care and program integrity, with an added focus on whether to improve the current E/M coding structure.