Association of
American Medical Colleges
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399
T 202 828 0400 F 202 828 1125
www.aamc.org

January 26, 2016

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Mark R. Warner
Senate Finance Committee
United States Senate
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

The Association of American Medical Colleges (AAMC or the Association) appreciates the continued efforts of the Senate Finance Committee (SFC) to improve care for Medicare patients with chronic conditions. The association supports the three goals articulated in the *Bipartisan Chronic Care working Group Policy Options Document:* increasing care coordination among individual providers across care settings who are treating individuals living with chronic diseases; streamline Medicare's payment system to incentivize the appropriate level of care, and facilitate the delivery of high quality care. The AAMC welcomes the opportunity to provide comments on the selected issues below.

Adjustment for Socio-Demographic Status: An Important Component of Chronic Care Management Policies

As discussions continue about policies to address the care for chronically ill patients, it is essential to keep in mind the need for a socio-demographic status (SDS) adjustment for accountability measures used in hospital and physician reporting and performance programs. Recent studies have clearly demonstrated that SDS variables (such as income and education, etc.) are risk factors for adverse outcomes, particularly readmissions. Hospitals and physician group practices that care for vulnerable patient populations are disproportionately disadvantaged when SDS factors are not accounted for in the payment scoring methodology. The AAMC believes that there are numerous ways to appropriately adjust for SDS, including incorporating SDS factors in the measure's risk adjustment methodology, or stratifying provider performance by SDS variables.

More generally, the AAMC strongly believes that all quality measures should be NQF endorsed prior to inclusion in a reporting or performance program. NQF endorsement demonstrates that a measure has been tested, is reliable, and can be used in a specific setting. In addition, all quality measures should be publicly reported for at least one year, in order to allow providers to gain experience with the measure, before it is used in a pay-for-performance program. The Association also believes that any new hospital

or physician pay-for-performance quality program should explicitly recognize and reward improvement on quality measure outcomes. The AAMC is available to discuss this further with Senate Finance Committee staff.

Expanding the Independence At Home (IAH) Model of Care (p.6)

The AAMC supports the SFC proposal to expand the IAH demonstration that pays qualifying medical practices fee for service payments for services furnished and makes them eligible for incentive payments if they meet performance standards on quality measures and if annual expenditures are less than an estimated spending target.

The AAMC has several suggestions in response to the request for ways other than the Hierarchical Condition Categories (HCC) score to identify chronic care beneficiaries since the HCC score used in isolation is not an accurate measure for this purpose. For example, the HCC risk scores are based on the prior calendar year's diagnoses and demographic factors. This means that it would not account for a patient who was healthy and then suddenly developed a chronic condition as there would be no relevant data. Also problematic are patients who are transferred from another provider and for whom the provider may not know the HCC score. The AAMC recommends that in addition to the HCC, other measures that should be included are functional assessments (e.g., limitations to activities of daily living), and the widely used Charlson co-morbidity index which predicts the risk of mortality for a patient who may have a range of comorbid conditions. In addition, the accuracy of the methodology requires the use of a SDS adjustment. The AAMC also urges the Working Group to consider and set payment levels that account for the added work effort that would be required of providers from collecting data that are beyond that available through claims, or commonly captured and easily accessible in the Electronic Medical Record.

Expanding Access to Home Hemodialysis Therapy (p. 7)

The AAMC and our member institutions strongly support patient-centered care. Changing the definition of originating site to provide the flexibility needed to provide that care is an important goal. The home should be an originating site for any form of dialysis, hemodialysis or peritoneal dialysis. There should be the ability to have face to face meetings at least quarterly for care and continued education. Because of the complexities of renal replacement therapies, the site of origination may temporarily change after an illness or hospitalization. For example, sometimes after leaving the hospital people are still too ill to continue their own dialysis and will go to an independent center; after further recovery they will then restart dialysis at home. Nothing in these rules should constrain the flexibility to provide the safest care optimal based on a patient's current condition.

Improving Care Management Services for Individuals with Multiple Chronic Conditions (p.11)

The Working Group is considering establishing a new high-severity chronic care management code that clinicians could bill under the physician fee schedule. The reimbursement would be for coordinating care outside of a face-to-face encounter.

The AAMC supports the payment for this code as it is a recognition of the additional time and effort needed to coordinate the care of these very ill and difficult to manage patients. The Working Group

correctly recognizes that the initial challenge is identifying those patients who would fall into the category of having multiple chronic conditions. Doing so is not an easy task, as there is no consensus on how many conditions the patient should have to qualify as having multiple chronic conditions.

The current chronic care management code (CPT code 99490) already is available for non-face to face coordination services for patients with two or more chronic conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. The Working Group should consider adopting a definition for chronic conditions for this code that is similar to that used in the chronic care management code. The AAMC believes that the five or more chronic conditions suggested by the Working Group, sets the bar too high and eliminates many patients who would benefit if their providers were reimbursed for a higher level of care coordination. An alternative to specifying a number of conditions is to look to the approach taken by commercial insurers, many of which have a focus on caring for those patients who they identify as super-utilizers, typically the 1-5% most expensive patients. Whatever methodology is used to identify these patients, an SDS adjustment should be included as the management of multiple conditions, combined with certain socio-demographic factors is an extremely complex undertaking for which providers should receive higher reimbursement.

Billing for this code should be available for both physicians (primary care and specialists) and non-physicians, whoever is caring for the patient. The billing provider could be identified based on the number of evaluation/management codes billed over a specified period of time. The AAMC suggests two additional requirements for billing: (1) the provider must have access to a consensus care plan in the EMR so that it is readily accessible to all members of the care team and (2) the billing provider must have a relationship with a behavioral health provider who will be part of the care team whenever appropriate. Furthermore, the Centers for Medicare and Medicaid Services (CMS) should avoid creating an administrative burden when developing the requirements to bill this code. The AAMC suggests that, unlike the CCM code (CPT code 99490), this new code should not restrict billing to one provider. It is typically the case that effective care coordination for complex chronically ill patients involves active efforts at coordination among multiple billing providers. Ideally, this payment mechanism could acknowledge and support such coordination and communication between providers, thereby reducing fragmentation in care and its harmful effects.

Provider communication and coordination can be greatly facilitated and encouraged through such innovations as eConsults, which are a means of asynchronous communication between providers (often a primary care provider with a specialist provider). Such tools enable enhanced care through more timely expert input when needed, without creating unnecessary visits and related services. These exemplify the reality that care coordination efforts often require the active participation of more than a single provider. Optimally, eligibility for multiple providers to bill with this new code would be linked to evidence of use of such tools to facilitate communication and coordination of care. In general, the requirements for billing the current CCM coded are very restrictive. To avoid similar problems with the new code, the AAMC recommends convening stakeholders to consider how to reduce the administrative burden while not creating incentives for fraudulent behavior.

Finally the AAMC supports making the code permanent, recognizing that with experience, it will be refined over time.

Addressing the Need for Behavioral Health Among Chronically Ill Beneficiaries (p.12)

The Working Group is considering developing policies that improve the integration of care for individuals with a chronic disease combined with a behavioral disorder.

It is not only behavioral health patients who would benefit from the provision of items and services such as meals, transportation, support groups to talk and socialize, or testing or training for job skills that are not part of a beneficiary's mental health treatment. The AAMC suggests that since the availability of each of these items or services can make a positive impact on the social determinants of health, they should be available to a broad range of patients. The most desirable policy would be for Medicare payment to be available for them. If it is necessary to limit their availability, then at a minimum, all patients who are chronically ill should have access to these, and similar, items and services.

Providing ACOs the Ability to Expand Use of Telehealth (p.17)

The Working Group is considering establishing a process for ACOs in the MSSP 2-sided risk model to receive a waiver of the geographic component of the originating site requirement for telehealth services. The AAMC supports the waiver and suggests the following:

- The waiver should be available to all ACOs, even those with only upside risk. Those ACOs also need the appropriate tools to adequately coordinate and manage care. From the experience of AAMC members in ACOs we have learned that it can take several years to develop the clinical and financial infrastructure necessary to transform care delivery and create an effective ACO structure. Medicare should do all that it can to encourage this learning, including allowing the use of technology, that will help ACOs mature to the point where they can reasonably take on risk. Disadvantaging ACOs that are in the learning stage is not a way to encourage the best care.
- Telehealth innovations that directly improve care coordination between providers, and those that enhance access to care for populations that experience barriers to appropriate use of services, should be enabled broadly through the reduction of regulatory barriers and the adoption of appropriate reimbursement incentives. Use of telehealth services that bring providers into more effective collaboration but do not generate a face-to-face billable encounter, including but not limited to innovations such as eConsults (described above), warrant expanded use.
- The present limitations in the originating site requirement should be eliminated entirely. Underserved populations are not confined to rural areas. As with hemodialysis, the home should be considered an originating site.

Maintaining ACO Flexibility to Provide Supplemental Services (p.18)

The Working Group is considering clarifying that ACOs participating in MSSP may furnish a social service or transportation service for which payment is not made under FFS Medicare, and also is

considering clarifying that ACOs in MSSP may furnish a remote patient monitoring service for which payment is not made under FFS.

The AAMC suggests that a principle be adopted that, as with Medicare Advantage plans, ACOs that take on full risk should be permitted to spend their resources in ways that, in their judgment, would best assist their patients. In the future, as a recognition that transportation and remote patient monitoring are important to improving and maintaining the health of certain patients, payment for these services should be incorporated into the payment system.

Expanding Use of Telehealth for Individuals with Stroke (p. 19)

The AAMC supports the Working Group's proposal to eliminate the originating site geographic restriction (now only in rural areas) to provide every Medicare beneficiary with ability to receive an evaluation critical to diagnosis of acute stroke via telehealth from a neurologist not on site. Providing all patients with access to a quick diagnosis by a neurologist and enabling the neurologist's guidance on timely and appropriate intervention by the care team at the originating site is an important way to improve care.

Ensuring Accurate Payment for Chronically Ill Individuals (p. 19)

The Working Group writes that "while demographic information alone explains less than one percent of the variation in the health care expenditures of Medicare beneficiaries, the addition of health history information increases the amount of variation in spending that is predicted by the model to over 12 percent of spending." The AAMC would appreciate a citation for this statement.

The Association suggests that when considering the HCC risk score other important factors are a diagnosis of Alzheimer's, dementia, or drug/substance abuse, any of which will increase the HCC risk score. Other factors that may help identify chronically ill patients are beneficiaries who have more than 2 changes of address in a year, as this often reflects a high level of social upheaval which may be tied to behavioral and other conditions, supporting the need for an adjustment for the patient's socio-demographic status.

The AAMC suggests that any changes to HCC should be applied equally in CMS payment models, including both MA plans and ACOs.

Providing Flexibility for Beneficiaries to be Part of an ACO (p. 21)

The AAMC supports allowing beneficiaries to be able to voluntarily elect to be assigned to the ACO in which their main provider is participating. The Association has the following responses to the Working Group questions:

- Beneficiaries should be allowed to receive services from providers not participating in the ACO.
- ACOs that are assigned beneficiaries should not receive an upfront collective payment for all services provided to the beneficiaries in the ACO. This has been tried in a number of Medicaid programs and has not proven successful.

- ACOs that have beneficiaries that voluntarily enroll should receive an upfront collective payment for all services provided to these beneficiaries. An upfront payment will make it easier for ACOs to determine how to best manage the care of their patients. It is likely to encourage ACOs to engage in care redesign that will improve outcomes and reduce costs.

Developing Quality Measures for Chronic Conditions (p. 22)

SFC is considering the development of measures that focus on the health outcomes for individuals with chronic disease. Topics include:

- Patient and family engagement
- Shared decision-making
- Care coordination, including care transitions and shared accountability within a care team
- Hospice and end-of-life care
- Alzheimer's and dementia
- Community-level measures in areas such as obesity, diabetes and smoking prevalence

Missing from this list is an explicit statement that when considering any condition, whether or not it is a chronic condition, an important measure of quality is that the wishes of the patient are followed. This can be documented in the medical record. Meeting that goal means providing true patient-centered care.

Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness (p. 24)

The AAMC supports the development of this code whenever a patient is diagnosed with Alzheimer's/Dementia or a life-threatening disease and has the following additional suggestions:

- If the patient is not able to engage in this discussion, payment should be available if the discussion is held with the patient's family or guardian, as they are the ones who will be involved in the patient's care and may have many questions about the likely course of the disease and the demands that will be placed on them as caregivers, in addition to needing to know about support services that are available.
- To ensure that every patient has access to this type of discussion, the code should not be limited to a face-to-face visit but also should be available if the service is provided as a telehealth visit.

While this code would serve the purpose of having a discussion with the patient or caregiver from the point of diagnosis, it is important for CMS to clarify that the services under this code are different from those covered by the Advanced Care Planning (ACP) code (CPT code 99497-99498) currently provides, and to ensure that providers can be eligible to receive payment for both codes. It is equally important to distinguish this from an evaluation/management visit code as it is possible to provide these services during a visit.

Allow ACOs in 2-sided risk models to waive beneficiary cost sharing, such as co-payments, for items/services that treat a chronic condition or prevent the progression of a chronic disease

The AAMC supports this proposal but, as was discussed earlier, distinctions should not be made between ACOs in 2-sided risk models and those that have upside risk only. The Association suggests that those

items and services that are subject to the waiver should be left to the discretion of the ACO as it is best positioned to manage its patients. In return for this level of flexibility, the ACO could be required to document why it has chosen particular items and services and to monitor whether those waivers have made a difference in treatment and/or outcomes.

Increasing Transparency at CMMI (p. 28)

The AAMC supports transparency but believes that new models should not require notice and comment rulemaking. Instead, there should be a process to ensure feedback from participants on a regular basis and a method for making revisions when appropriate.

Thank you for your consideration of these comments. The AAMC appreciates and supports the committee's efforts to improve care for Medicare patients with chronic conditions. We look forward to working with you address these challenges and ensure all Americans get the care they deserve. If you would like to discuss any of these comments in greater detail, please contact Leonard Marquez, AAMC Director of Government Relations, at lmarquez@aamc.org or 202-862-6281.

Sincerely,

Atul Grover, MD, PhD
Chief Public Policy Officer