June 22, 2015

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

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

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

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

Dear Senators Hatch, Wyden, Isakson and Warner:

On behalf of the Society of General Internal Medicine (SGIM), thank you for this opportunity to provide comments to inform the efforts of the Finance Committee's chronic care working group. SGIM is comprised of approximately 3,500 general internists who represent clinicians, educators, and researchers from all the nation's academic health centers. Our members provide clinical services and conduct research and educational activities to improve the health of adults, often with multiple complex, chronic conditions. Given the patient population our members treat, we are acutely aware of the impact chronic disease has on the Medicare program and the challenges inherent in treating patients with chronic disease.

Legislation, including the Affordable Care Act (ACA) and the recently passed Medicare Access and CHIP Reauthorization Act (MACRA), has included provisions that encourage physicians to practice in large groups. However, many small practices prefer to remain independent despite the legislative incentives. Programs designed to improve the continuous care of patients with chronic illnesses should be designed in such a way as to encourage participation by small practices. It will continue to be in the best interests of Medicare beneficiaries to have the broadest range of practice choices available, which will allow innovation on a smaller scale.

Any discussion of treating patients with chronic conditions should acknowledge the origins of most chronic diseases. Nearly all stem from the well-known and easily diagnosable medical conditions, like obesity, diabetes, hypertension, atherosclerotic vascular disease. All of these conditions can be successfully managed with early intervention. Prevention of chronic illness is ultimately the best approach to chronic care management. The most effective long term care of chronic illness will never match the return on the investment in a robust, well designed, effective, and properly funded primary care delivery system.

Successful chronic care management depends on the connection between patients and those who care for them, be it an individual clinician, a team, a practice or an

enterprise. Ultimately, it is the patient who must choose to maintain this bond. Any and all efforts to build models to improve chronic care management must first and foremost actively involve patients. This means working with patients to ensure that the process of engagement is respectful and acknowledges patient autonomy and freedom of choice. The best systems will be those that are based on principles of collaboration and mutual support - doctors, teams, practices and enterprises working with patients and their advocates.

Support for Team Based Care

Besides successful patient engagement, our members recognize that providing high quality, cost effective care to patients with multiple complex chronic conditions also requires a team of health care providers; a single physician alone cannot accomplish it. However, the costs of staffing health care teams are too high for many primary care practices because of the low levels of compensation they receive for this work. Because the physician compensation in new payment models, like accountable care organizations (ACOs), is still based on the fee for service system, it is imperative that it supports this team-based work. The patient management required by health care teams can be divided into three distinct kinds of work:

1. Managing social determinants of health and prevention
2. Managing multiple complex chronic conditions during office visits
3. Managing multiple chronic conditions through non-face-to-face services

1. Managing Social Determinants of Health and Prevention

Reimbursement for the first category, managing the social determinants of health and prevention issues, is now supported by the Medicare annual wellness visit. Providing this service creates a reasonable financial incentive for physicians to review the patient's risk factors and screen for and prevent problems such as falls, depression, urinary incontinence, and other potentially chronic conditions. The documentation requirements for this service are not overly burdensome to complete. Most importantly, patients who receive this service on an annual basis can be better managed by their physicians to avoid acute incidents. This is an important first step to reducing the frequency and severity of acute episodes.

2. Managing Multiple Complex Chronic Conditions during Office Visits

The existing outpatient evaluation and management (E&M) services cannot support the work of the health care teams required to manage the health of Medicare beneficiaries with multiple chronic conditions. As they are defined and valued, these services do not reflect the time and intensity of the services provided. SGIM is leading a coalition of 16 organizations that has submitted a proposal to CMS to do the needed

research to understand the work that occurs during, before and after these face-to-face encounters. This research would be the foundation for the creation of a new set of E&M services that better describe the work required to manage patients with complex, chronic conditions.

By extracting the data from electronic health records, observing the delivery of outpatient E&M services and the follow up required, and using other relevant forms of data, new outpatient E&M codes and the accompanying documentation requirements would be based on the best data available and better describe the work done by cognitive physicians. This research is similar to the provision included in the recently enacted Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) in that it will ensure that CMS knows exactly what these services encompass in terms of expertise and resources.

SGIM believes that the current fee-for-service system does not properly describe and value the cognitive E&M services that patients receive to keep them healthy and avoid acute episodes. We support efforts to restore accuracy and precision to the fee schedule for these important services by completing the necessary research to better understand the complexity of these services and the training and expertise of the physicians and health care teams who provide these services in the outpatient setting. Once this work is complete, we anticipate the new codes would more appropriately describe and value the work of the health care teams needed to treat chronically ill Medicare beneficiaries.

3. Managing Multiple Chronic Conditions through Non-Face-to-Face Services

Much of the work required to manage patients with multiple chronic problems occurs outside of the patient's office visit. While CMS has implemented the transitional care management and chronic care management services, most non-face-to-face work remains unpaid.

The chronic care management service is a good first step towards reimbursing the non-face-to-face care required to treat patients with chronic conditions, but the documentation requirements make the service unattractive at the current reimbursement rate. The service requires documenting the minutes of non-office based care each month, and primary care teams will spend nearly as much time documenting the care as actually providing care.

Also, the service does not align with how care is actually provided to chronically ill patients. For example, some months a patient might require only a few minutes of time from his primary care team. During other months when a patient's condition destabilizes, he might require several hours of non-face-to-face time from the team. Requiring a certain number of minutes to be documented each month as well as other criteria, such as having the patient agree to have a physician provide the service, is unworkable for many primary care physicians at the current reimbursement rate.

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A better alternative to the chronic care management service that would support the work of health care teams is to implement a per-member per-month payment for each patient with greater than two chronic problems and perhaps another level of monthly payment for patients with five or more problems. The patient's problem list could be re-certified every 13-15 months at the time of the Medicare annual wellness visit. Many private payers with capitated payment systems have implemented a similar system and have demonstrated positive outcomes. This payment system reduces the documentation requirement on practices and allows them to focus more time on providing care.

Improving these three revenue streams to support the work involved with managing these patients would provide the correct incentives for physicians to do the right thing and focus on providing high quality, coordinated care to chronically ill Medicare beneficiaries. Physicians would be able to afford to build and pay for strong effective care teams, including adequate nursing, social work, mental health and pharmacy staff all of which are needed for high quality care for patients with multiple complex chronic problems.

Chronic Problem Focused Care and Reimbursement

The existing reimbursement system is based on a traditional acute care model. A patient gets sick and visits the doctor; the doctor does an interview and physical exam, decides on a treatment and documents this work in a visit note format. Reimbursement is based on the complexity of the visit and the detail of the documentation. Despite the addition of reimbursement for non-face-to-face work with the implementation of the transitional care management and chronic care management services, the current fee for service payment system is not conducive to the sort of work needed to prevent and effectively manage chronic illnesses.

We must fundamentally rethink how we organize and reward the work needed to more effectively prevent and manage chronic illness. Early prevention is critical to reducing the burden of chronic illness. Much of this must take place outside of the physician's office, and will require a broader approach to education and financial incentives. An annual wellness visit has facilitated the preventive work, but more is needed to address social determinants and risky behaviors. We will need a much broader community and social perspective to make an impact on this. Congress should direct CMS to invest in preventive programs such as smoking cessation, nutrition education, obesity reduction, and other risk reduction for young people well before they reach Medicare age.

CMS has incentivized adoption of EMRs to better manage medical information and enable population based data driven interventions. However, EMRs currently in use are for the most part designed to support the acute care model and the associated reimbursement. Aside from the fact that they place a significant documentation burden on doctors, and may not increase efficiency or "productivity," they are not designed to support a chronic illness management. Much of the important clinical

information in current EMRs is obscured by repetitious templated data that hinders longitudinal perspectives and effective information sharing.

For more effective chronic disease prevention and management, we need information systems designed to support longitudinal care and care coordination. Well-designed information systems could fundamentally change the way we organize and use clinical information. For example, a problem oriented system could be designed to analyze and summarize the chronology of a chronic illness, including key test results, symptom progress correlated with medications and other interventions, telemonitoring data and multimedia documentation to give providers a clear picture of a patient's status, progress and goal attainment, as well as the quality of care provided. It could also be designed to more effectively facilitate team organization and coordination. It is still fairly early in the EMR transition, but we should be planning for how technology can better support chronic illness care in the future.

Alternative payment models could also incentivize the work and documentation needed for effective chronic illness care. The current fee for service payment model incentivizes episodic care and physician work that emphasizes intensity and risk. An alternative payment model based on care of chronic illness could instead incentivize cost effective care to improve outcomes of chronic problems. For example, a provider could be reimbursed for the care of a patient based on their chronic problems, with adjustments for severity, complexity, comorbidities, risk factors and even genetic predisposition, to prevent "adverse selection" and "cherry picking." With payments targeted to achievement of outcomes goals, a provider would be incentivized to achieve the best outcomes at the lowest cost, with reimbursement appropriate for individual patients. Information systems would naturally evolve to support this sort of chronic illness care to document the data needed for appropriate reimbursement and measurement of outcomes and quality.

Patient and Family Engagement

Congress should direct CMS to pursue policies that support patient and family involvement in care planning and setting goals of care. Patients with multiple chronic conditions typically see several providers and take multiple medications with potential interactions and side effects. Fragmented care may not be effective in helping patients achieve the goals that are most important to them, and may put them at risk for adverse outcomes. Care systems need to develop tools such as EMR enhancements to facilitate patient involvement in setting goals of care and assessing progress towards achieving them. Payment models should include incentives to encourage providers to incorporate these tools in practice and to coordinate these with the entire care team. For example, advanced directive planning and functional assessment should be incorporated in EMRs and used routinely to facilitate clinical decision making. Patient priorities and goals should be documented and shared to guide how clinicians interact with the patient and with each other. Quality metrics and incentives should include measures of patient and family participation, functional

status progress and achievement of patient oriented goals.

Shifting Care from Institutions to the Home Setting

Long term care for chronically ill patients will place a growing burden on our health care system and our economy. Medicare and other payers will be strained by the high costs of institutional care for chronically ill patients. Care provided in the home setting can leverage the investment that families are willing to make to keep their loved ones at home, lowering costs while enabling patients to maintain a higher quality of life. Services that help keep patients functional enough to stay at home and that assist families in caring for loved ones go a long way towards controlling the overall costs of long term care.

Medicare currently reimburses for home care services, but these are limited and tend to be focused on post-hospitalization care. We should explore programs that broaden the scope of home based services to include preventive care and other services that will give patients a better chance of remaining at home rather than declining to the point they need care in hospitals or nursing facilities. For example, Medicare's Independence at Home demonstration project showed a reduction in hospitalizations for participants and average savings of over $3,000 per participating patient. Programs targeted at the highest risk patients could reduce the risk of falling, help maintain functional status, provide adequate nutrition, enable social interaction, and help patients stay well enough to remain at home. Support for home visits, video conferencing, telemonitoring, community outreach workers, and other home based services could enable providers to be more directly focused on the goal of keeping patients at home. Respite or day care programs can be very helpful for families struggling to care for a loved one while maintaining their own financial viability. A small investment in supporting family based care can prevent major institutional expense, with better outcomes for the patient.

CMS could act immediately to reduce the administrative burden and uncertainties that currently limit the effectiveness of home care services. While it is important to reduce costs, the current strategy of requiring more and more documentation and of tightening qualification for home services can be counterproductive. For example, the lack of coverage for home services after an "observational" hospital admission may save money in the short term, but it results in a significant, and unnecessary, burden on patients who legitimately require home services. While it is important to control unnecessary or fraudulent charges, CMS needs to be more creative in developing ways to do this without putting excessive burdens on providers.

Thank you for your leadership on this important issue. SGIM looks forward to working with you as you explore proposals that will improve the care provided to chronically ill Medicare beneficiaries. If you have questions or require further information, please contact Erika Miller at 202-484-1100 or emiller@dc-crd.com.

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Sincerely,

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