

I appreciate the opportunity to submit recommendations to Senator Warner's Chronic Care Work Group.

I am writing on behalf of myself, though I have served in many capacities for The American College of Physicians (ACP), the largest medical specialty organization in the country, with 141,000 members. The ACP may be submitting its own recommendations separately, though I believe our viewpoints are closely aligned. I am currently the Governor Elect of The Virginia Chapter of the ACP as well as its Chair of Health and Public Policy. I am an ACP advisor to the AMA Relative Value Scale Update Committee (RUC) and serve on the ACP Coding and Payment Policy Subcommittee. In these positions, I have worked on issues of chronic care management for the last several years.

In order to improve chronic care management, health care providers must be economically incentivized to coordinate care outside the traditional fee for service reimbursement system of Medicare. The good news is that the physician community has already developed multiple mechanisms to do this. However, CMS and the federal government have not adopted many of these recommendations. In other cases, the mechanisms of care coordination are underutilized because they are overly burdensome. The following list details some specific recommendations for how to best improve the chronic care infrastructure.

- 1. Recognize that the Patient Centered Medical Home (PCMH), with an appropriate per member per month reimbursement structure, will give primary care providers the ability to coordinate care and guide patients more seamlessly through a dizzying array of health care options.** This is perhaps one of the most important means to improve care coordination. The PCMH is already legislated as a potential advanced payment model through the recently legislated MACRA. It is important, however, that the requirements for certification of PCMH not be set too high, for fear of disenfranchising many providers. Physicians' recent experience with various incentive programs such as PQRS, e-prescribing, and Meaningful Use reveals an overly burdensome regulatory framework. It would be appropriate for the workgroup and Senator Warner's office to work with regulators to minimize regulatory overreach.
- 2. Reimburse physicians for spending the time to discuss end of life issues with their patients.** Push for, or legislate, CMS to begin reimbursing for the complex advanced care planning codes 99497 and 99498, as already developed through the CPT and RUC process. CMS has not yet indicated they will pay for these services. In addition, less complex advanced care planning, that may not take as much as 30 minutes but is still important, should also be reimbursed.

3. **Continue the Primary Care Incentive Program.** This program, which reimburses primary care physicians a 10% bonus on the cognitive services they perform, gives primary care providers some flexibility to provide services outside the traditional fee for service system. It is extremely important, but It is set to expire at the end of 2015. It is strongly recommended by MedPAC that this program be continued.
  
4. **Make the Chronic Care Management (CCM) Code easier to administer.** The CCM code, for which CMS began to reimburse in 2015, is a good idea in principle but has low utilization because of cumbersome requirements. Specifically:
  - a. The requirement for a separate informed consent for the service should be removed.
  - b. The requirement that a certified EHR be utilized for this service should be removed.
  - c. The requirement that the summary of care record be transmitted electronically for purposes of care coordination be removed. Many EHRs, even when certified, do not have this capability. Facsimile copies of summary of care records should suffice until such time as the interoperability of EHRs makes this requirement possible.
  - d. The time it takes to create a Chronic Care Management Plan (which is required to be done annually) should count toward the

time requirements for the CCM. Currently it does not. Creation of a CCM can easily take 20-30 minutes.

- e. An appropriately performed and documented Medicare annual wellness visit should suffice as a Chronic Care Management Plan.
- f. CCM codes should reimburse not just for the first 20 minutes of care provided, but for each additional 20 minutes per month as well.

5. **Loosen the requirement for telehealth encounters.** Push CMS, or legislate, reimbursement for telephone consultations 99441-99443 and interprofessional telephone consultations 99446 – 99449, which have all been created through the CPT and RUC process. Begin reimbursing physicians for telehealth interactive audio-video real time communication regardless of where the patient lives. This service is currently available only under narrow conditions.

Thank you for your consideration, and please contact me if you have further questions.