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The Honorable Orrin G. Hatch
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
Co-Chair
Senate Committee on Finance
Chronic Care Working Group
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
Co-Chair
Senate Committee on Finance
Chronic Care Working Group
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Senators Wyden, Isakson, and Warner:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to offer our views and recommendations responding to the May 22 letter of the Senate Committee on Finance, following up on the Committee's recent hearing entitled, "A Pathway to Improving Care for Medicare Patients with Chronic Conditions." The AMA greatly appreciates the work the Committee and the newly formed Chronic Care Working Group are doing to address the impact of chronic disease on the Medicare program and its enrollees. Given the sobering statistics that show that treatment of chronic illnesses, such as heart disease, diabetes, and cancer now account for almost 93 percent of Medicare spending, as well as the increasing number of adults between the ages of 45 and 64 who are living with multiple chronic conditions, we agree that innovative solutions are needed to change how we provide care to this patient population in order to prevent chronic disease and improve patient outcomes.

The AMA "Improving Health Outcomes" Initiative is working to prevent diabetes and improve the treatment of hypertension. Along these lines, through the AMA's "Improving Health Outcomes" initiative, we are engaged in efforts to reduce the incidence of Type 2 diabetes, and to improve blood pressure control in people with hypertension. We offer recommendations below specifically related to these chronic conditions, followed by responses to the specific questions outlined by the Committee.

Diabetes: Diabetes is a chronic disease that has a significant human and economic impact. According to the Centers for Disease Control and Prevention (CDC), more than 26 million Americans have diabetes and another 86 million have prediabetes and are at risk of developing the disease. Among the Medicare-age population, more than a quarter (11 million) have diabetes and another 26 million have prediabetes. It is estimated that by 2020, if current trends continue, an estimated 52 percent of the adult population will have either Type 2 diabetes or prediabetes. Diabetes puts people at high risk for severe complications and

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other chronic diseases, including high blood pressure, depression, heart attack, and stroke. Moreover, diabetes has a huge financial impact on payers and individuals: medical expenses for people with diabetes are more than twice as high as for people without diabetes, and spending on Medicare beneficiaries with prediabetes and diabetes is estimated to be more than \$2 trillion over the next ten years.

As part of our diabetes prevention work, the AMA is working in partnership with the CDC and the Y-USA to spread the CDC's National Diabetes Prevention Program (NDPP). The NDPP includes a lifestyle intervention proven to prevent or delay progression to diabetes. Based on NIH-funded research, those with prediabetes saw a 58 percent reduction in the number of new cases of diabetes overall, and a 71 percent reduction in new cases of diabetes for those over the age of 60. **The AMA strongly supports the Medicare Diabetes Prevention Act (MDPA), S. 1131/H.R. 2102, which would allow Medicare beneficiaries at risk for diabetes to participate in the NDPP.** The year-long program includes 16 sessions of nutrition and exercise training and is offered by organizations such as the YMCA that have demonstrated their ability to effectively deliver diabetes lifestyle interventions. A recent study by the consulting firm Avalere Health LLC shows that this policy could reduce federal spending by \$1.3 billion over 10 years. This amount reflects a combination of an estimated \$7.7 billion in new spending on the diabetes prevention program offset by an estimated \$9.1 billion in savings. Savings from preventing diabetes would likely continue to increase beyond 10 years, suggesting even greater impact on longer-term federal spending.

This program also increases care coordination (between physicians and care teams and community programs) and incentivizes the appropriate level of care, which benefits the Medicare population greatly. Providing Medicare coverage of this program would increase care coordination among individual providers across care settings by allowing Medicare beneficiaries to be referred by their respective physician to a community-based diabetes prevention program that focuses on lifestyle change to prevent the progression to diabetes. Physicians receive feedback from these programs as to their patients' progress so they can support the patient in their efforts to make this important lifestyle change. Medicare beneficiaries enrolled in the program would be empowered to make changes in their lifestyle that will put them on the road to better health, especially since many seniors have multiple chronic conditions.

Hypertension: As noted above, the AMA is also involved in improving health outcomes for individuals with hypertension. Uncontrolled blood pressure is another condition many Medicare beneficiaries face. High blood pressure is the leading cause of death and disability worldwide, surpassing smoking, and it costs the nation nearly \$51 billion each year, which includes the cost of health care services, medications to treat high blood pressure, and missed days of work. In the United States, high blood pressure contributes to approximately 1,000 deaths per day. Only 54 percent of adults with high blood pressure have their condition under control. Research shows that using a team-based approach, applying evidence-based protocols and strategies, can improve the quality of health care. The AMA used these principles to develop an evidence-based framework to help physicians, care teams, and patients improve blood pressure control; this framework is called "M.A.P.," i.e., Measure blood pressure accurately, Act rapidly to address high blood pressure, and Partner with patients, families, and communities to empower blood pressure self-management.

The AMA supports Medicare coverage for home blood pressure monitors that would enable patients to take their blood pressure measurements at home and share the readings with their doctors. Research from the CDC shows that self-measured blood pressure can improve adherence and health outcomes for patients. The draft recommendation statement by the U.S. Preventive Services Task Force (USPSTF), Hypertension in Adults: Screening and Home Monitoring, states there is good evidence that home blood pressure monitoring may be used to confirm the diagnosis of hypertension after initial screening. However, Medicare does not currently provide coverage for the time that physicians and physician-led care teams spend in educating patients on the importance of self-monitoring their blood pressure, how they should take their blood pressure at home, follow-up with the patient, and review and incorporate the patient's results into their electronic medical record. **We urge Congress to enact policy for Medicare to provide coverage of services by physician practices for counseling and instructing patients on the importance and use of home blood pressure monitoring devices, and for the time spent in interpreting home blood pressure readings and making appropriate adjustments in patient's medications for hypertension.**

Below are the AMA's responses to the Committee's request for "feedback on the following issue areas, which outline specific policy categories that the Committee plans to consider as part of its chronic care reform efforts."

1. Improvements to Medicare Advantage for patients living with multiple chronic conditions.

Medicare Advantage (MA) plans should be allowed and encouraged to provide coverage for services pursuant to new payment and delivery models that improve care for beneficiaries with multiple chronic conditions. MA plans provide coverage for a significant and potentially growing sector of Medicare beneficiaries. It is important that MA plans be allowed – and encouraged – to provide flexibility for physicians and other providers to participate in, and develop, new models of care and delivery. Medicare policies for MA plans must encourage new models of care and delivery.

Congress should make explicit that physicians may bill for chronic care management services for appropriate beneficiaries in MA plans. In 2015, Medicare began providing separate coverage for chronic care management (CCM) services under the Medicare Physician Fee Schedule for CPT code 99410, and has since undertaken efforts to educate the physician community about CCM services. Congress ensured continued coverage for CCM services in enacting section 103 in the Medicare Access and CHIP Reauthorization Act (MACRA). Since care coordination is one of the cornerstones of the development of MA plans, the AMA believes that beneficiaries in MA plans who have chronic conditions would greatly benefit from receiving CCM services.

2. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS [the Centers for Medicare & Medicaid Services], or by proposing new APM structures.

Congress can build upon the work that is already under way to develop new APM models, including the Patient-Centered Primary Care (PCPC) payment system developed by a group of primary care

physicians, specialists, employers, unions, and health plans in Western Michigan with assistance from the Center for Healthcare Quality and Payment Reform. In this model, a primary care practice could elect to be paid under the PCPC system rather than the current system. The PCPC payment system has two components: a monthly “Core Primary Care Services Payment” for providing preventive services and chronic disease management, as well as “Service-Based Payments” for other services. For any group of patients who are enrolled and paid for under the PCPC payment system, a primary care practice could expect to see at least 50 percent of its revenues coming from the monthly Core Primary Care Services Payment. There are four different levels of the Core Primary Care Services Payment based on whether the patient has one of four chronic diseases (asthma, congestive heart failure, COPD, or diabetes) or significant risk factors. A primary care practice receiving the Core Primary Care Services Payment would commit to deliver high-quality care to patients as cost-effectively as possible, and the payment amount would be increased or decreased based on the practice’s performance on quality and resource use measures. A PCPC would be paid additional fees beyond the Core Primary Care Services Payment, and patients would provide some cost-sharing, for office visits for acute issues, tests and procedures performed in the office, and office visits for non-enrolled patients.

Beneficiaries should be given the option of being part of an ACO or other APM. Any new legislation for ACOs or APMs should specifically allow for voluntary attestation by Medicare beneficiaries. Providing beneficiaries with the opportunity to voluntarily align with an ACO or APM would balance the important considerations of beneficiaries’ freedom to choose their providers with the interest of the ACO or APM in reducing beneficiary turnover. This would also help provide a more defined and stable beneficiary population from the beginning.

APMs will be more successful if they can apply for waivers from certain Medicare coverage requirements. The AMA believes that any and all waivers that can improve care delivery should be available to all ACOs in the Medicare Shared Savings Program, as well as other APMs. Legislation could make explicit that ACOs and relevant APMs could receive a waiver from the following current requirements:

- Hospital discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services;
- The skilled-nursing facility (SNF) three-day stay rule, which requires Medicare beneficiaries to have a prior inpatient stay of no fewer than three consecutive days in order to be eligible for Medicare coverage of inpatient SNF care;
- Medicare requirements for coverage of telehealth services, such as limitations on the geographic area and provider setting in which these services may be received; and
- The homebound requirement for home health, which requires that a Medicare beneficiary be confined to the home to receive coverage for home health services.

APMs will be more successful if they are fully informed about their patients. An APM’s success depends upon the timely transfer of patient information and coordination of patient care. Medicare patients have many options, so it can be a challenge for APMs to monitor the services their assigned patients receive. We suggest the following information be made available in data reports to ACOs and other APMs, in addition to health status and utilization rates:

- Date of the beneficiary's original Medicare eligibility for Part A and Part B;
- Date of change in the beneficiary's eligibility status;
- An indicator identifying the change of an individual beneficiary's Health Insurance Claim Number with the date of the change;
- Hierarchical Condition Category score for each beneficiary;
- Opt-out information to the beneficiary attribution file to ensure members are not lost in the data reporting process;
- An indicator of a beneficiary's institutional/hospice status, to help identify domiciled patients;
- De-identified claims data in the Claims and Claims Line Feed or, as a less preferred alternative, provide aggregated data on substance abuse claims expenditures;
- Eligibility checks from hospitals, emergency departments, and post-acute providers; and
- De-identified cost and claims data related to substance use diagnoses and services, or at least the aggregate payment amount of these services.

Physicians who participate in APMs can achieve improvements in health care quality and costs without being required to have certified electronic health record technology (CERT). The AMA strongly opposes tying a physician's participation in alternate payment and delivery reform models of care to the use of certified EHR systems. Given the high costs, lack of flexibility, and poor usability that physicians have experienced in using these certified systems, they need to be free to pursue the use of technology that does not impede their ability to improve care and efficiency. Practices need the flexibility to redesign care in ways that will promote the best care for their patients while achieving quality and shared savings targets. Instead of complying with overly restrictive mandates, they should be given the flexibility to determine how best to deploy technology in a manner that drives efficiency and quality improvement.

3. Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions.

Fee-for-service needs to have greater flexibility to allow physicians to transition to new models of care, and needs to cover services such as joint treatment planning. Physicians in many different practice arrangements and specialties have ideas about how to improve care for their patients while also reducing health care spending. Physicians know there are big opportunities to improve treatment and care coordination for their patients with heart disease and stroke, cancer, osteoarthritis, and other conditions. Neither the Medicare fee schedule nor existing alternative payment models give physicians the flexibility or predictability that they need to really change the delivery of patient care. For example, if a physician consults with an endocrinologist about managing their patients with diabetes, or consults with a neurologist about their patients who have Alzheimer's, there is still no coverage in either regular Medicare or the Medicare Shared Savings Program for this joint treatment planning, and both the primary care physician and specialists will lose revenue they could have earned from face-to-face services. **The AMA urges Congress to consider requiring coverage for additional non "face-to-face" and care management services in order to incentivize providers to coordinate care for patients living with chronic conditions.** The AMA and the AMA/Specialty Society RVS Update Committee (RUC) support coverage for "Chronic Care Management" (CCM) services. The RUC has worked with the Current

Procedural Terminology® (CPT®) Editorial Panel and the CPT/RUC Complex Chronic Care Workgroup to describe and estimate resource costs associated with these important non “face-to-face” services. In 2013, CMS implemented coverage for “Transitional Care Management” services based on the work of CPT and the RUC. In 2015, CMS began coverage for CCM services billed under CPT code 99490, for patients with two or more complex chronic conditions which are expected to last at least 12 months or until the death of the patient, and place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline. This code involves services of less than *20 minutes* in a calendar month. Just recently, Congress mandated coverage for CCM services furnished by physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives, in section 103 of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

We urge Congress to consider requiring coverage for these additional services:

- **“Complex Chronic Care Management” (CCCM) Services:** Congress should direct Medicare to recognize and provide coverage for CPT codes 99487 and 99489, for “Complex Chronic Care Management Services,” which were designed to capture more intensive care coordination services, for patients whose conditions require a moderate to high level of medical decision making. CPT code 99487 involves *60 minutes* of clinical staff time directed by a physician or qualified health care professional, per calendar month. CPT code 99489 involves each *additional 30 minutes* of clinical staff time directed by a physician or qualified health care professional, per calendar month. Both services involve the following elements:
 - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
 - Chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
 - Establishment or substantial revision of a comprehensive care plan; and
 - Moderate or high complexity medical decision making.
- **Other Non “Face-to-Face” Services that Support Care Coordination:** The CPT/RUC Complex Chronic Care Workgroup, along with the RUC and the AMA, have also advocated for separate coverage for other non “face-to-face” services that are critical components of care management, which Medicare currently does not cover. These include team conferences, patient education, telephone calls, and anticoagulant management. We particularly urge Congress to enact policy for Medicare to provide coverage for physician practices for counseling and instructing patients in the use of home blood pressure monitoring devices, and for the time spent in interpreting home blood pressure readings and making appropriate adjustments in patient’s medications for hypertension. We sincerely believe that providing coverage for these services will prevent complications and unnecessary, more costly procedures and hospitalizations.

Closing the information loop for transitions of care would benefit patients, physicians, other health care providers. The AMA participated in a Closing the Referral Loop pilot project that involved physician-to-physician referrals in the ambulatory setting. During the pilot project it was learned that current EHR vendor systems do not have the functionality to facilitate the sharing of patient information,

only the ability to request a referral. This is leading to extensive customization (and cost) within each vendor system for a function that should be considered a standard operating practice.

Prior authorizations policies are burdensome for patients and physicians, resulting in delays in care and diversion of resources to administrative tasks. An AMA online survey in May 2010 of 2,400 physicians found that 63 percent of respondents typically wait several days for a response to private insurers' prior authorization requests, while 13 percent generally wait *more than a week*. We strongly oppose extended use of precertification in the Medicare program. To the degree that prior authorization is required by Medicare and other payers, however, we believe there needs to be a standard way to perform these requests to mitigate administrative burdens. Importantly, this process should be standardized across all payers, including Medicare, and seamlessly incorporated into EHRs.

4. The effective use, coordination, and cost of prescription drugs.

Prescription drugs present a real challenge in caring for patients with chronic conditions. There is a clear and growing need for care teams to have accurate, up-to-date medication lists that can be easily modified to reflect changes in patient care. Part of this solution includes an electronic use case which is equally applicable with regard to laboratory tests results. There is a clear challenge in coordinating care and treatment as increasingly there are drug utilization control tools like step therapy, increased tiering, etc. Another area that creates challenges to chronic care management is the difficult appeals processes. Physicians will reportedly forego the best option if it is lost in the appeals and reconsideration processes. Other issues include ensuring that pharmacists who are offering medication therapy management, or collaborative drug therapy management, are actually required to work in collaboration with the prescribers and treating physicians.

The structure of the Part D program contributes to fragmentation in the delivery of care to Medicare patients. Instead of coverage and formularies for drugs being integrated into patients' overall treatment plan, it is separate from everything else. **Facilitating development of APMs that integrate drug coverage into patients' comprehensive care could help overcome this fragmentation.**

5. Ideas to effectively use or improve the use of telehealth and remote monitoring technology.

The AMA strongly supports efforts to remove restrictions on Medicare coverage of telemedicine services that limit beneficiary access to telehealth services with a strong clinical evidence base. Specifically, the AMA supports removing Medicare geographic restrictions on coverage of telemedicine services; allowing dual eligibles to benefit from such services where Medicaid programs cover telemedicine; and removing all Medicare telemedicine restrictions in the context of alternative payment models. The AMA also recommends that the Committee include a technical modification that would allow CMS to consider concurrently new CPT codes for adoption and coverage as a telehealth service. (The Agency currently has to include the CPT code on the relevant fee schedule and wait until the subsequent year to include it as a covered telehealth service.) **The AMA opposes federal legislation that would preempt or waive state licensure and medical practice laws for telemedicine encounters and strongly affirms that physicians must be licensed in the state where the patient receives services.**

In order to deliver quality care and secure coverage, the AMA supports telemedicine delivered consistent with the following requirements and safeguards:

- Telemedicine services must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine;
- Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services;
- Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit;
- The patient's medical history must be collected as part of the provision of any telemedicine service;
- The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient;
- Telemedicine services must abide by laws addressing the privacy and security of patients' medical information;
- The standards and scope of telemedicine services should be consistent with related in-person services; and
- The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care, and positive health outcomes.

The AMA supports Medicare coverage of telemedicine services that includes care coordination with the patient's medical home and/or existing treating physicians. This includes at a minimum identifying the patient's existing medical home and treating physician(s) and providing to the latter a copy of the medical record. The AMA also supports expanding Medicare pilot programs to enable coverage of telemedicine services, including, but not limited to, store-and-forward telemedicine as well as demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation (CMMI) to address how telemedicine can be integrated into new payment and delivery models.

We would also strongly support waiving the Medicare telehealth geographic requirements and originating site restrictions for ACOs and other APMs. Studies have shown that certain medical services delivered using telecommunication technologies can be substitutable, cost effective, quality improving and preferred by beneficiaries. When an APM is built upon a care coordination and infrastructure that facilitates team-based communication, there are important patient protections inherent to this health care delivery model that may not be in place elsewhere. To ensure the appropriate use of telehealth services, an APM should be required to: outline a plan on how it will use telehealth services particularly to improve chronic care management; have a mechanism in place to transmit a record of the telehealth encounter to the patient's primary care provider if the eligible telehealth provider is not the patient's primary care provider; and, publicly post their use/approval of the waiver. We also recommend allowing CMS to deny or revoke a waiver as well as monitor an APM's billing under the waiver to reduce possible abuse. In an APM primary care delivery model, telehealth applications have a myriad of uses in preventing or managing numerous leading causes of illness, disability and death. In sum, telehealth

services facilitate prevention, coordination and cure and deserve to be available to all beneficiaries in all appropriate APMs.

6. Strategies to increase chronic care coordination in rural and frontier areas.

The best way to increase care coordination in rural and frontier areas is to fully cover care coordination services by physicians and other available providers, and remove impediments to providing care. The greatest impediments, according to many physicians, involve requirements for complying with Meaningful Use standards and the adoption of CERT. All of these are particularly difficult and at times nearly impossible for the small practices that predominate in rural areas. With many of the physicians in these areas approaching retirement age, there is also a clear risk that many will leave practice early, creating even more demands and time constraints that hinder care coordination among remaining practitioners.

The use of telehealth may be particularly beneficial in rural communities. For example, the Indian Health Service (IHS) has used both live video conferencing and asynchronous technologies to improve Native American health in particularly remote locations. The IHS has been successful in improving diabetes control by significantly lowering low-density lipoprotein cholesterol and hemoglobin A1c levels through the use of telehealth technologies. The IHS has also used the technology to consult with specialists throughout the country to improve its delivery of specialty care.

7. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers.

The AMA supports improvements in Medicare policies that allow patients to play a greater role in managing their health care and to engage with their health care providers in a meaningful way. We believe the formal shared decision-making process has three core elements to help patients become active partners in their health care: (a) clinical information about health conditions, treatment options, and potential outcomes; (b) tools to help patients identify and articulate their values and priorities when choosing medical treatment options; and (c) structured guidance to help patients integrate clinical and values information to make an informed treatment choice.

The AMA supports the concept of voluntary use of shared decision-making processes and patient decision aids as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions. We oppose any efforts to require the use of patient decision aids or shared decision-making processes as a condition of health insurance coverage or provider participation. But we support the development of demonstration and pilot projects to help increase knowledge about integrating shared decision-making tools and processes into clinical practice, as well as efforts to establish and promote quality standards for the development and use of patient decision aids, including standards for physician involvement in development and evaluation processes, clinical accuracy, and conflict of interest disclosures.

The AMA supports empowering patients by giving them the option of being part of an ACO or other APM, providing them with understandable fee/price information and incentives to make prudent choices,

and empowering the medical profession to enforce ethical and clinical standards that continue to place patients' interests first. The government's recent releases of Medicare claims data do not fulfill this need due to holes in the data and the lack of adequate context to enable patients to accurately predict the cost and quality of care they are likely to receive from a particular provider. Individual patients should have the freedom to choose their physician and system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.

In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit.

Legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements, and could include the input of the state medical society and the AMA.

8. Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.

The AMA fully supports physician-led interprofessional health care teams, and initiatives to support this team model. Only physicians have the leadership knowledge, skills, and expertise necessary to identify, engage, and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills. Care coordination and case management are integral to the team's practice, and transitions should be managed by the team in an effective, efficient manner that is transparent to the patient and the family. These models of care should incorporate the following elements and principals:

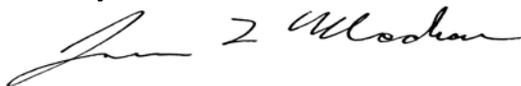
- **Patient-Centered Care:** The patient is an integral member of the team. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient. Patient and family-centered care is prioritized by the team and approved by the physician team leader. Team members are expected to adhere to agreed-upon practice protocols. Improving health outcomes is emphasized by focusing on health as well as medical care. Patients' access to the team, or coverage as designated by the physician-led team, is available 24 hours a day, seven days a week. Safety protocols are developed and followed by all team members.
- **Teamwork:** Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team. All practitioners commit to working in a team-based care model. The number and variety of practitioners reflect the needs of

the practice. Practitioners are trained according to their unique function in the team. Interdependence among team members is expected and relied upon. Communication about patient care between team members is a routine practice. Team members complete tasks according to agreed-upon protocols as directed by the physician leader. Independent physician practices and small group practices should be encouraged to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers.

- **Clinical Roles and Responsibilities:** Physician leaders are focused on individualized patient care and the development of treatment plans. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader. All members of a physician-led interprofessional health care team should be able to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care. Population management monitors the cost and use of care, and includes registry development for most medical conditions.
- **Practice Management:** Electronic medical records are used to the fullest capacity. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.
- **Public Reporting at the Team/Group Level:** Public reporting of quality and outcomes data for team-based care should only be done at the group/system/facility level, and not at the level of the individual physician. The current regulatory framework of public reporting for Meaningful Use (MU) should also provide “group-level reporting” for medical groups/organized systems of care as an option in lieu of requiring MU reporting only on an individual physician basis.

The AMA appreciates the opportunity to provide suggestions regarding how to improve care for Medicare patients with chronic conditions, and we look forward to working with the Committee and the Chronic Care Working Group on this important initiative.

Sincerely,

A handwritten signature in cursive script, appearing to read "James L. Madara".

James L. Madara, MD