



January 26, 2016

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The Honorable Mark Warner
Committee on Finance
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Dear Senators Hatch, Wyden, Isakson, and Warner:

On behalf of the Society of General Internal Medicine (SGIM), representing approximately 3,500 general internists, we appreciate the opportunity to provide comments on the Senate Finance Committee's Bipartisan Chronic Care Working Group Policy Options Document. 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. We are pleased to offer the comments below.

Expanding the Independence at Home Model of Care

SGIM supports innovative models for improving access to home care services for Medicare beneficiaries. Care provided in this 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 may go a long way towards controlling the overall costs of long term care.

The Independence at Home (IAH) model of care appears to be successful at improving health outcomes and controlling costs of care for homebound Medicare beneficiaries, based on available data. SGIM supports expansion of this program to more patients in more settings. If the program continues to show positive outcomes it may be justifiable to expand the IAH program to a "permanent, nationwide program." However, any expansion should include opportunities for continued innovation, and assistance for providers in building care coordination networks to enable effective implementation of the model. It would be advisable for the Centers for Medicare and Medicaid Services



(CMS) to coordinate with states as they transform their health care delivery systems through the State Innovation Model (SIM) program, to ensure that the IAH program is integrated with ongoing changes to care coordination systems at the state and local level.

SGIM supports implementation of risk models such as hierarchical condition categories (HCC) risk scores as a way to identify complex chronic care beneficiaries for inclusion in IAH instead of requiring that the individual undergo a non-elective hospitalization within 12 months of his or her IAH program participation. The IAH model may be most effective at cost containment when employed prior to hospitalization rather than being delayed until serious complications or decline have occurred. Use of HCC may also help ensure access to services by those who are in greatest need, and likely to benefit most, by preventing cherry picking of participants in the programs. Use of an established risk model such as HCC should make it easier for providers and the networks they participate in to adapt the IAH model to current care systems.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

SGIM strongly supports the development and implementation of a new high-severity chronic care management code that could be billed under the Physician Fee Schedule (PFS). According to a CMS report entitled, *Chronic Conditions among Medicare Beneficiaries*, 23 percent of beneficiaries have 4 or 5 chronic conditions and 14 percent have 6 or more. Given this data and the complexity of a patient with multiple comorbidities, we recommend that a new high severity code be used for patients with 4 or more chronic conditions or one chronic condition in conjunction with Alzheimer's or a related dementia. We believe that 5 chronic conditions is too high a threshold for this service.

We also recommend that the working group work with CMS to ensure that the documentation requirements for this service are not overly burdensome such that physicians are discouraged from billing for this service. One of the chief complaints of the existing chronic care management service is that the requirements, including documenting the time spent, are so burdensome that physicians forego billing for the service that is currently reimbursed at \$42. This must be considered when determining both the requirements and potential reimbursement rate. SGIM supports instituting the new code on a temporary basis to allow CMS and Congress to review the data and determine the service's effectiveness.

Increasing Convenience for Medicare Advantage Enrollees through Telehealth

SGIM strongly recommends that telehealth services should not be limited to those with traditional Medicare; they should be provided to Medicare beneficiaries both in



traditional Medicare and Medicare Advantage (MA). For beneficiaries who live in remote areas with limited access to primary care physicians and certain specialists, telehealth services are critically important and improve their access to services, particularly those that help them better manage their chronic conditions.

We understand that telehealth technologies are rapidly evolving, and we urge the working group and CMS not to create requirements that are so specific that new technologies cannot be utilized once they are developed. We also recommend that the working group instruct CMS to evaluate and include new technologies that allow patients to access telehealth services from their homes. In the absence of new telehealth facilities and services at home, SGIM recommends that phone consultations be considered and reimbursed as telehealth services.

Providing ACOs the Ability to Expand the Use of Telehealth

We urge the working group to modify the originating site requirements for reimbursement for telehealth services provided by ACOs in the Medicare Shared Savings Program (MSSP). As we discussed above for MA, SGIM believes that telehealth services can play a critical role in improving the access to care and outcomes for patients with chronic conditions. Patients' access to these services should not be limited because their provider participates in an ACO.

Ensuring Accurate Payment for Chronically Ill Individuals

The working group is considering making changes to the CMS-HHS Risk Adjustment Model. We strongly support this proposal, and make the following recommendations. Accurate risk adjustment is critical to the success of new value based payment models currently being implemented by CMS. SGIM recommends that as changes are being made to this model that socioeconomic factors be included. These factors play an important role in patient outcomes and are not always adequately accounted for by risk adjustment models. Also, we recommend that the model use more than one year of data to establish a beneficiary's risk score. One year is a very small snapshot of beneficiary's health and during that period he or she may either under or over utilize health care services. The risk model should account for this.

Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization

SGIM supports the working group's proposal to allow ACOs in MSSP Track One to choose whether their beneficiaries are assigned prospectively or retrospectively. We recommend that those ACOs that choose prospective assignment also have a retrospective readjustment to make sure that the panels are accurate. Attribution



methods adopted should also preserve beneficiaries' freedom to choose their own care providers.

Developing Quality Measures for Chronic Conditions

SGIM supports the development of quality of care measures that better capture the outcomes of care for chronic conditions and that better incorporate patient centered outcomes. However, in developing such measures it is important to consider the potential burden for collecting quality data that may be placed on providers. Quality of care data collected for this purpose should as much as possible be based on current data sources and current methods for collection of patient centered data, rather than require providers to devote additional time and effort to collecting data and documenting these measures. Requiring additional time and effort for documentation could detract from providers' ability to deliver the level of care that will lead to optimal outcomes, and discourage providers from participating in chronic care innovations.

Encouraging Beneficiary Use of Chronic Care Management Services

SGIM supports waiving the beneficiary cost sharing requirement for chronic care management services. As the working group points out, many beneficiaries have supplemental policies that cover this cost sharing requirement, but for those who do not, this would be a significant benefit. This change would reduce some of the burden on practices who may wish to provide this service, but find the requirements overly burdensome compared to the reimbursement level.

Establishing a One-time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness

When patients are diagnosed with a serious illness, they are expected to digest a significant amount of information critical to controlling their condition within the confines of a regular office visit. Our members face this challenge when educating their patients who are newly diagnosed with chronic conditions, and we believe that a one-time visit devoted to sharing this information and answering patient questions would be extremely beneficial may significantly improve outcomes. Therefore, SGIM strongly supports this recommendation.

Eliminating Barriers to Care Coordination under Accountable Care Organizations

SGIM supports allowing ACOs in two-sided risk models to waive beneficiary cost sharing for items and services related to the treatment of chronic conditions. We believe that any steps to reduce patients' barriers to care may improve access and outcomes, as well as lower costs of care. In this case, waiving co-pays and cost sharing may encourage patients to receive care they otherwise would not have received,



potentially improving their outcomes. We recommend that the items and services for which cost sharing could be waived be defined in rulemaking to ensure uniformity across ACOs.

SGIM appreciates the opportunity to provide comments to the working group on its policy options document, and looks forward to working with you as you consider the comments outlined above and policy options moving forward. Please do not hesitate to contact Erika Miller at emiller@dc-crd.com or 202-484-1100, if we may provide any additional information or assistance.

Sincerely,

A handwritten signature in black ink that reads "Marshall Chin". The signature is written in a cursive style with a prominent "M" and "C".

Marshall Chin, President
Society of General Internal Medicine