

January 26, 2016

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

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

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

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

The Society of Hospital Medicine (SHM) appreciates the opportunity to provide comments to the United States Senate Committee on Finance Bipartisan Chronic Care Working Group policy options document. SHM shares the Working Group's commitment to improving the care of patients with multiple chronic illnesses. We concur with the need to increase care coordination, streamline Medicare's payment systems and incentivize the delivery of quality care. These are critical elements of comprehensive policies to address inconsistencies and gaps in care for patients who are living with multiple chronic conditions.

SHM represents the nation's nearly 50,000 hospitalists, who work primarily in acute care hospitals as well as increasingly in post-acute care settings. They are committed to providing high-quality care for hospitalized patients and work to improve the quality and efficiency of hospital care. In their role, hospitalists manage the care for many patients with multiple chronic conditions and lead the coordination of care for patients throughout their hospital stays and upon discharge. Hospitalists also see many of the highest-risk patients, who frequently do not have access to outpatient primary care providers, but could benefit the most from efforts to improve care for chronic conditions.

We offer the following comments on the policies under consideration:

Expanding the Independence at Home Model of Care

The Independence at Home (IAH) demonstration project, created by the Affordable Care Act, is an important test of the provision of real-time and high-touch care for patients living with chronic conditions. Ensuring patients can adequately manage their conditions will help improve outcomes for these patients and prevent unnecessary, expensive hospital and other facility stays.

As chronic conditions, even those that are well-managed, can involve hospitalizations, it is critical that efforts to coordinate care include providers beyond the outpatient primary care providers engaged in the IAH demonstration. Hospitalists have filled the historical role of primary care providers in the hospital and are critical partners in the coordination of care during and after hospital stays. In addition, as the scope of hospitalist practice expands, they are increasingly practicing in post-discharge clinics, post-acute facilities and other settings, where their style of management and care coordination is a high-value asset.

SHM believes there is an opportunity to engage hospitalists in an IAH expansion, ensuring that patients with multiple chronic conditions are receiving the care and support they need throughout the full continuum of care. The Working Group should consider expanding the eligibility for provider participation to ensure patients can access high-quality coordinated care to help manage their illnesses wherever they interact with the healthcare system.

One barrier to expanding the IAH demonstration is the difficulty in accessing primary care providers for patients during the discharge process, particularly for those patients who are most at-risk and could benefit the most from the coordination of care in the IAH model. Many at-risk patients face financial and social barriers to having consistent access to primary care services. As the Working Group considers this policy, it should address the needs of these patients, particularly those who do not already have relationships with an outpatient primary care team.

Providing Medicare Advantage Enrollees with Hospice Benefits

SHM agrees with the Working Group that the piecemeal approach to hospice care as currently experienced by Medicare Advantage (MA) enrollees needs to be addressed. As hospice is an important element of end-of-life care, earlier impediments to advance care planning must also be addressed in a comprehensive policy. The recently implemented advance care planning Common Procedural Terminology (CPT) codes (99497 and 99498) are an important initial part of helping patients make decisions about their end-of-life care, including whether to access hospice care. SHM recommends that, in addition to streamlining the accessibility of hospice benefits for MA enrollees, the Working Group must also dismantle barriers to end-of-life care conversations for all Medicare beneficiaries. Similar to policies under consideration related to the chronic care management (CCM) CPT codes, SHM recommends eliminating patient financial liabilities to encourage their use. This would help ensure patients and their families are actively informed and involved in end-of-life care decisions, particularly, in determining whether hospice care is the right option for them.

Improve Care Management Services for Individuals with Multiple Chronic Conditions

The Working Group is considering whether it would be helpful to institute a new high-severity chronic care management (CCM) code. We concur that the current structure of the CCM codes reimbursed by Medicare may not effectively capture the full amount of work performed by clinicians managing the care of some patients with multiple chronic conditions. SHM encourages the Working Group to keep in mind the same concerns and barriers about the current CCM codes as they contemplate a new high-severity CCM code. With the current codes, issues of labor-intensive documentation for providers, and added beneficiary cost-sharing prevents widespread use. SHM recommends that any new codes account for these issues prior to implementation.

Although hospitalists are not eligible to bill for the current CCM codes, SHM notes that hospitalists, by virtue of their patients and efforts around care coordination, are positioned perfectly to have an important role in the provision of care management for patients with multiple chronic conditions. SHM recommends the Working Group account for patient care management needs *across the spectrum of providers and settings in the healthcare system*.

Encouraging Beneficiary Use of Chronic Care Management Services

The Working Group is considering waiving beneficiary co-payment associated with the CCM code. SHM endorses this policy recommendation and believes such a change would lessen beneficiary financial risk while encouraging the use of the CCM code. The Working Group should also consider how to lessen the documentation burden associated with billing the codes, which currently stands as a significant provider disincentive for its use.

Increasing Transparency at the Center for Medicare & Medicaid Innovation

SHM appreciates that the Working Group is considering a methodology to balance enabling the Center for Medicare & Medicaid Innovation (CMMI) to act as a testing ground for new payment and delivery system models, while ensuring that stakeholders have a transparent role in the development of model policies. The Comprehensive Care for Joint Replacement (CCJR) notice and comment rulemaking period last year demonstrated the need for greater transparency on certain models established under the CMMI. SHM strongly supports a structured rulemaking process for all mandatory models, such as the CCJR. For any mandatory models, the notice and comment process should be engaged when significant changes are proposed. Since mandatory models do not give providers the option to choose what model fits for their practice, nor to work with CMS to tailor the requirements, a notice and comment rulemaking period would be the only source of input and collaboration between providers and CMMI on the underlying policies of the model. We note that the Affordable Care Act grants the Secretary of Health and Human Services the authority *through rulemaking* to expand models that either reduce spending without decreasing quality or increase quality without increasing spending. Since any expansion would move a model from “optional” to “mandatory” for providers, it follows that any mandatory CMMI model should also trigger a similar rulemaking requirement.

However, SHM harbors reservations about requiring notice and comment rulemaking for all CMMI models, as this would impede CMMI from making real-time adjustments or decisions on models in

progress. It would also restrict the high degree of flexibility CMMI maintains in working with groups and health systems when adapting models to address local needs and realities. Models that are optional and require participants to intentionally enter into an agreement with CMMI should not necessarily trigger a rulemaking process.

Conclusion

SHM appreciates participating in the Chronic Care Working Group's policy deliberations. We concur there is much work to be done to improve care for patients living with multiple chronic conditions and to streamline the Medicare payment system to encourage better care coordination. We look forward to continued work with the Committee as bipartisan legislative solutions are further developed. If you have any questions or require further information, please do not hesitate to contact Joshua Lapps, Government Relations Manager at jlapps@hospitalmedicine.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert Harrington, Jr.", written in a cursive style.

Robert Harrington, Jr, MD, SFHM
President, Society of Hospital Medicine