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Senate Committee on Finance Chronic Care Working Group 219 Dirksen Senate Office Building Washington, DC 20510-6200

Response to the December 2015 Bipartisan Chronic Care Working Group Policy Options Document

Dear Chairman Hatch, Ranking Member Wyden, Sen. Isakson, and Sen. Warner:

The American Academy of Neurology (AAN), the world's largest association of neurologists representing 30,000 professionals, welcomes the opportunity to submit comments in response to the Policy Options Document developed by the Senate Finance Committee's Chronic Care Working Group. The AAN remains strongly committed to improving the care and outcomes of persons with neurologic illness in the most cost effective manner.

Each year, neurologic disorders affect an estimated 50 million Americans and cost hundreds of billions of dollars in medical expenses and lost productivity. It takes significant time and skill to provide ongoing cognitive care to manage complex chronic conditions for people with neurologic diseases like Alzheimer's disease, Parkinson's disease, stroke, epilepsy, traumatic brain injury, ALS, multiple sclerosis (MS), and headache. Often, these diseases represent the highest-need, highestcost Medicare beneficiaries.

Neurology is primarily a non-surgical, non-procedural specialty. This means that neurologists provide face-to-face care, also known as evaluation and management (E/M) services, to people with complex neurologic conditions. In 2012, two-thirds of neurologists received 60 percent or more of their payment from E/M services and over 20 percent received all of their payment from E/M services.¹ Neurologists are trained to treat and to ensure continuity of care for Medicare patients with chronic neurologic diseases. In fact, the majority of neurologists (over 70 percent) see their Medicare patients on an ongoing basis, not as a one-time consultation or referral.¹¹

Patients are waiting longer than ever before to see a neurologist. Between 2014 and 2015, there was a *56 percent increase* in wait time for a new patient visit with a neurologist and a *36 percent increase* in wait time for a follow-up visit.^{III}

Many patients with neurologic conditions view their neurologist as their principal care physician. The neurologist cares for the underlying condition such as MS, epilepsy, or Parkinson's and coordinates the rest of the Medicare beneficiary's health care needs as necessary. For example, a patient with ALS will typically call

2016 AAN Annual Meeting Vancouver Convention Centre - Vancouver, BC, Canada April 15–April 21, 2016 2017 AAN Annual Meeting Boston Convention & Exhibits Center - Boston, MA April 22–April 29, 2017 their neurologist when they have a cough or a urinary tract infection because generalists often are not comfortable managing them. The care of patients with chronic illness requires the full spectrum of health care expertise. Focusing reforms or incentives to only primary care physician specialties would unnecessarily restrict the expertise that the sickest Medicare beneficiaries may require. The AAN urges the Working Group to keep this in mind as the final proposal is drafted.

In addition, we strongly discourage the use or reference to "primary care services" in the final proposal. Physicians who see patients face-to-face bill Medicare under new or established patient evaluation and management visit codes. There simply is no code in the fee schedule for "primary care services." Primary care physicians and cognitive specialists like neurologists bill *identical* codes and either may coordinate care for individual patients.

The Academy's comments on specific items from the Policy Options Document are below.

Expanding Use of Telehealth for Individuals with Stroke

The Academy strongly supports the elimination of the originating site geographic restriction on reimbursement for telestroke services. Removal of this barrier to telestroke care would uniformly increase stroke care coordination, improve patient outcomes, and ultimately reduce Medicare and Medicaid spending.

Stroke is a leading cause of serious long-term disability and the second leading cause of dementia, with nearly 800,000 strokes occurring per year.^{iv} About two-thirds of the total hospitalizations for stroke occur among adults age 65 and older,^v and approximately 94 percent of strokes occur in an urban or suburban area.^{vi} Unfortunately, a number of barriers prevent or slow treatment for a large number of patients, including the lack of availability of stroke specialists who can evaluate the patient and determine if he or she is a candidate for treatment. Timely access to a neurologist who can oversee administration of the latest therapies through expanded use of telestroke greatly improves the number of patients who receive the evidence-based treatment for stroke and reduces disability from stroke.^{vii}

Tissue Plasminogen Activator (tPA) is a clot-busting drug that helps reverse disability from the most common type of stroke if given within the first 3 to 4.5 hours of symptom onset. **The faster a patient receives treatment for stroke, the better the chances for recovery with minimal or no disability**. However, about one-third of Americans live more than an hour from a primary stroke center,^{viii} and only 27 percent of stroke patients arrive at the hospital within 3.5 hours of symptom onset.^{ix} Additionally, there are currently only four neurologists per 100,000 persons in the US,[×] meaning that even emergency departments in urban and suburban areas are not able to have stroke neurologists readily available. As a result of these barriers, only 3 to 6 percent of stroke patients receive tPA.

Telestroke can help fill this void, and evidence-based research supports its use and effectiveness. For instance, evidence shows that telestroke has proven to be very effective in increasing the use of tPA and reducing the amount of time it takes to get treatment to patients, in both urban and rural areas.^{xi} Another recent study of four urban hospitals in Illinois found that their utilization of tPA increased by two to six times after telestroke was implemented.^{xii}

Finally, telestroke can save money by reducing stroke-related disability and the need for costly inpatient rehabilitation or long-term care. **Stroke is currently the leading cause of Medicare admissions to inpatient rehabilitation facilities, accounting for nearly 20 percent of all such admissions.**^{xiii} According to one study, patients receiving tPA were more likely to be discharged to home than to inpatient rehabilitation or nursing homes and the study projected savings in rehabilitation and nursing home costs of \$10.2 million (in 2013 dollars) per 1,000 additional patients treated with tPA.^{xiv} In addition, a similar study published in the *New England Journal of Medicine* showed patients receiving clot-busting therapy were at least 30 percent more likely to have minimal or no disability at three months when compared to patients who did not receive this treatment. The study also found that these patients have shorter hospital stays and are more frequently discharged to their homes rather than to nursing homes.

An analysis conducted by the American Heart Association/American Stroke Association found that lifting the rural site requirement specifically for telestroke evaluations **could result in \$1.2 billion in net savings to Medicare and Medicaid over 10 years**. In addition to strong data in support of telestroke's efficacy, the savings from reduced disability would begin to accrue almost immediately, as opposed to years down the road. We strongly urge the Working Group to include the elimination of the originating site geographic restriction for telestroke in your final proposal.

Providing ACOs the Ability to Expand the Use of Telehealth

In addition to removing the originating site requirement for telestroke services, the Academy supports its removal for all telehealth services, including those provided by accountable care organizations (ACOs). Telehealth is a valuable tool to maintain care, especially for patients with limited mobility or for those who need remote monitoring.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

People with complex medical conditions routinely need and receive care that Medicare does not pay for, particularly for non-face-to-face care. The Chronic Care Management (CCM), CPT code 99490, is an attempt to address such a gap and to improve the care coordination of these patients. CPT also created code 99487 to describe similar staff services for a full 60 minutes, and code 99489 to describe an additional 30 minutes of staff service, but CMS does not pay for those codes. **More frequent contact at home can catch emerging problems at an early stage and help avoid hospitalization, but providers cannot long continue to provide these services at no charge.**

Even though CMS covers payment, it is difficult for providers to bill 99490. When a neurologist is coordinating care after a stroke, it may not be clear whether the primary care physician is billing 99490 to coordinate care of diabetes, congestive heart failure, and other disorders. Documentation requirements for 99490 are not clear, and collection of copayment is a disincentive. We suggest that CMS require patients to authorize non-face-to-face services in advance, to avoid later questions of attribution.

We note that the current highest level office visit for an established patient, 99215, includes 15 minutes of immediate post-service time by the provider and eight minutes of immediate post-service time by staff. **Payment for provider and staff time should significantly exceed those times, to ensure that payment is made only for truly complex care.** We propose that the Working Group support payment for non-face-to-face time in increments of 30 minutes of provider time and 20 minutes of staff time, when the provider and/or staff perform services of the types listed in the current CCM code. We suggest that codes include provider or staff time within a calendar month, rather than within a 30-day period.

In addition, there are many patients who need chronic complex care, but who do not qualify for service as defined in code 99490. That code describes **staff services**, **not provider services**, to patients who have two or more illnesses that are expected to last twelve months or for the life of the patient and put the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. **Medicare should cover similar cost-effective non-face-to-face services as follows:**

• Non-face-to-face care provided by the **physician**, rather than by staff.

- Services by staff or physician to patients with a **single complex chronic condition** placing the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Patients with prolonged but self-limited illness such as Guillain-Barre syndrome, or exacerbations of chronic illness such as sickle cell anemia, may have lower expenses and better outcomes if managed aggressively as outpatients.
- Services by staff or physician to patients with a **single acute illness** placing them at high risk for hospitalization.

We suggest that CMS develop G codes to allow reporting of these services while research is performed to determine the effects on costs and outcomes.

Furthermore, the AAN supports CMS payment for well-defined services including: Anticoagulant Management (CPT Codes 99363 and 99364); Education and Training for Patient Self-Management (CPT Codes 98960-98962); Medical Team Conference (CPT Codes 99366-99368); Telephone Services (CPT Codes 99441-99443 and 98966-98969); and Analysis of Computer Transmitted Data (CPT Code 99091).

Encouraging Beneficiary Use of Chronic Care Management Services

As noted, we support waiving cost sharing for CCM services, or for the similar services proposed above. Though requiring beneficiaries to authorize such services in advance could reduce confusion, maintaining the copay is likely to constitute a barrier.

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

The AAN strongly supports development of a payment code to recognize the extraordinary attention required following the diagnosis of Alzheimer's Disease/dementia or other similar life-changing illness. Too many individuals diagnosed with dementia are never given the opportunity to fully discuss the diagnosis, their options for treatment and support, or develop a comprehensive care plan. We urge the Working Group to also include other neurodegenerative disease such as amyotrophic lateral sclerosis (ALS), Parkinson's disease, and multiple sclerosis (MS) as eligible conditions for a Medicare-covered planning visit for patients and/or caregivers.

Depending on the condition and stage of illness at diagnosis, the planning session may need to include genetic counseling, caregiver support resources, and care planning options. A payment code for a unique planning visit could be similar to codes for Advance Care Planning, for which CMS began coverage of in 2016. The goals of the planning visit would be distinct from the existing and proposed CCM codes.

Developing Quality Measures for Chronic Conditions

The AAN believes measuring caregiver support, outcomes, affordability, and engagement with the health care system are essential for all chronic conditions and not just Alzheimer's disease and dementia. We recommend that the policy not specify individual disease states, but rather reiterate the importance of assessing these concepts for all chronic conditions.

Expanding the Independence at Home Model of Care

The Academy was a supporter of the original Independence at Home Act and welcomed its inclusion in the Affordable Care Act. With the progression of the alternative payment models, such as accountable care organizations, however, we suggest that many of the services included in the demonstration are or

could be done through an ACO model. A separate mechanism to provide such services may be unnecessary.

Conclusion

There are more than 600 neurologic conditions—most are chronic and too many lack cures or disease-modifying treatments. Diagnosis and management of neurodegenerative diseases in particular requires extensive time and expertise. Efforts to improve the management of chronic care in Medicare beneficiaries must recognize the continuum of needs of patients with chronic illness. For chronically ill patients with aggravating factors such as cognitive or functional impairment and/or reliance on caregivers, advanced care coordination is needed. For patients with chronic illnesses that can be managed with medication and lifestyle changes, more basic care coordination is appropriate. The AAN hopes the Committee bears that distinction in mind when considering reform.

The AAN appreciates the opportunity to provide feedback on the Working Group's proposal. Incorporation of the ideas outlined above into the Senate Finance Committee's draft legislation is key to addressing the unique needs of Medicare beneficiaries with chronic neurologic illness. If you have questions or would like to discuss any of these proposals further, please contact Mike Amery, Esq., at <u>mamery@aan.com</u> or (612) 928-6126.

Sincerely,

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Terrence L. Cascino, MD, FAAN President, American Academy of Neurology

ⁱ Skolarus LE, Burke JF, Callaghan BC, Becker A, Kerber KA. Medicare payments to the neurology workforce in 2012. *Neurology*. Epub 2015 Apr 1.

ⁱⁱ Craft K., Donofrio P., Shepard K. et al. Practice and payment trends in neurology in 2012. Neurology. 2013; 3: 233-239.

^{III} American Academy of Neurology. Neurology Compensation and Productivity Report. 2015 Report Based on 2015 Data.

¹^v Go, Alan S., et al. Heart disease and stroke statistics—2014 update: A report from the American Heart Association. *Circulation*. 2014.129.3: e28.

^v Hall MJ, et al. National Center for Health Statistics Data Brief: Hospitalization for Stroke in U.S. Hospitals, 1989-2009. May 2012. Accessed online at: <u>http://www.cdc.gov/nchs/data/databriefs/db95.pdf</u>.

^{vi} Based on 2013 CDC survey data which reported the prevalence of stroke was 2.4 percent for adults living within a MSA and 3.2percentfor adults living outside a MSA. Using US Census Bureau estimates of the population living in MSAs and non-MSAs, we estimated the total number of strokes occurring in MSAs and non-MSAs

vⁱⁱ Schwamm, LH, et al. A review of the evidence for the use of telemedicine within stroke systems of care: A scientific statement from the American Heart Association/American Stroke Association. *Stroke*. 2009. 40. 7: 2616-2634.

viii Adeoye O, et al. Geographic Access to Acute Stroke Care in the United States. Stroke. 2014; 45. Published online Aug. 26, 2014.

^{1x} Tong D, et al. Times from symptom onset to hospital arrival in the Get With the Guidelines-Stroke Program 2002 to 2009: temporal trends and implications. *Stroke*. 2012; 43: 1912-1917.

^{*} Freeman, WD, et al. The workforce task force report clinical implications for neurology. *Neurology*. 2013.81.5: 479-486.

^{xi} Schwamm, LM, et al., 2009.

xii Cutting S, et al. Telestroke in an urban setting. *Telemed JE Health*. 2014; 20 (9):855-7.

^{xiii} MedPAC, 2015.

xiv Fagan SC, et al. Cost-effectiveness of tissue plasminogen activator for acute ischemic stroke. *Neurology*. 1998; 50: 883-890. The original numbers in 1996 dollars have been updated for inflation.