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The Honorable Orrin Hatch
Chairman
Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

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

On behalf of the American College of Osteopathic Family Physicians (ACOFP), I appreciate the opportunity to offer comments on the policy options under consideration by the Senate Finance Committee's Bipartisan Chronic Care Working Group. The ACOFP is encouraged by the ongoing efforts of the working group, and we are eager to build upon our comments submitted to the committee last year by the ACOFP and the osteopathic profession as a whole. We also applaud the committee for working in a transparent manner and for continuing to engage stakeholders throughout this process.

The ACOFP represents more than 20,000 practicing osteopathic family physicians, residents, and students throughout the United States who are dedicated to improving health outcomes for all patients. Osteopathic family physicians are trained in a whole-person approach with a focus on prevention, and take into account how a patient's individual circumstances and lifestyle affect their overall health and well-being. As our country struggles with the increased prevalence of chronic disease, especially a growing patient population with multiple chronic conditions, the osteopathic approach serves as a model for how our broader health care system can successfully reduce the burden of this deeply concerning public health problem.

As the working group and the Finance Committee review this feedback, we again would like to highlight the value of prevention in addressing chronic illness. Unfortunately, the current scoring process used by the Congressional Budget Office (CBO) is not equipped to reflect the long-term cost savings of preventive efforts included in legislative proposals. As the full impact of prevention is often not fully realized until many years later, the true long-term cost savings of preventive efforts may not be readily apparent in the ten-year budget window. We again encourage the committee to take into consideration legislation to require the CBO to extend the budget window when an initial analysis finds that a provision would result in substantial savings outside the budget scoring window.

Expanding the Independence at Home Model of Care

The success of the Independence at Home (IAH) demonstration program has been recognized by Congress, health care providers, and most importantly, by patients. The IAH model allows providers to spend more time with chronically ill patients in a setting where the individual is most comfortable, and produces tangible results with reduced hospitalizations and savings for the Medicare system.

Should IAH be expanded into a permanent, nationwide program, considerations should be made to ensure that smaller practices are able to participate. Osteopathic family physicians often operate smaller practices in rural and underserved areas, and accordingly, could be adversely affected by even a small number of chronically ill patients in their beneficiary assignments. Allowing multiple small practices to pool risk would provide certainty for participating practices and help establish positive networks of shared resources. While recognizing there could be reasonable limitations on such risk pooling arrangements, appropriate flexibility should be provided with respect to practice size, group size, or geographic restrictions.

Regarding the Working Group's consideration of the use of hierarchical condition categories (HCC) risk scores as a way to identify complex chronic care beneficiaries for inclusion in IAH rather than requiring the individual undergo a non-elective hospitalization within 12 months of his or her IAH participation, there may be advantages and disadvantages to both. Emphasis should be placed on a process that captures potentially high-cost patients with high risk of readmission. While HCC are one good indicator of potential future costs, they are not necessarily linked to hospitalizations or care transition to prevent readmissions.

Expanding Access to Home Hemodialysis Care

Home hemodialysis therapy offers patients expanded access to the care they need, especially for those in rural areas or underserved communities.

With regard to the Working Group's consideration of additional safeguards for patients receiving home dialysis therapy, ACOFP encourages the implementation of safeguards that require an in-person physician visit depending on the severity of the patient's condition. We suggest a reasonable interval would be at least one in-person physician visit every six months, and once every three months for patients with more severe conditions. While these serve as general guidelines, ultimately physician discretion should determine the most appropriate interval.

ACOFP also recommends against considering the home as an originating site for the purposes of telehealth services. There are simply too many variables that can affect the quality of care and increase costs and this problem would only be magnified by each additional patient's unique circumstances.

Providing Medicare Advantage Enrollees with Hospice Benefits

ACOFP recognizes the Working Group's intent to align Medicare Advantage (MA) plans with Medicare Part A plans which provide hospice benefits. As the Working Group notes, the current system leads to disruptions in care or fragmented delivery. Ensuring an appropriate and seamless transition from curative care to hospice treatment should be a priority whether a patient is covered under Part A or an MA plan.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

Chronic Care Management (CCM) codes represent an important step toward appropriate recognition of care management services and we support the Working Group's intent to develop a new high-severity CCM code.

As the committee develops this policy, the shortcomings of the current CCM codes should be examined and addressed. Unfortunately, the current CCM code may only be used for a patient with two or more chronic conditions, once per month for a 20-minute period of clinical staff time. Further, the administrative burden of documenting care to bill for these codes compared to the low reimbursement rate is a disincentive for many physicians and should be addressed.

If preventive care is to be truly valued, investments should be made on the front end that allow primary care physicians to spend the necessary additional time with patients to ensure they understand their care plan, and to do so with minimal administrative burdens. Not only would this be extraordinarily more cost-effective than paying for hospitalizations or more acute treatment in the future, but most importantly, it would greatly improve a patient's quality of life and general well-being.

Patient criteria for this code should be beneficiaries with three or more chronic conditions, one chronic condition in conjunction with Alzheimer's or a related dementia, or a chronic condition combined with impaired functional status.

As to the providers who would be eligible to bill a new high-severity CCM code, ACOFP supports the concept of physician-led, team-based care. Eligible providers should be DOs or MDs in primary care fields like family medicine, internal medicine, pediatrics, or geriatrics, as is current Medicare policy.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

The foundation of the osteopathic medical profession is the focus on the "whole person," and our training takes into account not only a patient's immediate symptoms and conditions, but also other factors like psychosocial or socioeconomic determinants of health. We applaud the committee for working to address the pervasive fragmentation of behavioral health and primary care that currently exists throughout our health care system.

As long-time proponents of the Patient-Centered Medical Home (PCMH), ACOFP encourages the working group to use the PCMH as a model of how care can be coordinated and better integrated across specialties to address the full spectrum of a patient's needs.

Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

With regard to the Working Group's efforts to provide flexibility for MA plans, ACOFP supports allowing MA plans to offer additional supplemental benefits not currently allowed that are related to the treatment of chronic conditions or prevention of the progression of the chronic disease, as well as adjustments to provider networks that allow for greater inclusion of providers to treat such conditions. Broader networks ensure that patients have access to the care they need and deserve. In order to ensure that care is not disrupted, costs should not be shifted back to the beneficiary.

All MA plans should be included, otherwise only a small subset would benefit from this change. Chronic diseases could be identified by both their cost and ICD-10 codes.

Increasing Convenience for Medicare Advantage Enrollees through Telehealth

Telehealth services offer patients and providers an expanded set of options in the delivery of care. However, ACOFP believes that expanding telehealth services should not be used as a substitute for network adequacy requirements.

At first, telehealth services provided under MA should be limited to those currently available under traditional Medicare. Additional services could be considered after a certain period of time, for example after five years, though we defer to the committee on what an appropriate time period would be.

Expanding Use of Telehealth for Individuals with Stroke

ACOFP is concerned by legislative approaches that target a single disease for telehealth expansion and the precedent this action would set for future expansions of telehealth services. As osteopathic family physicians, we understand the need for early intervention for stroke, but remain concerned with the legislative approach to this matter.

Ensuring Accurate Payments for Chronically Ill Individuals

ACOFP supports the Working Group's views that accurate risk adjustment is imperative to ensuring providers and plans are fairly paid for the costs incurred for carrying for chronically ill individuals. As the committee notes, HCC codes can under-predict high cost, complex individuals, and ACOFP strongly supports efforts to further refine risk assessment models. We appreciate the committee's attention to this important matter.

Developing Quality Measures for Chronic Conditions

With regard to the development of new quality measures, we urge the Working Group to ensure that any new measures have a demonstrable benefit and are measurable, and do not simply add work to the physician workflow and contribute to a "check-the-box" mentality. Physicians have been subjected to increased reporting burdens and measures of questionable value which contribute to increased physician burnout and lower job satisfaction. Of greatest concern, however, is the effect this burden has in diverting attention to computer screens and away from patient interaction. There are the additional issues of the increased burden upon staff and the volume of work to be processed, among many others, but ultimately this issue is patient-centered – measures must provide real benefits for the patient and his or her health and well-being.

Whole-person, patient-centered care is the guiding philosophy of osteopathic family medicine. As such, patient engagement and satisfaction is an important factor in care. However, we urge the committee to exercise caution when considering new patient-reported measures, as patient expectations may not always align with medical realities or best practices. Additionally, other unrelated factors may weigh into a patient's satisfaction regardless of the appropriateness of the care provided. To this end, we again highlight the importance of the patient-physician relationship and urge that any such patient-reported measures be developed in partnership with patients and physicians.

Finally, before adding any new measures, efforts should first focus on streamlining and aligning measures across federal programs.

Encouraging Beneficiary Use of Chronic Care Management Services

ACOFP supports waiving the beneficiary co-payment associated with the current CCM codes to reduce beneficiary confusion about chronic care management services and to encourage greater utilization of preventive services. Again, we urge the Working Group to ensure that in waiving the co-payment that costs are not shifted to beneficiaries through higher premiums or other methods. Further, we refer to our previous comments above about the existing shortcomings of the CCM codes.

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

ACOFP supports the establishment of a one-time visit code for care planning purposes. We appreciate the Working Group's recognition of the fact that a serious diagnosis like Alzheimer's or other life-threatening condition merits a conversation with a patient to determine the best course of action moving forward. This code

should reflect the time spent with the patient to appropriately address the topic and care plan, and should also take into consideration the complexity of the illness(es).

The central philosophy of osteopathic family medicine guides us in providing whole-person care, and having these conversations is something many do even without reimbursement because it is for the benefit of our patients. ACOFP supports policies that recognize the value of these critical services.

Expanding Access to Prediabetes Education

Diabetes represents one of the most significant and growing burdens on our health care system, and osteopathic family physicians are at the forefront of preventive efforts to reduce the prevalence of this disease. ACOFP supports the Working Group's efforts to expand access to evidence-based lifestyle interventions under Medicare Part B that help people with prediabetes reduce their risk of developing diabetes. Such efforts should be coordinated with a primary care physician to ensure appropriate delivery of care.

We are grateful for the opportunity to work together with you and for the committee's consideration of these comments. The ACOFP appreciates your continued efforts to improve chronic care management and improve the health of patients throughout our country, and we look forward to continuing this important work to develop whole-person, patient-centered solutions.

Sincerely,

Kevin V. de Regnier, DO, FACOFP *dist.*
ACOFP President