3300 Woodcreek Drive
Downers Grove, Illinois 60515
630-573-0600 / 630-963-8607 (fax)
Email: info@asge.org
Web site: www.asge.org

January 26, 2016

The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate
Washington, D.C. 20510

The Honorable Johnny Isakson
U.S. Senate
Washington, D.C. 20510

The Honorable Mark Warner
U.S. Senate
Washington, D.C. 20510

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

The American Society for Gastrointestinal Endoscopy (ASGE) applauds you for initiating a bipartisan process to address the challenges in caring for Medicare patients with chronic conditions and appreciates your solicitation of ideas from public and private stakeholders on ways to improve outcomes for this patient population. We are pleased to have the opportunity to comment on the Bipartisan Chronic Care Working Group Policy Options Document that summarizes key policy ideas offered by the stakeholder community that have the potential to improve care coordination in the Medicare program.

Specifically, ASGE offers comment on the following sections of the options document:

- **IMPROVING CARE MANAGEMENT SERVICES FOR INDIVIDUALS WITH MULTIPLE CHRONIC CONDITIONS**
- **MAINTAINING ACCOUNTABLE CARE ORGANIZATION FLEXIBILITY TO PROVIDE SUPPLEMENTAL SERVICES**
- **PROVIDING FLEXIBILITY FOR BENEFICIARIES TO BE PART OF AN ACCOUNTABLE CARE ORGANIZATION**
- **ENCOURAGING BENEFICIARY USE OF CHRONIC CARE MANAGEMENT SERVICES STUDY ON OBESITY DRUGS**

IMPROVING CARE MANAGEMENT SERVICES FOR INDIVIDUALS WITH MULTIPLE CHRONIC CONDITIONS

The chronic care working group is considering establishing a new high-severity chronic care management code that would reimburse clinicians for coordinating care outside of a face-to-face encounter for Medicare's most complex beneficiaries living with multiple chronic conditions.

We believe a new high-severity chronic care management code would be an appropriate and welcome addition to existing codes and should recognize work/time spent by physicians and other qualified health care professionals rather than the work/time of office staff on behalf of these complex patients. The CPT Editorial Panel is considering a draft proposal during its February 2016 meeting for such a code, but legislative action to accomplish this same goal would be greatly appreciated. The specific requirements of such a code, however, should be focused on increments of time spent rather than being overly prescriptive in the details of the content of such a service. A nomenclature such as "initial 20 minutes" and "each subsequent 20 minutes" within a calendar month in conjunction with a satisfactory descriptor of the type of patients and types of services on behalf of whom this work is performed would greatly facilitate greater provision of such services on behalf of a patient population in great need. This approach would also enfranchise specialty physicians, rather than just focusing on primary care.

The Working Group should consider modifications to the existing chronic care management codes, which reflect work/time of physician staff under the physician's supervision. These services are quite complex to implement because existing CPT code 99490 must be implemented within an Annual Wellness Visit or a highest level patient visit, the former being a service not provided by specialists, and the latter requiring more time or more detail of history, physical exam and decision making than might be pragmatically required to implement chronic care management.

The detailed prescriptive requirements particularly related to content of the comprehensive plan of care, electronic health record content and 24/7 access is too great a hurdle for many solo, small group and rural practitioners; and often for specialists involved in care coordination of individuals with one dominant health problem (e.g. cirrhosis, inflammatory bowel disease for gastroenterologists). The requirement for the patient having two or more serious chronic conditions similarly precludes patients with one disease problem which requires complex care.

Lastly, we believe the patient copay should be waived as an incentive to patients to receive such services. We are aware that primary care physicians currently encounter much resistance in trying to obtain patient written consent when the copay issue is broached. Patients feel they have traditionally received such services gratis as part of existing evaluation and management services and do not appreciate the complexity and resource costs of more complex services.

MAINTAINING ACCOUNTABLE CARE ORGANIZATION FLEXIBILITY TO PROVIDE SUPPLEMENTAL SERVICES

The Chronic Care Working Group is considering clarifying that Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP) may furnish a social service or transportation service for which payment is not made under Medicare fee-for-service.

ASGE supports this clarification. It is not uncommon for Medicare patients to forgo or miss their colonoscopy appointment (or clinic appointments) because of a lack of transportation. With respect to colonoscopy, in addition to transportation to the appointment, the sedation aspect typically means an escort following the procedure is also required and this is a hardship for some patients. An ACO would want to provide its own transportation/escorting to ensure compliance, particularly because colon cancer screening is a quality metric in MSSP.

PROVIDING FLEXIBILITY FOR BENEFICIARIES TO BE PART OF AN ACCOUNTABLE CARE ORGANIZATION

The Chronic Care Working Group is soliciting feedback on whether a beneficiary who voluntarily elects to be assigned to an ACO should be allowed to receive services from providers that are not participating in the ACO. Under such a scenario, ASGE strongly supports allowing a beneficiary to receive services from providers not participating in the beneficiary's ACO. Specialists may not be part of an ACO, but as long as they accept Medicare, their services should be available to beneficiaries regardless of whether the specialist is in the beneficiary's ACO. We also wish to bring to the Working Group's attention situations where beneficiaries are being assigned to an ACO based upon services provided by a specialist. While, in some cases, a specialist may be managing a patient's primary care, this is not the situation in all cases. A beneficiary should be assigned to a specialist in an ACO only when that specialist is managing that patient's overall care.

ELIMINATING BARRIERS TO CARE COORDINATION UNDER ACCOUNTABLE CARE ORGANIZATIONS

The Chronic Care Working Group is considering allowing ACOs in two-sided risk models to waive beneficiary cost sharing, such as co-payments, for items/services that treat a chronic condition or prevent the progression of a chronic disease.

ASGE supports this idea and suggests that the ACO should be allowed to determine which items/services are exempt from cost sharing, as they would have the best understanding of what services are not being fully utilized among their unique population of patients. Even in a one-sided risk model, there could be the potential for cost savings to the Medicare program if incentives are tied to otherwise underutilized services that stop or slow the progression of disease. If a waiver of cost sharing for items/services that treat a chronic condition or prevent the progression of a chronic disease is instituted, then that waiver should include copays, coinsurance and deductibles.

ASGE wishes to take this opportunity to remind the Working Group that under current law, Medicare beneficiaries who receive a screening colonoscopy for the prevention of colorectal cancer and have a potentially precancerous polyp removed during the screening are required to pay a coinsurance. When the screening occurs without the discovery and removal of a polyp, coinsurance does not apply. Consistent with the idea to encourage the use of services that can prevent or stop the progression of disease by eliminating beneficiary cost sharing, we urge the Working Group to support legislation and Congressional action this year to waive beneficiary coinsurance for colorectal cancer screening colonoscopy with polyp removal. The "Removing Barriers to Colorectal Cancer Screening Act," (S. 624), which currently has 29 cosponsors, would accomplish this much-needed change in beneficiary cost-sharing policy.

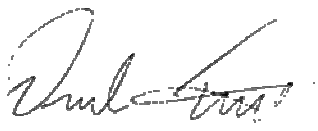
STUDY ON OBESITY DRUGS

The Chronic Care Working Group proposes to study the utilization and effect of obesity drugs in both the Medicare and non-Medicare populations. Part of this study would focus on use and effect of medical interventions for individuals not taking obesity drugs. We support this proposal, which begins to compare the effectiveness of obesity drugs to non-pharmacological interventions in combatting obesity. In addition to including established surgical interventions, this study should also encompass obesity treatment devices approved by the Food and Drug Administration (FDA), including the gastric band system, electrical stimulation systems, and the gastric balloon systems. In particular, two new gastric balloon systems (ReShape and Orbera) were FDA approved in 2015 and are unique in that their placement can be performed endoscopically - a much less invasive procedure to surgery. The ASGE and its Association for Bariatric Endoscopy would welcome such a study to identify the most appropriate options for Medicare and non-Medicare populations.

Conclusion

ASGE appreciates your consideration of its input and looks forward to future opportunities of engagement as you continue your process of addressing the needs of patients with chronic conditions. Should you require additional information and for future communications on this topic, please contact Camille Bonta, ASGE Washington representative, at cbonta@summithealthconsulting.com or (202) 320-3658.

Sincerely,



Douglas O. Faigel, MD, FASGE
President
American Society for Gastrointestinal Endoscopy