AMDA - The Society for Post-Acute and Long-Term Care Medicine

11000 Broken Land Parkway
Suite 400
Columbia, MD 21044-3532

(410) 740-9743

Washington DC
(301) 596-5774

Toll Free
(800) 876-AMDA

Fax
(410) 740-4572

www.amda.com
www.paltcmedicine.org

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The Honorable Orrin Hatch
Chairman, Senate Committee on Finance
104 Hart Senate Office Building
Washington, DC 20510

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

The Honorable Johnny Isakson
United States Senator
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senator
475 Russell Senate Office Building
Washington, DC 20510

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

AMDA – The Society for Post-Acute and Long-Term Care Medicine (AMDA) appreciates the opportunity to comment on the December 2015 Senate Committee on Finance Bipartisan Chronic Care Working Group Policy Options Document.

AMDA is the only medical specialty society representing the community of over 50,000 medical directors, physicians, nurse practitioners, physician assistants, and other practitioners working in post-acute and long-term care (PA/LTC) settings. AMDA's 5,500 members work in skilled nursing facilities, long-term care and assisted living communities, Continuing Care Retirement Communities, home care, hospice, Program for All-Inclusive Care for the Elderly (PACE), and others.

AMDA applauds the Committee's effort to address the needs of patients requiring chronic care management. AMDA supports Congressional and Centers for Medicare & Medicaid Services (CMS) proposals to provide a separate fee for managing patients' chronic care management needs. AMDA members care for some of the nation's most vulnerable populations who reside in a variety of PA/LTC settings including home health, skilled nursing facilities (SNF) and assisted living (AL) communities. Virtually all of these patients have multiple complex chronic care needs that require a well-coordinated, interprofessional system of care with supporting reimbursements and incentives. Over the past decade, AMDA has recommended specific suggestions for taking care of complex patients transitioning across settings of care.[1 1 1] To date, much of this care has not been reimbursed or incentivized. While we support and appreciate the work done to date, we believe Congress must continue to expand the resources and incentives required to care for the most complex of these patients who require ongoing rather than episodic attention.

We believe one of the ways to improve chronic care in PA/LTC settings, which was not discussed in the committee's document, is to strengthen the role of the Medical Director. Every nursing facility in the country is mandated to have a Medical Director by the Federal Nursing Home Reform Act (OBRA '87). However, the role and involvement of Medical Directors varies a great deal. Since passage of that law, AMDA has been working to strengthen the role of the Medical Director by creating an educational curriculum as well as a Certified Medical Director (CMD) credential under the American Board of Post-Acute and Long-Term Care Medicine (ABPLM). Studies have shown that CMDs improve quality of care for the most vulnerable and medically complex population residing in the nation's nearly 16,000 nursing homes.

Medical Directors work in concert with physicians, nurse practitioners, physician assistants, and other practitioners to coordinate care for this population. ABLPM is currently working on a set of core competencies and a curriculum that will help facilitate a competent workforce to care for the population in the PA/LTC setting. We believe the expansion of such training programs and development of core competencies for medical directors, attending physicians, and other professionals in PA/LTC medicine are essential to improving care for this population.

Moving forward, it is imperative that **policies promote workforce development and competencies to care for the PA/LTC population.** Although payment models have the opportunity to drive practitioner behavior that improves the quality of care, we believe, ultimately, that increasing the quality and quantity of the workforce to care for an exponentially growing number of frail elderly, and building competency to care for them, is more likely to achieve these results.

Likewise, policies should **align with patient goals of care.** Value-based payment models should reflect the goals and values of the patient. This is particularly important in the PA/LTC patient population where goals of care are often different from those in the ambulatory or hospital setting. Most AMDA physician members practice in PA/LTC settings and work in collaboration with interprofessional teams and family members/caregivers to care for patients with advanced and often terminal illnesses such as dementia, cancer, COPD, and congestive heart failure. These patients' goals often focus on being cared for in the least restrictive setting and achieving or maintaining medical stability, dignity, comfort, quality of life, and function as they approach the end of life. In addition to these general comments, we offer the following specific comments on the proposal:

<u>Improving Care Management Services for Individuals with Multiple Chronic Conditions</u>

AMDA supports proposals that provide additional chronic care management services to this vulnerable population. Over the last several years, AMDA has worked with the American Geriatrics Society and other stakeholders on improving the Current Procedural Terminology (CPT) coding system to better reflect the chronic care services clinicians provide on a daily basis. Therefore, we strongly support the establishment of a permanent, high-severity Chronic Care Management (CCM) code to reimburse clinicians for coordinating care for beneficiaries living with multiple chronic conditions. These include individuals who reside and/or transition across the PA/LTC continuum including SNFs and nursing facilities (NFs). Currently, CMS does not reimburse for the CCM code in the SNF setting and has yet to make a determination on whether it will reimburse for billing the code in the NF setting despite multiple requests for reimbursement.

AMDA also supports reimbursement for already established and valued CPT does for care plan oversight (99379-99380). These codes describe the work completed to ensure care coordination for patients in nursing facilities and are in line with CMS requests for additional codes that describe CCM

services. In fact, these codes seem to more accurately reflect the work that an attending physician in SNF and NF settings performs in overseeing the often complex interprofessional care that residents in these settings receive. These codes have been assigned RVUs and AMDA encourages CMS to consider adding reimbursement to these codes.

Patients living with multiple chronic conditions face significant challenges when moving from one care setting to another within our nation's fragmented health care system. Poor communication during transitions can lead to confusion about a patient's condition, duplicative tests, inconsistent patient monitoring, medication errors, delays in diagnosis and lack of follow through on referrals. We support expansion of current CMS demonstration projects that provide additional reimbursement for high acuity patients in the SNF setting given that the experience of our members participating in these projects have shown to decrease re-hospitalizations, improve quality of care, improve quality of life, and provide significant savings to Medicare.

High acuity patients in a SNF setting have unique medical and social needs. For this reason, we encourage the committee to consider the unique challenges of serving complex patients under a chronic care code and encourage this code to be classified as needing no coinsurance as well.

Telehealth

AMDA supports provisions to expand the use of telehealth into non-rural, non-underserved areas as a means of treatment of acute illness in a timely fashion. We face a significant physician shortage in primary care and even more so a competent geriatric workforce that is able to care for the frail elderly in the PA/LTC sector. Therefore, we must judiciously expand the use of telehealth to provide necessary services to this population. We note however, that person-centered care and face-to-face care remains an important pillar of our work and telehealth must not become a complete substitute to seeing patients when necessary. We stand ready to work with the committee and the federal agencies to carefully craft telehealth policies.

Ensuring Accurate Payment for Chronically Ill Individuals

We believe that appropriate and accurate payment for the high-risk chronically ill population that utilizes PA/LTC services is one of the most important needs in the shifting health care delivery landscape. Unfortunately, many of the current time-based payment models and quality reporting programs penalize professionals who see this population. AMDA has made several comments in response to CMS' request for information on this topic and urges this committee to work with stakeholders to address this urgent concern and identify proper risk adjustment strategies. Appropriate risk adjustment strategies should go beyond the current methodology of adjusting based on Hierarchical Coding Categories (HCC) that correlate poorly with overall cost per patient. Therefore, we support the committee's interest in studying the impact of functional limitation use to improve payment structures. We strongly urge this committee to look to models such as Independence at Home and/or other third party groups that use frailty adjustments. These programs more accurately adjust for the cost of these patients and, thus, clinicians are not seeing as "high cost" and penalized under value-based models.

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

AMDA strongly supports changes to attribution methodology under the current Accountable Care Organization (ACO) models. In addition to concerns with risk adjustment which we noted above, correct patient attribution to ACOs simply place the high risk population at a disadvantage, which could eventually leave this population without access to care. In the past, we have worked with CMS on this issue, and we urge this committee to work with CMS to re-evaluate the risk adjustment methodologies. In this regard, we support the prospective assignment included in the committee's proposal. Physician relationship with patients/residents in SNF/NF care is unique from that of the ambulatory and hospital settings. Patients in SNFs (POS 31) are shorter stay patients who are receiving continued acute medical care and rehabilitative services. While their care may be coordinated during their time in the SNF, they are then transitioned back in the community. Patients in a SNF (POS 31) require more frequent practitioner visits – often from 1 to 3 times a week. In contrast, patients in NFs (POS 32) are almost always permanent residents and generally receive their primary care services in the facility for the duration of their life. CMS has recently recognized this difference and finalized a proposal to change the definition of primary care services for the purposes of ACO attribution. In short, CMS elected to delete SNF (POS 31) from the definition of primary care for the purposes of ACO attribution and agreed with AMDA that in this post-acute setting, the physician relationship with the patient is not that of a typical primary care physician since it usually is not their community primary care physician, to whose care the patient will return upon discharge after rehabilitation in the SNF. Prospectively assigning patients would allow for better planning of services in these distinct and unique roles and settings.

Development of Quality Measures for Chronic Conditions

As the Committee noted, improvement in health care delivery for individuals with chronic disease, including older adults, is facilitated in part by the development of quality measures that specifically target the unique needs of these individuals. However, we do not have sufficient measures to assess the quality of care received by this vulnerable population in the PA/LTC sector. CMS should include the development of measures that focus on health outcomes for individuals with chronic disease in its quality measures plan. Unfortunately many of the current quality reporting programs, such as the Physican Quality Reporting System (PQRS), were designed for the ambulatory setting and although reportable in the SNF/NF, do not reflect best practices or unique patient needs and goals of this population. We urge this committee to shift focus away from a "check-the-box" approach to a more person-centered comprehensive approach to quality of care and quality of life measurement that includes realistic parameters based on individual goals of care, prognosis and comorbidities.

In addition, quality measures for this population should be aligned across providers (clinicians and facilities) as well as care settings. Currently, there are distinct legislated programs, Merit Based Incentive Payment System (MIPS) for clinicians and IMPACT Act/Skilled Nursing Facility Value-Based Purchasing programs for facilities. CMS is implementing these two programs separately, creating the same siloed approach that has existed historically and resulted in fragmentation of care. A more comprehensive approach that looks at the patient as the intersection of these programs is advisable to achieve desired outcomes.

Use of Health Information Technology

AMDA supports the use of health information technology (HIT) to improve communication and

information sharing to improve the quality of care for chronic care patients in care transitions. Effective HIT should incorporate several elements, including standardized processes, mandatory performance measures, and established accountability for these processes among the health care providers coordinating a patient's care.
AMDA believes that interoperability among the various technology systems—such as the administrative systems, medical record systems, diagnostic tools, transcription, and security, and others—is critical for effective transitions of care.

In PA/LTC settings it is likely that medical directors and attending physicians are not always on site, yet have to make critical medical decisions and share that information with the facility. Policies around HIT and information sharing should acknowledge this reality of practice in the PA/LTC sector. Very often policies use the general term "providers" in PA/LTC when in reality these policies solely focus on the facility providers and do not reflect the reality of clinician or attending "providers" who practice in these facilities. One such example is the Meaningful Use (MU) program. While physician "providers" are subject to the MU requirements, the PA/LTC facilities in which they practice are not. Thus, while the two entities treat the same patients, they are subject to different Medicare programs, reporting requirements, and potential penalties. The misapplication of the MU rule hinders the ability to share information.

While we are pleased to see HIT solutions to chronic care management, we urge the committee to focus on patient and family needs in building a truly interoperable health care system rather than focusing on specific "check-box" type reporting requirements, which tend to be different depending on the type of provider. Likewise, we note that in the PA/LTC sector an interoperable system is one that is built for team-based care. As already mentioned, very often medical directors and attending physicians are not on site but are nonetheless required to make important decisions including whether or not to send a patient back to the hospital based on the information provided from the previous care setting as well as the clinical staff in the facility. Thus, a vital part of HIT is interoperability of information both across the care team and across care settings.

Conclusion

AMDA appreciates the opportunity to submit these comments and looks forward to continuing to serve as a resource to the Chronic Care Working Group to improve patient outcomes and strengthen our health care delivery system. Please contact AMDA Policy and Advocacy Director, Alex Bardakh, with any questions or comments at abardakh@amda.com.

Sincerely,

Naushira Pandya, MD, FACP, CMD
President

[1] AMDA. (2009). *Improving Care Transitions From the Nursing Facility to a Community-Based Setting*. [White Paper]. **http://www.amda.com/governance/whitepapers/transitions_of_care.cfm**

[1] AMDA. (2010). *Improving Care Transitions between the Nursing Facility and the Acute Care Hospital Settings.* [White Paper]. http://www.amda.com/governance/whitepapers/H10.cfm.

[1] AMDA. (2010). *Transitions of Care in the Long-Term Care Continuum* [Clinical Practice Guideline]. http://www.amda.com/tools/clinical/TOCCPG/index.html