AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes
100+*years*

Chicago Headquarters:
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org

Washington Office:
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org

www.facs.org

January 29, 2016

The Honorable Orrin Hatch,
Chairman
Senate Finance Committee
United States Senate
Washington, D.C. 20510

The Honorable Ron Wyden,
Ranking Member
Senate Finance Committee
United States Senate
Washington, D.C. 20510

The Honorable Johnny Isakson
United States Senate
Washington, D.C. 20510

The Honorable Mark Warner
United States Senate
Washington, D.C. 20510

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

On behalf of the more than 80,000 members of the American College of Surgeons (ACS), I would like to thank you for the opportunity to provide feedback on how best to improve outcomes for Medicare patients with chronic conditions. We appreciate the Senate Finance Committee's leadership in recognizing the need to analyze current law, discuss alternative policy options, and develop bipartisan legislative solutions.

The College recognizes that formulating a long-term solution to improving care for Medicare patients with chronic conditions is a challenging, yet essential undertaking. This is especially true given the need to limit the growth in health related spending, coupled with the increase in members of the "Baby Boom" generation soon aging into the Medicare program. The ACS has a rich history of quality improvement efforts and many surgical patients are affected by these chronic conditions. Any efforts toward reforming chronic care must include surgical input when surgical care and chronic care management are needed for a particular patient. Thus, we applaud these efforts and ask that consideration be given beyond primary care and patient centered medical homes, but rather these endeavors are inclusive of crucial components such as surgical care. Treatment of the chronically ill involves complex, cross specialty relationships. Reforms for the surgical patient with chronic illnesses should also include optimizing chronic conditions prior to surgical care and post-operative care coordination with the chronic care teams. The ultimate goals are to increase quality for the patient and efficiently use health care resources. When combined, these actions can and will reduce growth in health care spending. We continue to assert that quality improvement and cost reduction are directly related objectives.

1. **Improving Care Management Services for Individuals with Multiple Chronic Conditions**

The policy under consideration would establish a new high-severity chronic care management code that clinicians could bill under the Physician Fee Schedule. A new code would reimburse clinicians for coordinating care outside of a face-to-face encounter for Medicare's most complex beneficiaries living with multiple chronic

conditions. Managing multiple chronic conditions requires increased levels of patient and provider interaction beyond the typical in-person visit that often includes practice team members such as social workers, dieticians, nurses, and behavioral health specialists. The current chronic care management code 99490 covers a portion of that labor-intensive cost, whereas the proposed new high-severity code payment would be higher to compensate providers who require more than the typical allotted time per month. ACS believes the results of implementing 99490 should be examined before moving to a new policy.

The service(s) that the workgroup describes above already exist. CPT code 99487 describes complex (high-severity) chronic care management (CCCM) when there is no face-to-face visit during the calendar month. CPT code 99487 specifies 60 minutes of clinical staff time in the descriptor. Further, CPT code 99489 is an add-on code for each additional 30 minutes of clinical staff time for non face-to-face CCCM.

CCCM services are provided to patients who typically have multiple co-morbidities and frequently, multiple medications requiring ongoing non face-to-face care coordination. The typical patient has several chronic conditions, sees multiple care providers, requires a variety of therapeutic and diagnostic services and has a management plan that requires frequent revisions. The goal of CCCM is to prevent hospitalization and to efficiently integrate care, maximize the patient's potential function and well-being and prevent hospitalization.

Codes 99487 and 99789 were reviewed by the AMA/Specialty Society Relative Value Scale Update Committee (RUC) using the following typical patient descriptions which clearly coincide with the description of high-severity chronic care described by the workgroup.

> *Typical Patient (99487) (Child)* A 6-year-old child with spastic quadriplegia, gastrostomy, gastroesophageal reflux with recurrent bouts of aspiration pneumonia and reactive airway disease, chronic seizure disorder, failure to thrive and severe neurodevelopment delay. He receives home occupational, physical and speech therapy services.
>
> *Typical patient (99487) (Adult)* An 83-year-old woman with congestive heart failure and early cognitive dysfunction, who has been hospitalized twice in the prior 12 months, is becoming increasingly confused and refuses an office visit. She has a certified nursing assistant supervised by a home care agency, participates in a remote weight and vital signs monitoring program and sees a cardiologist and neurologist.

Recommendations for both physician work RVUs and practice expense inputs were submitted to CMS, however the Agency chose not to implement payment. As stated in the final rule for CY2015:

> "At this time, we believe that Medicare beneficiaries with two or more chronic conditions as defined under the CCM code (99490) can benefit from care

Chicago Headquarters:
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office:
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
www.facs.org

> management and want to make this service available to all such beneficiaries. Like all services, we recognize that some beneficiaries will need more services and some less, and thus we pay based upon the typical service. However all scope of service elements apply for delivery of CCM services to any eligible Medicare beneficiary. We will evaluate the utilization of this service to evaluate what types of beneficiaries receive the service described by this CPT code, what types of practitioners are reporting it, and consider any changes in payment that may be warranted in the coming years. We are maintaining the status indicator "B" (Bundled) for CY 2015 for the complex care coordination codes, CPT codes 99487 and 99489."
>
> Further, "We are not convinced that the care management services are sufficiently unique based upon the beneficiary's specific chronic conditions to warrant separate codes, especially given the beneficiary must have at least two chronic conditions. As noted above, we will be monitoring this service and will consider making changes if they appear warranted. After consideration of the comments received on this proposal, we are finalizing the proposal with the following modification. Rather than creating a G-code we are adopting the new CPT code, 99490, to describe CCM services effective January 1, 2015. We intend to evaluate this service closely to assess whether the service is targeted to the right population and whether the payment is appropriate for the services being furnished. As part of our evaluation, we will consider the whether this new service meets the care coordination needs of Medicare beneficiaries and if not how best to address the unmet needs."

The American College of Surgeons echoes CMS' concerns regarding how the Agency would monitor appropriate reporting for chronic care management and complex chronic care management. We have not seen any data analysis for CCM code 99490 regarding the beneficiaries served, the type of provider reporting the service, and the site of service to make an informed comment about implementing the CCCM codes 99487 and 99489 or creating different codes for the level of patient that the Workgroup describes. We also do not have data on any savings that may or may not have been achieved with code 99490. Considering all of these factors, the College believes the outcomes of implementing code 99490 should be fully evaluated before moving to a new policy.

2. Ensuring Accurate Payment for Chronically Ill Individuals

The ACS supports and commends the chronic care workgroup's efforts for further study of possible changes to the Hierarchical Condition Category (CMS-HHC) Risk Adjustment Model. However, ACS has consistently raised concerns with relying exclusively on claims data for purposes of risk adjustment because claims data does not address the nuances of comorbidities, severity, complications, patient experience, or socioeconomic status (SES). Therefore, the HCC methodology does not adequately account the ranges of patient complexity and circumstances that are out of the provider's control and may unfairly impact providers that care for disadvantaged populations. Because physician offices are not required to do not include all of a

Chicago Headquarters:
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office:
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
www.facs.org

patient's diagnoses and patient-specific data on a claim, the CMS-HCC risk score is flawed and will continue to lack validity and reliability. ACS strongly supports the use of clinical data, which can more directly reflect the delivery of care. Unlike administrative data, which aggregates experience for system management requirements, clinical data are patient specific and can be more precisely stratified to define best practice.

3. Developing Quality Measures for Chronic Conditions

The chronic care working group is considering requiring that CMS include the development of measures that focus on the health care outcomes for individuals with chronic disease into its quality measures plan. The policy under consideration includes the development of the following types of quality measures: patient and family engagement, shared decision-making; care coordination; community-level measures, and end of life care. ACS generally supports the development of the different types of measures outlined in the work group's recommendations. However, the ACS strongly recommends that this policy take into consideration scenarios where patients with multiple chronic conditions require surgical intervention. Specifically, the work group should think about how to align and connect measures that incorporate surgeons into the chronic care measurement framework when this patient population requires acute or nonemergent surgical care.

The ACS has recently been working on a measurement framework to focus on the continuum of care, with a focus on the various phases of surgical care. We believe this work could inform the chronic care work group on how to best to incorporate surgical care into the measurement of patients with chronic conditions. The ACS measure framework encompasses the various phases of surgical care: preoperative, perioperative, intraoperative, postoperative, post discharge—when measured together the phases address the totality of surgical care by addressing key workflows. The measure framework also addresses gaps identified by the chronic care work group, including care coordination (between anesthesia and primary care), shared decision making, patient and family engagement, multiple and complex conditions. In addition, the framework measures functional status, geriatrics and frailty. The framework has been constructed to transition toward bundled care and allow for more detailed, procedure-specific metrics to be added when necessary which is consistent to the goals of MACRA. ACS is currently engaging various stakeholders to further discuss the measure framework, and the measures are of interest to the American Board of Surgery for MOC. We welcome the opportunity for further discuss the ACS framework in order to align efforts with the chronic care work group.

4. Eliminating Barriers to Care Coordination under ACOs

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. The working group is soliciting feedback on whether the items/services eligible for reduction should be defined through rulemaking or be left to the discretion of the ACO. The

Chicago Headquarters:
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office:
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
www.facs.org

College believes this decision should be left to the discretion of each individual ACO. Such flexibility should extend beyond ACOs to Alternative Payment Models (APMs) in development by stakeholders. In developing APMs, the government should allow providers the flexibility to design models that accomplish the goals of better care coordination, reduced costs, and better outcomes.

The working group is also soliciting feedback on the type of cost sharing that could be waived, such as copays, coinsurance, or deductibles. The College believes that flexibility in the type of cost sharing that could be waived should be left up to each individual ACO and those developing APMs. However, these ACOs and APMs should be granted the flexibility to waive cost sharing on items that have been shown to improve clinical outcomes.

Your acknowledgement of the need to ensure public policy is in line with the best outcomes for Medicare patients with chronic conditions is greatly appreciated. We thank you again for your leadership and commitment, and look forward to working with you on this very important endeavor.

Sincerely,

David B. Hoyt

David B. Hoyt, MD FACS
Executive Director, ACS

Chicago Headquarters:
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org

Washington Office:
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
www.facs.org