AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Statement of
American Academy of Family Physicians
Submitted for the Record

U.S. Senate Committee on Finance

Chairman's Mark of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017

May 18, 2017

AAFP Headquarters
11400 Tomahawk Creek Pkwy.
Leawood, KS 66211-2680
800.274.2237 • 913.906.6000
fp@aafp.org

AAFP Washington Office
1133 Connecticut Avenue, NW, Ste. 1100
Washington, DC 20036-1011
202.232.9033 • Fax: 202.232.9044
capitol@aafp.org

On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, thank you for the opportunity to submit a statement for the record to the Committee on Finance regarding the *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017*.

1. **As suggested in the December 2015 Chronic Care Working Group (CCWG) Options Document, the AAFP recommends that the Committee eliminate beneficiary cost-sharing from the chronic-care management service codes.**

The CCWG set forth as one of its policy options that it was "considering waiving the beneficiary co-payment associated with the current chronic care management code as well as the proposed high severity chronic care code." However, the *CHRONIC Care Act of 2017* (S. 870) does not include this policy. The AAFP recommends that the Committee reconsider its decision.

In the fall of 2014, CMS established payment for chronic care management (CCM) through a new billing code, CPT 99490, payable under the Medicare physician fee schedule on a fee-for-service basis beginning on Jan. 1, 2015.[1] The CCM service includes a range of activities, such as enhanced access to appointments, creation of a patient-centered care plan, and coordination with other providers.[2] The beneficiary must sign an agreement to have the services provided, and the service may be provided by only one practitioner. In 2015, CMS established payment for the CCM code at $40.39, which may be billed once per patient per month and can be discontinued at any time by election of the beneficiary.

In the fall of 2016 (consistent with one of the CCWG's other policy options), CMS established physician payment for complex chronic care management (complex CCM) services. CMS established payment for two new codes (CPT 99487 and 99489), bringing the total to three codes that pay from $43 (the 2017 payment rate for CCM) to $141 (the 2017 payment rate for complex CCM plus the complex CCM add-on), depending on the amount of physician time spent with the patient. The AAFP views these developments as highly conducive to the delivery of primary care to beneficiaries with multiple chronic conditions.

Elimination of beneficiary cost-sharing from these three service codes would align CCM and complex CCM services with others within the Part B benefit. Part B currently covers a range of preventive services without cost sharing, including mammography,

[1] Further, Congress has codified chronic care management services in Medicare Part B, in April 2015, through enactment of MACRA Section 103.

[2] Centers for Medicare and Medicaid Services, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015, 79 Fed. Reg. 67,547, at 67,721 (Nov. 13, 2014) ("CY2015 Final Rule").

pap smear, prostate cancer screening, colorectal cancer screening, as well as the Medicare annual wellness visit. CCM and related services, however, do **not** fall under the Medicare preventive services umbrella, even though such services provide substantial resources to support primary-care physicians in helping manage chronic patients in order to prevent inpatient and emergency-department visits. As a result, under the CCM and Complex CCM codes the beneficiary is responsible for monthly co-insurance of 20 percent of the total charge, regardless of whether the patient sees the doctor in a separate face-to-face encounter. (Until the Part B annual deductible is met in a given year, the Medicare beneficiary is responsible for the entire amount).

In the experience of AAFP members, for Medicare beneficiaries who lack supplemental coverage, cost-sharing for these non-face-to-face services has led to beneficiary confusion and provider difficulty in collecting the beneficiary's share of the payment. This also leads to many beneficiaries cancelling their enrollment in the services. Given the relatively low cost of chronic-care management and its immensely high value, the AAFP believes that chronic-care management should be available without beneficiary cost sharing and urges the Committee to add this policy option into the *CHRONIC Care Act of 2017*.

2. **The AAFP continues to express its support for four of the policy options that were selected for inclusion in the *CHRONIC Care Act of 2017*:**

Section 101. Extending the Independence at Home Demonstration Program

The Independence at Home (IAH) model uses home-based primary-care teams to carry out plans of care tailored to meet the needs of Medicare beneficiaries with multiple chronic conditions and a history of hospitalization and other high-cost interventions. The Centers for Medicare and Medicaid Services (CMS) has released evaluation results of the IAH demonstration showing that participating practices in the first and second years of the program have improved quality while achieving substantial savings. In short, the IAH demonstration is showing exactly how comprehensive, coordinated, patient-centered primary care can help improve quality and lower costs in our health-care system for patients with complex chronic illness.

The IAH program is authorized through September 30, 2017. CMS reports that in Performance Year 2, 15 participating practices were caring for 10,484 beneficiaries. The AAFP supports a 2-year extension of the program as called for in the *CHRONIC Care Act of 2017* but believes that Congress should go much further and expand the demonstration on a nationwide basis. Under such expansion, many more practices will participate and accordingly many more Medicare beneficiaries with complex chronic illness will benefit from 24/7 in-home visits that are proven to reduce hospital and emergency department admissions, and improve overall quality of care. It should be noted that while the AAFP strongly supports team-based primary care, and robust cooperation between

physicians and all members of the health-care team, the AAFP remains committed to the position that such teams be led by physicians.

Section 303. Increasing Convenience for MA Enrollees Through Telehealth

The AAFP supports the provision of additional telehealth benefits in Medicare Advantage in the *CHRONIC Care Act of 2017*. Regarding eligibility for payment, it should not matter whether a patient service is rendered in person or through telemedicine. If it is a valid service, it should be paid regardless of whether it was performed face-to-face or through a telecommunications device. This should hold true for traditional Medicare, Medicare Advantage, and Medicare ACOs. Thus, MA plans' telehealth services should not be limited to those currently allowed under traditional Medicare, and traditional Medicare should expand its coverage of telehealth services in such a way that it focuses on the service provided and not the means by which it is provided. In short, if Medicare covers a service when provided in-person, it should cover the same service provided by means of telehealth, assuming the service otherwise meets Medicare coverage requirements.

Section 304. Providing ACOs the Ability to Expand Use of Telehealth

Similarly, the AAFP supports the provision of additional telehealth benefits in Medicare ACOs in the *CHRONIC Care Act of 2017*. Telehealth can provide effective care for patients as well as provide improved access and convenience. These valuable and cost saving services should not be limited to specific geographies, and these restrictions should be lifted. The capital equipment costs for an originating site have plummeted since the enactment of the policies limiting originating sites based on geography. We do not believe safeguards are needed to ensure proper clinical equipment is used.

In sum, payment should be made for physician services that are reasonable and necessary, safe and effective, medically appropriate, and provided in accordance with accepted standards of medical practice. The technology used to deliver the services should not be the primary consideration; the critical test is whether the service is reasonable and medically necessary. Care provided via telemedicine should be paid as are other physician services.

Section 401. Providing Flexibility for Beneficiaries to be Part of an ACO

The AAFP supports prospective beneficiary assignment to ACOs as contemplated by the *CHRONIC Care Act of 2017*. The voluntary choice by a patient of a primary care physician is necessary in achieving the goal of patient-centeredness. The AAFP has maintained that prospective and voluntary assignment to ACOs is preferable to retrospective assignment, since prospective attribution increases patient engagement with a usual source of primary care and does not impinge on patient choice. In addition, providing physicians with a

prospective list of patients for whom they are responsible facilitates proactive population management, which leads to improved outcomes. In contrast, retrospective attribution methodologies are particularly burdensome to physicians, because it is challenging for physicians to engage in effective population health management if they do not know which patients are to be targeted for delivery, management, and coordination of care.

Physician and patient participation in an ACO should be voluntary, and the benefit structure should encourage patients in an ACO to select a primary care physician. For example, ACOs should be allowed to encourage patients who voluntarily enroll in an ACO to choose to receive primary care within the ACO through incentives such as lower copayments and coinsurance.