



**Association of
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President and Chief Executive Officer

June 22, 2015

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

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

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

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

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

The Association of American Medical Colleges (AAMC or the Association) applauds the Senate Finance Committee's (SFC) efforts to improve care for Medicare patients with chronic conditions by establishing a bipartisan working group to look at this issue. The Association is pleased to respond to the Committee's request for feedback on policies which could improve care coordination for this complex set of Medicare patients.

The AAMC is a not-for-profit association representing all 144 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

Academic medical centers (AMCs), which include clinical faculty providing care to patients at teaching hospitals, are leaders in providing coordinated care for clinically complex and vulnerable patients while also performing innovative research and training the next generation of clinicians. Currently, the AAMC is a facilitator-convener for Bundled Payments for Care Improvement (BPCI) and leads a Center for Medicare and Medicaid Innovation (CMMI) innovation grant on the use of eConsults and eReferrals to improve communication between specialists and primary care physicians. Our responses reflect the findings from this important work. Thus, the AAMC actively engages with several of our member institutions in their efforts to redesign care in a more patient-centered and cost-effective way.

Fragmentation in the health care system results in patients with multiple chronic illnesses often being seen across many specialties. Particularly for this population, maintaining a single locus for as much care as is appropriate is an important goal. Incentives aligned across providers are key to achieving this end. It is important to design a system that avoids redundant care, conflicting management advice, and high costs and inconvenience that result from poorly coordinated care. To that end, below are a number of considerations that must be incorporated into effective chronic care solutions.

Encourage collaboration and communication. Policies must encourage collaboration and communication across different providers and across care settings. This means beginning with a holistic view that avoids artificial distinctions based on setting or provider type. Incentives need to foster collaboration between providers and not create barriers or competition between types of primary care providers and specialists or between physicians and hospitals.

Clarity and accountability across teams. Complex patients often require services from a broad group of providers. Many times, the primary care practice will be the natural home for care coordination, but for certain patients at certain periods, that responsibility may naturally shift to one or more specialty practices. One example would be a cancer patient's transition of care coordination from a primary care physician to an oncologist.

Multiple program participation. Complex patients may see multiple providers, and also may qualify for multiple alternative payment models (APMs). Incentives and rules must be aligned across programs so that all are rewarded for good outcomes.

Risk Adjustment. Any cost and outcome measurement of complex patients must have sufficient risk adjustment (either directly through measurement or through the comparison group) to ensure that measurement is as accurate as possible, while still supporting optimal quality of care.

The committee poses a series of challenges in various payment models to maximize care for this vulnerable population. AAMC has provided feedback on specific categories below and urges the committee to consider these suggestions as a part of its chronic care reform efforts.

Issue Area 2: Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings Program (MSSP) ACO program, piloted APMs currently underway at the Centers for Medicare and Medicaid Services (CMS), or by proposing new APM structures.

Currently, a single patient with multiple conditions could be assigned to multiple APM programs. For example, a patient may be assigned to an MSSP ACO, a Patient Centered Medical Home (PCMH), and a BPCI bundle. As new APMs are tested, with new care coordination services, program overlap will become more challenging for health care professionals and patients. For specialty care models, this program overlap will become even more challenging.

In order to reduce costly duplication and improve care quality, it is important for participants in new payment models to understand the policies that govern how a beneficiary is "assigned" to an APM program and which providers will receive "credit" for achieving quality outcomes and savings. A patient should not have to balance advice from multiple care managers; rather, involved care managers must have a single care plan. Which organization is managing a patient's care must be predictable in order for providers to take timely action to improve care.

The rules governing individual initiatives are clear – but how CMS addresses overlap remains opaque. Program eligibility and precedence rules must be clearly defined and transparent. The order in which various programs undertake alignment of beneficiaries and which program trumps the next in a crowded market are worthy of public discussion. Congress could require CMS to make its current rules for program overlap public and solicit stakeholder feedback. The AAMC would welcome a methodology that keeps the patient at the center, rather than creating a competitive environment where only one APM can engage in care redesign at a time. It may be that different APMs are most suitable for different patients,

depending on patients' needs, so rules that categorically elevate one APM over another for the purposes of beneficiary assignment and shared savings may not be appropriate.

Another concrete way to improve care for patients with complex conditions is to create waivers, such as the 3-day skilled nursing facility (SNF) rule, telehealth, and home visits in the post-operative period available to as many APMs as possible. The AAMC was disappointed that the recent MSSP final rule restricted many waivers to the new, untested Track 3 model, especially when so many MSSP participants engage in Track 1. In addition, programs that use a waiver, such as the SNF waiver, in good faith upon patient entry into the APM program, should be able to rely on that waiver even if it is later discovered that the beneficiary is not eligible for the APM. The central tenet of APM programs is to redesign care to meet patient needs. Providers currently have little confidence that waivers which are critical to increasing community-based care are truly reliable options.

Issue Area 3: Reforms to Medicare's current fee-for-service (FFS) program that incentivize providers to coordinate care for patients living with chronic conditions.

Care coordination for complex patients should be encouraged and adequately compensated. In CY 2013, CMS paid for transitional care coordination when a patient transitions from an institutional setting. In the CY 2014 and CY 2015 Physician Fee Schedule (PFS) Final Rules, CMS finalized policies for a new care coordination code that would pay providers a separate fee starting in 2015 for providing chronic care management (CCM) services. Paying for these services and recognizing the care that occurs outside of the face-to-face visit are positive first steps. The AAMC is concerned that administrative complexity, and the ability for only one provider to bill the services will affect the appropriate billing of the services. Simplifying the documentation and reporting requirements for these codes would be a significant improvement. The AAMC recommends convening stakeholders to assess where the administrative burden might be reduced while avoiding the creation of incentives for fraudulent behavior.

A second improvement to the FFS program is to recognize the joint accountability required for effective care coordination. Coordination is necessarily a two-way process. If the system pays only for one provider or one aspect of coordination, it is much less likely to be effective. New technologies allowing primary care providers to receive timely, electronic consultations from specialist colleagues offers one example. The AAMC's Health Care Innovation Award has introduced a payment model for asynchronous e-consults where specialists and primary care physicians both get credit for the time they spend on the consult, but only after the consult is complete and not converted to a referral for a specialty visit. In the model, a primary care physician (PCP) asks a specialist a targeted clinical question, using a standardized template. No one receives credit unless the eConsult is completed (that is, the specialist responds, enabling the PCP to manage the patient's problem or needs), at which point both providers split the allocated relative value unit (RVU) credits. The purpose is not to double the reimbursement amount by paying two providers, but rather to acknowledge the joint responsibility for high quality care in the most appropriate setting and to divide a payment between those accountable for the care. Without this shared payment, specialists have little financial incentive to provide electronic support instead of insisting on seeing the patient in person for a separately billed appointment. This model, or similar ones, may offer new tools to draw specialists into APMs and create sustainable reductions in unnecessary care.

Issue Area 4: The effective use, coordination, and cost of prescription drugs.

Pharmacy is a critical component of health outcomes and health care costs. While technology has facilitated the ability of a provider to know the patient copay for different drugs, providers face many operational challenges to improving Part D care. For example, the numerous Part D vendors make it

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difficult to build relationships, negotiate discounts, or affect formulary decisions. CMS or CMMI should facilitate conversations with these vendors and address these barriers before drugs are incorporated into the care redesign.

Issue Area 5: Ideas to effectively use or improve the use of telehealth and remote monitoring technology and strategies to increase chronic care coordination in rural and frontier areas.

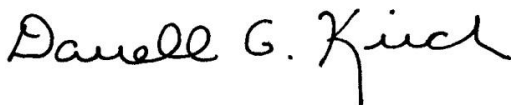
The Association has supported CMS' recent efforts to expand telehealth services, by expanding the definition of originating sites, but CMS is hampered by the existing Medicare telehealth laws. State laws on telehealth also provide another challenge. Congress should revisit these requirements and make sure they are not a barrier to new and innovative ways to communicate. Again, the eConsult pilot is an example of the types of innovative work that could benefit patients with complex conditions.

Opportunity to ensure Medicare beneficiary health care access and address physician workforce shortages.

One critical component the committee must address is ensuring there are enough physicians to meet the needs of the growing number of Medicare beneficiaries. The AAMC estimates that by 2025 the United States will face a shortage of between 46,000 and 90,000 physicians, with specialty shortages particularly acute. In addition to primary care physicians, patients with chronic illnesses rely on subspecialist physicians, such as cardiologists, nephrologists, and endocrinologists, to manage and provide necessary care. Our nation's medical schools and teaching hospitals have increased their capacity to train new doctors, despite the fact that the number of federally-supported residency slots has remained effectively stagnant since 1997. Without an increase in Medicare support for Graduate Medical Education (GME), we face a shortfall of physicians across dozens of specialties. We urge you to use this opportunity to address the physician shortage by increasing Medicare support for GME. Incorporating GME expansion provisions, such as those included in "The Resident Physician Shortage Reduction Act of 2015" (S. 1148), will guarantee provider access to Medicare beneficiaries and all patients.

Again, the AAMC appreciates and supports the committee's efforts to improve care for Medicare patients with chronic conditions. We look forward to working with you address these challenges and ensure all Americans get the care they deserve. If you would like to discuss any of these comments in greater detail, please contact Leonard Marquez, AAMC Director of Government Relations, at lmarquez@aamc.org or 202-862-6281.

Sincerely,



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cc: Atul Grover
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