



AMERICAN OSTEOPATHIC ASSOCIATION

1090 Vermont Ave., NW, Suite 500, Washington, D.C. 20005-4949 ph (202) 414-0140 | (800) 962-9008 | www.osteopathic.org

June 22, 2015

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

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

The American Osteopathic Association (AOA), the American College of Osteopathic Family Physicians (ACOFP), and the American College of Osteopathic Internists (ACOI), representing more than 110,000 osteopathic physicians (DOs) and osteopathic medical students nationwide, commend the Senate Finance Committee for forming its bipartisan chronic care working group in order to develop legislative solutions to improve care for Medicare beneficiaries with chronic conditions. We are pleased to have the opportunity to submit these comments in response to the Committee's letter seeking recommendations from health care stakeholders. The comments in this letter reflect the views of our organizations.

Effective management of chronic conditions in the Medicare population should employ holistic, coordinated and patient-centered care -- the key values of osteopathic medicine. Yet instead of just treating symptoms, osteopathic physicians also focus on prevention and wellness as keys to maintaining health. We therefore encourage the Committee to also consider prevention strategies as part of this initiative, in order to stop chronic conditions before they even have a chance to develop.

In doing so, it is important to recognize that the current scoring process by the Congressional Budget Office (CBO) does not provide a complete picture of the impact prevention efforts can have to generate savings in legislative proposals addressing chronic disease. Certain expenditures for preventive medicine generate savings when considered in the long term, but these may not be apparent in the ten-year budget window. We therefore call on the Committee to consider legislation that would require CBO to extend the budget window when an initial analysis finds that a provision would result in substantial savings outside the normal scoring window.

2. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures;

While there are significant opportunities to develop and test new APMs and advance existing models currently underway, it is important to note that the Center for Medicare and Medicaid Innovation (CMMI) is already testing new or modified alternative payment models in traditional Medicare, and has the ability to scale those it finds to be effective. In developing its legislation to promote or advance transformative policies for patients with chronic conditions in the Medicare program, we encourage the Committee to align its efforts surrounding alternative payment models with those of CMMI.

Given the comprehensive approach already used in osteopathic medicine, we believe the Patient-Centered Medical Home and other coordinated care models, when comprised of physician-led integrated health care teams, are well-equipped to address chronic conditions on a broader level.

However, PCMHs currently receive fee-for-service payments and, in some areas of the country, an additional per patient/per month payment. These additional payments, where they do exist, do not sufficiently cover the tools, infrastructure, staffing, training, and administrative costs associated with advanced primary care. Moving away from fee-for-service to a more comprehensive care payment system has the potential to improve the health care management of a practice's patient-population which will help to reduce costs in the long term. Many large group practices which have the patient-centered medical home as their foundation most likely have the ability to join the next generation of advanced primary care.

PCMHs also represent a significant opportunity for small or solo practices to retain their independence and autonomy, which is particularly important for primary care physicians and the relationships they develop with their patients. Small practices with limited resources and small patient-population size will need additional financial support and tools to build the necessary infrastructure to provide advanced primary care under a population-based payment system. Efforts should also ensure that PCMH accreditation standards are not burdensome for physicians, and that the adoption of the PCMH is as seamless as possible. We urge Congress to continue to recognize multiple accreditation entities as valid indicators that a practice is a PCMH.

CMS should also explore ways to allow smaller practices to manage risk. One method would be to allow multiple smaller practices to pool both their risks and their resources. Many small practices would be severely impacted by just a few very sick patients in their beneficiary assignments. By pooling patient panels, this risk could be spread out among numerous practices. These same practices could then share resources and staffing such as behavioral counselors, nutritionists, therapists, etc. As well, they would share in savings.

For a population-based approach, some aspects of documentation could be significantly simplified. Many current documentation requirements focus on justifying payments under fee-for-service, and preventing fraud and abuse. Electronic health records (EHRs) could be a significant asset to enhancing and analyzing medical documentation, but only if care is documented in a more structured format that is machine-readable. For example, EHRs should have the capacity to document for advanced primary care that is paid prospectively on a per patient/per month basis. Documentation should reflect team-based care, treatment planning, patient and family counseling, and diagnostic work. Therefore, the clinical aspects of documentation will need to be enhanced. While transition to it will be challenging, the ICD-10 code set could allow for better population health management if implemented correctly. Overall, as we move to

value-based care, we hope that there will be less non-substantive data for physicians to need to record to support today's E and M coding.

3. Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions;

The osteopathic profession has long encouraged a shift in the care model from the current fragmented fee-for-service approach to one based on better incentives for prevention, and for collaborative care along the continuum of the chronic condition experience. Currently, Medicare provides incentives for single, interventional procedures instead of services that incorporate coordinated team-based care, medication management, counseling, patient and family education, etc. The Medicare Access and CHIP Reauthorization Act (MACRA) passed earlier this year encourages a shift into alternative payment models that promote value-based care by offering significant incentives and support. Yet this transition will not be fully realized until 2019 under the new law, and in the meantime patients with chronic conditions continue to be under-managed in Medicare. We therefore offer the following recommendations for reforms in the meantime to the current fee-for-service Medicare program:

- Chronic Care Management Codes: We encourage the values assigned to CMS' new Chronic Care Management code (CPT code 99490) to be reconsidered. When finalizing this code, CMS did not adopt the AMA/Specialty Society RUC recommended values for it (work time of 30 minutes, work RVU of 1.0, and 60 minutes of clinical labor time), and instead reduced the clinical labor time to 20 minutes. In addition, CMS decided to use the lower level Transitional Care Management CPT code 99495 as the comparison code for determining the appropriate work RVU for code 99490. We are concerned this undervalues the code. The severity of a patient's chronic conditions determines the amount of staff time necessary for establishing a care plan for a new patient. Depending on the patient's condition, establishing a care plan could take twenty minutes to an hour or possibly more. We believe sixty minutes of clinical labor time is more appropriate for valuing this service. Lastly, the administrative burden required to document the care for these codes discourages physicians from providing it. We recommend that the process for payment of indirect chronic care be simplified.
- Medicare Primary Care Incentive Payment: The Affordable Care Act created a program that provides a 10 percent payment incentive for primary care services in Medicare when furnished by primary care practitioners. Under the law, this valuable program will sunset at the end of this year. Allowing this program to expire would undermine progress we've made in ensuring that primary care providers have the resources and time to effectively coordinate care for their sickest patients, the majority of whom are those with chronic conditions. We therefore encourage the Committee to extend this incentive program through 2018, in order to bridge the time during which many providers will transition to alternative payment programs under MACRA. Steps should also be taken to ensure that thresholds in the program do not preclude primary care physicians from receiving this incentive payment, and that participation requirements do not discourage small or solo practices from participating.
- Advanced Care Planning: Osteopathic physicians provide patient-centered care for the continuum of the patient's life. This care involves input from the patient, patient's family, and medical care team to determine the best course of action for each patient. This patient-empowered model of care requires the consideration of numerous clinical, emotional, and social factors that osteopathic physicians are uniquely trained to balance and align with the patient's goals. The osteopathic profession encourages its physicians to engage patients and their families in discussion and documentation of advance care planning regarding end of life decisions.

To better enable these discussions, we support:

- Legislative: Passage of the Care Planning Act. This legislation would compensate a team of health care professionals for providing a voluntary, structured discussion about the patient's goals, illness, and treatment options. A written plan would reflect the informed choices made by patients in consultation with their health care team, faith leaders, family members and friends;
 - Regulatory: CMS being required to cover CPT codes 99497 and 99498 created by the CPT Editorial Panel for CY 2015, and pay separately for these important services. We believe these are separately identifiable services, and physicians should be paid for advance care planning conversations they have with their patients.
- Remove Medicare Silos: The flow of health care dollars should not be limited within individual segments of the program - Medicare Parts A & B should be blended. There are many scenarios in which a physician's treatment decisions could easily save resources in other parts of Medicare—for example, additional office visits with a particularly complex patient, while costing more in Part B, could decrease hospital readmissions and emergency room visits in Part A. Similarly, additional time spent counseling a patient during an office visit (Part B) could result in Part D savings due to better medication adherence and management. Currently, physicians receive no incentives in Medicare for their care coordination efforts that can reduce hospital admissions, readmissions, and length of stay, and this is particularly significant for patients with chronic conditions. We believe that the removal of barriers between Parts A and B is one of the most important steps Congress can and should take.
 - Increase Access to Data: The ability to obtain accurate and timely data can enable a physician to identify patient populations in advance, identify and manage risk factors early, evaluate key economic and resource use indicators, and know what other treatment services patients may be receiving in order to coordinate care. We therefore recommend physicians be provided with access to timely and meaningful data for patients with more than one chronic condition from CMS on a monthly basis.

As alternative payment models are adopted by more physicians, the importance of risk adjustment both in these programs and in Medicare fee-for-service quality scoring, increases significantly for treatment of patients with chronic conditions. There is already wide acceptance of the need to risk adjust outcome performance measures to account for differences in patient health status and clinical factors present at the start of care. But socioeconomic status (SES) and other demographic factors may also influence patient outcomes. We therefore recommend that measures used in public reporting, quality measurement, and alternative payment models be adjusted for SES to improve the relevance and accuracy of performance results. Doing so will ensure that physicians will not be disincentivised from serving less healthy individuals who may require more intensive interventions.

5. Ideas to effectively use or improve the use of telehealth and remote monitoring technology;

We believe that the utilization of technology in patient care should be to increase access to care, and must not be used in a way that would diminish patient-centered, comprehensive, personal medical care or the quality of care being provided to the patient. Telemedicine provides improved access to medical care and services to patients in rural or distant areas, and allows for easier access to care for immobile patients and those with limited mobility. Cost-effectiveness, through reduced travel times and staffing efficiencies, is an additional benefit of delivering health care services through telemedicine. To this end, the osteopathic

profession supports the concept of telemedicine and advocates that public and private payers adopt payment systems that are inclusive of it.

It is important to recognize there is a cost to the adoption of needed technologies to support telemedicine. In some areas, this cost and a lack of access to high speed internet service can prevent implementation. Therefore, consideration must also be given to reimbursement for the adoption of the necessary infrastructure, in addition to the service itself. Finally, there must be recognition that there may be barriers to the patient. Successful remote monitoring and telehealth services require the ability to communicate on both ends.

In addressing licensure in telemedicine, the osteopathic profession opposes a national licensure system, since it would remove the ability of states to best determine how to balance the needs of their population with protecting public health within borders. A national license would also create a system under which states would be bound to enforce standards and requirements that they have not devised. We therefore support state-based licensure, and the Interstate Medical Licensure Compact—this will allow states to continue to govern the health care services provided to its citizens, while providing a streamlined process for physicians to obtain multiple state licenses.

6. Strategies to increase chronic care coordination in rural and frontier areas;

In many areas, rural populations can be older and sicker, and rural practices have fewer resources available to meet health care needs. Recognizing this, osteopathic medicine has long emphasized the importance of practicing in rural and underserved areas; while DOs make up 8 percent of all physicians in the United States, they comprise 40 percent of all physicians that practice in medically underserved areas. Patients in rural and frontier areas already face challenges posed by distance, difficulties securing transportation, and weather, to name but a few. Until these barriers are addressed, access to effective chronic care will remain limited in these areas.

Overall, health information technology and interoperability among systems can promote seamless access to all clinically and administratively relevant information. True across-the-board interoperability for electronic health records and other health information technology, availability of high speed internet service, and the simplification of the installation, operation, and maintenance of the technology, are all essential to effectively serve patients in rural and frontier areas. Advanced delivery models depend on full unfettered access by clinicians and patients in order to maximize on the patient/provider decision-making process and ensure comprehensive care coordination. The osteopathic profession supports an open interoperability platform and supports the long-term goal of a “Learning Health System”, which fundamentally depends on such interoperable systems to support coordinated health care and data analytics. Technologies should be integrated into health care in ways that complement the practice of medicine, so that care is patient-centered, instead of technology-centered.

Patients in rural and frontier areas also face a lack of physicians as many factors discourage physicians from locating in these areas. Expansion of programs to incentivize physicians to both train and practice in Health Professional Shortage Areas (HPSAs) would greatly improve access to chronic disease care for patients living in rural and frontier areas. One such program is the Teaching Health Center GME program, which trains primary care medical and dental residents in community-based settings such as community mental health centers, rural health clinics, federally qualified health centers, and Indian Health Services clinics. Since physicians often end up practicing in the same locations where they completed their residency, this program can ensure rural areas have an adequate, long-term workforce optimally trained to treat patients with chronic

conditions. While funding for this program was extended beyond its original 2015 expiration date to 2017 under MACRA, it requires longer-term stability in order to continue. We urge the Committee to consider legislation to move this program under Medicare with permanent funding that ensures a Per-Resident Amount (PRA) appropriate to cover the complete costs associated with a resident's training.

7. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers;

The absolute best care provided absent compliance will still result in poor outcomes. Osteopathic physicians work in partnership with their patients and believe the body is capable of self-regulation, self-healing, and health maintenance. Therefore, shared decision-making in a patient's care plan requires patients to be well-educated about their conditions and health care options, including self-management of their conditions. The more patients understand their treatment options and how to maintain good health, the more likely it is they will comply with treatment and achieve better outcomes. To this end, physicians must be provided the opportunity through proper payment to be able to take the necessary time with patients to educate and engage them in the treatment plan.

The patient's responsibility cannot be overlooked and is critical to successful chronic disease management. While we appreciate and support a beneficiary's ability to seek and receive care based upon their individual needs, we believe that the current lack of shared responsibility between beneficiaries and the Medicare program advances fragmentation in delivery and drives utilization. To address this issue, we propose that all Medicare beneficiaries with one or more chronic conditions be required to select a primary care physician. Eligible primary care physicians would be DOs or MDs with a primary practice designation of family medicine, internal medicine, pediatrics, or geriatrics, as currently defined by Medicare. The relationship that is created between a patient and his or her physician through care coordination is of great benefit. To support this new policy, we propose that the current cost-sharing arrangements be adjusted to promote care coordination.

8. Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.

The osteopathic philosophy of medicine is a "whole person" approach to health care that values the physical, psychological, and social aspects of a patient. Providing such care to patients with chronic conditions is time consuming; physicians can see three to four simple acute illness patients in the time it takes to see one complex chronic disease patient. Continued adoption of the PCMH and other alternative payment models with physician-led, multidisciplinary care teams could help ease this problem by allowing the physician to share some care responsibilities to other members of the health care team.

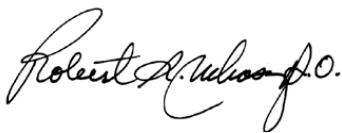
The composition of the physician-lead team is critical to the success and efficiency of care provided, and it is important that the team be comprised of members who can best handle the chronic conditions of the patients. Depending on the coordinated care model, the physician-led health care team can include primary care physicians, nurse practitioners, physician assistants, mental health practitioners, social workers, care coordinators, pharmacists and community health services. While primary care physicians can be the ideal facilitator of a PCMH, specialists are an essential component of each team to ensuring comprehensive efficient care.

We also encourage the Committee to consider expanding the Independence at Home Demonstration program. This team-based, primary care model provides care to chronically ill beneficiaries in their homes, and produced \$25 million in savings in the first year of its Medicare demonstration program (an average of \$3,070 in savings per beneficiary). More importantly, beneficiaries treated by these practices had fewer hospital readmissions within 30 days, and when they were hospitalized, had significantly improved follow-up within 48 hours.

The osteopathic profession supports early intervention and treatment programs for minorities suffering from hypertension, diabetes, and other chronic conditions that disproportionately affect minority populations. We encourage the Committee to find ways to direct additional resources in Medicare targeted at reducing these health disparities.

We appreciate your consideration of these comments, and again commend the Committee for seeking ways in which to ensure Medicare beneficiaries with chronic conditions can receive higher quality and more efficient care.

Sincerely,



Robert S. Juhasz, DO
President
American Osteopathic Association



Kevin V. de Regnier, DO, FACOFP *dist.*
President
American College of Osteopathic Family Physicians



Judith A. Lightfoot, DO
President
American College of Osteopathic Internists

About the American Osteopathic Association

The American Osteopathic Association (AOA) represents more than 110,000 osteopathic physicians (DOs) and osteopathic medical students; promotes public health; encourages scientific research; serves as the primary certifying body for DOs; is the accrediting agency for osteopathic medical schools; and has federal authority to accredit hospitals and other health care facilities. More information on DOs/osteopathic medicine can be found at www.osteopathic.org.

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About the American College of Osteopathic Family Physicians

The American College of Osteopathic Family Physicians (ACOFP) was founded in 1950 and today represents more than 20,000 practicing osteopathic family physicians, residents and students throughout the United States. Osteopathic Family Physicians are Doctors of Osteopathy (DOs) who choose to specialize in family practice and Osteopathic Manipulative Treatment (OMT), a method in which they use their hands to diagnose and treat the patient by paying particular attention to joints, bones, muscles and nerves. They provide disease prevention, diagnosis, and treatment strategies for families through all of life's stages, from infancy to end-of-life. More information can be found at www.acofp.org.

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About the American College of Osteopathic Internists

The mission of the ACOI is to advance the practice of osteopathic internal medicine. Through excellence in education, advocacy, research and the opportunity for service, the ACOI strives to enhance the professional and personal development of the family of osteopathic internists. More information can be found at www.acoi.org.

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