



SENT BY EMAIL

November 22, 2011

Jonathan Blum
Deputy Administrator and Director, Center for Medicare
Centers for Medicare & Medicaid Services
Room 305H, Humphrey Building
200 Independence Avenue, SW
Washington, D. C. 20201

Re: Payment for Chronic Care Coordination and Transition of Care

Dear Mr. Blum,

The American Geriatrics Society (AGS) is writing to follow up on our meeting with you and Jeffrey Kellman on August 26, 2011 at which we discussed the Centers for Medicare & Medicaid Services (CMS) proposal to have the American Medical Association (AMA)/Specialty Society Relative Value Update Committee (RUC) review all Evaluation & Management (E/M) Services. At that meeting we articulated our concerns about such a review and are grateful that you understood those concerns and that CMS withdrew its proposal. We also understand that CMS is interested in addressing what it has heard about inadequate payments to primary care physicians and that CMS is interested in looking at ways to make appropriate payment for chronic care provided to Medicare beneficiaries with multiple chronic conditions.

We realize that CMS is looking at many options for improving care by implementing new models of care delivery and payment systems. However, it will be a number of years before those programs have a widespread impact on Medicare beneficiaries and it is unclear whether they will replace or supplement the fee-for-service program. Given that the vast majority of Medicare beneficiaries receive care through the fee-for-service program, and will continue to do so for the foreseeable future, AGS believes that CMS should take steps to improve chronic care delivery and care coordination for those patients as soon as possible (i.e., in the proposed rule for the CY 2013 Physician Fee Schedule). AGS acknowledges that taking the steps we recommend in this letter will not solve all the payment policy issues facing geriatricians and other primary care physicians, or completely address the unmet medical needs of Medicare beneficiaries with multiple chronic conditions. However, implementing our recommendations would provide immediate benefits to vulnerable Medicare beneficiaries and would be an important start from which lessons will be learned that can inform additional improvements, both within the fee-for-service program and in new payment models, including accountable care organizations (ACOs) and medical homes.

Therefore, we are writing to make two specific coding and payment recommendations for CMS to consider including in its proposed rule for the CY 2013 Physician Fee Schedule. As described below, the recommended codes would provide additional payment to (1) care teams, under the direction of a physician, for providing chronic care to frail, vulnerable patients who are functionally impaired and

require the ongoing assistance of a caregiver, and (2) physicians responsible for transitioning care of a patient from an inpatient site of care to a home, domiciliary or other similar site of care.

The care described by these proposed codes is typically delivered by geriatricians, or other primary care physicians, to patients who have many avoidable readmissions to an acute care hospital or avoidable visits to the emergency department had they received appropriate chronic care or had their transition from hospital care to home care, properly managed.

AGS believes that the need for appropriate payment to primary care physicians caring for frail patients with functional impairment and for those transitioning to home care, is immediate and doing so would send a strong signal that CMS is committed to improving the care of these vulnerable patients. Importantly, establishing a payment for the care provided to patients transitioning to their homes from an acute hospital stay would be an important step that would help CMS achieve its goal of reducing unnecessary readmissions and would further align hospital and physician incentives in this regard. Until now, CMS has focused largely on the hospitals role in arranging for follow up care but the reality is that the patient's primary care physician is frequently the individual who is responsible for the transition and who does most of the work. Creating a code that describes this work would allow CMS to more easily track transitions of care, better understand how it is being delivered, by whom it is being delivered and whether it is successful in avoiding readmissions.

AGS also believes that making payment for these services would also be a very public, tangible first step toward our shared goal of appropriately reimbursing primary care providers who use the team approach to care for frail vulnerable patients. We believe our coding proposal would not only be useful in the fee-for-service environment, but also for ACOs as they track care and allocate resources internally for the care of these patients.

AGS is also committed to participating in the Current Procedural Terminology/Relative Value Update Committee (CPT/RUC) workgroup process which is intended to result in the submission of recommendations to CMS for codes and relative value units that describe a variety of chronic care services provided by primary care physicians. However, it is unlikely that those recommendations will be forthcoming in time for the physician fee schedule proposed rule for CY 2013. AGS does not believe it is appropriate to wait for the CPT/RUC workgroup to complete its work before taking any action in this area.

There is one critically important point that needs to be made. The physician and clinical staff work described in the two codes we propose is not included in any current E/M service. Specifically, the work described in our proposed codes is not included in the pre, intra or post service work of any existing E/M code. We would be pleased to discuss this with you as we have heard that there may be some disagreement over this issue. We believe that the history of these codes, dating back to the origination of the resource-based relative value system supports our contention.

Our proposal is based on the following concepts that we discussed during our meeting:

- Current E/M codes do not describe chronic care management and, therefore, do not describe the work of primary care physicians in caring for the chronically ill;

- Care for patients with multiple chronic illnesses, especially those with functional impairment, is focused on counseling, education, medication reconciliation & management, prevention of exacerbations and ongoing communication between patients and caregivers on one hand and the health care team on the other;
- The current E/M office visit codes do not reflect the substantial work actually being performed for these patients. For example, existing E/M codes require taking an extensive history and performing an extensive physical examination, which are not typically required during visits with multiply ill functionally impaired patients;
- Chronic care is increasingly being performed by teams; these teams are supervised by physicians with a significant amount of care provided by non-physician health professionals;
- Much of the care between visits is performed by a case manager (usually a nurse or social worker), and/or other health professionals, working under the supervision of a physician; and
- Transition from one site of care to another is often fraught with poor communication among health professionals and caregivers and can result in patients returning to the original site of care for reasons that were easily preventable.

Chronic Care Code

CMS should establish the following HCPCS code:

Chronic care management of a patient with functional impairment severe enough to require one or more caregiver(s) to provide, on an ongoing basis, at minimum, the following: patient history, physical assistance, ongoing support for activities of daily living and, where authorized, decision-making for the patient; includes all non face-to-face care (e.g., coordination of care, telephone calls, on-line communications, refills) provided directly by or under the supervision of a physician; per 30 days, minimum of 30 minutes contact with the patient and/or caregiver

This is a code intended for use by primary care physicians only and we believe it should only be billed by one primary care physician per month at the conclusion of the 30 day period during which this care was furnished.

We understand that there will be implementation issues regarding payment for this service and we would be pleased to work with you to address them. For example: is this a completely stand-alone code or should payment vary based on whether there was a face-to-face service provided during the month? What documentation requirements should be required? Can the code be billed if the only physician involvement is supervision? Can other codes, such as those for home health or hospice certification be billed in the same month as the proposed chronic care management code? If the patient has more than one physician who qualifies as a primary care physician, what process, if any, needs to be established to assure that the correct primary care physician reports the service?

Transition of Care Code

CMS should establish the following HCPCS code:

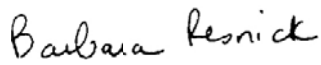
Transition care management for a patient transitioning from an inpatient site of care (e.g., acute care hospital, skilled nursing facility) to an outpatient site of care (e.g., home, domiciliary) including review of the discharge note and plan of care, medication reconciliation, interaction with other health professionals (including the physician(s) responsible for care at the inpatient

site) and caregivers, implementing the intended plan of care and arranging follow-up; per 30 days after discharge from inpatient care.

Our intent is for the patient's primary care physician to bill for this service. As with the chronic care code, we realize there are a number of implementation issues. For example: should this code include one post discharge visit? Should the code include 30 days of care? How can CMS identify the physician who should bill for this service? Should non-primary care physicians be allowed to bill for this service?

We would like to schedule a meeting at your earliest convenience to discuss these proposals and any additional steps that are appropriate to take. Again we thank you for the time and attention you have paid to this issue and we look forward to working on this important initiative to attain our common goal of improving care for Medicare beneficiaries and all patients with functional impairment.

Sincerely,



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