May 23-24, 2017

Improving the Care of Patients with Chronic Disease

The Senate should pass legislation to improve the care of patients with chronic disease, S. 870, based on *The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017,* with improvements to strengthen chronic care management services, as detailed below in the "What is ACP Asking of Congress" section. House members should develop companion legislation that includes these provisions.

What's it all about?

As seniors continue to live longer and our population ages, it is time to re-examine how Medicare provides care for seniors with multiple chronic conditions. According to the Centers for Medicare and Medicaid Services (CMS), in 2010, more than two-thirds of Medicare beneficiaries had multiple chronic conditions, and treatment of these illnesses such as diabetes, congestive heart failure, and cancer account for almost 93 percent of Medicare spending. Although a bipartisan consensus in Congress has emerged on the need to address this issue, significant challenges remain to developing and reforming care for patients with multiple chronic conditions.

CMS has come to recognize over time the complexities and challenges of providing care for patients with multiple chronic conditions and the value of providing reimbursement to physicians for the time spent coordinating care for these patients outside their office visit. In 2015, CMS added a Chronic Care Management code that will reimburse physicians for at least 20 minutes of non-face-to care clinical staff time to coordinate care for beneficiaries with two or more chronic conditions. Last year, CMS added a new Complex Chronic Care Management Code that would allow for physicians to bill for at least 60 minutes of care coordination for these patients that takes place outside their face-to-face encounter with patients. Although these reforms are steps in the right direction, additional changes to Medicare are needed to adequately value the time and services needed to treat patients with multiple chronic conditions.

What's the current status?

The Chairman and the Ranking Member of the Senate Finance Committee, along with a bipartisan Chronic Care Working Group led by Senator Johnny Isakson (R-GA) and Mark Warner (D-VA), have worked together to develop a framework of policy options and subsequently legislation to improve the quality and lower costs of care for patients with multiple chronic illness. This bipartisan legislation, known as the Creating High Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act (S. 870), was introduced in the Senate on April 6, 2017 by Sens. Orrin Hatch (R-UT), Ron Wyden (D-OR), Johnny Isakson (R-GA), and Mark Warner (D-VA). Throughout the process, ACP and other stakeholders were given the opportunity to provide feedback and suggestions on the legislation and ACP has endorsed the legislation:

- ✓ View ACP's support letter on the CHRONIC Care Act
- ✓ View the text of the CHRONIC Care Act

This legislation includes many provisions that are consistent with ACP policy and that we offered input on during the drafting of the bill, including:

Section 101 – Extending the Independence at Home Model of Care - a demonstration project under Medicare that uses physicians and nurse practitioner-directed home based primary care teams for Medicare beneficiaries with multiple chronic illness. This section would extend this demonstration for an additional two years.

Section 303 - Increasing Convenience for Medicare Advantage Enrollees through Telehealth – this section would allow a Medicare Advantage plan to offer appropriate telehealth benefits in its annual bid amount beyond the services that currently receive payment under Part B.

Section 305 - Expanding Use of Telehealth for Individuals with Stroke - This section would expand the ability of Medicare beneficiaries presenting with stroke symptoms to receive a timely consultation via telehealth to determine the best course of treatment, beginning in 2018.

Section 401 - Providing Flexibility for Beneficiaries to Be Part of an Accountable Care Organization -This section would give Accountable Care Organizations (ACOs) in the Medicare Shared Savings Plan the choice to have their beneficiaries assigned prospectively at the beginning of a performance year so that beneficiaries may voluntarily align with their main doctor for ACO assignment.

Why should the 115th Congress address it?

If Congress does not act to improve the way we treat patients with chronic conditions and spend Medicare dollars more wisely, the sustainability and accessibility of Medicare coverage for seniors remains at risk. Unless reforms to Medicare are implemented, the program will not work to give physicians the time needed to treat patients with chronic conditions and provide patients with the services needed to adequately treat their chronic conditions.

What is ACP asking of Congress?

The Senate should pass S. 870, the CHRONIC Care Act, with the following added improvements, and companion legislation should be introduced in the House:

Eliminate Beneficiary Co-Pay for Chronic Care Management (CCM) Services: CMS now pays for non-face-to-face CCM services for Medicare beneficiaries who have multiple (two or more) chronic conditions, an effort championed by ACP. However, beneficiaries are responsible for copayments on these services, which can cause undue strain on a doctor-patient relationship because patients are not accustomed to paying for a service when they do not see the doctor face-to-face. It is often difficult to convince patients that their copayment is worth the service. This co-pay should be eliminated by treating CCM services under the preventive services category under Medicare Part B to eliminate any beneficiary cost-sharing associated with the services.

Require reimbursement and coverage of additional codes for more complex CCM services: CMS now provides payment for doctors that provide Complex Chronic Care Management services for patients that last at least 60 minutes in length as well as payment for chronic care management services that last at least 20 minutes in length. CMS has not issued any new codes that would allow physicians to bill for chronic care management services that last between 20 -40 and 40-60 minutes. ACP urges Congress to direct CMS to authorize two new codes that would authorize physicians to bill Medicare for CCM services that would recognize the value of care for clinicians who treat patients with chronic care conditions between 20-40 minutes and 40-60 minutes.

Who can I contact to learn more?

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Digital version of this issue brief can be found at: https://www.acpservices.org/leadership-day/policy-priority-issues.