June 22, 2015

Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Medicare Chronic Care Policy Recommendations

Dear Chairman Hatch, Ranking Member Wyden, Sen. Isakson, and Sen. Warner:

The American Academy of Neurology (AAN), the world’s largest association of neurologists representing 28,000 professionals, appreciates the opportunity to submit comments in response to the Senate Finance Committee request for input on chronic care management in Medicare. The AAN is committed to improving the care and outcomes of persons with neurologic illness in the most cost effective manner. As such, the Academy welcomes the Committee’s focus on chronic care reform.

Each year, neurologic disorders affect an estimated 50 million Americans and cost hundreds of billions of dollars in medical expenses and lost productivity. It takes significant time and skill to provide ongoing cognitive care to manage complex chronic conditions for people with neurologic diseases like Alzheimer’s disease, Parkinson’s disease, stroke, epilepsy, traumatic brain injury, ALS, multiple sclerosis (MS), and headache. Often, these diseases represent the highest-need, highest-cost Medicare beneficiaries.

Neurology is primarily a non-surgical, non-procedural specialty. This means that neurologists provide face-to-face care, also known as evaluation and management (E/M) services, to people with complex neurologic conditions. In 2012, two-thirds of neurologists received 60 percent or more of their payment from E/M services and over 20 percent received all of their payment from E/M services.¹ Neurologists are trained to treat and to ensure continuity of care for Medicare patients with chronic neurologic diseases. In fact, the majority of neurologists (over 70 percent) see their Medicare patients on an ongoing basis, not as a one-time consultation or referral.²

Patients are waiting longer than ever before to see a neurologist. Between 2013 and 2014, there was a 43 percent increase in wait time for a new patient visit with a neurologist and a 15 percent increase in wait time for a follow-up visit.³ Many patients with neurologic conditions view their neurologist as their principal care physician. The neurologist cares for the underlying condition such as MS, epilepsy, or Parkinson’s and coordinates the rest of the Medicare beneficiary’s health care needs as necessary. For example, a patient with ALS will typically call their neurologist when they have a cough or a urinary tract infection because generalists often are not comfortable managing them.

¹ The American Academy of Neurology.
² The American Academy of Neurology.
³ The American Academy of Neurology.
AAN Proposals
There are more than 600 neurologic conditions—most are chronic and too many lack cures or disease-modifying treatments. Diagnosis and management of neurodegenerative diseases in particular requires extensive time and expertise. Efforts to improve the management of chronic care in Medicare beneficiaries must recognize the continuum of needs of patients with chronic illness. For chronically ill patients with aggravating factors such as cognitive or functional impairment and/or reliance on caregivers, advanced care coordination is needed. For patients with chronic illnesses that can be managed with medication and lifestyle changes, more basic care coordination is appropriate. The AAN hopes the Committee bears that distinction in mind when considering reform.

The AAN offers the following ideas for the working group to consider in its work to improve care for Medicare beneficiaries with chronic conditions.

Interoperability
The recently passed Medicare Access and CHIP Reauthorization Act of 2015 sets a goal for electronic medical record (EMR) interoperability. Until this goal is realized, however, care coordination will be significantly hampered. Providers need to know what other providers are doing with regard to the patients they treat for coordination to occur. Time and resources are wasted when lack of this information leads to repeated tests or by trying medications that have already been ruled out. Transitions between facilities, as is common with patients with multiple chronic conditions, further exacerbates this communication breakdown. Establishing full EMR interoperability is key to the goal of care coordination.

Transformative policies that improve outcomes for patients living with chronic disease either through modifications to the current Medicare Shared Savings ACO Program, piloted alternative payment models currently underway at CMS, or by proposing new APM structures

Bundled Payments
Though just in the concept stage, one approach may be to consider how to incentivize care coordination for a specific episode over a specific time frame. For neurology, this could include particularly high-cost, resource-rich episodes such as post hospital stroke care or the care for patients with advanced Alzheimer’s disease for a defined period of time. Many providers are involved in providing this care across multiple settings, representing an acute need for focused coordination and collaboration to ensure the best care for the beneficiary.

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

Improve Care Coordination Incentives by Relying on a Patient Perspective of Care
An essential part of providing better care for those with chronic conditions will be to incentivize appropriate care by the most appropriate physician. Just as important is encouraging medical students to go into primary care as well as cognitive specialties like neurology. For some time, federal policy has recognized the need to promote primary care but has failed to understand that cognitive providers are in the same crisis as primary care with regard to recruiting new physicians.
A recent example is the Medicare Payment Advisory Commission (MedPAC) proposal for a monthly per-beneficiary payment for primary care mentioned by Mark Miller at the Finance Committee hearing titled “A Pathway to Improving Care for Medicare Patients with Chronic Conditions.” MedPAC recommended the payment as a replacement for the 10-percent Medicare Primary Care Bonus, which expires at the end of this year.

Cognitive specialists provide E/M services to individuals with complex medical conditions. These face-to-face services require a high level of expertise and often lead to the specialist coordinating both specialized and primary care for patients with chronic conditions. Both the Primary Care Bonus and the per-beneficiary payment MedPAC recommendation leave out the millions of Medicare beneficiaries who rely on physicians other than primary care providers for their coordination of care for their chronic conditions.

As drafted, the MedPAC per-beneficiary payments for primary care would pay physicians a monthly fee for coordinating care for Medicare beneficiaries. Although we find merit in the premise, MedPAC chooses to restrict the payment only to the listed specialties of family medicine, general internal medicine, pediatrics, and geriatrics. This excludes many physicians who commonly coordinate care for Medicare patients with chronic diseases such as Alzheimer’s, MS, ALS, rheumatoid arthritis, diabetes, HIV, mental health conditions, and many other serious, complex conditions. MedPAC’s own data shows that their proposal will only cover 21.3 million (about 40 percent of) beneficiaries. While another 30 percent of beneficiaries are enrolled in a Medicare Advantage plan, this gap shows how difficult it is to know how many patients rely on physicians other than primary care providers and whether a per beneficiary payment is the right investment to make to improve care coordination.

As the Committee considers MedPAC’s recommendation, it is critical to understand there is no code in the fee schedule for “primary care services.” Physicians who see patients face-to-face bill Medicare under new or established patient E/M visit codes. Primary care physicians (PCPs) and cognitive physicians bill identical codes and either may coordinate care for individual patients. Because PCPs and cognitive specialists bill the same codes, data show that incomes and recruiting are profoundly similar. This is unlike procedural-oriented specialties, which have substantially higher incomes and can use financial incentives to recruit the best and the brightest into their fields.

This was recognized by the National Commission on Physician Payment Reform stating in March 2013, “[w]hile the discussion about reimbursement has generally focused on services performed by primary care physicians, the commission believes that the real issue is not one of relative payment of specialists versus primary care physicians but, rather, of payment for E/M services as contrasted with procedural services.”

The per-beneficiary payment currently envisioned by MedPAC will continue the flawed policy of the Primary Care Bonus resulting in PCPs receiving higher reimbursement rates than cognitive specialists for providing identical care. This will further compound the challenges already facing cognitive specialties, ultimately leading to even greater access to care problems for some of Medicare’s highest need, highest cost beneficiaries who rely on cognitive physicians.

For any plan to establish a per-beneficiary payment, we urge the consideration of two approaches:

1. Allow Medicare beneficiaries the ability to designate the physicians they rely on whether they are PCPs or cognitive specialists, or
2. Determine the lead provider using a plurality rule—whoever sees the patient the most during the year is the lead or primary provider

While in many instances it is appropriate for PCPs to provide the coordination role, there are complex chronic diseases for which the specialist is in the best position to anticipate the needs of the patient, identify problems and initiate interventions early to avoid serious complications. From the perspective of the patient, the physician in the best and most appropriate position to provide these services should be encouraged to do so. Picking winners and losers based on specialty designation is not the answer and we urge Finance Committee members to reject any proposals that would compensate some physicians more than others based only on specialty designation rather than on the services provided to Medicare beneficiaries.

Restructure Medicare Fee Schedule

It is vitally important to recognize that the payment disparities facing providers is not divided by primary care versus specialties, but rather a need to balance E/M with procedural care. The current Medicare physician fee schedule is flawed in large part due to inherent biases that favor procedures and testing over non-procedural care. These biases persist in spite of data showing inequity of provider reimbursement and the rapid growth of these services without a corresponding increase in medical need.

What is needed is a complete revision of the Medicare fee schedule that narrows the payment gap between E/M services and procedures to ensure access to all health care services.

Data exist to show that the intensity of work between different health care services is minimal. In research conducted by the University of Cincinnati, specialties—surgeons, internists, family medicine physicians, and neurologists—reported similar overall levels of work intensity, although the specific dimensions of work intensity were more variable. Yet varying “intensity” of physician services is used in the current fee schedule to justify reimbursing procedures at higher rates than face-to-face or cognitive care. The AAN believes the fee schedule should factor in value to the patient and the importance of the service when determining reimbursement rates. Patients with chronic neurologic conditions and their caregivers highly value time with their providers, yet current incentives undervalue this kind of care, therefore reducing time available to spend with patients.

The AAN strongly urges the Committee to take the opportunity to make a significant impact in the disparity between non-procedural and procedural specialties. Incentives should be aligned with the services beneficiaries most value.

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

Improve Care, Reduce Disability, and Save Costs by Improving Patient Access to Telestroke Care

Currently, Medicare only reimburses for telestroke care that occurs in a rural area. We strongly encourage the Committee to make telestroke care more widely available by supporting the Furthering Access to Stroke Telemedicine (FAST) Act (S. 1465/HR. 2799). The FAST Act would allow Medicare to reimburse for telestroke services that originate in urban and suburban areas.

Expanding telestroke care to all areas would increase stroke care coordination among providers, incentivize appropriate levels of care and facilitate the delivery of high quality care, improve patient outcomes, and reduce Medicare and Medicaid spending.
Stroke is a leading cause of serious long-term disability and the second leading cause of dementia, with nearly 800,000 strokes occurring per year.\(^8\) About two-thirds of the total hospitalizations for stroke occur among adults age 65 and older,\(^9\) and approximately 94 percent of strokes occur in an urban or suburban area.\(^10\) Unfortunately, a number of barriers prevent or slow treatment for a large number of patients, including the lack of availability of stroke specialists who can evaluate the patient and determine if he or she is a candidate for treatment. Timely access to a neurologist who can oversee administration of the latest therapies through expanded use of telestroke greatly improves the number of patients who receive the evidence-based treatment for stroke and reduces disability from stroke.\(^11\)

Tissue Plasminogen Activator (tPA) is a clot-busting drug that helps reverse disability from the most common type of stroke if given within the first 3 to 4.5 hours of symptom onset. The faster a patient receives treatment for stroke, the better the chances for recovery with minimal or no disability. However, about one-third of Americans live more than an hour from a primary stroke center,\(^12\) and only 27 percent of stroke patients arrive at the hospital within 3.5 hours of symptom onset.\(^13\) Additionally, there are currently only four neurologists per 100,000 persons in the US,\(^14\) meaning that even emergency departments in urban and suburban areas are not able to have stroke neurologists readily available. As a result of these barriers, only 3 to 6 percent of stroke patients receive tPA.

Telestroke can help fill this void, and evidence-based research supports its use and effectiveness. For instance, evidence shows that telestroke has proven to be very effective in increasing the use of tPA and reducing the amount of time it takes to get treatment to patients, in both urban and rural areas.\(^15\) Another recent study of four urban hospitals in Illinois found that their utilization of tPA increased by two to six times after telestroke was implemented.\(^16\)

Finally, telestroke can save money by reducing stroke-related disability and the need for costly inpatient rehabilitation or long-term care. Stroke is currently the leading cause of Medicare admissions to inpatient rehabilitation facilities, accounting for nearly 20 percent of all such admissions.\(^17\) According to one study, patients receiving tPA were more likely to be discharged to home than to inpatient rehabilitation or nursing homes and the study projected savings in rehabilitation and nursing home costs of $10.2 million (in 2013 dollars) per 1,000 additional patients treated with tPA.\(^18\) In addition, a similar study published in the New England Journal of Medicine showed patients receiving clot-busting therapy were at least 30 percent more likely to have minimal or no disability at three months when compared to patients who did not receive this treatment. The study also found that these patients have shorter hospital stays and are more frequently discharged to their homes rather than to nursing homes.

An analysis conducted by the American Heart Association/American Stroke Association of the impact of lifting the rural site requirement specifically for telestroke evaluations found that the FAST Act could result in $1.2 billion in net savings to Medicare and Medicaid over 10 years. While the AAN supports broadly eliminating geographical barriers to telemedicine, we recognize that the Congressional Budget Office is a significant barrier to advancing sweeping changes in telehealth. Due to this, we believe the FAST Act is an ideal first step in this area due to the strong data in support of telestroke’s efficacy, compounded by the fact that savings from reduced disability begin to accrue almost immediately, as opposed to years down the road. We urge the committee to include the FAST Act in your proposal.
Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers

Incorporate Patient Preference Through Advanced Care Planning

Advanced care planning is critical to the care of those with chronic disease. Often this term is identified with end-of-life care. However, while it incorporates those decisions, it also incorporates the full course of chronic disease. Patients and their families need to know about their diagnosis, the prognosis, the issues they are likely to encounter, and treatment options.

The Care Planning Act of 2015 (S. 1549), recently introduced by Senators Isakson and Warner, would establish Medicare coverage for voluntary advanced care planning, thereby increasing access to this important service. Research shows that advanced care planning conversations significantly improve outcomes for patients, including care that is consistent with their wishes, fewer hospitalizations, higher hospice utilization, and an increased likelihood of dying in their preferred location. As this legislation recognizes, the care that Americans receive near the end of life often does not reflect their values, goals, and preferences. The Care Planning Act of 2015 includes many provisions that would help improve documentation of patients’ wishes for their care near the end of life and move toward greater patient-centered care.

Overall, the AAN supports the goals of the Care Planning Act of 2015, but would support extension of the eligibility categories. We are concerned that many patients with neurologic conditions would not qualify for these services upon diagnosis, even if their illness was a serious progressive condition like MS or Parkinson’s disease. Further, limiting these services to the late-stages of serious diseases may miss the opportunity to have these conversations sooner. The AAN would also support extending coverage to individuals without chronic conditions, similar to the approach taken in the Personalize Your Care Act by Reps. Blumenauer and Roe. Patients with these additional diagnoses and their families should have access to advanced care planning, including discussions surrounding the prognosis, likely future problems such as respiratory failure in ALS, and a comprehensive review of treatment and management options.

The AAN also encourages the working group to look at states that have made progress in implementing advanced care planning such as the “Honoring Choices Minnesota” and “Honoring Choices Wisconsin” initiatives.19

Conclusion

The AAN looks forward to working with the Committee as the next steps in the working group’s plans take shape. Incorporation of the ideas outlined above into the legislative plans of the Committee is key to addressing the unique needs of Medicare beneficiaries with chronic neurologic illness. If you have questions or would like to discuss any of these proposals further, please contact Mike Amery, Esq., at mamery@aan.com or (612) 928-6126.

Sincerely,

Terrence Cascino, MD, FAAN
President, American Academy of Neurology


10 Based on 2013 CDC survey data which reported the prevalence of stroke was 2.4 percent for adults living within a MSA and 3.2 percent for adults living outside a MSA. Using US Census Bureau estimates of the population living in MSAs and non-MSAs, we estimated the total number of strokes occurring in MSAs and non-MSAs


