THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE
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The Honorable Ron Wyden
Chairman
Senate Committee on Finance
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Senate Committee on Finance
239 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

AMDA—The Society for Post-Acute and Long-Term Care Medicine appreciates the opportunity to comment on the Senate Finance Committee white paper entitled, "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B." This paper outlines the Committee's interest in physician payment reform and improving care for those with chronic illness, signifying an important step forward in the ongoing endeavor to modernize traditional Medicare. The Society is the only medical specialty society representing the community of medical directors, physicians, nurse practitioners, physician assistants, and other practitioners working in the various post-acute and long-term care (PALTC) settings. The Society's members work in skilled nursing facilities, long-term care and assisted living communities, CCRCs, home care, hospice, PACE programs, and other settings. The Society is fully supportive of efforts to update and strengthen Medicare and looks forward to collaborating with the Committee to help in shaping policies ensuring high-quality, sustainable care.

The Society knows this is a complex subject but also a very important one that needs to be addressed and must involve refining the Medicare Physician Fee Schedule (MFS) to reflect the realities of medical practice today more accurately. The lack of appropriate adjustment to account for inflation has significantly eroded reimbursement for all medicine. Using the Medicare Economic Index (MEI) is a better approach and needs to be addressed in a manner that ensures that physician payments keep pace with inflation and the cost of delivering medical care. Ultimately there is too much spent on medical care in our country versus outcomes and there needs to be changes.

The PALTC workforce and patient population is heterogenous and complex. PALTC clinicians offer a range of services delivered by NFs, SNFs, home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). Between NFs and SNFs there are differences in patient populations, care team members, care interventions, and expected length of stays. For example, SNFs are designed for short-term rehabilitative support, with an average length of stay of about 30 days and a goal of returning the patient to the community or resuming normal activities and function, while NFs offer longer-term care including supporting activities of daily living, often with the

goal of preserving the patient's quality of life and health as much as possible. PALTC clinicians should not be viewed as monolith, and a one-size-fits-all approach for engagement will not work.

Reducing Physician Reporting Burden Related to the Merit-based Incentive Payment System (MIPS)

The Society shares the U.S. Senate Finance Committee's concerns about the administrative burden placed on physicians subjected to MIPS reporting requirements, the program's lack of improvement in patient outcomes, especially for the chronically ill, and quality of care, and the limited scope of quality measures for specialists. There is also a growing body of evidence that the program is disproportionately harmful to small, rural, and independent practices, as well as practices who care for underserved patients. Clinicians practicing in PALTC still face an unfair comparison group when benchmarked against their peers in internal or family medicine. For many years, The Society has advocated for a more granular approach to these comparison groups and ensure that PALTC based clinicians are evaluated on a scale against other PALTC-based clinicians given the significant difference in practice and cost for this population when compared to the population in the ambulatory environment.

Finally, MIPS does not provide actionable, timely feedback to physicians to understand their utilization and identify opportunities to reduce avoidable spending for Medicare patients and the program, despite this being required under MACRA.

While CMS has tried to improve the program by introducing the MIPS Value Pathways (MVPs) option, but the Society remains concerned about the applicability of the MVPs to the PALTC population. Likewise, we are concerned about the resources necessary to develop MVPs and should establish a far more flexible MVP framework and create quality and cost measures based on clinical pathways and patient reported outcome measures (PROM) for diagnosis and treatment of specific medical conditions.

Given that PALTC has typically been a more difficult sector to develop appropriate quality and cost measures, we strongly encourage the development of subgroup compositions of multiple specialties, across multiple locations, and in various sizes to achieve the MVP's goals of improving care and reducing avoidable costs. Specifically, lawmakers need to work with specialty societies like the Society and other MVP developers to develop and test new and innovative cost measures that are clinically appropriate for an MVP.
Physicians should have access to analyze Medicare claims data to identify opportunities to reduce spending, measure the impacts of care delivery changes, and quickly identify when services for patients need to be changed.

Incentivizing Participation in Alternative Payment Models (APMs)

Physician practice run APMs have seem to have success and should be further supported via virtual APMs, and a continuation of some percent incentive indefinitely. The Society encourages the development of a more robust pipeline of APMs that are designed and focused for the frail chronically ill elderly in the PALTC sector. The creation of APMs that would enable clinicians to deliver better care to their patients at a lower cost to the Medicare program is a goal the Society supports. Given that the PALTC field is very interdisciplinary, it is vitally important that these APMs consider models that incentivize such team-based longitudinal care. We strongly supported passage of the provisions in MACRA that were designed to facilitate the creation of APMs that attribute lives to physician practices, and were disappointed that, nearly ten years after the passage of

MACRA and even longer since the creation of the Center for Medicare and Medicaid Innovation (CMMI), most PALTC-based clinicians still participate in models not build for their population and do not have the opportunity to meaningfully share in the savings they create.

PALTC has played a critical role in the success of value-based care models, with some of the most significant cost savings and care improvements in ACO and episodic payment models generated by intentional and targeted post-acute care partnerships. In a synthesis of findings from 21 CMS Innovation Center models, 14 models (or 66 percent) had reductions in spending driven by post-acute care utilization.
Despite this, PALTC providers and facilities have been challenged in their ability to meaningfully participate in value-based care models to date. Current program policies in ACO models do not align well with PALTC clinicians, including those that determine which patients ACOs are accountable for, setting financial benchmarks, and the quality measures that must be reported. As a result, PALTC very rarely participate as Participant Providers in models and have been limited to SNF Affiliates, Preferred Providers, Other Entities, and/or enter separate contractual arrangements with ACOs; all of which pose limitations.

As one of the highest-cost and most complex patient populations, PALTC patients and their clinicians present a significant opportunity for improved outcomes and reduced costs for Medicare beneficiaries. Medicare spent nearly $57 billion on post-acute care, around 15 percent of total spending. Forty percent of inpatient hospital discharges are followed by PALTC services, totaling nearly two million SNF stays per year alone. As such, meaningful integration of these patients into broader APM efforts will be essential for CMS to meet its laudable goal of having all traditional Medicare beneficiaries in accountable care relationships by 2030.

When Congress created the Physician-Focused Payment Model Technical Advisory Committee (PTAC), many were hopeful that this would result in the creation of better APMs that would help physicians deliver higher-quality care to their patients. Recently, the PTAC held a daylong hearing on the needs of the PALTC community in value-based care. It is disheartening however, that many of the previous models PTAC recommended have not been implemented by CMMI.

Increasing Access to Chronic Care Management (CCM) Services

CCM has not delivered on its promise overall (unlike Transitional Care Management Services) and despite the demonstrated benefits of CCM in improving patient outcomes and reducing hospitalizations, the latest data points to a stark underutilization, with only four percent of eligible Medicare beneficiaries receiving CCM services representing only 882,000 out of an estimated 22.5 million.

Any new code, such as CCM, that requires CMS to estimate use and adjust the Conversion Factor (CF) need to be subject to a one- and three-year review with return of monies overestimated directly to the practitioners instead of being kept by CMS. Underestimates would have to be included in adjusting the following year's CF. Additionally, there should be a concerted effort by CMS to partner with states to further increase access to CCM services. This could be achieved through the inclusion of CCM services in state Medicaid plans. Such measures would not only amplify the reach of CCM but also enhance patient engagement in self-management of their health conditions to prevent exacerbations, particularly for those managing chronic diseases.

Waiving patient cost-sharing for CCM services is an important step towards removing obstacles to care management services, including patient-initiated navigation (PIN), and ensuring that Medicare beneficiaries receive the comprehensive care coordination they require.

Telehealth Access Through Legislative Reform

The Society supports the role of telehealth in the PALTC setting and advocates for the permanent removal of restrictions limiting Medicare patients' access to these services. Through legislative proposals such as the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act (S. 2016/H.R. 4189) and the Telehealth Modernization Act (S. 3967/H.R. 7623), there is a pathway for permanency of the advances made in telehealth accessibility, particularly vital for patients managing chronic conditions.

The Society also supports H.R. 8261, the "Preserving Telehealth, Hospital, and Ambulance Access Act," which will extend through 2026 many of the above telehealth provisions we strongly support including audio-only telehealth services, exemptions to geographic and originating site restrictions, and delaying the in-person requirements for health services via telemedicine. We are glad Congress is prioritizing legislative action to extend the telehealth services and we urge the Senate to pass companion legislation to extend important telehealth provisions currently scheduled to lapse at the end of the year.

The Society appreciates the Senate Finance Committee releasing this white paper and engaging in a meaningful exploration of physician payment issues. We are eager to collaborate with you on developing and enacting meaningful solutions to these problems to help ensure patients in the PALTC setting are receiving quality care.