Duke University Health System
Vice President for Medical Affairs
& Chief Medical Officer

As a world-class academic and health care system, Duke Medicine strives to transform medicine and health locally and globally through innovative scientific research, rapid translation of breakthrough discoveries, educating future clinical and scientific leaders, advocating and practicing evidence-based medicine to improve community health, and leading efforts to eliminate health inequalities.

Duke Medicine conceptually integrates the Duke University Health System, the Duke University School of Medicine, and the Duke University School of Nursing. It is the combination of research, clinical care, and education that takes place through the efforts of our faculty, staff, students, and trainees at many different sites throughout our region and worldwide.

We appreciate the thoughtful approach that the Senate Finance Committee has taken with respect to chronic care reform in the Medicare program and welcome this opportunity to share our perspectives that will support your goal of improving care for this vulnerable population. The below comments represent feedback on the issue areas identified in the Committee's May 22, 2015 request for comments. Because Duke Medicine has experience in chronic care coordination, we urge you to consider our strengths when developing legislative solutions. We are eager to share our real world experiences and data-driven practices with you in improving care for all.

We support the Committee as it continues its important work and hope you will call on Duke Medicine if we may be of further assistance.

CONTACT:
Catherine Liao
Assistant Director
Office of Government Relations
Duke University Health System
Catherine.Liao@duke.edu
(919) 416-8913 (desk)
(919) 357-5692 (mobile)

1. Improvements to Medicare Advantage for patients living with multiple chronic conditions

Medicare Advantage (MA) programs currently offer unique disease management benefits specifically targeted for individuals with chronic conditions (e.g. diabetes, ESRD, etc.). Most of these initiatives are single disease programs sponsored by the payer and implemented by the payer (and sometimes the provider). Often they involve the payer's clinical personnel and documentation systems which are not integrated with the provider's. This creates confusion for beneficiaries and members of the health care team as disparate teams are reaching out to the patient to achieve the same goals. Improvements to MA should include incentives for managing multi-morbid patients with programs that are integrated between sponsoring payer and providers. A metric or star rating that takes into consideration the extent to which payers have collaborated with providers at the *workflow* level for patients with multiple chronic conditions may be of value.

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

We believe alternative payment models (APMs) provide opportunities for providers to test their abilities to move into an increasingly value-driven health care market. Notwithstanding, the speed of transition to value-based reimbursement from fee-for-service varies depending on provider resources and capabilities. With that in mind, we favor approaches that represent a gradual transition to financial risk. Many of these programs, such as the Medicare Shared Savings Program (MSSP) or the Bundled Payment for Care Improvement (BPCI) program, require significant upfront investment that represents a form of opportunity cost or risk unto itself. We believe models that allow provider groups to calibrate their risk exposure both in terms of dollars and timeline would represent true transformation. Models that individualize, but continue to incentivize and challenge, will likely engage additional providers to enter into APMs.

Additional comments specifically about improving the MSSP include providing Track 1 MSSPs the same options for improved shared savings, skilled nursing facilities self-attestation/alignment of beneficiaries, and flexible Minimum Savings Rates/Minimum Loss Rate (MSR/MLR) amounts as potentially available to Track 2 and Track 3 ACOs (as outlined in the June 4, 2015 Centers for Medicare & Medicaid Services final rule updating and improving policies governing the MSSP).

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

The recent introduction to the Medicare Physician Fee Schedule of American Medical Association Current Procedural Terminology (CPT) code 99490 – for **non-face-to-face** care coordination services furnished to Medicare beneficiaries with multiple chronic conditions – represents a much needed step forward in ensuring that provider efforts are appropriately compensated when focusing on optimizing care for Medicare beneficiaries in their homes and communities. We support relaxing of the eligibility criteria to allow for beneficiaries with a single disease to qualify for CPT code 99490. We further support the continuation of such

innovative payment models including the ability to implement via remote monitoring and other methods by which technology is leveraged maximally. Finally, as detailed in #7 below, we support modification/elimination of the co-pay obligation for CPT code 99490 for beneficiaries who have met participation standards, which should include patient self-engagement in meeting health goals.

4. The effective use, coordination, and cost of prescription drugs

Our experience has shown that when prescribers are given concise, real-time information about cost, they will support prescribing patterns that take total cost of care into consideration. As such, we are in favor of efforts that bring cost and price transparency to the provider in a way that allows the prescriber to individualize therapy not only based on clinical needs but also on the financial means and resources of the beneficiary.

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

We support the ability for providers to maximize the use of technology including telehealth when providing care for Medicare beneficiaries. As a somewhat new field, the use of demonstrations and pilots may prove useful in broader outreach with telehealth and remote monitoring. The Center for Medicare and Medicaid Innovation (CMMI) provides an ideal home for grants and pilot projects that support the use of telehealth and remote monitoring.

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

Rural and frontier areas offer the greatest promise for the application of technology and established practices in chronic disease management. Here too, low- to no-risk pilot projects chartered out of CMMI would be of benefit. These areas also suffer from difficulty recruiting health care providers to either join an established practice or begin a new clinical enterprise. Primary care has continued to migrate toward an employment model with larger health systems, and the financial incentives are not aligned to encourage growth in rural and frontier areas. Consideration should be given, beyond what is currently available, for incentives that promote practice in these areas.

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

Empowering patients in their own care may provide the greatest return among any of the efforts to bend the cost curve while improving quality. Our experience with efforts to engage patients, such as patient compacts, have shown that explicit dialogue about what beneficiaries can do to optimize their outcomes and advocate for themselves can truly pay off. ACO regulations provide waiver protections for provider groups to explore unique ways to incentivize beneficiaries in their own health care. We support the continued application of such waiver protections but also advocate for them to be made available in other APMs, particularly where providers are taking financial risk.

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

Team-based care is the hallmark of population health management. Our experiences have shown that the more proximal a care coordinator is to the primary care provider, the more effective the care management. As such, providers should be encouraged to find ways to deliver certain care management services from the primary care provider's office. This is not to suggest that all care coordination must reside in the provider's office, but that even centralized programs need to take into consideration the importance of tight affinity with the primary care provider. This approach, in conjunction with the ability of all members of the team to function at the top of their experience and training, will enable patients to get the right care at the right time by the right provider.

We also support federal efforts that would enable states to allow members of the team to be as effective as possible at the top of their license. This includes efforts to allow expansion of incident to billing practices. This approach is consistent with the continued migration to a Patient-Centered Medical Home. We believe that the adoption and implementation of this model creates the best environment to improve our population's health and to ensure success in a value-based market. Oversight and recognition is currently available through the National Committee for Quality Assurance (NCQA) and The Joint Commission. We support additional incentives that encouraged and supported further growth of the Medical Home model.

1131 Davison Building, Duke South-DUMC 3701 ● 200 Trent Drive ● Durham, North Carolina 27710
Telephone (919) 668-2496 ● Fax: (919) 681-5184