

HealthPartners Chronic Care Initiatives

IMPROVING EXPERIENCE, AFFORDABILITY AND HEALTH OUTCOMES FOR THOSE WITH CHRONIC CONDITIONS

HealthPartners is committed to the Triple Aim of simultaneously providing an excellent patient experience and quality care at an affordable price. Founded in 1957, HealthPartners is the largest consumer-governed, non-profit health care organization in the nation, and we are the only integrated organization in our market, with insurance solutions for groups, individuals, Medicare and Medicaid, combined with health care service delivery. We are dedicated to improving health and well-being in partnership with our members, patients and the community. Our 4.5 star-rated Medicare plan serves over 50,000 Medicare beneficiaries. We have the highest rated special needs plan (Minnesota Senior Health Options) in the state, also at 4.5 CMS Stars. Our care system serves more than a million patients with more than 1,700 physicians. Our work in chronic care excellence is also highlighted through our Accountable Care Organization (ACO) work, as a Pioneer ACO with Medicare – Park Nicollet Health System, and in achieving the highest (Level 3) ACO accreditation from the National Committee on Quality Assurance (NCQA) for the HealthPartners Medical Group.

This document summarizes several HealthPartners programs and recommendations to address Chronic Care Solutions for Medicare Beneficiaries.

➤ FOCUS ON THOSE LIVING WITH MULTIPLE CHRONIC CONDITIONS

Much work to date has focused on those with single chronic conditions, such as diabetes or coronary artery disease. However, **addressing the needs of those with multiple chronic conditions is the area of important focus.** Most Medicare beneficiaries have more than one chronic condition. HealthPartners has experience with a range of programs services for those with multiple chronic conditions:

- ✓ Health Care Homes
- ✓ Care delivery redesign
- ✓ Safe transitions of care (this population has more transitions and hospitalizations than typical adults)
- ✓ Healthy living strategies

To better support this effort, we need meaningful measures and outcome based evidence for optimal care for those with multiple chronic conditions, including mental health conditions. We also recommend that **CMS recognize, through payment and program supports, non face-to-face care and consultation for patients with complex conditions (including the broad spectrum of telehealth, such as telephonic visits, e-visits, and video visits).** This type of care is essential in helping our patients and member manage their chronic conditions.

➤ MEDICATION THERAPY MANAGEMENT (MTM)

HealthPartners offers extensive MTM services, engaging members who need multiple medications, and those that utilize a large amount of health care resources. We know that our members and patients may experience medication related problems whether they take no chronic prescription medications or twenty. For that reason, access to MTM services is not restricted to those members that we target. Because Part D plan sponsors are only responsible for managing drug costs, not total costs, there is little incentive for a Pharmacy Benefits Manager (PBM) alone to develop a MTM program that focuses on taking the right medications and amounts that have the potential to also reduce the total cost of care. We recommend that **CMS align financial incentives to ensure high quality MTM programs,** either by rewarding PDPs for high quality MTM programs directly, or moving the MTM benefit out of Part D and into Part B where the incentives will be aligned for best care and financial accountability.

➤ **PAYMENT ALIGNMENT**

Patients with more than one chronic condition often access many providers across multiple clinic groups. By realigning care delivery payment to support care transformation, intensive care coordination and between visit supports, the system is focused on managing total health. HealthPartners has a decade of experience providing disease management under a Total Cost of Care approach. In these cases, centralized support from the health plan disease management program in partnership with care delivery is crucial to coordinating care effectively. Collaborative communications and processes between care systems and the health plan, including electronic medical record integration, allows sharing of resources and the ability to do live referrals. We recommend that **CMS support payment alignment (with integrated experience and quality metrics) as an approach to support care transformation, health care homes, intensive care coordination, between visit care support and ultimately improved health outcomes.**

➤ **EXPAND TELEHEALTH COVERAGE TO INCLUDE URBAN SERVICES AND PROVIDER ACCESS**

Frail elderly and those with multiple chronic conditions can often be well served by providing them telehealth services in their homes or in other settings in the community. This is true in metropolitan areas as well as rural areas. Allowing those in urban settings to receive care via telehealth reduces stress and danger of complicating problems such as falls or accidents in getting to and from the provider's care setting. We recommend that CMS **expand coverage of telehealth services to the entire Medicare population regardless of their geographic location.**

We also recommend that CMS **ensure that certain licensed Medicare participating physicians or practitioners who are licensed in one state may provide services via telemedicine to certain Medicare beneficiaries in another state.** We strive to provide care that is convenient for our beneficiaries and available to them when they need it, whether they are on vacation, or traveling away from their home practitioner for any reason. We believe that effective telemedicine is facilitated by the expanded use of state licensure compacts and are supportive of at least a minimum standardization of licensing that takes into account new developments in telemedicine while maintaining safety protocols and preventing fraud.

➤ **SUPPORT HEALTHY LIVING STRATEGIES AND OUTREACH FOR OPTIMAL CARE**

Helping beneficiaries achieve optimal care for in managing chronic conditions requires more than clinic based care and services. Integration of healthy living strategies and outreach programs can aid in both managing and preventing chronic conditions.

HealthPartners supports a broad range of programs, initiatives and research on healthy lifestyle behaviors for chronic disease management and prevention in our commercial population that could be expanded to Medicare beneficiaries. These include health assessments, digital health trackers and self-management tools, telephonic health coaching, and community initiatives to support better eating, increased physical activity, tobacco cessation, and decreased alcohol consumption (Optimal Lifestyle Metrics). We recommend CMS **support a broad range of health promotion and lifestyle intervention strategies for the management and prevention of chronic conditions in the Medicare population.**

Outreach on optimal care, is an important component helping beneficiaries achieve health outcomes. HealthPartners has experience with outreach across our disease management programs, including letters, calls, newsletters, personal coaching, phone-based support, telephonic health assessments, electronic mail, texting, social networking, and more. These healthy living and outreach efforts must take into account health literacy, language preference, availability of home supports and a range of other factors. We recommend that CMS **explore and support the use of a broad range of healthy living strategies and outreach approaches for helping beneficiaries with chronic conditions.**

➤ **CONTACT**

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