MATRIX
MEDICAL NETWORK

June 22, 2015

VIA ELECTRONIC DELIVERY

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, D.C. 20510

Dear Senators Hatch, Wyden, Isakson, and Warner:

Matrix Medical Network ("Matrix") appreciates the opportunity to provide these comments in response to your request for policy ideas to improve care and cost outcomes for Medicare beneficiaries with multiple chronic conditions. As the nation's leading provider of in-home health assessments, Matrix employs a network of over 500 community-based nurse practitioners ("NPs") on a full and part-time basis in 32 states, including Utah, Oregon, Georgia, and Virginia (see appendix for a listing of all states). Nurse practitioners have the highest state-approved scope of practice authority for nursing care, and may perform medical diagnosis, prescribe medical, therapeutic or corrective measures, provide patient education, and conduct other activities of primary care depending on the law of the state in which they are licensed.

In 2014, Matrix visited the homes and conducted clinical reviews of over 400,000 beneficiaries. Matrix customers include more than 30 Medicare Advantage Plans ("MA") Plans, both national and regional, who engage our NP network to initiate and extend primary care to the home for enrollees in order to proactively coordinate and improve access to care. Our NPs have unique contact with beneficiaries, both in terms of location and duration and are well-positioned as a result to identify and coordinate the needs of chronically ill individuals. In addition to identifying clinical needs during the home visit, the NP is also able to gain insight into the living environment and social determinants of health that may be impacting responses to chronic care management.

Our in-home assessments average one hour in duration, covering the beneficiary's medical history, current medication regime, physical examination, functional status, depression screening, a home environment review along with all components of Medicare's Annual Wellness Visit. The results of our assessment are shared with the beneficiary's primary care provider. Our in-home visits are a critical component of engaging patients with providers to improve quality and cost outcomes in a patient-centric manner. Further, our visits help those with multiple chronic conditions gain access to care and engage in their own well-being. According to a 2014 Matrix survey consisting of 115,972 beneficiaries, 99.2 percent of enrollees found our in-home health assessments beneficial.

Physical impairment is a major obstacle that many beneficiaries must overcome to effectively deal with their disease. CMS' data indicates that over 36 percent of Medicare beneficiaries have functional limitations as indicated by being unable to perform one or more activities of daily living. Many of these people with chronic disease need additional support in dealing with their condition – and that is where Matrix excels.

IMPROVEMENTS TO MA FOR CHRONICALLY ILL PATIENTS

MA plans are well-known for offering care coordination whereas traditional Medicare lags behind. Matrix helps to facilitate such coordination by visiting beneficiaries in their homes, on behalf of the MA plans, to perform a physical exam, take a baseline assessment of the health issues the enrollee is experiencing, document which medications he/she is taking and administer screening tests for some cancers, kidney function, and diabetes. We also help determine which screenings and preventive care measures may be overdue. Such efforts are key to establishing care plans for MA enrollees.

An important step that several members of the Committee and Congress have already taken is supporting the use of in-home health assessments during the MA rule-making process. CMS has repeatedly proposed requiring an additional physician office visit, which could also be performed by another NP per CMS' proposal, in order to confirm the diagnoses of an in-home health assessment. This duplication would place an unnecessary burden on the beneficiary with higher health care spending and copayments or result in fewer beneficiaries having access to a comprehensive health assessment in their home. We appreciate Congress' input that erecting such barriers to a comprehensive assessment could jeopardize access to care for those with chronic illnesses.

For this year, CMS instead established best practices for in-home assessments and highlighted the fact that these assessments can have significant value in improving the care of MA enrollees and promoting wellness, disease prevention, and care coordination. CMS also observed that home visits afford access to considerably more information than office visits. We ask and encourage Congress to look for ways to promote the use of in-home assessments, on an annual basis, to facilitate better care, especially for those with multiple chronic conditions.

ESTABLISH A CHRONIC ILLNESS MANAGEMENT PROGRAM IN MEDICARE FEE-FOR-SERVICE ("FFS")

While many MA plans utilize in-home health assessments to better understand the health needs of beneficiaries and identify health issues that those with chronic illnesses are experiencing, traditional Medicare does not, despite CMS' view that "in-home assessments can have significant value as care planning and care coordination tools. In the home setting, the provider has access to more information than is available in a clinical setting. For example, the provider is able to evaluate the enrollee's home for potential risks, the need for support to enable an enrollee to continue living in the community, and other relevant aspects of the enrollee's living situation."[1]

CMS data from 2010 indicates that 68% of Medicare beneficiaries had at least two or more chronic conditions. While many patients with a number of chronic conditions do a very effective job in managing their health, CMS reports that 30% of beneficiaries with 4-5 chronic conditions and 63%

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[1] Advance Notice of Methodological Changes for Calendar Year 2016 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter, page 140.

of beneficiaries with 6 or more chronic conditions were hospitalized at least once during the year. The chronically ill often receive care from multiple clinicians across a variety of sites of care. Their care also involves a large number of different medications. Failure to coordinate care and ensure appropriate care follow-up often puts the health and safety of this frail population at risk, as well as raising costs of care. Targeting these "poorly" managed patients with additional clinical support should be a key goal of Congress.

Congress should consider covering in-home health assessments conducted by certified providers, for vulnerable, high-cost beneficiaries to improve care and cost trends. Congress took similar steps when establishing the Medicare outpatient prescription drug benefit program by requiring drug plans to offer Medication Therapy Management (MTM) services to beneficiaries with several chronic conditions, multiple medications, and high prescription drug costs.

Similar to Part D, Congress could establish an annual Medicare chronic illness management program that is targeted to those beneficiaries who have complex and high cost chronic conditions that are not effectively managed. Under such a program, beneficiaries enrolled in traditional Medicare would qualify to receive an annual in-home health assessment and enrollment in an intensive face-to-face clinical management program in their home if they have:

- **Four or more chronic conditions;**
- **Been hospitalized at least three times in the last 12 months;**
- **High prescription drug costs per MTM threshold; and**
- **Take more than 6 prescription drugs.**

Beneficiaries who meet the criteria would receive an in-home health assessment to diagnose their conditions and gauge their level of need. A comprehensive care management plan would be developed after the initial visit and the beneficiary would be enrolled in an intensive face-to-face clinical management program in their home. This would involve the NP leading an extended team of RNs and other clinical specialists such as social workers. The team would follow the patient with subsequent home visits, augmented with telephonic contact with the patient as appropriate and coordination with the primary care provider. These efforts would ensure that the patient is adhering to the care plan, make certain the prescribed medications are available and being taken, continue to monitor the home environment and support network, and evaluate the patient's physical and mental capabilities on a regular basis.

Monitoring the behavioral health of the beneficiary with multiple chronic conditions is critical to improving their overall health. CMS reports that over 30 percent of Medicare beneficiaries have mental health issues. Behavioral health issues including depression are much higher for those who have multiple chronic conditions. These behavioral health challenges must be effectively managed in order to achieve an improvement in the physical health of the individual. Using a multi-specialty team including mental health experts to manage all facets of the beneficiary's health achieves this objective.

Programs that coordinate care and manage chronic disease are more effective when provided through **clinical teams with direct patient face-to-face contact** rather than relying entirely on telephonic contact such as a disease management program to get behavior change. Prior CMS telephonic care demonstration programs have not shown consistent positive results.

MA EXPERIENCE SUGGESTS POSITIVE OUTCOMES COULD BE ACHIEVED IN MEDICARE FFS

Our experience delivering in-home assessments and piloting chronic care management programs for health plans strongly suggest that similar positive results could be achieved in Medicare FFS, including:

More Effective Use of Prescription Drugs

An important component of any chronic care management program is the comprehensive review of both prescription and over-the-counter medications. Beneficiaries with chronic conditions are especially vulnerable to adverse drug interactions as they tend to take numerous prescription medications to deal with a myriad of health issues. This review is best performed in the home, as the beneficiary has **all** of their medications readily available, rather than relying on the beneficiary to remember each of their medications when visiting his/her primary care provider. These in-home medication assessments include: assessing adherence and the presence of adverse side-effects, education about how to take the medication, and contacting a primary care provider if the medication needs to be adjusted.

A sample of Matrix data for beneficiaries taking an average of 13 medications found that 24 percent were contra-indicated, 18 percent had potentially adverse interactions, and 15 percent were being taken outside of the guidelines. There are instances where our NPs will find that a beneficiary has been prescribed blood pressure medication by one physician only to be prescribed similar medication following a hospital discharge. By initiating the chronic care management program through a health risk assessment in the home, our NPs can flag prescription drug duplication which reduces potential harm to the beneficiary and reduces unnecessary Medicare spending. It is far more accurate to compile a beneficiary's drug inventory while in their home where he/she has access to his/her medication. This is an important reason why comprehensive in-home visits, like those provided by Matrix, should be promoted.

Greater Beneficiary Engagement in their Health

A critical component to delivering needed care to beneficiaries with chronic conditions is an informed and engaged beneficiary. In order to both educate and involve beneficiaries, Matrix provides each beneficiary with a detailed personalized prevention and immunization report following the in-home health assessment (in addition to sending the findings to their primary care providers). Such information, particularly for the chronically ill, helps to eliminate care gaps and improve health status. For example, after a recommendation at the in-home assessment, 22 percent of beneficiaries received a mammogram and 10 percent received a colonoscopy within 120 days. Matrix also screens beneficiaries for colon cancer and diabetes which can result in life-saving and life-improving follow-up care. By focusing on the beneficiary and his/her living environment, support structure (or lack thereof) and arming the patient with the information needed to better understand his/her health status Matrix assists his/her personal health engagement.

More Effective Use of Primary Care Providers and Care Coordination Teams

In-home health assessments combined with subsequent care management visits facilitate the effective use of primary care providers for the chronically ill in multiple ways. First, Matrix's in-home assessments take roughly one hour to complete because of their comprehensive nature. The average evaluation and management visit in an office setting lasts just 8 to 10 minutes by a physician and 10 to 20 minutes by an NP. Primary care providers simply do not have the time to conduct such a thorough evaluation in the office, particularly for beneficiaries with multiple

chronic conditions. Through these health assessments conducted in the home, primary care providers are afforded better opportunities to receive a more complete "picture" of the patients. Further, by sharing the results of these assessments with primary care providers, Matrix enables primary care providers to have access to all of the relevant health-related information that is needed to form a care plan for the chronically ill. Thus, the professionals conducting the in-home assessment and follow-up visits function as core parts of the beneficiary's care coordination "team" and can play an impactful role in assessing beneficiary progress in coordination with primary care providers. In fact, a survey of primary care providers found that 79 percent of responding primary care providers reviewed the Physician Summary from Matrix and included it in the patient's medical record and nearly 60 percent found the information useful. These beneficiary health reports make the primary care providers' jobs easier and allow for a more accurate and comprehensive care plan and should be widely promoted for the chronically ill.

Thank you for allowing us to submit our ideas for improving care for Medicare beneficiaries with chronic illnesses. As a critical component in delivering such care, Matrix stands ready to help with your important initiative. Should you wish to discuss these proposals further or if you have any questions please contact me at (480) 862-1906 or ckanach@Matrixhealth.net.

Respectfully Submitted,

Chuck Kanach
Senior Vice President
Matrix Medical Network

Appendix

States Where Matrix Operates

Arizona
Arkansas
Connecticut
Delaware
Florida
Georgia
Idaho
Indiana
Kansas
Kentucky
Maine
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
New Jersey
New Mexico
New York
North Carolina
Ohio
Oregon
Pennsylvania
South Carolina
Tennessee
Texas
Utah
Virginia
Washington
West Virginia
Wisconsin