



June 22, 2015

Dear Senators Mark R. Warner and Johnny Isakson,

Thank you for the opportunity to submit comments to the Finance Committee's chronic care working group.

Pursuant to your request, Mountain States Health Alliance (MSHA) reached out to three internal experts for their recommendations on how Medicare can improve care to recipients with multiple chronic conditions. The three experts, whose comments are included below, have professional focuses ranging from managed care to electronic health records, to primary medical homes.

Section I: Recommendations from Ian Bushell, MD , Chief Clinical Integration Officer , Crestpoint (MSHA's health plan) /ANEW (MSHA's Accountable Care Organization):

Improvements towards managing multiple chronic conditions:

Medical benefits need to cover diabetic eye exam
Increase behavioral health benefits
Increase behavioral health access

Encourage effective use of coordination and cost of drugs:

Eliminate the "donut hole"
Cover chronic condition/maintenance meds at lowest tier copay (ie: insulin, inhalers)
National legislation to encourage/mandate generic manufacture of certain drugs (insulin)
Need CMS ability to negotiate drug prices with evaluation of value of improvement in mortality or quality adjusted life years.
Reduce MTM (medication therapy mgmt.) restriction to >2 conditions and not >3.

Encourage effective use of PCP:

Encourage expansion of typical PCP roles: (allowed/endorsed/create or increase reimbursement)

"Home-ists" (home visits/coordination)

"Extensivists" (intensive outpatient mgmt. to prevent hospitalizations)

“SNF-ists” (skilled nursing facility patient mgmt./coordination)
Encourage more geriatric expertise (training, reimbursement)
Create national geriatric resource for clinical expertise.

Care Coordination in rural areas:

Add a transportation benefit for FFS Medicare

Care coordination tools for members:

Add member incentives (like in Medicare Advantage) for preventive services,
Change premiums based on participation
Encourage partnering with community and faith based organizations to better reach/partner with patients.

Section II: Recommendations from Jeffrey R. Merrill, MD, Medical Director of Clinical Transformation for MSHA’s Physician Medical Group and KJ Gulson, Director of Operations, MSHA’s Physician Medical Group:

- 1. Improvements to Medicare Advantage for patients living with multiple chronic conditions:**
 - a. Create new prospective payment models for providers and hospitals to fund building the IT and human resources infrastructure (case managers, dieticians, social workers, clinical pharmacists, etc) that are needed to manage populations of patients with chronic illnesses. These prospective payments should incentivize providers and health systems to prevent avoidable problems in the first place. This type of payment reform could include meaningful prospective payments (such as capitated payments), meaningful per member per month payments, and/or additional payments tied to certain services that would provide the health plan with valuable information (such as completing an annual patient assessment form, completing an annual health risk assessment, completing a process to optimize a patient’s risk assessment factor score, closing clinical quality measure care gaps, etc). Until payment reform such as this occurs, improving the care of chronic conditions will remain challenging. Such payment reform is needed for all types of Medicare plans.
 - b. Increase behavioral health benefits and access by creating simple reimbursement mechanisms for primary care providers to add behavioral health specialists (licensed clinical social workers, psychologists, etc) to their primary care teams such that these professionals can bill both independently from and in conjunction with a patient’s visit with his/her primary care provider. This is needed for all types of Medicare plans.

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:**
 - a. Since high performing primary care is the key to both improving outcomes of patients with chronic disease and bending the cost curve, these programs should only attribute patients to a primary care provider. Patients should not be attributed to urgent care or subspecialty providers. This should be true of all Medicare plans.
 - b. Patients should be incentivized and required to have so many visits per year with a primary care provider. To be eligible for such a program, patients should be required to meet certain milestones annually (such as an annual health risk assessment/annual wellness exam, obtain certain screening tests and other lab tests required to monitor chronic diseases, etc). This should be true of all Medicare plans

3. **Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions:**
 - a. See # 1.a. above

4. **The effective use, coordination, and cost of prescription drugs:**
 - a. Eliminate the copay for maintenance medications for certain high cost, chronic diseases (diabetes, hypertension, COPD, CHF, depression, etc)
 - b. Improve and simplify reimbursements for services provided by clinical pharmacists in the primary care, emergency department, inpatient, post-acute, and retail pharmacy settings such that these subject matter experts can be utilized across the entire care continuum to prevent medication related problems and help to improve patient outcomes.

5. **Ideas to effectively use or improve the use of telehealth and remote monitoring technology:**
 - a. To improve access to care, to lower the cost of care, and to improve patient outcomes, all Medicare plans should allow providers and other qualified members of the health care team (care coordinators, care navigators, case managers, clinical pharmacists, clinical staff, health coaches, dietician, etc) to be reimbursed for healthcare services delivered virtually and for monitoring of health conditions via remote monitoring technology.

6. **Strategies to increase chronic care coordination in rural and frontier areas:**
 - a. See # 5 above
 - b. Include a transportation benefit for all Medicare plans

7. **Use of care coordination teams to offer Medicare patients the tools they need to meaningfully engage with their health care providers:**
 - a. Create a reimbursement mechanism over and above the current chronic care management code, as this code just reimburses for 20 minutes of chronic care management consuming and require much more than 20 minutes of non - face to face time per month by the appropriate clinical staff along the care continuum. Health care providers need to be reimbursed for including these resources on their care teams.
 - b. Creation of a national, standard, evidence-based clinical quality measure data set for chronic disease states recognized by all payers (both CMS and commercial payers) that focus on measures proven to lead to improved outcomes and lower health care costs.
 - c. Creation of care coordination tools that allow the care team to easily and efficiently communicate and deliver timely evidence-based care at the right place, at the right time, and by the right care giver along the care continuum. These care coordination tools should be integrated with, or include, electronic health records. In addition, these tools would include data analytic capabilities to help manage populations of patients with chronic diseases. Care givers must be equipped with the proper tools to help them be successful in delivering efficient, high quality, lower cost care. These care coordination tools would also integrate with technology aimed at improving patient engagement (patient portals, telehealth, remote monitoring, mobile phones, etc)
8. **Ways to more effectively utilize primary care providers in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions:**
 - a. See #1-7 above, with the emphasis being on payment reform allowing primary care providers to receive prospective types of payment. These types of payments would allow them to financially afford to build high performing care teams that perform at the top of their licenses and support them in delivering efficient and cost effective care to a population of patients. In this way, the strained supply of primary care providers can focus on more complex evaluation and management services that cannot be performed by less trained members of the care team.

I hope these comments will prove helpful as you proceed with your chronic care reform efforts. Dr. Bushell , Dr. Merrill and Ms. Gulson stand ready to provide additional written comments or to testify before your committee as you deem appropriate.

I look forward to hearing back from you as to how MSHA can further assist in this effort. Please feel free to contact me at mooreeg@msha.com or call 423-764-1112.

Sincerely,



Elliott G. Moore

VP Community & Government Relations