Billings Clinic

2800 Tenth Avenue North
PO Box 37000
Billings, MT 59107-7000

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Sent by email to: chronic_care@finance.senate.gov

Dear Senate Finance Committee Work Group:

In response to your request for feedback on the Bipartisan Chronic Care Policy Options Document, we thank you for your ongoing work on legislative solutions based on real world experience and data-driven evidence that will improve care for the vulnerable Medicare population. There are several specific proposals from the options document on which we would like to provide comment.

Background on Billings Clinic

Billings Clinic is Montana's largest physician-led health care organization, consisting of a multi-specialty physician group practice, a 304-bed hospital and Level II trauma center, and a 90-bed skilled nursing and assisted living facility. Billings Clinic employs approximately 4000 full and part-time employees, including more than 400 physicians and advanced practitioners offering more than 50 specialties. Our organization includes partnerships with 11 critical access hospitals serving communities in Montana, Wyoming and the western Dakotas. Billings Clinic has been a key participant in many Medicare programs and demonstrations in the past. As a result, we have gained a breadth and depth of experience in disease management, care coordination, improving quality, and reducing cost. The organization was selected as one of ten nationwide to participate in the Medicare Physician Group Practice (PGP) Demonstration Project and participated in this Initiative from 2004-2010. Billings Clinic has subsequently participated in multiple bundled and alternative payment initiative in both the public and private sector, including MSSP and the CMS Bundled Payment for Care Improvement Initiative (BPCI). We are the sole owner of New West Health Services, the largest Medicare Advantage program in Montana. We are committed to the exploration of new payment models that share risk and hold the promise of improved care quality.

Receiving High Quality Care in the Home

We don't have any specific comments to offer on this section, but do very much agree with your statement that "home-based primary care teams allow providers to spend more time with their patients to better coordinate health care services, perform medical and functional assessments in a familiar and safe environment, and accept increased accountability for all aspects of the

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patient's care plan. This approach seeks to improve patient outcomes while reducing health care costs – often accomplished by preventing the need for more expensive care in institutional settings." We continue to seek creative ways to meet these goals.

Advancing Team Based Care

Under this section, we would like to comment on the following proposal:

*Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries.

There is substantial evidence that shows that chronic are costs are appreciably higher for patients with unaddressed behavioral health diagnoses. We strongly support the improvement of primary care and behavioral health integration, and studies such as the GAO ACO study on integration of these services. The Montana Governor's Council on Innovation in Healthcare (funded by a SIM grant) is exploring the primary care/behavioral health integration model proposed by Jürgen Unutzer at University of Washington as one such effective model.

Expanding Innovation and Technology

In this section, we would like to offer summary comments that apply to several proposals:

*Increasing Convenience for MA Enrollees through Telehealth

*Providing ACOS the Ability to Expand Use of Telehealth

*Expanding Use of Telehealth for Individuals with Stroke

There is a well-established evidence base for certain service and technology combinations demonstrating that certain telehealth services can and do fundamentally change or disrupt the way healthcare is delivered in positive ways. This is done by expanding care delivery capacity/efficiency and improving health care outcomes particularly in under-served and rural areas. Telehealth, whether it be synchronous or asynchronous, offers the ability to enhance consultations between patients and providers, enable remote monitoring, improve the transmission of medical information, help support patients self-management and generally improve communication and education between providers and patients when appropriate infrastructure is in place to ensure care is coordinated and enhances communication between and among the patient and medical team members. In an ACO primary care delivery model, telehealth applications have a myriad of uses in preventing or managing numerous leading causes of illness, disability and death. In sum, telehealth services facilitate prevention, coordination and cure and deserve to be available to all.

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Payment for telehealth services is a huge opportunity, particularly for a large, rural state like Montana. Furthermore, being able to use telehealth in non-rural areas helps cover workforce shortages and increases physician productivity. Examples include mental health visits, CDE visits, nursing home to emergency department transitions, and prevention of hospital admissions. Billings Clinic believes that Congress and CMS should allow telehealth payments for outreach, and for in between touches with non-physicians and community based health coaches. The availability of high speed internet and HIPAA compliant texting technology make telehealth safe from a privacy standpoint.

Billings Clinic urged in its comments to CMS on the MSSP rulemaking to allow for a telehealth waiver. The scope of the waiver we favored would waive the limitation on telehealth payment to services furnished within specific types of geographic areas. This means allowing providers not in designated health professional shortage areas, i.e., urban and suburban area providers, to bill for telehealth services. This waiver could allow ACOs to realize cost savings and improve care coordination. Studies have shown certain medical services delivered using telecommunication technologies can be substitutable, cost effective, quality improving and preferred by beneficiaries.

*Maintaining ACO Flexibility to Provide Supplemental Services

Our experience is consistent with the growing evidence that provision of social services in conjunction with health care services can lower health care use and costs, and can improve health outcomes. Allowing ACOs participating in the MSSP to furnish a social service or transportation service, as well as remote patient monitoring, is a clarification we support.

<u>Identifying the Chronically Ill Population and Ways to Improve Quality</u>

*Ensuring Accurate Payment for Chronically Ill Individuals

Per MedPAC's 2014 recommendation, the committee should consider requiring CMS to apply the same risk adjustment methodology to MA plans and ACOs. Doing so allows for consistent risk adjustment for Medicare beneficiaries.

*Providing Flexibility for Beneficiaries to be Part of an ACO

Chronic disease benefits from care coordination that is managed most cost effectively at the primary care level. CMS needs to encourage the primary care relationship more overtly through incentivizing both providers and beneficiaries to seek their care from practices organized to provide services this way. CMS has resisted prospective attribution in ACOs, but needs to encourage it to achieve the benefits of population health management. If a Track 1 provider can choose prospective assignment without having to accept an "upfront, collective payment", then we support prospective assignment.

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*Developing Quality Measures for Chronic Conditions

Quality measure work is time and resource intensive, and work to develop these measures is currently being funded by CMS and is being done by numerous organizations. We feel that quality measures need to be less process-based, fewer in number, less burdensome and instead be more aligned or harmonized between and among programs, patient-centered and outcome focused. While we support aspects of this policy recommendation, it does little if anything to address the quality measurement problem, and feel a GAO report to identify community-level measures related to chronic care would contribute little if anything since the GAO does not have the expertise or capacity to develop and test specific measures in any realm.

Empowering Individuals and Caregivers in Care Delivery

*Encouraging Beneficiary Use of Chronic Care Management Services

We are supportive of waiving any co-pay, particularly if it would benefit poorer Medicare beneficiaries. Aside from waiving copays, patients should have ability to receive incentives from Medicare for participating in care management programs such as diabetes education and monitoring. Such incentives have worked well in the private insurance market.

While we appreciate the efforts to recognize the time and resource intensive nature of providing chronic disease management, as well as the desire to incent annual wellness visits to prevent chronic disease, we have found the chronic care management (CCM) and the annual wellness visit AWV) codes, and the associated co-pays, to be confusing and a barrier to more widely using them. The AWV has great potential to play in solving the problems of chronic care management. Unfortunately, Medicare tells beneficiaries it is a free physical, when in reality it is not a physical. The patient expectation is not compatible with the AWV form. Furthermore, if you have multiple chronic conditions then there is no AWV because the clinician always finds something else to address. This means that the visit is either coded with an office visit, which has copay, or for chronic care management (CCM), which also has a copay. CCM may not be used widely however because providers have to put in many compliance efforts in order to follow the CCM rules. We like the total care management (TCM) code better because it doesn't require a co-payment from the beneficiary like the CCM code does, and does build in payment to the provider for the extra work required with transitions of care.

A possible solution toward incentivizing patients is offering one copay free visit per year. Commercial plans often incentivize beneficiaries to participate in these types of wellness programs by waiving co-pays.

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*Expanding Access to Pre-diabetes Education

Since an estimated one in four Medicare beneficiaries fit in the definition of pre-diabetic, we support payment for evidence-based lifestyle interventions that help people with pre-diabetes reduce their risk of developing diabetes. Covering diabetes self-management training (DSMT) for pre-diabetic beneficiaries and allowing non-providers to provide this training is important, and making the CDC's National Diabetes Prevention Program a covered benefit under Medicare would help achieve this goal.

Other Policies to Improve Care for the Chronically Ill

*Study on Obesity Drugs

We support a study to determine the use and impact of obesity drugs in the Medicare and non-Medicare populations. Many health problems and lifestyle habits are set and embedded by the time a person reaches Medicare at age 65. In order to have a healthier Medicare population, the United States needs to invest in population health at a younger age. As a nation, we could give more support to public health targeting younger populations. Specifically regarding obesity-related medical costs, we feel members of the committee should address the underlying causes for the obesity "epidemic", particularly in the pre-Medicare years.

We appreciate your seeking input from the physician and integrated organization community. If you would like anything further such as data on cost savings, please contact JJ Carmody, Director of Reimbursement, at jcarmody@billingsclinic.org, or Heidi Duncan M.D., Physician Director of Health Policy, at hduncan@billingsclinic.org. We hope our responses to your questions are helpful in the Committee process.

Sincerely,

Nicholas Wolter, M.D.
Chief Executive Officer