Billings Clinic

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June 22, 2015

The Honorable Orrin G. Hatch
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20515

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20515

The Honorable Johnny Isakson
Co-Chair of the Chronic Care Working Group
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20515

The Honorable Mark Warner
Co-Chair of the Chronic Care Working Group
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20515

Sent via email: chronic_care@finance.senate.gov

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

In response to your communication dated May 22, 2015 and on behalf of Billings Clinic, thank you for the opportunity to provide comments to the Senate Committee on Finance's Chronic Care Working Group as you develop bipartisan legislative solutions based on real world experience and data-driven evidence that will improve care for the vulnerable Medicare population. We understand you are interested in improving disease management, streamlining care coordination, improving quality, and reducing Medicare costs.

Background on Billings Clinic

Billings Clinic is a physician-led health care organization, consisting of a multi-specialty physician group practice, a 285-bed hospital, and a 90-bed skilled nursing and assisted living facility. Billings Clinic employs over 3,700 full and part-time employees, including 266 physicians and 98 physician assistants and nurse practitioners. 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.

Billings Clinic Feedback

Generally speaking, to better treat the chronically ill requires an increase in resources both in terms of staff and time, and the concept of the chronic care management (CCM) code goes a long way toward paying for this goal although it has some regulatory barriers as noted below in our discussion of fee-for-service Medicare. Better chronic care management will involve more time to give each patient more individual treatment to develop a rapport, and also more time to develop a plan of care with the patients, which would increase compliance with treatment. Treatment compliance will in turn increase those with chronic disease's level of health and should result in decreasing medical costs for the patient and better quality of life. Obstacles to success are multi-factorial. They include lack of patient compliance/willingness to participate; lack of resources in terms of workforce and time; low insurance reimbursement; the standards of care shared throughout the hospital.

Better care for the high risk/chronically ill patient generally works like this at Billings Clinic. First, we review clinical notes especially those of the primary care provider. Clinicians follow the plan of care indicated in the primary care physician's last note to be sure that the plan of care is being followed. Non-physician staff (care navigators) then calls or write letters as indicated to follow up with the patient and remind them of appointments, procedures, or labs that are needed. Billings Clinic staff also monitors whether or not Medicare and other patients have an advanced directive on file and if not, an alert is sent to the primary care physician to discuss this topic with the patient, if appropriate and if the primary care physician decides it is necessary.

At Billings Clinic, we use care navigators extensively. These are staff who are not necessarily trained physicians, but social workers, dieticians, nurses, and clinical aides among other specialties. The following table will give you an estimate of the nature, complexity, and importance of a care navigator's weekly work load:

Care Navigator Accountable/Processes[1]	Time spent/week
Hospital admission review	1 - 2 hours
Hospital discharge review and phone calls; coordination of care	20 - 30 hours
ED discharge review and phone calls; coordination of care	5-8 hours
TCM review and coding	1 - 2 hours
High Risk patient list update, patient review and coordination of care	2 hours
Referrals from Providers and others for coordination of appointments, review	1 hour
DM registry coordination and activities	4-5 hours
Misc. Administrative assignments	as assigned
DNKA; contact of patients and sending letters	0 - 1 hour

[1] We used to review diabetic patients with appointment coming up in the next two weeks and be sure labs were ordered. We currently are not doing this as time does not allow and hopefully Chart Prep is catching these labs.

Care Navigator Accountable/Processes[1]	Time spent/week
Continuing Education	1 hour
Huddles	1.5 - 2 hours

Care managers/navigators working with physician-driven protocols have been a big asset in Billings Clinic's ability to manage the chronically ill. In addition to having service line associated cancer care navigators, we have recently been able to hire care navigators to imbed in our family medicine and internal medicine practices. It is too early yet to quantitatively evaluate the impact of care navigators, but we already have many patients and physicians telling us that they are a success.

We appreciate that you are seeking feedback in a variety of specific areas including Medicare Advantage, the Medicare Shared Savings Program (MSSP) for Accountable Care Organizations, the current fee-for-service program, prescription drugs and telehealth. We have feedback in these five areas in addition to some other evidence in the areas of end-of-life care and holistic, life-time medicine.

A. <u>Medicare Advantage</u>

Commercial plans have requirements for patients to have specific tests for certain high risk patients. For instance, if a patient's family history shows a number of relatives with a particular type of cancer (e.g., breast cancer), commercial plans incentivize those patients to have more frequent and more in depth cancer screenings by waiving co-pays or using other incentives. CMS could allow Medicare Advantage plans to follow this commercial lead which is a type of more individualized, precision medicine or value-based insurance design that tailor treatment and services to patient needs.

Another element that Congress could direct CMS to allow is requirements for beneficiary engagement for high risk/high utilizers. Billings Clinic is currently involved in a community wide effort to identify super utilizers. This effort is focused on all patients and all payers, not Medicare specifically. We will be looking at data on patients who are high utilizers of emergency departments for both hospitals in the city of Billings. We will also be reviewing readmissions for both hospitals as well as analyzing another category of high utilization at the Federally Qualified Health Center. This program is being operated by a coalition of local and regional stakeholders, including both local hospitals, the community health department and the Mountain-Pacific Quality Improvement Organization (QIO) in response to our Community Health Improvement Plan and three Community Health Needs Assessments. Data analysis is being funded through MT DPHHS/Montana Healthcare Foundation (given to public health agencies through a grant process) and PacificSource Foundation and has a goal of improving access to health care. Programs similar to this are employed by Medicaid programs as well as commercial insurers to curb over-utilization of high cost services. We believe there is an opportunity for the Medicare program to take advantage of these programs in order to better manage patients with chronic conditions, both in the Medicare Advantage program and in traditional fee-for-service.

B. Alternative Payment Models and Accountable Care Organizations

It has been our experience that the chronically ill really need regular contact, or "touches", and that doesn't necessarily have to be done in the office, but does require phone calls or HIPAA-compliant secure contact done by trained staff (usually nurses). These services are often not billable in our old fee-for-service world so hopefully the move to alternative payment models and value-based payment will make it easier for us to afford these staff.

Underlying all this extra support is the need for good, accurate and up-to-date data. HIT is vital to improving the health of the chronically ill. Currently there are barriers to this goal, including lack of interoperability among Electronic Health Records vendors and lack of transparency. We believe the federal government – whether it be Congress or the Administration – needs to act to put health information exchange standards in place. Putting funds behind such action is also important.

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.

Medicare Advantage plans currently spend resources providing home visits to identify the chronic conditions requiring treatment as well as care coordinators that provide overlapping services; they would prefer that this same service be provided in primary care practices, and alternative payment models should be developed to promote home visits. A comprehensive annual visit is a cornerstone for a strong physician-patient relationship and coordination of chronic conditions. (See comments below about Annual Wellness Visit.)

C. Medicare Fee-for-Service and Patient Engagement

The annual wellness visit (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. 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.

Chronic condition management requires more physician and patient interaction, whether that is face to face with clinicians or other care givers (social workers, navigators, dieticians, nurses) or phone calls and charge reviews. The CCM code only makes a small dent in the cost of the time and effort the care of these patients entails. At Billings Clinic, programs are being developed to try to automate and streamline these efforts, but, this is still a highly manual process. We estimate that if two-thirds of Medicare patients fall into a high risk category requiring more intensive management, the man hours required to effectively manage this population is quite a financial obstacle.

Chronic disease benefits from care coordination that occurs in the intervals between provider visits. Unfortunately, fee-for-service Medicare as it currently stands incentivizes technology and specialty care and a continued emphasis on acute sick care. Primary care in fee-for-service Medicare needs to move toward greater reliance on capitated payments for management of chronic disease patients. The patient centered medical home (PCMH) in some instances is a step in this direction, and Congress should do more to facilitate the implementation of PCMHs.

D. Prescription Drugs

Another problem Billings clinicians face is a lack of data availability to know if patients are filling their prescriptions. There is no transparency between pharmacy information systems and Billings Clinic's electronic health records. Once again, interoperability in health information exchange or requiring MA and Part D plans to share encounter data would help this situation.

Other barriers to medication adherence exist. Rules around when prescriptions can be filled can create barriers for patients who are traveling or live in extremely rural areas. The doughnut hole in coverage under Part D and Part D copays are a barrier to patients following prescription plans. These barriers cause patients to skip doses, fail to monitor their health status (like blood sugars) or make other lifestyles choices to afford drugs (poor diet, lack of social interaction). We believe that the cost of covering drugs would be made up for in reduced hospital admissions and emergency room visits.

Our Medicare Advantage plan (New West Health Services) was unable to adopt a more cost effective formulary because CMS rules don't allow consideration of therapeutic class substitution that is commonly used in the commercial insurance market to curtail costs. When a drug is more cost-effective, it also has lower cost-sharing to the beneficiary and thus higher medication adherence rates.

Medicare Part D in fact encourages continued utilization of high cost brand drugs because benefit design rules don't allow for effective incentives to encourage the member to choose lower cost alternatives. We suggest that Congress, or the Secretary at Congress's direction, modify the Part D benefit design to allow for more use of generic drugs. Furthermore, Medicare and Medicaid budgets are being overrun by the growth of new specialty drugs that have initial prices that are economically unsupportable; government programs are encouraging this practice because they do not have the design flexibility to permit alternative treatments.

E. Telehealth and Rural/Frontier Health Challenges

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, in between touches with non-physicians, and community based health coaches. There is 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.

There is a well-established evidence base for certain services and technology combinations demonstrating that certain telehealth services can and do fundamentally change or disrupt the way healthcare is delivered in positive ways 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 communications between and among the patient and the 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 beneficiaries.

F. End of Life and Holistic, Life-time Medicine

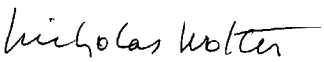
Above all, Medicare needs to break up payment silos and get to whole care thinking. This may mean grander entitlement reform and shifting away from copays and coinsurance. It could ultimately even mean combining the Medicare Parts A and B trust funds.

Furthermore, a lot of 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. We are hopeful that health insurance coverage changes resulting from the Patient Protection and Affordable Care Act will move us toward this goal. As a nation, we could give more support to public health targeting younger populations.

In closing, we would be remiss if we didn't address end of life care and the cost of care at this delicate time in a beneficiary's life. Program changes that would incentivize smarter, more humane end of life care include tax breaks for elder care similar to what exists for child care and incentives for hospice care over hospital care and home care over nursing home care.

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,



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