Legacy Health

1. **What improvements should be made to Medicare Advantage for patients living with multiple chronic conditions?**
    a. **Patients with Medicare – whether it be MedAdvantage or FFS Medicare continue to have a very hard time seeking behavioral health support (psychiatrist, psychologist, psych NP, etc) due to access issues mostly related to fee structure. Patients with multiple chronic conditions are much more likely to have behavioral health needs & need that support. Given the importance of behavioral health integration into primary care, it would be helpful if it was easier to bill for those services within primary care to help with both access, continuity and reducing the stigma still associated with those specialties**
    b. **Even with the benefits of Medicare Advantage & some of the flexibility there, the world is still built on FFS payments to providers. Recognizing that primary care is a team sport – it's very hard for most PCPs to provide team based care because they have no way to be compensated for the care the other team members provide – ie social workers, pharmacists, nurse case managers. The new CCM fee is a first step but it's cumbersome in how it's set up & continues to put the cart before the horse. To use the code, you need to have care mgmt staff but many clinics don't have the staff to let them use the code. Continuing on the FFS payment (ie requiring a CPT code to get paid) just perpetuates the treadmill that many offices are on & prevents them from doing things differently.**

2. **What transformative policies should be implemented to improve outcomes for patients living with chronic diseases? Specifically, please address modifications to the current Medicaid Shared Savings ACO Program, to piloted alternate payment models (APMs) currently underway at CMS, or through new APM structures?**
    a. **If you want to be transformative, you need to provide the seed money to primary care clinics to allow them to build the infrastructure that will let them utilize the existing tools. As noted above, it's hard to use the new CCM**

code when you don't have a staff member to help but you can't afford the staff member up front to allow you to use the code to get paid. Creating a system where there was a "loan" or some other up front seed money that could be paid off from the CCM codes would allow many more clinics to effectively utilize this.

b. **Paying for care provided by other team members would also be transformative – it's been well recognized that pharmacy, social worker and nurse support for patients with chronic disease can make a large difference in both quality of life for those patients and financially. However, for most clinics the ability to afford those staff is out of reach – it's reserved for large health systems which can spread the cost out more generally. If we are continuing in the FFS world – whether medadvantage or not – being able to bill for part of their time would help the sustainability of many of those roles outside of the grant world. Most work that is being done in this realm is within the pilots as discussed but is not created in a way that is sustainable long term**

c. **For shared savings – benchmark the savings to the regional average – not the national average. For sites in the West (ie Oregon), our Medicare spending is already at the low end in the nation due to increased use of hospice, lower LOS, etc. Expecting us to continue to make large decreases in spending as they are in the East is unrealistic – there are diminishing returns. It is hard to participate in those projects when the expectations are unrealistic.**

3. **What reforms to Medicare's current fee-for-service program may incentivize providers to coordinate care for patients living with chronic conditions?**

   a. **The CCM fee is created in a CPT widget driven world with documentation requirements that make it harder to achieve. Also by attaching it to a CPT, that means there's a patient co-pay. It's another payment from the patient which reduces their incentive to participate. In addition, many sites have already been doing this care management for awhile – for free since there wasn't a billing – now patients will be charged for something they were**

getting as a free benefit. If we really want patients to engage in their care and PCPs to coordinate much more deliberately, I would recommend getting rid of the patient payment – make it like the AWV or other preventive services that are covered 100%

b. **Pay for regular physicals – right now a regular physical for a patients on FFS Medicare is not a covered benefit – an AWV is covered but not a regular physical. The AWV is helpful at times (although the documentation requirements are quite onerous & not always helpful). It is a significant barrier for patients that they can't get a physical & they don't understand why not. The physical is a time when the provider has time to examine the whole patient – not just deal with the 3-4 chronic diseases. Often other things get caught because there is more time. The AWV's focus on checking off boxes isn't as conducive as the hands on approach of the physical. Patients are very confused by the AWV & why it isn't a physical.**

4. **What changes should be made to the Medicare program to foster the effective use, coordination, and cost of prescription drugs?**
    a. **The part D rules are very confusing for many of my patients and the donut hole – despite the improvements – is still a large barrier for patients to get and take their medications. More modifications to the donut hole would be helpful**
    b. **Trying to coordinate medications between specialists and primary care is complicated when there is no source of truth – no easy way to get a complete claims summary. A central, easy to access database would be helpful – similar to PDMP for controlled substances in Oregon.**
    c. **The MTM services right now are only paid for in retail pharmacies but leaves out the clinical pharmacists that are becoming increasingly more present within clinics. As noted above, sustainability of paying for those staff members limits their utility, being able to charge the MTM service would allow this to be much more widespread with the benefits that are already evident in the literature.**

5. **What ideas do you have to effectively use or improve the use of Telehealth and remote monitoring technology?**
    a. **Remove rural designation for reimbursement specific to telehealth services**
    b. **Awareness and coverage of home monitoring options for chronic conditions**
    c. **Education service for telehealth services and chronic conditions (ex. Remote check-in visits)**

6. **What are suggested strategies to increase chronic care coordination in rural and frontier areas?**
    a. **As noted above – alternative payment mechanisms for ancillary staff, up front seed money for getting staff. Ability to share staff across clinics without fear of antitrust because the 2 clinics may be competitors.**
    b. **Improving telehealth access, funding the set-up of the technology to get the tools within the site**

7. **What are the best options to empower Medicare patients to play a greater role in managing their health and meaningfully engage with their health care providers?**
    a. **The current information that is available to patients is confusing. Continuing to work on health literacy levels in the information will be helpful.**
    b. **The yearly enrollment process is cumbersome & very confusing even for my patients who want to be engaged & are very savvy. They end up with plans that don't do what they thought & are stuck with large bills at times. I know a lot of resources have been put into place to help this but it still doesn't seem enough.**

8. **What are ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions?**
    a. **See above**