Oregon Association of Hospitals and Health Systems Survey

Respondent #1

Health System with PPS and Type B hospitals

1. 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?

The MSSP is headed in the right direction, with more rational sharing of savings between providers and CMS. Continued effort should be made to improve this program and incent providers to participate. These incentives should drive higher value services, both in terms of cost and quality, but to get more robust participation CMS will need to make sure the program continues to evolve in ways that makes it more attractive to providers. This will mean that the program will need to provide tangible to benefits to providers that improve services, on both a cost and quality front, and these benefits will need to be substantial enough to warrant the time, resources and expenses that providers will be required to devote to the program. CMS will also need to go against their natural instincts and try not to completely bury providers in the bureaucracy and red tape that normally accompanies any government program.

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

"The most effective strategy here would be to create incentives that move more of the providers to engage in the MSSP where they will be incentivized to better coordinate care for Medicare members. The current fee for service reimbursement system provides very little in the way of incentives to do this work, and providers need to be able to stay in business."

3. What changes should be made to the Medicare program to foster the effective use, coordination, and cost of prescription drugs?

"Recognize pharmacists as providers to provide medication therapy management (MTM) including chronic disease therapy management and transitions of care services. Clearly define the types of MTM that will be covered under each part of Medicare (A, B, C, & D) and coordinate across benefit plans to prevent duplicate clinical services and ensure all appropriate patients are evaluated in a face-to-face interaction by a pharmacist to ensure effective drug therapy and medication adherence. Standardize a cost-effective formulary and the prior authorization process across Medicare Part D plans to prevent confusion and unnecessary therapy changes in the elderly when switching plans. Create standardized cost sharing for members to prevent spikes in drug costs across the year which leads to medication non-adherence. "

4. What ideas do you have to effectively use or improve the use of Telehealth and remote monitoring technology?

"Include Medication Therapy Management in Telehealth."

5. "What are suggested strategies to increase chronic care coordination in rural and frontier areas?"

"Some suggestions include technologies to help with monitor high risk chronic illness patients (diabetes, heart disease); coordinated case management in the ED, ambulatory and inpatient setting; use of home health resources; patient navigators assigned to high risk patients to help with the social, behavior and life style challenges that contribute to poor compliance and outcomes. Partnerships forged with county, public health, payers and private health care providers in the coordination of care. "

6. 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?

"Create financial incentives for patients adherent to chronic disease medication regimens and for participating in Medication Therapy Management services."

R**espondent #2**

Behavioral Health hospital

1. What improvements should be made to Medicare Advantage for patients living with multiple chronic conditions?

I think there should be a residential benefit for these patients because stepping a patient down from inpatient is difficult without the option for sub-acute or residential tx. In our community payment rates are a huge problem. Most outpatient providers do not accept Medicare pts because the reimbursement is very low. Those providers who do accept Medicare are flooded with pts and it can be difficult to financially sustain a high number of Medicare pts without a mix of other payors.

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?

"Managed Medicaid Organizations or CCOs, commercial insurnace companies and CMS need to adopt a dual-diagnosis code for treatment. It is very difficult to treat an individiual with two behavioral health diagnoses because the payment system always wants to put our pts in one bucket (i.e. mental health or addictions) rather than allowing providers to tx the pt as a dually-diagnosed individual. Increasing funding for supervised housing would greatly improve the quality of life for our pt living with chronic disease and decrease inpatient admissions. Housing is such a great issue and there are almost no options for patients living with multiple chronic diseases."

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

"If Medicare paid for a discharge planning meeting at discharge it might incentivize providers to do better with coordinating care for pts. I think we need to think about how coordinating care looks because we can incentivize all we want, but without knowing what coordinating looks like we may not actually do anything that positively effects the pt. The payment for outpatient suboxone providers should be increasing. In the tri-county region around Portland only 2 physicians prescribe Suboxone for Medicare pts and there are huge waiting periods for a pt to begin seeing either of these providers. This causes a lot of providers for pts coming out of inpatient care."

4. What changes should be made to the Medicare program to foster the effective use, coordination, and cost of prescription drugs?

We don't usually have any issues with medications being covered by Medicare, but we have a lot of problems finding outpatient providers who prescribe to Medicare pts because the office visit or group therapy reimbursement is so low.

5. What ideas do you have to effectively use or improve the use of Telehealth and remote monitoring technology?

Telehealth could be used to check in with pts who living in supportive housing. Telehealth can also be a tool for pts to attend outpatient even when they live far away from an outpatient clinic. I've seen group therapy done with ipads where everyone can see each other's faces, but they are all at home. Telehealth could increase the number of prescribers available to our pts if the reimbursement was reasonable.

6. "What are suggested strategies to increase chronic care coordination in rural and frontier areas?"

"See answer about telehealth. Also, if there were temporary housing conditions set-up for pts to attend outpatient in a different area outside of their normal residence it could assist in recovery. When the pt is done with treatment they could return to their residence, but most pts cannot travel far distances everyday to receive tx and housing is so difficult that transportation becomes a barrier to tx many times."

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?

"Providing them with the tools and options to make choices about their lives. If they have a lot of options for tx and they have options for housing they may choose to engage with their providers, but we see a lot of readmissions with our Medicare pts and penalizing providers for readmissions when there aren't any housing options for pts or there aren't any prescribers for pts seems like the wrong path. We are using the stick on the wrong group. Instead of creating a great carrot for our pts with lots of options to improve on their current lifestyles we punish those who are trying to help them with low reimbursement and penalties. Our hospital is currently working on a readmissions committee to better understand what causes pts to return to inpatient instead of engage in outpatient. I don't have the answers yet, but I am looking forward to our commitee diving a little deeper into these issues. If you have a follow up survey I'll let you know what we find out."

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?

I think some PCPs are uncomfortable treating mental illness and addictions. If they became more comfortable treating these issues and recognizing them it could help with getting pts to the tx they need. I do think a case manager who works with the pt's PCP, inpatient, and outpatient provider is a good strategy to help in the coordination of care for a pt. I rarely see the hospital intervention teams work because when a pt presents to the hospital with an acute mental health condition and no support system it is very difficult to safely discharge them home without some amount of monitoring. I do think that HIPAA actual prevents some coordination of care because every organization is interpreting this law diffiferently and they all allow different levels of communication. It would be amazing if providers had an integrated electronic system for sharing information that did not violate HIPAA. We would like to coordinate with other providers more, but pts can be poor historians and it can be difficult to even find out who was providering care for a pt.

Respondent #3

PACE program

1. What improvements should be made to Medicare Advantage for patients living with multiple chronic conditions?

"Medical homes with integrated physical and behavioral medicine. Making sure they have broad referral networks. Reward care coordination and diversion from emergency and inpatient care."

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?

Behavioral health medical homes. There is a huge need and without care coordination this population is going to suffer and not get good care and continue to cost us huge amounts of money. A PACE like program for those older adults with chronic mental illness, and one for older adults with developmental delays. These are very different populations then the frail elderly. Because neither of these groups used to live to old age, there are no good systems in place, they have special needs including supportive decision making at times that is different from other populations. And in Oregon mental health resources are particularly awful for older adults (younger too for that matter)

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

"The reality is that without systemic change, I am unsure how providers can coordinate better. That being said, finding a way to pay for non face to face care (only for primary care) which often is the most cost effective for primary care. Rewarding cognitive work and not procedural work is the best hope for Medicare."

4. What changes should be made to the Medicare program to foster the effective use, coordination, and cost of prescription drugs?
part D is a shadow of what Sen Kennedy wanted as I am sure you know. Give us all access to the VA formulary at VA prices. Part D without being able to negotiate bulk rates is a tragedy for both Medicare and the country. With the next generation of medications (like for Hep C) - which will soon come to many rheumatology and oncology and neurology medications will bankrupt us if we can't use a different strategy. This will kill the U.S. Unless Medicare can negotiate for all.

5. What ideas do you have to effectively use or improve the use of Telehealth and remote monitoring technology?

"telehealth makes a lot of sense but remote monitoring should be required to show efficacy, safety and cost effectiveness."

6. "What are suggested strategies to increase chronic care coordination in rural and frontier areas?"

"allowing telehealth consults and allowing rural provider to distant specialist consults. "

Respondent #4

Health System with PPS, CAH and Type B hospitals

1. What improvements should be made to Medicare Advantage for patients living with multiple chronic conditions?

"• Expand care management codes
• Expand telemedicine covered services
• Allow for more flexibility on “inpatient only” procedures
• Look at Medical Home for chronic conditions and payment methodologies to support it ie tiered coordination capitation payments
• Fix the “observation” issue
• Allow for new “patient management models for chronic conditions” that are not based on the current covered/non covered models. "

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?

"Simplify the transition of care and chronic care management codes to make them easier to manage and report. We did not utilize the TCM codes last year because they were simply too onerous to track, It’s hard to believe anyone in clinical practice designed these documentation methodologies; certainly not on purpose. Our primary care providers and their care teams follow the CCM care protocols and provide strong chronic care management – it shouldn’t be this hard. Some of our colleagues in other practices report hiring specialized nurses to manage and track this work. We should not have to hire more people just to document the work we are already doing. "

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

"KILL IT! It doesn't work, and needs to be more like the CCO projects in Oregon. Places like Central Oregon are too small to be an ACO--so what is our option? We need more flexibility, less regulations for the sake of regulations, and to be able to use the lessons we have learned with Medicaid on our Medicare populations."

4. What changes should be made to the Medicare program to foster the effective use, coordination, and cost of prescription drugs?

Are you serious? Ouch, you hit a nerve. How do you fix a program that is fraught with fraud, abuse and mismanaged by an incredibly inefficient federal government? Too few of the dollars ever reach the patient and even then there is little rational use of those dollars. They would have to rid themselves of the money they get from the Pharma Lobby before they would ever even be able to attempt to make change to the prescription drug program. You could have better asked my suggestions for achieving world peace? Any meaningful response to this question would just not be politically acceptable. They have to restrict access to only those entities that have a proven (objective) benefit to patients. They should develop a formulary and only allow access to medications that have objective positive outcomes. The VA program does this. It apparently is OK to restrict access to veterans but not the general public. A

great example. A cancer drug with a 30% response rate, but no prolonged disease-free period and no increase in overall longevity should not be given to patients in my opinion. Just ignore for a second that there are many examples of this and they cost tens of thousands of dollars/month.

5. What ideas do you have to effectively use or improve the use of Telehealth and remote monitoring technology?

"Telehealth ideas. Mental health/substance abuse issues. There is an extensive implementation of this in eastern Montana (aka “West Dakota”) that has been successful for years. Also, dermatology."

6. "What are suggested strategies to increase chronic care coordination in rural and frontier areas?"
"Chronic Care Coordination. I need BILINGUAL social workers and nurse navigators!!! Seriously. Fund THAT. Additionally, find a way to fund psychiatric emergency care by telepsych within 12 hours. That would be a HUGE improvement!"

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 Medicare patient would have to get a PCP office to accept their insurance for them to have a way to engage. Most practices are closing to Medicare because the reimbursement is so horrible. BMC will no longer accept until they have whittled down their current amount because fiscally they can do better without it. If he is talking about the dually eligible these are the disabled so they need outreach and help engaging…given they likely lack adequate social resources to manage often even getting to an appt. *Medicaid recipients are the #1 ""No showers"" for appointments. If he is referring to the Medicare elderly then I don’t think other than a lack of providers taking Medicare there is an issue. Though, we are hearing that more and more poor memory patients are alone in their homes due to lack of resources through APD and housing so likely there is some issues there as well. Ask patients what they know about what they know already about their health dx. Use a cluster of behaviors that if modified could improve their health and ask which one of these would they be interested in knowing more about? After they have received that information assess their readiness and motivation to change any behaviors. Then, if they are interested, you can help them develop goals and a plan. The Conversation Project is one way to encourage conversations between families and ultimately providers regarding care goal discussions for patients with chronic illnesses. Early palliative care consultations-within the last 2 years of life- is another way to engage patients with chronic illness. We provide education and realistic outcomes and encourage early care goal discussions."

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?

Identify who they are, acutize via risk factors, provide outreach and help them engage. This could be done with bachelor level providers or MA’s. You could pair, for example, an MA with a “medical” only patient and use the bachelors level for comorbid. Have an RN be the team lead…better yet…a PARAMEDIC who has a broader scope with an LCSW!! However, we don’t just do this randomly and quite frankly it becomes cost prohibitive to do everything in pairs. If we don’t go to patients home we will not effectively meet these patients needs. I think the model that St Charles Family Care-Bend is proposing with the interdisciplinary enhanced primary care model with the OHP patients is a great way to more effectively utilize PCPs and Care Coordination teams. I guess we will know soon if it has made an

impact. Our OHP model-Better Health/Lower Cost storyboard-is an excellent example and could be applied to any population. Robin Henderson can get you a copy if you are interested.

Respondent #5

Health System with PPS and Type B hospitals

1. What improvements should be made to Medicare Advantage for patients living with multiple chronic conditions?

"The Medicare Advantage plans should follow the same rules as traditional Medicare (2Midnight rule). Allowing patients with Medicare Advantage to access Long Term Acute Care Hospitals (LTACH), currently they only authorize skilled nursing homes from the hospital."

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?

ACP programs should partner with the local hospitals to pay for Outpatient Case Management and should be held responsible for readmissions to the hospitals. The hospitals need assistance from their community partners to assist patients and keep them home and healing. The penalty should not just be for the hospitals.

3. What reforms to Medicare's current fee-for-service program may incentivize providers to coordinate care for patients living with chronic conditions?
"There is a great deal of difficulty in getting durable medical equipment authorized due to the numerous regulations stipulated by CMS. Patients are not getting the DME needed due to this. Wave the 3 Midnight qualifying stay for beneficiary to access their nursing home benefits. Do away with observation and pay hospitals for short stays, make everyone inpatient and reimburse according to the DRG (if < 2days it is a per diem, if >2 days the full DRG). Increase the reimbursement for nursing homes so they can hire more qualified personnel. The patients are sicker going into the nursing homes and the pay for licensed personnel and the organizations has not increased to the level to care for these patients."

4. What changes should be made to the Medicare program to foster the effective use, coordination, and cost of prescription drugs?

"Abolish the donut hole for beneficiary's, these are the chronically ill and need their medications.. "

5. What ideas do you have to effectively use or improve the use of Telehealth and remote monitoring technology?

"My organization is using tele-health on non-homebound patients. Reimbursing home health agencies for using this service and demonstrating reduction in readmissions and unnecessary hospitalizations."

6. "What are suggested strategies to increase chronic care coordination in rural and frontier areas?"

The use of tele-health and tele-monitoring.

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?

"Good question. Maybe holding patients accountable for his/her health."

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?

"Increasing outpatient case management and pay for this service along with paying the primary care providers a better wage to care for these chronically sick people."

Respondent #6

Independent CAH hospital

1. What improvements should be made to Medicare Advantage for patients living with multiple chronic conditions?

"Provide an adequate Medical Home or Care Coordination per member per month payment (as an add-on to capitation rates) to primary care providers to hire care coordinators and care for these patients."

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?

1. Expand the AIM Medicare Shared Savings ACO Program to allow any and all small and rural hospitals to participate if they meet the volume criteria. There should not be a competitive cap on participation.

2. Make quality a carrot instead of a stick for small and rural hospitals, i.e., increase the cost-sharing ration to more than 50% for providers that meet quality criteria rather reduce payments below 50% for providers that don't meet quality criteria.

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

"1. Provide an adequate Medical Home or Care Coordination per member per month payment to primary care providers to hire care coordinators and care for these patients. 2. Share savings with providers, such as the AIM ACO Program."

4. What changes should be made to the Medicare program to foster the effective use, coordination, and cost of prescription drugs?

"1. Support the 340b program and require that some (e.g. 25%) of the savings be used to pay for medications for the poor. 2. Provide an adequate Medical Home or Care Coordination per member per month payment to primary care providers to hire care coordinators who make sure they take their medications."

5. What ideas do you have to effectively use or improve the use of Telehealth and remote monitoring technology?

"Telemedicine payment should be the same as if the patient were in the provider's office. There really is no difference, since the time spent with the provider (the professional component) and the facilities and required equipment (technical component) are equivalent. Telemedicine is not about saving money, it is about improving access with limited numbers of providers and specialists. It will also avert patient travel and expense, avoid unnecessary transfers, and improve compliance with appointments. CMS needs to embrace telemedicine and incent providers to use it. "

6. "What are suggested strategies to increase chronic care coordination in rural and frontier areas?"

1. Provide an adequate Medical Home or Care Coordination per member per month payment to primary care providers to hire care coordinators and care for chronically ill patients. 2. Pay for and incent the use of telemedicine to avoid unnecessary travel and to improve patient compliance.

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?

In addition to meaningful use requirements, CMS should separately fund the development of patient portals that facilitate patient education, on-online completion of forms, on-line appointments, interoperability between providers, personal health data entry, e-mails with providers, and secure messaging with providers. Managing personal health begins with education and communication.

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?

"Telemedicine and primary care provider payment (medical home incentive money) are the two keys. Telemedicine will stretch limited provider resources with a more efficient model for patient/provider interactions. Adequate CMS funding and incenting of medical homes will facilitate the hiring of care coordinators to better manage these patients. Telemedicine payment and medical home incentives are investments. CMS needs to spend a little money to save a lot of money."

Respondent #7

Outpatient MH provider

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

The inequality of reimbursement rates for Medicare vs. Non-Medicare treatment providers is vastly different and unfair. Medicare patients need and deserve treatment just as much as the commercially insured client yet often times they are denied care due to the severe lack of providers available. There is a lack of providers due to the low reimbursement rate when compared to insured clients...hence, a vicious and unhealthy cycle.

2. "What are suggested strategies to increase chronic care coordination in rural and frontier areas?"

"Show providers the respect deserved by treating them equally in terms of reimbursement rate, or at least more comparable."

3. 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?

"Re-evaluate the strict and at times unreasonable stipulations surrounding the expectations for documentation on a Medicare patient, thereby enabling the providers to do the actual work and not be constrained by pushing paper."

R**espondent #8**

CAH that is part of a system

1. What improvements should be made to Medicare Advantage for patients living with multiple chronic conditions?

"Require option for payer and providere to incentivize Care Coordination and Medical Home model of care. Remote, rural facilities should be guaranteed contracting at cost based reimbursement rates, but quality of care should be transparent to payer."

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?

Current changes to the Medicare Shared Savings ACO program, including the AIM grant funding, should be very helpful. Our facility just started in a new ACO January 1 of this year. Having more timely claims data would be helpful. There are significant barriers to entry for rural providers due to the cost of the program along with legal and IT requirements. The National Rural ACO program is an example of a business model that has packaged the resources needed to participate in a Medicare Shared Savings ACO program and has made participation possible.

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

"Shifting resourses (payment) to the front end of care such as better pay for care coordinators, tele-health and behavioral health. Continue to reward keeping patients well or chronic illness maintained and reducing ED visits and hospitalizaton. Also review and consider payment for palliative care."

4. What ideas do you have to effectively use or improve the use of Telehealth and remote monitoring technology?

"More pilot projects, particularly in rural areas with low population density and a lack of access to primary care due to physician shortage and/or lack of transportation options."

5. "What are suggested strategies to increase chronic care coordination in rural and frontier areas?"

see previous

6. 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?

"Maybe a Medicare Health Savings Account combined with a slightly higher deductible. The Medicare patients need more skin in the game as an incentive without putting them in financial jeopardy."

7. 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?

"Incentivize team based care and have each provider on the team (primary care physician, physician assistant, pharmacist, dietician, behavioralist, etc.) be able to work at the top of their license. Also, figure out a more streamlined approach to documenting patient visits. A lot of time is spent documenting the patient visit to assure proper coding and reimbursement. "

Respondent #9

Health System with PPS and CAHs

1. What improvements should be made to Medicare Advantage for patients living with multiple chronic conditions?

"Incentives for patient self-care (or disincentives for lack of self-care). Provider coordination and case management does nothing if the patient is non-compliant with self-care."

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?

"Ensuring best practice care processes are the best way to ensure quality outcomes. Payment methodologies should be centered around adoption of best practices and an expansion of alternatives for access."

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

"Ensure each step that contributes to a better outcome (coordination, case managment, behavioral health, etc.) are reimbursed fairly. "

4. What changes should be made to the Medicare program to foster the effective use, coordination, and cost of prescription drugs?

"Contractual discounts from the manufacturers at the CMS level. This has been a fight for many years. Other countries do it, but the largest purchaser of drugs in the US does not?"

5. What ideas do you have to effectively use or improve the use of Telehealth and remote monitoring technology?

"Reimburse for virtual care, telemedicine consults and e-visits. Reimbursement should be less than a regular visit, but not so little that the provider has no incentive. That will do it."

6. "What are suggested strategies to increase chronic care coordination in rural and frontier areas?"
Increase the use of technology.

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?

"incentivize them (or, disincentivize them) so that they have some skin in the provider's care process. Aligning financial incentives is the only thing proven to work universally."

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?

"Use lower cost (and more numerous)providers such as PA's and NP's. Ensure they have the same scope of practice across the US. They already know how to work as a team. Their outcomes are as good, and sometimes better, than MD's."

health resources; patient navigators assigned to high risk patients to help with the social, behavior and life style challenges that contribute to poor compliance and outcomes. Partnerships forged with county, public health, payers and private health care providers in the coordination of care. "

6. 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?

"Create financial incentives for patients adherent to chronic disease medication regimens and for participating in Medication Therapy Management services."