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January 28, 2016

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, DC 20510

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

AARP appreciates the opportunity to provide comments to the Senate Finance Committee's Bipartisan Chronic Care Working Group (working group) as you consider a more finite list of policy options and develop bipartisan legislation to advance. We commend the Committee's bipartisan and transparent approach to these important issues. AARP is pleased to see some of our previous recommendations and suggestions included in the working group's "Policy Options Document" released in December. Below we are providing feedback on many policy options included in the policy options document.

Receiving High Quality Care in the Home

Expanding the Independence at Home Model of Care

AARP strongly supports expanding the current Independence at Home (IAH) demonstration into a permanent, nationwide program. The IAH demonstration uses home-based primary care teams designed to improve health outcomes and reduce Medicare spending for beneficiaries with multiple chronic conditions. The primary care teams are directed by physicians and nurse practitioners who visit and care for individuals in their homes and are available 24 hours per day. The vast majority of older adults want to live independently in their homes and communities. Models of care that help enable them to do so are vital. As the working group notes, the first year of the

IAH demonstration has shown positive results, including Medicare savings. We urge the committee to include IAH expansion in your bipartisan chronic care legislation. IAH also has a history of bipartisan support.

We are supportive of using hierarchical condition categories (HCC) risk scores as a way to identify complex chronic care beneficiaries for inclusion in IAH, instead of requiring that the individual undergo a non-elective hospitalization within 12 months of his or her IAH program participation. IAH could help individuals with high needs and costs avoid a non-elective hospitalization, meaning better care for the beneficiary and savings to both Medicare and Medicare beneficiaries. Individuals without such a hospitalization, but who meet other appropriate criteria for the program should be eligible to benefit from the program.

AARP urges measures of beneficiary and family caregiver experience be included in the IAH quality measures as IAH is expanded. Feedback from beneficiaries and their family caregivers, who are often critical to helping their loved ones live at home, provides important information about the quality of care and quality of life of both parties. AARP also urges that the IAH expansion allow for the waiver of co-payments or cost-sharing for beneficiaries in the program. Such a provision may encourage individuals to participate in the program. The working group may want to consider whether allowing for savings to be calculated over more than one year for a practice's initial year or two in the program would encourage practices to join IAH, since they often have to make upfront investments to participate in the program.

Advancing Team-Based Care

Providing Medicare Advantage Enrollees with Hospice Benefits

Medicare beneficiaries enrolled in Medicare Advantage (MA) can face fragmented care when they seek hospice services. Since the Medicare hospice benefit was created in the 1980's, it has been carved out of Medicare Advantage and is provided via the traditional Medicare program in one of two ways. Beneficiaries either:

1. Disenroll from MA and enroll in the traditional program; or
2. Stay in MA but receive hospice through Medicare Part A.

This can create a situation in which beneficiaries, their family caregivers and even their providers are unclear what part of the Medicare program will pay for their care. Unfortunately for beneficiaries and their families, this confusion occurs when the beneficiary has a terminal illness and is late in life, further compounding an already emotional and stressful time.

While it may be possible for Medicare Advantage Organizations (MAOs) to provide the Medicare hospice benefit, we believe careful study and rigorous oversight is first necessary to ensure the benefit received by those enrolled in MA is the same or better as compared to the traditional program and that beneficiaries and their families are not

adversely impacted. In addition, if it is determined to allow MAOs to offer hospice, it is critical that payment and star ratings metrics be calculated the right way in order to allow the benefit to work as best as possible and for MAOs to be incentivized correctly to provide the most optimal beneficiary and family experience they can.

Hospice is a unique, interdisciplinary team approach to end-of-life care that not only benefits a person with a terminal illness, but also provides services and support to their family. We believe it is critical the benefit remains a person-and family-centered approach that provides quality care to beneficiaries and their families. On its face, allowing MAOs to administer the hospice benefit has the potential to encourage greater accountability among MA plans for the full continuum of care for all life-stages and transitions.

For these reasons, we recommend a broad, multi-year demonstration program to determine if allowing all MAOs to offer hospice care is in the best interest of the beneficiary and their family. Any demonstration program should include a diverse set of geographic locations, rural and urban areas and both PPO and HMO plans. With that in mind, we offer the following important recommendations and beneficiary safeguards for an MAO/hospice demonstration program:

- MAOs must cover the full scope of the Medicare hospice benefit, including the required care team and written care plan;
- For services in the Medicare hospice benefit (services under the FFS benefit), no additional cost sharing should be allowed beyond what is allowed under traditional Medicare;
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey should be used to assess consumer and family experiences with hospice care; and
- Quality metrics used should include measures of access, beneficiary choice, if beneficiaries and families received the care they needed and their wishes were followed, and evaluation of how beneficiary and family caregivers experienced care.

The evaluation of the demonstration should answer the following questions:

- Was access to an adequate number of hospice providers decreased by MAOs?
- Did MAOs use preauthorization requirements for hospice and, if so, how did it impact access to care?
- Was the quality of the hospice benefit the same for MA enrollees as it is for those in the traditional program and how was quality impacted or not?
- Was the breadth of the services provided under the MA hospice benefit equal to the current traditional program offerings?
- If an MA enrollee sought a faith based hospice provider, was one available?
- How does the beneficiary and family experience with hospice compare under MA and traditional Medicare?

Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations

AARP supports, with caveats, the concept of long-term or permanent authorization for Special Needs Plans (SNPs). We understand that long-term or permanent authorization would allow for greater planning of, and investment in, specialized models of care than is possible under ongoing short-term extensions.

Institutional SNPs or I-SNPs have been shown to perform better than other SNPs and Medicare Advantage (MA) plans on the majority of available quality measures for SNPs. In addition, compared with other MA plans, I-SNPs also perform well on a number of process measures. Therefore, AARP supports the working group's recommendation to permanently authorize I-SNPs.

In contrast, chronic condition SNPs or C-SNPs tend to perform no better on most quality measures than other SNPs and MA plans. In addition, many of the chronic conditions currently covered under C-SNP authorization should be managed by regular MA plans. One approach the working group may be considering is to phase out authority for some C-SNPs as they are currently structured. This would happen at the same time new tools are provided to general MA plans to better focus on people with chronic conditions. We urge the working group to ensure the transition is done cautiously by allowing enough transition time to ensure services are not disrupted for beneficiaries currently served by C-SNPs. The working group should also evaluate whether highly specialized C-SNPs should be permitted to continue, or changes to C-SNP authority should be made, in cases where people with certain conditions or multiple chronic conditions may not be well-served by general MA plans.

Dual-eligible SNPs or D-SNPs have the potential to integrate care for Medicare beneficiaries who also receive Medicaid benefits. Such integration would include primary and acute care, behavioral health, and long-term services and supports, and should lead to better care coordination and improved outcomes for dual beneficiaries. Therefore, AARP supports the working group's proposal to limit permanent reauthorization to D-SNPs that are fully integrated, meaning that the D-SNP assumes clinical and financial responsibility for Medicare and Medicaid benefits. We also urge the working group to consider eliminating administrative barriers to high quality integration such as misaligned grievance and appeals processes, marketing rules that do not support an integrated benefit, and the need for beneficiaries to carry two enrollment cards.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

AARP supports consideration of establishing a new "high severity" chronic care management (CCM) code in the Medicare physician fee schedule to pay for non-face-to-face care coordination services for eligible patients. This would supplement the existing CCM code that has been available to physicians starting January 1, 2015 and

pays them an average of \$42 a month. The existing CCM services may be provided to a very broad set of patients and are meant to pay for an average of 20 minutes per month of non-face-to-face care coordination services. Offering a higher payment rate for high-severity patients will enable physician practices to spend more time supporting those patients.

First, we agree that patient eligibility criteria should be based on a combination of chronic conditions and functional status. We suggest a broad definition of high-severity to include the options the working group mentions – five or more chronic conditions; one chronic condition in conjunction with cognitive impairment; or one chronic condition combined with impaired functional status – and adding beneficiaries with a high hierarchical condition categories (HCC) score (e.g., 2.5+), and beneficiaries with five or more prescription medications.

Additionally, the new code must include the following elements in order to provide maximum benefit to the individual:

- Services covered by the new code must include coordinating needed long-term services and supports, as well as medical care;
- Zero co-insurance for this code's services;
- The ability to include a family caregiver in care coordination management activities; and
- Clear, consumer-friendly information explaining what is being offered, and providing the opportunity to opt out.

Providers should be required to document the services they provide and to monitor the extent to which the new code and the original CCM code are used.

Second, providers who may be eligible to coordinate this care should include not only primary care physicians and practitioners, but also specialists who are appropriate to manage complex chronic conditions, such as endocrinologists for advanced diabetes, cardiologists for advanced congestive heart failure, and oncologists for cancer.

Third, the preferred methodology for measuring the impact of care coordination would be randomization of targeted beneficiaries who are willing to participate. Without randomization, measuring the impact will be extremely difficult.

Last, we support temporarily instituting the code while giving the Secretary authority to continue, discontinue, or modify based on effectiveness, feedback, utilization, and other factors.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

AARP supports the bipartisan working group's proposal for a Government Accountability Office study on the status of integrating behavioral health and primary care among private sector Accountable Care Organizations (ACOs), public sector

ACOs, ACOs participating in the Medicare Shared Savings Program, as well as private and public sector medical homes. A significant body of evidence supports the integration of primary care and behavioral health because independent systems of care lead to worse health outcomes and higher total spending. This is especially the case for individuals with comorbid physical and behavioral health conditions. Therefore, it is important to understand the extent to which ACOs and medical homes are integrating care, to know whether barriers to integration exist for these systems, and to identify promising strategies to help these systems overcome any barriers.

Expanding Innovation and Technology

Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

We are encouraged by the working group's inclusion of several of our June 2015 recommendations regarding allowing Medicare Advantage Organizations (MAOs) the flexibility to provide tailored benefits and plan features to better serve people with chronic and multiple chronic conditions. While we encourage continual improvements to requirements and incentives for all MA plans to improve care coordination and serve people with chronic conditions, we also support allowing MAOs to provide tailored plans to better meet the needs of people with chronic conditions. As such, we strongly support the working group's broad ideas of allowing MAOs to offer:

- Additional supplemental benefits not currently allowed that are related to the treatment of the chronic condition or prevention of the progression of the chronic disease;
- Reduction in cost sharing for items/services that treat the chronic condition or prevent the progression of the chronic disease;
- Adjustments to provider networks that allow for a greater inclusion of providers and non-clinical professionals to treat the chronic condition or prevent the progression of the chronic disease; and
- Care improvement and/or voluntary wellness programs specifically tailored for the chronic condition.

The working group also asks whether all plans should be permitted the flexibility described above or if a subset of plans – based on quality, experience, or other criteria – should be eligible. We believe the answer is a hybrid of the above approach. While all MAOs should be eligible to develop a benefit design tailored to a specific chronic condition, plans should be required to demonstrate experience in, or the ability to serve, these populations. Any such plan should also be held to rigorous quality, outcome and improvement metrics and simultaneously be subject to termination if they fall below certain benchmarks. Quality of care metrics should be designed to specifically measure performance for the chronic population being served. The goal of any such chronic care

plan should be to achieve the highest quality possible and be given the flexibility and incentives to be innovative in doing so. Recognizing that many beneficiaries have more than one chronic condition, these plans should possess the capability to handle a myriad of conditions and work in a team-based fashion in order to provide the best care to individuals who often require the most complex care coordination.

We also recommend that identifying which chronic diseases the new plans should be tailored to be data driven and triggered by a percentage of the Medicare population affected by certain types of conditions. The working group should also carefully consider eligibility and enrollment rules for these new tailored plan options and consider whether beneficiaries should be permitted to enroll upon a medical diagnosis outside of the annual open enrollment period.

Lastly, as noted earlier in the discussion about Special Needs Plans, changes to the availability of C-SNP plans should be carefully coordinated with such improvements to general MA plans, and an adequate transition should be allowed to ensure minimal disruptions to care. C-SNPs for highly specialized conditions that would not be well-served by general MA plans should be permitted to remain.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

As the working group considers giving MA plans new flexibility to establish benefit structures tailored to the individual needs of people with chronic conditions, we agree that new supplemental benefits should be considered for addition as supplemental benefits. Criteria for additional supplemental benefits should be expanded to include services that improve or maintain health or functioning, and should not be limited to benefits that prevent, cure, or diminish an illness or injury. In addition, the criteria should also include support for family caregivers, in addition to the beneficiary.

Additional categories of services which should be considered as supplemental benefits include non-medical social services. We are pleased the working group is considering the addition of nutrition services. As the senior population continues to grow, along with the incidence of chronic disease, food security issues will only continue to put more pressure on the health care system. By providing nutritional benefits to those who need them, we can help people live at home and age-in-place, helping to delay or prevent more costly institutional care and unnecessary hospitalizations, saving taxpayer dollars. In addition, supplemental benefits should also include communications devices, home improvements, assistive devices, long-term services and supports, specialized transportation, and training and other supports for family caregivers.

While additional supplemental benefits should be permitted to allow MA plans to better serve these populations, CMS should be required to closely monitor, on an ongoing basis, these additional benefits and their suitability and use in the market, and we agree that the working group must also carefully consider safeguards to discourage abuse or inappropriate use of supplemental benefits.

Increasing Convenience for Medicare Advantage Enrollees through Telehealth

AARP supports the expanded use of telemedicine in Medicare, including Medicare Advantage. Telemedicine helps make care more cost-efficient and reduces reliance on other more costly services, while also benefiting the enrollee and potentially their family caregiver. Neither traditional Medicare nor MA telemedicine use should be limited by originating site or geographic restrictions.

MA plans should be allowed to include additional telehealth services in their annual bid amounts. The bid should include any savings gained from the use of telemedicine services. MA plans should be allowed to provide more telehealth services than is currently permitted under traditional Medicare. These additional telehealth services should include services such as store and forward, monitoring, e-mail, etc. Any additional telemedicine services that are not included in the plan bid amount should be charged against the plan rebate.

Efforts should be made to ensure that quality of care is maintained. Services via telemedicine should be required to be provided in conjunction with quality reporting, to ensure technology is being used to improve care instead of merely reducing the plan's cost burden. Additionally, while we support the broader use of telehealth services to manage chronic conditions and better involve family caregivers, we caution that any telehealth expansion should be mindful of privacy and personal health information sharing.

Providing ACOs the Ability to Expand Use of Telehealth

AARP supports allowing accountable care organizations (ACOs) with two-sided risk to provide, at their own expense, telehealth services originating from any location, including the beneficiary's home. Continued, robust quality measurement would help ensure availability of appropriate equipment and proper technology use. Telehealth should be enhancing care provided by the ACO, not used solely as a way to cut costs.

Maintaining ACO Flexibility to Provide Supplemental Services

AARP supports clarifying that ACOs are allowed to provide social services, transportation, and remote monitoring at their own expense. These supplemental services improve access and quality of life for beneficiaries and also help support family caregivers assisting their loved ones. There should not be any confusion or lack of awareness about their permissibility.

Expanding Use of Telehealth for Individuals with Stroke

AARP supports removing the originating site geographic restriction for stroke patients. Removing the restriction allows patients to get a diagnosis from a neurologist before

reaching the hospital, or while at a facility without a neurologist on site, allowing for timely treatment.

Identifying the Chronically Ill Population and Ways to Improve Quality

Ensuring Accurate Payment for Chronically Ill Individuals

AARP supports improvements to the Medicare Advantage risk adjustment model that improve accuracy of payments to plans based on enrollees' costs. While the risk adjustment model has improved over time, the current model still results in payments that undercompensates plans for the cost of care for enrollees with higher health needs, including chronic conditions and individuals requiring complex care, and overcompensates plans for the cost of care of healthier enrollees.

We are pleased the working group is examining improvements to the risk adjustment model to improve its accuracy and lead to more equitable payments. We are supportive of the changes to the model being considered by the working group to take into account:

- Changes in predicted costs associated with the total number of conditions of an individual beneficiary;
- Changes in predicted costs associated with the interaction between behavioral/mental health conditions with physical conditions;
- Differences in costs associated with beneficiaries who are dually eligible for both Medicare and Medicaid through different eligibility pathways; and
- The use of more than one year of data to establish a beneficiary's risk score.

We are also pleased the working group is examining the issue of whether the use of functional status could be used to improve the accuracy of risk-adjustment payments. As the working group is aware, a high number of individuals with chronic conditions have long-term service and support needs. A goal of changes to the risk adjustment model should be to avoid disincentives for enrollment of these high-need individuals.

Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization

AARP supports allowing ACOs in the Medicare Shared Savings Program (MSSP) Track One to choose whether beneficiaries are prospectively or retrospectively assigned. We also support Medicare beneficiaries being able to voluntarily be assigned to an ACO in which their "main provider" participates. ACOs, however, must provide potential participants with clear, timely information about what the ACO program is and their right to choose whether or not to participate.

We support allowing a beneficiary who voluntarily elects to be assigned to an ACO to receive services from non-ACO providers. An important feature of the ACO design is the opportunity for beneficiaries to use non-ACO providers. This feature gives ACOs a

strong incentive to offer quality care and good access to services from ACO providers – and it protects beneficiaries in cases where the ACO does not.

However, we do not support ACOs receiving an upfront collective payment for all services provided for beneficiaries who are assigned prospectively or who voluntarily enroll in the ACO. The purpose of ACOs is to test and enhance the fee-for-service model with performance incentives. Offering an upfront, per capita payment too closely resembles Medicare Advantage plans or other bundled payment models. Moreover, prospectively assigned beneficiaries should be treated the same as retrospectively assigned beneficiaries.

Developing Quality Measures for Chronic Conditions

AARP strongly supports requiring the Centers for Medicare & Medicaid Services (CMS) to include in its quality measures plan the development of measures which focus on health outcomes for individuals with chronic illnesses. There are a lack of measures specifically addressing the unique needs of persons with chronic disease and their family caregivers. This targeted focus should help fill that gap. We also commend and strongly support the recognition and inclusion of family caregivers in the proposed topic areas.

Empowering Individuals & Caregivers in Care Delivery

The title of this section of the policy options document uses the term “caregivers”. While it is important to recognize the role of caregivers, it is not totally clear to whom “caregivers” specifically refers. Different people may vary in their interpretation of the term to mean everything from family caregivers (defined broadly) to health care providers to direct care workers or other providers of long-term services and supports to other social service providers. We encourage the working group to use a term that better clarifies your intent. If you mean family caregivers (defined broadly), we suggest using that term. You may find the definition of “family caregiver” in the RAISE Family Caregivers Act (S. 1719), recently passed by the Senate, to be helpful in this regard.

Encouraging Beneficiary Use of Chronic Care Management Services

The working group is considering waiving the beneficiary co-insurance for services associated with the CCM code and the new high-severity CCM code. AARP has strongly, and repeatedly, recommended waving this cost-sharing. Out-of-pocket costs pose a barrier to eligible high-risk beneficiaries who could benefit from care management services. Since beneficiaries with multiple chronic conditions tend to have high out-of-pocket spending for health care, any cost sharing burden that could discourage them from receiving these vital services should be removed. Removing the cost-sharing will also eliminate beneficiary confusion over bills and charges for services for which they did not see a provider.

Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness

The working group is considering requiring CMS to implement a one-time payment to clinicians to recognize the additional time needed to have conversations with beneficiaries who have received a diagnosis of a serious or life-threatening illness, such as Alzheimer's/dementia. The intended purpose of the proposed visit would be to discuss the progression of the disease, treatment options, and availability of other resources that could reduce the person's health risks and promote self-management. AARP's feedback on this proposal includes several ways to improve it.

It is important that this payment is for conversations with beneficiaries diagnosed with a serious or life-threatening illness and not just limited to one illness or condition or a statutory list of illnesses. Beneficiaries with different serious or life-threatening illnesses and their family caregivers could benefit, as could Medicare, from these conversations including through more effective treatment and care coordination, reducing unnecessary care, and empowering individuals to make more informed decisions. CMS should define "serious or life-threatening illness" with input from stakeholders and the public, rather than defining this term or including a specific list of diseases in statute. CMS may want to consider criteria for what makes an illness (or combination of conditions) serious or life-threatening, such as the nature of and amount of change the condition brings to the beneficiary's life and health; impact on health, function, or daily activities and need for assistance; impact on life expectancy; impact on quality of life; duration of impact; complexity of decision-making among treatment options; and whether planning for future care needs would make a meaningful and beneficial difference to the beneficiary and his or her family caregivers. A short-term condition that has minimal impact on the beneficiary would not meet the criteria for this planning visit.

Given that serious and life-threatening illnesses and care needs change and progress over time, some individuals and their family caregivers may need a series or more than one in-depth conversation with their physician or non-physician provider. These conversations are part of quality care and the payment system should incentivize this level of care, as appropriate. To better empower individuals and family caregivers, we urge modifying this proposal to allow for a range of visits as needed, such as up to four such visits per year.

Importantly, the planning visit should involve family caregivers, as appropriate, as family caregivers (broadly defined) are often the main provider of supportive services, especially to those with a serious or life-threatening illness. Family caregivers are often critical sources of support for their loved ones as a disease progresses and play an essential part in the treatment their loved one receives, whether it's administering medications, performing personal care such as help with bathing or eating, or coordinating care among multiple providers or post-surgery. The "availability of other resources" noted in the proposal must include referral to evidence-based family caregiver support services, as appropriate. Services provided under the planning visit

should also be able to be provided to a family caregiver with or without the presence of the beneficiary.

While illnesses vary, it would make sense for the planning visit to have some core elements in general and the flexibility to enable providers to include elements that may be relevant to a particular serious or life-threatening illness. The planning visit should also consider that the beneficiary may have multiple conditions, including multiple serious or life-threatening illnesses. Non-physician providers should also be eligible to provide this planning visit.

Eliminating Barriers to Care Coordination under Accountable Care Organizations

AARP supports two-sided risk ACOs waiving cost sharing for treatment of chronic conditions. Elimination of cost-sharing will incentivize beneficiaries to seek providers within the ACO, helping to fully realize the potential of coordinated care. Services for which cost-sharing can be waived, though, should be determined through rulemaking, and not left to ACO discretion. Consistency across ACOs will avoid disadvantaging and confusing beneficiaries. Regulations will also prevent ACOs from cherry-picking persons and circumstances for which they waive cost-sharing.

Expanding Access to Digital Coaching

AARP has reservations about the working group's proposal to require CMS to provide education and tools to help beneficiaries learn more about their health conditions and assist them with self-management of their health. We believe that given the finite resources available to CMS, that it might be more prudent for the agency to focus on maintaining and improving existing consumer tools (e.g., the Compare websites, the Star Ratings site, and Medicare and You). Taking on the added responsibility of collecting information on a myriad of chronic conditions, ensuring its accuracy, and keeping the information up-to-date would likely prove to be a daunting task. Health plans and providers should provide beneficiaries and their family caregivers with the necessary tools to allow them to make informed decisions and to actively engage in the management of their health care. CMS should strongly encourage Medicare health plans and providers to provide such health management education and tools to the beneficiaries they serve. To the extent that CMS is voluntarily engaged in such activities, it should continue to do so, as resources allow.

Other Policies to Improve Care for the Chronically III

Study on Medication Synchronization

AARP supports the general idea behind medication synchronization. However, we remain concerned that asking patients to pay all of their monthly cost-sharing at one time could create a financial hardship, particularly for patients who take multiple or expensive medications. It is also unclear whether medication synchronization programs adequately explain the financial implications of participation prior to enrollment.

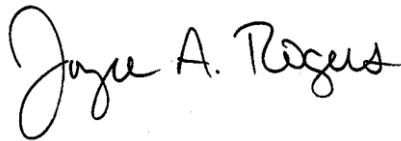
Therefore, AARP strongly suggests that any study should instead focus on researching the effects of medication synchronization on beneficiaries' cost-sharing requirements and the potential impact on drug adherence.

Study on Obesity Drugs

The pharmacological treatment of obesity is limited by low adherence, modest efficacy, adverse effects, and weight regain after medication cessation.^[1] Moreover, given current obesity drug prices^[2] and the implication that patients must take them indefinitely, it is unlikely that Medicare will attain cost-savings. Consequently, AARP recommends allowing drug manufacturers — who have a clear financial incentive to demonstrate the effectiveness of their products — to finance this research instead of taxpayers.

Thank you for the opportunity to provide feedback on the working group's chronic care policy options. We appreciate your thoughtful and bipartisan consideration of these issues and improving care for Medicare beneficiaries with multiple chronic conditions and their family caregivers. If you have any questions, please feel free to contact me, or have your staff contact Ariel Gonzalez, Director of Federal Health and Family, at 202-434-3770 or agonzalez@aarp.org.

Sincerely,



Joyce A. Rogers
Senior Vice President
Government Affairs

^[1] American Diabetes Association, "Standards of Medical Care in Diabetes-2016," *Journal of Clinical and Applied Research and Education*, Diabetes Care 39 (Supp 1).

^[2] Monthly obesity drug prices are approximately \$200 per month. S.Z. Yanovski and J.A. Yanovski, "Long-term Drug Treatment for Obesity: A Systematic and Clinical Review," *Journal of the American Medical Association*, 311(1): 74-86.