



June 22, 2015

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 Senator Isakson and Senator Warner:

The Association of Asian Pacific Community Health Organizations (AAPCHO) would like to thank the Senate Finance Committee for the opportunity to comment on ways to improve addressing chronic care conditions in the Medicare population. Additionally, we would like to thank you for developing a chronic care working group, signifying the crucial need to address the complexities of these health issues in the Medicare population.

AAPCHO is a national nonprofit association representing 35 community health organizations, including 29 Federally Qualified Health Centers (FQHCs) that provide quality, comprehensive health care services to medically underserved Asian American, Native Hawaiian, and other Pacific Islander populations. We are dedicated to promoting advocacy, collaboration, and leadership to improve the health status and access of these medically underserved populations in the U.S., its territories, and its freely associated states.

Hepatitis B

AAPCHO has set both diabetes and hepatitis B as two of our policy priorities because of the high prevalence of both chronic conditions in AAPCHO member center patient populations. In the U.S., it was estimated in 2009 that 1.32 million foreign-born individuals have chronic hepatitis B, with total population estimates reaching as high as 2.2 million.¹ Hepatitis B disproportionately affects AAPIs, as 1 in 12 Asian Americans and Pacific Islanders (AAPIs) have the disease. Asian Americans are particularly at risk and constitute more than half of all those infected in the U.S.² Hepatitis B prevalence rates for Asian Americans living in major metropolitan areas in the US have been reported from 10-15%³. Chronic hepatitis B infection leads to

¹ Kowdley KV, Wang CC, Welch S, Roberts H, Brosgart CL. Prevalence of Chronic Hepatitis B Among Foreign-Born Persons Living in the United States by Country of Origin. *Hepatology*. 2012; 56(2): 422-33.

² Centers for Disease Control and Prevention. 2015. *Viral Hepatitis – CDC Recommendations for Specific Populations and Settings*. Retrieved from: <http://www.cdc.gov/hepatitis/populations/api.htm>.

³ Centers for Disease Control and Prevention. 2006. *MMWR weekly: Screening for chronic hepatitis B among Asian/Pacific Islander populations --- New York City, 2005*. Retrieved from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5518a2.htm>.

cirrhosis, liver failure, or hepatocellular carcinoma (HCC) in 15%-40% of patients, and roughly 25% of patients need liver transplantation per year because of decompensated cirrhosis.⁴

The goal of treatment is the prevention or reversal of decompensated cirrhosis and reduction in the risk of HCC. In 2010, the CDC reported that rates of HCC were increasing and attributable to undiagnosed hepatitis B. Early detection and treatment for hepatitis B is key to improving health outcomes and reducing long-term costs to the health system. Liver-related disease mortality has shown a 10% reduction with comprehensive HBV screening.⁵ Early treatment for chronic hepatitis B has been demonstrated to be cost-effective and can improve health, reduce premature deaths, and prevent expensive complications, but the benefits of early care can only be achieved if people are routinely screened for hepatitis B infection.⁶

However, there are significant barriers to HBV screening in the U.S., including the silent nature of the disease and the lack of HBV screening currently being conducted at the primary care level. Increasing HBV screening is critical to saving lives, as those who are diagnosed can take advantage of lifestyle changes and FDA approved medications that can help prevent end-stage liver disease and liver cancer. In addition, many new treatments are now in development promising a bright future for preventing morbidity and mortality among infected individuals.

Preventive Care

Under the authority granted by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), CMS has the authority to cover preventive services that have received an “A” or “B” grade from the USPSTF after a service undergoes an NCD. In May 2014, the USPSTF updated its HBV screening recommendations and issued a “B” grade for testing those at risk for HBV infection.

The revised USPSTF hepatitis B screening recommendations are a significant advance in efforts to identify those with chronic HBV and link them to care. However, Medicare coverage currently does not include HBV screening for any population. This lack of coverage does not reflect current science or recommendations from the nation’s leading medical and public health experts. We

⁴ McMahon BJ. Hepatocellular carcinoma and viral hepatitis. *Viral Hepatitis*. Wilson RA, ed. New York: Marcel Dekker 1997; 315-330.

⁵ Veldhuijzen IK, Toy M, Hahné SJ, De Wit GA, Schalm SW, de Man RA, Richardus JH. Screening and Early Treatment of Migrants for Chronic Hepatitis B Infection is Cost-Effective. *Gastroenterology*. 2010; 138(2): 522-530.

⁶ Pollack H, Wang S, Wyatt L, Peng C, Wan K, Trinh-Shevrin C, Chun K, Tsang T, Kwon S. A comprehensive screening and treatment model for reducing disparities in hepatitis B. *Health Affairs* 2011; 30(10): 1974-1983.

ask you to urge CMS to initiate an NCD consideration of hepatitis B screening under the “Preventive and Screening Services” category in light of the new evidence-based recommendations.

Adoption of USPSTF’s revised grade for HBV testing would allow Medicare to play a crucial role in helping to identify those who are unaware they are HBV positive. Of the identified and reported cases of HBV in the U.S. between 2007 and 2012, 15.6% were over the age of 65 and part of the Medicare covered population. Seniors who are Medicare beneficiaries and are unaware of their HBV infection are likely to have been living with the disease for a very long time and it is vital to ensure they are linked to care and treatment before they develop advanced liver disease or liver cancer. Additionally, those with end stage renal disease are at higher risk for HBV infection and are less likely to respond to the HBV vaccine, and would benefit greatly from screening and subsequent linkage to care.

Care coordination; Patient Centered Medical Home

Often, patients seen at AAPCHO centers face many barriers to treatment of prevalent diseases in at-risk patient populations, such as hepatitis B. The Patient Centered Medical Home and Chronic Care Model seek to alleviate barriers to care by improving the communication and coordination of care between the patient, providers, and institutions, highlighting care management, and emphasizing patient self-management. The care manager and an emphasis on patient engagement is particularly important for patients who face barriers to care in the form of language, education, or access issues. These barriers can impact health care outcomes negatively. Hard-to-reach, LEP populations can greatly benefit from these health home models, as all points of care, from prenatal care to the care of the child, are addressed.

Diabetes

Diabetes also disproportionately affects AAPIs. Nationwide, nearly 30 million Americans have diabetes and an additional 86 million have prediabetes. Currently, half of all Americans age 65 or older have prediabetes and are at risk for developing type 2 diabetes. In AAPIs, 8.4% have diagnosed diabetes, according to the Centers for Disease Control’s national survey data.⁷ An estimated 11.2 million (nearly 30 percent) Americans over age 65 have been diagnosed with diabetes,⁸ a figure that will continue to increase if we do not act to prevent diabetes in this population. The

⁷ Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

⁸ Centers for Disease Control and Prevention. National diabetes statistics report, 2014. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2014.

annual cost of diagnosed and undiagnosed diabetes, gestational diabetes, and prediabetes has skyrocketed to \$322 billion in 2012, a 48 percent increase in just five years.

The National Diabetes Prevention Program (National DPP) at the Centers for Disease Control and Prevention (CDC) is a partnership consisting of government agencies, private insurers, and community organizations designed to provide evidence-based community programs to prevent type 2 diabetes in individuals at highest risk – specifically, individuals with prediabetes.

Currently, the Medicare program will pay to screen a beneficiary for diabetes and Medicare will pay for drugs and services if that individual is determined to have diabetes. However, if it is determined the individual has prediabetes, the patient's doctor is unable to prescribe or refer the individual to the National DPP because it is currently not considered a covered benefit under the Medicare program. The dramatic success achieved by seniors in the original clinical trial and the overall success of the intervention in the community-based setting warrants coverage of this program for our nation's Medicare population.

Care Coordination and Delivery Reform

Because of the complex nature of diabetes, ongoing patient self-management education and support are critical to preventing acute complications and reducing the risk of long-term complications. New prevention initiatives in the Affordable Care Act (ACA) have steered us in the right direction. States that have expanded their Medicaid program have seen a 23 percent increase in the number of Medicaid enrollees with newly identified diabetes; compared to just 0.4 percent in states that did not expand Medicaid.⁹ Early diagnosis and treatment have the potential to lead to improved long-term health outcomes for people with diabetes. Between 33.4 – 48.7 percent of patients with diabetes still do not meet recommended targets. Variation in quality of diabetes care across providers and practice settings exists, especially for certain patient populations such as those with complex comorbidities, financial or other social hardships, and/or for patients with limited English proficiency, thus there remains significant potential to improve diabetes care through improved care coordination and disease management.

The American Diabetes Association's 2015 Standards of Medical Care support the Chronic Care Model (CCM) of delivering health care because its six core elements for the provision of optimal diabetes care have been shown to be an effective framework for improving the quality of diabetes care. The six elements include: (1)

⁹ Kaufman HW, Chen Z, Fonseca VA, and McPhaul MJ. Surge in newly identified diabetes among Medicaid patients in 2014 within Medicaid expansion states under the affordable care act. *Diabetes Care* 2015; 10: 2337-2334.

delivery system design (moving from a reactive to a proactive care delivery system where planned visits are coordinated through a team-based approach); (2) self-management support; (3) decision support (basing care on evidence-based, effective care guidelines); (4) clinical information systems (using registries that can provide patient-specific and population-based support to the care team); (5) community resources and policies (identifying or developing resources to support healthy lifestyles); and (6) health systems (to create a quality-oriented culture).

How and when care is delivered is critically important to people with diabetes. Preliminary data suggests that Patient Centered Medical Homes (PCMH) and Accountable Care Organizations (ACOs) can provide high-quality care for people with diabetes at decreased costs. Under a PCMH, a patient's care is coordinated through their primary care doctor in order to ensure they receive appropriate care when and where they need it and in a manner the patient can understand. An early PCMH demonstration project in North Carolina in the late-1990s involved more than 1,200 practices and 3,000 physicians. This Medicaid Managed Care initiative coordinated care for the sickest and most high-risk enrollees with diabetes and annual savings were estimated to be at least \$161 million through reductions in emergency room visits, pharmacy utilization, and both inpatient and outpatient care.¹⁰ A similar PCMH initiative in Pennsylvania involving more than 56,000 patients with diabetes has seen diabetes self-management goals increase from 20 to 70 percent.¹¹ Consumers report greater satisfaction under team-based care models, such as the PCMH.¹²

ACOs, groups of doctors, hospitals, and other health care providers who voluntarily work together to provide coordinated high quality care to Medicare patients, also have potential to improve care delivery for people with diabetes. The Medicare ACO program was established to reduce health care costs by encouraging the formation of these networks to coordinate patient care and potentially receive bonus payments if care is delivered more efficiently. The early results of ACOs show improvements in people with diabetes reaching blood pressure and LDL-cholesterol targets and lower readmission rates.¹³ While ACOs are still in the early stages and not all ACOs in the program are meeting the goals of improving outcomes and saving money, preliminary data suggests they can provide high quality care for people with diabetes at decreased cost.

¹⁰ Steiner BD, Denham AC, Ashkin E, Newton WP, Wroth T, Dobson LA Jr. Community care of North Carolina: improving care through community health networks. *Ann Fam Med* 2008; 6: 361-367.

¹¹ Gabbay RA, Siminerio L. Pennsylvania statewide implementation of the chronic care model and patient centered medical home impacts diabetes care (Abstract). *Diabetes* 2010; 59(Suppl.1):A345.

¹² Nielsen, M., Gibson, L., Buelt, L., Grundy, P., & Grumbach, K. (2015). The Patient-Centered Medical Home's Impact on Cost and Quality, Review of Evidence, 2013-2014.

¹³ Centers for Medicare & Medicaid Services. Pioneer accountable care organizations succeed in improving care, lowering costs. July 2013. Available online: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-16.html>

Team-based care has the potential to reduce health disparities and improve diabetes management and care for specific racial, ethnic and socioeconomic populations who are below average in meeting these targets. The key principles of both the CCM and PCMH align well with recommended diabetes care as it relates to patient-centered care, self-management, patient empowerment, and team-based care.¹⁴

We believe that practices like these can greatly help to address severe chronic issues in the Medicare population. AAPCHO would like to thank you for the opportunity to comment on the Senate Finance Committee's step forward in the fight against chronic illness. We hope that you will consider our suggestions. If you have any concerns or questions, please contact AAPCHO's Senior Policy Analyst at iweerasinghe@aapcho.org.

Thank you,



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AAPCHO

¹⁴ Bojadzievski T, Gabbay RA. Patient-centered medical home and diabetes. *Diabetes Care* 2011; 34: 1047-1053.