



June 22, 2015

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

Re: Senate Finance Committee Working Group on Chronic Care Request for information

Submitted via email to chronic_care@finance.senate.gov

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

On behalf of National Alliance on Mental Illness (NAMI), I am pleased to submit the following comments to the Senate Finance Committee on ways to improve chronic disease management for Medicare beneficiaries. NAMI is the nation's largest national organization representing people living with serious mental illness and their families. Through our 1,100 affiliates in all 50 states, our members advocate on behalf of people living with illnesses such as schizophrenia, bipolar disorder, major depression and severe anxiety disorders.

NAMI applauds the Committee's decision to form a bipartisan working group to address chronic disease management and the challenge it poses to our health care system in general and the Medicare program in particular. Our consumer and family membership understands first-hand the real world experience of living with serious mental illness, and for too many, a multiple chronic medical conditions that can complicate full recovery and a life in the community. Everyday our members face the difficult challenge of navigating a fragmented health care world where both the mainstream primary and specialty medical care system and the specialty mental health system fail to deliver coordinated integrated treatment. In NAMI's view, people living with serious mental illness have the most to gain from a reformed delivery model that is based on the provision of evidence-based, coordinated care, the use of sophisticated electronic health records, and the delivery of patient-centric services designed to improve quality and outcomes while reducing cost.

Of particular concern to NAMI in the context of developing innovative policies to address chronic disease management is making sure that the provider incentives, quality measures, beneficiary access protections and overall efforts to promote broader access to

care within Medicare focus on beneficiaries living with a serious mental illness AND a single (or more likely) multiple chronic medical conditions.

In 2006, the National Association of State Mental Health Program Directors released a series of reports documenting lower life expectancy and premature mortality for individuals with serious mental illness served in the public sector mental health system. These reports examined medical histories and port-mortem records and found alarming rates of medical co-morbidities that were directly related to premature death among these individuals: heart disease, cancer, pulmonary disorders, diabetes, etc. that were significantly higher than the general population not diagnosed with serious mental illness. In the aggregate, these reports found life expectancy for these individuals that was 25 years lower than the general population. To put this in graphic terms, an American living with schizophrenia has a life expectancy that barely approaches that of an adult in Bangladesh.

To be clear, this amounts to a crisis and national disgrace that BOTH the public health AND public mental health systems must come to grips with. The causes of these higher rates of medical co-morbidities among non-elderly adults with serious mental illness are varied and complicated.

- **Tobacco** -- Significantly higher rates of tobacco consumption are documented in this population. Further, research has demonstrated that nicotine's impact on the brain can actually serve to temporarily ease the symptoms of schizophrenia.
- **Substance Abuse** -- The incidence of co-occurring substance abuse is disproportionately high among adults with serious mental illness.
- **Poor Diet and Sedentary Lifestyle** – Non-elderly people with serious mental illness comprise roughly 1/3 of the SSI rolls and 1/4 of the SSDI rolls. These individuals receive monthly cash assistance that typically places them below 100% of the federal poverty level. This provides limited opportunities to afford more expensive whole grains, fruits and vegetables are critical to a healthy diet. Further, many reside in institutions, group homes and other restrictive settings where they are offered limited opportunities for community engagement and are much more likely to lead an isolated, sedentary lifestyle with limited opportunities for physical exercise. These factors place this population at much greater risk of obesity with all of its related maladies.
- **Side Effect of Psychotropic Medications** -- For many individuals living with mental illness the side effects associated with the psychotropic medications essential for their treatment, maintenance of functioning and prevention of acute symptoms can contribute to (or exacerbate) medical conditions – in particular metabolic syndrome, weight gain, hypertension and risk of obesity.
- **Poor Access to Primary Care** – Perhaps no factor contributes more to early mortality and comorbidity of chronic disease in this population than abysmal access to primary and specialty medical care – BOTH for ongoing care for a chronic medical condition AND accurate diagnosis and appropriate intervention even for an acute medical condition. In NAMI's view, if this type of dereliction of

care were being experienced by any other measured population, it would be deemed a crisis demanding immediate attention.

Given the scope and depth of this public health crisis, it should come as no surprise that NAMI enthusiastically embraces innovative models to chronic disease management that offer the promise of eradicating system fragmentation, incentivizing real care coordination, improving quality, promoting cost savings and health outcomes for individuals with multiple chronic conditions.

Addressing Multiple Chronic Conditions

NAMI supports the Working Group's focus on improving care for people living with multiple chronic conditions. It is critically important to recognize that the Medicare population is changing and that multiple chronic conditions are more prevalent in every cohort within Medicare. In fact, the majority of people with Medicare have five or more chronic conditions, including many that are also living with serious mental illness.

In the shift to value-based payment structures, it is also critically important to understand the tremendous gaps in measuring the quality of care for these patients. NAMI is a member of the Partnership to Fight Chronic Disease (PFCD). PFCD recently issued a White Paper on multiple chronic conditions and found that there are few clinical guidelines that address treating people with multiple chronic conditions. Since guidelines form the basis for quality measures, not only are quality measures addressing multiple chronic conditions in short supply, the existing single condition guidelines may penalize providers providing quality care to someone with multiple chronic conditions. The movement to pay-for-value must recognize and address this significant gap.

Supporting Three Main Bipartisan Goals

The Committee's May 22nd letter lists three main bipartisan goals for policies under consideration:

- Increasing care coordination;
- Streamlining Medicare's current payment systems; and
- Facilitating the delivery of high quality care, improving care transitions, producing stronger patient outcomes, increasing program efficiency, and contributing to an overall effort that reduces growth in Medicare spending.

NAMI supports these criteria for evaluating policy changes and offers the following comments.

Increasing Care Coordination

Care coordination is critical to delivery system reform, particularly for people living with mental illness and a co-morbid chronic condition. Finding new finance mechanisms to

encourage team-based care within traditional Medicare is essential, but challenging within the confines of the fee-for-service framework. Adding primary care reimbursement for care coordination is an important recognition of the time spent away from the patient to make the needed connections with other providers. It does not, however, increase the accessibility to the team-based care and reimbursement streams needed to realize a team-based approach to patient-centered care.

In designing team-based reforms, NAMI would encourage consideration of chronic care models that focus not only on providers, but also include the patient and caregiver in the care team to garner the greatest benefit from care coordination efforts. It is important that care coordination embrace the resources available outside the medical system that work to improve health, including engagement and referrals to community-based organizations, public health resources, and social services. Many times poor health is a reflection of a constellation of issues related to unstable housing, poverty, transportation, food insecurity, and the like.

Though these issues may seem remote when considering Medicare financing reforms, they have direct impacts on costs and health and as such are essential aspects of managing costs and improving health in general.

Streamlining Medicare's Current Payment Systems

Financial reforms are needed to promote the improvement of health outcomes instead of the volume of services, but caution is needed when those policy goals meet the reality of caring for populations with complex needs. As noted above, the current status of quality measurement for people living with multiple chronic conditions, the majority of the Medicare population, has significant gaps. Without addressing those shortcomings, a significant piece in the move to value is missing – assuring that quality does not suffer. Quantifying costs is much easier and without the counterbalance of assuring quality, we are concerned that cost-containment will dominate to the detriment of patients.

Improving Quality and Bending the Cost Curve

When considering costs, it's important to factor in the sheer growth in the Medicare population – more than 10,000 people a day are added to the Medicare rolls. Spending targets need to recognize the reality of sheer volume driving spending higher. Improving the health of the Medicare population yields benefits well beyond those considered within Medicare spending. Better health allows people to age in place, to continue working, and remain active with their families and within their communities. This is especially the case with non-elderly Medicare beneficiaries with significant disabilities that are enrolled in the program for longer periods of time.

Each of these benefits has favorable economic outcomes, none of which are currently captured within current scoring methodology. Also, the benefits of secondary and tertiary prevention investments in population health improvement often occur outside the current

10-year scoring window. Reforms are needed to provide policymakers with a more complete picture of the budgetary and other economic benefits of population health improvements.

Comments on Specific Issue Areas:

1. Improvements to Medicare Advantage for patients living with multiple chronic conditions;

Medicare Advantage (MA) is the one part of Medicare that currently aligns incentives to coordinate care across care settings and providers, and, as such has yielded many innovative care models that should inform policy development. MA plans have the ability to adapt more readily to individual patient needs and offer coordination that traditional fee-for-service does not which could better serve patients living with multiple chronic conditions. Incentivizing better outcomes while recognizing the complexity of health needs people living with multiple chronic conditions present is critical to reforms. Policy changes should continue to identify, recognize, and reward these innovations should shape reforms that build on success by encouraging replication.

2. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternative payment models (APMs) currently underway at CMS, or by proposing new APM structures

Alternative payment models (APMs) may not work well in all patient populations, particularly those populations with complex needs such as serious mental illness and co-morbid medical conditions. NAMI recommends caution to avoid establishing incentives that limit the provider's ability to tailor treatment to the individual. With a focus on cost containment, the significant limitations in measuring quality for complex conditions make it difficult to assure patient health is not compromised. There is a need for greater transparency and opportunities for input on the development of new APMs and demonstration programs within the Center for Medicare and Medicaid Innovation. Assuring that patients, caregivers, providers, and other stakeholders have greater opportunities to participate in the design and development of these models before implementation will help to assure they meet the needs of the diverse Medicare population served and set goals for health and financial outcomes achievable within the practical realities of medical practice.

Chronic diseases take time to develop and the investments needed to reduce their prevalence will take time to materialize. There are short-term immediate steps that can deliver short-term results, such as managing care transitions, addressing "hot spots" and boosting medication adherence and self-management. These strategies offer enormous

promise beyond the longer term goals of savings through prevention and chronic disease management.

3. Reforms to Medicare’s current fee-for-service program that incentivizes providers to coordinate care for patients living with chronic conditions;

Under FFS Medicare, care coordination is often left to the patient and caregivers with little support for navigating the system, understanding care regimens, and identifying social services and other resources. Reforms should include opportunities to bridge the gaps and provide support not only for providers but also for patients and caregivers.

The recent addition of a new payment code for primary care providers relating to care coordination activities was an important recognition of the time and effort needed to coordinate care for patients. More is needed to facilitate the team-based care needed to make a significant difference. However, simply adding new payment codes to the existing system does not resolve the fundamental structural problem that limits quality improvement and savings generation: the limits on incentives to do more when the savings generated accrue somewhere else in the health system.

NAMI would also recommend expansion of the current Hospital Readmission Reduction program authorized as part of Section 3025 of the Affordable Care Act. This initiative requires CMS to reduce payments to IPPS hospitals with excess readmissions. CMS currently limits the scope of this program to reductions in hospital payments for excessive readmissions related to a number of limited conditions acute myocardial infarction, heart failure and pneumonia. NAMI recommends that the Committee press CMS for expansion of these conditions to psychiatric conditions such as acute psychosis, mania and depression. This could go a long way toward incentivizing coordinated care for patients upon discharge after a short-term acute inpatient psychiatric admission.

4. The effective use, coordination, and cost of prescription drugs;

There is significant potential to increase the benefit of prescription drugs and lower costs overall through policies that promote medication adherence. We know that more than 1 in 5 new prescriptions go unfilled, and 2/3 of patients do not adhere to their prescription medicines. As many as two out of three medication-related U.S. hospital admissions and 125,000 deaths a year are a direct result of poor medication adherence. IMS Institute estimates that improving use of medicines could save \$213 billion annually, of which \$105 billion would be from improved adherence.

Under Part D, stand-alone PDPs currently have little incentive to improve medication adherence among their members than Medicare Advantage Part D plans as they only see the costs of added utilization of medicines and not the offsets in additional health care costs that flow from better management of chronic conditions. Reforms should include aligning incentives for medication management and improved adherence through shared savings or other models that promote improved outcomes for patients.

Though Medicare currently covers Medication Therapy Management (MTM) services for certain Medicare beneficiaries, the current eligibility for the program is not sufficient to target those beneficiaries with potentially the most to gain from MTM. For example, just using high drug utilization as a criteria for MTM services, would miss people with low drug utilization caused by poor adherence and people with high medical spending on ambulatory-sensitive conditions that would benefit from better medication management and adherence.

The Committee should consider whether or not MTM is optimally targeted to impact beneficiaries who would most benefit from participation. Evidence to date suggests that eligibility criteria for MTM participation may be better targeted to reach beneficiaries at high risk for negative health events, high medical spending, or poor adherence. Part D plans are currently limited in their ability to target MTM services to beneficiaries based on their clinical behavior and actions under Medicare Parts A and B. PDPs cannot discern when their enrollees are admitted to an ER or institutional care provider based on a medication-related event or incur significant medical costs as a result of high healthcare utilization.

Furthermore, current MTM activities are considered administrative costs under the Medical Loss Ratio (MLR) rules and improvements to the program via additional beneficiary services increase plan bids and premiums, potentially impacting a plan's ability to compete in the market. One simple modification would be to reclassify MTM activities as "quality improvement" under the MLR. Additional solutions for realigning incentives should include policies that share the savings, which accrue to Parts A and B with Medicare Part D for medication-related management interventions. Additionally, quality improvement bonuses relating to medication management services provided by PDPs could be tied to outcomes that lower costs within Parts A and B.

Finally, the Committee needs to address current limitations in the Medicare Part D program that limit access to medications to treat obesity. As noted above, Medicare beneficiaries living with serious mental illness are at dramatically higher risk of obesity than the general population. As noted above, poor diet, sedentary lifestyle, side effects of psychotropic medications all contribute to this risk.

Currently, Part D enrollees who need weight loss drugs lack coverage and are forced to pay for the drugs out of pocket because this class of drugs is specifically excluded by statute from Part D. Combating obesity must be a priority in addressing chronic disease management. NAMI would also commend to the Committee S 1509, the Treat and Reduce Obesity Act recently introduced by your colleague Senator Tom Carper. This important legislation addresses the current gaps in coverage under Part D for medications to treat obesity.

Conclusion

NAMI is grateful for the Finance Committee's bipartisan interest in this critical priority for our nation's health care system. We look forward to working with you to produce meaningful reforms for Americans living with multiple chronic conditions.

Sincerely,

A handwritten signature in black ink, appearing to read "Mary Giliberti". The signature is written in a cursive style with a large initial "M".

Mary Giliberti, J.D.
Executive Director