

June 22, 2015

The Honorable Orrin Hatch
Chair, Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Johnny Isakson
Co-Chair, Working Group on Chronic Care
Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Mark Warner
Co-Chair, Working Group on Chronic Care
Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Co-Chairs Isakson and Warner, and other members of the Working Group:

On behalf of Otsuka Pharmaceutical Development & Commercialization, Inc. (OPDC), I am providing comments in response to the Committee's recent letter to chronic care stakeholders. OPDC is a U.S.-based affiliate of Otsuka Pharmaceutical Co. Ltd., a global health care company seeking to advance patient care by developing novel medicines and digital health products. Our company is deeply committed to improving the lives of patients coping with chronic conditions ranging from kidney disease to severe mental illness.

As a company, we are encouraged by the Committee's close attention to important issues surrounding chronic illness and the need to modernize Medicare and Medicaid to more effectively serve these high-need populations. As the Committee notes, more than 90 percent of Medicare resources are devoted to treating chronic conditions. In addition, individuals with six or more chronic conditions account for nearly half of all Medicare spending. These numbers are staggering and reveal both the severity of chronic illness in this country and the grave significance of policies for more effectively and efficiently meeting the needs of this population.

The figures pertaining to mental and behavioral health are not far behind. As the Medicaid and CHIP Payment and Access Commission (MACPAC) noted during its February 2015 meeting, nearly half of all Medicaid expenditures were spent on behalf of less than 18 percent of enrollees who had a behavioral or mental health diagnosis.¹ While Medicaid spending on mental health treatments made up a modest share, total spending on these beneficiaries was substantial. These findings reveal several important points about mental health and chronic care. First, the vast majority of health care spending is devoted to treating mental illness and chronic disease combined. Second, there is significant overlap between these two broadly defined disease states. Evidence confirms that individuals with mental health conditions are highly likely to have physical health comorbidities.²

¹ MACPAC, Public Meeting, Feb. 26, 2015, 191-92, transcript *available at* <https://www.macpac.gov/wp-content/uploads/2014/12/February-2015-Public-Meeting.pdf> (citing 2011 data).

² Valerie A. Lewis et al., *Few ACOs Pursue Innovative Models that Integrate Care for Mental Illness and Substance Abuse with Primary Care*, 33(10) HEALTH AFFAIRS 1808-1816 (2014).

The Centers for Disease Control and Prevention (CDC) defines chronic conditions broadly to include “conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living.”³ Although the CDC does not list mental illnesses among the chronic conditions, this definition would seem to capture many significant mental health conditions. For example, schizophrenia often emerges in adolescence or young adulthood and must be carefully managed with a range of treatments to prevent it from debilitating daily functioning.

Our company is a strong proponent of mental health parity and has seen firsthand how this important policy is making a world of difference for many individuals. Nonetheless, the term “parity” may be somewhat of a misnomer insofar as it perpetuates a false dichotomy between mental and physical health. As Representative Tim Murphy eloquently stated at a recent hearing, “mental illness, especially serious mental illness, is a brain illness and as such must be seen as and treated for what it is.”⁴ Former Representative Patrick Kennedy added, “these are real, physical illnesses, and they need to be treated with the same urgency that we would treat cancer or any fatal [condition] in this country.”⁵

Like other chronic conditions, mental illness leads to far more serious medical—as well as socioeconomic—complications if it is not properly treated. Similarly, innovative approaches to care coordination, care transitions, and other timely interventions can have an enormous benefit among these needy populations. Accordingly, we urge the Committee to think comprehensively about chronic conditions by ensuring that new policies address all pervasive conditions that afflict Americans and, if not properly controlled, burden the daily functioning of individuals and weigh down the health care system as a whole.

Regardless of how the Committee’s working group defines chronic conditions, the resulting policies should address severe and persistent mental illness, which have untold implications for the management of other chronic conditions. As the Department of Health and Human Services (HHS) has acknowledged, most chronic care guidelines do not appropriately account for the significant impact that mental health and substance abuse has on disease management.⁶ To oversimplify slightly, an individual whose depression or psychosis is properly managed through a holistic approach regimen of care is far more likely to proactively address other physical conditions such as hypertension or cholesterol. Evidence suggests that inadequately treated behavioral health conditions contribute to poor physical health outcomes.⁷

Therefore, interventions that narrowly focus on a singular condition like diabetes or asthma will have a limited impact, particularly in the Medicaid program. Legislative solutions that seek to realign incentives must recognize that mental health issues serve as a threshold impediment to educating and empowering patients to appropriately manage other conditions. Only interventions that focus on the whole person and are designed to confront the compounding nature of physical, mental and behavioral health factors have the potential to achieve meaningful change in chronic care.

³ U.S. DEPT. OF HEALTH AND HUMAN SERVS., *MULTIPLE CHRONIC CONDITIONS—A STRATEGIC FRAMEWORK: OPTIMUM HEALTH AND QUALITY OF LIFE FOR INDIVIDUALS WITH MULTIPLE CHRONIC CONDITIONS* (2010).

⁴ Rep. Tim Murphy, “Opening Statement Of The Honorable Tim Murphy,” *Energy & Commerce Subcommittee on Health Hearing “Examining H.R. 2646, The Helping Families In Mental Health Crisis Act”* (Jun. 16, 2015), at <http://murphy.house.gov/latest-news/chairman-murphy-statement-hr-2646-sets-the-stage-for-more-reform/>.

⁵ <http://energycommerce.house.gov/hearing/examining-hr-2646-helping-families-mental-health-crisis-act>.

⁶ Rep. Patrick Kennedy, Testimony of Patrick Kennedy, *Energy & Commerce Subcommittee on Health Hearing “Examining H.R. 2646, The Helping Families In Mental Health Crisis Act”* (Jun. 16, 2015), available at <http://energycommerce.house.gov/hearing/examining-hr-2646-helping-families-mental-health-crisis-act> (minute 32 of the webcast).

⁷ Lewis et al., *supra* note 2.

Payment Reform

As part of the working group process, OPDC recommends that Members of the Working Group and the Committee carefully evaluate delivery and payment reforms that integrate medical and behavioral health providers. At the state level, certain Medicaid and multi-payer reforms, such as patient-centered medical homes (PCMHs), have demonstrated real progress in confronting chronic conditions by integrating medical and behavioral health services. As the federal government continues to award billions of dollars each year to states to test and implement alternative payment models, recipients should be encouraged to adopt features that have a proven track record, such as the integration of providers and services.

With mental illness, in particular, integration of providers and services is key for patients to sustain their course of treatment and maintain progress in their health status. Similarly, medication adherence interventions help assure that patients are appropriately managing chronic conditions by taking maintenance medications as prescribed. Given the proven track record of medication adherence, we believe these services should be widely available to patients and that quality measurements should assess both providers and plans for their proper utilization.

In the Medicare context, accountable care organizations (ACOs) should strive to integrate covered medical and behavioral health services. Based on comprehensive assessments and survey data, only 14 percent of ACOs have complete or nearly complete integration of behavioral and primary care services while more than 40 percent have little to no integration.⁸ Policymakers should carefully evaluate this data to discern the specific impact on those with chronic health care needs. If not an outright requirement of the Medicare Shared Savings Program, ACO performance measures should assess the degree of integration from both a structural and patient experience standpoint. Measures should also be strengthened to ensure not only that ACOs are generating savings, but that they are providing full access to needed treatments for individuals with mental health needs and other chronic conditions.

Care Transitions

As the Committee's letter recognizes, a central objective of chronic care policy must be the improvement of care transitions, which often expose the highly fragmented nature of our health care system. Individuals with serious mental illness are particularly vulnerable to poor transitions from a controlled inpatient setting, where they are often on medications to the home or community, where services and medications may be disrupted. Institutional providers, which are punished for costly hospital readmissions, should also be empowered to help patients manage their health after discharge through reimbursement for follow-up by discharge planners and interfacing with case managers and others in the community.

Our company has worked with provider partners to test programs that closely monitor psychiatric discharges to ensure individuals have needed coordination and timely services. We believe this program has applications beyond its existing context and would be pleased to share the preliminary findings of this initiative with the working group. An important first step for the Medicare program, however, is to augment the current set of quality measures that evaluate Medicare Advantage plan performance to assess care transitions for individuals with chronic illnesses.

Given the established link between mental illness and other chronic conditions, all inpatient admissions for a primary diagnosis that is chronic in nature should feature a mental health screening prior to discharge. Such screenings would not only ensure that mental health needs are being addressed, but that physical health conditions will not be exacerbated by an underlying mental health issue. These screenings would add little to no cost in the inpatient setting, but could prevent significant complications and readmissions from occurring. The Agency for Healthcare Research and Quality's (AHRQ's) hospital discharge protocol recommends that all patients be given a risk-assessment tool to assess social and behavioral needs, including housing, food

⁸ Lewis et al., *supra* note 2.

security, substance use, and mental health.⁹ However, federal health care programs do not uniformly require such assessments for patients admitted with a diagnoses unrelated to mental health. If Medicare were to pilot a screening program, we are confident that readmissions for the same chronic conditions would be reduced.

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On behalf of OPDC, I appreciate the opportunity to submit our comments to the working group on chronic care and I would be pleased to pursue further discussions with you about our recommendations if that would be helpful.

Sincerely,



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⁹ See AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, HOSPITAL GUIDE TO REDUCING MEDICAID READMISSIONS § 6 (2014).