



June 22, 2015

The Honorable Orrin Hatch
Senate Finance Committee
Washington, DC 20510

The Honorable Ron Wyden
Senate Finance Committee
Washington, DC 20510

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

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

Dear Senators:

Third Way commends the United States Senate Committee on Finance for taking the initiative to improve chronic care, and we are grateful for the opportunity to provide recommendations at your request. As the Committee's call for recommendations highlights, chronic disease presents an extraordinary and growing challenge to the health of Americans, the future of Medicare, and the federal budget. Chronic diseases cause 7 of 10 deaths each year¹ and account for 86% of all health care spending.² Nearly half of Medicare spending goes to beneficiaries with six or more chronic diseases.³ And it is projected to get worse—the number of people with a chronic condition will grow from 149 million in 2015 to 171 million in 2030—nearly half of the U.S. population.⁴

People with chronic diseases face many obstacles in health care that prevent them from getting the care that they want and need. When that care is not available—or too difficult to get—it leads to wasteful care, from preventable hospital trips to duplicative diagnostic tests. But when people have their chronic conditions under control, they need less care. Removing obstacles to high quality care would help people with chronic conditions get better care, be more satisfied with their health care, and cut down on the waste in the system. By cutting down on waste, we estimate a total federal savings of \$135 billion over ten years, simply by improving patient formed decisions about all the plans av

We encourage the Committee to examine our policy recommendations, detailed below, which cover three areas:

1. Engaging Patients as Partners in their Care
2. Improving Access to High Quality Care
3. Preventing Chronic Disease

Under each area, we offer examples of what patients need, specific policy proposals, and potential fiscal impact. This agenda is drawn from a series of Third Way proposals that cut waste in health care by removing obstacles to quality patient care. They directly improve the patient experience and come from innovative, evidence-based ideas pioneered by health care professionals and organizations, and show how to scale successful pilots from red and blue states. On our website, <http://thirdway.org/issue/health-care>, we feature hundreds of these

local examples across our recommended policy proposals. Together, they make cutting waste a policy agenda instead of a mere slogan.

Thank you for your consideration.



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1. Engaging Patients as Partners in their Care

Policy areas: medical discussion guides, electronic health records, drug therapy support programs, and dual eligible beneficiaries

The beginning, middle, and end of the health care experience should be about the person with a chronic disease. The care they receive should fit their goals and preferences, support their ability to care for themselves, and have no gaps in their coverage as they see multiple health professionals. Policymakers need to provide the tools and support so patients can be full partners in their care:

- Medical discussion guides (also known as decision aids) can help individuals discover and discuss their preferences with their doctors;
- Electronic health records to document individuals' goals and care across all of their providers to prevent gaps in their care;
- Payments to providers that support personalized strategies to increase adherence to medication regimens; and
- A single source of coverage for older and disabled Americans that takes care of all of their health care and long-term care needs.

Policymakers can do all of this while streamlining health care in ways that improve the patient's experience so no resources are wasted on unneeded care, which means the taxpayer saves money without sacrificing care.

Medical Discussion Guides: Empower Patients, Promote Engagement with Providers

Improving the patient's experience: Fran learned about options for treating her chronic low back pain, from which she has suffered for more than 20 years, through a process her physician at Stillwater Medical Group uses to engage patients in Minnesota's St. Croix Valley and western Wisconsin.⁵ The practice uses medical discussion guides to help patients make a wide range of decisions surrounding preference-sensitive care, such as whether to get a pacemaker for heart failure, whether to get an insulin pump for diabetes, and more. "Having the shared decision-making as a tool, it's empowering because you are in control," Fran says. When patients are informed, empowered, and engaged, they often choose less expensive treatment that better reflects their preferences.

Policy recommendation: Medical discussion guides should be standard medical practice because they empower patients to take a meaningful role in managing their health and promote engagement with providers.⁶ Congress can encourage use of shared decision-making with the following steps:

- Define shared decision-making in statute and clarify the statutory definition of a patient decision aid;
- Establish standards and a certification process for discussion guides;
- Establish quality measures to verify use of discussion guides and shared decision-making, and require Medicare participating providers and health plans to report on them;
- Incentivize providers to offer discussion guides and engage in shared decision-making as a routine step in receiving Medicare payments, or establish a Medicare payment to providers for a follow-up counseling visit after a patient with a preference-sensitive condition has viewed a patient decision aid; and
- Engage health professionals by expanding the existing statutory reference to provider education about discussion guides to include reference to medical school and continuing medical education curricula.

Potential savings: Based on econometric modeling by Avalere and the Actuarial Research Corporation, we estimate that federal budgetary savings from this proposal will be \$11.3 billion over 10 years, with an additional \$5.6 billion in savings to states and the private sector.⁷ Savings result from the use of discussion guides for four conditions with proven savings potential: lower back pain, coronary heart disease, breast cancer, and hip and knee osteoarthritis.

Electronic Health Records: A Lifetime Electronic Health Record to Guide and Coordinate Care

Improving the patient's experience: Five-year old Jenny Jones, a patient at Texas Children's Hospital in Houston, had three visits in six months to the ER for uncontrolled asthma.⁸ At first, the hospital staff blamed Jenny's mother for not following the treatment plan they'd given her. But then they discovered she was confused because six different physicians had given Jenny six different treatment plans. That kind of problem led Texas Children's Hospital to create a complete record from multiple sources to give clinicians a clear view of all the recommended treatments and medications so that they could all get on the same page.

Policy recommendation: Eleven years after President George W. Bush set a national goal for all Americans to have an electronic health record by 2014, almost no patients in the U.S. have a complete electronic record. Instead, while more records than ever are stored in the computer systems of individual hospitals and doctors' offices, no one has the clear responsibility for assembling all the information about each patient in a complete package and making it available when needed. Providing all Americans with a complete, lifetime health record—compiled from individual systems and available 24/7—would improve the patient experience and help ensure that patients with chronic diseases get optimal care whenever and wherever they need it.

The federal government should pay health information exchanges for the creation of a longitudinal record for each Medicare beneficiary and through other federal programs.⁹ The record would come from either a centralized or decentralized model.

A *centralized* model is sometimes called a health record bank, which is “a private, independent organization that provides a secure electronic repository for storing and maintaining an individual’s lifetime health and medical records from multiple sources and assuring that the individual always has control over who can access their information.”¹⁰ It is like a checking account at a local bank: various entities can make deposits into your account once you give them permission—from your job depositing your paycheck to the federal government depositing your tax refund. And you can access your account anywhere—from online to at a nearby ATM—since the entire system is on a common platform and linked together. The estimated costs of geographically-based health record banks are about \$8 per year/per account/per person for large group of subscribers. A *decentralized* health information exchange, which assembles records from multiple sources for transmission, but without storing a copy, would also qualify for funding as long as it provided patients with a complete health record.

In both models, providers and plans would still retain (and use) the original records they generate, and the exchanges would assemble and transmit a complete and unaltered copy of the patient's medical records, including diagnoses, treatment history, test results, allergies, and prescriptions. The records would also show each patient’s goals for their care so that providers could clearly tell patients how their care will help them achieve those goals. Making explicit goals is particularly important for people with chronic diseases who face tough choices when it comes to the way they must manage their diseases.

Potential savings: Based on econometric modeling by the Actuarial Research Corporation, we estimate that an investment in a fully implemented system for complete, longitudinal health records would save the federal government \$42.6 billion over ten years by eliminating wasteful, unnecessary care.¹¹

Drug Therapy Support Programs: Effective Use of Prescription Drugs to Prevent Expensive Care

Improving the patient’s experience: Judy, a working mom with Type II diabetes and high cholesterol, struggles with taking her medications, putting her at high risk of poor health outcomes and hospitalization.¹² Judy’s pharmacist intervened with a program that synchronized her refill schedule, calls when she forgets to pick up her medications, and utilizes a pill bottle with sensors that triggers a text message to Judy when she doesn’t open the bottle on time.

Policy recommendation: Innovative providers and payers across the country are using drug therapy support programs to help people like Judy, targeting specific obstacles to medication adherence for individual patients while accepting accountability for improving outcomes and saving money. Congress can improve and advance drug therapy support through the following steps:

- Require the Centers for Medicare & Medicaid Services to establish high-priority criteria for adherence improvement efforts;
- Establish a method for determining who is taking responsibility for helping each patient with adherence (i.e. physician or pharmacist);
- Provide a performance-based payment to providers willing to deliver drug therapy support services;
- Expand the role of pharmacists through payment policy for drug adherence and through prescribing agreements with physicians;
- Improve Medicare’s medication therapy management program with better criteria for targeting services; and
- Continue to improve and expand the use of adherence quality measures to encourage more effective drug therapy support programs.

Potential savings: Based on econometric modeling by Avalere and the Actuarial Research Corporation, we estimate that the federal savings would be \$5.3 billion over 10 years.

Dual Eligible Beneficiaries: Coordinate Care for the Most Vulnerable with Chronic Illnesses

Improving the patient’s experience: After having four heart attacks in four years, M.C. Kim tried to enter a cardiac rehabilitation program that would teach him how to reduce his chances for another heart attack.¹³ Instead of covering the program, Kim’s Medicare office told him to call Medicaid while his Medicaid office told him to call Medicare—and both denied coverage. Better care coordination might have covered Kim’s cardiac rehabilitation and prevented some of his 20 trips to the emergency room over a 6-year period.

Policy recommendation: Congress should adopt policies to coordinate care and integrate coverage for dual eligible beneficiaries and align Medicare and Medicaid financing so that just one program takes responsibility for coordinating an individual’s care. This can be done by taking the following steps:

- Focus first on full benefit dual eligible beneficiaries. Later, expand to partial duals.
- Require that every dual eligible beneficiary be covered by a public or private care coordination program that integrates financing sources. One example of a care coordination model is the Better Care Programs (BCPs) envisioned under Senator Ron Wyden’s Better Care, Lower Cost Act.¹⁴
- Begin with a voluntary open enrollment period. Use automatic enrollment into the highest quality, lowest cost option only in states with multiple care coordination options and only for beneficiaries who do not choose a plan.
- Give states the option to assume full responsibility for coordinating care for duals as many states are already doing under demonstration programs and to receive a payment from the federal government for the Medicare portion of their care. If a state does not elect to do so, the federal government would take responsibility through Sen. Wyden’s Better Care Program.
- Share with states that accept responsibility for care coordination a portion of the Medicare savings their efforts generate.

- Experiment with giving beneficiaries who are in the most costly 10% of all Medicare beneficiaries additional benefits like care coordination and lower out-of-pockets cost when such services are not available through other types of Medicare plans like Special Need Plans. The payment for such services could go to a physician group or high quality health plan, would be adjusted for more challenging patients, and would be based on projected savings from avoiding a portion of the high-cost care.

Potential savings: Based on econometric modeling by Avalere and the Actuarial Research Corporation, we estimate that the federal savings from this proposal would be \$38.9 billion over ten years due to eliminating duplicative services and filling in gaps in routine care that can prevent more expensive care down the road for people with chronic diseases and disabilities.

2. Improving Access to High Quality Care

Policy areas: behavioral health care and telehealth

Access to high quality care is not a given for many people with chronic diseases. People with behavioral health conditions that range from depression to severe mental illness often receive too little care too late. People in rural or urban areas with too few providers for basic care end up getting regular care through the emergency room for avoidable or preventable problems. Improving behavioral health care and deploying telehealth care improves access while removing obstacles to higher quality care.

Behavioral Health Care: Improve Behavioral Health Care for Individuals with Chronic Illnesses through Alternative Payment Models

Improving the patient's experience: R.A., a 58-year-old man diagnosed with Type 2 diabetes four years ago, visited his primary care physician for a diabetes check-up.¹⁵ Six months before the visit, R.A. began having trouble falling and staying asleep and felt tired most of the time. He became less active, stopped exercising, gained 12 pounds, and lost interest in things he used to enjoy. He denied feeling sad or depressed, but he had trouble concentrating at work, frequently forgot things, and often felt irritable, impatient, and frustrated. Fortunately, R.A.'s primary care physician understands that depression without sadness, called nondysphoric depression, occurs more often in patients with medical illnesses, and diagnosed the condition and recommended treatment.

Policy recommendation: Patients with chronic conditions, such as diabetes, are at least twice as likely to suffer from depression.¹⁶ In fact, 33% of people living with diabetes experience depressive symptoms severe enough to necessitate treatment.¹⁷ Policymakers can improve the integration of high quality behavioral health care with medical care through two steps:

- Ensure coordination between medical health and behavioral health care using the Patient Centered Medical Home and bundled payments; and
- Use accountable care organizations and managed care organizations to create accountability for integrating behavioral health and medical care.

Potential savings: Based on econometric modeling by the Actuarial Research Corporation, we estimate that the federal savings from this proposal would be \$40 billion over 10 years, with greater savings of \$207 billion possible in private health spending, due to the higher prevalence of untreated mental health problems among the nonelderly.

Telehealth: Make Telehealth an Easy Way for Patients to Get Care

Improving the patient's experience: Richard Setzenfand's physicians know his weight, blood pressure, pulse, and blood oxygenation level before the Pittsburgh man leaves his house each morning.¹⁸ Medical devices in Mr. Setzenfand's home wirelessly send health information to his physicians, who were able to adjust doses of two blood-pressure drugs without an office visit. This telehealth technology was able to reduce heart failure readmissions at the University of Pittsburgh Medical Center by nearly half.

Policy recommendation: Complications from chronic disease don't restrict themselves to regular office hours, so why should health care? Use of telemedicine in chronic disease management can involve patients in their care, offer continuous monitoring by providers, and quickly identify and respond to complications or exacerbations.¹⁹ But regulatory and payment barriers that haven't caught up to new technologies and payment methods impede the widespread adoption of telehealth services. Policymakers can change this by taking the following actions:²⁰

- Modernize Medicare and Medicaid payment policy for telehealth to allow for payment to health care professionals for care by real-time video, audio, secure chat or email, or computer-assisted communication from any location to any other location.
- Authorize use of telehealth for populations served under value-based payments to accelerate the adoption of technologies and programs that engage patients in their care and avoid intensive, often costly, services.

Potential savings: A growing body of evidence finds cost savings from the use of telehealth programs that move care to more appropriate and lower cost settings, especially for patients with chronic conditions.²¹ To cite just one example, Medicare's Health Buddy program, which uses telehealth to facilitate data exchange between patient at home and their providers demonstrated savings of 8-13% per beneficiary per quarter.

3. Preventing Chronic Disease

Policy areas: diabetes prevention and Medicare quality transparency

The best way to improve chronic care in America is to eliminate the need for it through prevention. Numerous strategies are possible, and we focus below on two that have proven to be effective: preventing diabetes and letting health plans get credit for their success in preventing disease.

Diabetes Prevention

Improving the patient's experience: At a regular check-up, David's Minneapolis-area physician told him his blood sugar was in the prediabetic range and he was at risk for Type 2 diabetes.²² Alarmed, David, who had watched his mother-in-law and friends struggle with diabetes, enrolled in a diabetes prevention program at his local Y. The program offered healthy diet and exercise tips that helped David lose weight and significantly reduce his risk of developing diabetes.

Policy recommendation: David's story illustrates how our health care system should operate, but too many obstacles now impede adequate diabetes screening and prevention. Type 2 diabetes is largely preventable, and effective programs exist to help at-risk individuals change their lifestyle to delay or avoid a diagnosis. Policymakers can ensure these diabetes prevention programs are available to patients who will benefit through the following steps:²³

- Provide Medicare payment for prediabetes programs so providers can help patients prevent diabetes through screening and referrals. Under this, providers can give patients with prediabetes a referral to a prevention program; and
- Require Medicare and all other public and private health plans to measure and report success with diabetes prevention.
- Launch additional initiatives to prevent diabetes through obesity treatments that are currently not covered under Medicare like prescription drugs for weight loss.

Potential savings: Based on econometric modeling by Avalere and the Actuarial Research Corporation, we estimate that this diabetes prevention proposal would reduce federal spending by \$8.2 billion over 10 years.²⁴

Medicare Quality Transparency: Give Medicare Beneficiaries Complete Information about their Plans

Improving the patient's experience: Like millions of Americans, Mary is worried about managing her Type 2 diabetes—particularly about controlling her cholesterol and lowering her risk of coronary artery disease.²⁵ But she cannot find reliable information on how well her current doctors, who are in original, fee-for-service Medicare, are helping patients just like her. Medicare doesn't track these quality measures or provide consumers effective information. If original Medicare was required to provide the same consumer friendly, comparative quality information as Medicare Advantage, Mary could make informed decisions about all the plans available to her, so she could pick the right coverage for her and her health.

Policy recommendation: Information about Medicare's performance in preventing chronic disease will help both beneficiaries in choosing a plan and assist policymakers and public health experts in developing new prevention strategies and in making existing efforts more effective. Policymakers can make the two main parts of Medicare—original Medicare with its supplemental coverage as well as Medicare Advantage—comparable for consumers and informative for chronic disease prevention efforts by taking the following steps:

- Improve Medicare Advantage quality measurements by using population-based outcomes measures within a geographic area. This can be done by properly accounting for plans serving a higher number of dual eligibles and by using a more strategic and stable approach to changing star ratings. Another improvement would be to add quality measures about whether providers are recording patient’s goals for their chronic care and are effectively explaining how their care will help them with their life goals.
- Review the process for adjusting payments to plans in Medicare Advantage based on their members’ conditions, which is called risk adjustment. Just as it is important to account for variations in the populations served by health plans in quality measures so they have an incentive to seek out and serve people who have greater challenges with their health and health care, it is equally important to ensure payments to plans are adjusted based on their members’ conditions. For example, a recent proposal by the Centers for Medicare and Medicaid Services to stop adjusting Medicare Advantage payments for chronic kidney disease would undermine the incentive for plans to diagnosis and treat that disease. Congress needs to ensure effective risk adjustment for all chronic conditions so that health plans have the right incentives to treat people with chronic conditions and be held accountable for the results through reporting of quality measures.
- Apply the same quality measures from Medicare Advantage to original Medicare, so that original Medicare receives a star rating (within a geographic area) which is displayed for beneficiaries in Medicare’s Plan Finder, alongside Medicare Advantage plan choices and star ratings.
- Overhaul Plan Finder to provide accessible cost and quality information to inform beneficiary enrollment decisions. Plan Finder should include original Medicare’s new star rating and permit beneficiaries to view their total cost of care on one screen whenever possible.
- Make it easier for beneficiaries to act upon their choices once they find their preferred plan on Plan Finder but providing online enrollment in Medigap plans.

Potential savings: Although this proposal will not directly produce savings, it provides the basis for doing more to encourage beneficiaries to enroll in a high quality health plan—whether it is public or private—that saves money by improving care for people with chronic conditions, which renders much expensive care unnecessary.

ENDNOTES

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