

June 22, 2015

VIA ELECTRONIC SUBMISSION TO: chronic_care@finance.senate.gov

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Johnny Isakson
Senator
Committee on Finance
United States Senate

The Honorable Mark Warner
Senator
Committee on Finance
United States Senate

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

On behalf of the nation's 2700 YMCAs serving 10,000 communities, the YMCA of the USA applauds the Senate Finance Committee for its commitment to address the challenges posed by Medicare beneficiaries suffering from chronic conditions by creating the chronic care reform working group. As a leading nonprofit dedicated to strengthening community through youth development, healthy living and social responsibility, we appreciate the opportunity to suggest policy strategies that will help address the growing burden of chronic disease care.

Two-thirds of the \$2 trillion spent annually on health care in the United States goes towards the treatment of diseases that are largely preventable. As a nation, we spend far more on health care than any other developed country in the world, and yet our mortality rate is not keeping pace with many other nations due, in part, to the minimal investment in prevention in the United States. In fact, the U.S. investment in disease prevention is less than five cents per health care dollar – with over 90 percent of health care funding going toward treating people once they are sick – driving up human and economic costs. In addition, clinical care is responsible for only 20 percent of health outcomes.

The vast majority of the health care and health care reform conversation has focused on the clinical setting (specifically, access and quality); yet the 80 percent of health factors that occur outside the clinical setting (such as health behaviors, social and economic factors, and the physical environment) have not been adequately addressed and are often ignored in these discussions. But recent shifts in policy and the business operations of health care systems reflect a transition towards increased valuation of population health, with a focus on achieving improved health care outcomes, improved quality of care, and reduced costs of care.

The importance of prevention and control of chronic disease cannot be underestimated. The conditions we are aiming to prevent and control are often gateway diseases to other chronic conditions. For example, those at most risk for developing diabetes (those with prediabetes) are often also at risk for developing hypertension and cardiovascular disease. Currently, half of all Medicare beneficiaries have prediabetes. Likewise, heart disease, diabetes and obesity are common comorbidities for people living with arthritis. The control of arthritis, the **nation's most common cause of disability**, can also mean the control of its comorbidities.

With these factors in mind, YMCA of the USA suggests that policymakers seriously consider policy recommendations that substantively involve the settings where Americans spend the vast majority of their time – their neighborhoods and communities.

Recommendation: *Advance incentivizes for individuals to participate in evidence-based programs to prevent and control chronic disease, including reimbursement and limits on copays and deductibles for such services.*

Through our experience across the country, we know that evidence- and community-based programs are instrumental in ensuring that older Americans receive the attention they need while also routinely reducing health care costs. For most of the past decade, the Y has led efforts to scale evidence-based programs that have been shown to reduce risks for—or complications of—chronic diseases. Most of these programs are aimed at affecting individuals by changing specific health behaviors in a safe, accessible and affordable group setting. Such Y programs that are being **brought to scale, include the YMCA’s Diabetes Prevention Program, Enhance®Fitness (arthritis self-management), Tai Chi: Moving for Better Balance (falls prevention for older adults), and LIVESTRONG at the YMCA (cancer survivorship physical health).** More are in the program development pipeline, such as a blood-pressure self-monitoring program, a childhood obesity intervention, programs for **people with Parkinson’s disease, and a program for people with** early signs of cognitive decline (dementia). A common element in these proven programs is to build upon and leverage the peer support inherent in a group setting.

There is a large portfolio of programs that are evidence-based and have been shown to produce cost-effective and transformational outcomes. However, these programs are under-utilized. In order to make these types of evidence-based programs feasible and sustainable, employers, insurers and payers (public and private) can support individuals and families by incentivizing participation in evidence-based programs, by providing reimbursements to program providers, and reducing or limiting copays and deductibles to patients. For the nation to receive the full benefit of its investment in the (often federally funded) research that has gone into developing and scaling these proven interventions, it is imperative that programs can accept referrals from health care providers and can eventually be reimbursed by third-party payers.

Recommendation: *Incentivize physicians to refer eligible Medicare beneficiaries to evidence-based programs.*

Across the United States, the American Medical Association (AMA) is encouraging physicians **to screen patients for prediabetes and refer eligible patients to participate in the YMCA’s Diabetes Prevention Program.** The AMA recognizes that by educating physicians about local resources and programs and encouraging prediabetes screening, physicians can help reduce the burden of the diabetes and hypertension epidemics.

In order for similar work to take hold in communities across the country, care systems, such as Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMHs) and Federally Qualified Health Centers (FQHCs), need to be educated and encouraged to find ways to partner with community-based organizations and individuals (such as community health workers or patient navigators) that already have the **community’s trust and know** how to navigate in the community. By including community-based organizations and community health workers in the medical home, systems like ACOs, PCMHs, and FQHCs will deepen their impact in the prevention and control of chronic disease, while also reducing health care costs. Medicare should also incentivize physicians through a referral fee for connecting eligible beneficiaries to proven prevention and care community programs.

Recommendation: *Incentivize all qualified providers to deliver evidence-based programs.*

In its 2012 [recommendation](#), the U.S. Preventive Services Task Force (USPSTF) recommended that patients with a BMI of 30 or higher should be able to receive intensive behavioral therapy (IBT) for weight management. The recommendation noted that IBT may be impractical within many primary care settings, so patients may be referred from primary care to community-based programs for these interventions. However, today while Medicare covers IBT for beneficiaries meeting the criteria, it only reimburses clinicians for the delivery of IBT. Medicare can reduce the prevalence of obesity, and its complications, by ensuring that all qualified providers (including community-based providers of evidence-based programs, nutritionists, etc.), and not just clinicians, are reimbursed for IBT. The Treat and Reduce Obesity Act of 2015 (S. 1509/H.R. 1509) could ensure that qualified providers are reimbursed for IBT and evidence-based, community-based lifestyle health programs.

Recommendation: *Prevent or delay diabetes among at-risk Medicare beneficiaries to decrease the human and economic tolls of diabetes.*

People at high-risk for diabetes need access to preventive services. Programs like the **YMCA's** Diabetes Prevention Program, which is recognized by the Centers for Disease Control and Prevention as part of the National Diabetes Prevention Program (NDPP), is an evidence-based lifestyle intervention which helps people with prediabetes reduce their risk of developing type 2 diabetes. In a randomized clinical trial funded by the National Institutes of Health and reported in the *New England Journal of Medicine* in 2002, NDPP was shown to reduce the risk of adults with prediabetes developing diabetes by 58 percent. Medicare-aged adults (60 years and older) with prediabetes were able to reduce their risk by 71 percent. Follow-up research has confirmed that these outcomes last for at least a decade after participating in the program and the program can be offered successfully and produce a cost-savings when delivered in group settings at YMCAs and other community-based locations.

While employers, insurers and states are increasingly providing coverage for the **YMCA's** DPP and other NDPP-recognized programs, access to these program must be more broadly available, especially to the Medicare population. CMS should provide Medicare coverage for the NDPP for Medicare beneficiaries with prediabetes. Current legislation, the Medicare Diabetes Prevention Act of 2015 (S. 1131/H.R. 2102), would make this recommendation into a reality. In a recent CBO-like study, Avalere Health found that this legislation could reduce federal spending by \$1.3 billion over 10 years. Savings from preventing diabetes would likely continue to increase beyond 10 years, suggestion an even greater reduction in long-term federal spending. In 2014, the Community Preventive Services Task Force recommended lifestyle interventions modeled on the DPP as effective and cost effective.

Recommendation: *Include community-based organizations (CBOs) as part of the expanded team-based care model, including access to electronic medical records (EMRs).*

As the U.S. health care system continues to evolve, it is valuable to consider ways that health care providers and community-based organizations (CBOs) can be integrated in deeper and more intentional ways to address the broad array of factors impacting health outcomes. CBOs have great potential as partners in bridging the gap between the community and clinical setting by identifying the underlying reasons why so many individuals in a community are disconnected from quality care, and filling gaps with a variety of resources (human, technical, financial, etc.) that can advance a culture of health in our communities and bring value to the health care sector which cannot address socio-cultural problems by itself.

In an expanded team-based care model, CBOs can help beneficiaries navigate community environments while also implementing practical and evidence-based solutions, and saving lives and health care dollars. A diverse set of partners working outside the formal clinical setting should be considered as necessary collaborators with traditional health care providers to improve health outcomes and achieve desired cultural and business shifts towards achieving greater value for health- over disease-based care.

In order to best deliver patient outcomes and continuity of care, electronic medical records should be available to the entire care coordination team, including CBOs, as long as all partners are HIPAA compliant.

Recommendation: *Dedicate resources to community prevention, care management and control strategies.*

Strategies that encourage valuable community change, which in turn lead to improved health outcomes, should be uplifted and prioritized. It is essential that more money and resources in the health system are directed to community prevention, care management and control strategies. Community Health Workers (CHWs) often address the social and economic factors leading to poor health outcomes and tend to be from the community they serve. Many states are advancing legislation for accreditation and integrating CHWs into the health systems. CHWs can be instrumental in creating sustainable and long-term community change by building meaningful and deeper partnerships with nurse practitioners, care coordinators, mental health professionals, social workers, primary care physicians and other allied health and health professionals. CHWs serve to build trust between community and clinic staff and can ensure that community concerns are relevant in the local health care and clinical systems. CHWs can also be trained to be health coaches in order to offer EBPs while also providing culturally-competent psychosocial peer support.

In summary, the YMCA of the USA is hopeful that the workgroup will consider policy recommendations that:

- **Recognize that the majority of factors that affect one's health** outcomes are located in the places where people live (neighborhoods and communities), not health care settings.
- Prioritize strategies that are proven to deliver substantive outcomes, such as evidence-based community programs (like the NDPP).
- Encourage true partnerships between the traditional health care system and community-based organizations so that beneficiaries can have seamless care, including strategies that allow CBOs to use/access EMRs and reimburse community health workers for patient navigation services.

The YMCA of the USA applauds the chronic care reform workgroup on its efforts to find bipartisan policy solutions to those Medicare beneficiaries struggling with multiple chronic conditions. We thank you for your service and your efforts to ensure that Americans are afforded the opportunity to live their healthiest lives.

Sincerely,



Matt Longjohn, MD, MPH
National Health Officer
YMCA of the USA