PARTNERSHIP TO FIGHT CHRONIC DISEASE

January 26, 2016

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

Re: Senate Finance Committee Working Group on Chronic Care Policy Options

Submitted via email to chronic_care@finance.senate.gov

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

The Partnership to Fight Chronic Disease (PFCD) applauds the Senate Finance Committee's continuing efforts to improve the quality of care for people living with chronic conditions. We appreciate the opportunity to review and provide comments on the thorough Policy Options document the Working Group published in December.

PFCD, a non-partisan coalition of hundreds of patient, provider, community, business and labor groups, and health policy experts active at the state, federal, and international level, advocates for policies that work to better prevent and manage the number one cause of death, disability and rising healthcare costs: chronic diseases.

We have organized our response according to the topics covered in the December 2015 Policy Options document.

Advancing Team-Based Care

Several policy options under consideration address particular concerns with specific financing models, including Accountable Care Organizations. We would encourage consideration of incorporating aspects of what is working well in practice, such as

successful multi-payer advanced primary care programs,[1] into existing and new demonstration programs aimed at improving team-based care.

Providing Continued Access to Medicare Advantage Special Needs Plans (SNPs) for Vulnerable Populations

Other than demonstration programs, Medicare Advantage 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 enhance care for chronically ill beneficiaries. Providing greater certainty in the SNPs program by making it permanent would provide the steadiness needed to encourage broader replication of best practices and innovation in care delivery for vulnerable populations.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

Care coordination is critical to delivery system reform, particularly for people living with chronic illness. 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. The 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. Adding a "high-severity" code is further recognition of the efforts needed to assist patients with complex health needs.

Though adding new payment codes to the existing fee-for-service system does not resolve the fundamental structural problem that limits quality improvement and savings generation, they are a good first step to encouraging team-based chronic care management as we seek to transition to new models that encourage greater coordination of care and align incentives accordingly.

If a new high-severity code is added, we encourage consideration of the complexity of the needs of the beneficiary, which may include several criteria such as mental capacity, behavioral health needs, and the number and severity of chronic conditions. In determining both whether to add a new code and its duration, we urge consideration of how that decision affects the transition away from traditional fee-for-service desired for Medicare long term.

Addressing the Need for Behavioral Health among Chronic Ill Beneficiaries

Comorbid medical and behavioral health conditions are the rule rather than the exception. This comorbidity makes treatment of other chronic conditions more challenging and more

[1] See, e.g., C Jones, et al., "Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care," Population Health Management, Sept. 2015.

costly.[2] The high prevalence of comorbidity also makes greater integration of behavioral health services and traditional medical care critically important. A number of integrated health programs are working in communities nationwide that can serve as models for replication. Many evidence-based models are described in searchable databases online to help inform best practices.[3] Although additional research into working models is helpful, it is not clear what a GAO study would add to the information already available to assist in developing policies to facilitate behavioral health integration.

Increasing Convenience for Medicare Advantage Enrollees through Telehealth

Telehealth and remote monitoring can help to identify problems earlier and facilitate interventions before significant complications result leading to reduced readmissions. New technologies facilitate remote monitoring to detect problems early – often before noticeable symptoms – allowing for intervention that prevents more serious, costly complications that continue over time.

Currently, Medicare Advantage plans cannot offer enrollees the option of accessing covered services, e.g., primary care provider office visits, through telehealth technologies as a part of their basic Medicare coverage, rather than as a supplemental benefit. Telehealth also offers significant potential in facilitating access to specialists in areas of shortages, including behavioral health services. Technology that facilitates specialty consultations, virtual visits, and provider education can help bridge the gaps effectively and efficiently.

For example, for stroke victims, immediate access to specialty care can significantly lessen the severity of disability and length of recovery. For rural and underserved areas, however, without telestroke services, access to needed specialty care may require a hospital transfer which carries additional risks. We support expanding the originating site geographic restriction for the narrow purpose of promptly identifying and diagnosing strokes.

Identifying the Chronically Ill Population and Ways to Improve Quality

Ensuring Adequate Payment for Chronically Ill Individuals

Assuring that payments are adequate to cover the care needed for chronically ill Medicare beneficiaries is critically important. We encourage consideration of the interaction of behavioral health conditions with physical health conditions in the costs of care, as research proves that behavioral health comorbidity increases symptom burden, functional impairment, and costs.[4]

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[2] S Goodall, et al., "Mental Disorders and Medical Comorbidity," The Synthesis Project, Robert Woods Johnson Foundation, Policy Brief No. 21, Feb. 2011, http://www.rwjf.org/en/library/research/2011/02/mental-disorders-and-medical-comorbidity.html.

[3] Informative sources include: SAMHSA-HRSA Integrated Center for Integrated Health Solutions, http://www.integration.samhsa.gov/integrated-care-models; National Council for Behavioral Health, Integrated Health Care & Health Homes, http://www.thenationalcouncil.org/areas-of-expertise/integrated-healthcare/; SAMHSA, A Guide to Evidence-Based Practices (EBP), http://www.samhsa.gov/ebp-web-guide.

[4] S Goodall, et al., "Mental Disorders and Medical Comorbidity," Robert Woods Johnson Foundation, Feb 2011.

Developing Quality Measures for Chronic Conditions

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. As we described in our white paper on multiple chronic conditions,[5] there are very 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.

As suggested in the Working Group's Policy Options document, we support requiring that the Centers for Medicare and Medicaid Services include measures that focus on the health outcomes of individuals with chronic disease. Further, we encourage that a special emphasis be placed on identifying and facilitating the development of measures that capture health outcomes for people with multiple chronic conditions. We also support the Working Group's recommending a GAO report on community-level measures on chronic care management to facilitate evaluation.

Empowering Individuals and Caregivers in Care Delivery

Encouraging Beneficiary Use of Chronic Care Management Services

As noted in the Policy Options document, copayments and other out-of-pocket costs can be a deterrent for beneficiaries seeking and utilizing recommended care. We agree that assessing a copayment from beneficiaries for the chronic care management code and the proposed "high severity" code could confuse beneficiaries and present barriers to their appropriate use by providers. We suggest waiving the cost-sharing associated with these services to avoid confusion among beneficiaries as to why they have a copayment for services occurring outside an office visit. It is not clear whether beneficiaries with chronic conditions seek to have chronic care management so much as clinicians, recognizing the need, provide care management. Accordingly, the extent to which waiving copayments would incentivize beneficiaries to seek these services should not be a deciding factor.

Expanding Access to Prediabetes Education

Diabetes is directly linked to obesity and is also associated with diminished quality of life, higher burden of illness, and increased Medicare costs. Providing access to the Diabetes Prevention Program (DPP) to Medicare beneficiaries would go a long way to stemming the growth in diabetes prevalence and in equipping those living with diabetes with the skills needed to manage their health effectively. The Medicare Diabetes Prevention Act of 2015

[5] White paper is accessible online at: http://www.scribd.com/doc/137602733/Needs-Great-Evidence-Lacking-White-Paper

(HR 2102/S 1131) would provide access to the eligible diabetes prevention programs to qualified Medicare beneficiaries.

To promote access, we urge the Working Group to allow and encourage entities currently not defined as "providers" under Medicare statute, to deliver evidence-based, prediabetes prevention programs. Currently, the largest entities currently delivering the DPP, including YMCA of the USA and Omada Health, are not "providers" under Medicare. The CDC allows non-Medicare providers, including nonprofit organizations, health departments, and federally qualified health centers to deliver the DPP, as long as these entities meet CDC's standards for providing DPP. Requiring prediabetes education to be delivered only by Medicare providers would stop these important efforts. An Avalere Health analysis estimated that Medicare's covering the Diabetes Prevention Program could save the federal government $1.3 billion over ten years.[6]

Similar policy changes are needed to assure broader access to Medicare's Diabetes Self-Management Training (DSMT) benefits. Under current law, certified diabetes educators – the main group of health care professionals who provide most of the essential training and education for this service, are not included as covered providers. An American Medical Association (AMA) physician-working group and the National Committee for Quality Assurance (NCQA) have issued recommendations to foster greater adoption of DSMT taught by diabetes educators. The Access to Quality Diabetes Education Act (H.R. 1726/S.1345) would recognize state-licensed or state–registered certified diabetes educators as Medicare providers. When previously scored, CBO estimated the legislation would have an unscorable, de minimis impact on the federal budget.

Allowing referrals and reimbursement for other evidence-based self-management services would go a long way empowering and enabling Medicare patients and caregivers to managing their health. For chronically ill patients, the Stanford Chronic Disease Self-Management Program, Better Choices, Better Health® is a gold-standard program for self-management skill development, which is being reimbursed by a range of payers other than traditional Medicare. This tested model is delivered in community-based settings and online and includes training for chronic disease self-management generally as well as condition-specific training.[7]

Other Policies to Improve Care for the Chronically Ill

Increasing Transparency at CMMI

We commend the Working Group's recognition of the need for greater transparency and opportunities for input on the development of policies and programs considered by the Center for Medicare and Medicaid Innovation (CMMI). We also appreciate the balance

[6] Avalere Health, "Estimated Federal Impact of H.R. 962/S. 452 'The Medicare Diabetes Prevention Act,' http://www.diabetes.org/assets/pdfs/advocacy/estimated-federal-impact-of.pdf, Feb. 2014.
[7] See, Chronic Disease Self-Management Program (Better Choices, Better Health® Workshop, http://patienteducation.stanford.edu/programs/cdsmp.html.

needed between assuring transparency and facilitating the timely development, testing, and evaluation of new models.

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 Medicare population served and set goals for health and financial outcomes achievable within the practical realities of health care practice.

Accordingly, we suggest that CMMI engage in a rulemaking-style public comment period before issuing a Request for Applications for new models. The Request should include a description of and seek input on proposed payment methods, any federal laws waived, quality measures, project duration and reporting of milestones, and benchmarks and measurement of cost savings and health outcomes.

To facilitate needed changes to models during Phase 1 (or, "the preparation phase") of implementation, instead of a formal rulemaking, we suggest posting the changes on the CMMI website to assure that the public is aware of the changes before they are implemented.

Suggested Additional Studies

Medication Synchronization

Reducing barriers to medication adherence holds significant potential to lessen the estimated $105 billion a year poor medication adherence adds to health care costs.[8] People with chronic conditions often rely on multiple medications to maintain their health. With access to medication synchronization, a patient's prescriptions could refill all their chronic care prescriptions at the same time. It removes a barrier to adherence by eliminating the need for separate trips to the pharmacy and can facilitate, if needed, a conversation between the patient and prescriber to discuss the importance of proper adherence.

We support requiring a study to examine current barriers to coordinating prescription refills, best practices used by commercial health plans and pharmacy providers, and the feasibility of medication synchronization programs in Medicare.

Obesity Medicines

Obesity presents a significant and growing cost burden on Medicare. Research shows that people who enter Medicare obese live almost as long as their normal weight peers, but

[8] IMS Institute for Healthcare Informatics, "Avoidable Costs in U.S. Healthcare: The $200 Billion Opportunity from Using Medicines More Responsibly," June 2013. Available online at http://www.imshealth.com/portal/site/imshealth/menuitem.c76283e8bf81e98f53c753c71ad8c22a/?vgnextoid=12531cf4cc75f310VgnVCM10000076192ca2RCRD

suffer a great deal more disability, burden of illness, and associated costs.[9] Today Medicare covers intensive behavioral therapy (IBT) and bariatric surgery for Medicare beneficiaries meeting specific criteria for obesity, but it only reimburses clinicians for IBT and does not cover prescription medicines FDA-approved to treat obesity. The usage of behavioral therapy services and bariatric surgery is low for those who qualify. We support development of a study on the current use and impact of obesity medications as suggested in the Policy Options document.

We appreciate the opportunity to share additional comments on the Working Group's important efforts to improve care for people living with chronic conditions. We stand ready to assist in these ongoing efforts and look forward to continuing the conversation.

Sincerely,

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[9] DN Lakdawalla, DP Goldman, & B Shang,"The Health & Cost Consequences of Obesity among the Future Elderly," Health Affairs web exclusive. 2005; W5:R30-R41. Available online at http://content.healthaffairs.org/content/early/2005/09/26/hlthaff.w5.r30.full.pdf+html