PARTNERSHIP TO FIGHT CHRONIC DISEASE

June 22, 2015

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 Request for information

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 continued interest in improving the quality of care for people living with chronic illnesses and formation of the chronic care working group ("Working Group") focused on Medicare reforms in particular. We look forward to helping identify policy changes that improve outcomes for people living with chronic illness and contribute to bending the cost curve.

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 outline of the Working Group's May 22, 2015 letter with specific comments for each area of inquiry following the general comments below.

The success or failure of these policy changes depends in large part on how the Congressional Budget Office (CBO) evaluates these policies and their potential budgetary impacts. Improving health has wide-ranging effects that extend well-beyond medical costs

and reforms are needed to assure that scores reflect the overall benefits as well as the costs involved to enable more informed decision-making.

Addressing Multiple Chronic Conditions

We appreciate 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 fact, the majority of people with Medicare have five or more chronic conditions, including many dealing with cognitive limitations and behavioral health comorbidities that must be considered.

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[1], 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.

Seizing Prevention Opportunities

We must not forget the need to capitalize on opportunities to prevent the development of chronic conditions, whether it's the onset of one condition or one more, as costs and complexity of care increase exponentially with the addition of each new chronic condition. The obesity epidemic is the source of growth for many of these issues and more needs to be done both in prevention and treatment to reverse its growing prevalence within Medicare. Research shows that people who enter Medicare obese live almost as long as their normal weight peers, but suffer a great deal more disability, burden of illness, and associated costs.[2]

In 2012, the U.S. Preventative Services Task Force (USPSTF) recommended that patients with a BMI of 30 or higher should be able to receive intensive behavioral therapy (IBT). The recommendation noted that IBT might be impractical within many primary care settings, so patients may be referred from primary care to community-based programs. Today Medicare covers intensive behavioral therapy and bariatric surgery for Medicare beneficiaries meeting specific criteria for obesity, but it only reimburses clinicians for the delivery of IBT and does not cover prescription medicines approved to treat obesity. The usage of behavioral therapy services and bariatric surgery is low for those who qualify. Highlighting the need for additional treatment options and education for providers and

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

[2] DN Lakdawlla, 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

beneficiaries, the lack of uptake of IBT also argues for other qualified providers (nutritionists, community-based providers of evidence-based programs, etc.), not just clinicians, be reimbursed for such services.

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 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 (HR 2102/S 1131) would provide access to the eligible diabetes prevention programs to qualified Medicare beneficiaries. Also, Access to Quality Diabetes Education Act of 2015 (HR 1726/S 1345) would improve access to and understanding of the benefits diabetes self-management training in Medicare.

Supporting Three Main Bipartisan Goals

The 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.

We commend these criteria for evaluating policy changes and offer the following comments.

Increasing Care Coordination

Care coordination is critical to delivery system reform, particularly for people living with chronic illness. Finding new finance mechanism 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, we encourage consideration of the Wagner chronic care model and consider policies that not only focus on the provider community, but also include the patient and caregiver in the care team to garner the greatest benefit from care coordination efforts. It's 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 housing, 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.

Each of these benefits has favorable economic benefits, none of which are currently captured within current scoring methodology. Also, the benefits of 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;

Outside 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 should inform policy development. As

noted in *Health Affairs*, pivotal features of "medical home runs"[3] that generated significant results for chronically ill patients include:

> "(1) An exceptional form of individualized caring tailored to preventing ED use and unplanned hospitalization for chronic illness; (2) efficient service provision; and (3) careful selection of, and coordination with, medical specialists."

Two of the four primary care sites recognized for delivering exceptional care and lower costs were Medicare Advantage special needs plans (CareMore and Leon Medical Centers) that specialize in care for chronically ill patients. An emphasis on primary care and the ability to tailor services to meet the needs of their chronically ill patients were critical to their success. Medicare Advantage 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. Caution is needed 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 Medicare population served and set goals for health and financial outcomes achievable within the practical realities of medical practice.

Just as chronic diseases take time to develop, the investments needed to reduce their prevalence will take time to materialize. While there are low-hanging fruit that can yield short-term results – managing care transitions, addressing "hot spots", and boosting

[3] A Milstein and E Gilbertson, "American Medical Home Runs." Health Affairs 28(5); 2009:1317-1326. Available online at http://content.healthaffairs.org/content/28/5/1317.abstract.

medication adherence and self-management, for example – we are likely to see a lull in the savings generating between waste reduction and efficiency gains and when the benefits from longer-term investments in prevention and chronic disease management bear fruit.

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

Today, with traditional 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 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, but 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. For example, a nursing home's efforts to reduce hospitalizations for a dually eligible beneficiary are laudable, but since Medicare pays the nursing home after a hospitalization and pays more than Medicaid does, the nursing home actually has a financial disincentive to avoiding the hospitalization. Reforms must recognize these inherent conflicts.

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

The Part D drug benefit has been an important addition to the Medicare program since 2006, improving access to medicines and reducing costs for beneficiaries who participate in the program. There is also a large body of research recognizing the important role that medicines play in keeping patients out of the hospital and emergency room, which helps reduce health care costs overall. While much progress has been made in Part D so far, there is significant potential to increase the benefit of prescription drugs and lower costs overall through policies that promote medication adherence and self-management. In practice, more than one in five new prescriptions go unfilled,[4] and two-thirds of patients do not adhere to their prescription medicines.[5] As many as two out of three medication-related U.S. hospital admissions[6] and 125,000 deaths a year are a direct result of poor medication

[4] MA Fischer, NK Choudhry, "Trouble Getting Started: Predictors of Primary Medication Nonadherence." Am. J. of Med., 2011 November; 124(11): 1081.e9 – 1081.e22; See also, MA Fischer, MR Stedman, J Lii, et al. "Primary Medication Non-Adherence: Analysis of 195,930 Electronic Prescriptions." J. Gen. Intern. Med., 2010 April; 25(4): 284–290.
[5] Greenberg Quinlan Rosner Research. "Medication Adherence: A survey of adults nationwide." Apr 2013.
[6] J Osterberg & T Blaschke, "Adherence to Medication," New Engl. J. Med., 2005;353(5):487-497.

adherence.[7] IMS Institute estimated that improving use of medicines could save $213 billion annually, of which $105 billion would be from improved adherence.[8]

Stand-alone Part D plans currently have less incentive to improve medication adherence among their members than Medicare Advantage Part D plans since stand-alone plans only see the costs of added utilization of medicines and not the offsets in other health care services that follow 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.

Additionally, the efficacy of the MTM program in improving adherence is limited because it focuses primarily on Comprehensive Medication Reviews (CMRs) for beneficiaries and not interventions that aim to improve adherence and/or identify omissions in care. Congress should direct the Secretary to test innovative interventions that may improve adherence, such as medication synchronization. This approach seeks to improve adherence and patient outcomes by synchronizing medication refills for patients on complex regimens to be processed for pick up at the same time. This process also offers an opportunity to conduct a comprehensive review of the patient's medications and deliver medication management services.

5. Ideas to effectively use or improve the use of telehealth and remote monitoring technology; and

6. Strategies to increase chronic care coordination in rural and frontier areas;

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. For example, a recently FDA-approved implantable device monitors subtle pressure changes in congestive heart failure patients allowing medical interventions that resulted in a 28 percent reduction in the rate of heart failure

[7] McCarthy R, "The price you pay for the drug not taken." *Bus Health*. 1998;16:27-28,30,32-33.
[8] IMS Institute for Healthcare Informatics, "Avoidable Costs in U.S. Healthcare: The $200 Billion Opportunity from Using Medicines More Responsibly," June 2013.
http://www.imshealth.com/portal/site/imshealth/menuitem.c76283e8bf81e98f53c753c71ad8c22a/?vgnextoid=12531cf4cc75f310VgnVCM10000076192ca2RCRD

hospitalizations at six months and a 37 percent reduction in heart failure hospitalizations over 15 months.[9]

Currently, Medicare Advantage plans cannot offer enrollees the option of accessing covered services, e.g., physician office visits, through telehealth technologies as a part of their basic Medicare coverage, rather than as a supplemental benefit as currently required by CMS. Legislative action is needed to allow plans to offer these services.

Telehealth technologies also hold tremendous promise to increasing care quality and coordination in rural and frontier areas. Provider shortages makes accessing quality care a challenge for people living in these areas. Technology facilitates specialty consultations, virtual visits, and provider education can help bridge the gaps effectively and efficiently. In Virginia, more than half the hospitals offer telehealth services and INOVA health care systems enVision eICU® was one of the first teleICUs in the country. Using telehealth technology, expert physicians and nurses evaluate and manage treatment of critically ill patients in 71 beds from a remote location, 24 hours a day, 7 days a week. Coverage includes six intensive care units in four hospitals with disaster response access to an additional 14 regional hospitals.[10]

In South Dakota, Avera eCARE eEmergency provides 675 rural clinicians with immediate access to board-certified emergency medicine physicians and experienced emergency nurses to assist in the diagnosis and treatment of stroke, heart attack, and other critical conditions. Funded through a HRSA grant, the program has served more than 15,000 patients at 70 locations through two-way video interaction or transfer assistance. Avoided transfers alone have saved $6.8 million in costs in just 850 encounters.[11]

The potential of these services in promoting access and better outcomes is being held back, however, by payment structures that limit reimbursement for services provided remotely. Many of these programs currently depend on grants and demonstration funding. These services also confront challenges with respect to the provision of services across state lines.

7. **Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers**; and

Engaging and empowering Medicare patients and their caregivers in playing a greater role in managing their health are critically important to improving outcomes. The vast majority of the decisions that affect health occur outside the medical setting, but more can be done in those interactions to improve self-management skills. Those skillsets should include understanding preventive care services covered by Medicare and the importance of utilizing those currently underutilized services – vaccinations, the annual wellness visit,

[9] See http://www.dicardiology.com/article/cardiomems-heart-failure-monitoring-adds-benefit-when-combined-device-therapy
[10] See http://www.inova.org/healthcare-services/inova-telemedicine-program
[11] See http://www.hfma.org/Leadership/Archives/2011/Spring-Summer_2011/Case_Study__Bringing_Needed_Care_to_Rural_Patients/

screenings – and promoting healthy behaviors, including physical activity and healthy eating. Assuring communications provided to Medicare enrollees and caregivers are presented in a health literate, culturally competent manner is foundational to achieving greater engagement.

Allowing referrals and reimbursement for 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 (CDSMP) is a gold-standard program for self-management skill development, which is being reimbursed by a range of payers other than traditional Medicare. Though Medicare Part B covers diabetes self-management training, it does not cover self-management training for chronically ill patients without diabetes.

Medicare should also do more to increase the utilization of existing preventive care services and to empower providers to discuss the benefits of physical activity, healthy diets, ways to avoid falls, and other important preventive measures as a part of these annual visits, as well.

8. **Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions**.

In considering ways to more effectively utilize primary care providers and care coordination teams to maximize outcomes for patient with chronic conditions, Congress should look to promising practices currently being tested in the states for examples.

For more than ten years, Vermont has relied on community health teams to provide population based prevention and care coordination for patients. All payers, including Medicare, use the teams to manage patients. Medicare's participation is through the CMS Multi-payer advanced primary care demonstration. The teams are salary based and do not bill for services provided. The teams are funded through contributions from Medicare, Medicaid and private health plans.

The teams consist of nurses, nurse practitioners, dieticians, social and mental health workers, public health workers, and pharmacists. Vermont also engages community health workers as a part of the care teams. The interdisciplinary nature of the teams is designed to provide "whole-person" care that addresses multiple chronic conditions that most patients have. The teams are responsible for coordinating patient care and services, referrals (to intensive lifestyle programs like the diabetes prevention program), transitional care and coaching, social services and medication management.

The CHTs work with primary care practices, community health centers, hospitals and other health care providers to engage patients and assure they are following their particular care plan. The teams and practices have a variety of quality related goals that they monitor jointly using electronic medical records.

A recent independent evaluation of the CHTs by RTI International (commissioned by CMS) found that the teams reduced the rate of growth in Medicare spending by nearly $1800 per year. Findings on the impact of the demonstration on quality and outcomes are forthcoming.

As you can see from our comments, our partners have a lot of knowledge and passion to share in helping to shape Medicare reforms that improve the lives of people living with chronic disease. We stand ready to assist in these ongoing efforts and look forward to continuing the conversation.

Sincerely,

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