The Honorable Max Baucus
Chair, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Charles Grassley
Ranking Member, Senate Finance Committee
135 Hart Senate Office Building
Washington, DC 20510

May 15, 2009

Dear Chairman Baucus and Senator Grassley:

The Partnership to Fight Chronic Disease (PFCD) strongly supports your – and the Senate Finance Committee's – efforts to enact meaningful health care reform in this Congress, and we thank you for the opportunity to comment on your recent paper, "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs" (hereafter referred to as the "policy options paper").

PFCD is a national and state-based coalition of hundreds of partner organizations committed to reforming the health care system to better prevent, detect, and manage the nation's number one cause of death, disability and rising health costs: chronic illness. We believe that finding ways to motivate all participants in our health care system – individuals, providers and payers – to embrace health promotion and wellness, catch disease early, and do everything possible to slow the progression of disease is critical to improving our nation's health, guarding the financial stability of our health care system, and expanding our nation's economic horizons.

As such, PFCD commends you for your focus on reforming the health care delivery system to provide better quality care to all Americans in a manner that promotes health as well as more responsible management of our nation's finite health care resources. We believe that ideas outlined in the policy options paper represent constructive steps towards these goals.

The following comments are intended to strengthen the ideas brought forward in that paper. We begin by sharing our more general comments, and then offer more detailed comments about how to improve upon the current policy options. While we believe that disease prevention and management should be a focus in all publicly-funded programs (e.g., Medicaid, SCHIP) as well as private benefits plans, we are limiting our comments in this letter to Medicare, as that is the program discussed in the policy options paper.

- **Reforms to the Medicare delivery model and payment system must shift the focus from rewarding acute care and treatment after a health crisis to helping beneficiaries pro-actively**

manage their health by emphasizing prevention, early intervention, and appropriate treatment.

We need systemic changes in how we deliver and pay for health care in Medicare because, as counterintuitive as it sounds, health is not always the highest priority in the program right now. More often than not, delivery and payment are built around treating illness and responding to health problems only when they have become acute. Our resources go to responding to the acute health crisis, and not in managing health and preventing the crisis from occurring. Promotion of health, physical and mental wellbeing is not routinely practiced because it is not routinely rewarded. Yet, prevention and management of chronic disease are integral to the sustainability of our health care system's financing, not to mention the quality of patients' care, health, and lives.

Given the amount of spending within Medicare that is associated with treatment of patients with chronic disease (an estimated 96 percent of total spending), it is critical that changes to the Medicare delivery model and payment system ensure that those who are chronically ill are enabled to better manage their health to prevent costly complications and future hospitalizations.

Thus, PFCD is supportive of the ideas introduced within the policy options paper that encourage care coordination and better management of chronic illness among high-cost beneficiaries – especially those who have been hospitalized. For instance, the "Payment for Transitional Care Activities" option – which suggests Medicare would provide reimbursements to physicians to contract with community-based care coordinators or those employed by the practice to provide care coordination and transitional care to patients and family caregivers post-hospital discharge—is a major step in the right direction.

However, much more must be done to improve prevention and management of chronic disease among <u>all</u> Medicare beneficiaries – not just those who have been hospitalized or are acutely ill. For instance, at the very least, this option should be broadened to include care coordination payments for beneficiaries with high-cost chronic illness who are at highest risk of hospitalization. Also, people dually eligible for Medicare and Medicaid should be covered as they are not only often dealing with chronic conditions, but also must navigate different health coverage systems. Care coordination should also help those who are chronically ill – and those at-risk of developing a chronic illness due to the presence of risk factors such as high blood pressure or obesity – avert more serious health problems and costly complications by paying for care coordination aimed at preventing, detecting, and managing disease.

Likewise, we suggest that the proposed CMS Chronic Care Management Innovation Center recognize the value of evaluating interventions that are targeted to the broader Medicare population, and those that help to control disease earlier in its process.

Without changes in Medicare payments and delivery models that emphasize chronic disease prevention and control, we will fail in our efforts to control Medicare costs and improve the health of our population.

Below, we offer more specific ideas for how payment and delivery models could be changed to increase the focus on prevention, early detection and appropriate management of disease within Medicare.

- **Introduce care coordination and disease prevention and management in Fee-for-Service Medicare.**

  One of the greatest challenges to reforming the traditional Medicare program and improving the ability of beneficiaries to manage their health relates to prevention and care coordination. We must do more to capitalize on the medical knowledge we have – both in improving the delivery of recommended care and facilitating the follow through on those recommendations by patients. This is particularly important when it comes to treatment and prevention of chronic illness among Medicare beneficiaries.

  Coordination, continuity of care, and care management are of paramount importance as they can help to facilitate the U.S. health system's transition from an acute care, post-crisis model to one that is focused on prevention and early management of disease. Embracing care coordination arrangements has the potential to improve the delivery of chronic and acute care, to drive down errors and wasteful spending, and to reduce disparities in care.

  Fortunately, there are solid, evidence-based studies that demonstrate the essential features of how to design successful programs in these areas —including formal transitional care programs and programs that integrate care coordination with provider practices.

  One approach to improving care coordination, achieving better health outcomes, and lowering costs is patient-centered medical homes and quality-driven incentives for care improvement. Both the Geisinger and Marshfield clinic models have demonstrated quality improvements and cost reductions as part of the Medicare Physician Group Practice demonstration. However, most primary care practices (83%) have fewer than 4 physicians (accounting for nearly 40 percent of the overall primary care workforce) and cannot replicate all the strategies used by the larger, multi-disciplinary practices like Geisinger and Marshfield. Thus, it is important that other, complementary approaches to strengthening care coordination be advanced.

  An approach that would benefit solo and small physician practices is facilitation of community health teams. These teams include care coordinators, nurses, nurse practitioners, social and mental health workers, dietitians, and community outreach workers that work with smaller practices to provide prevention and care coordination for all patients. The advantage of these teams – as with a medical home model – is that they emphasize management of health (as opposed to just treatment of disease). They greatly enhance communication between providers and patients, and offer the ability to focus on disease prevention and early detection. They also support patient self-management by helping patients and family caregivers understand and are following their providers' recommendations for making behavior changes, taking their medications, and following up when needed.

  Several states have already created community health teams, including Vermont, North Carolina, and Rhode Island. Published empirical research on these models from North Carolina and other settings show these approaches improve clinical outcomes and reduce healthcare

spending. The data indicate that well-designed community health teams could save 3 to 7 percent in overall Medicare spending for a 0.6 percent investment.

The community health teams approach, which was envisioned by Senator Baucus' white paper draft from November 2008 is noticeably absent from the policy options paper. Federal support for community health teams must be a part of any proposal to transform the health care delivery model; thus we strongly support its inclusion in any legislative proposal to improve the Medicare delivery model.

While the policy options paper mentions the value of in-person interventions for disease management, we also suggest that the value of "remote" services, such as health information technology, remote monitoring and telephonic interventions be recognized and incorporated as part of the solution.

For instance, the Veterans Health Administration (VHA) introduced a national home telehealth program, Care Coordination/Home Telehealth (CCHT) to coordinate the care of veteran patients with chronic conditions and avoid their unnecessary admission to long-term institutional care. VHA's experience is that an enterprise-wide home telehealth implementation is an appropriate and cost-effective way of managing chronic care patients in both urban and rural settings. An analysis of the program's success over its years in operation (2003-2007) shows the benefits of the program to lowering cost: routine analysis of data obtained for quality and performance purposes from a cohort of 17,025 CCHT patients shows the benefits of a 25 percent reduction in numbers of bed days of care, 19 percent reduction in numbers of hospital admissions, and mean satisfaction score rating of 86 percent after enrollment into the program. The cost of CCHT is $1,600 per patient per annum, substantially less than other non-institutionalized care programs and nursing home care.

In addition, it is important to recognize the value of including family members and patient caregivers in the care coordination process. This can be done by encouraging communication between community health teams and patients as well as their caregiver support network.

- **Financial incentives patients and providers face in Medicare must be designed to lower barriers to patient compliance with provider recommendations and prescribed care to prevent, detect, and manage disease.**

  There are far too many "missed opportunities" for improving beneficiaries' health in the current Medicare program. While rates of screening among the Medicare population have increased over time, with majorities of female beneficiaries receiving individual screening services such as pap smears (72 percent) and mammograms (75 percent), data also show that few beneficiaries receive comprehensive screening for multiple conditions. For instance, according to a General Accounting Office (GAO) study, only 10 percent of female Medicare beneficiaries are screened for cervical, breast, and colon cancer and are immunized against influenza and pneumonia. As for male beneficiaries, just 27 percent receive colorectal screening and are immunized against influenza and pneumonia. Moreover, research has shown that chronically ill patients receive the clinically recommended preventive care less than 60 percent of the time.

Incorporating population-based health programs in which clinicians are encouraged to improve rates of clinically recommended preventive services and treatments among all members of a targeted group (e.g., patients in a health plan), not just those who may seek treatment represents a step forward into new and innovative "next generation" models of care management, and a true opportunity for quality and cost improvements in the system. This can also include investments to replicate proven, evidence-based models working with community-based organizations to improve population health and well-being.

To make this happen, payments to Medicare providers must encourage a greater emphasis on primary care, and helping patients prevent and manage and slow the progression of disease – so that more costly problems are delayed or, ideally, wholly avoided. To that end, much more must be done to help promote prevention across the continuum of care:

- Primary prevention – which entails avoiding the development of disease – is a necessity, as it will help the entire population in Medicare move toward better health.
- Secondary prevention – which is aimed at early disease detection to increase opportunities for interventions to prevent progression of the disease and emergence of symptoms – is also critically important.
- Finally, tertiary prevention – which attempts to reduce the negative impact of an already established disease by restoring function and reducing disease-related complications – must also be a priority.

Our nation's primary health care providers—physicians, nurses, pharmacists, and other clinicians—are instrumental to this cause. Unfortunately, the health care system is not organized in a way that fully supports them.

The policy options paper proposes one option for improvement in financial incentives to promote better prevention and disease management: paying primary care physicians (and other designated providers) 5 percent more. We support the idea of incentivizing physicians to go into primary care. We also suggest that training incentives be offered to other providers such as preventive medicine physicians who dedicate their careers to disease prevention and health promotion.

As mentioned earlier, the policy options paper is largely silent on how to reform the payment mechanisms for providers to better prevent, detect, and manage chronic illness for the Medicare population. More must be done to recognize the benefits of lifestyle medicine – time spent by providers working with their patients and family caregivers to improve health by eliminating poor health behaviors. After all, as much as 80 percent of heart disease and 80 percent of type-2 diabetes – two major cost drivers for Medicare – are preventable through healthy eating, physical fitness, and not smoking. Reimbursing providers to help patients and family caregivers make the lifestyle changes needed to improve their health could yield significant reductions in chronic disease.

The tide has begun to shift as the benefits of prevention and disease management become more widely recognized. For example, selected providers and large group practices are working to take action. Because of participation in the CMS Physician Group Practice demonstration project, the Marshfield Clinic is now paid based on the quality of care they provide for common

chronic illnesses such as heart disease and diabetes. For providing quality care, earnings of up to 80 percent of the Medicare savings that result from their treatment are possible. Early results from the study show a 50 percent increase in electronically documented foot exams for diabetics and a 29 percent decrease in hospitalizations.

In addition to changing provider incentives in Medicare, Congress must better align financial incentives for patients to encourage healthy behaviors and self-management practices. Strengthening the communication between beneficiaries and their providers can facilitate better compliance with recommended care – like taking medications as directed and making needed lifestyle changes. Medicare benefits for patients and financial incentives should be better aligned to both encourage greater communication and to motivate beneficiaries to follow through on the medical guidance they receive from their providers.

Right now, many Americans do not have the information, resources, or motivation needed to appropriately prevent disease and manage their health. Nearly half of all American adults—90 million people—have difficulty understanding and using health information, according to a report by the Institute of Medicine. This problem, known as "low health literacy," is associated with poorer health outcomes and higher use of health care services.

While education is fundamental to improvement in these areas, research has shown that incentives that directly affect what patients pay out-of-pocket can also impact the likelihood that they will engage in healthy behaviors and actively work to prevent and manage chronic disease. Such incentives have also been shown to have the potential to reduce overall health spending, as they help to ensure disease is better managed and thus less severe.

Patients should not face high financial barriers to following prescribed care regimens that help them avoid more serious illness. To that end, we recommend no, or very low, copays on services that are important to maintaining health and managing disease. Evidence shows that programs that lower patient financial barriers generate higher levels of compliance with prescribed treatment regimens related to lifestyle change, diet modification, and medication use.

For instance, a diabetes management program known as the Asheville Project provided free screenings, diabetes self-testing supplies, and diabetes medicines to all participants who met regularly with their pharmacist coach. Under the program, participants brought their blood sugar under control within a year on average and had about 50 percent fewer absences from work. The program resulted in an average net decrease of 34 percent in health care costs for each patient. Asheville's cardiovascular management program decreased cardiovascular-related medical costs from 31 percent of total health care costs to 19 percent during a six-year study period while increasing the use of cardiovascular medicines nearly threefold. The program also resulted in a greater than 50 percent decrease in the risk of a hospitalization or an emergency room visit due to a cardiovascular event.

In conclusion, we would again like to thank you for this opportunity to share our comments. We hope that the additional plans that come out of the Senate Finance committee related to coverage and financing issues will also recognize the importance of chronic disease prevention and management. We look forward to working with you to passing meaningful health reform during this Congress.

Sincerely, the undersigned PFCD partners:

PFCD National Partners and Affiliated Organizations

Advanced Medical Technology Association (AdvaMed)
Alliance for Aging Research
The Alliance for Health Education and Development
Alzheimer's Foundation of America
American Association of Colleges of Pharmacy
American Association of Diabetes Educators
America's Agenda: Healthcare for All
American College of Preventive Medicine
The American Dieticians Association
American Osteopathic Association
American Pharmacists Association
The Association of State and Territorial Health Officials (ASTHO)
Community Health Charities of America
The COSHAR Foundation
DMAA: The Care Continuum Alliance
GlaxoSmithKline
Healthcare Leadership Council
Health Dialog
Healthways
IHRSA: International Health, Racquet & Sportsclub Association
Kerr Drugs
Marshfield Clinic
Medical Fitness Association
Men's Health Network
Mental Health America
Milken Institute
National Alliance for Caregiving
National Alliance of State Pharmacy Associations
National Alliance on Mental Illness
National Association of Manufacturers
National Business Coalition on Health
National Coalition for Promoting Physical Activity
National Council for Community Behavioral Healthcare
National Health Foundation
National Kidney Foundation
National Latina Health Network
National Multiple Sclerosis Society
National Patient Advocate Foundation
Partnership for Prevention
Pharmaceutical Industry Labor-Management Association (PILMA)
Pharos Innovations
Prevent Blindness America
SEIU
Southwest Area Manufacturers Association

US Preventive Medicine
XLHealth
YMCA of the USA

PFCD Arkansas

Alzheimer's Arkansas Programs and Services
American Academy of Family Physicians, Arkansas Chapter
Arkansas Association of Charitable Clinics
Arkansas Respiratory Health Association
Chamber Alliance Program
Harmony Health Clinic
Lupus Foundation of America, Arkansas Chapter
University of Arkansas for Medical Sciences, Fay W. Boozman College of Public Health
American Cancer Society, Arkansas Chapter
Surgeon General for the State of Arkansas, Joseph W Thompson, MD, MPH

PFCD Colorado

Alliance of Health Disparities
Colorado BioScience Association
Colorado Gerontological Society
Mission Medical Clinic
NAMI
National Association of Hispanic Nurses
Rocky Mountain Stroke Association
SEIU

PFCD Connecticut

American Cancer Society CT
Central Connecticut Coast YMCA
Charter Oak Health Center
Commission on Substance Abuse Policy and Prevention City of New Haven
ConnectiCare, Inc.
Epilepsy Foundation of Connecticut
Ovation Benefits Group

PFCD Delaware

Delaware Ecumenical Council on Children and Families (DECCF)
Integrated Social Solutions
H&S Enterprise, Inc
William "Hicks" Anderson Community

PFCD Illinois

American Cancer Society, Illinois Division Inc.
Alzheimer's Association – Greater Illinois Chapter
Chicagoland Chamber of Commerce
Employers' Coalition on Health
Epilepsy Resource Center/Division of Sparc
Gilead Outreach and Referral Center
Illinois Chamber of Commerce
Illinois Pharmacists Association
League of United Latin American Citizens Metropolitan Chicago
Mental Health America Illinois
Mental Health Summit
NAACP Lake County
National Alliance on Mental Illness – Greater Chicago

PFCD Indiana

Indiana Black Expo, Inc.
Indiana Minority Health Coalition
Indiana Dietetic Association

PFCD Iowa

American Cancer Society – Iowa
Arthritis Foundation, Iowa Chapter
Community Health Charities of Iowa
Des Moines WomenHeart
Iowa Biotechnology Association
SEIU, Iowa Change that Works

PFCD Maryland

Maryland Academy of Family Physicians
United Seniors of Maryland

PFCD Minnesota

American Cancer Society – Minnesota
Native American Community Clinic, Minneapolis
SEIU Healthcare Minnesota
United Cerebral Palsy of Minnesota

PFCD New Hampshire

Advanced Laser Therapy
Council for Children and Adolescents with Chronic Health Conditions
Fitness Professionals Association of New Hampshire
Keene Family YMCA

National Alliance on Mental Illness New Hampshire
New Hampshire Association for Acupuncture and Oriental Medicine

PFCD New Jersey

Action CF
City of East Orange, NJ Department of Health and Human Services
Elevator Constructors Local 5
Heat and Frost Insulators Local 14
Heat and Frost Insulators Local 32
Heat and Frost Insulators Local 42
Heat and Frost Insulators Local 89
HealthCare Institute of New Jersey
IBEW Local 102
IBEW Local 164
IBEW Local 269
IBEW Local 351
IBEW Local 400
IBEW Local 456
Juvenile Diabetes Awareness Coalition
Lung Cancer Circle of Hope
New Jersey Alliance for Action
New Jersey Association of Mental Health Agencies
New Jersey Business and Industry Association
New Jersey Health Care Quality Institute
New Jersey Hospice and Palliative Care Organization
New Jersey Hospital Association
New Jersey State Association of Pipe Trades
New Jersey State Chamber of Commerce
Next Step
Partners in Care, Corp.
Pipefitters Local 274
Plumbers Local 14
Plumbers Local 24
Plumbers and Pipefitters Local 9
Plumbers and Pipefitters Local 322
Public Utility Construction/Gas Appliance Local 855
Road Sprinkler Fitters 669
Sheet Metal Workers Local 19
Sheet Metal Workers Local 22
Sheet Metal Workers Local 25
Sheet Metal Workers Local 27
Sheet Metal Workers Local 137
Sprinkler Fitters Local 692
Sprinkler Fitters Local 696
Steamfitters Local 475

PFCD North Carolina

The Arc of NC
Dr. Paul Cunningham, Dean, Brody School of Medicine, East Carolina University
Easter Seals UCP
Mental Health Association - NC
NASW-NC
Partnership for a Drug Free NC
State Employees Association of North Carolina (SEANC)

PFCD Ohio

David C. Epstein, MD, MBA
Fairhill Partners
National Kidney Foundation Serving Ohio
Ohio Dietetic Association
Ohio Osteopathic Association
Prescription Assistance Network of Stark County, Inc.
Prevent Blindness Ohio
Summa Health System

PFCD Pennsylvania

AIDS Community Alliance of South Central Pennsylvania
American Liver Foundation, Western PA/West Virginia Chapter
Women of Hope & Faith, Inc.

PFCD South Carolina

Bethel Baptist Church
Bethel Senior Daycare Center
Chi Eta Phi Sorority, Inc.
Columbia Hospital Alumni Association
Diabetes Today Advisory Council
Dianne's Call
Eau Claire Cooperative Health Centers, Inc.
Family Outreach Word and Worship Center
Greater Columbia Chamber of Commerce
James R. Clark Memorial Sickle Cell Foundation
Madison Alexander, LLC
Midlands Diabetes Coalition
Palmetto Center for Advocacy
Quality of Life Wellness Programs
South Carolina Asthma Alliance
South Carolina Pharmacy Association

South Carolina Public Health Institute
Tri-County Black Nurses Association
United Way Association of South Carolina
Vista Smiles
Walterboro Christian Center

PFCD Wisconsin

AIDS Resource Center of Wisconsin
Community Health Charities of Wisconsin
Health Care Committee, Metropolitan Milwaukee Association of Commerce
SEIU Wisconsin State Council
Wisconsin Dietetic Association
Wisconsin Manufacturers and Commerce