

January 26, 2016

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Mark Warner
Committee on Finance
United States Senate
Washington, DC 20510

Dear Senators Hatch, Wyden, Isakson, and Warner:

On behalf of the Endocrine Society, which represents more than 18,000 physicians and scientists in the field of endocrinology, we appreciate the opportunity to provide comments on the Senate Finance Committee's Bipartisan Chronic Care Working Group Policy Options Document. Founded in 1916, the Endocrine Society represents physicians and scientists engaged in the treatment and research of endocrine disorders, many of which are chronic conditions, such as osteoporosis, diabetes, hypertension, infertility, obesity, and thyroid disease. Many of the Society's members care for Medicare patients and are eager to explore ways to better deliver the chronic care their patients require. We are pleased to offer the comments below.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

The Society strongly supports the development and implementation of a new high-severity chronic care management code that could be billed under the Physician Fee Schedule. According to a Centers for Medicare and Medicaid Services (CMS) report entitled, *Chronic Conditions among Medicare Beneficiaries*, 30 percent of beneficiaries with diabetes have 5 or more other chronic conditions; 40 percent have 3-4 other chronic conditions; 25 percent have 1-2 other chronic conditions; and only 5 percent have diabetes as their only chronic condition. Given this data and the complexity of a patient with diabetes with multiple co-morbidities, we recommend that a new high severity code be used for patients with 4 or more chronic conditions or one chronic condition in conjunction with Alzheimer's or a related dementia. We believe that 5 chronic conditions is too high a threshold for a service.

Like the currently reimbursed chronic care management service, we recommend that providers of this service should not be limited by specialty. Endocrinologists and other cognitive specialists should be eligible to bill for this service. However, we believe that only one provider should be eligible to bill this service at a time for a single beneficiary.



We also recommend that the working group coordinate with CMS to ensure that the documentation requirements for this service are not so overly burdensome that physicians are discouraged from billing this service. One of the chief complaints of the existing chronic care management service is that the requirements, including documenting the time spent, are so burdensome that physicians forego billing for the service that is currently reimbursed at \$42. This must be considered when determining both the requirements and potential reimbursement rate. The Society supports instituting the new code on a temporary basis to allow CMS and Congress to review the data and determine the service's effectiveness.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

The chronic care working group is considering allowing Medicare Advantage (MA) plans to expand the supplemental benefits, including counseling services, fitness benefits, enhanced disease management, and remote access technologies, offered. The Society supports this proposal. While it would be a great benefit to our patient population, particularly those at risk for developing diabetes and those with diabetes, we believe these services could help prevent Medicare beneficiaries from developing additional chronic conditions. Also, we recommend that the services of registered dietitians be considered as a supplemental benefit. While we believe these services would be beneficial to those in MA programs, we also believe that they would be helpful to those in the traditional Medicare program. The Society strongly recommends that the working group consider adding these benefits to traditional Medicare.

Increasing Convenience for Medicare Advantage Enrollees through Telehealth

The Society strongly recommends that telehealth services should not be limited to those with traditional Medicare, but should be provided to Medicare beneficiaries both in traditional Medicare and MA. For beneficiaries who live in remote areas with limited access to primary care physicians and certain specialists, telehealth services are critically important and improve their access to services, particularly those that help them better manage their chronic conditions.

We understand that telehealth technologies are rapidly evolving, and we urge the working group and CMS not to create requirements that are so specific that new technologies cannot be utilized once they are developed. We also recommend that the working group instruct CMS to evaluate and include new technologies that allow patients to access telehealth services from their homes. In the absence of new telehealth facilities and services at home, the Society recommends that phone consultations be considered and reimbursed as telehealth services.

Providing ACOs the Ability to Expand the Use of Telehealth

We urge the working group to modify the originating site requirements for reimbursement for telehealth services provided by ACOs in the Medicare Shared Savings Program. As we discussed above for MA, the Society believes that telehealth services can play a critical role in improving the access to care and outcomes for patients with chronic conditions. Patients' access to these services should not be limited because their provider participates in an ACO.



Maintaining ACO Flexibility to Provide Supplemental Services

The Society supports providing ACOs with the flexibility to provide supplemental services, including furnishing social services, transportation services, and remote patient monitoring, not covered by traditional Medicare. However, as discussed previously, we recommend that Medicare cover many of these supplemental services. ACOs should not be prohibited from providing these services, particularly if paying for these services upfront will ultimately improve patient access and outcomes while lowering costs.

Ensuring Accurate Payment for Chronically Ill Individuals

The working group is considering making changes to the CMS-HHS Risk Adjustment Model. We strongly support this proposal to ensure that all relevant factors are taken into account. Accurate risk adjustment is critical to the success of new value-based payment models currently being implemented by CMS. The Society recommends that socioeconomic factors be included in the methodology as changes are made. These factors play an important role in patient outcomes as inability to pay for medications severely restricts patients' ability to adhere to their care plan. These factors have traditionally not been accounted for by risk adjustment models. Also, we recommend that the model use more than one year of data to establish a beneficiary's risk score. One year is a too small a snapshot of beneficiary's health; during that period he or she may either under or over utilize health care services. The risk model should account for this variation in a patient's experience with chronic health conditions over their lifetime.

Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization

We agree that it will be important to provide flexibility for beneficiaries to choose to be part of an ACO. We expect the working group is receiving valuable feedback from patient advocacy and consumer organizations on this issue. As the working group considers this issue and the issue of risk adjustment, we also believe it will be critical for CMS to carefully design its patient attribution methodology. The agency should consider a mutual consent process in which both the provider and the patient must consent before a patient is attributed to the provider or his practice. If attribution is based solely on the assignment of costs and usage patterns, the potential for inappropriate linkages of patients to providers increases. Inappropriate attribution could be potentially devastating to individual providers and small groups. We urge CMS to carefully consider this issue as it formulates the required regulations to give all providers the greatest chance to succeed.

We also support providing ACOs with upfront payments for patients who prospectively choose or are prospectively assigned to an ACO. Providing payment in advance would allow ACOs to invest in staff, technology, or other services that can improve the quality of care that a patient receives that may be otherwise difficult to implement, particularly for small practices. CMS would likely need to build in a mechanism to be reimbursed a portion of this upfront payment should the patient withdraw from the ACO or receive the plurality of services from a different physician/ACO during the year.



Developing Quality Measures for Chronic Conditions

The Society supports the working group's recommendation to require CMS to include the development of measures focused on the health outcomes of beneficiaries with chronic disease as part of the agency's quality measures plan. However, we urge the working group and CMS to ensure that these measures are risk adjusted appropriately and that quality information attributed to providers only reflects factors within their control.

Before making any proposals on community-level measures, particularly those in areas such as obesity and diabetes, the Society would like to review the Government Accountability Office (GAO) report the working group may recommend. We think it is critical to gain a better understanding of how these measures relate to chronic care management and provider interventions.

Encouraging Beneficiary Use of Chronic Care Management Services

The Society supports waiving the beneficiary cost sharing requirement for chronic care management services. As the working group points out, many beneficiaries have supplemental policies that cover this cost sharing requirement, but for those who do not, this would be a significant benefit. Even a small co-pay of \$8 per month may be a significant amount to a patient who must balance payments for multiple medications and co-pays for provider visits. Eliminating this fee may encourage more patients to utilize this service. Furthermore, this change would reduce some of the burden on practices who may wish to provide this service, but may find the requirements overly burdensome compared to the reimbursement level.

Establishing a One-time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness

When patients are diagnosed with a serious illness, they are expected to digest a significant amount of information critical to controlling their condition within the confines of a regular office visit. Our members face this challenge when educating their patients about a diagnosis of diabetes. We believe that a one-time visit devoted to sharing this information and answering patient questions would be extremely beneficial for patients newly diagnosed with diabetes and has the potential to significantly improve outcomes. Therefore, the Society strongly supports this recommendation and urges the working group to consider diabetes a serious illness, particularly given the burden of this disease and how often it is a co-morbidity. Currently, a very limited population of beneficiaries has access to diabetes self-management training, which improves disease management and outcomes, and we recommend that this training be included in this visit for patients with diabetes.

Eliminating Barriers to Care Coordination under Accountable Care Organizations

The Society supports allowing ACOs in two-sided risk models to waive beneficiary cost sharing for items and services related to the treatment of chronic conditions. In this case, waiving co-pays and cost sharing may encourage patients to receive care they otherwise would not have received, potentially improving their outcomes. We recommend that the items and services for which cost sharing could be waived be defined in rulemaking to ensure uniformity across ACOs.



Expanding Access to Prediabetes Education

The Society is very appreciative of the inclusion of payment for evidence-based lifestyle interventions that help people with prediabetes. Prediabetes is a growing epidemic in which early intervention is not only effective but critical in preventing diabetes. Studies have continually demonstrated the effectiveness of these programs, which the Society believes should be expanded and more often utilized in at-risk patients. These studies have also found that these programs are particularly effective among the Medicare population and have been estimated to reduce healthcare expenditures due to diabetes complications by up to \$190 billion over a ten-year period. The Medicare Diabetes Prevention Act (H.R. 2102/S. 1131) would provide coverage of the National Diabetes Prevention Program to achieve this end. The Society supports this legislation and requests that the working group recommend coverage for these services in its final recommendations.

Expanding Access to Digital Coaching

The Society agrees that providing Medicare beneficiaries with easy access to accurate medical information could improve outcomes, and supports the proposal to expand the medically-related information and education tools available on CMS' website. A simple way to provide this information would be to link to resources provided on specialty society and patient advocacy groups' websites. To ensure that this information is accurate, we recommend that this information be reviewed by appropriate personnel at CMS.

Study on Medication Synchronization

The Society strongly supports the study proposed by the working group to determine if synchronization of refills for a patient's medication could have an impact on outcomes for patients with chronic conditions. Given the number of prescriptions taken by beneficiaries with multiple, chronic conditions, medication synchronization would be a way to improve beneficiary understanding of their drugs and compliance with their prescriptions. We would appreciate the opportunity to review the study when completed, and believe that this is something that should occur each time a patient receives a new prescription.

Study on Obesity Drugs

The Society supports the working group's recommendation to require a study on the use and impact of obesity drugs. Obesity is a serious disease that can exacerbate other chronic diseases like diabetes and heart disease. More than one-third of the U.S. population and 40 percent of the Medicare population have obesity. These individuals should be provided with a full continuum of care including evidence-based treatment approaches that include behavioral, nutritional, surgical, and pharmaceutical interventions. The Society appreciates the working group's recognition of this growing epidemic and the need to study how these interventions can improve the care and health of these patients.

The Society also supports current legislation, the Treat and Reduce Obesity Act, that would provide coverage for Part D drugs to treat obesity among the Medicare population. We urge the working



group to review this legislation and to recommend the coverage of these drugs to help treat this growing epidemic.

Price Increases of Insulin

The Society appreciates the opportunity to provide comments to the working group on its policy options document, and looks forward to working with you as you consider the comments outlined above and policy options moving forward. An additional area related to the care of diabetes we strongly urge the working group to address is the dramatic insulin price increases patients are experiencing. Injectable insulin, which keeps some people with diabetes alive and keeps others out of serious health crises, has soared in price in the last decade. Given that the committee is looking at ways to improve the delivery of and outcomes from chronic care, we think it is critical that this issue is examined and understood. Recognizing that one in three Medicare beneficiaries is affected by this disease and that one third of Medicare dollars is spent on diabetes or one of its comorbidities, the working group should take these considerations into account when finalizing its recommendations.

Thank you for your consideration of the Society's comments. Please do not hesitate to contact Stephanie Kutler, Director, Quality Improvement at skutler@endocrine.org or Meredith Dyer, Associate Director, Health Policy, at mdyer@endocrine.org, if we may provide any additional information or assistance.

Sincerely,

Lisa Fish, MD
President, Endocrine Society