OCAN Comments

Suggested Amendments to SFC Chronic Care Working Group Policy Options Paper

The Obesity Care Advocacy Network (OCAN) is pleased to provide the following comments in response to the Senate Finance Committee (SFC) Chronic Care Working Group (CCWG) options paper, which was released by the committee during December of 2015. OCAN's mission is to unite and align key obesity stakeholders and the larger obesity community around key obesity-related education, policy and legislative efforts in order to elevate obesity on the national agenda.

Study on Obesity Drugs (page 30)

Policy under Consideration

The Chronic Care Working Group is considering requiring a study to determine the use and impact of obesity drugs in the Medicare and non-Medicare populations. The study could: specifically detail the utilization of such drugs and any subsequent impact on medical services that are directly related to obesity, including by subpopulations determined by the extent of obesity; examine medical interventions for individuals not taking obesity drugs; and examine the experience of MA-PDs that cover obesity drugs as a supplemental benefit.

Reason for Consideration

Obesity is a serious problem that is often directly related to or exacerbate chronic diseases. Prescription drug treatments may be an effective policy intervention, but more information is needed to better understand the impact on quality and overall costs to the Medicare program.

OCAN Position:

We agree that our country's obesity epidemic is a serious issue. Today, more than one in three U.S. adults have obesity and more than 40 percent of adults between the ages of 65 to 74 have obesity, costing American taxpayers hundreds of billions of dollars every year. These sobering facts and the growing science surrounding obesity underscore the importance of developing a policy approach that facilitates patient access to the full continuum of care of evidence-based obesity preventative and treatment modalities including behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions.

While the Work Group's initial policy options paper recognizes this by its inclusion of a study to evaluate the utilization and impact of pharmaceutical therapies for individuals with obesity, we are concerned regarding how such a study would work given the lack of coverage for obesity drugs. We would encourage the Work Group to include aspects of the Treat and Reduce Obesity Act into the final legislative package. Securing Medicare Part D coverage for obesity drugs will spur greater patient access to this treatment avenue both inside and outside of the Medicare program.

Improving Care Management Services for Individuals with Multiple Chronic Conditions (pages 11-12)

Policy under Consideration

The chronic care working group is considering establishing a new high-severity chronic care management code that clinicians could bill under the Physician Fee Schedule. A new code would reimburse clinicians for coordinating care outside of a face-to-face encounter for Medicare's most complex beneficiaries living with multiple chronic conditions.

OCAN Position:

When policymakers at CMS proposed new Medicare payments for non face-to-face chronic care management services beginning in 2015, obesity was left out of the discussion because it was not on Medicare's list of chronic conditions eligible for this new enhanced payment, which are listed in the Medicare Chronic Conditions Chartbook.

LINK TO MEDICARE CHRONIC CONDITIONS CHARTBOOK:

http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf

The Chartbook highlights the prevalence of chronic conditions among Medicare beneficiaries and the impact of chronic conditions on Medicare service utilization and spending. The obesity community argued that the Chartbook should include obesity especially given that 13 of the15 conditions listed (high blood pressure, high cholesterol, ischemic heart disease, arthritis, diabetes, heart failure, chronic kidney disease, depression, COPD, atrial fibrillation, certain cancers, asthma, and stroke) are commonly associated with obesity and/or are exacerbated by obesity.

In making this argument, we highlighted how obesity clearly met the criteria CMS outlined in the proposed rule as the rational for selecting the 15 conditions eligible for the chronic care management payments. Specifically, (1) obesity is highly prevalent among the Medicare population; (2) obesity is chronic; i.e., typically lasts for more than 12 months; (3) obesity poses increased risk for death, acute exacerbation/decompensation, or functional decline; (4) obesity results in increased use of health care services; and (5) successful care management of obesity can improve outcomes/reduce costs.

1. The prevalence of obesity in older adults is high. The prevalence of obesity is estimated to be 37% among men and 34% among women ages 60 years and over. About 35% of people aged 65 and older were affected by obesity in 2007-2010. The prevalence of obesity in the U.S. continues to rise, including for individuals aged 65 and older. In fact, by 2050, the number of persons aged 65 and older in the US is expected to more than double, rising from 40.2 million to 88.5 million.

2. Obesity is a chronic condition, which typically lasts well longer than 12 months. Obesity is a chronic condition that poses lifelong challenges for many individuals. In addition to the AMA via its recent Board decision, numerous healthcare professional organizations, such as the American Heart Association, American Diabetes Association, and the American Association of Clinical Endocrinologists define obesity as a chronic disease. Obesity is also recognized as a chronic disease in the NHLBI Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, which state, "Obesity is a complex multifactorial chronic disease developing from interactive influences of numerous factors—social, behavioral, physiological, metabolic, cellular, and molecular." The long-term negative effects of obesity have been well-documented (see number 3, below).

3. Obesity poses an increased risk for death, acute exacerbation/decompensation, or functional design. Studies have demonstrated that obesity results in higher morbidity for a range of health conditions – including many on the list of 15 chronic conditions proposed by CMS - hypertension, type 2 diabetes, coronary heart disease (CHD), stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and some types of cancer (endometrial, breast, prostate, and colon), among others. Approximately 75% of people with morbid obesity have at least one co-morbid condition, often type 2 diabetes, hypertension or sleep apnea, which increases the risk of premature death.

4. Obesity results in increased use of health care services, including hospitalizations. The medical costs of obesity in the US were estimated to be $147 billion, and per person health care spending for adults with obesity is 56% higher than for normal weight adults. Patients affected by obesity incur 46% increased inpatient costs, 27% more physician visits and outpatient costs, and 80% increased spending on prescription drugs. A recent study of Medicare beneficiaries noted that patients with obesity were more likely than normal weight patients to have five or more office/clinic visits and visits to a personal physician.

5. Successful care management can improve outcomes/reduce costs. Most importantly, CMS notes that care management can improve outcomes and/or reduce costs for the identified conditions. The benefits of care management in individuals with obesity have been well documented. As noted in a report by STOP Obesity Alliance Research Team at The George Washington University School of Public Health and Health Services, "In general, care coordination mechanisms can take a variety of forms, many of which may be useful for improving primary care practice around obesity. Providers make decisions in the context of health care systems (e.g., care settings, payment structures and arrangements) and patient access depends on the system structure and ease of navigating health care resources." Inclusion of obesity in the proposed complex chronic care management payment would build on CMS' 2011 coverage of face-to-face intensive behavioral therapy (IBT) for obesity, giving providers a mechanism to be reimbursed for the extensive non-face-to-face time they spend managing their patients with obesity and other chronic illnesses.

Sadly though, CMS sidestepped this issue when the agency issued its final regulations surrounding chronic care management. We hope that the working group will address this and other payment issues associated with obesity in its recommendations.

Expanding Access to Pre-diabetes Education (Page 26)

Policy under Consideration

The chronic care working group is considering recommending that Medicare Part B provide payment for evidence-based lifestyle interventions that help people with prediabetes reduce their risk of developing diabetes. In addition, the working group is also soliciting feedback on whether there is evidence to support coverage of services analogous to DSMT for beneficiaries who are at risk of complications from other chronic conditions.

OCAN Position:

The SFC Working Group should strongly consider obesity as a primary chronic disease state that should be considered under this policy option.

Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees (pages 13-14)

Policy under Consideration

The chronic care working group is considering giving MA plans the flexibility to establish a benefit structure that varies based on chronic conditions of individual enrollees. This flexibility would allow a MA plan to provide tailored benefits that would reasonably be expected to improve the care and/or prevent the progression of the chronic conditions affecting MA enrollees.

Specifically, the chronic care working group is considering allowing MA plans to offer among other things: Additional supplemental benefits not currently allowed that are related to the treatment of the chronic condition or the prevention of the progression of the chronic disease;

OCAN Position:

The SFC should consider including obesity as a major treatment area as part of the process by which chronic diseases would be identified for which MA plans benefits would be tailored.

Developing Quality Measures for Chronic Conditions (Pages 22-23)

Policy under Consideration

The chronic care working group is considering requiring that Centers for Medicare & Medicaid Services (CMS) include in its quality measures plan the development of measures that focus on the health care outcomes for individuals with chronic disease. Topic areas related to chronic conditions that the working group is specifically considering include:

- Community-level measures, in areas such as obesity, diabetes and smoking prevalence.

OCAN Position:

The importance of healthcare quality measurement to improve outcomes is clear. However, there are very few quality measures established to drive optimal outcomes for people with obesity. In recognition of these gaps, a diverse group of stakeholders from obesity, diabetes, and primary care organizations recently convened to discuss obesity quality measurement.

The roundtable discussion focused on understanding the evolving quality landscape, particularly how quality measures are developed, used and integrated into private and public reporting programs. In addition, participants evaluated what current measures exist surrounding obesity and how they are being used, as well as the main opportunities for adaptation. Finally, the group discussed opportunities around measurement gaps and what efforts related to quality measurement should be prioritized.

Until appropriate quality measures for obesity care and management exist, health care providers treating people affected with obesity won't be able to measure and improve health outcomes. We urge the Senate Finance Committee to continue to think about potential ways to ensure that adequate quality measures exist for all chronic conditions and we look forward to working with the Working Group on such proposals.

Again, we appreciate the opportunity to provide these comments. Should you have any questions or need additional information, please contact OCAN Washington Coordinator Chris Gallagher at chris@potomaccurrents.com or via telephone at 571-235-6475. Thank you.

Sincerely,

Academy of Nutrition and Dietetics, American Association of Clinical Endocrinologists, American Society for Metabolic and Bariatric Surgery, Endocrine Society, Novo Nordisk, Inc., Obesity Action Coalition, Obesity Medicine Association and The Obesity Society

About the Obesity Care Advocacy Network:

The Obesity Care Advocacy Network is a diverse group of organizations that have come together with the purpose of changing how we perceive and approach the problem of obesity in this nation. The founding organizations of OCAN acknowledge obesity is a complex and chronic disease that needs to be treated seriously.

The mission of the Network is to unite and align key obesity stakeholders and the larger obesity community around key obesity-related education, policy and legislative efforts in order to elevate obesity on the national agenda. The primary goals of the Network are: to prevent disease progression, improve access to evidence-based treatments for obesity, improve standards of quality care in obesity management, to eliminate weight bias, and to foster innovation in future obesity treatments.