June 22, 2015

The Honorable Johnny Isakson
United States Senator
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senator
475 Russell Senate Office Building
Washington, DC 20510

The Honorable Orrin Hatch, Chairman
Committee on Finance
United States Senate
104 Hart Senate Office Building
Washington, DC 20510

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

SUBMITTED ELECTRONICALLY

Re: U.S. Senate Committee on Finance Chronic Care Working Group request for public comments, dated May 22, 2015

Dear Senators Isakson and Warner:

On behalf of Trust for America's Health (TFAH), I would like to thank you both for your leadership in bringing attention to and addressing the challenges and opportunities afforded to us by our nation's ongoing battle with chronic disease. TFAH is a nonprofit, nonpartisan public health advocacy organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority.

Our recommendations pertaining to disease prevention and health promotion are largely in part based on our longstanding commitment to addressing the obesity epidemic. For over ten years, we and the Robert Wood Johnson Foundation (RWJF) have issued an annual report that examines this immense public health problem in detail. Last year, we released *The State of Obesity: Better Policies for a Healthier America*, in which we examined trends and explored strategies for addressing the obesity crisis. In 1980, no state was above 15 percent; in 1991, no state was above 20 percent; in 2000, no state was above 25 percent; in 2007, only Mississippi was above 30 percent.[1] Today, rates of obesity exceed 35 percent for the first time in two states, are at or above 30 percent in 20 states and are not below 21 percent in any. More than half of Americans are living with one or more serious, chronic disease ranging from type 2 diabetes to cancer. These and other comorbidity rates are expected to increase significantly over the next two decades, particularly due to the obesity epidemic.

Obesity is a growing threat to the Medicare program. The epidemic is particularly problematic for Baby Boomers, (45-to 64-year-olds)[2] who have the highest obesity rates of any age group – topping 35 percent in 17 states and 30 percent in 41 states. By comparison, obesity rates for current seniors (65+-year-olds) exceed 30 percent in only one state (Louisiana).[3]

In addition to the incredible hardship this burden places on American families, the prevalence of chronic disease translates into incredible costs for our health care system. As you noted in your May 22nd letter to stakeholders, these costs are in many ways disproportionally born by the Medicare program since older adults are more likely to be living with multiple chronic conditions. However, at a population level, even modest improvements in health outcomes can generate tremendous savings for our health care programs. An earlier edition of our obesity report estimated that if every state could reduce the average body mass index (BMI) of their residents by just 5 percent by 2030, nearly every state (except one) could save between 6.5 percent and 7.9 percent in health care costs.[4]

In general, TFAH believes that the most promising opportunity we have with respect to these issues is to place more of a focus on and, most importantly, an investment in primary prevention in both our health care system and in the communities in which we live. Prevention, in the form of both recommended clinical preventive services and investments in our communities should be viewed as a critical priority for funding. There is a perception at times that health usually can only be restored in our physician's office or in a hospital, but it can be promoted just about anywhere. The National Prevention Council, chaired by the U.S. Surgeon General and with the participation of over 20 different federal Departments and agencies, has thus crafted a National Prevention Strategy that calls on all sectors of American life – transportation, education, housing, and many others – to consider the mutually beneficial rewards of prevention.

Several years ago, TFAH released a report of economic findings based on a model developed by researchers at the Urban Institute and a review of evidence-based studies conducted by the New York Academy of Medicine. TFAH concluded that an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save the country more than $16 billion annually within five years. This is a return of $5.60 for every $1.[5]

Below we outline several specific policy recommendations. However, we respectfully note that while the Committee is well positioned to provide legislative leadership on many of these issues, overlapping jurisdiction on many issues involving primary prevention will require ongoing collaboration and partnership with your colleagues.

Recommendation #1: Consider reimbursement for recommended community prevention

Authorities granted to the Centers for Medicare and Medicaid Services (CMS) under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Patient Protection and Affordable Care Act of 2010 (ACA) have considerably expanded Medicare coverage for many preventive services recommended by the U.S. Preventive Services Task Force (USPSTF), including counseling regarding obesity.

Yet to date, CMS coverage determinations for recommended preventive services have been limited in scope, particularly around the settings in which Medicare beneficiaries can receive covered services. For example, the Medicare National Coverage Determination (NCD) for Intensive Behavioral Therapy for Obesity limited coverage to counseling that is furnished in a

primary care setting.[6] Both the USPSTF recommendation and the evidence base on which that recommendation is founded supports referral to counseling provided in a community-based program. We urge the Committee to consider how Medicare could be strengthened by ensuring that beneficiaries have access to evidence-based, qualified providers both in and outside the clinical setting. Such a change would also align with relatively recent change in fee-for-service Medicaid regulations that effectively make it possible for additional types of providers to receive reimbursement for providing physician-recommended preventive services.

Further, a number of additional evidence-based recommendations formed by the U.S.S Task Force on Community Preventive Services ("The Community Guide")[7] fall outside the purview of CMS' coverage decision-making authority. These recommendations help to identify effective community-level interventions to prevent a wide variety of negative health outcomes, including cancer, cardiovascular diseases, diabetes, tobacco use, and obesity. We urge the Committee to consider the Community Guide as a resource for what other types of services would be effective and beneficial for the Medicare population.

Recommendation #2: Authorize and fund a Healthy Aging demonstration project

Medicare has a direct interest in assuring a healthier aging population. If Americans are healthier when they reach the age of 65, it could save Medicare billions of dollars. We recommend the Committee authorize (and support funding for) a Healthy Living, Healthy Aging pilot program for pre-Medicare-eligible Americans. Such a pilot would invest in proven community-based disease prevention programs to help prevent disease and promote for Americans under the age of 65, potentially by focusing on the "pre-Medicare" population aged 55 to 64 years old.

Recommendation #3: Pilot and scale new organizational models, under new financial arrangements and payment methodology, which seek to address true population health

Preliminary data from the Medicare Shared Savings ACO Program is indeed promising and this work should continue. However, primary prevention requires us to think about promoting health before individuals develop illness or disease and become patients that enter the health care system.

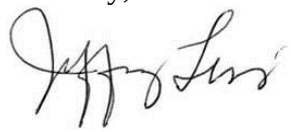
This work is not without precedent. For example, in Minnesota an organization called Hennepin Health has constructed a promising model as a Medicaid demonstration project and partnership between the county medical center, a federally qualified health center, the metropolitan health plan, and the county human services department. The model is essentially a primary care medical home that includes care coordination with social services and supports to address critical issues for the affected population – safe and adequate housing, substance abuse counseling, employment services, etc.[8]

We respectfully urge you to consider the Hennepin Health model and how Medicare and other CMS payment policy could be aligned to support communities that are engaging in broader population health work.

Conclusion

We thank you again for your important leadership on these and other health issues and for the opportunity to provide these comments in support of your ongoing work to address chronic disease towards the goal of strengthening the Medicare program. We look forward to working with you and your staff should we be able to provide assistance as you consider any upcoming legislation. If you have any questions, please feel free to contact me or have a member of your staff reach out to Jack Rayburn, TFAH's Senior Government Relations Manager at (202) 223 – 9870 x 28 or jrayburn@tfah.org.

Sincerely,



Jeffrey Levi, PhD
Executive Director

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[1] Trust for America's Health. F as in Fat: How Obesity Threatens America's Future. Washington, D.C.: Trust for America's Health, 2013.
[2] *The 45-64 Year Olds cohort, includes most Baby Boomers, who range from 49-67 years old.
[3] Trust for America's Health. The State of Obesity: Better Policies for a Healthier America. Washington, D.C.: Trust for America's Health, 2014.
[4] Trust for America's Health. F as in Fat: How Obesity Threatens America's Future. Washington, D.C.: Trust for America's Health, 2012.
[5] Trust for America's Health. Prevention for a Healthier America. Washington, D.C.: Trust for America's Health, 2008.
[6] National Coverage Decision (NCD) for Intensive Behavioral Therapy for Obesity (210.12). Centers for Medicare and Medicaid Services. November 2011. http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=353&ncdver=1&NCAId=253&ver=6&NcaName=Intensive+Behavioral+Therapy+for+Obesity&bc=AiAAAAAAIAAA&
[7] The Community Guide. The Guide to Community Preventive Services. http://www.thecommunityguide.org.
[8] Nancy Garrett. How a Social Accountable Care Organization Improves Health and Saves Money and Lives. November 12, 2013. http://healthyamericans.org/health-issues/prevention_story/how-a-social-accountable-care-organization-improves-health-and-saves-money-and-lives