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May 15, 2009

The Honorable Max Baucus
Chairman, 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

Dear Chairman Baucus and Senator Grassley:

The National *Changing Diabetes*[®] Program (NCDP) commends the Senate Finance Committee's commitment to reforming the U.S. health care system to improve the quality of patient care and reduce health care spending. We, too, share this commitment to change and thank you for the opportunity to comment on your policy paper, "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs."

Since 2005, NCDP— a program of Novo Nordisk, Inc. — has served as a catalyst, convener and aligner by bringing together innovators in diabetes education, treatment and policy. Our vision is to improve the lives of people affected by this disease by creating change in the U.S. health care system and moving it toward an ideal diabetes environment that fully supports all aspects of diabetes prevention, treatment and care.

We applaud the extensive efforts the Committee has undertaken to involve non-government stakeholders in your health care reform efforts. The Committee's policy paper outlines many significant steps toward repositioning the U.S. health care system around prevention and chronic disease management as oppose to its current acute-care orientation. We hope our comments are helpful in providing the Committee guidance as you proceed with legislative drafting.

This letter begins by outlining the key points NCDP urges the Committee to consider. We then apply these perspectives to the specific programs under consideration.

KEY POINTS

- 1. Because of its prevalence, financial and human toll as well as the solid evidence that type 2 diabetes can be effectively prevented and managed, diabetes should be the flagship for testing the effectiveness of new models, initiatives and program changes.**

The current state of diabetes and the projected impact of the disease on the U.S. requires a focused response.

Diabetes prevalence is alarming with no indication of leveling off.

- 23.6 million people have diabetes, 6.3 million of whom are undiagnosed.
- An additional 57 million have pre-diabetes.
- A person born after the year 2000 has a one in three chance of developing diabetes.
- By 2025, an estimated 50 million people will be living with diabetes.
- The most pervasive chronic diseases are linked to diabetes. For example, heart disease, depression and asthma are all linked to diabetes.

The financial and human toll of diabetes is significant and the death rate is accelerating.

- According to a Lewin Group study commissioned by NCDP, the direct and indirect economic costs of diabetes and pre-diabetes totaled \$218 billion in 2007.
- This staggering amount includes \$18 billion for people with undiagnosed type 2 diabetes and \$25 billion for people with pre-diabetes.
- One in every four Medicare dollar is spent on a person with diabetes.
- Since 1987, the death rates due to heart disease, stroke and cancer have declined. During the same period, the death rate due to diabetes has increased by 45 percent.

Much is known about how to prevent and treat type 2 diabetes and how to effectively manage the disease to avoid costly complications.

- The Diabetes Prevention Program (DPP), a major multicenter clinical research study, found that people at risk for developing diabetes can prevent or delay the onset of diabetes by losing a modest amount of weight through diet and exercise. DPP participants reduced their risk of developing diabetes by 58 percent during the study.
- The United Kingdom Prospective Diabetes Study demonstrated that controlling blood glucose levels reduced the risk of both diabetic eye disease and kidney disease for people with type 2 diabetes.
- The Diabetes Control and Complications Trial (DCCT), a major clinical study funded by the National Institute of Diabetes and Digestive and Kidney Diseases, showed that keeping blood glucose levels as close to

normal as possible slows the onset and progression of the eye, kidney, and nerve damage caused by diabetes.

2. Patients must be at the center of the care system.

The management and treatment of a chronic disease like diabetes happens almost entirely outside the walls of a hospital or doctor's office. A reformed health care system must center on the needs of the patient, first and foremost. This includes, for example, designing quality measurement programs which the patients can understand and utilize.

3. Team-based diabetes care, supported by health information technology, is a vital clinical model to promote, test and finance.

Diabetes is a disease that must be managed daily to maintain good health and prevent costly complications. Diabetes management requires education, coaching and timely feedback from different team members that is not currently accessible to most people with diabetes. NCDP supports the advancement of a patient-centered team-based approach to diabetes management. A vital part of a successful team is access to the most current patient health information which health information technology can provide and be used to connect team members, the patient and adequate decision support systems.

4. Accuracy in forecasting diabetes-related costs is essential.

In light of the fact that Medicare already faces staggering increases in future costs, it is important to bring to bear existing knowledge and methodology that may improve the accuracy of forecasting health care costs. Epidemiological data that accounts for the natural history of diabetes and the impact of diabetes treatments can refine current governmental forecasts of future costs attributable to diabetes and significantly alter our understanding of the budgetary impact of proposed health care programs.

Diabetes must be a priority for a reorganized health care delivery and financing system. We encourage the Committee to emphasize diabetes in all programs and demonstrations. More specifically, we urge the Committee to consider diabetes the barometer for the success of health care reform.

SECTION I: PAYMENT REFORM**Focusing Quality Initiatives on Diabetes and Other Chronic Conditions:**

The Committee's paper includes several options to improve quality of care in Medicare. As the Committee considers the elements of these options, we strongly encourage you to emphasize the following core elements:

- Chronic care management, including the full range of proven diabetes prevention and care management practices.
- Patient-centered care that is strongly team-based and includes patient education and self-care training.
- Use of quality measures directly relevant to diabetes and other chronic conditions. Many diabetes-specific measures are available for consideration.
- Incentives to reward higher chronic care quality by providers.
- Incentives to encourage beneficiaries' participation in programs that promote healthy behavior and lifestyle change.

Physician Quality Reporting Initiative (PQRI):

We support the proposed option to expand Medicare's already successful Physician Quality Reporting Initiative. The program design changes identified in the Committee's options paper represent thoughtful improvements.

However, we encourage the Committee to consider:

- Integrating the PQRI more directly with improved chronic care management; specifically, team-based, patient-centered care and self-care.
- Incorporating additional, condition-specific measures including evidenced-based measures of diabetes prevention and care.
- Extending the program to additional types of non-physician practitioners critical to the diabetes care team, including certified diabetes educators.

Payment for Transitional Care Activities:

We support, in general, the proposal for Medicare to pay for integrated, transitional care management for the chronically ill. Given the high human and economic cost of the six major chronic conditions you identify, this initiative is desperately

needed. It is also an excellent way to promote the development of genuine team-based, patient-centered care practices across the nation.

We offer several recommendations in the design of your initiative:

- The Committee targets six chronic care conditions with the transition care activity. Diabetes certainly deserves its place in this list. In fact, research shows that many cases of the other five disease states - congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, depression and asthma - are linked to, and in cases of heart disease, even caused by uncontrolled diabetes. Therefore, we urge the Committee to consider prioritizing the diseases to ensure that diabetes is the first priority for implementation of transition care activities.
- Chronic care management activities (i.e. assessment, coaching, education, self-care training) should be available to both beneficiaries recently hospitalized and those at high risk of hospitalizations. The devastating impact of, for example, unmanaged diabetes does not follow a specific or predictable schedule. Also, chronic conditions, especially diabetes, often affect so many co-morbidities that tracking by DRG can give an incomplete picture.
- As a group, dual eligibles are Medicare's most vulnerable beneficiaries. A high proportion of dual eligibles have multiple, often high-risk chronic conditions. Therefore, the program should encourage partnering of Medicare with state Medicaid programs. In addition to reducing Medicare hospital admissions, care management of high-risk chronic conditions like diabetes will help states reduce costly admissions to nursing homes and home- and community-based programs.

Section II: LONG-TERM PAYMENT REFORMS

CMS Chronic Care Management Innovation Center:

We enthusiastically support the creation of a Chronic Care Management Innovation Center within the Centers for Medicare and Medicaid Services (CMS). The Committee's options paper lays out the objectives and functions quite well. The tight focus on chronic conditions, building new models and capabilities, piloting concepts without the obstacle of proving immediate budget neutrality and the explicit support for team-based care are all outstanding.

In addition, we recommend that the Committee consider the following:

- While improving chronic care within Medicare is the primary objective, the Center should be encouraged and empowered to partner with other major purchasers and payers, particularly state Medicaid and CHIP agencies, large employers (public and private) and health plans.
- CMS resources, particularly staff and research funding, are very tight. The new Center will require an adequate staff and a strong research budget.

- Many Americans already enrolled in Medicare have one or more chronic conditions. Diabetes (diagnosed and undiagnosed) or pre-diabetes is often one of them.
 - Ninety percent of seniors have at least one chronic disease and 77 percent have two or more chronic diseases.
 - In publicly funded health programs, spending on chronic disease represents an even greater proportion of total spending: more than 96 percent in Medicare and 83 percent in Medicaid.

Therefore, the new Center should also be directed to explore demonstrations to improve chronic care management and prevention interventions for the pre-retiree population and thus reduce future demands on Medicare finances.

- Long-time federal policy on joint Medicare and Medicaid waivers has made it extremely difficult to implement demonstrations to improve care coordination for dual eligibles. Even though overall federal outlays would be reduced, the two programs are unable to share savings or align chronic care for dual eligibles in the fee-for-service system. For example, state Medicaid programs have no fiscal incentive to coordinate care to reduce Medicare hospital admissions and Medicare has no budget rationale to help a state Medicaid agency reduce nursing home admissions. Both beneficiaries and taxpayers suffer. The Secretary of Health and Human Services (HHS) should be encouraged to use her waiver authority to support joint Medicare-Medicaid demonstrations that are budget neutral overall to the federal government. The new Center could play an instrumental role in developing such new demonstrations.

SECTION III: HEALTH CARE INFRASTRUCTURE INVESTMENTS

Health Information Technology in Support of Delivery System Reform:

The new federal health information technology (HIT) initiative is a critically important step to improving our delivery system. People with diabetes are likely to experience other co-morbidities and juggling interaction and coordination with various physicians and other care practitioners. HIT has the potential to be a critical element for care coordination and patient monitoring. As you consider further improvements to the nation's HIT infrastructure, we encourage you to consider ways to:

- Encourage the development and use of clinical support systems for chronic care management, particularly for diabetes patients who have multiple co-morbidities.
- Use HIT to directly support team-based models of care delivery.
- Extending federal incentives for electronic health records (EHRs) to all members of the care team, including care managers and certified diabetes educators.

Improving Quality Management:

We support the proposal to expand Medicare's overall quality management program. CMS and its partners have made excellent progress.

As the Committee's options paper recognizes, continued improvement is closely linked to ongoing collaboration among stakeholders, the alignment around and uptake of current measures, developing and vetting of new performance measures and transparency of performance.

- NCDP has funded a study by Jefferson Medical College to assess the number of quality measures being used to measure diabetes quality—a Clinical Barometer for diabetes in America. We hope to release the results in the fall but early results are astonishing. Clinical endpoints for diabetes, such as blood glucose and cholesterol levels, are currently subject to a wide variety of metrics, which has led to a system of measurement that is both redundant and inconsistent. Strong leadership is needed to drive a consensus effort to streamline and harmonize measures.
- Where diabetes-specific measures have not been endorsed for particular care settings, such as hospital and post-acute care, we urge the Committee to hasten their development and/or endorsement.
- We also strongly recommend advancing measures that support the prevention of chronic conditions, including diabetes.

SECTION IV: MEDICARE ADVANTAGE

Pay for Chronic Care Management in Medicare Advantage:

We strongly support the inclusion of bonuses for improved chronic care management by Medicare Advantage plans. The approach used should directly support integrated, team-based care management for chronic disease beneficiaries, including persons with or at-risk for diabetes. The Medicare Advantage bonus payments should be designed to mirror the similar initiative for persons enrolled in Medicare fee-for-service.

Extra Benefit in Medicare Advantage:

As you consider ways to streamline the process of offering extra benefits by Medicare Advantage plans, we recommend that federal policy permit Medicare Advantage plans to offer limited incentives to beneficiaries for participation in programs that encourage healthier behavior, life-change and self-care. These programs should be designed carefully so as not to penalize patients or erect barriers to coverage.

We want to thank you both for your leadership on health care reform. We hope our comments will be helpful to the Committee as it continues its important work on reforming health care. We again urge the Committee to consider infusing diabetes more overtly into its initiatives and programs. We whole heartedly believe that if

America has a health care system that works for people with diabetes, we will indeed have a system that can work for everyone. We look forward to answering any questions the Committee may have.

Sincerely,

A handwritten signature in black ink that reads "D Haza". The "D" is large and stylized, and "Haza" is written in a cursive script.

Dana Haza

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National Changing Diabetes Program

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