The Honorable Kathleen Sebelius
Secretary, U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

September 13, 2012

Dear Secretary Sebelius:

The Partnership to Fight Chronic Disease looks forward to the release of additional guidance on the essential health benefits package. The Partnership to Fight Chronic Disease is a coalition of patients, providers, community organizations, business and labor groups, and health policy experts committed to raising awareness of the number one cause of death, disability, and rising health care costs in the U.S.: chronic disease.

The treatment of chronic diseases, such as heart disease, lung disease, diabetes, depression, and arthritis, account for 84 cents of every dollar spent on healthcare.[1] These often preventable and highly manageable conditions affect almost one in two Americans. Assuring that essential health benefits include evidence-based services[2] that prevent or delay the onset or progression of chronic disease holds significant promise to both improve health and help to keep costs down by avoiding, or at least delaying, the need for expensive services as health deteriorates. Recognizing this need, the Affordable Care Act includes "preventive and wellness services and chronic disease management" as required essential health benefits.

This set of services, however, is not well defined in the Affordable Care Act or subsequent publications on essential health benefits released by the Institute of Medicine or the U.S. Department of Health and Human Services. Thus greater guidance is needed to help states include patient-centered, evidence-based best practices that many health plans, employers, and states have adopted and demonstrated to be effective.

---

[1] Chronic Conditions: Making the Case for Ongoing Care, Robert Woods Johnson. Feb. 2010. Available online at http://www.rwjf.org/pr/product.jsp?id=50968.

[2] In this document, we use the term "evidence-based" to mean "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient." It reflects the integration of clinical expertise, patient values, and the best research evidence into the decision-making process. See D Sackett, et al, "Evidence based medicine: what it is and what it isn't: It's about integrating individual clinical expertise and the best external evidence," BMJ 1996; 312:71-72. Available online at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2349778/pdf/bmj00524-0009.pdf.

Given the importance of these benefits and the opportunity that well-designed benefits have to both improve health and lower costs, the Partnership to Fight Chronic Disease has developed specific recommendations for the definition and evaluation of "preventive and wellness services and chronic disease management" benefits. In so doing, we recognize the needs to offer benefits appropriate to the population being served, to allow flexibility in the design of plans offered in the Exchanges, to reflect the evolving nature of the evidence base in benefits offered, and to deploy benefits strategically in response to specific patient needs. We offer the following recommendations for consideration in developing guidance on these important elements of essential health benefits:

- "Preventive and wellness services and chronic disease management" should be considered interconnected, distinct benefits that work to preserve and enhance health across the continuum of health status.
    - Rationale: The Affordable Care Act groups these benefits together on the list of required essential health benefits. They are related as they represent the range of opportunities to preserve and promote health and wellness among people in good health, those with health risks, and those already living with a chronic health condition in various stages of severity. These services are also important to consider individually as distinct benefits for inclusion in the package of essential health benefits to provide the best opportunity to enhance health while improving access to coverage.

- In addition to US Preventive Services Task Force guidelines for preventive care services, states should consider the recommendations included in evidence-based, peer-reviewed medical guidelines systematically developed and vetted by authoritative sources such as the Community Preventive Services Task Force, NIH, CDC, and medical provider organizations.
    - Rationale: Though the Affordable Care Act requires that benefits rated an "A" or "B" by the US Preventive Services Task Force be included as essential health benefits, this Task Force is not the only source of authoritative information on recommended services. Also, the evidence base evolves at a faster rate than any one organization can keep pace. States and health plans should have the flexibility to include recommended preventive health services from other evidence-based, authoritative sources developed and vetted through a rigorous, peer-reviewed process.

- Preventive care services, particularly those related to screening for health risks and chronic conditions, will help inform individuals of their health risks. To promote wellness among those identified as at risk, plans should have the flexibility to implement, adopt, and deploy wellness services proven to be effective through referrals to evidence-based wellness services.

- Rationale: Many of the recommended preventive services work to identify a health risk. To optimize the benefit of that information, people may need additional support to make the behavioral changes needed to improve their health. Plans participating in the exchanges should have the flexibility to refer their members having identified health risks to evidence-based wellness services that work to address those risks and improve health. Many employers, including those from which benchmark plans may be selected, have adopted wellness services as a way of promoting health among employees and lowering costs. For example, the Federal Employee Health Benefits program's letter to insurance carriers for 2013 plans requires plans to "offer programs that promote health and wellness" and specifically require plans to submit proposals for overweight and obesity reduction programs.[3]

- "Chronic disease management" should include patient-centered care management services provided in response to the careful assessment of the needs of the patient and proven benefit of the intervention. Such services should include if appropriate for a given patient:
  - stratifying the health risks patients face and tailoring services accordingly;
  - managing the care of patients with complex needs;
  - managing care transitions between providers and care settings to simplify transitions for patients;
  - determining and addressing gaps in care to avoid patient health deterioration;
  - providing comprehensive medication review and reconciliation to improve adherence and patient outcomes and education about medication therapy and importance of adherence;
  - supporting self-management skill development, behavioral change, and health coaching to enable and empower patients and family caregivers;
  - providing supportive end-of-life care;
  - identifying and managing health risks to avoid health declines from preventable complications or the development of additional chronic conditions; and
  - referral and access to community-based prevention, health promotion, and disease prevention programs and services when available.

    - Rationale: There is a strong evidence base demonstrating the importance of promoting patient-centered, team-based care management and self-management support and education at varying levels of intensity for both improving outcomes of people with chronic conditions and managing long-term costs. Plans should have

[3] Office of Personnel Management, FEHBP Program Carrier Letter, Letter No. 2012-09 March 29, 2012. Available online at http://www.opm.gov/carrier/carrier_letters/2012/2012-09.pdf.

the flexibility to target such services based on the populations served and individual health status.

- Affordability, evaluated from the perspective of a consumer, is an important consideration in the evaluation of essential health benefits for the health insurance exchanges. Striking the balance between making coverage options both meaningful and affordable to purchasers in the exchanges presents many challenges. When making such determinations, states should evaluate affordability from the perspective of the total costs to the consumer, including costs relating to accessing and following through on recommended care. They should also assure that total costs – premiums, deductibles, and coinsurance – are clearly communicated to consumers.
    - Rationale: To maintain their health, people at risk for or living with a chronic condition may need regular access to a primary care provider, recommended tests to monitor their condition, and medications to reduce health risks or prevent disease progression. High deductibles on services needed to manage chronic conditions, particularly for people at lower income levels, pose a significant deterrent to seeking and receiving care needed to prevent chronic disease development and progression. Only by considering total costs to the individual and considering the impact of high deductibles on access to care, particularly for low-income or chronically ill consumers, can a state evaluate affordability accurately for these populations.

- Essential health benefits should be counted as meeting health plan medical loss ratio (MLR) requirements for covering direct clinical services and quality improvement activities. Evidence-based preventive, wellness, and chronic disease management services can improve health quality by improving health outcomes, reducing hospital admissions and rehospitalizations, or promoting wellness and health activities.
    - Rationale: Assuring that these benefits count toward the MLR requirements helps consumers by providing incentives for health plans to offer benefits that will work to lower the burden of chronic disease and promote better health.

- The services listed in section 3502 of the Affordable Care Act should be considered as meeting "preventive and wellness services and chronic disease management" essential health benefits requirements.
    - Rationale: Section 3502 of the Affordable Care Act includes list of services to be provided by Community Health Teams and is illustrative of the types of services a health plan should offer as a part of its benefits package for people covered who need care management services. These services include:

- Coordinating and providing access to high-quality health care, preventive, and health promotion services;
- Promoting access to quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care;
- Providing access to medication management services, including medication reconciliation;
- Promoting effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services;
- Providing local access to the continuum of health care services in the most appropriate setting, including access to individuals that implement the care plans of patients and coordinate care, such as integrative health care practitioners; and
- Providing care management and support during transitions in care settings.

In the process of developing these recommendations, we thought it important to provide some working examples to demonstrate how "preventive and wellness services and chronic disease management" as are actually working to support patient-centered care and improve outcomes in practice. Targeted deployment of these programs based on evaluating and addressing the needs of the patient population served, particularly those at high-risk and/or chronically ill, has shown significant health and cost improvements. HHS and states should encourage plans to include such programs informed by risk stratification to target at need populations as a part of essential health benefits for "preventive and wellness services and chronic disease management."

- **Managing care transitions example: Transitional Care Nurse Model**

  This evidence-based, nurse-led model works to improve outcomes and lower costs by equipping the patient and family caregivers with the knowledge, skills, and resources essential to prevent future decline and re-hospitalization, as shown in multiple studies. A patient is enrolled when hospitalized. Within 24 hours, a transitional care nurse (TCN) performs an assessment. Over the next 1 to 3 months, the TCN performs an in-home assessment, provides weekly in-home or telephonic visits, attends doctor visits as needed, develops and tracks progress on a personalized care plan, and regularly collaborates with the patient, the family caregiver, and the

patient's primary care provider. In one study with Aetna, the program reduced hospital readmissions significantly within three months of patient enrollment and cut healthcare costs by $439 per member per month.[4]

- **Readmission reduction example: McKay-Dee Hospital Center**

  The Center has readmission rates in the lowest three percent in three clinical areas reported to CMS, and in the lowest one percent for congestive heart failure. Low readmission rates are attributable to: comprehensive quality improvement strategies; standardization of care; information systems designed to monitor quality; interdisciplinary care coordination; discharge planning with individualized patient education; scheduling of follow-up appointments before discharge; and integration with community providers.[5]

- **Health coaching example: Health Dialog Telephonic Health Coaching**

  In a randomized study of 174,120 people, health coaches contacted participants by telephone to coach them about shared decision-making, self-care, and behavioral change. People were identified for outreach based on analysis of their financial risk and predicted medical costs based on past medical claims. After a year, people receiving enhanced outreach had lower overall medical costs including a 10% reduction in hospital admissions for net savings of $6.00 per person per month, or a 3 to 1 ROI.[6]

- **Medication therapy management example: Minnesota Experience**

  Pharmacists provided face-to-face medication therapy management services for Blue Cross Blue Shield health plan members with at least 1 of 12 medical conditions. In the year-long program, more than 600 drug therapy problems were identified and resolved and patient achievement of therapy goals increased from 76 percent to 90 percent. Total healthcare costs dropped from $11,965 to $8,197 per person, generating a 12 to 1 return on investment.[7]

---

[4] MD Naylor, KH Bowles, KM McCaluley, et al. "High-Value Transitional Care: Translation of Research into Practice," Journal of Evaluation in Clinical Practice, published online March 16, 2011; MD Naylor, et al., "Transitional care of Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial," Journal of the American Geriatric Society, 2004;52: 675-84; MD Naylor, et al., "Comprehensive Discharge Planning and Home Follow-up of Hospitalized Elders," JAMA 1999;281(7): 613-20.

[5] S Silow-Carroll and JN Edwards, "Intermountain Healthcare's McKay-Dee Hospital Center: Driving Down Readmissions by Caring for Patients the "Right Way," The Commonwealth Fund, February 16, 2011, http://www.commonwealthfund.org/Publications/Case-Studies/2011/Feb/Intermountain-Healthcare.aspx.

[6] D Wennberg, A Marr, L Lang, et al., "A Randomized Trial of a Telephone Care-Management Strategy," N Engl J Med 2012; 363:1245-55.

[7] B Isetts, S Schondelmyer, M Artz, et al., "Clinical and Economic Outcomes of Medication Therapy Management Services: The Minnesota Experience," Journal of the American Pharmacist Association, 2008; 48(2): 203-11.

- **Care coordination example: Wisconsin Wrap Around Intensive Case Management**

  This intensive care management program engages Medicaid health plan and community care managers and relevant providers as part of a team for coordinating care across systems and services. Participants are identified by high and frequent hospital or emergency department visits for health conditions manageable by appropriate outpatient care. A care team develops and implements an individualized care plan driven by an analysis of the individual's medical, psychosocial, and other needs. Participants experienced a 31 percent reduction in emergency department visits and a 73 percent reduction in inpatient stays compared with pre-intervention in inpatient stays. Per member per month costs declined by more than $3,500.[8]

- **Prevention program example: Community-based Diabetes Prevention Program**

  The NIH and CDC led Diabetes Prevention Program showed that people with prediabetes who lose a modest 5 to 7 percent of their body weight and increase their physical activity to 150 minutes a week can prevent or delay the onset of type 2 diabetes.[9] In the DEPLOY trial, similar results were demonstrated in a much lower cost, community-based setting at local Y's.[10]

- **Telehealth prevention and wellness: HealthNet's Quit for Life program (QFL)**

  QFL is a telephone-based tobacco cessation program where members are assessed and counseled via telephone by a trained tobacco cessation counselor. Members often self-refer or are referred by their physicians. Health Net also indentifies members for outreach through identification as smokers from an asthma program or use of smoking cessation medication who are not enrolled in QFL. Once enrolled, a counselor assesses the member's enthusiasm to actively participate in the program, his/her readiness to quit, and medication recommendations. Counselors reassess participants after 6 months, as well. To date results demonstrate a 31% completion rate and a 25% quit rate for participants in the program.

- **Self-care management program example: Stanford Chronic Disease Self-Management Program (CDSMP)**

  The Stanford suite of Chronic Disease Self-Management Programs (CDSMP) is available across the United States. Providers should tap into the Aging Network's nationwide infrastructure to

[8] Medicaid Health Plans of America, "2010-2011 Best Practices Compendium," available online at http://www.mhpa.org/_upload/2010CompendiumFINAL.pdf. Accessed January 5, 2012.
[9] CDC, National Diabetes Prevention Program, available online at http://www.cdc.gov/diabetes/prevention/about.htm. Accessed April 30, 2012.
[10] R Ackerman, E Finch, E Brizendine, et al., "Translating the Diabetes Prevention Program into the Community: The DEPLOY Pilot Study, Am J Prev Med 2008: 35(4);357-63.

increase health promotion and disease/disability prevention, through self-management education and support for people living with chronic conditions. CDSMP is a low-cost, evidence-based intervention that has been shown to improve self-management skills and health status, and reduce the need for more costly medical care.[11]

- **Multidisciplinary team-based secondary and tertiary prevention example: Cardiac Rehabilitation Programs**

  Cardiac rehabilitation programs are multidisciplinary, medically supervised programs for patients with recent cardiovascular events, designed to optimize cardiovascular risk reduction, foster healthy behaviors and adherence to preventive medications, and reduce disability. Core components include baseline patient assessment, nutritional counseling, aggressive risk factor management, psychosocial and vocational counseling, and physical activity counseling and exercise training. Recent studies have demonstrated mortality benefits of 21-34% at five years[12] and 31% lower risk of heart attack at four years[13] following participation in cardiac rehabilitation.

- **Workplace risk-reduction intervention: Sleep Apnea and Motor Vehicle Accidents**

  Sleep apnea is associated with increased health benefit utilization and has been recognized as a significant yet preventable cause of motor vehicle accidents. A commercial trucking company evaluated the impact that sleep apnea treatment had on health care costs and disability rates. In the 24 months following treatment, total health care costs for each treated driver decreased an average of $2,700 in the first year and another $3,100 in the second year. The treated drivers also missed fewer workdays because of short-term disability and had a lower rate of short-term disability claims. In total, the employer saved more than $6,000 over two years in total health plan and disability costs per treated driver.[14]

- **Telephonic patient education example: Maine Telephonic Diabetes Education and Support**

[11] The Stanford Chronic Disease Self-Management Program results in significant, measurable improvements in health and quality of life for people with chronic conditions. Multiple studies have indicated significant improvements in health status, self-efficacy, and psychological well-being; an increase in participants' exercise routines; fewer social role limitations and reduced fatigue; and enhanced partnerships with physicians. Research on cost savings has also shown impressive results. The program, offered both online and through community-based organizations, helps participants develop the skills and coping strategies they need to manage their symptoms through action planning, interactive learning, behavior modeling, problem-solving, decision-making, and social support for change. In FY2010, AoA funded 46 State and territory grants for CDSMPs and the President's FY2012 budget includes $10 million CDSMP funding.

[12] Suaya JA, Stason WB, et al. "Cardiac rehabilitation and survival in older coronary patients." *J. Am. Coll. Cardiol.* 2009;54:25-3.

[13] Hammill BG, Curtis LH, et al. "Relationship between cardiac rehabilitation and long-term risks of death and myocardial infarction among elderly Medicare beneficiaries." *Circulation*. 2010;121:63-70.

[14] Hoffman B, Wingenbach D, et al., "The Long-term Health Plan and Disability Cost Benefit of Obstructive Sleep Apnea Treatment in a Commercial Motor Vehicle Driver Population," J Occ & Env Med. 2010; 52(5): 473-477.

The pilot program is designed to increase access to diabetes self-management training and education. The pilot utilizes personal, one-on-one contact for participants with Certified Diabetes Educators, evidence-based interventions, and participant incentives. It has operated for 8 years as a public-private partnership between major health insurers, a non-profit corporation, and the Maine Office of Employee Health and Benefits and achieved $1300 per patient per year cost savings, improved medication adherence, and solid improvement in clinical indicators, including blood pressure, cholesterol, and A1c levels.[15]

We appreciate your consideration of these recommendations as a part of efforts to provide additional guidance to the states and health plans on essential health benefits. We welcome the opportunity to discuss these recommendations with you and your staff at your convenience and look forward to working with you to support these efforts.

Sincerely,

Kenneth E. Thorpe, Ph.D.
Chair, Partnership to Fight Chronic Disease
Robert W. Woodruff Professor and Chair
Department of Health Policy and Management
Rollins School of Public Health, Emory University

[15] Bushey J and Gradie M, "Telephonic Delivery of Chronic Disease Self-management Education: Lessons from the TDES Program," Oct. 2010, available online at http://www.mcd.org/docs/TDESMPHA102010.pdf. For program information, please visit http://www.tdes.me/.