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May 15, 2009

The Honorable Max Baucus
Chair
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Charles Grassley
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Grassley:

On behalf of our over 200 members providing care along the continuum from wellness through complex case management, DMAA appreciates the opportunity to provide comment on the Committee's description of policy options document entitled "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs."

In general, DMAA believes that delivery reform options must move our system toward wholesale change in delivery, not just payment enhancements. DMAA believes such change requires increased emphasis on and availability of prevention and wellness programs for healthy and at-risk individuals. DMAA understands that a subsequent Finance Committee document, "Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans," outlines proposals to ensure expanded access to prevention and wellness programs. We look forward to providing additional comments on that document.

Successful care management models rely on core components to support and provide wellness, health promotion and chronic care management: 1) population identification strategies; 2) comprehensive needs assessments (physical, psychological, economic, and environmental); 3) health promotion programs that increase health risk awareness; 4) patient-centric health management goals and education including prevention, behavior modification and support; 5) self management interventions aimed at influencing behavioral change; 6) routine reporting and feedback loops between patient, caregivers, providers, health plan and ancillary providers; and 7) evaluation of clinical,

humanistic, and economic outcomes. DMAA encourages the Committee to include these key components among the definition of care management models.

DMAA remains concerned that the prevalence of chronic illness and projected growth within the Medicare population alone, far surpasses the resources of existing primary care provider and nurse workforces. As such, physician-led care teams can benefit from the support of non-providers who possess a wealth of expertise and experience in supporting and promoting integrated, coordinated care. This demonstrated expertise and experience in supporting and promoting integrated, coordinated care through a variety of high-quality, proven intervention modalities can serve as a necessary supplement to in-person care delivery, especially in communities lacking sufficient primary care providers and nurse case managers.

DMAA appreciates the Committee's thoughtful deliberation on these difficult issues. We hope these comments will be useful to you and your staff and we stand ready to provide additional resources as necessary.

Sincerely,

Tracey Moorhead
President and CEO

DMAA: The Care Continuum Alliance
Comments on
Senate Finance Committee
Description of Policy Options
"Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs"
May 15, 2009

Payment for Transitional Care Activities

Note: DMAA understands that Senate Finance Committee staff is considering incorporating transitional coaching legislation proposed by Sen. Michael Bennet (S. 1009) in the final legislative vehicle in lieu of the options outlined below. DMAA is especially encouraged that S. 1009 considers an expanded population-based approach and contemplates reimbursement based on the population in a certain area and not per-provider service. DMAA is developing detailed comments on S. 1009 which we will soon share with Senate Finance Committee staff. In the interim, DMAA offers the following comments on the proposed policy options:

Proposed Option:
Support integrated, transitional care management for chronically ill patients who experience hospitalization by reimbursing providers for targeted interventions that have proven successful in the Medicare Coordinated Care Demonstration program, the Medical Home, and other care management models.

DMAA requests the addition of the following language after this paragraph:
"*Successful care management models share common processes and strategies including:* p*opulation identification strategies and processes; comprehensive needs assessments that assess physical, psychological, economic and environmental needs; proactive health promotion programs that increase awareness; patient-centric health management goals and education including prevention, behavior modification programs and support for the patient-physician relationship; self-management interventions aimed at influencing behavioral changes; routine reporting and feedback loops; and evaluation of clinical, humanistic, and economic outcomes*."

Proposed Option:
Under this option, Medicare would reimburse physicians for certain care management activities performed by nurse care managers (or other qualified non-physician professionals, such as diabetes educators). Qualified activities would include providing in-person care assessment and management, coaching, education and self-management support to patients.

If the Committee chooses to support an approach to improving transitional care that is based on a payment system for individual services provided, DMAA recommends that the Committee modify the proposed option as follows:

DMAA requests the addition of the following language:
"Medicare would reimburse qualified care managers for certain care management activities."
"*Qualified activities would include providing care assessment and management, coaching, education and self-management support to patients using innovative, high-quality services with proven patient benefits, cost efficiencies for health systems and providers and quality improvement outcomes such as phone encounters, online interactions, telehealth programs, and remote monitoring applications.*"

To be eligible for reimbursement, physicians could directly hire qualified care managers or contract with care managers in their community. These services would only be paid for beneficiaries who have been discharged from the hospital within the previous six months for a stay classified by a DRG related to the following major chronic diseases:

- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Asthma
- Diabetes, and
- Depression

Medicare would also pay a modest supplemental fee to a primary care practice for each patient who (1) has been discharged from the hospital after a stay classified in a DRG for one of the major chronic disease, (2) receives at least one currently covered evaluation and management service or one of the newly covered care management services within 30 days after discharge, and (3) is not readmitted to a hospital for a stay classified as a chronic disease DRG within 60 days after the initial discharge.

DMAA Comments:
If the Committee chooses to support an approach to improving transitional care that is based on a payment system for individual services provided, DMAA DMAA believes the unit of billing for these services should include either an in-person visit or a call with a licensed clinical professional (MD, RN, LPN, case manager, physician assistant, health educator, etc). DMAA believes the committee should define "qualified care manager" as a "licensed clinical professional." This expansion of providers and service units is crucial to support the concept of the multi-disciplinary team approach to care coordination.

Proposed Option:
The Committee is seeking input on whether this policy should be expanded to include care coordination payments for beneficiaries with high-cost, chronic illness who are at highest risk for hospitalization.

DMAA Comments:
DMAA believes that high-cost, high-risk chronically ill beneficiaries are an important subset of the Medicare fee-for-service population and encourages the expansion of this proposal to include these population segments. However, DMAA cautions that identification of individuals is key to successful cost containment. Identification driven exclusively from recent hospitalization and chronic disease diagnoses will not realize the full opportunity to impact cost trends as the identified populations will not be appropriately targeted (i.e., some are not likely to be readmitted and some who are likely to be admitted or readmitted will not be identified at all).

Identification of at-risk, high cost, chronically ill populations must be driven by predictive analytics and an understanding of socio-economic and community factors. CMS does not current posses the analytical capabilities for this type of targeted identification and DMAA recommends that organizations seeking to provide services to this expanded population be required to utilize such predictive analytic capabilities. Such analytic models can be fed by administrative data, electronic medical record data, risk analysis and provider chart review on historical re-admissions. Without this more sophisticated analytic capability, the proposal to expand populations served through care management runs the risk of focusing too narrowly on a small, high-cost group without addressing the broader population with the real risk of becoming high-cost.

CMS Chronic Care Management Innovation Center

Proposed Option:
Under this option, the Secretary of HHS would establish at CMS a Chronic Care Management Innovation Center (CMIC) for the purpose of testing and disseminating payment innovations that foster patient-centered care coordination for high-cost, chronically ill Medicare beneficiaries. CMIC would be given permanent authority to broadly test care coordination models that show promise of improving the quality and cost-effectiveness of care delivered to chronically ill beneficiaries in fee-for-service Medicare. CMIC would act in consultation with an advisory board comprised of members from relevant federal agendas and outside clinical and analytical experts.

To be considered for wide-scale testing, care models must focus on patients will multiple chronic conditions who are at highest risk for hospitalization or readmission. CMIC would have flexibility in targeting patient populations most appropriate for care management interventions but would be encouraged to include: (1) beneficiaries with multiple chronic conditions and an inability to perform 2 or more activities of daily living

(i.e., homebound patients); and (2) beneficiaries with multiple chronic conditions, at least one of which is a cognitive impairment (including dementia).

Initial testing would focus on models that met at least the following criteria: (1) places the patient, including family members and other informal caregivers, at the center of the care team; (2) focuses on in-person contact with beneficiaries; (3) maintains a close relationship between care coordinators and primary care physicians and (4) relies on a team-based approach to interventions such as comprehensive case assessments, care planning (including end-of-life care planning, such as advanced directives), and self-management coaching. Additional criteria, or amendments to these criteria, could be made by CMIC in consultation with its advisory board.

Examples of models that might qualify include:

- Advanced Patient-Centered Medical Homes
- Transitional Care Teams
- Patient/Physician Shared Decision-making aids

DMAA suggests the addition of the following language after this list of examples:
"Successful care coordination models share common processes and strategies including: Population identification strategies and processes; comprehensive needs assessments that assess physical, psychological, economic and environmental needs; proactive health promotion programs that increase awareness; patient-centric health management goals and education including prevention, behavior modification programs and support for the patient-physician relationship; self-management interventions aimed at influencing behavioral changes; routine reporting and feedback loops; and evaluation of clinical, humanistic, and economic outcomes."

DMAA Comments:
DMAA understands from Finance staff that the CMIC proposal is intended to offer opportunities to test chronic care management and coordination interventions and program designs. Committee staff noted that CMIC would have authority to conduct broad, evidence-based testing" and to design, launch, modify, evaluate and cease any projects undertaken.

DMAA recommends that the Committee consider expanding innovations testing to incorporate interventions for at-risk populations in addition to diagnosed, chronically-ill populations. DMAA recommends that such an entity have authority to test "care management" activities. DMAA further suggests that the entity have responsibility for designing a care-management departing with accountability for reducing utilization and cost and improving beneficiary health status.

Finally, DMAA urges the Committee to consider the CMIC as an opportunity to test models with a wide range of intervention strategies proven beneficial to the health of

chronically ill beneficiaries, including those services that are not in-person specific and those which have proven successful in private-sector populations.

Proposed Option:
To reduce the start-up times of new testing, CMIC would develop a standard process for evaluating the design and performance of payment models under consideration for broad-scale testing. Testing in the pilot phase would not be required to meet up-front budget neutrality, but CMIC would have the authority to terminate or modify the design and implementation of the models that were determined to be unsuccessful once testing began.

DMAA Comments:
DMAA applauds the Committee's recognition of the complex external influences and other factors that have impacted many chronic disease management pilots' efforts to demonstrate budget neutrality in what is often a compressed period of time to achieve narrowly defined program outcomes, and of the importance of sharing knowledge and data specifically realized from collaborative efforts to engage and improve the health of beneficiary populations.

Proposed Option:
The Secretary would measure and evaluate the initial phase of these pilots based on demonstrated improvement in quality of care (including patient-level outcomes measures) and achievement of cost-reduction or budget-neutrality. The Secretary could expand the duration and scope of projects under this section, to an extent determined appropriate by the Secretary, if the Secretary were to determine – and the Office of the Actuary certify – that such expansion would result in any of the following conditions being met: (1) the expansion of the project is expect to improve the quality of patient care without increasing spending under the Medicare program; (2) the expansion of the project is expected to reduce spending under the Medicare program without reducing the quality of patient care.

This option would also establish a Medicare Rapid Learning Network within CMIC for the purpose of smaller-scale evaluation of emerging evidence-based care management models. CMS would recruit and competitively contract with a diverse network of providers/practices for the purpose of rapid-cycle demonstration testing across a broad array of settings and geographic areas. These sites would exhibit diversity across region, provider size, provider type/setting, and other appropriate factors. The Secretary would have the authority to expand testing to additional populations via the above pilot authority.

The Committee is seeking input from members, CBO, and CMS on the design, score and implementation of the options proposed in this section.

DMAA Comments:
With regard to evaluation of programs tested, DMAA recommends that evaluation not be restricted to payment design, but include clinical model and population health burden identification.

Finance Committee staff specifically asked DMAA for guidance on crafting CMS authority to conduct studies in this area and to ensure greater flexibility in design and implementation of such studies. DMAA recommends the attached *Health Affairs* article, "Next Steps: How Can Medicare Accelerate the Pace of Improving Chronic Care."

Medicare Shared Savings Program (i.e., Accountable Care Organizations)

Proposed Option:
Under this option, the Medicare program would allow groups of providers who voluntarily meet quality thresholds to share in cost-savings they achieve for the Medicare program. Beginning in 2012, groups of providers – such as individual physician practices, physician group practices, networks of physician practices, hospital/physician joint ventures, hospitals employing physicians, etc – would have the opportunity to qualify for sharing of the cost savings they achieve for Medicare.

DMAA Comments:
DMAA suggests the value of potential non-provider partners to physician practices and hospital/physician collaborations working to achieve quality indicators such as those specified in the proposal is considerable, particularly when considering the integration of the extended hospital and medical staff in a virtual ACO model.

Pay for Chronic Care Management

Proposed Option:
In addition to maintaining the current risk-adjusted payment model, the Committee could consider proposals to pay plans a bonus for chronic care management along with competitive bidding. Plans would be eligible for added payments if they manage chronic care in an effective manner. The bonus payments would be designed to mitigate pressure on MA plans to compress their bids by reducing activities of managing and coordinating care. Bonus payments would be available to MA plans that have evidence-based programs to manage the care of chronically ill beneficiaries. The amount available would be based on plan activities and performance targets, as specified below.

Plans that conduct certain activities or meet or exceed specified performance targets would be eligible for bonus payments. There are many ways to design bonus payments for chronic care. One way would be to make an additional payment of 3 to 5 percent of Medicare's national average (fee-for-service) monthly per capita cost. For example, plans could earn 1 to 2 percent for conducting certain care management activities – like

having a medical home, gain sharing with their primary care providers. Plans could earn another 1 or 2 percent for meeting or exceeding quality improvement targets. While bonus payments would not be available until the new benchmarks are fully phased in, the following is an example from 2009 to illustrate the proposed bonus payments. In 2009, the national average monthly Medicare cost was $741. If this option were implemented in 2009, MA plans would be eligible to receive an additional $22 to $37 per enrollee per month. This would be a flat amount available across all areas of the country and would not depend on a plan's bid, the benchmark or service area. It would depend solely on how the plan performed.

DMAA Comments:

DMAA strongly supports the Committee's acknowledgement that the current MA risk adjustment is inadequate for beneficiaries with sustained high risks and/or co-morbid chronic conditions and complex diagnoses that elude the current RA methodology. DMAA would encourage the Committee to consider the inclusion of stakeholders such as Chronic Care SNP providers in the process to determine performance targets that concomitantly encourage effective chronic disease management and care coordination in MA and financial feasibility for high risk focused plans as well as the Medicare program.