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May 22, 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:

DMAA: The Care Continuum Alliance appreciates the opportunity to provide comment on the Committee's description of policy options document titled, "Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans."

DMAA represents more than 200 organizations providing care to more than 160 million Americans through wellness, chronic care management and complex case management. DMAA members include wellness, disease and care management organizations, pharmaceutical manufacturers and benefits managers, health information technology innovators, biotechnology innovators, employers, physicians, nurses and other health care professionals, and researchers and academicians.

DMAA appreciates the Committee's thoughtful deliberation on health care reform issues. We are very pleased with the Committee's interest in and strong emphasis on prevention and wellness, and we look forward to working with you. 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 Comments on
Senate Finance Committee
Description of Policy Options
"Expanding Health Care Coverage:
Proposals to Provide Affordable Coverage to All Americans"
May 22, 2009

Section II: Making Coverage Affordable

Proposed Options - Standard Benefits

Four benefit categories are permissible in the reformed market: lowest, low, medium, and high. All policies (except grandfathered policies) issued must comply with one of the four categories. All insurers must offer coverage in each of the four categories. All plans are required to provide primary care and first-dollar coverage for preventive services, emergency services, medical and surgical care, physician services, hospitalization, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, including x-rays, maternity and newborn care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services. Plans may not set lifetime limits on coverage or annual limits on any benefits.

> DMAA Comment:
> DMAA strongly supports access to primary and preventive care benefits and services in any standard benefit package. DMAA also supports provisions to eliminate beneficiary co-payments for primary and preventive care benefits. DMAA would discourage the Committee from allowing even nominal cost-sharing for prevention services.

SECTION IV: Role of Public Programs

Proposed Option – Other Improvements to Medicaid

The proposal contains statutory requirements regarding transparency in the development, implementation, and evaluation of Medicaid and CHIP section 1115 demonstration programs that impact eligibility, enrollment, benefits, cost-sharing, or financing. States could also be required to include information regarding the actions taken to meet the public notice requirements detailed in the proposal as a part of their waiver submission to CMS. Additional transparency-related statutory requirements on the Secretary may be imposed, as well.

> DMAA Comment:
> DMAA is aware that many states have utilized the Section 1115 waiver process to implement successful disease management programs for Medicaid populations. DMAA is hopeful that formalizing the mechanics for transparency will promote the use of these waivers rather than discourage applications. The proposed option appears to formalize the mechanics for how this process occurs through the creation of specific opportunities for public input and comment. DMAA supports increased flexibility for the use of Section 1115 waivers (and other similar vehicles) for states to implement care coordination services within their Medicaid programs. DMAA further encourages the committee to consider removing the need for 115 waivers where the proposed state plan changes are promoting preventive care.

Proposed Option – Dual Eligibles
This proposal would establish a new Medicaid demonstration authority of five years for exploration of alternative approaches to coordinating care for dual eligibles. Medicaid 1915(b) waiver authority permits states to use savings from coordinating care for dual eligibles between Medicare and Medicaid in their waiver applications. Because Medicare is the first payer and covers most acute care, savings achieved through coordinated care for dual eligibles would primarily be to Medicare in the form of reduced acute care utilization (fewer emergency room visits, less inpatient hospital admissions). This proposal allows Medicaid 1915(b) waivers to recognize Medicare savings in the 1915(b) cost effectiveness test. States have the option of using 1915(b) waivers to increase contracting with managed care organizations, such as Medicare Advantage SNPs for dual eligibles, to help coordinate care for dual eligibles. All other 1915(b) authorities remain unchanged. To ensure that coordination for duals occurs, a new office within CMS, the Office of Coordination for Dually Eligible Beneficiaries (OCDEB), is established. OCDEB is responsible for identifying and leading agency efforts to align Medicare and Medicaid financing, administration, oversight rules, and policies for duals. OCDEB is required to report directly to the CMS administrator and to prepare annual reports to document dual eligible spending with separate subtotals for Medicare and Medicaid and other health care categories, such as hospitals, physicians, home health, longer-term care services, waiver spending, and other expenditures. The Office develops outreach and training to improve coordination, propose policy changes, identify issues that might need legislative solutions, and develop strategies to ensure good outcomes for duals during care transitions, as well as develop procedures to assist “attainers” navigating the transition from Medicaid only to Medicare and Medicaid.

> DMAA Comment:
> DMAA strongly supports expanded care coordination services for Medicaid populations in order to build on successes already achieved by Medicaid programs for this vulnerable population of low-income beneficiaries.
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> With regard to the proposed creation of the Office of Coordination for Dually Eligible Beneficiaries (OCDEB) within CMS, DMAA would support the creation of such an entity provided the new office be required to closely coordinate and collaborate with other HHS offices, including the proposed Chronic Care Management Innovation Center outlined in a separate Senate Finance Committee options paper addressing delivery system reforms.

SECTION VI: Prevention and Wellness

Proposed Option - Promotion of Prevention and Wellness in Medicare
The policy options make a wellness visit available to Medicare beneficiaries once every five years and provide a personalized prevention plan. Incentives are provided for Medicare beneficiaries to utilize preventive services. Examples of these incentives include reducing or eliminating cost sharing for screenings and offering rebates for completion of health promotion programs like tobacco cessation. The policy options would also align Medicare coverage for preventive services with scientific evidence to ensure patients receive appropriate screenings.

DMAA Comment:
DMAA recognizes the increased prevalence of chronic illness in Medicare populations and recommends that the Committee consider providing wellness visits available to these populations more frequently than once per five year period. DMAA strongly supports beneficiary incentives including reductions or eliminations of cost-sharing requirements for preventive screenings and health promotion programs.

Proposed option – Coverage of Evidence Based Preventive Services
This option would give the Secretary the authority to withdraw Medicare coverage for preventive services that are rated "D" by the US Preventive Task Force unless deemed medically necessary by a prescribing physician.

DMAA Comment:
DMAA would not support this approach to eliminate coverage for preventive services.

Proposed Option - Promotion of Prevention and Wellness in Medicaid
The option clarifies preventive services covered at the state's option for adults under Medicaid. These optional benefits are defined as all services rated "A" and "B" by the U.S. Preventive Services Task Force (USPSTF) and immunizations recommended by the Advisory Committee on Immunizations. States that OPT to cover all "A" and "B" rated services and immunizations receive a one percent increase in the federal share of the FMAP reimbursement rate. The options provide incentives for Medicaid beneficiaries to utilize preventive services. Examples of these incentives include reducing or eliminating cost-sharing for screenings and allowing states to apply for funding to reward Medicaid enrollees for completing health promotion programs like tobacco cessation.

DMAA Comment:
DMAA supports the removal of cost-sharing for clinical services rated "A" or "B" by the US Preventive Task Force. DMAA supports clarification of preventive services for adult Medicaid populations but believes it is important that any changes to Medicaid law (Title XIX) clarify that such coverage is allowed without limiting the State's current authority to cover other preventive services subject to a State Plan Amendment approved by CMS.

Proposed Option – "Right Choices" Grants
A short term promotion to boost prevention and wellness makes capped grants available to states until the Health Exchange is operational. (N.B. The Health Exchange proposal is outlined in Section 1 of the options document, Insurance Market Reforms, and would apply to the non-group and small group markets.) Grants may be used to provide primary preventive services such as tobacco use screening, influenza immunization, counseling on daily aspirin use, hypertension screening, or obesity screening.

Proposed Option – Prevention and Wellness Innovation Grants
A competitive grant program to promote health and human service program integration, improve care coordination and access to preventive services and treatments, and better integrate the delivery of health care services to improve health and wellness outcomes. This option identifies three approaches states may choose to implement while allowing flexibility to encourage innovation: 1) Promotion of multidisciplinary community care teams; 2) Development of individualized plans for health and human services needs of low-income beneficiaries; and 3) Innovative approaches incorporating an evaluation component that assesses the impact of the proposed innovation on the health status of participating individuals.

> DMAA Comment:
> DMAA supports the expansion of goals of the proposed "Right Choices" and prevention and innovation grants option and will look forward to working with the Committee regarding specific requirements for these grant programs.

Proposed Option - Employer Wellness Credits
A third option creates tax incentives for qualified comprehensive workplace wellness programs. The proposal outlines the components required to be considered a qualified wellness program.

> DMAA Comment:
> DMAA strongly supports this provision. DMAA applauds and appreciates the Committee's work with Senator Harkin to move forward on this important proposal.

SECTION VIII: Options to Address Health Disparities

Proposed Option – Collection of Data
The proposal would establish uniform categories for collecting data on race, ethnicity, and language data on Medicare and Medicaid enrollees. Funding is provided to upgrade SSA databases so that they can communicate with one another. Additionally, the collection of access and treatment data for people with disabilities is required. CMS must determine where people with disabilities access primary care and the number of providers with accessible facilities and equipment to meet the needs of the disabled. Access to intensive care units is evaluated.

Proposed Option – Public Report, Transparency and Education
Quality reporting requirements include provisions to collect data on patients with disabilities by type of disability. Health care quality data must be published by race, ethnicity and gender.

Proposed Option – Reduction in Infant Mortality and Improved Maternal Well-Being
Funding is provided to states, tribes, and territories to develop and implement targeted approaches to reducing infant mortality. Awards are based on the applicants' ability to demonstrate the capacity to engage in one or more types of evidence-based approaches to reduce infant mortality and its related causes, and consequences, such

as preterm births, infant and child disability, reduced health status of women during their childbearing years, and maternal mortality. The Secretary must publish an evaluation of funded projects including a formal assessment of the funded projects for their potential, if scaled broadly, to improve health care practice, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs.

DMAA Comment:
DMAA supports efforts to eliminate health care disparities and believes the proposals to improve and expand data collection could better inform health care providers at all levels. DMAA urges the Committee, to allow sufficient implementation time following the approval of uniform reporting categories for reporting quality data by race, ethnicity, gender and language. This implementation time will be critical to accommodate changes in Medicaid Management Information Systems (as well as separate Medicaid eligibility systems and other health-related data systems) currently in use across the states and territories.