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May 26, 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 entitled "Financing Comprehensive Health Care Reform: Proposed Health Systems Savings and Revenue Options."

DMAA represents over 200 organizations providing care to over 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 pleased by the Committee's focus on increasing availability of preventive care and urge the Committee to consider funding approaches that utilize a value-based benefit structure to support a system of care designed to promote better health.

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
"Financing Comprehensive Health Care Reform:
Proposed Health Systems Savings and Revenue Options"
May 26, 2009

SECTION I: Health System Savings

Options - Ensuring Appropriate Payment

- The Committee notes policy options of adjusting annual market basket updates for Medicare fee-for-service providers (and other recommendations to address Medicare spending growth) described in the MedPAC 2009 *Report to Congress*. These include reducing or eliminating market basket updates in 2010 for any provider payment area recommended by MedPAC.
- For home health, another option may be to direct the Secretary to "re-base" payments to better reflect the current number and mix of HH services and their level of intensity and to take into account the relative margins related to specific conditions and service areas. Finally, other options may include establishing a provider-specific annual cap on the number of allowable outlier episodes that HHAs can be reimbursed for in a year.
- Among other options that may be considered as a way to make Part B provider payments more 'rational through reforms that appropriately value services', the committee may consider the establishment of an expert panel to assist CMS in evaluating and adjusting payment for potentially misvalued physician services.

  DMAA Comments:
  DMAA members offer care coordination along the continuum from wellness through complex case management and in a wide variety of settings and interventions. Home health care services are an important "care extender" segment of this continuum. DMAA believes that the provision and utilization of health and care management services in the home has been proven efficient and effective in realizing the delivery of quality health care to the patient and has demonstrated improved outcomes and cost savings for care providers. DMAA is concerned that significant cuts to home health payments will threaten access to quality home health care. As such, DMAA recommends that the Committee select proposals designed to support the appropriate use of technology to increase the cost effectiveness of care delivered in the home (where most patients prefer to remain) and avoid payment policies that encourage care delivery in an institutional rather than residential setting. While inequities in payment updates for providers must be addressed, multiple challenges to access to health care in the home must be acknowledged. Home health technology has been used to respond to workforce shortages, reduce costs through declines in hospitalizations and emergency care, and improve the quality of home health care, through home health technology acquisitions. The consideration of telehealth applications and other innovations in the delivery of care by remote providers must be considered as cost components of

any across-the-board payment system adjustments or updates. Home health cost report data, used to calculate profit margins, should include the cost of care technology as a bona fide care expense.

DMAA views positively the Committee's efforts to strengthen CMS' processes to identify and evaluate potentially misvalued physician services. The review process for work relative values has not been effective at realizing decreases in relative values assigned to physician services. DMAA strongly believes that any expert panel created to support or enhance the RUC's efforts must consist of experts outside CMS with a wide range of experience in various care settings – such a representative panel could provide critically important perspectives in resolving issues around the payment of physician services.

With regard to adjusting Part B provider payments, DMAA would urge the Committee to consider the use of physician-led health care teams to deliver and coordinate care for chronically ill populations. Physician-led health care teams would include other licensed clinical professionals such as nurse case managers, pharmacists, and others. 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-physician 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.

Finally, DMAA urges the Committee to consider the principles of value-based benefit design to ensure appropriate payment and support for activities that are founded in evidence-based medicine. Many private plans and employers have successfully implemented value-based design coverage plans to ensure the provision of high value services. Such plans have demonstrated improved health outcomes and health care cost reductions through the application of evidence-based medicine guidelines. These plans can also shield beneficiaries from costs for procedures that are shown by evidence not to be beneficial for their personal conditions.

Options - Modifying Beneficiary Contributions

The paper states that the Committee may consider proposals to simplify Medicare beneficiary cost-sharing obligations and make them more consistent with benefits that are available in the private sector. Suggestions to realize desired consistency and simplification of the obligations include making changes to Medicare's cost-sharing requirements while simultaneously placing certain restrictions on Medigap policies. It is noted that in realizing both changes, beneficiaries with supplemental policies would not

be insulated from the effects of Medicare cost-sharing modifications. Proposals considered by the Committee could include the following:

- Introduce an out-of-pocket maximum on beneficiary cost sharing for all Part A and B services;
- Replace the current complicated mix of cost-sharing provisions with consistent cost sharing and a combined annual deductible covering all Part A and B services;
- Modify Medigap to require some cost sharing for services along with catastrophic protection (e.g., prohibit Medigap policies from paying for the first $100 of a beneficiary's cost-sharing liabilities (first-dollar coverage) and limit coverage to 95% of the next $5,000 in Medicare cost sharing);
- Impose nominal cost sharing in Medigap, e.g., $5-10 copayments for primary care visits and $20-$25 copayments for specialists; and
- Index all cost sharing to the growth rate in average Medicare costs.

Option – Means Testing Part D Premiums

The proposal considers requiring beneficiaries whose incomes exceed certain thresholds to pay higher premiums for Part D drug coverage. Higher premiums could apply only to basic coverage. The income thresholds could be set at the same levels and adjusted in the same manner under Part B. The proposals also consider requiring prescription drug plans to offer some level of coverage in the coverage gap in their enhanced benefit packages.

DMAA Comments:

DMAA supports efforts to streamline cost-sharing provisions and annual deductibles across services in Parts A and B. DMAA is concerned that, absent enactment of the proposed elimination of co-payments for preventive services, proposals to increase costs to beneficiaries (e.g., imposing additional cost-sharing requirements on Medigap holders or increased premiums for higher income beneficiaries) would inhibit these beneficiaries from obtaining needed services and medications. DMAA urges the Committee to consider providing incentives to Medicare and Medicaid beneficiaries to obtain recommended preventive services.