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August 24, 2010

Donald M. Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Attention: CMS-1053-P

Dear Administrator Berwick:

On behalf of the more than 200 members of DMAA: The Care Continuum Alliance, I respectfully offer the following comments for your consideration in response to the Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011 proposed rule issued July 13, 2010, in the *Federal Register*. Our comments are focused on Section 4103 of the Affordable Care Act (ACA) - Medicare Coverage of the Annual Wellness Visit Providing a Personalized Prevention Plan.

DMAA: The Care Continuum Alliance represents organizations providing services to more than 160 million Americans through wellness, chronic care management and complex case management. DMAA: The Care Continuum Alliance members include wellness, disease management and population health management (PHM) organizations; health plans; labor unions; employer organizations; pharmaceutical manufacturers; pharmacy benefit managers; health information technology innovators and device manufacturers; physician groups; hospitals and hospital systems; academics; and others. These diverse organizations share our vision of aligning all stakeholders toward improving the health of populations through collaborative, whole person, whole population management. Our members seek to improve health care quality and contain health care costs by providing targeted interventions and services to individuals who are well, at-risk or managing one or more chronic conditions.

The new Medicare annual wellness visit presents a tremendous opportunity to improve the health and well-being for Medicare beneficiaries. In addition, cost savings associated with healthier beneficiaries can contribute to the long-term sustainability of the program. However, we have two specific concerns regarding the proposed regulation as currently drafted:

Include the HRA at implementation

Section 4103 of the Affordable Care Act (ACA) creates Medicare coverage and physician payment for an annual wellness visit that includes the creation of a personalized prevention plan that takes into account the results of a health risk assessment (HRA). Despite the statutory requirement that the new wellness visit create a personalized prevention plan that includes a HRA, the proposed rule states that guidelines, standards and HRA models are not yet available; therefore, it will not be part of the initial implementation of the provision. While a national HRA standard may ultimately prove useful, HRA is too important to delay.

The HRA is an essential component to identify individuals who are at-risk for, or currently managing, chronic illness. The use of sophisticated HRA tools enables targeted programs designed to benefit these individuals and provide services and support based on current health status. The development of a personalized prevention plan and targeted programs for Medicare beneficiaries is the key goal of Section 4103 and one that will be difficult if not impossible to achieve without the use of a HRA. Importantly, these tools have been shown to improve health care status and quality and reduce health care costs. Numerous studies have demonstrated the value of the HRA in identifying risks, particularly in older adults and Medicare beneficiaries. HRAs increase patient engagement and lead to medical cost savings [1,2]. The findings published in the Journal of Occupational Medicine, in 2006[3] are particularly compelling with respect to the Medicare population.

Considering the positive relationship between the use of an HRA in health promotion participation, reduced medical costs and the impact of change in behavior and health status[4], CMS should follow the statutory directive and include the HRA as a requirement beginning in 2011. As a starting point, we strongly urge CMS to consider allowing the use of HRAs that have been accredited or certified by nationally recognized independent quality organizations such as the National Committee on Quality Assurance (NCQA) and URAC while the Agency considers the development of national standards. Both NCQA and URAC have rigorous accreditation standards and certification processes for HRAs that should serve as a model.

Include depression screening for subsequent annual wellness visits

Our second concern is that a review of risk factors for depression is not included as a requirement in subsequent annual wellness visits. The regulation states that a review of medical literature is not conclusive for the determination of optimum frequency for depression screening.

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[1] Serxner SA, Gold DB, Grossmeier JJ, Anderson DR, "The relationship between health promotion program participation and medical costs: a dose response, "J Occup Environ Med, Nov 2003; 45 (11): 1196-2000.

[2] Huskamp H, M Rosenthal, "Health Risk Appraisals: How Much Do They Influence Employees' Health Behavior," Health Affairs, 28, no. 5 (2009): 1532-1540.

[3] Ozminkowski R, Goetzel R, et al., "The Savings Gained from Participation in Health Promotion Programs for Medicare Beneficiaries," J Occup Environ Med, Vol. 48, No. 11, Nov 2006.

[4] Pai CW, Hagen SE, Bender J, Shoemaker D, Eddington DW, "Effect of health risk appraisal frequency on change in health status," J Occup Environ Med. 2009 Apr; 51(4): 429-34.

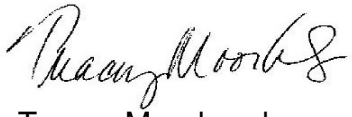
Depression in older Americans, especially those suffering from multiple chronic illnesses, is very common and widely documented. The United States Preventative Services Task Force (USPSTF) states that depression is a common occurrence in older adults and that those at risk for depression remain at risk throughout their lifetime[5]. In its December 2009 recommendation on depression screening for adults, the USPSTF states that there is direct evidence that links primary care depression screening programs to improved health outcomes.

The link between depression and chronic conditions, such as diabetes and chronic breathing disorders, has also been well recognized[6]. According to a study completed at the Washington University School of Medicine, the mere presence of diabetes doubles the odds of depression[7].

We strongly recommend that CMS reconsider its assertion that it would be "premature and beyond current evidence" to require depression screening for subsequent visits.

We appreciate the opportunity to provide comments on this proposed rule and would be pleased to provide additional information.

Sincerely,



Tracey Moorhead
President and CEO

[5] U.S. Preventive Services Task Force, "Screening for Depression in Adults," Recommendation Statement, Dec. 2009.
[6] Kunik M, Roundy K, et al., "Surprisingly High Prevalance of Anxiety and Depression in Chronic Breathing Disorders," CHEST, April 2005, Vol. 127, No. 4, 1205-1211
[7] Lustman, P, Anderson R, et al., "The Prevalence of Comorbid Depression in Adults with Diabetes,"