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May 14, 2010

The Honorable Kathleen Sebelius
Secretary Health and Human Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Attention: DHHS-2010-MLR

Dear Secretary Sebelius:

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 Request for Information on medical loss ratios issued April 14, 2010.

DMAA: The Care Continuum Alliance represents organizations providing services along the continuum of care 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 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; academicians; and others. These diverse organizations share DMAA: The Care Continuum Alliance's vision of aligning all stakeholders toward improving the health of populations. 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.

General Comment:

The Patient Protection and Affordable Care Act (PPACA), PL 111-148, directs the Department of Health and Human Services (HHS) to require that health insurance issuers annually report on the percentages of premiums spent on clinical services and activities that improve health care quality. Further, PPACA directs the National Association of Insurance Commissioners (NAIC) to establish uniform definitions for expense categories that comprise the medical loss ratio (MLR) for certification by HHS.

As HHS moves toward certifying NAIC uniform/standard definitions of MLR, DMAA: The Care Continuum Alliance urges the Department to recognize the continuous innovation and evolution of health care delivery systems toward the goals of improved quality and health outcomes and greater efficiency. To that end, HHS should establish a transparent and ongoing process with state regulators and other stakeholders that recognizes the

need for flexibility in classifying services for the calculation of the MLR and that avoids stifling the development, continued evolution and broader adoption of population health improvement initiatives. Specifically, as the Department develops a regulatory definition of "activities that improve quality," DMAA: The Care Continuum Alliance cautions against defining too narrowly the services in this category. The definition should recognize the evolving nature of the delivery and financing of health care and not inadvertently suppress innovation by restricting the category to a limited set of activities.

DMAA: The Care Continuum Alliance has previously defined “quality improvement” as an essential element and fundamental goal of population health management. The definition we adopted states: quality improvements flow from population health management strategies that “support the physician or practitioner/patient relationship and plan of care; emphasize prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies; and evaluate clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.”[i] We recommend HHS consider this definition and the associated population health management strategies in the development of criteria for inclusion in the category of “activities that improve health care quality.”

Wellness, disease and case management services improve and support the health of populations and are important activities that improve quality and result in better health outcomes. These services support an efficient and effective health care delivery system that facilitates the engagement and support of providers and patients to mitigate illness and improve long-term health. Wellness, disease and case management services are built on a foundation of evidence-based clinical care and measured by their clinical impact on health status. Such programs and services educate patients and promote self-management skills and behavior change; provide coaching and nurse support; ensure safe transitions in care; improve medication adherence and management; coordinate care between providers and care settings; and enhance quality through evidence-based decision support, data analytics, disease registries and other technologies. These services are primarily provided by licensed, clinical health care practitioners in and across numerous health care delivery settings and offer benefits far beyond cost containment and claims adjustment activities.

DMAA: The Care Continuum Alliance believes costs associated with these services should be classified as either “medical expenses” or “quality improvement expenses” for the purpose of calculating a health plan’s MLR under the requirements of PPACA. A recent paper developed on minimum loss ratios by the American Academy of Actuaries describes “case management, disease management, 24-hour nurse hotlines, wellness programs” as more “akin to benefits than administrative expenses” and appropriately factored into the value of benefits for the calculation of medical loss ratio (American Academy of Actuaries, February 2010).

These services have proved efficient and effective in improving the quality and cost of care, as demonstrated by the continued investment in population health management by commercial insurers. Further, DMAA: The Care Continuum Alliance has worked with numerous external stakeholders to develop measurement methodologies to guide evaluation of population health management programs and services. (*Outcomes Guidelines Report Volume 4.* DMAA: The Care Continuum Alliance, 2009; attached) We recommend that the Department refrain from setting evaluation guidelines and, instead, support the private sector’s continued work on measurement design and evaluation of

these services. DMAA: The Care Continuum Alliance is glad to serve as a resource for the Department to share its experience developing scientifically sound, consensus measures for population health management programs.

Specific comments:

(B)(1) What Definitions and Methodologies Do States and Other Entities Currently Require When Calculating MLR-Related Statistics?

Current NAIC guidance regarding the classification of expenses, including quality improvement activities such as wellness, disease and case management, is not binding on state insurance regulators. This has led to significant variation in state legislative and regulatory requirements for MLR calculations. Existing NAIC guidance issued in 2002 – Statement of Statutory Accounting Principles (SSAP) 85 – identifies case management and disease management programs as "cost containment expenses." NAIC defines "cost containment expenses" as "expenses that actually serve to reduce the number of health services provided or the cost of such services." Additional NAIC guidance directs "cost containment expenses" to be allocated as "administrative expenses" in the MLR calculation.

DMAA: The Care Continuum Alliance has previously communicated its belief that NAIC SSAP 85 is outdated and fails to appropriately account for and reflect the significant positive impact on quality and health outcomes that wellness, disease and case management programs provide. (See attached letter to Randall Stevenson, NAIC, 13 Sept. 2007.) DMAA: The Care Continuum Alliance has posited that the above-mentioned activities should more appropriately be classified as costs related to clinical care.

(B)(3)(b) What, if any, lists of activities that improve health care quality currently exist? What are the pros and cons associated with including various kinds of activities on these lists (for example disease management and case management)?

DMAA: The Care Continuum Alliance is unaware of existing lists of "activities that improve health care quality." At a minimum, HHS should be consistent with other statutory references in PPACA with respect to "activities that improve health care quality." In Section 1311, which establishes Health Benefit Exchanges, PPACA requires exchanges to implement quality improvement strategies, including:

> *(g) REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES.—*
> *(1) STRATEGY DESCRIBED.—A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for—*
> *(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;*
> *(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;*

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

(D) the implementation of wellness and health promotion activities; and

(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

(2) GUIDELINES.—The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) REQUIREMENTS.—The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

Section 2717 of PPACA, provides additional guidance by establishing quality reporting requirements for all plans with respect to benefits and provider reimbursement structures that:

(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;
(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;
(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and
(D) implement wellness and health promotion activities.

DMAA: The Care Continuum Alliance does not suggest that the MLR definition of "activities that improve health care quality" be limited to the activities referenced in this language, but rather be inclusive of them.

It also is important to note that PPACA establishes a National Strategy for Quality Improvement in Health Care (Section 3011) "to improve the delivery of health care services, patient health outcomes, and population health." Priorities identified as key to the strategy's development include many common to population health management programs: an emphasis on improved outcomes and efficiency; enhanced use of health care data; reduction of disparities across populations and geographic areas; awareness of high-cost chronic conditions; research on and dissemination of best practices to improve patient safety and reduce medical errors and preventable admissions.

(B)(3)(c) To what extent do current calculations of medical loss ratios include the amount spent on improving health care quality? Is there any data available relating to how much this amount is?

Section 2718, for the first time, introduces new terminology focused on "activities that improve health care quality" and attempts to ensure a broader commitment to delivering high-quality health care. However, data is not readily available at the state or federal levels with regard to current spending on health care quality activities. The lack of uniform definitions further inhibits efforts to collect such data.

DMAA: The Care Continuum Alliance stands ready to serve as a resource for HHS on population health management, medical claims costs and costs associated with activities that improve health care quality, including those regarding the efficacy or measurement of such services for the purposes of determining appropriate classification as either medical or quality expenses.

Sincerely,

Tracey Moorhead
President and CEO

[i] Dictionary of Disease Management Terminology, Second Edition. p. 152. DMAA: The Care Continuum Alliance. 2006.