

May 15, 2009

The Honorable Max Baucus
The Honorable Charles Grassley
U.S. Senate
Washington, DC 20510

Re: Comments on Senate Finance Committee Policy Options for Transforming the Health Care Delivery System

Dear Senators Baucus and Grassley:

Thank you for the opportunity to comment on the April 29, 2009 Policy Options paper with proposals to improve patient care and reduce health care costs. As organizations representing a broad and diverse array of consumers and patients, we have come together with a common vision of a health care system that delivers quality, patient- and family-centered care to all patients, all the time.

Patient-centered care is a straightforward concept. It is care that meets the patient's needs and preferences – at the right time, in the right setting, for the right reason, at the right cost. Any policy option or proposal to reform our delivery system must have as a measure of its promise the ability to achieve the following things:

- *Care is comprehensive, coordinated, and individualized, based on an assessment of the total needs and preferences of the patient and, where applicable, his or her family caregiver.*
- *Patients' experience of care is routinely assessed and improved.*
- *Patients and their family caregivers are full partners in their care, and provided with support for self-management of chronic illnesses and health care decision-making.*
- *Transitions between settings of care are smooth, safe, effective and efficient.*
- *Patients can access care when and where they want and need it.*
- *Care is connected to and integrates the community resources patients and family caregivers need to maintain their health and well-being.*
- *Continuous quality improvement and the elimination of disparities are a top priority.*

We thus commend you for proposing delivery system policy options that emphasize primary care, care coordination and payment strategies that will promote greater collaboration and shared

accountability. Further, a number of the options zero in on our most vulnerable, high-risk, high-cost patients who are falling through the cracks of our current system. We are pleased that you are laying the groundwork for a fundamental shift that links payment to quality and enables us to get more for our health care dollars. These strategies should reward value over volume, coordination over fragmentation, engagement over estrangement, and drive continuous improvements in the care patients receive.

Below we provide detailed comments on specific options, and we look forward to working with you throughout the legislative process to turn these proposals into action.

Section I: Payment Reform – Options to Improve the Quality and Integrity of Medicare Payment Systems

Linking Payment to Quality Outcomes

Establishment of a Hospital Value-Based Program

We appreciate and applaud your efforts to take a strong lead in the area of value based purchasing, by acknowledging that in order to achieve a high performing health care system, we need to reward results. As you consider options for value based purchasing, we urge you to ensure that we are driving toward a system that is patient- and family-centered and delivers the high quality, safe, and coordinated care that patients need. This means assessing and rewarding hospitals based on performance measures that reflect what is important to consumers and patients. We commend you for including patient experience of care in the list of likely measures for the program. We hope you will also encourage the use of other key measures of patient-centered care, including outcomes, functional status, transitions and care coordination that minimize errors and maximize patient and family understanding, and reduction of disparities.

It is also very important to ensure that the hospitals that serve our most vulnerable, high-risk, and underserved citizens are not unintentionally penalized. We commend you for allowing hospitals to be assessed both on their improvement over time as well as their attainment of certain quality thresholds. We believe there also must be adequate risk adjustment methodology in place to support hospitals that serve the sickest, most at-risk patients, particularly as CMS moves toward the use of more outcome-related performance measures.

The committee report should specify that performance measures under Medicare's Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) should disaggregate quality data by patient race, ethnicity, education level, gender, and primary language, and that evidence of equally high-quality care for these populations will be among the performance measures. In addition, disaggregated performance data should be publicly reported through appropriate vehicles such as the U.S. Department of Health and Human Services' Hospital Compare website. Such public reporting will improve the accountability and transparency of hospital efforts to eliminate health care inequities.

We believe these measures should also extend to Medicare home health agencies, hospices, and skilled nursing facilities. Measures of home health equality should be disaggregated by patient

race, ethnicity, education level, gender, and primary language, and these data should be publicly reported on the U.S. DHHS Home Health Compare and Nursing Home Compare websites. Similarly, proposed quality reporting programs for inpatient rehabilitation, hospices, and long-term care hospitals should disaggregate data, reward institutions that show evidence of providing equally high quality care across these dimensions, and publicly report these data.

Primary Care

Primary Care Bonus

We strongly support the proposal to provide a 5% Medicare bonus payment to providers of primary care services. Twenty-first century medicine requires team-based coordinated care that is anchored in primary care. To achieve this, we need increased payments to primary care physicians, and elimination of the distortions in the physician fee schedule that have produced an over-supply of procedure-based specialist services at the expense of the chronic care management, coordination, and support that patients desperately want and need. We believe the 5% bonus payment is an important step forward, although we note that the Medicare Payment Advisory Commission (MedPAC) recommended a 10% bonus for services furnished in health professional shortage areas. We urge you to increase this bonus payment to the 10% level recommended by MedPAC. We strongly support keeping such bonus payments budget-neutral. We also note that quality primary care, particularly in underserved areas, can often be effectively provided by physician assistants and nurse practitioners and these professionals also need to be adequately compensated.

Care Management

We believe that it is critical that we lay the foundation for more comprehensive reform of payment that results in better coordinated, more effective and efficient care for complex patients who account for the majority of health care spending. Over the long term, we hope you will enact policies that move us towards payment models that provide a capitated amount for care management activities that is risk-adjusted and tied to the severity and complexity of the patient's needs, including the number and nature of chronic conditions, physical and cognitive limitations, mental health needs, language access needs, and social and environmental factors, and other factors from a patient's health history that should be considered (e.g. if a patient has suffered longstanding health disparities, he or she may need additional services to recover or rehabilitate that are not directly related to the current episode of care). Further, any such care management payments should be linked to reporting and performance on patient-centered measures of quality and patients' experience of care, which are stratified by certain characteristics (e.g. race, ethnicity, gender, disability, primary language, socioeconomic status) to identify whether particular patient subgroups suffer lesser quality even if a clinician's total profile does not indicate disparities.

Transitional Care

We also applaud the proposal to provide payment for effectively managing transitions of care from hospital to post-acute settings, including the home. Patients, particularly those with multiple chronic conditions, are too often discharged from the hospital without the information, support and follow up they need to take care of themselves or recognize symptoms that require attention. We support the provision of the outlined care management activities as a comprehensive package to ensure that the needs and preferences of patients are met. We think it is particularly important that your proposed option recognizes that there are targeted interventions and care delivery models outside Medicare demonstration projects, such as models to improve care transitions, that have proven successful.

However, we urge you to ensure that legislative language recognizes the need to include family caregivers as potential recipients of appropriate qualified services, such as support of patient self-management, core proficiencies of caregiving related to patients with functional limitations and/or cognitive impairments and guaranteed respite care for those caring with persons with multiple chronic conditions. This is essential to improving care and reducing costs for high risk patients, such as individuals with multiple chronic conditions with cognitive or other functional limitations.

We also ask that you consider making other providers in addition to physicians eligible for payment for delivery of transitional care services. Lastly, we support expanding the policy to cover care coordination payments for high-cost beneficiaries with chronic conditions, since these services would enable this high-risk group to live more independently and avoid further disability and future hospitalizations.

Section II: Long-Term Payment Reforms – Options to Foster Care Coordination and Provider Collaboration

Chronic Care Management

We strongly support the creation of a Chronic Care Management Innovation Center at CMS, with enhanced authority to broadly test and disseminate care coordination models that show promise of improving the quality and cost-effectiveness of care. We believe CCMIC must have as its guiding principle the improvement in both access and quality of care for our highest risk, most vulnerable beneficiaries, particularly those with multiple chronic conditions. Accordingly, we urge you to consider adding beneficiaries with multiple chronic conditions who are at risk of progressive disability as a third target population.

We particularly appreciate your inclusion of key patient-centered criteria such as (1) placing the patient, including family caregivers, at the center of the care team; (2) focusing on in-person contact with beneficiaries; (3) maintaining a close relationship between care coordinators and primary care physicians; and (4) relying on a team-based approach to interventions such as comprehensive care assessments, care planning, and self-management coaching. We encourage you to include the following additional criteria:

- Ensuring that the care team has ready access to patients' up-to-date medical histories at the point of care;

- Ensuring patient and caregiver access to self-management supports;
- Identifying and accommodating the needs of patients with physical or cognitive limitations, language or cultural differences or other issues that could impede access to care;
- Planning, managing, and tracking patient care transitions, including ensuring special accommodations that may be necessary;
- Assessing the capacity and needs of family caregivers;
- Connecting the patient and family caregiver to community-based support services and evidence-based programs, including the use of community-based care coordinators and emotional supports for the family caregiver;
- Ensuring the availability of care during evening and weekend hours;
- Providing care at home for the most vulnerable and costly of Medicare's beneficiaries;
- Frequently collecting survey data on patient and caregiver experience of care and using the data to improve care;
- Incorporating patient decision tools into care decision-making;
- Continually assessing and improving quality, health outcomes, and functional status of patients, as well as engaging in relevant public reporting programs;
- Collecting race, ethnicity, primary language and gender data, and using that data to eliminate health disparities and improve experience of care.
- Holding hospitals, nursing homes and physicians accountable for appropriate hospice referrals of patients near the end of life.

Also, we believe it is important to clarify that any care planning and self-management coaching criteria clearly require that such interventions are evidence-based and *consistent with patient needs and preferences*. Also, CCMIC could play an important role in developing and testing models of culturally and linguistically appropriate practices.

Recognizing that most physician practices are comprised of one or two doctors, we endorse the concept of community care teams made up of non-physician professionals to provide the necessary coordination and transition services that are so critical to high quality and safe care for the most vulnerable. Such teams have proven their value in Vermont, North Carolina and Rhode Island among others.

We also endorse the concept of a Medicare Rapid Learning Network. We believe such a network could help leverage 21st century information tools to ensure rapid-cycle sharing of best practices in payment and delivery system reform. We do suggest, however, that you add a provision giving CMS the authority to participate in promising local and regional multi-stakeholder projects to improve care delivery, such as the southeastern Pennsylvania medical home pilot or the recently authorized multi-payer medical home effort led by a federally qualified health center (FQHC) in upstate New York. We note, for example, that your proposal to permanently authorize and expand Section 646, the Medicare Health Care Quality Demonstration, (page 19 of the Options Paper) includes a requirement to include multi-payer projects. We believe such a requirement should not be limited to Section 646, but should be a key element of testing, evaluating and promoting innovative payment models.

Hospital Readmissions and Bundling

We support your proposals to encourage better coordinated, integrated and accountable care by addressing avoidable and preventable hospital readmissions. Patients who are re-hospitalized after a recent discharge incur higher-than-expected costs, experience greater-than-expected clinical complications, and are less satisfied with their healthcare, relative to discharged patients who transition seamlessly to their regular lives and occupations. Dying patients are especially vulnerable to repeated readmissions which can be minimized with appropriate use of hospice care.

We do, however, suggest that in conjunction with the readmission policy, you adopt MedPAC's 2008 recommendation to publicly report hospitals' Medicare readmission rates as a precursor to payment adjustments.

We also support the move towards a payment policy that would bundle inpatient hospital payments with post-acute care services initiated within 30 days of discharge. We believe this will give hospitals and other post-acute care providers new incentives to better coordinate patients' care, provide transition management services such as patient or caregiver coaching and use of transition checklists, and establish effective linkages between institutional care, primary care and community supports for patients and caregivers.

We do, however, recognize that a bundled payment for expected services puts hospitals more at risk for costs that exceed the payment. This could give hospitals inappropriate incentives to reduce needed care for patients or disregard patient preferences about kinds and sources of post-acute care. We are pleased to see that your proposal includes a requirement that CMS develop patient protection rules and ensure that patients receive appropriate post-acute care and that access to care is maintained. It is critical that patients have explicit remedies to address care delayed or denied. We believe, in addition, it is essential that payments are risk-adjusted to ensure that they are linked to patients' complexity of needs. In addition, the bundled payment policy needs to be aligned with the policies under value-based purchasing and quality reporting, so that a sufficient portion of hospitals' payment is contingent upon their performance on patient-centered measures of quality, including outcomes, functional status, use of shared-decision aids, reduction of disparities, and patient and family satisfaction. Further, bundling must ensure payment is adequate so there are no disincentives to delay or deny care because of costs. Payment must be risk-adjusted and tied to the severity and complexity of the patient's needs, including the number and nature of chronic conditions, physical and cognitive limitations, mental health needs, language access needs, social and environmental factors, and other factors from a patients' health history that should be considered (e.g. if a patient has suffered longstanding health disparities, he may need additional services to recover or rehabilitate that are not directly related to the current episode of care). Some of these services may require ongoing adjustments to a bundled rate if usage exceeds the bundled rate. For example, the costs of providing language services are incurred at each encounter with a patient.

We also recommend that this program be assessed on an ongoing basis for its impact on institutions serving lower income, high risk, and disparity populations to ensure it doesn't have a disproportionate impact on access to care.

Section III: Health Care Infrastructure Investments – Tools to Support Delivery System Reform

Health IT

Encouraging Health Information Technology Use and Adoption in Support of Delivery System Reform Goals

We strongly support the expansion of Medicare incentive payments for the meaningful use of health IT to nurse practitioners and physician assistants. Many patients seeking care in underserved areas depend on the services of these professionals for the majority of their health care needs, so this expansion will be an important step in decreasing health disparities and making high quality, better coordinated care available to all.

Well-coordinated care requires that all who have a role in caring for a patient throughout his or her course of treatment have access to the information necessary for providing that care. Incentivizing physician practices and hospitals to adopt HIT is a giant step forward in achieving the goal of rewarding coordination over fragmentation, but to achieve our ultimate goals of coordinated care, shared accountability, and patient-centered care, we encourage you to expand HIT incentives to health care providers who deliver services in other key settings such as nursing homes, rehab facilities, and home health agencies. These entities deliver care to some of the most vulnerable and complex patients, many of whom move from care setting to care setting on a frequent basis, and urgently need effective use of HIT effectively to improve both the delivery of care and their communication with other providers.

Perhaps the most important – but often forgotten – members of the health care team are the patient and their family caregivers at home. HIT has tremendous potential to enable patient-centered care, by connecting the health care system to the patient in a way that puts meaningful and actionable information into the hands of patients and caregivers. We therefore encourage you also to provide incentives for clinicians to adopt and actively use patient facing technologies, such as those that provide patients and caregivers with the ability to access their own personal health information and digitally interact with providers, as well as patient decision aids that facilitate shared decision making.

Comparative Effectiveness Research

We want to thank you for your leadership on this issue. Patients and clinicians need access to the latest research comparing the effectiveness of different treatments, drugs and devices. Armed with better information, patients and their clinicians can choose the wisest course of action that is most effective for them and not waste time or money on unnecessary tests or procedures and less effective treatments. We need a robust federal commitment to comparative effectiveness research, and endorse your proposal to establish a long-term framework, financed with an all-payer trust fund. We encourage you to ensure that the outcomes of comparative effectiveness research will be made available to patients, consumers, and their caregivers in ways that are easy to access and understand, including through electronic means.

We do, however, suggest that you emphasize that reducing harmful health disparities is one of the goals of comparative effectiveness research, and that representatives of ethnic and minority communities, as well as health care consumers, are to be explicitly included in the governance and advisory bodies created by this section. We applaud the language in S. 3408 that requires that comparative effectiveness research take into account the potential for differences in the effectiveness of health interventions with certain subpopulations, such as racial and ethnic minorities, women, children, and older adults with multiple chronic conditions.

Workforce

We support your proposal to develop a national workforce strategy and to work with the Senate Committee on Health, Education, Labor and Pensions to develop policies to address healthcare workforce shortages.

Although there is an overall shortage of health care workers in all fields, the situation is particularly severe in geriatric care because it attracts fewer specialists than other disciplines and experiences high turnover rates among direct-care workers (e.g., nurses' aides, personal care attendants). The growing number of older patients who are living longer with multiple chronic conditions is outpacing the number of health care providers with the knowledge and skills to provide the best possible care.

As identified in the IOM report, *Retooling for an Aging America*, we must ensure that all health care providers are trained in and demonstrate competence in geriatric care; increase the recruitment and retention of geriatric specialists and caregivers; and redesign models of care and broaden provider and patient roles to achieve greater flexibility. We encourage you to consider implementing financial incentives, such as linking educational loan repayment to a service commitment to the aging population, to attract more professionals to geriatric careers. Congress should authorize and fund an enhancement of the Geriatric Academic Career Award (GACA) program to support junior geriatrics faculty in other health professions in addition to allopathic and osteopathic medicine. Congress should also significantly increase support for research and demonstration programs that promote the development of new models of care for older adults in areas where few models are currently being tested, such as prevention, long-term care, and palliative care, and promote the effective use of the workforce to care for older adults.

Enhancing the diversity of the health professions workforce is also a critically important element of any comprehensive strategy to address health care inequities. Racial and ethnic minority providers are more likely than majority-group providers to seek to work in medically underserved communities, and are often able to help bridge cultural and linguistic barriers between health systems and patients. In addition, when racial and ethnic minority patients have a choice, they often prefer receiving care from providers from the same racial and ethnic background. It is therefore important that any national workforce strategy prioritize and stimulate diversity efforts.

Section IV: Medicare Advantage – Options to Promote Quality, Efficiency and Care Management

Linking Payment to Quality

We strongly support your proposal to link some portion of payment to Medicare Advantage plans to their performance on quality measures. We believe such measures should provide a picture of whether plans support patient-centered care for their enrollees, with a particular focus on measures of care coordination, care transitions, and patient and caregiver experience.

Pay for Chronic Care Management

We support the goal of your proposal to give Medicare Advantage (MA) plans a bonus for chronic care management, alongside a competitive bidding program. However, managed care plans are established and specifically designed to manage care for their enrollees, particularly those with chronic conditions. That was a key goal that drove the creation of the MA program. Thus, it does not make sense to now provide bonus payments for these plans to do what they were originally established to do. We would, however, support a bonus payment for care management activities for highly complex patients that go above and beyond the traditional role of managed care plans. This could include transitional care benefits; evidence-based self-management supports and programs; assessment and care planning that includes medical, prevention and social services; medication management that reduces errors and adverse events; and post-hospital transitional care. Activities could be integrated into care models such as advanced medical homes, or other innovative models to improve the quality of care for our most complex, high risk beneficiaries. Such bonus payments should also be based on enrollees' health outcomes, not solely on the structures and processes in place. You might also consider ways to structure incentives to MA plans so they are not penalized for keeping patients healthy – and therefore not collecting on a more positive risk adjustment – through the use of bonus payments tied to care management and retaining enrollees over the long term.

Simplify Extra Benefits

We agree that the first priority in provision of extra benefits should be the provision of an annual out-of-pocket limit on cost-sharing for all medical services covered under Parts A and B. This is the simplest, most fool-proof way to ensure that Medicare Advantage benefit packages provide financial protection to beneficiaries in need of high-cost treatments and do not design benefits that discriminate on the basis of health status.

The second priority for extra benefits should be reduced cost sharing for A/B services or enhanced Part D coverage. Once these priority goals are accomplished, additional benefits, such as dental or vision coverage or gym membership, are appropriate.

Summary of Recommendations

In summary, our specific recommendations are as follows:

- *Hospital Value-Based Program*

- Encourage the use of measures of critical elements of patient-centered care, such as outcomes and functional status, transitions, care coordination, and reduction of disparities.
- Establish an adequate risk-adjustment methodology to help hospitals that serve the sickest, highest-risk patients.
- Specify that performance measures under RHQDAPU should disaggregate quality data by race, ethnicity, level of education, gender, and primary language, and that this data should be publicly reported.
- *Primary Care*
 - Adopt MedPAC recommendation of a 10% bonus for primary care services in health professional shortage areas, recognizing that primary care often can and should be provided by physician assistants and nurse practitioners.
 - For transitional care, include family caregivers as potential recipients of appropriate qualified services, such as support of patient self-management, shared decision-making, respite care, and linkages to community-based services.
 - Support a long-term transition to payment models that provide a capitated amount for care management activities that is risk-adjusted and tied to the severity and complexity of the patient's needs. Those payments should be linked to performance on measures of quality and patient-centeredness.
- *Chronic Care Management*
 - Expand criteria for the expansion of care coordination models to include a broader set of patient-centered elements.
 - Give CMS authority to participate in promising local and regional multi-stakeholder projects to improve care delivery.
 - Lay groundwork for a shift away from fee-for-service toward more coordinated, integrated and accountable care.
- *Hospital Readmissions and Bundling*
 - Adopt MedPAC's recommendation to publicly report hospitals' readmission rates as a precursor to payment adjustments.
 - Couple the move towards bundled payments with risk-adjusted payments that are linked to patients' complexity of needs.
 - Align the bundling policy with value based purchasing and quality reporting policies to ensure a sufficient portion of hospitals' payment is contingent on providing patient-centered care and producing good health outcomes.
- *Health IT*
 - Expand HIT incentives to nursing home, rehab facilities, and home health agencies.
 - Provide incentives for clinicians to use HIT to better engage their patients and caregivers in their care, such as technologies that provide patients and caregivers with the ability to access their own personal health information and digitally interact with caregivers, as well as patient decision aids that facilitate shared decision-making.
- *Comparative Effectiveness Research*
 - Explicitly include representatives of ethnic and minority communities, as well as health care consumers, in any governance and advisory bodies.

- Ensure comparative effectiveness research results are publicly available, including through electronic means.
- *Medicare Advantage – Paying for Chronic Care Management*
 - Provide bonus payments to plans only for care management activities that go above and beyond the traditional role of managed care plans and focus on meeting the needs of our most complex, high risk and vulnerable patients. Bonus payments should be based on health outcomes, and should incentivize plans not only to better manage care, but also to retain enrollees over the long term.
- *Workforce*
 - Ensure that primary care providers are trained in and demonstrate competence in geriatric care;
 - Increase the recruitment and retention of geriatric specialists and caregivers through such means as providing financial incentives;
 - Redesign models of care and broaden provider and patient roles to achieve greater flexibility;
 - Enhance the diversity of the health professions workforce

Again, we appreciate the opportunity to comment. We applaud your efforts to improve the health care delivery system, and look forward to working with you to achieve a more patient- and family-centered system that ensures every American receives the high-quality, affordable health care they need and deserve.

Sincerely,

National Partnership for Women & Families
 AFL-CIO
 Alzheimer’s Association
 American Hospice Foundation
 Bazelon Center for Mental Health Law
 Center for Advancing Health
 Childbirth Connection
 Consumers Union
 Health Care for America Now
 Healthwise
 Leadership Conference on Civil Rights
 Medicare Rights Center
 National Alliance for Caregiving
 National Consumers League
 National Council on Aging
 National Health Law Program
 National Women’s Law Center
 Northwest Federation of Community Organizations
 SEIU
 Washington Community Action Network