



MISSION: To promote continuous improvement in the quality and efficiency of health care management through processes of accreditation and education.

May 17, 2010

**Member
Organizations**

Academy of Managed
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American Association
of Preferred Provider
Organizations

American College of
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Insurance Plans

American Health
Quality Association

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American Medical
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American Nurses
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American Psychiatric
Association

Blue Cross Blue Shield
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Case Management
Society of America

National Association of
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Pharmaceutical Care
Management
Association

Marianne Fazen, PhD
Board Chairperson

Alan P. Spielman
President and CEO

Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup, NAIC
New York State Department of Insurance
25 Beaver Street
New York City, NY 10004

Dear Mr. Felice:

I am writing on behalf of URAC to offer comments in response to the Health Care Reform Solvency Impact Subgroup's exposure draft of the Blanks Agenda Item Submission Form, released on May 12, 2010.

URAC is an independent, nonprofit organization whose mission is to promote continuous improvement in the quality and efficiency of health care management through the processes of accreditation, education and measurement. To support these goals, URAC's Board of Directors represents the full spectrum of stakeholders interested in our health care system, including consumers, employers, health care providers, health insurers, purchasers, workers' compensation carriers and regulators.

In response to your request on Wednesday for prompt feedback on your call, we have attached an edited version of Line 5.1 on page 10 of the Blanks form. Our recommendations are based on both language previously submitted by the Disease Management Association of American (see yellow highlighted provisions), which we endorse, and our own suggested additions (see blue highlighted provisions).

We believe that one of the key goals Congress set out to achieve in enacting the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) was to adopt public requirements and, just as important, to provide powerful public *incentives* for private activities that would lead to the enhancement of the overall quality of the American health care system. In this context, tackling any of the various regulatory issues that are now or will soon be considered as part of the implementation of the PPACA without carefully considering steps that will either encourage or discourage efforts to boost health care quality would be a serious oversight.

As you know, there are few regulatory decisions in connection with the PPACA that offer more robust opportunities to enhance -- *or detract from* -- effective health care quality initiatives than the rules surrounding the definitions and the proper calculation of the new minimum medical loss ratio standards under Sec. 1001: 2718 of the new reform law.

We would therefore urge you to consider our recommended additions to the categories your subgroup has identified in 5.1, especially in light of other sections of the PPACA specifically endorsing a far broader range of activities designed to promote and improve health care quality.

Finally, the PPACA requires that health plans that participate in the new exchanges be accredited under Section 1311. Congress clearly recognized the fact that independent accreditation and quality measurement and improvement ultimately provide value to patients in the form of enhanced quality of care.

The following PPACA legislative provisions enclosed in attachment B: Section 1311 (g); Section 2717 (a); and Section 3011 are just some examples -- among others in the PPACA -- that endorse a very broad range of established activities that have been demonstrated to improve health care quality.

Importantly, both the federal government and most states have already enacted legislation specifically promoting health care quality improvement. Many states mandate quality data collection and reporting for purposes of independent accreditation from organizations such as URAC.

We believe it would be inconsistent with current law, the general thrust of the PPACA, and especially the specific provisions highlighted in attachment B, to establish overly limited, and narrowly defined, descriptions of activities designed to improve health care quality. We would therefore respectfully urge you to carefully consider adopting the more robust descriptions of quality improvement activities as outlined in the attached document. Finally, we would urge you to include a new category under Line 5.1 dedicated to activities associated with the accreditation process.

We greatly appreciate the opportunity to provide input on this important issue.

Sincerely,



Alan P. Spielman
President and CEO

ATTACHMENT A

URAC Recommended Edits to NAIC Blanks Form

Line 5 – Improving Health Care Quality Expenses Incurred

Expenses, other than those billed or allocated by a provider for care delivery (i.e., claims costs), that are designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care. The following shown in lines 5.1 and 5.2 are the items that will be considered quality of care expenses if they are designed to improve health care quality, promote the delivery of high quality care, reduce or mitigate risk factors of disease, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care.

Exclude: Cost containment expenses that do not directly relate to the quality of health care. These are reported in line 7.1.

Line 5.1 – Type A: Expenses for Health Improvements other than Health Information Technology

Expenses, other than those billed or allocated by a provider for care delivery (i.e. claims costs), that are designed to improve or maintain the quality of a patient's health, promote the delivery of high quality care, reduce medical errors, increase patient compliance with treatment plans and medication adherence, mitigate or reduce the risk factors of disease, to medication or medical treatment plans, reduce health disparities, and advance the delivery of patient-centered medical care in ways that can be objectively measured and verified. In addition,

The following are items that will be included as quality of care expenses meeting these criteria:

1. **Care coordination** (not just general care management) – Actions and programs to promote the active hands-on participation (e.g. face-to-face, telephonic or web-based interactions, or other modalities with patients and their providers) to coordinate a patient's care between multiple providers (such as making sure medical records are shared between all the patient's physicians, making/verifying appointments, and medication compliance/medication therapy management) and arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center and prevention of hospital readmissions).
2. **Chronic Disease Management Hands-on** individually tailored programs for specific chronic conditions that interact with the insured (e.g. face-to-face, telephonic or web-based interactions, or other modalities with patients and their providers) to (a) remind insured of doctor appointment, (b) check that insured is following a medically effective prescribed regimen for dealing with the specific disease/condition, (c) incorporating feedback from insured in the management program, (d) provide coaching on dealing with the disease/condition.
3. **Preventive Care and Wellness Programs: Hands-on** Programs that interact with the insured (e.g. face-to-face, telephonic or web-based interactions, or other modalities with patients and their providers) related to: Wellness and/or health risk assessment, wellness / lifestyle coaching programs, coaching programs designed to educate individual members on managing clinically effective for dealing with a specific chronic diseases, and coaching or education programs designed to change individual members' behavior (e.g. smoking, obesity).
4. **24 Hour Nurse Hotlines:** Expenses for 24 hour nurse hotlines should be included in care coordination, chronic disease management, and preventive care and wellness

programs to the extent they meet those expense requirements. Any other expenses for 24 hour nurse hotlines should be excluded from Improving Health Care Quality Expenses and instead included in Claims Adjustment Expenses.

5. Accreditation of programs that address the aforementioned quality of care activities, by a nationally recognized accreditation entity, in order to demonstrate that these clinical and quality functions are meeting national, contemporary standards for the delivery of high quality care and to promote best practices in these functions.
6. **Other costs** approved by the Secretary, in consultation with the NAIC, which in her discretion, upon an adequate showing that the costs improve the quality of healthcare; the burden shall be on the proponent to show that the costs improve the quality of healthcare.

The following items are broadly excluded as not meeting this criteria:

- Utilization Review
- Fraud Prevention activities
- Any function not expressly included in Type A items 1 through 5, above.

Line 5.2 – Type B: Health Information Technology Expenses Related to Health Improvement

Expenses for Health Information Technology (HIT), consistent with the purposes described in A, above, defined as depreciation on hardware and expenses for software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for use by health plans, health care providers, or patients for the electronic creation, maintenance, access, or exchange of health information and the personnel costs associated with implementing those technologies or licenses, but limited to the following expenses;

1. Monitoring or reporting clinical effectiveness;
2. Advancing the ability of providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently;
3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;
4. ~~Costs directly related to upgrades in HIT that are required to be made in order to comply with new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended. (Discuss – Exclude as administrative or include as Fed requirement)~~
5. Other costs approved by the Secretary, in consultation with the NAIC, which in her discretion, upon an adequate showing that the costs improve the quality of healthcare; the burden shall be on the proponent to show that the costs improve the quality of healthcare.

ATTACHMENT B

SELECTED QUALITY SECTIONS OF PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) (P.L. 111-148)

1. Section 1311 (g) REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES.
– 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;...
- (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*; and
- (D) the implementation of *wellness and health promotion activities;*”

(Emphasis added.)

2. Section 2717 – ENSURING THE QUALITY OF CARE

(a) QUALITY REPORTING.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care 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.*”

(Emphasis added.)

3. PART 2—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY
SEC. 3011. NATIONAL STRATEGY.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

“PART S—HEALTH CARE QUALITY PROGRAMS

“Subpart I—National Strategy for Quality Improvement in Health Care

“SEC. 399HH. NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE.

“(a) ESTABLISHMENT OF NATIONAL STRATEGY AND PRIORITIES.—

“(1) NATIONAL STRATEGY.—*The Secretary, through a transparent collaborative process, shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.*

“(2) IDENTIFICATION OF PRIORITIES.—

“(A) IN GENERAL.—The Secretary shall identify national priorities for improvement in developing the strategy under paragraph (1).

“(B) REQUIREMENTS.—*The Secretary shall ensure that priorities identified under subparagraph (A) will—*

“(i) *have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care for all populations, including children and vulnerable populations;*

“(ii) *identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care;*

“(iii) *address gaps in quality, efficiency, comparative effectiveness information (taking into consideration the limitations set forth in subsections (c) and (d) of section 1182 of the Social Security Act), and health outcomes measures and data aggregation techniques; As revised by section 10302.*

“(iv) *improve Federal payment policy to emphasize quality and efficiency;*

“(v) *enhance the use of health care data to improve quality, efficiency, transparency, and outcomes;*

“(vi) *address the health care provided to patients with high-cost chronic diseases;*

“(vii) *improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections;*

“(viii) *reduce health disparities across health disparity populations (as defined in section 485E) and geographic areas; and*

“(ix) *address other areas as determined appropriate by the Secretary.*

(Emphasis added.)