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May 15, 2009

VIA ELECTRONIC MAIL

Senator Max Baucus, Chairman
Senator Chuck Grassley, Ranking Member
United States Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Comments to Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs

Dear Senators Baucus and Grassley:

We are writing to offer our comments on the Senate Finance Committee's description of policy options regarding reform of the U.S. health care delivery system. We applaud your attention to these vital issues and appreciate the opportunity to provide our thoughts based on our experience working with consumer groups in 43 states to improve access to quality health care for all.

Community Catalyst is a national non-profit advocacy organization working to build the consumer and community leadership that is required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society.

Our vision for the U.S. health care delivery system, particularly one that promotes better care for people with complex health care needs, is one that reflects the following principles:

- Places **patients and families at the center** of care planning and delivery
- Promotes **primary care, prevention, wellness and independence**
- Facilitates access to **all necessary medical and non-medical resources and services**
- **Educates and empowers patients and families** and incorporates their perspectives in plan design and governance
- **Coordinates care across health care settings**, from primary and acute to long-term and home- or community-based care
- **Employs interdisciplinary care teams** that address the full range of patient needs
- Ensures that patients get the right care at the right time and right place, **regardless of income, race, ethnicity or primary language**
- Uses **communications systems** that simplify patient records and interactions and facilitate care coordination
- **Pays health care providers fairly while ensuring accountability**
- Allows **public access** to payment, access and quality data
- Supports **racial and ethnic diversification of all health professions**
- Offers **strong beneficiary protections**
- **Improves overall value**

We believe the Committee's delivery system policy options document represents a positive step towards reaching this vision. Recognizing that there is not just one solution to fix what is wrong with the delivery system, the Committee has offered a variety of constructive and practical proposals. The document reflects a strong commitment to assuring that national health reform incorporates measures to improve quality and coordination of care, laying a foundation for an improved system that meets the health care needs of our country's most vulnerable populations.

While we believe the Committee has provided a good framework for the future of the U.S. health care delivery system, our comments and recommendations would build on this framework to further improve the quality of care in a number of key areas.

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

Linking Payment to Quality Outcomes

We strongly support options that would strengthen quality-based payment incentives and create mandatory public reporting requirements on quality measures for hospitals, physicians, skilled nursing facilities, and nursing homes. In particular, we applaud the proposed public reporting of individual hospital performance data. But it is equally important that payments to hospitals, even those based on quality performance, be transparent to the public. Therefore, data on incentive payments to hospitals should be published annually in an accessible location and in consumer-friendly language. We agree that the HospitalCompare.gov website might be easily adapted to include this information.

We appreciate that the hospital value-based program will not only use existing quality performance measures but also will allow the Secretary to add other relevant measures. To that end, we recommend that the Secretary set benchmarks for reducing racial and ethnic disparities, and for improving access for those whose primary language is not English. One recommended benchmark is meeting all fourteen *National Standards on Culturally and Linguistically Appropriate Services*. Currently, recipients of federal funds are only required to meet four of these standards. The Committee should also direct the Secretary to seek guidance in developing additional benchmarks from organizations focused on improving health for minorities and immigrants. Finally, the committee should speed progress in reducing disparities by providing financial incentives to providers who meet or exceed the benchmarks. These incentives should dovetail with, or be built into, the quality improvement and value-based purchasing measures that the Committee proposes for hospitals, physicians and other providers.

Strengthen Reporting and Consumer Protection Requirements as a Condition of Medicare DSH Payments

An additional aspect of any hospital value-based program relates to disproportionate share (DSH) funds, which are meant to offset care rendered to low-income and Medicaid patients. These public funds significantly subsidize the uncompensated care hospitals provide to low-income patients. In the absence of strong government oversight, there have been numerous accounts of hospitals—including those receiving DSH funding—employing unfair billing and collection practices with severe financial consequences for uninsured and underinsured patients. Moreover, the Medicare Payment Advisory Commission (MedPAC) and others have found that DSH payments are not always directed to hospitals providing the highest levels of uncompensated care.

Thus, we recommend conditioning Medicare DSH payments on compliance with strengthened reporting and consumer protections, including eligibility criteria and public notice requirements for free care programs and the use of fair billing and collection practices.

Please note that we will provide additional views regarding DSH in our forthcoming comments to the Committee's proposals contained in *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans*.

Primary Care

We support payment reforms that invest in primary care and community-based care rather than institutional care. Primary care providers play a critical role in coordinating patient care, particularly for individuals living with chronic illness. We support paying primary care providers to coordinate patient care using methods that account for the complexity and intensity of patients' needs and that foster an interdisciplinary team approach to care delivery, including strengthened roles for paraprofessional and non-medical providers.

Primary Care and General Surgery Bonus

We agree with the Committee's proposal to provide bonus payments to primary care providers and general surgeons as one means to address the dire primary care workforce shortage that exists in many areas of the country. We support, however, an increase in the proposed bonus payment to 10 percent, as recommended by MedPAC. Access to primary care services is also essential for the healthy growth and development of children. We urge the Committee to provide financial incentives for primary care services delivered to children in Medicaid.

Paying for Coordinated Care that Works for Patients and Families

We agree that developing a framework based on best practices is critical to creating the right payment incentives for coordinated care that lowers costs and leads to better outcomes for the health care consumer. Our vision for the U.S. health care delivery system, as outlined above, is grounded in coordinated care models that improve care for patients and families. We recommend these principles guide the creation of standards that providers must meet in order to qualify for extra reimbursements.

In particular, we note that patient and family-friendly care coordination uses an expanded model of health that addresses individuals' physical and behavioral health care needs within their family and home, as well as non-medical needs, such as food and transportation. This allows providers to identify factors that increase the chances of poorer health outcomes; to work with the individual and family caregivers to develop a plan of care to address those issues; and to maneuver around traditional barriers to addressing needs by integrating medical and non-medical services as part of a patient's routine care. Patient and family-friendly care coordination anticipates the needs of the whole person, medical and non-medical, and provides or arranges for the patient to receive proactive, continuous, appropriate care across health care settings.

Evidence suggests that coordinated care of this kind can mean higher quality care, better outcomes and reduced reliance on expensive medical interventions. In Massachusetts, for instance, a study of the Senior Care Options (SCO) program, which provides a full array of health care and social services for low-income seniors, showed that frail elders enrolled in SCOs were able to remain in their homes

for longer periods of time prior to entering nursing homes.¹ They also spent less time in nursing facilities compared with similar populations outside of the program.

Finally, we strongly support reimbursing physicians that effectively coordinate care for chronically ill Medicare beneficiaries who are either transitioning from a hospital to a post-acute setting or who are at highest risk for hospitalization.

Care Coordination Models that Work for Children

When developing strategies to support care coordination, including Patient Centered Medical Homes (PCMH), it is critical to recognize that children have different needs than adults. For example, PCMH for adults is largely focused on chronic disease management. In pediatrics, however, PCMH must be designed to address the needs of the whole child. We urge the Committee to support the development of PCMH programs that meet the unique needs of children. Please note that we will provide additional views regarding care coordination strategies for children in our forthcoming comments to the Committee's proposals contained in *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans*.

Addressing Pediatric Workforce Shortages and Fostering a Diversified Workforce

Access to a wide-range of health care providers is important for children. We appreciate the Committee highlighting the need for a National Health Care Workforce Strategy. We agree this is an important aspect of delivery system reform and recommend that special attention be paid to shortages of pediatric sub-specialists, as well as oral health and mental health providers who specialize in treating children.

The Committee should explicitly include goals for racial and ethnic diversity in its proposals to expand the primary care and general surgery workforce. It should also expand support for training of underrepresented minorities in all health professions. The Committee should also direct the Secretary to ensure that diversifying the workforce is an essential element of a national health care workforce strategy.

Providing Incentives to States Seeking to Coordinate Care and Integrate Benefits

In addition to offering extra payments to primary care providers for coordinating care, we recommend the Committee consider offering federal grant funding or other mechanisms such as shared savings to states that incorporate effective care coordination models in their public programs. One means of doing this would be to integrate payments from all sources to allow better coordination of services.

Integrating payments is particularly relevant to dually eligible beneficiaries, who face serious challenges in negotiating two separate systems of care in Medicare and Medicaid. Public spending on care for dually eligible beneficiaries is disproportionately high. Still, dually eligible beneficiaries are more likely to report forgoing care, experiencing medical errors, paying high out-of-pocket costs and being unnecessarily placed in hospitals and nursing homes. Moreover, because Medicaid and Medicare cover different benefits, there is an incentive for each program to shift costs to the other. Integrated payment adapted to a single set of coverage rules and administrative processes can make it easier for dually eligible patients to get care and reduce incentives to shift costs. Where possible,

¹ JEN Associates, Inc. (2008, June 6). *MassHealth Senior Care Options program evaluation: Pre-SCO enrollment period CY2004 and post-SCO enrollment period CY2005 nursing home entry rate and frailty level comparisons*. Retrieved May 4, 2009 from http://www.mass.gov/Eeohhs2/docs/masshealth/sco/sco_evaluation.txt.

Medicare and Medicaid dollars should be combined, with a single agency responsible for organizing and coordinating all services.

A number of integrated care models—such as the PACE and Medicare Advantage Special Needs Plan (SNP) programs—have attempted to address these problems. However, the legislative and regulatory frameworks governing these models have either made it difficult to bring them to scale or have not built a structure sufficient to support them. We support establishing an Office of Medicare/Medicaid Integration charged with developing pathways for programs to improve care for dually eligible beneficiaries, including those that integrate the delivery of Medicare and Medicaid services.

We were extremely pleased to see proposals related to dually eligible beneficiaries in the Committee's recently released policy options document, *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans*. Please note that we will provide additional views on these proposals in our forthcoming comments to that document.

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

We commend the Committee for seeking paths that foster care coordination for people with chronic conditions or other complex health needs. We firmly believe that through better coordination, the U.S. health system would:

- Reduce avoidable hospitalizations and preventable readmissions
- Decrease the use of unnecessary and expensive procedures
- Decrease the number of unnecessary visits to emergency rooms
- Minimize administrative expenses

Chronic Care Management

Chronic Care Management Innovation Center

The creation of a Chronic Care Management Innovation Center (CCMIC) is an important step in realizing these goals. The Committee's preference for pilot programs over demonstration programs is wise. Pilot programs allow innovative approaches to be fully tested for a longer period of time and across many more sites than demonstration projects. Thus, if a pilot program shows positive results, it can more easily move to scale and evolve into a permanent program.

We support the requirement that the CCMIC consult with an advisory board, but strongly recommend that the board include advocates with experience in representing people with chronic conditions and their families. Furthermore, to ensure that the CCMIC is not siloed within CMS, we recommend the advisory board include representatives of Medicaid and Medicare as well as any prospective CMS office focused on integrating care for dually eligible beneficiaries.

The proposed criteria for choosing innovative models are well-suited for improving the quality of care for people with chronic illnesses and, in fact, have been characteristics of successful coordinated care demonstration projects.² We recommend, however, that models chosen meet the additional criteria derived from the principles articulated in our vision for the U.S. health care delivery system (*see page 1*).

² Whelan, E.M. (2009, February 12). Setting the health system up to fail. *Center for American Progress*. Retrieved on May 7, 2009 from http://www.americanprogress.org/issues/2009/02/coordinated_care.html.

Finally, while the Advanced Patient-Centered Medical Homes model might certainly meet CCMIC's criteria, transitional care teams and shared decision-making aids should be considered "tools" that might be *employed by* a chronic care model. Other examples of models that qualify might also include fully integrated care programs for dually eligible beneficiaries that suffer from chronic illnesses.

Hospital Readmissions and Bundling Policy

Hospital Readmissions and Post-Acute Bundling Policy

We applaud the Committee's emphasis on reducing preventable hospital readmissions. Developing a hospital payment policy that offers greater incentives to coordinate patient care, particularly in the transition out of a hospital, makes sense and will further the Committee's overall objectives of improving quality of patient care while also reducing costs.

This approach will also foster greater accountability among hospitals and providers. We would urge the Committee, however, to take additional steps to also foster **greater transparency**. Specifically, the Committee should adopt MedPAC's recommendation that hospital readmission data be made public³ so patients and families can make informed choices about their care.

Bundling Policy

Studies have shown that bundling certain episodes of care for payment, especially when combined with other evidence-based practices, work to reduce costs and improve the quality of care for patients. For example, Geisinger Health Systems demonstrated measurable reductions in complications and hospital readmissions related to cardiac bypass surgery when it combined an episode-based care payment policy with systems to ensure doctors followed best clinical practices for the surgery.⁴

While we support the Committee's bundling approach, we recommend that it accelerate the timetable for phasing in the bundling policy to no more than five years. In addition, we suggest that any delivery reform legislation require public reporting of comparative performance data for the various episodes of care.

Moving From Fee-for-Service to Payment for Accountable Care

Medicare Shared Savings Program (i.e. Accountable Care Organizations)

Though not fully tested, the Accountable Care Organization (ACO) model shows promise as a pathway toward improving health care and can be viewed as an important piece of the delivery reform puzzle. We support the Committee's flexible approach to the form of the ACO, *i.e.* that the program be open to a variety of provider group models that meet specified criteria.

³ Hackbarth, G.M. (2009, April 1). *Reforming the health care delivery system*. Statement of the Medicare Payment Advisory Commission Chairman before the Committee on Ways and Means, U.S. House of Representatives, 111th Congress..

⁴ See Steele, G.D. (2009, April 21). *Reforming the healthcare delivery system*. Testimony of the President and Chief Executive Officer of Geisinger Health System before the Committee on Finance, U.S. Senate, 111th Congress.

The criteria listed in the policy options document provides a good start, but we recommend that instead of allowing ACOs the discretion to “define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care,” any legislation require ACOs to employ processes derived from the principles articulated in our vision for the U.S. health care delivery system (*see page 1*).

While the Committee’s current proposal would pay ACOs on a fee-for-service basis, we recommend the Secretary permit ACOs to also be paid on a partially or fully capitated basis to allow for better coordination of services and a more flexible approach toward providing patients necessary medical and non-medical services. This mirrors the current recommendation of the Massachusetts Payment Reform Commission, which will be using ACOs as a means to transition to a global payment system within five years.⁵

Finally, in order to foster greater accountability and transparency, ACOs’ annual reports on quality measures should be publicly available.

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

We applaud the Committee for providing a package of proposals aimed at providing resources and infrastructure to enable a reformed delivery system to work more efficiently, fairly and without conflicts of interest.

Comparative Effectiveness Research

Comparative Effectiveness Research (CER) is an opportunity to help ensure health care providers and patients have the tools to choose the most clinically effective, culturally appropriate and safest health care treatments and strategies. There are serious gaps in evidence on what works best in health care, including the effectiveness of treatments for many groups—such as women, children, minorities, older adults, and people with special health care needs—who are not included in sufficient numbers in many studies today. With resources to expand comparative effectiveness research, scientists will be able to fill the evidence gaps that currently impede clinicians in their decision making process.

We support an institutionalized, independent entity to oversee comparative effectiveness research that will not be unduly influenced by the political process. We support the recommendation that diverse stakeholders, including consumers, be involved in setting the research agenda.

We support protections for patients in the use of comparative effectiveness research to ensure that CER is not used as the rationale for inappropriate coverage restrictions. CER should support patient-specific care and assist doctors and patients in making individualized treatment decisions according to patient characteristics such as race/ethnicity, age and sex.

We recommend further that entities undertaking comparative effectiveness primary research should utilize rigorous scientific standards, be transparent, include diverse populations and adhere to strict conflict of interest policies to ensure industries with a vested interest in the results do not influence the studies or reporting of results. Clinical panels conducting comparative effectiveness secondary

⁵ See Special Commission on the Health Care Payment System. (2009, May 8). *Proposed Recommendations*. Retrieved on May 9, 2009 from http://www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Government&L2=Special+Commission+s+and+Initiatives&L3=Special+Commission+on+the+Health+Care+Payment+System&sid=Eeohhs2&b=terminalcontent&f=dhcfp_payment_commission_meeting_information&csid=Eeohhs2#A1

studies, such as systematic reviews of available evidence, should not include members that receive funding from the industry involved (*e.g.*, pharmaceutical and medical device manufacturers).

Academic Detailing

The creation and support of programs to provide clinicians with the best information on the comparative effectiveness of treatments is an important part of translating research to use in practice. Academic detailing programs such as those outlined in the Independent Drug Education and Outreach Act of 2009⁶ (IDEA) would provide one non-coercive means to disseminate comparative effectiveness research and provide the information necessary for prescribers to utilize all the available evidence in their treatment decisions.

Prescriber education is a positive way to deliver relevant, unbiased information about the best drug treatments gleaned from federal comparative effectiveness research without linking it to proscribed reimbursement or coverage decisions. IDEA will provide prescribers with face-to-face clinical consults by specially trained pharmacists, nurse practitioners or physicians. These ‘academic’ detailers provide information on the therapeutic and cost-effective utilization of prescription drugs, particularly data from the comparative effectiveness research conducted by the AHRQ. Studies show individual educational outreach is demonstrably more effective than static practice guidelines, didactic presentations or group educational visits.^{7,8}

Commercial pharmaceutical sales representatives can promote only their own company’s product (*e.g.* neither generic nor competitor’s drugs) and have a financial incentive to increase use of the newest, generally most expensive treatments. Moreover, these representatives often lack scientific training. Academic detailers provide the best, most up-to-date information to doctors. That may be a new, more expensive drug or an established and less-expensive therapy.

Implemented in seven states and numerous private settings, as well as in Australia and Canada, prescriber education has been demonstrated to pay for itself in reduced drug costs, and estimates indicate that a nationwide expansion could yield more than \$400 million of savings in a single drug class alone.^{9,10} IDEA would spur adoption of academic detailing by providing grants to states, counties and other entities. This would overcome the barrier of start-up costs, allowing programs to become established and self-sustaining.

Prescriber education is an efficient way to deliver relevant research findings to clinical decision-makers at the point of service. The voluntary, visit-based approach relies on the decision-making of the individual clinician and her knowledge of a patient’s unique needs. Evidence

⁶ S.767 and H.R.1859.

⁷ O’Brien, M.A. *et al.* (2007). Educational outreach visits: effects on professional practice and health care outcomes. *Cochrane Database of Systematic Reviews*, 4. Art. No.: CD000409. DOI: 10.1002/14651858.CD000409.pub2.

⁸ Avorn, J., Soumerai, S.B. (1983). Improving drug-therapy decisions through educational outreach. A randomized controlled trial of academically based "detailing." *New England Journal of Medicine*. 308:1457-1463.

⁹ Coukell, A. (2008, March 12). Testimony before the Special Committee on Aging, U.S. Senate, 110th Congress. *Pew Prescription Project*. Retrieved May 15, 2009 from <http://aging.senate.gov/events/hr190ac.pdf>.

¹⁰ Carrejo, A. (2008, March 12). Testimony before the Special Committee on Aging, U.S. Senate, 110th Congress. *Kaiser Permanente*. Retrieved May 15, 2009 from <http://aging.senate.gov/events/hr190ac2.pdf>.

from an established program in Pennsylvania shows physicians embrace and welcome this approach to translation of medical evidence.¹¹

IDEA would leverage the success of existing state and regional programs which have established credibility in their medical communities and are already engaged in cross-program learning and collaboration. State programs are being run or implemented in Pennsylvania, Vermont, Maine, New Hampshire, Massachusetts, New York, South Carolina, and the District of Columbia, and have been received positively in their respective prescriber communities. By becoming a central resource to these programs and new ones, IDEA could leverage lessons learned and existing best practices to bring prescriber education to scale nationally in an efficient and cost-effective way.

Physician Payments Sunshine Act

We were particularly pleased to see the proposal to require drug and medical device companies to annually report their payments and gifts to physicians, as proposed in S.301.¹² Disclosure of pharmaceutical and device company payments is an important piece of a national health care agenda to promote quality and reduce costs.

MedPAC¹³ and the Institute of Medicine¹⁴ have been joined by numerous consumer,¹⁵ industry and medical groups¹⁶ in calling for federal transparency legislation. Legislation requiring reporting by industry of payments to prescribers is crucial, because conflicts of interest can influence prescribing, increase costs and are detrimental to trust in the medical profession and pharmaceutical and device industries.

Some specific questions have been put forth for the Finance Committee to consider. Below, we offer our thoughts for those considering these questions:

(1) Should pharmaceutical and device companies be required to report gifts and payments to recipients beyond physicians and physician practices?

The Institute of Medicine and MedPAC recommend that reporting include a broader group of recipients.¹⁷ Industry financial relationships extend beyond physicians and include hospitals, medical associations, patient groups and other practitioners such as nurses and pharmacists, and are problematic as well. We believe groups and individuals beyond physicians should be included in disclosure legislation, but not if their inclusion puts the passage of legislation at risk.

¹¹ Eisenhower, N.D. (2008, March 12). Testimony before the Special Committee on Aging, U.S. Senate, 110th Congress. *Pennsylvania Department of Aging*. Retrieved May 15, 2009 from <http://aging.senate.gov/events/hr190ne.pdf>.

¹² Pew Prescription Project. (____). Physician Payments Sunshine Act guide. Retrieved May 15, 2009 at http://www.prescriptionproject.org/sunshine_act.

¹³ MedPAC. "Report to the Congress: Medicare Payment Policy" March 2009. Ch.5

¹⁴ Institute of Medicine. "Conflict of Interest in Medical Research, Education, and Practice" April 2009. The National Academics Press, Washington DC. <http://www.iom.edu/CMS/3740/47464/65721.aspx>

¹⁵ PhRMA. "PhRMA Statement on the Senate Sunshine Act". May 22, 2008.

http://www.phrma.org/news_room/press_releases/phrma_statement_on_the_senate_sunshine_act/

¹⁶ American Academy of Dermatology Association et al. Letter to Senator Charles E. Grassley in support of the Physician Payments Sunshine Act. June 2, 2008.

¹⁷ MedPAC. (2008, June). Report to the Congress: Reforming the delivery system. Chapter 6. Retrieved May 15, 2009 from www.medpac.gov/documents/Jun08_EntireReport.pdf. See also Institute of Medicine. (2009, April 28). Conflict of interest in medical research, education and practice. Recommendation 3.4. Retrieved May 15, 2009 from <http://www.iom.edu/CMS/3740/47464/65721.aspx>.

(2) *What should the reporting threshold be?*

Two options have been proposed. S.301 would require companies report all payments of any size once a physician has received an aggregate of \$100 or more in a year. We support this option. The Committee's document proposes that companies report every gift and payment greater than \$10 in value with no cumulative 'trigger' threshold. We believe this threshold is also acceptable, and compliance may be easier. Comprehensive disclosure is essential, and therefore it is important that any *de minimus* threshold not exceed \$10.

(3) *Should some drug and device companies with lower revenue be exempt from disclosure?*

Any company with resources to obtain FDA approval to market a medical product is large enough to track gifts and payments to physicians. Some groups have suggested exempting companies with revenues under \$30 million per year. This, however, would mean that up to 70 percent of medical device companies would not be required to report.¹⁸ This is not sufficient, as patients use products produced by all companies, not only by large manufacturers. We support the current language of S.301, which includes all pharmaceutical and medical device companies.

(4) *Should a federal disclosure law preempt state laws?*

A narrow preemption is appropriate. It is acceptable to preempt state disclosure requirements in the interest of creating a national standard that benefits all consumers and reduces the burden for companies. However, a federal law should only prevent states from collecting the same information for the same purpose as is required federally. In addition, the federal government should not compromise states' ability to take additional steps to address the problem or collect additional information.

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

For too long, Medicare Advantage (MA) plans have received excessive payments without sufficient mechanisms for ensuring that they provide better care or sufficient extra benefits. Thus, we support the Committee's package of proposals aimed at promoting quality, efficiency and care management in the Medicare Advantage program. We believe, however, these reforms must be pursued alongside a revamping of the risk adjustment system. In particular, reform of the risk adjustment system should be aimed at accurately and efficiently predicting expenses for enrollees, taking into account the severity of their chronic conditions, the multiplicity of conditions and any resulting frailty. This would help to ameliorate any overpayment to MA plans that serve relatively healthy enrollees and any underpayment to plans that serve beneficiaries with complex health care needs.

* * *

We thank you again for the opportunity to provide comments on this important set of proposals. Comprehensive health care reform cannot be accomplished without addressing the inefficiencies and fragmentation inherent in our current delivery system. We appreciate the Committee's efforts thus far

¹⁸ Seventy percent of the 1600 member companies have annual revenues below \$30 million. *See* Ubl, S. (2008, May 22). Letter to Senators Grassley and Kohl in support of the Physician Payments Sunshine Act (S. 2029). *Advanced Medical Technology Association*. Retrieved May 15, 2009 from <http://www.aging.senate.gov/letters/advamedendorsementltr.pdf>.

to improve people's lives and get better value for our health care expenditures. As described above, we believe there are several additional opportunities to strengthen the options as they relate to vulnerable populations. We look forward to working with the Committee as it continues its work.

Sincerely,



Robert Restuccia
Executive Director



Renée Markus Hodin
Project Director