



Promoting Quality Health Care

Through Accreditation, Education & Measurement

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Written Testimony Provided to the
U.S. Senate Committee on Finance

Health Reform Policy Options

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Chairman Baucus and Members of the Committee:

URAC appreciates the opportunity to provide written comments to the Committee regarding the Committee's "Description of Policy Options for Transforming the Health Care Delivery System" (Policy Options). As you may be aware, URAC was founded 19 years ago by representatives of provider groups, insurers, health care purchasers, consumers, and regulators to develop and enforce industry standards for proper utilization management of health care services. We accredit over 500 health care organizations across the country. As the health care industry evolves, URAC continues to address emerging issues and we now offer over 25 accreditation and certification programs across the health care spectrum. Our programs have governmental recognitions by four federal agencies and thirty nine states. For more information about URAC and its governmental recognitions, please refer to the appendix of this statement.

As a nationally recognized health care accreditation organization, URAC shares the Committee's concerns about our current health care system with respect to cost, efficiency and quality. Many of the proposals addressed in Policy Options closely align with URAC's strategic priorities and accreditation expertise in case management, disease management, wellness standards and measures, utilization management, health plan operations, pharmacy quality management and health information technology. This testimony focuses on these areas of synergy, as URAC stands ready to provide resources about quality measures and to support public/private partnership solutions in the health care system.

As set forth in our testimony delivered to the Committee last month (Roundtable to Discuss Reforming America's Health Care Delivery System, April 21, 2009), URAC shares the Committee's objectives to improve health care quality and promote better care coordination (e.g., the right care at the right time for each and every patient). URAC works toward these goals by bringing diverse health care stakeholders together to develop voluntary accreditation standards that set the bar for health care organizations and encourage continuous quality improvement. Our clients span the breadth of the health care spectrum and include care management companies, health plans, pharmacy benefit managers, utilization review

organizations, wellness organizations, and other health vendors doing business both in the commercial sphere and through government programs such as Medicare, Medicaid, and the Federal Employees Health Benefits Program.

Regardless of the precise direction of legislative reform, sustained improvements in the health care delivery system will require the innovations, clinical expertise and service capabilities of health plans and other care management organizations working in collaboration with health care providers and consumers. For example, strategic approaches such as case management and disease management incorporate collaborative practice models to identify and engage patients with chronic illness or high cost conditions who will benefit from improved self-management (e.g., diet, exercise, and medication adherence) and evidence-based medical treatment. Collaborative programs such as these capitalize on patient data, the clinical expertise of health providers, and the coordination capabilities of managed care working together to provide the most in-need patients with the best health information and the most medically appropriate interventions.

Private accreditation organizations such as URAC play a valuable role in our health care system by defining and synthesizing innovative practices such as those described above to drive improvements across the industry. Through the accreditation process, URAC galvanizes health care organizations to keep pace with health care advancements more readily than if undertaken by legislation or regulation alone. Companies undergo URAC reviews on a two or three year cycle to establish compliance with contemporary standards and encourage adoption of leading health management approaches. During the accreditation review, our team of clinical reviewers works with health organizations to share best practices and validate their quality improvement efforts.

URAC's educational approach to accreditation yields conclusive results; accredited companies regularly emerge ahead of the curve in adopting best practices that protect and empower consumers and ensure clinical and organizational quality. A prime example is the reduction of adverse drug events by promoting direct contact between patients and physicians, which was highlighted in URAC's recent Best Practices Awards Conference. By promoting similar evidence-based innovations at the management level, URAC drives health care organizations to voluntarily adopt improvements that promote coordination and ripple through the entire health care delivery system.

Accreditation by an external organization such as URAC promotes transparency and accountability within the health care delivery system. Companies seek accreditation under URAC standards to improve internal operations and demonstrate to consumers, participating providers, and clients that they have undergone a rigorous external review to validate the quality of their services. Moreover, purchasers in both the private and government sectors recognize URAC accreditation as a meaningful seal of approval as they evaluate bids and select vendors.

As Congress embarks on this important effort to improve the nation's health care system, we look forward to sharing information about quality standards, measures, and operational review functions and to support public/private partnership solutions in the health care system, as we have for the past 19 years. It is our hope that you find the following comments on Policy

Options and the description of URAC's role within the health care industry informative to your ongoing reform discussions.

URAC COMMENTS ON POLICY OPTIONS

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

URAC fully supports efforts to move Medicare from paying for services provided, to a value-based system of reimbursement. Paying providers to report quality measures, as CMS now does for hospitals and physicians, has served as an important transitional step towards measuring and paying for performance, thereby putting a premium on every health care dollar spent.

Over the past two years, URAC has revised all of its accreditation programs to align with the goals of value-based purchasing programs, helping organizations define quality systems and set the framework for continuous quality improvement. The revisions also address the need for greater consumer empowerment and health care transparency, consistent with the committee's proposals to enrich and improve the content of CMS's online consumer-oriented websites which provide comparative information on hospitals, nursing homes, and home health agencies.

• Establishment of a Hospital Value-Based Program (VBP)

URAC supports the committee's proposal to improve the *Hospital Compare* website and the option requiring the Secretary to work with hospitals, patients, researchers, policymakers, and other stakeholders to modify the *Hospital Compare* website to make it more user-friendly. This option is consistent with URAC's strategic priorities that encourage transparency of cost and performance/quality data and engaging consumers in their health care management. Experienced in accrediting health websites, URAC would be pleased to have the Committee and the Secretary evaluate our standards' potential for helping assure the *Hospital Compare* website is more user-friendly.

• Medicare Home Health Agency and Skilled Nursing Facility Value-based Purchasing Implementation Plans

URAC supports the committee's proposed option directing the Secretary to complete Medicare value-based purchasing implementation plans for home health agencies and skilled nursing facilities by 2011 and 2012, respectively.

• Promotion of Adherence to Appropriateness Criteria for Imaging Services

URAC fully supports the committee's desire to ensure that advanced diagnostic imaging services (ADIS) are utilized in accord with evidence-based, medical appropriateness criteria, also giving due consideration to the impact of radiation exposure on patient safety. The soaring and unrestrained growth and cost of ADIS has led Congress to reduce Medicare payments for such procedures, and led to the rising market presence of Radiology Benefits Management (RBM) programs. RBMs, which are now employed by a substantial number of health insurers, review

provider imaging procedure requests against evidence-based appropriateness criteria. URAC's believes RBMs can play a vital role in preventing overutilization of ADIS, but should be subject to the same oversight of other utilization review organizations which have a monetary incentive to restrain costs. We believe the committee's exploring of the RBM option is worthwhile, and that pairing this option with the requirement for oversight by an experienced utilization review accrediting body such as URAC's would help ensure RBM imaging decisions are in the best interest of the patient.

- **Payment for Transitional Care Activities**

With highly regarded accreditation programs for case management and disease management, a major URAC strategic priority is enhancing the continuity, coordination, and quality of care. As such, URAC fully supports this option which would encourage enhanced care management of selected chronically ill Medicare patients, by reimbursing physicians for using nursing care managers (or other non-physician professionals) to support patients recently discharged from the hospital with congestive heart failure, chronic obstructive pulmonary diseases, coronary artery disease, asthma, diabetes, and depression. URAC would also support expansion of this proposed policy to cover Medicare beneficiaries with high-cost, chronic illness who are at highest risk for hospitalization.

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

- **Chronic Care Management-CMS Chronic Care Management Innovation Center**

Consistent with our strategic priorities, URAC supports the establishment of a CMS Chronic Care Management Innovation Center (CMIC) for the purpose of testing and disseminating payment innovations that foster patient-centered care coordination for high-cost, chronically ill Medicare beneficiaries. URAC's has extensive expertise in accrediting and case management and disease management programs, and would be pleased to share at the Committee's request, our accreditation standards and insights from reviewing hundreds of care management programs

- **Extension and Expansion of the Medicare Health Care Quality Demonstration Program**

URAC supports the option of permanently authorizing Medicare Health Care Quality Demonstration programs, by permanently authorizing Section 646 of the Medicare Modernization Act to allow testing of pilots which have the goal of achieving quality improvements through a major redesign of the health care delivery system. We are particularly supportive of Section 646's examination of ways of improving shared decision making between providers and patients, which is congruent with URAC's strategic priority of engaging consumers in their own health care management.

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

URAC is pleased that Congress, under the HITECH Act included in the American Recovery and Reinvestment Act (ARRA), is providing substantial Medicare and Medicaid monetary incentives to hospitals and physicians to support adoption of electronic health records (EHRs) in 2011 (with disincentives for non-adoption taking effect in 2015). To maximize widespread EHR adoption and resultant benefits for patients, providers and payors, URAC also supports the committee's proposed option for expanding eligibility for the EHR Medicare physician incentive payments to include nurse practitioners and physician assistants under certain conditions, as well as exploring providing additional health IT incentives for health care providers not included in the Medicare and Medicaid incentives included in the ARRA.

URAC's major concern with these EHR incentive programs is that, with such large outlays of federal funds at stake, it is critical that there be independent validation of the statutory requirement that hospitals and physicians demonstrate "meaningful" use of EHR technology that is certified as meeting standards of interoperability, clinical functionality, and security (to be defined by the Secretary by the end of 2009). Such validation should go beyond looking at the technical aspects of EHR software and hardware, but should also examine how effectively these tools are integrated into a robust quality improvement program.

Assuring federal funds are prudently disbursed will require impartial, independent on-site validation/certification that the "meaningful" use EHR requirement is being fully satisfied—a role well suited for an experienced health IT accreditation organization. URAC's has extensive expertise in accrediting the implementation and use of information technology and would be pleased to share at the Committee's request our accreditation standards and insights from reviewing these programs.

• Improving Quality Measurement

URAC supports the committee's proposed option to build a more permanent and robust infrastructure for strengthening and improving quality measurement and development processes. The goal would be establish national priorities for quality measure development that support health care reform and address gaps in quality measurement, as well as provide assessment and dissemination of clinical best practices to help educate and support quality improvement activities of health care providers. URAC develops and recognizes performance measures, as well as structure and process health quality measures in its accreditation programs and recognizes the value of continuing to develop a more robust infrastructure for our national quality measurement development process.

• Comparative Effectiveness Research

Comparative effectiveness research can be an important tool in effecting health care reform and

improving quality and efficiency, providing clear information to help physicians and patients make informed decisions about their choices for care, a goal consistent with a number of URAC's strategic priorities.

URAC is pleased that the ARRA included \$1.1 billion in discretionary funding for federal comparative effectiveness research, and fully supports the committee's proposed option of strengthening the nation's comparative effectiveness infrastructure by establishing a long-term or permanent framework to set national priorities for comparative clinical effectiveness research and to provide for the conduct of such research.

- ***Nursing Home Compare website***

URAC supports the proposed option requiring the Secretary to provide additional information on the *Nursing Home Compare* website, and to consult with state long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, and other representatives of programs or groups as the Secretary determines appropriate. This option is consistent with URAC's strategic priorities that encourage transparency of cost and performance/quality data and engaging consumers in their health care management. URAC would be pleased to offer the Committee and Secretary the opportunity to evaluate our health website accreditation standards for their potential in helping make the *Nursing Home Compare* website more user-friendly.

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

- **Pay for Chronic Care Management**

As a highly regarded nationally recognized accreditor of case management and disease management programs, URAC knows first hand the multiple benefits which accrue to chronically ill patients who receive coordinated case management of their care. As such, URAC supports the committee's proposed option to pay Medicare Advantage (MA) plans a bonus for chronic care management.

CONCLUSION

URAC appreciates this opportunity to comment on the Policy Options outlined by the Committee, as it continues its deliberations on health care reform. URAC expertise in ensuring the quality of health care through our industry spanning accreditation programs provides the experiential foundation for our testimony.

One final suggestion we have for the Committee to consider is how to stimulate innovation across the health care spectrum and share industry best practices. The Committee is considering dozens of options to incentivize performance and to enhance the delivery of quality health care services. In our experience implementing these reforms effectively will require active management, leadership, and education. Thus, we suggest the Committee also consider a funding mechanism for programmatic support to organizations who can assist health care providers scale up to meet new health care quality performance expectations. Such a program

could be managed by the Agency of Healthcare Research and Quality.

We hope that our comments will be helpful to your efforts to improve health care quality and promote better care coordination. Information about URAC accreditation standards, governmental recognitions, operational reviews and additional resources are available to the Committee, and can be accessed through the policy maker portal on the URAC website (<http://www.urac.org/policyMakers/resources/>).

Please do not hesitate to contact URAC Vice President for Government Relations, Product Development and Education John DuMoulin (jdumoulin@urac.org, 202/962-8836) and URAC Government Relations Director Mara Osman (mosman@urac.org, 202/962-8838) for additional information and resources as the Committee continues to address issues related to health care reform.

Thank you for your time and consideration.

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APPENDIX

OVERVIEW OF URAC

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. Our strategic priorities are to:

- Enhance Continuity of Care;
- Encourage Transparency: Cost & Performance/Quality Data;
- Engage Consumers in their Health Care Management;
- Enhance Operational Management Effectiveness; and
- Engender Support for Evidence-Based Decision-Making

To support these goals, our 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.

Incorporated in 1990, URAC pioneered utilization management accreditation by creating a nationally recognized set of standards to ensure accountability in managed care determinations of medical necessity. As the health care industry evolves, URAC continues to address emerging issues: we now offer over 25 accreditation and certification programs across the health care spectrum:

- Case Management
- Claims Processing
- Consumer Education and Support
- Core Organizational Quality
- Credentialing Support
- Credential Verification Organization
- Disease Management
- Drug Therapy Management
- Health Call Center
- Health Content Provider
- Health Network
- Health Plan
- Health Provider Credentialing
- Health Utilization Management
- Health Web Site
- HIPAA Privacy
- HIPAA Security
- Independent Review Organization
- Mail Service Pharmacy
- Medicare Advantage Deeming
- Pharmacy Benefit Management
- Specialty Pharmacy

- Vendor Certification
- Wellness
- Workers' Compensation Pharmacy Benefit Management
- Workers' Compensation Utilization Management

Government Recognition of URAC Accreditation

Federal and state policymakers recognize the value of private accreditation to promote cost-efficiency and to ensure that their constituencies receive quality health care. At the federal level, four federal agencies recognize URAC accreditation. The Centers for Medicare and Medicaid Services recognize URAC Medicare Advantage Health Plan Accreditation for the Medicare Advantage (formerly Medicare+Choice) Program; the Office of Personnel Management recognizes all URAC accreditation programs under the Federal Employee Health Benefits Program; TRICARE/Military Health System recognizes URAC's Health Network Accreditation, Case Management, Disease Management, and Utilization Management Accreditations; and the Department of Veterans' Affairs recognizes URAC's Health Call Center Accreditation.

Many states have found URAC's accreditation standards helpful in meeting regulatory requirements for managed care plans and other health care organizations and functions. Thirty-nine states and the District of Columbia currently reference accreditation through statute, regulation, agency publication, Request for Proposal or contract language, making URAC the most recognized national managed care accreditation body at the state level.

URAC Standards: Establishing Quality Benchmarks

URAC accreditation serves as a symbol of excellence in the health care industry, promoting prevailing industry standards and consumer protections. In the rapidly evolving field of health care, URAC standards are developed through a dynamic process that identifies best practices and promotes high quality performance measurement. All stakeholders in the health care arena actively participate with URAC in developing these quality benchmarks through an inclusive process that incorporates an opportunity for public comment.

URAC's standards development process begins with a period of careful research, debate and discussion among stakeholders. An initial set of standards is then proposed and made available for a public comment and review. URAC's advisory committees review the submitted comments, make appropriate changes, and the draft standards are then beta tested with a discrete group of companies in order to ensure that they work in practice. After beta testing, the standards may be modified again, and then they are forwarded to URAC's Board of Directors for consideration and approval. URAC revises its standards through this process at least every three years.

URAC Accreditation Review Process

The URAC accreditation review process begins with applicants for accreditation submitting material through AccreditNet, URAC's secure online application system. When an application

arrives, a reviewer is assigned to conduct an assessment of the submitted documentation for compliance with URAC standards. Any standard that appears non-compliant is noted and communicated to the client with a recommended course of action to meet the standard. Then an onsite review is conducted for each applicant.

URAC staff reviewers are clinical experts who provide application support through the entire accreditation process, including a sharing of best practices during the onsite review. The objective of the onsite review is to verify operational compliance with URAC standards. URAC reviewers, for example, interview the applicant's staff and review a statistically valid sampling of relevant documentation, including specific quality information. With respect to quality data, URAC accepts nationally recognized measures, such as HEDIS measures to evaluate plan performance and CAHPS data to evaluate consumer satisfaction. URAC may also consider other credible, CMS-recognized quality measures such as the Wisconsin MEDDIC-MS and MEDDIC-MS SSI Performance Measures.

The findings from an applicant's onsite review are anonymously presented to the URAC committees that make the accreditation determinations through an Executive Summary report. Committee members include industry peers and experts such as physician providers, plan physicians, quality management professionals, information technology experts, pharmacists and security/privacy officials. Levels of accreditation are awarded in accordance with corporate policy and URAC's accreditation scoring methodology. Applicants receive an official notification letter with their accreditation status and a certificate of accreditation.

FEDERAL RECOGNITIONS (In Detail)

1. Centers for Medicare and Medicaid Services (CMS) recognize URAC Medicare Advantage Health Plan Accreditation for the Medicare Advantage (MA) Program.

CMS granted URAC deemed status in May 2006 for both local PPO and HMO health plans approved under its Medicare Advantage Deeming Program. Deemed status is official recognition by the nation's third largest payer that URAC accreditation meets or exceeds CMS's own regulatory standards for plan quality in six areas: quality assessment and improvement; confidentiality and accuracy of enrollee records; antidiscrimination; access to services; provider participation rules; and advance directives. CMS's approval of URAC for deeming authority was published in the Federal Register on Friday, May 26th, 2006. Deeming authority is granted based on CMS's determination that URAC's standards are at least as stringent as those specified under Medicare.

Should an Medicare Advantage (MA) organization receive accreditation from a CMS approved accrediting organization such as URAC, as an alternative for meeting some Medicare requirements, an MA organization may be exempt from CMS monitoring of certain requirements in subsets listed in section 1852(e)(4)(B) of the Social Security Act. In essence, the Secretary deems that the MA organization has met the Medicare requirements via its accreditation (by URAC or other accrediting organization approved by CMS).

2. The Office of Personnel Management (OPM) recognizes all URAC accreditation programs under the Federal Employee Health Benefits Program (FEHBP).

The FEHBP provides health care coverage to approximately eight million federal employees, retirees, and their dependents. Since July 2000, URAC accreditation has been listed in the annual Guide to Federal Employees Health Benefits.

3. The TRICARE/Military Health System, the Department of Defense's managed health care program, recognizes URAC Health Network (HN), Case Management (CM), Health Utilization Management (HUM), and Disease Management (DM) Accreditations.

Through TRICARE, the federal government provides health care services throughout the world to 8.7 million military personnel and their families and military retirees.

Tricare first recognized URAC's Health Network Accreditation in a 2002 Request for Proposals (RFP) (Solicitation No. MDA906-02-R-0006, Aug. 1, 2002). In 2008, TRICARE expanded its recognition of URAC's accreditation standards to include case management (CM), health utilization management (HUM), and disease management (DM). The 2008 RFP (Solicitation No. H94002-07-R-0007, March 24, 2008) requires contractors' networks and utilization and case management programs to be "accredited by a nationally recognized accreditation organization no later than 18 months after the start of health care delivery" and that the accreditations be maintained "in all geographic areas covered by the contract" and "throughout the contract and all exercised options." The RFP further requires that the contractor's disease management programs "meet national accreditation standards for disease management and chronic care management" within the 18 month time frame. TRICARE has specifically identified URAC as a nationally recognized accreditation organization.

4. The Department of Veterans' Affairs (VA) recognizes URAC Health Call Center Accreditation.

The Veterans Health Administration (VHA) has 22 regional Veterans Integrated Service Networks (VISNs) that were instituted to administer the health services for VA hospitals and clinics. (The VHA has 173 medical centers, 650 outpatient community and outreach clinics, and over 51,000 medical center beds with the VHA treating nearly one million patients a year in VA hospitals alone.) In Directive 2000-035 (October 5, 2000), the VHA established as policy that each VISN must ensure that all of its enrolled patients are provided 24x7 direct telephone access to clinical staff who are trained to provide health care advice and information. These telephone care programs/call centers must meet specified minimum standards and must get accredited by URAC or another appropriate accrediting body. URAC is currently the only accrediting body for telephone care and triage call centers.