

Marilyn Tavenner
President &
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January 29, 2016

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Building
Washington, D.C. 20510

The Honorable Johnny Isakson
131 Russell Building
Washington, D.C. 20510

The Honorable Mark Warner
475 Russell Building
Washington, D.C. 20510

Dear Chairman Hatch, Ranking Member Wyden, and Senators Isakson and Warner:

On behalf of America's Health Insurance Plans (AHIP), we are writing in response to the Senate Finance Committee's Chronic Care Working Group Policy Options document released on December 22, 2015. Based on the document, the Working Group's goals include increasing care coordination among providers treating individuals with chronic diseases, developing payment systems to incentivize the delivery of services to individuals with these conditions, and improving outcomes while promoting efficiencies that will reduce health care costs.

AHIP and our members strongly support the Working Group's goals. As we noted in our response to the Working Group's call for recommendations last summer, a recent RAND Corporation study,¹ co-authored by AHIP staff and published in the *American Journal of Managed Care*, concluded that chronic care management programs have become a standard strategy used by health plans to manage the health of their commercial enrollees. The innovative chronic care management programs developed by Medicare Advantage plans are also serving as the foundation for changes promoted by the Administration and others to foster delivery system reforms throughout the Medicare program.

The Working Group's Policy Options document recognizes the potential for these reforms while suggesting proposals to address current legislative and regulatory barriers to continued innovations by Medicare Advantage and Part D plans. We greatly appreciate the Working Group's work in this area. Below we offer recommendations and supporting information to promote the Working Group's goals.

¹ Results from a National Survey on Chronic Care Management by Health Plans, Soeren Mattke, MD, DSc; Aparna Higgins, MA; and Robert Brook, MD, ScD. *American Journal of Managed Care*. May 2015.

Providing Medicare Advantage Enrollees with Hospice Benefits (page 8)

We generally support the Working Group's proposed policy to incorporate the full scope of the Medicare fee-for-service hospice benefit into Medicare Advantage. Such a policy would allow for a more complete integration of services under Medicare Advantage across the continuum of care for beneficiaries and provide plans with greater opportunities to incorporate care coordination into an improved hospice benefit. In conjunction with the proposed policy, we have identified additional issues regarding the Medicare hospice benefit that the Working Group should consider:

- *Eligibility criteria:* Medicare currently limits hospice to individuals with a life expectancy of six months or less. Providing access to individuals with life expectancies of up to 12 months could better support beneficiaries and their families during the end of life.
- *Inclusion of curative care:* Curative care is not currently covered by Medicare for individuals who elect hospice care, including Medicare Advantage enrollees. Providing curative care to beneficiaries receiving hospice benefits, in combination with the expansion in the eligibility criteria described above, may prevent unnecessary medical procedures that decrease quality of life while increasing costs to the Medicare program. We have been pleased to note the establishment by the Center for Medicare and Medicaid Innovation (CMMI) of the Medicare Care Choices Model, which allows Medicare beneficiaries to receive curative care after electing hospice,² and look forward to the continued expansion of this policy as part of the coordinated, integrated Medicare Advantage benefit package.

The Working Group also requests comments on integrating individuals with hospice into the Medicare Advantage Star Ratings System. AHIP strongly supports initiatives to hold health plans and providers accountable for quality of care. However, it may be difficult to differentiate patients' personal issues around life expectancy that may result in negative ratings versus the quality of experience provided. Thus additional work is needed in this area. Our members look forward to working with the Working Group, the Centers for Medicare & Medicaid Services (CMS), national standards-setting groups, and other stakeholders to ensure quality metrics incorporated into the Star Ratings System appropriately measure the quality of care delivered to Medicare Advantage enrollees in hospice while ensuring the unique characteristics of individuals at the end of life are taken into account.

Our members have also noted full integration will require Medicare Advantage plans to address operational challenges during the early years of implementation that have direct implications on the ability of health plans to provide beneficiaries in hospice with the full value that the integration of these services has to offer. We urge the Working Group and CMS to be mindful of these issues and work with health plans, hospices, and other key stakeholders to address them.

² <https://innovation.cms.gov/initiatives/Medicare-Care-Choices/>

Recommendations: CMS should work with key stakeholders to develop appropriate hospice-specific measures before incorporating them into the Star Ratings System. Hospice measures that are established through this process should be placed on the display page of medicare.gov for an extended period without including plan scores in the calculation of Part C or D summary measures or the Overall Rating used to calculate eligibility for quality-based bonuses. We also urge CMS to work with Medicare Advantage plans and other stakeholders to address operational issues and promote a smooth transition to integration of hospice into the Medicare Advantage program.

Allowing End Stage Renal Disease Beneficiaries to Choose a Medicare Advantage Plan (page 9)

We support the Working Group's policy proposal to eliminate existing limitations for Medicare beneficiaries with end stage renal disease (ESRD) to enroll in a Medicare Advantage plan. However, it will be necessary to ensure the risk adjustment and payment systems appropriately address the additional costs for ESRD beneficiaries, including those new to Medicare. There may also be new operational issues in implementing the recommendation, and we look forward to working with the Working Group and CMS to consider creative solutions to address them.

Recommendations: CMS should ensure risk adjustment factors for ESRD beneficiaries, including new enrollees, are appropriate. CMS should also work with stakeholders to address any operational issues.

Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations (page 10)

We fully support the Working Group's policy proposal to permanently reauthorize all Special Needs Plans (SNPs) including plans for beneficiaries with specified chronic conditions (C-SNPs), those for beneficiaries dually eligible for Medicare and Medicaid (D-SNPs), and those for beneficiaries who require an institutional level of care (I-SNPs). Plans have made substantial investments to develop and operate these products, which are demonstrating success in improving beneficiary outcomes in comparison to the fee-for-service program.³ Short-term reauthorizations are inconsistent with the further development of these innovative programs by creating uncertainty for organizations to continue these investments. Permanent reauthorization would alleviate this uncertainty and further our members' commitment to creating programs tailored to enrollees in these plans.

³ Cohen, Robb. Lemieux, Jeff. Mulligan, Teresa. Schoenborn, Jeff. Medicare Advantage Chronic Special Needs Plan Boosted Primary Care Reduced Hospital Use Among Diabetes Patients. *Health Affairs* Vol. 31, No.1: 110-119. January 2012.

In addition, we have the following comments addressing issues about C-SNPS and D-SNPS raised by the Working Group and others:

- **C-SNPs:** C-SNPs should be permanently reauthorized without additional limits on the conditions on which these plans focus. The Medicare Payment Advisory Commission has previously suggested that C-SNPs be limited to conditions such as ESRD, HIV/AIDS, and severe mental health conditions. As noted in research cited above, C-SNPs specializing in other conditions such as diabetes are significantly improving the health outcomes of their enrollees. Further limiting C-SNPs to specific conditions could restrict beneficiary access to Medicare Advantage plan innovations that are critically important for individuals with chronic conditions.
- **D-SNPs:** AHIP and our members strongly support the development of fully integrated programs for dually eligible beneficiaries. Many of our members currently participate as Medicare-Medicaid Plans (MMPs) in states operating demonstration projects under CMS's Financial Alignment Initiative and work on a daily basis to making these programs a success. However, the Working Group should recognize that full integration may be outside a health plan's control because it requires agreement and commitment of resources from the state as well as the plan. In such cases when full integration is not possible, we believe it would be inappropriate to deny beneficiaries access to the tailored programs developed by D-SNPs to meet the needs of dual eligibles in these states.

Recommendations: We recommend permanent reauthorization by the Congress of all SNPs, including C-SNPs, D-SNPs, and I-SNPs. The Working Group should also promote state cooperation to increase access to fully integrated plans through continued collaboration with MMPs and recommending that CMS offer technical assistance to states previously reluctant to work with D-SNPs or other coordinated care plans.

Improving Care Management Services for Individuals with Multiple Chronic Conditions (page 11)

The Working Group notes it is considering "establishing a new high-severity chronic care management code that clinicians could bill under the Physician Fee Schedule". As we described in our June letter, we believe that development of new physician incentives to improve chronic care management should be incorporated into alternative payment models (APMs) established by the Medicare Access and CHIP Reauthorization Act of 2015. These reforms will promote quality and value rather than perpetuate the inefficiencies of the fee-for-service program.

Recommendation: We recommend the Working Group reconsider the proposal to add a new Current Procedural Terminology code in the Medicare Physician Fee Schedule and instead focus on promoting reforms through APMs.

Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees
(page 13)

We support the Working Group's proposal to permit Medicare Advantage plans the flexibility to vary benefits – such as supplemental benefits, reductions in cost-sharing, adjustments to provider networks, and care improvement/wellness programs – based on the chronic conditions of individual enrollees. AHIP's member plans have pioneered innovative benefit designs that use research and clinical guidelines to promote better health, manage chronic conditions, and target populations with specific health needs. These types of value-based insurance design (VBID) features can improve quality of care by encouraging individuals to access critically needed, high-value services and health improvement activities including preventive care, which aligns with national goals of improving patients' health and overall health status and changing financial incentives in a way that drives quality and promotes consistency in health care delivery.

CMMI recently announced a model test to permit the use of VBID in seven states. The model test includes features recommended by AHIP and our members, such as permitting plans to use positive incentives to engage in disease management and wellness programs. We have several other recommendations for Medicare Advantage VBID programs that address issues raised by the Working Group.

Recommendations:

- Expansion of VBID should occur nationwide to permit more beneficiaries with chronic conditions to participate in these programs, and support participation by all Medicare Advantage organizations. CMS should approve all proposals to use VBID that have clinical value and can demonstrate improvements in quality due to implementation of the changes.
- Medicare Advantage plans should be permitted to target VBID programs to specific individuals within their plan benefit packages. These individual-based models permit the tailoring of benefit packages to specific needs (e.g., by customizing benefits for individuals with multiple chronic conditions).
- Medicare Advantage plans should not be limited by statute or regulation from applying VBID to specific chronic diseases to take advantage of the full range of activities in place in the commercial market that work so well for individuals with diverse conditions.
- Medicare Advantage plans and Accountable Care Organizations (ACOs) should be placed on a level playing field. That is, any new flexibility provided the Medicare Advantage plans should also be made available to ACOs and vice versa.
- Extending VBID to Medicare Advantage plans for the general population should not affect C-SNP reauthorization. As noted above, we support permanent reauthorization of all SNP types under current conditions. Eliminating or significantly changing C-SNPs would inappropriately limit options for beneficiaries developed by health plans that are applying innovative programs to address the needs of beneficiaries with chronic conditions.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees (page 15)

We strongly support the Working Group's proposal to allow Medicare Advantage plans to offer additional supplemental benefits, such as medical services and non-medical social services (e.g., transportation) aimed to improve the health status of beneficiaries with chronic conditions. This policy is consistent with the goals of the Accountable Health Communities Model recently announced by CMMI, which is funding bridge organizations to screen Medicare beneficiaries for health-related social needs and refer them to, or provide them with, services that meet these needs. Moreover, providing this additional flexibility will allow health plans to apply lessons learned from participating in state Medicaid programs or in the Social HMO demonstration to coordinate medical and non-medical benefits, including long-term services and supports for Medicare beneficiaries.

Recommendations: We recommended that Medicare Advantage plans be permitted to offer non-medical benefits to their enrollees. The Working Group should not restrict the additional supplemental benefits that can be provided by plans. CMS should be provided with the authority to review and approve additional supplemental benefits on a plan-by-plan basis.

Increasing Convenience for Medicare Advantage Enrollees through Telehealth (p. 19)

Our member health plans consider telehealth as fundamental to providing Medicare benefits. Health plans have embraced telehealth through the widespread use of nurse hotlines, remote monitoring services, electronic office visits, and other innovative ways of providing value to enrollees. However, current law limits Medicare Advantage plans from incorporating telehealth benefits into their basic benefit package that go beyond the scope of services included in the fee-for-service benefit. As a result, Medicare Advantage plans use supplemental benefits funded by rebates or premiums to offer expanded coverage of remote access technologies, which has increased premiums and/or limited the availability of other additional benefits or buy-downs of Medicare cost sharing. Permitting these plans to broaden the use of telehealth in delivering basic benefits is more consistent with the most current medical practices and should enhance value and reduce premiums for their enrollees.

The Working Group specifically requests comments on how expanding telehealth services should affect Medicare Advantage network adequacy standards. Today, these standards take the form of time and distance requirements that are specific to provider types and geography. We support network adequacy standards that recognize the important role telehealth may play in improving beneficiary access to care.

Recommendations: Medicare Advantage plans should be permitted to include all telehealth services in their basic benefits package. In addition, CMS should be given the authority to consider the impact of beneficiary access to telehealth when approving Medicare Advantage plan

networks. Also, CMS should ensure that any flexibility provided to ACOs with regard to telehealth is extended to Medicare Advantage plans.

Ensuring Accurate Payment for Chronically Ill Individuals (page 19)

The Working Group requests information on potential changes to the Medicare Advantage risk adjustment system to promote more accurate payment for beneficiaries with chronic conditions. Our June letter to the Working Group noted that recent changes by CMS to eliminate codes for early stage chronic kidney disease and diabetes neuropathy from the risk adjustment model are inconsistent with national health policy goals to deliver high-quality, coordinated care for Medicare beneficiaries, particularly for those with high-cost, high-burden chronic conditions who can benefit the most from early identification and care management services offered by Medicare Advantage plans. These Medicare Advantage innovations, which are demonstrated by recent studies to improve quality and reduce unnecessary costs, are the model for changes CMS is attempting to implement in the Medicare fee-for-service program.

New research demonstrates CMS's recent changes to the risk adjustment model are inconsistent with promoting these Medicare Advantage plan innovations that are moving the program forward. Avalere finds the model under-predicts costs for individuals with multiple chronic conditions by \$2.6 billion on an annual basis, and also under-predicts for specific chronic conditions, such as rheumatoid arthritis, dementia, and lower levels of Chronic Kidney Disease (CKD).⁴ The under-prediction of costs for lower levels of CKD is of particular concern to plans, as these conditions were recently eliminated from the model. We strongly urge the Working Group to encourage CMS to put forward risk-adjustment related policies that support stability in the Medicare Advantage program and promote plan practices demonstrated to improve the lives of beneficiaries throughout the Medicare program.

CMS has subsequently proposed changes to improve the accuracy of the model for dual eligibles and individuals with disabilities. CMS recently issued new information to help our members better evaluate the impact of this proposal. AHIP strongly supports policy changes to ensure payment models sufficiently support Medicare Advantage plans focused on beneficiaries with complex needs, including dual eligibles. However, we will raise concerns if the proposed changes reduce funding to the Medicare Advantage program to support the coordinated care models that are working so well for beneficiaries with low-incomes and others with complex needs.

Recommendation: Changes to the Medicare Advantage risk adjustment model should be consistent with national health policy goals for early detection and prevention of chronic diseases. Changes that reduce the overall funding for the program, particularly following recent payment cuts included in the Affordable Care Act, are inconsistent with this goal.

⁴ Avalere Health, "Analysis of the Accuracy of the CMS-Hierarchical Condition Category Model" (January 2016).

Developing Quality Measures for Chronic Conditions (page 22)

The Working Group is considering requiring CMS to develop quality measures “that focus on the health care outcomes for individuals with chronic disease.” We note the measures cited in the document include measures that are more process- than outcome-oriented. For example, the proposed categories for measures focusing on patient and family engagement, though valuable, likely are not truly outcome-based. Also, there are already community-level measures for obesity, diabetes, and smoking prevalence that could be utilized in this effort.

Recommendation: We recommend working with standards-setting organizations, health plans, providers, and other stakeholders to incorporate more outcome-based measures into Medicare’s quality assessment activities.

Expanding Access to Digital Coaching (page 27)

The Policy Options document notes the Working Group is considering a proposal requiring CMS to “provide medically-related information and educational tools on its website to help beneficiaries learn more about their health conditions and help them in the self-management of their own health.” It is our understanding the Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, and Institute of Medicine already provide similar resources.

Recommendation: We recommend that the CMS website link to, encourage use of, or provide information that is consistent with information from these other sources.

Study on Medication Synchronization (page 29)

Medication synchronization is already a component of Part D plan practices. These processes support activities to improve medication adherence, for which Part D plans are held accountable under the Star Ratings System. However, additional flexibility could be provided to these plans to support a more comprehensive approach to ensuring Medicare beneficiaries are complying with prescription drug therapies.

Nationwide expansion of enhanced medication therapy management (MTM) flexibility provided under the Part D Enhanced MTM model being tested by CMMI beginning in 2017 is a crucial component of this approach. Under the CMMI model test, eligible basic stand-alone Part D prescription drug plans in specified areas will be able to target MTM services to beneficiaries based on risk level and implement innovative strategies to individualize beneficiary and prescriber outreach and engagement in collaboration with their network pharmacy providers and medical prescribers. This demonstration has the potential to achieve savings over the long term.

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Recent research has found increased medication adherence decreases overall health care costs by reducing hospitalization and emergency department use.⁵

Recommendation: We do not recommend mandating a study of medication synchronization in Medicare Part D. Instead, we support expanding the flexibility provided to plans under the Part D Enhanced MTM model being tested by CMMI to all Part D plans. Targeting criteria proposed by the plan for beneficiaries receiving MTM should be subject to review and approval by CMS.

Thank you for considering our comments and recommendations on these important issues. We appreciate your commitment to advancing chronic care reform on behalf of our nation's Medicare beneficiaries. We look forward to continuing to work with you to address this priority.

Sincerely,



Marilyn B. Tavenner
President and CEO

⁵ For example see Roebuck, M Christopher, et. al., Medication Adherence Leads To Lower Health Care Use And Costs Despite Increased Drug Spending. *Health Affairs* Vol. 30 No. 1: 91-99. January 2011.