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Submitted electronically via chronic_care@finance.senate.gov

The Honorable Orin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senator
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mark R. Warner
United States Senator
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

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

Anthem is pleased to have this opportunity to propose solutions for improving the chronic care system in the United States through programmatic improvements in Medicare.

Anthem is working to transform health care with trusted and caring solutions. Our health plan companies deliver quality products and services that give their members access to the care they need. With nearly 71 million people served by its affiliated companies, including more than 38 million enrolled in its family of health plans, Anthem is one of the nation's leading health benefits companies. For more information about Anthem's family of companies, please visit www.antheminc.com/companies.

Anthem invests substantial resources into the development of innovative benefits and disease management programs that help to keep beneficiaries healthy, detect diseases at an early stage, and help beneficiaries with chronic illness manage their health. We place a strong emphasis on early detection and prevention of chronic conditions and comorbidities. The value of the Medicare Advantage (MA) program for Medicare beneficiaries is the access to care coordination and other specialty care. MA plans also have the ability to provide specialized coverage through special needs plans (SNPs) to a subset of the sickest and most expensive Medicare-eligible beneficiaries.

Anthem's innovative programs have resulted in industry-leading health outcomes by providing proactive and innovative solutions to the complex problems associated with aging and chronic conditions.

CareMore Health System, an Anthem subsidiary which operates MA plans, including SNPs, has developed a care model which is holistically centered on each individual and excels by simplifying access to quality care, increasing communication, and intensely focusing on prevention and treatment. This unique focus has resulted in improved patient outcomes, including:

- Congestive Heart Failure Program participants experienced 52% fewer admissions compared to the Medicare Fee for Service (FFS) average.¹
- End Stage Renal Disease Program participants experienced 67% fewer hospital days and 50% fewer admissions compared to Medicare FFS.²
- Diabetes Program participants have a 66% lower amputation rate compared to Medicare FFS.³

Anthem's MA plans also support chronic care management through an intense focus on hospital to home-care transitions in our Stabilization programs. Through a highly coordinated team, we implement focused interventions, provide education, and work with beneficiaries to access social and community resources to help prevent unnecessary hospital readmissions, which results in better care outcomes. Beneficiaries that successfully complete the voluntary Stabilization program are transferred to additional care programs which may better suit their needs.

In addition to improving quality of care, our innovative approach to managing chronic disease and frailty also protects the precious financial resources of both seniors and the Medicare Program.

As the Committee referenced, the impact of chronic illnesses on the Medicare program is significant. As more individuals begin to age into the Medicare program, it is vital that Congress consider systematic improvements to ensure every individual has access to optimal, effective, timely and sensitive health care. With our extensive experience, focus on beneficiary health, and industry-leading chronic care outcomes, we offer our insight and recommendations which meet the Committee's main goals. Today, the Medicare program is one that focuses on the medical aspects of care. However, we have learned that to truly impact chronic illness, a holistic approach is necessary. There is real opportunity to improve Medicare's support of individuals with chronic illness and we thank the Committee for their focus on this important issue.

Our recommendations follow below.

I. Improvements to Medicare Advantage for patients living with multiple chronic conditions

Support Care Model Improvements

Individuals with chronic disease generally have more complex care needs, use more health services, and receive care from more and different health professionals as compared to individuals without chronic disease. Individuals with complex health care needs require medical support, but also may require behavioral health services, home-based care and services, and an array of additional social- and community-based assistance. For example, individuals with chronic health needs may experience functional limitations and require assistance from family members and caregivers. They may also more frequently rely upon community and social services as part of their daily lives.

¹ CareMore 2013 Hospital Metrics. Admissions are rates per 1,000 beneficiaries. CHF, first row, Medicare CHF rate (21.1% Am J Manag Care. 2012;18(2):96-104).

² CareMore 2013 Program Effectiveness Metrics. Based on individuals in the CareMore ESRD Program in 2013. Medicare average is unadjusted 2010 data from United States Renal Data System (www.usrds.org) accessed July 2012.

³ CareMore 2013 Executive Summary. Non-traumatic lower extremity amputation rate per thousand members per year, excluding individuals with ESRD. Medicare average is for FFS beneficiaries, not age adjusted, from most recent data available, American Journal of Preventive Medicine, 2005.

Integrated care models which focus on a highly-coordinated and diverse team of health care professionals are successful in improving health outcomes for individuals with chronic disease and complex conditions. These models are relationship-based and importantly focus on the whole person, not just a single disease in isolation. Based on our experience in caring for individuals with chronic disease, this unique focus is vital to truly impact chronic care management.

To ensure continued support for strong chronic care models of care, which do impact health outcomes and reduce beneficiary and program costs, we offer the following recommendations:

❖ ***Support the Provision of Holistic Team-Based Care***

A holistic team-based approach can improve chronic illness outcomes by moving to a model focused on overall health care, instead of disease care. As previously discussed, to impact outcomes, Anthem plans, such as CareMore, provide a high-touch and time-intensive process of care that is focused on the totality of an individual's needs. We employ multidisciplinary teams that may consist of a primary care provider, social worker, nutritionist, pharmacist, education specialist, care manager, and other specialized caregivers who work together to ensure care is appropriately tailored to each individual's medical, behavioral health, social, and community needs.

To support this team based model, we recommend that Medicare FFS be permitted to bundle professional medical payments. This would help support and advance team-based models of care through payment models.

Additionally, changes to Graduate Medical Education (GME) policies could also better support integrated team-based models of care. As we have discussed, to address the needs of individuals with chronic disease, there has been greater emphasis on preventive and chronic care management in integrated team-based models. This is care that often takes place in community settings and relies upon on non-physician health care professionals. However, GME has historically focused on individual clinicians in hospital settings. We recommend that a portion of GME funding be tied to the development of a curriculum focused on integrated team-based models of care that support chronic care management.

❖ ***Support Family-Based Models of Care***

Families and caregivers are an integral part of the support team for individuals with chronic illness. For optimal care management, we cannot ignore home-based care.

Historically, Medicare has better supported family- and home-based models of care by including services such as family respite, certain home-aide assistance, and home-care benefits, as part of the Medicare benefit package. However, these benefits have been significantly reduced or eliminated.

The elimination of these benefits has had grave impacts on the provision of health care and has also impacted program costs. For example, family respite care is a benefit that has been significantly reduced and is now only available in very limited cases. Respite care is the provision of short-term care in a facility outside the home, which provides a temporary break to family members and caregivers. The physical, emotional, and financial aspects of providing care to a chronically ill individual can be overwhelming for caregivers, without sufficient support. By supporting caregivers, they will in turn be able to provide better care. Additionally, without sufficient support, chronically ill individuals could end up in a hospital, should the caregiver not be able to provide continued care, whereas a respite facility would be the more appropriate place of service.

Thus, we recommend reinstating benefits that support a family-based model of care for all of MA. Alternatively, at a minimum, we recommend reinstatement of these benefits for SNPs. SNPs could file these benefits as part of their model of care. That model of care would then be reviewed by the National Commission for Quality Assurance (NCQA). If approved by NCQA, then a SNP would be permitted to offer these important benefits.

❖ *Increase Scope of Practice for Non-Physicians*

Improving access to primary care is of critical importance to those struggling with chronic illness. In addition, effective care models need to have the ability to be replicated in different states and geographies. Today, scope of practice guidelines vary, which can create unnecessary barriers to the expansion of proven chronic care management programs. To help improve chronic care management and support innovative models of care, we offer the following recommendations:

- Nurse practitioners and other providers with advanced degrees should be granted the autonomy to provide services allowed by their state licenses – such as writing prescriptions for medications, administering treatments, and ordering and interpreting diagnostic tests – without the oversight of a physician.
- Support increased standardization in employment structures across states. In some locations nurse practitioners may be required to be employed by a physician, while in others they are permitted to work individually.

As previously discussed, extended health care professionals, such as nutritionists, health educators, and social workers are important components of an integrated, multi-disciplinary care team. These teams are a critical component in ensuring better health outcomes and improving member lives. To better support team based models of care, we recommend that Medicare reimburse these extended health care professionals for the care provided. Specifically, we recommend that services such as nutrition and health education be added as Medicare FFS benefits. This will ensure the care provided by these professionals is appropriately reimbursed, allowing greater beneficiary access to holistic care programs.

Support Patients with Chronic Conditions through Appropriate Payment

Each health plan operating in the MA and prescription drug (Part D) programs enroll a unique mix of individuals with different demographic features, diagnoses, and healthcare needs. These beneficiary-specific factors can translate to dramatically different healthcare costs. Recognizing this, the Centers for Medicare & Medicaid Services (CMS) risk adjusts plan payments based on beneficiary demographics and health status.

It is vital that the risk adjustment model is an accurate predictor of cost. The model has over-predicted the cost of the least costly beneficiaries and under-predicted the cost of the most costly beneficiaries.⁴ Recent actions have intended to correct this disparity and make the model more accurate and predictive of costs. However, these actions have resulted in significant and disproportionate payment cuts to plans serving the most vulnerable and chronically ill Medicare beneficiaries, placing these plans' ability to continue to offer best-in-class chronic care management at risk.

Previously, we addressed model improvements to better support chronic care management. Appropriate payment is also vital to ensure chronic care programs are appropriately supported, allowing more beneficiaries access to best-in-class models of care. To ensure continued support for strong chronic care

⁴ MedPAC, Report to the Congress: Medicare and the Health Care Delivery System. June 2012. Accessed at: http://www.medpac.gov/documents/reports/jun12_entirereport.pdf?sfvrsn=0.

management programs, we offer the following recommendations addressing risk adjustment model improvements:

❖ ***Support Appropriate Chronic Care Management for Individuals with Chronic Kidney Disease by Recognizing Chronic Kidney Disease Stages 1 – 5 and Diabetic Neuropathy in the MA Risk Adjustment Model***

Over 26 million people have Chronic Kidney Disease (CKD), yet only 10% are aware they have it, and another 73 million are at risk⁵. It has been documented that 40 percent of the population ages 60 and over have CKD⁶. Additionally, a recently released analysis estimates that the prevalence of CKD is rising⁷. Moreover, clinical studies have found that CKD is significantly under-diagnosed. A recent study found that only 12 percent of primary care providers were properly diagnosing CKD in patients who are at the highest risk of kidney disease.⁸ Early detection and education is critical to the health of each individual at risk for this disease.

The elimination of CKD stages 1, 2, and 3, as well as Diabetic Neuropathy from the MA risk adjustment model directly impacts beneficiaries who rely upon the specialized disease management provided by best-in-class clinical models that are focused on providing care to the highest-risk Medicare beneficiaries. CKD cannot be reversed; disease progression can only be stopped, slowed, or managed. Care interventions do improve health and prolong the need for more intensive interventions. This is care that makes a drastic difference in each individual's life, as well as in the lives of their family and caregivers. Early care also helps the larger health care system by prolonging the need for more intensive care – such as dialysis or kidney transplants. Moreover, early care and education can impact and reduce the associated co-morbidities, such as heart disease and drug toxicity for many individuals. As previously cited, CareMore's unique clinical model of care has produced substantially improved health outcomes for Medicare beneficiaries. Additionally, due to the CareMore's innovative approach, the average CareMore member with CKD 3 is projected to progress to dialysis in slightly over 24 years, as opposed to less than 6 years in Medicare FFS.

We urge Congress to recognize the value of early identification and treatment of chronic illness, and resulting superior clinical outcomes, via full restoration of payment codes for CKD stages 1, 2, and 3 and Diabetic Neuropathy.

❖ ***Support Appropriate Care Management for Individuals with Alzheimer's Disease and Related Dementias by Recognizing Dementia in the MA Risk Adjustment Model***

We believe it is critical to address necessary systematic improvements in health care quality for individuals currently living with Alzheimer's disease and Related Dementias (ADRD). With an aging population and estimates that 13.8 million individuals or more will have Alzheimer's by 2050, barring

⁵ Tuot DS, Plantinga LC, Hsu CY, et al. Chronic kidney disease awareness among individuals with clinical markers of kidney dysfunction. Clin J Am Soc Nephrol. Aug 2011;6(8):1838-1844.

⁶ National Health and Nutrition Examination Survey (NHANES), 2012.

⁷ The Future Burden of CKD in the United States: A Simulation Model for the CDC CKD Initiative, Thomas J. Hoerger, PhD. et al., American Journal of Kidney Diseases, DOI: 10.1053/j.ajkd.2014.09.023, published online 25 November 2014.

⁸ Szczech LA, et al. Primary Care Detection of Chronic Kidney Disease in Adults with Type-2 Diabetes: The ADD-CKD Study (Awareness, Detection and Drug Therapy in Type 2 Diabetes and Chronic Kidney Disease), PLOS One November 26, 2014.

medical breakthroughs, there is an urgent need to find a better solution to improve the quality of life for individuals affected by ADRD, as well as their families and caregivers.⁹ Currently, the MA risk adjustment model does not recognize the diagnosis and treatment of dementia care. Therefore, plans providing this care are not appropriately reimbursed; this in turn limits the plans' ability to provide expanded care.

CareMore's specialized Brain Health Program is holistically centered around each individual member and excels by simplifying access to quality care, increasing communication, and providing a high-touch, time-intensive process of care. A multidisciplinary team consisting of a primary care provider, social worker, nutritionist, neurologist, neuropsychologist, pharmacist, education specialist, care manager, and other specialized ADRD caregivers work together to ensure care is appropriately tailored to each individual member.

To increase each member's quality of life through the delivery of high quality care and care coordination the Brain Health Program focuses on the following objectives:

- Reduction of unnecessary hospitalizations
- Reduction of falls and accidents, with an increase in overall safety
- Reduction of medication errors
- Optimization of medications across all chronic conditions
- Increased treatment adherence
- Increased coordination of care
- Increased member, family, and caregiver satisfaction

Over the course of a six-month screening period, CareMore was able to significantly impact health outcomes, leading to improved quality of care, while also providing critical support to families and caregivers. Specifically, our care model resulted in:

- 100% reduction in unnecessary emergency department (ED) visits and hospitalizations due to Behavioral and Psychiatric Systems of Dementia.
- Significant reduction in falls. Before joining the Brain Health Program, 71% of participants had a documented fall, with 40% requiring an ED visit. Throughout the Brain Health Program, falls were reduced, with only 14% experiencing a fall. Notably, no one required a medical visit. CareMore was able to impact and reduce falls through a comprehensive program, including: home safety evaluations to help families identify even hidden dangers, increased education, regular visits with a social worker, a complete pharmacy review to identify any drug interactions, a dietary review with a registered dietician to ensure optimal nutrition, and regular meetings with care staff to provide continuing support.
- More caregivers began taking an active role in medication monitoring. We saw a trend where individuals with dementia were allowed to manage their own medications. Through education, we were able to impact medication safety, with 76% of caregivers stating they had an increased understanding of safety issues.

⁹ Hebert LE, Weuve J, Scherr PA, Evans DA. Alzheimer disease in the United States (2010-2050) estimated using the 2010 Census. *Neurology* 2013;80(19):1778–83.

- 67% of caregivers also made changes to increase safety. We work with members, families, and caregivers to provide education and training about home safety, social safety, and public safety. Changes, from ensuring throw rugs are properly secured to ensuring members with ADRD don't have access to car keys, can greatly impact a member's life. We also connect members to the Alzheimer's Association and additional community programs.
- 68% of members in the Brain Health Program made dietary and hydration changes. Members with ADRD experience changing tastes, and proper hydration needs to be watched closely. We work with registered dietitians to provide education and to assist the member as their tastes change. Additionally, the ability to chew food declines as the disease progresses. Chewing evaluations are completed to take into account food-related choking hazards.
- 100% reduction in ED visits for urinary tract infection (UTI). Before joining the Brain Health Program, 19% of participants had a history of UTI, with 5% visiting an ED. This is often due to reduced hydration. We were able to impact proper care management and help support families and caregivers through nutritional education and dietary assistance.
- 94% reported the Brain Health Program improved their understanding of ADRD.
- 94% of caregivers stated they feel satisfied and supported and are better caregivers since participating in the Brain Health Program.

CareMore's Brain Health Program has made a significant difference in the lives of our members with ADRD and their families and caregivers. However, these innovations are not widely available as the MA risk adjustment model does not account for ADRD diagnosis and treatment.

As discussed, the current Medicare risk adjustment model consistently under-predicts the risk scores for high-cost populations, which results in underfunding vulnerable subgroups like those with ADRD. Currently, dementia care is not represented in the risk model. Therefore, plans providing this care are not appropriately reimbursed; this in turn limits the plans' ability to provide expanded care. Additionally, Medicare permits the creation of specialized SNPs for dementia, but due to inadequate recognition and support, these SNPs are not widely available. We strongly recommend that dementia be recognized in the risk adjustment model to ensure effective health care for persons with ADRD is more widely available.

❖ ***Increase Transparency in Chronic Care Management Reimbursement Mechanisms by Requiring MA Risk Adjustment Model Changes be Subject to a Formal Public Comment Opportunity with a 60-day Comment Period***

Currently, risk adjustment model changes are proposed in CMS' Annual Advance Notice and finalized in the Final Notice. Risk model changes should not be included in the Advance Notice process, where plans have a short two-week window to fully analyze, understand, and model proposals, often with incomplete information. As discussed previously, risk adjustment changes have direct and significant impacts to beneficiaries as they impact availability and access to specialized chronic care services. It is important to offer stakeholders a thorough opportunity to understand, analyze, and discuss with CMS, the impacts any proposed change could have upon beneficiaries. Robust stakeholder conversation and increased transparency will help support the creation of a more accurate model. To support increased transparency, Anthem recommends that any changes to the risk adjustment model be subject to a formal public comment opportunity with a minimum 60-day comment period.

❖ *Strengthen Chronic Care Management through Reform of the Risk Adjustment Model*

Anthem recommends that the MA risk adjustment model be reviewed to ensure that it accurately reflects the costs of caring for beneficiaries – especially the highest-risk Medicare beneficiaries with chronic illness.

Anthem recommends that an independent analysis be conducted by an external research organization, with no current or prior role in the development of the MA risk adjustment model, to analyze the accuracy of the implemented risk adjustment model and provide recommendations on areas of necessary improvement.

After this analysis is released and a stakeholder process is convened, we recommend a revised MA risk adjustment model be published, with at least a 60 day public comment period. The revised model should:

- Promote early detection of chronic diseases, prevention of complications and disease progression, and disease management.
- Take into account recommendations from the Medicare Payment Advisory Commission and MA plans and providers;
- Include all chronic conditions prevalent in the MA population, including, but not limited to Chronic Kidney Disease stages 1 - 5, Diabetic Neuropathy, and Dementia;
- Include a frailty factor for MA plans and SNPs who enroll frail members; and
- Ensure the care management and disease related costs associated with caring for beneficiaries with more than one chronic condition are accurately represented.

❖ *Limit Discretionary Medicare Advantage Coding Pattern Adjustments to Levels Already in Statute*

Coding pattern adjustment methodology updates should be fully transparent and should not be increased beyond the levels already deemed to be appropriate in law. Discretionary adjustments, on top of the statutory adjustments, are duplicative and have a significant impact on program stability, diverting support from and directly impacting the care provided to beneficiaries. Moreover, MA plans should not be penalized for detecting chronic illness and providing high-quality care.

Increase the Accuracy and Value of Quality Ratings Through Star Ratings Improvements

CMS evaluates Medicare health plan quality through a 5-Star Rating Program. Star Ratings are intended to provide Medicare beneficiaries a clear standard for evaluating plan quality. The Star Ratings began as a program with a keen focus on quality of care, with the intent of allowing beneficiaries to be better informed when selecting a health plan. However, over time, the Star Ratings has evolved into a model that is strongly incentivized by payment. As plans are incentivized to improve quality, it is of vital importance that the process, measures, and methodologies are correct and transparent to ensure the Ratings properly represent the care provided.

Ensuring a clear picture of quality is especially important for beneficiaries requiring specialized chronic care management; beneficiaries should be able to rely upon the Star Ratings as a useful and meaningful tool in selecting the right plan for their specific needs.

To ensure continued support for transparent and meaningful quality measurement, we offer the following recommendations addressing necessary Star Ratings improvements:

❖ ***Increase Transparency in Health Care Quality Reporting by Retaining the 4-Star Thresholds***

The Star Ratings utilize predetermined thresholds which provide transparency into the score that is required to receive a 4-Star. CMS is removing the predetermined thresholds for the 2016 Star Ratings, detrimentally impacting MA plans, providers, and beneficiaries.

Plans and providers value the transparency and stability the predetermined 4-Star thresholds provide and use them as benchmarks to track achievement, which helps ensure the provision of quality health care services. Establishment of transparent and stable performance standards, which permit plans to evaluate their performance and understand what is required to achieve ratings of 4 Stars or higher, has been a helpful and stabilizing component of the Stars. Without this transparency, plans and providers are left uncertain as to the goals that CMS is setting and expecting them to achieve.

Plans leverage the thresholds when setting quality expectations for network providers. Plans often set quality expectations and performance targets jointly with providers. Elimination of the thresholds will determinately impact plans' collaboration efforts with provider networks.

It is critical this transparency remains to ensure plans and providers are able to clearly set quality expectations and to support chronic illness quality management and improvement. The Stars program should strive for complete transparency to ensure beneficiaries can rely upon the Star Ratings as an accurate tool in selecting the most appropriate plan for their specific circumstances and needs. Thus, we recommend that Congress reinstate the 4-Star thresholds for 2016 and future years.

❖ ***Ensure Individuals with Low-Socioeconomic (Low-SES) Receive Quality Health Care Through Necessary Adjustments to the Star Ratings***

An immediate, short-term solution is required to protect access to plans that serve low-income beneficiaries. The Star Ratings do not take into account demographic differences such as low-income seniors who experience higher rates of chronic disease, disability and mental illness and which often results in increased resources and slower health improvement. Those with low-socioeconomic (low-SES) characteristics are more likely to become sick, get diagnosed and treated later, and die sooner than individuals with higher-SES. These beneficiaries are consistently more complex to manage than higher-SES beneficiaries, even after adjusting for socioeconomic characteristics.

Low-SES beneficiaries are more likely to have certain risk factors (e.g. low-income, low levels of education) that are strongly correlated with poorer health outcomes. When beneficiaries with low-SES characteristics are covered by a health plan, their poorer health outcomes significantly influence health plan performance on quality metrics. The current 5-Star rating system penalizes plans that care for a greater proportion of beneficiaries with low-SES characteristics, by not adjusting for the significant affect that low-SES has on population health outcomes and therefore plan performance.

Today, the quality ratings of plans serving beneficiaries with low-SES characteristics are not a true picture of quality, which directly impact payment and these specialized plans ability to further invest in innovations to improve chronic care management. It is also critical to ensure that methodological shortcomings do not limit the number of specialized plans who have chosen to serve those with low-SES characteristics and chronic illness.

Any solution must hold plans accountable for providing high quality coverage to all beneficiaries, while recognizing the challenges that are present and which grow as a plan's share of low-SES membership increases.

We recommend the following short-term solution, while a stakeholder process is initiated to discuss longer-term solutions. A visual of our short-term solution is also included in the Appendix.

- This short-term solution focuses on plan improvement from year-to-year within a subset of clinical measures on which plans with a significant low-SES membership have been shown to struggle. The improvement would be determined using a test of statistical significance determined by the Administrator.
- The subset of clinical measures includes Part C Domains 1 and 2 and Part D Domain 4. The research has showed that there are a number of clinical measures where low-SES populations performed worse when compared to high-SES beneficiaries, due to unique low-SES characteristics.
- Plans would be eligible to earn an adjustment to compensate for the structural bias in the Star Ratings against plans serving low-SES members. The eligibility for, and amount of, the adjustment would be based on a contract's statistically significant improvement on the subset of measures and the contract's share of low-SES membership. The adjustment would apply to a plans' Overall Star Rating as well as its Part C and D Summary scores.
- Plans would be evaluated based on the percentage of eligible measures with statistically significant improvement to account for annual changes in Star Ratings measures that may result in fluctuations in the number of eligible subset measures (i.e., addition of measures, retirement of measures, changes in measure specifications).

❖ ***Require Changes to the Stars Measures and Methodologies be made Prospectively; Require Measures and their Methodologies be Finalized Prior to the Start of the Measurement Period***

The Star Ratings should accurately reflect plan quality and be used as an effective and accurate tool for beneficiaries making enrollment decisions. This is especially important for beneficiaries with chronic illness who may require transparency into specific quality measures. MA plans and providers have frequently experienced retrospective changes to the Star Ratings. Specifically, CMS may alter the quality requirements during or after the measurement period. This does not support program transparency or accuracy of quality reporting and should not occur. Retrospective policies result in inaccurate information being provided to beneficiaries. This limits beneficiary transparency and beneficiaries' ability to choose from a variety of quality plan choices that may best serve their specific needs.

Accordingly, Anthem strongly recommends CMS apply all modifications on a prospective basis and finalize measures and their methodology prior to the start of the measurement period in order to give plans transparent and adequate notice. This transparency is critical to ensure beneficiaries are able to rely upon the Star Ratings as a true measure of quality when selecting a plan.

❖ ***Support Increased Transparency by Requiring Formal Rulemaking***

To support transparency and program stability, proposed and final changes to the Star Ratings should be published in Federal Register well in advance of the measurement period. Stakeholders should be

provided at least 60 days to comment on any proposed changes. These transparency improvements would ensure that there is a robust discussion on quality and chronic care quality measurement via an appropriate stakeholder review processes.

Ensure Equitable Payment for Chronic Care Management

The Medicare CY 2015 FFS Physician Payment Rule provides for a new service and resulting payment for chronic care management. However, there is not a companion payment in MA to support chronic care management. Instead, CMS is eliminating risk adjustment payments for the care management of some of the most chronically ill MA beneficiaries. To ensure best-in-practice models are available to all beneficiaries, Anthem strongly recommends that equitable payment be provided to MA plans for chronic care management activities.

Ensure Technical Issues Do Not Interrupt the Provision of Consistent Health Care

Members with chronic conditions achieve better health outcomes when they have access to a consistent set of benefits that support their care plan. However, interaction between two technical aspects of the MA program has resulted in a perverse incentive for plans to interrupt access to a consistent set of benefits.

Among the multiple compliance requirements of MA bidding is the Total Beneficiary Cost (TBC) requirement, otherwise known as the TBC rule. The TBC rule restricts the amount of benefit reductions or increased premiums that an enrollee may experience year over year. Beneficiaries enrolled in plans that experience temporary variations in Star Ratings could end up experiencing significant year to year benefit fluctuations as a result of the TBC requirements.

For example, an MA plan might decide to absorb costs to keep benefits constant for their members if they believe the Star Rating drop is a one-year phenomenon. However, rules related to the TBC requirement would not make that a feasible option. If an MA plan did keep benefits constant and the Quality Bonus Payment was restored the following year, the TBC requirement would actually require an increase of benefits, thus locking in the negative impact the plan was willing to absorb for one year. This issue will likely force MA plans to cut benefits, due to the TBC requirements, and then add them back the next year. This is not a good outcome for beneficiaries and does not support effective care – especially for those with chronic illness who are best supported through a consistent care plan and set of benefits.

To ensure very technical issues do not get in the way of patient care, we recommend that Congress (1) Permit plans to petition for an exception to the TBC rule for plan benefit packages encountering unusual or extraordinary circumstances and (2) Require the Secretary to revise the TBC to allow plans with negative margins additional flexibility to alter benefits.

II. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures

Utilize Medicare Advantage Experience in the Development of ACO Policies

MA plans have a long history of managing and coordinating care for members, via a long-standing infrastructure that is required to support risk-based arrangements. In these arrangements, MA plans bear the risk of caring for their members via receipt of a capitation payment from CMS. In addition, MA plans have led the creation of multiple innovative partnerships with providers—so that providers may share in the benefits and risk of providing high quality care to our members. MA organizations already have

established the infrastructure that is absolutely necessary to promote care coordination and risk sharing relationships with providers, including development of robust networks, IT systems, and reliable data and data sharing mechanisms. As care integration and risk-sharing models in the FFS system are considered, a strong role for managed care should remain. New models should rely on and use the infrastructure the MA organizations have built, rather than using limited resources to reinvent the system.

Anthem believes that CMS should explore opportunities to create partnerships between MA organizations and ACOs, relying on the infrastructure of a managed care, particularly in areas where there has not been high uptake, or success, in ACO participation. Relying on this existing infrastructure will allow new partnerships to evolve, by building upon best-practices and minimizing the administrative hurdles that impede beneficiary care.

III. Reforms to Medicare’s current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions

Increase Chronic Care Support Through Medigap Innovations

Medigap plans are an essential supplement to the Medicare benefit for many seniors. While Medigap plans do an excellent job helping Medicare beneficiaries meet the significant financial burden of their care, significant restrictions on the types of Medigap plans that can be offered limit the ability of Medigap plans to contribute to improving the quality of care received by beneficiaries. Today, Medicare beneficiaries may choose from standardized benefit designs. While this standardization facilitates beneficiary “apples-to-apples” comparison, it stifles innovation by plans that could improve care quality and patient outcomes. Furthermore, these restrictions limit Medigap plans’ ability to successfully pursue cost-savings that could be incorporated back into the system and help improve care.

Anthem recommends the implementation of a demonstration permitting Medigap plans to offer consumers a choice to save money and obtain better value by encouraging Medigap plans to innovate. For example, depending on current plan design, a Medigap plan could lower copayments or offer premium discounts or deductible credits to patients who choose providers that Medicare identifies as high value. Such value-based insurance designs (VBID) show promise in reducing beneficiary use of low-value services while encouraging use of high-value services.

For any Medigap demonstration to be successful, it is important that plan sponsors receive meaningful flexibility to alter plan designs in ways that can truly impact care. Currently, Medigap plans have very limited ability to influence beneficiary behaviors and treatment choices. Even if they choose to introduce care management programs, they cannot require members to participate. Without increased influence over behaviors and choices, it will not be reasonable to expect plans to be able to meaningfully improve the quality of care or lower costs. To be effective, Medigap plans should be able to provide incentives for using preferred provider networks and implement some limited prior authorization policies to limit the use of low-value services and the overutilization of care.

Complementing this more flexible approach, Medigap plans could choose to implement care management services and tools to reduce Medicare spending and improve beneficiary care. In addition, these services could either be required or incentivized through VBID tools. For example, plans may choose to sponsor case management initiatives targeted at beneficiaries transitioning from the hospital to home or beneficiaries living with chronic conditions that place them at high risk of hospitalization.

Participation should be encouraged through shared savings agreements that allow Medigap plans and CMS to share the benefits of reduced costs. If a Medigap plan were to invest in care management on its own today, the plan would see only about 20 percent of any savings realized—which might not even

offset the plan's investment—and the remainder would accrue to the Medicare FFS program. Specifically, a demonstration could test a model under which shared savings would be used in the Medigap market to align Medicare, Medigap, and beneficiary incentives toward the delivery of high-value care at reduced costs.

IV. Ideas to effectively use or improve the use of telehealth and remote monitoring technology

Eliminate Telehealth Originating Site Restrictions, Allowing All Beneficiaries Access to Health Care Technologies

Telehealth has the ability to empower patients and caregivers, while improving the lives of our beneficiaries. The use of telehealth technology provides patients with real-time access to physicians who are able to consult and provide quality care without needing to visit an urgent care or other more costly care setting. This allows patients to establish a relationship with a licensed physician, nurse practitioner or other provider. The consultations include a documented patient evaluation, including a review of the patient's medical history and an establishing discussion to determine a diagnosis and identify underlying conditions or contraindications to the treatment recommended. Patients are then able to forward the documentation from their consultation to their selected care provider(s) to uphold the patient's continuity of care.

Anthem includes real-time, telehealth services as a supplemental Medicare benefit. This offering is a secure, structured telehealth solution which allows doctors and beneficiaries to engage in real time, live video visits.

Online visits are also currently being offered as a covered benefit in most of our commercial markets. This solution offers consumers and employers increased access to care and convenience for urgent medical issues, using board certified doctors, and a more affordable option for care after hours and on weekends.

Federal support for telemedicine and telehealth presents a major opportunity for technological advancement that will result in improved patient care in the form of reduced costs, improved quality, better chronic care monitoring, and increased access.

We strongly recommend that Congress work to eliminate access barriers such as originating site restrictions that limit the reimbursement of telehealth services in urban areas and prohibit beneficiaries from receiving reimbursements for telehealth services from their home, instead requiring them to travel to an approved "originating site."

Increase Support of Remote Monitoring Technologies

Another way we have used technology and communication to improve the lives of our members is through remote monitoring technologies. Remote monitoring technologies use digital technologies to collect medical and health data from a beneficiary and electronically transmit that data to a health care professional in another location. These innovative technologies assist individuals with chronic illnesses help manage their care. For example, we provide wireless scales to members with Congestive Heart Failure (CHF). Sudden weight fluctuations are often an early warning indicator of health decompensation for members with CHF. Without accurate and updated information, providers are not able to be responsive to the care needs of patients who require immediate intervention. This could lead to a painful and expensive hospitalization. To address this issue, members simply step on their wireless scale daily, and data is then sent electronically to our database which is tracked by our nurse practitioners. If the member experiences a weight gain of 3 pounds overnight or 1 pound per day for more than 3 days, we immediately call the member and schedule a same-day appointment to address their condition.

Wireless health monitoring devices represent a breakthrough approach to caring for seniors with chronic conditions. This technology allows members and providers to keep a close watch on member health and opens new lines of effective and proactive communication. The results have been significant as participating members experienced 52% fewer hospital admissions compared to Medicare FFS average¹⁰

Today, Medicare does not appropriately reimburse for remote monitoring services. Though the provision of wireless health monitoring devices has improved the outcomes of our CHF members, additional technologies could be implemented through appropriate funding, which in turn would help improve chronic care outcomes and reduce larger costs by providing earlier and quicker interventions and care.

V. Strategies to increase chronic care coordination in rural and frontier areas

Support Access to Specialized Health Care for All Beneficiaries

As discussed, the current Medicare risk adjustment model consistently under-predicts the risk scores for chronically ill individuals, which results in the underfunding of these vulnerable subgroups. Moreover, access to necessary specialized care is limited because certain chronic conditions, that are prevalent in the Medicare population, are not fully recognized.^{11, 12, 13}

To ensure all beneficiaries have access to innovative care, the risk adjustment model needs to be accurate and a true representation of the Medicare population and care provided. Thus, we reiterate the risk adjustment model recommendations previously discussed in this letter.

VI. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers

Encourage Engagement and Innovations through Value-Based Insurance Design (VBID)

Anthem is focused on ensuring the provision of high-quality plans that improve care delivery, promote wellness and management of chronic conditions through innovation, and achieve meaningful cost-savings for our members. In order to remove the barriers that prevent access to services, MA plans should be allowed to tailor VBID to enhance the management of chronic conditions, and target specific diseases through both MA and SNPs.

¹⁰ CareMore 2013 Hospital Metrics. Admissions are rates per 1,000 beneficiaries. CHF, first row, Medicare CHF rate (21.1% Am J Manag Care. 2012;18(2):96-104).

¹¹ CMS, Evaluation of the CMS-HCC Risk Adjustment Model, March 2011. Accessed at: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Evaluation_Risk_Adj_Model_2011.pdf

¹² Pope, G, Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model, Summer 2004. Accessed at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/04summerpg119.pdf>

¹³ Kaiser Family Foundation, Medicare Patients' Access to Physicians: A Synthesis of the Evidence, December 2013. Accessed at: <http://kff.org/medicare/issue-brief/medicare-patients-access-to-physicians-a-synthesis-of-the-evidence/>

Anthem is supportive of VBID designs that incentivize beneficiaries to use high-value services, and is interested in the ability of MA/MA-PD plans to offer incentives (e.g., lower cost-sharing) that drive increased utilization of health care improvement programs. These flexible incentives help generate patient engagement, leading to higher levels of compliance with evidence-based medicine standards. Anthem particularly supports the ability of MA/MA-PD plans to use VBID for beneficiaries with complex, chronic conditions, including Chronic Obstructive Pulmonary Disease, End Stage Renal Disease, Congestive Heart Failure, and/or Dementia, as a method for reducing the use of unnecessary, duplicative care, and increasing more effective care and beneficiary engagement.

By allowing MA plans to target certain chronic conditions via VBID, more individuals may benefit from effective and targeted care, leading to improved health outcomes, reduced out-of-pocket costs, and decreased system-wide costs.

Anthem believes there is strong potential to improve care quality and reduce costs through VBID, but has identified several barriers that may impede implementation. For example, MA plans are not allowed to tailor benefits to patient sub-groups, who may benefit from high-value services. Plans are also limited in their ability to vary copays in certain circumstances. These standards weaken a plan's ability to reduce costs and promote smart health care consumption decisions among members. Modifying these standards would allow plans to produce meaningful change in member behavior.

VII. Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions

Support Access to Specialized Care Coordination Models

As discussed, Dementia and Chronic Kidney Disease are not appropriately recognized in the risk adjustment model. Therefore, plans providing this care are not appropriately reimbursed; this in turn limits the plans' ability to provide expanded care. These systematic barriers prevent the development and expansion of programs like CareMore's specialized Brain Health Program. Innovative programs, such as these, effectively utilize primary care providers, specialty providers, and care coordination teams to impact health care outcomes. To ensure holistic and fully integrated programs are more widely available, we strongly recommend that Medicare appropriately recognize and support the provision of coordinated care models for chronic illnesses which are prevalent in the Medicare population.

Anthem appreciates this opportunity to offer our recommendations to the Senate Committee on Finance's Chronic Care Working Group. Should you have any questions or wish to discuss our proposals further, please contact Samuel Marchio at Samuel.Marchio@Anthem.com or (202) 628-7831.

Sincerely,



Elizabeth P. Hall
Vice President

Appendix

Short-Term Star Ratings Low-SES Recommendation:

	Statistically significant improvement on at least 25% but less than 30% of the measures within Part C Domains 1&2 and Part D Domain 4	Statistically significant improvement on at least 30% but less than 35% of the measures within Part C Domains 1&2 and Part D Domain 4	Statistically significant improvement on at least an 35% but less than 40% of the measures within Part C Domains 1&2 and Part D Domain 4	Statistically significant improvement on 40% or more of the measures within Part C Domains 1&2 and Part D Domain 4
20-34% of LIS Cohort	0.1 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.2 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.3 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.4 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score
35-49% of LIS Cohort	0.2 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.3 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.4 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score
50-74% of LIS Cohort	0.3 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.4 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score
75%-100% of LIS Cohort	0.4 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score

Measures Included in Star Rating Proposal

2015 Star Ratings Part C Domains 1&2, Part D Domain 4

Part C Domain 1-- Staying Healthy: Screenings, Tests, and Vaccines

- C01 - Colorectal Cancer Screening
- C02 - Cardiovascular Care – Cholesterol Screening
- C03 - Diabetes Care – Cholesterol Screening
- C04 - Annual Flu Vaccine
- C05 - Improving or Maintaining Physical Health
- C06 - Improving or Maintaining Mental Health
- C07 - Monitoring Physical Activity
- C08 - Adult BMI Assessment

Part C Domain 2 – Managing Chronic (Long Term) Conditions

- C09 - SNP Care Management
- C10 - Care for Older Adults – Medication Review
- C11 - Care for Older Adults – Functional Status Assessment
- C12 - Care for Older Adults – Pain Screening
- C13 - Osteoporosis Management in Women who had a Fracture
- C14 - Diabetes Care – Eye Exam
- C15 - Diabetes Care – Kidney Disease Monitoring
- C16 - Diabetes Care – Blood Sugar Controlled
- C17 - Diabetes Care – Cholesterol Controlled
- C18 - Controlling Blood Pressure
- C19 - Rheumatoid Arthritis Management
- C20 - Improving Bladder Control
- C21 - Reducing the Risk of Falling
- C22 - Plan All-Cause Readmissions

Part D Domain 4 – Drug Safety and Accuracy of Drug Pricing

- D09 - MPF Price Accuracy
- D10 - High Risk Medication
- D11 - Diabetes Treatment
- D12 - Medication Adherence for Diabetes Medications
- D13 - Medication Adherence for Hypertension (RAS Antagonists)
- D14 - Medication Adherence for Cholesterol (Statins)