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Submitted electronically to: chronic_care@finance.senate.gov

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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

Re: United States Senate Committee on Finance Bipartisan Chronic Care Working Group Policy Options Document

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

Anthem, Inc. (“Anthem”) appreciates this opportunity to provide comments regarding the U.S. Senate Finance Committee’s Bipartisan Chronic Care Working Group Policy Options document. As a committed participant in the Medicare Advantage (MA) and Part D programs, Anthem supports the Working Group’s efforts to improve care for the millions of Americans managing chronic illness, and we look forward to continuing to partner with you on this important issue.

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 over 72 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.

Overview

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 assist beneficiaries with chronic illness in managing their health. We place a strong emphasis on early detection and prevention of chronic conditions and comorbidities. 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 special needs plans (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.

Thus, Anthem strongly supports the Chronic Care Working Group's efforts to improve care for Medicare beneficiaries with chronic conditions, and we are pleased to have the opportunity to provide comments on the Working Group's Options Paper. In looking to improve care for Medicare beneficiaries with chronic conditions, we have identified several priority areas, which we believe align with the policy directions set forth in the Options Paper:

- Permanently authorize SNPs to ensure that vulnerable beneficiaries will continue to have access to the care they need;
- Ensure a fair, accurate, and stable payment structure for MA plans, including strengthened chronic care management through reform of the risk adjustment model, and a reduced or eliminated coding pattern intensity adjustment for chronic condition SNPs (C-SNPs).
- Provide MA plans with additional flexibility to create and deploy tailored, innovative benefit designs and provide additional supplemental benefits for those with chronic illness; and
- Promote access to telehealth services by consistently removing geographic limitations on telehealth services and allowing the home to be an originating site, and making telehealth part of the basic benefit package in MA.

As it moves forward, we also urge the Working Group to continue assessing how a unique type of healthcare workforce is needed to care for individuals with multiple chronic conditions. Anthem believes that efforts to improve the health of chronically-ill Medicare beneficiaries are intrinsically tied to training the clinical workforce to be able to provide services, such as certain behavioral health services, caregiving services, respite, and podiatry care, that are not covered by Medicare but are critical in caring for those with chronic conditions.

With our extensive experience, focus on beneficiary health, and industry-leading chronic care outcomes, Anthem looks forward to continuing to work with the Committee as it develops and implements policies designed to improve disease management, streamline care coordination, improve quality, and reduce Medicare costs.

Our detailed comments follow below.

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. 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, Anthem urges the Working Group to consider 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. To impact outcomes, Anthem plans 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 fee-for-service (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 would better support integrated team-based models of care. 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 type of care 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. Anthem recommends that the Working Group consider a policy that would see 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.

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 for the Working Group's consideration:

- Nurse practitioners and other providers with advanced degrees should be granted the autonomy to provide services allowed by their state licenses – such as writing medication prescriptions, administering treatments, and ordering and interpreting diagnostic tests.
- 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.

Extended health care professionals, such as registered dietitians and other clinically qualified nutrition professionals, health educators, and social workers are important components of an integrated, multi-disciplinary care team. To better support team based models of care, we encourage the Working Group to consider directing Medicare to reimburse these 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.

Receiving High-Quality Care in the Home

Expanding Access to Home Hemodialysis Therapy

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 center 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.

However, a limited set of telehealth services are covered under the Medicare fee schedule for physicians and other health professionals. Medicare only reimburses for telehealth services when the originating site (i.e., where the patient is) is located in a Health Professional Shortage Area (HPSA) or in a county that is outside of any Metropolitan Statistical Area (MSA). The originating site must be a medical facility (e.g., practitioners' offices, hospitals, rural health clinics) and not the patient's home. These restrictions make accessing telehealth services difficult for many Medicare beneficiaries who would benefit from such care.

Anthem commends the Working Group for considering expanding Medicare's qualified originating site definition to include free-standing renal dialysis facilities located in any geographic area. The Working Group states that this would give Medicare beneficiaries who receive dialysis therapy at home the option to go to a freestanding renal dialysis facility to have their monthly visit with their clinician via telehealth without geographic restriction. While this option would certainly eliminate barriers for some patients, we urge the Working Group to broaden this option to benefit a wider array of patients suffering from chronic conditions.

We urge the Working Group to pursue a policy option that allows Medicare providers—including FFS, MA plans, and Accountable Care Organizations (ACOs)—to assess which of their patients would benefit most from telehealth services and to, in turn, be able to use and be reimbursed for such providing services. Consistently removing geographic limitations on telehealth services and allowing the home to be an originating site will ensure a level playing field across risk-bearing organizations, and also increase access to timely, high-value care among chronically ill beneficiaries.

Advancing Team-Based Care

Providing MA Enrollees with Hospice Benefits

Anthem agrees with the Working Group that the current hospice system can be improved via an expansion of the model to better support individuals and their families. Specifically, Anthem supports the carve-in of hospice benefits into the basic MA benefit package. The current fragmented system is highly problematic. For example, there are systematic issues related to how hospice is coordinated with Part D. Today, it is often not clear what is unrelated to hospice, and therefore, what responsibilities the Part D plan sponsor must take on. In addition, there are system-wide technological and administrative process issues which increase confusion for both hospices and Part D sponsors—which negatively impact beneficiaries. We believe there is a better solution to providing comprehensive care via a beneficiary-focused carve-in model supporting more timely and effective coordination.

In developing this model, Anthem believes that Medicare hospice eligibility should be extended from six months to twelve months of life. Extending hospice eligibility would make it easier for beneficiaries to utilize appropriate services. In addition, clinicians would be more likely to offer hospice care as it is very difficult to predict the decline of a severely ill patient.

Additionally, Medicare hospice should integrate curative care, as well as palliative care. The current benefit structure requires the member to sacrifice access to curative therapy, which Anthem defines as the full range of Medicare benefits available. This restriction prevents many patients from choosing the hospice benefit, as it places the beneficiary in the position of deciding between their benefits and end of life care. To better integrate hospice and curative care, Anthem recommends that when a patient elects hospice, the MA plan should continue to be paid the same risk adjusted revenue, but have a standard discount applied in order to generate savings to the Centers for Medicare & Medicaid Services (CMS) (we recommend that the Working Group direct CMS to create a hospice fee-for-service benchmark to be used for determining revenue to plans). We strongly believe that such a program would result in better care coordination and a more satisfactory experience for members. We would also add that as new models are developed, quality should be clearly defined and the new benefit should be measured through consensus-based quality measures.

Providing Continued Access to SNPs for Vulnerable Populations

Anthem is strongly supportive of a permanent authorization of all SNP types, and urges the Working Group to move forward with their proposal. SNP enrollees—who are among the sickest and most expensive Medicare-eligible beneficiaries—rely on these plans to provide specialized coverage. SNPs were created to develop innovative care delivery, and have a proven ability to achieve positive outcomes for individuals with multiple chronic conditions. Permanently authorizing all SNPs ensures that vulnerable beneficiaries will continue to have access to the care they need, and encourages further innovation and growth among SNPs. It also provides program stability, allowing MA plans to make longer-term investments in new care models.

Permanent authorization also would signal to states (including policymakers, Medicaid directors, legislators, governors) that they have a *reliable* long term option for promoting Medicare-Medicaid integration. In the current environment, some states are reluctant to invest in dual eligible SNPs (D-SNPs) if the option could disappear through loss of authorization in the future. In addition, permanent authorization would make it easier for all stakeholders to talk about how the SNP model can be refined and made more effective.

We support the ultimate goals of full integration of Medicare and Medicaid services within D-SNPs, but urge the Working Group to consider a thoughtful approach to achieving maximum integration of coverage options for dual eligibles. We believe that more work needs to be done to ensure that the opportunities and requirements associated with fully-integrated dual eligible SNPs (FIDE SNPs) are understood and agreed upon by states and plans alike.

D-SNPs must engage with the relevant state Medicaid agency to obtain a contract, and the contract must address eight specific requirements. The D-SNP then submits the contract to CMS for review and approval. There have been numerous cases in which CMS rejects the D-SNP's contract developed by the state and requires changes, effectively undermining the state's decisions. On the other hand, a broad reading of the Medicare Improvements for Patients and Providers Act (MIPPA) strongly suggests that states have a significant role in ultimately determining the D-SNP environment. They can determine and control the number of D-SNPs, the specific D-SNP players, the extent of integration, scope of benefits, and categories of duals included under an agreement.

A reasonable resolution to this disparity would be to clarify that states have a partnership interest in D-SNPs along with CMS, and to require that CMS work with states to develop and agree on state-specific D-SNP agreements that are appropriately tailored to features of the state's Medicaid program but within a general federal framework. This could be analogous to the waiver process used in Medicaid, though on a smaller scale.

The Working Group’s proposal to require SNPs to integrate all Medicare and Medicaid benefits could perpetuate the disparity if it does not also establish a role for states as partners in the program design. Anthem believes the proposal should allow for the fact that states are at different points along the managed care continuum and many are not yet ready politically or environmentally to have aged, blind, disabled (ABD), intellectual disabilities/development disabilities (I/DD), and long-term services and supports (LTSS) populations in managed care. Simply requiring that D-SNPs must be fully integrated by a certain date would mean that D-SNPs in such “lagging” states would have to cease operations, thereby denying dual eligibles in those states any possible incremental benefits of partial integration. Therefore, instead of requiring D-SNPs to offer fully integrated benefits at a national-level, Anthem recommends that the Working Group direct CMS to convene more educational programs and initiatives so that stakeholders, including plans and states, can better comprehend rules pertaining to FIDE SNPs, including contracting requirements and best practices for delivering coordinated care, in order to pursue workable solutions to increasing integration within each state.

Without first facilitating increased opportunities for states and plans to formulate mutually agreed-upon and effective contracts fitting unique state populations and programs, states may fail to see the benefits of D-SNPs and FIDE SNPs, while plans may continue to struggle with how to best partner with the state. We believe that this interim step to full integration will enable additional contracting with future FIDE SNPs to offer the best, most appropriate care possible and to fulfill the Working Group’s ultimate goal of improved chronic disease management.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

While the Medicare CY 2015 FFS Physician Payment Rule provides for a new service and resulting payment for chronic care management, there is not a companion payment in MA to support chronic care management. Instead, CMS has eliminated risk adjustment payments for the care management of some of the most chronically ill MA beneficiaries, including those with certain stages of chronic kidney disease (CKD) and diabetic neuropathy. Moreover, the current model does not accurately represent the care management provided to all chronically ill MA members, including those with Dementia.

We agree that managing multiple chronic conditions requires increased levels of patient and provider interaction beyond the typical in-person visit that often includes practice team members such as social workers, dietitians, nurses, and behavioral health specialists. In fact, many MA plans provide highly integrated, team-based care to their members. However, these plans would be ineligible for either the existing chronic care management (CCM) code, or the high-severity CCM code, despite the fact that they deliver the type of robust, coordinated chronic care management the Working Group is aiming to promote. To ensure best-in-practice models are available to all beneficiaries, Anthem strongly recommends that the Working Group ensure equitable payment is provided to MA plans for chronic care management activities, as well.

Addressing the Need for Behavioral Health Among Chronically-Ill Beneficiaries

Anthem applauds the Working Group for considering policies that improve the integration of care for individuals with a chronic disease combined with a behavioral health disorder. Many individuals receiving care for behavioral health conditions also have physical health conditions that require medical attention, and vice versa. Unfortunately, our physical and behavioral health care systems tend to operate independently, without coordination between them—gaps in care, inappropriate care, and increased costs can result.

To address these issues, Anthem encourages the Working Group to consider a policy that requires a closer link between the behavioral health specialist and primary care provider (PCP) who are responsible for a patient's care. For example, one approach could require that, in order for a behavioral health specialist to receive reimbursement for an initial evaluation of a Medicare beneficiary, that specialist must make contact with the patient's PCP within seven days of the initial visit. This follow-up would be billed under a special code that could be monitored and audited by CMS and/or its contractors. Behavioral health specialists who do not contact the patient's PCP would not be reimbursed for the visit. Requiring this type of feedback loop would promote further integration of comprehensive care strategies for beneficiaries who have often been relegated to a siloed system of care.

Expanding Innovation and Technology

Adapting Benefits to Meet the Needs of Chronically-Ill MA Enrollees

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. We applaud the Working Group for considering giving MA plans the flexibility to tailor benefit designs to enhance the management of chronic conditions, and target specific diseases through both MA and SNPs. Implementation of such a policy will remove the barriers that prevent access to needed services for the chronically ill.

Specifically, Anthem is supportive of value-based insurance design (VBID) benefit structures that incentivize beneficiaries to use high-value services, and is interested in the ability of MA and MA prescription drug (MA-PD) plans to offer incentives (e.g., lower cost sharing) that drive increased utilization of health care improvement programs. These flexible incentives—which should be made available to MA plans, MA-PD plans, and SNPs—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, ESRD, 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.

In addition to allowing MA plans to adapt their benefits to the needs of their chronically-ill enrollees, Anthem encourages the Working Group to consider extending the same flexibilities to Medigap plans. 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 VBIDs 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 care management initiatives targeted at 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.

Expanding Supplemental Benefits to Meet the Needs of Chronically-Ill MA Enrollees

The Chronic Care Working Group is considering allowing MA plans to offer a wider array of supplemental benefits than they do today. These additional supplemental benefits could be medical services or other non-medical, social services that improve the overall health of individuals with chronic disease. Anthem strongly supports this proposal, and encourages the Working Group to 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.

Anthem also notes that families and caregivers are an integral part of the support team for individuals with chronic illness. For optimal care management, the Working Group 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. Supporting caregivers will enable them to, in

turn, provide better care. Additionally, without sufficient support, chronically ill individuals could end up in a hospital if a caregiver is not be able to provide continued care, whereas a respite facility would be the more appropriate place of service.

Thus, Anthem recommends that the Working Group consider directing CMS to reinstitute benefits that support a family-based model of care. Alternatively, at a minimum, we recommend reinstatement of these benefits for SNPs. SNPs could file these benefits as part of their Model of Care (MOC). The MOC 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.

Increasing Convenience for MA Enrollees Through Telehealth

Anthem commends the Chronic Care Working Group for considering permitting MA plans to include certain telehealth services in its annual bid amount. As mentioned elsewhere in this letter, we believe that telehealth has the potential to transform access to care and result in lower costs. Anthem strongly supports removing barriers and restrictions to the coverage of telehealth, such as expanding reimbursement of telehealth in Medicare FFS for set period of time, making telehealth part of the basic benefit package in MA, and allowing for reimbursement of remote patient monitoring in Medicare FFS. We urge the Working Group to promote these same policies in its ongoing work.

Providing ACOs the Ability to Expand Use of Telehealth

Anthem again stresses its belief that telehealth technologies are essential to care coordination. We support policies that allow providers to leverage technology to bring care directly to patients when they need it. By moving appropriate care to lower cost settings, including the home and the workplace, telehealth offers the promise of reducing unnecessary ER utilization, hospitalizations and even general overhead, and supporting preventive care efforts for chronic care patients.

To that end, we encourage implementation of a policy that would grant certain Medicare Shared Savings Program (MSSP) participants a waiver of the geographic component of the originating site requirements as a condition of payment for telehealth services. Anthem strongly recommends that the Working Group propose to extend this approach consistently throughout the program to MA plans, as well as all tracks of MSSP participants. Medicare beneficiaries across the program should have access to these innovative practices. Anthem recommends that MA plans be eligible to bill for telehealth services in the same manner as ACOs to ensure that enrollees have the same opportunity to access immediate, appropriate care in the lowest-cost setting. Creating a level playing field within the Medicare program, with respect to policy standards and expectations, will allow innovation to flourish.

Maintaining ACO Flexibility to Provide Supplemental Services

Anthem firmly believes that Medicare program standards should be applied consistently across entities – in this case, providers and plans that bear risk for the cost and quality of care. For example, if greater use of telehealth services could benefit the patients of ACO providers, it logically follows that beneficiaries enrolled in MA plans could also benefit. Likewise, if patients of ACO providers may appropriately receive home health services without being homebound, similarly situated MA enrollees should be eligible for the same benefits and services. Accordingly, we recommend that the Working Group ensure any flexibilities offered to ACOs are also extended to MA plans.

Expanding Use of Telehealth for Individuals with Stroke

Per our earlier comments regarding the Working Group’s policy option to “Expand Access to Home Hemodialysis Therapy,” Anthem supports efforts to eliminate the originating site restriction and the prohibition on beneficiaries receiving reimbursements for telehealth services from their home. However, we encourage the Working Group to maximize the benefits of telehealth services for more Medicare beneficiaries by removing unnecessary barriers to their use. Consistently removing geographic limitations on telehealth services will not only ensure a level playing field across risk-bearing organizations, but also increase beneficiary access to timely, high-value care.

Identifying the Chronically-Ill Population and Ways to Improve Quality

Ensuring Accurate Payment for Chronically-Ill Individuals

Each health plan operating in the MA and 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, 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, including those who are chronically ill. Recent actions have intended to correct this disparity and make the model more accurate and predictive of costs (e.g., implementation of the 2014 CMS-HCC risk model). 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.

Therefore, Anthem strongly supports the Working Group in making changes to the risk adjustment model that support clinically-accurate and appropriate payment—this is critical to ensuring that chronic care programs are appropriately supported, allowing more beneficiaries access to best-in-class models of care. Specifically, we support the following policies:

- **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. We suggest 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;
- Include all chronic conditions prevalent in the MA population, including, but not limited to Chronic Kidney Disease stages 1 - 5, Diabetic Neuropathy, and Alzheimer’s disease and related dementias (ADRD);

- Include a frailty factor for MA plans and SNPs who enroll frail members;
 - Ensure the care management and disease related costs associated with caring for beneficiaries with more than one chronic condition are accurately represented;
 - Account for the costs incurred during the final year of life.
- Reduce or Eliminate Coding Pattern Adjustment for C-SNPs

As the Working Group knows, SNPs are a type of MA plan that focus on certain vulnerable groups of Medicare beneficiaries. C-SNPs enroll special needs individuals who have one or more medically complex chronic conditions that are substantially disabling or life threatening; have a high risk of hospitalization or other significant adverse health outcomes; and require specialized delivery systems across domains of care.

Payments to MA plans, including SNPs, are risk adjusted using a risk adjustment model that modifies payments based on factors that reflect beneficiaries' health status using diagnoses information. However, diagnosis coding in traditional FFS Medicare has historically been less efficient than MA diagnosis reporting due to the fact that, unlike in MA, procedure codes rather than diagnoses form the basis for how providers are reimbursed in FFS Medicare. Because the MA risk adjustment model is calibrated using FFS data and costs, CMS in 2010 began offsetting the effect that MA plans' more accurate coding is having on plan reimbursement by reducing payments across all MA plans—known as a “coding pattern intensity adjustment” (CPIA). The Affordable Care Act (ACA) established a mandatory minimum CPIA starting in 2014, which was increased by the American Taxpayer Relief Act of 2012 (ATRA). Under current law, the minimum CPIA for 2016 requires a 5.41 percent cut to risk revenue, a percentage cut which grows by 0.25 percent each year until it reaches 5.90 percent in 2018.

Given that C-SNPs serve beneficiaries who have more conditions and provide more high-touch care to their members, these plans are more likely to be coding appropriately, even if they have higher coding compared to FFS. Therefore, Anthem urges the Working Group to address the CPIA for C-SNPs in order to ensure adequate payment for specialized plans that serve the sickest patients. Specifically, we recommend that the CPIA—which is 5.41 percent in 2016—should be reduced or eliminated for C-SNPs.

Eligibility for a reduction or complete elimination of the CPIA could be conditioned on a C-SNP's receipt of a 3-year approval of its MOC from the National Committee for Quality Assurance (NCQA). C-SNPs with a 3-year approval have scored highly on the clinical and non-clinical elements that make up the four core standards of the MOC: description of the SNP population; care coordination; SNP provider network; and MOC quality measurement and performance improvement. Conditioning eligibility on a 3-year MOC approval would provide a degree of stability that would allow C-SNPs to know in advance that they would be exempt from the CPIA for a period of time.

Eligibility could be further limited to those plans with an average of 4 stars or higher on the four SNP-specific measures included in the CMS' Star Ratings program (SNP Care Management; Care for Older Adults—Medication Review; Care for Older Adults—Functional Status Assessment; and Care for Older Adults—Pain Assessment). While there would be less stability in tying eligibility to Star Ratings, C-SNPs would have an additional incentive to improve or maintain their SNP Star ratings from year-to-year.

Alternatively, the amount of the CPIA reduction could be based on a C-SNP's performance on the SNP-specific Star measures; C-SNPs with an average of 4 or more stars on these measures would receive the largest reduction, while plans with between 3 and 4 stars would receive a more moderate reduction. C-SNPs with fewer than 3 stars on the selected SNP measures would not be eligible for a reduction in the CPIA. This approach would also give C-SNPs an additional incentive to improve or maintain their SNP Star ratings from year-to-year.

- 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. Congress recently passed H.R. 3881, which extend from 45 days to 60 days the annual notice period for the announcement of payment rates under MA, and gives stakeholders at least 30 days to comment on proposed changes. Anthem appreciates the extra time provided, effective 2017, to review rates and other contemplated program changes. However, risk adjustment changes can have a significant impact on member care. Therefore, we urge the Working Group to take an extra step to include risk adjustment policy changes in regulation, with a 60-day comment period, to allow for more robust stakeholder feedback. This will help support the creation of a more accurate model.

Providing Flexibility for Beneficiaries to be Part of an ACO

Anthem believes that the most accurate method of assigning a beneficiary to a provider is based on the beneficiary's active selection. For example, CMS could ask beneficiaries to identify their primary care providers and then conduct assignment based on the beneficiary's declaration. This approach ensures that each beneficiary is assigned to the provider he or she views as chiefly responsible for coordinating and managing care. While Anthem agrees that prospectively assigning beneficiaries to ACOs will better enable providers to meet spending and quality targets, we are concerned that this could create an uneven playing field among ACOs and MA plans by removing many of the standards and beneficiary protections that govern plan activity.

Developing Quality Measures for Chronic Conditions

Anthem supports initiatives to develop care coordination measures that more comprehensively assess key elements of care management, particularly given our ongoing concern that the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey serves as the primary data source for CMS' assessment of plans' care coordination efforts. The survey data present a number of limitations, some of which disproportionately impact SNPs. For example, the existing measures do not adequately consider the appropriate role of non-physician members of the care team. In addition, members may be more likely to find the measure language confusing, resulting in inaccurate responses. Finally, some of the measures request member comment on plan processes that they cannot reasonably be expected to assess (e.g., whether their primary doctor is fully informed on their specialty care).

As policymakers considers measure development related to care coordination, Anthem offers the following recommendations. First, we encourage reliance on encounter data to the extent possible, due to its administrative simplicity. However, CMS should assess whether using encounter data is likely to capture the full clinical picture. The Agency should also ensure that any measures take into account the full range and variety of care coordination practices that plans employ. Second, we encourage CMS to review existing SNP MOC requirements to determine whether they may also be applied to evaluating care coordination (e.g., number of members eligible for care management services versus number of members

receiving care management services). We also note that appropriately adjusted outcome measures could play a role in assessing care coordination, but should not be used as substitutes for measures that directly assess care coordination activities and programs. Given that there already are significant reporting requirements in care coordination and care transitions, Anthem also recommends that any future care coordination measures build upon those existing requirements.

Finally, in the context of an Alzheimer's and Dementia-specific measure, we urge the Working Group and CMS to ensure that measure tools are based on a stratified model. For example, the care provided to a 65 year old Alzheimer's patient is different from the care provided to a 75 year old patient, which is different from the care provided to an 80 year old patient. It is critical that any measure take into account these differences in order to ensure appropriateness and accuracy.

Empowering Individuals and Caregivers in Care Delivery

Encouraging Beneficiary Use of CCM Services

The Working Group is considering waiving the beneficiary co-payment associated with the current CCM code, as well as the proposed high severity CCM code described above. As stated earlier in this letter, we urge the Committee to 1) ensure equitable payment be provided to MA plans for chronic care management activities and 2) consider 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 (e.g., lower copayments or offer premium discounts or deductible credits to patients who choose providers that Medicare identifies as high-value).

Establishing a One-Time Visit Code Post-Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness

The Working Group's consideration of a policy that would require CMS to implement a one-time payment to clinicians to recognize the additional time needed to have conversations with beneficiaries who have received a diagnosis of a serious or life-threatening illness, such as Alzheimer's and Dementia is commendable, as it aims to acknowledge that providers are often constrained in their ability to spend sufficient time educating patients, who are newly-diagnosed with a serious illness, about disease progression, treatment options, and other resources. However, a payment code for a one-time visit to discuss issues associated with a new diagnosis with no requirement to ensure that appropriate follow-up care is received could further exacerbate the problem of siloed care, rather than promote care integration. Rather than incentivize a single visit that has no bearing on follow-up care or outcomes, the Working Group should ensure that MA plans, including SNPs, that are already providing integrated care are appropriately supported for doing so.

As an example, CareMore's Brain Health Program is holistically centered on 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 caregivers work together to ensure care is appropriately tailored for individuals with ADRD. This model ensures that ADRD patients not only receive information immediately following their diagnoses, but that a robust care team is deeply involved in their ongoing care.

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
- 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. Throughout the Brain Health Program, falls were reduced from 71% of participants with a documented fall to only 14% experiencing a fall. CareMore was able to impact and reduce falls through a comprehensive program, including: home safety evaluations, complete pharmacy reviews to identify any drug interactions, and regular meetings with care staff to provide continuing support.
- 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 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. Therefore, rather than propose a one-time visit code, Anthem encourages the Working Group to put forth policies and eventual legislation that promotes—and ultimately ensures proper payment for—the type of integrated care plans provide to the vulnerable and chronically ill.

Eliminating Barriers to Care Coordination Under ACOs

As Medicare providers assume greater risk for the cost and quality of beneficiaries' care, we urge CMS to take a comprehensive view of risk-based arrangements across the program. In particular, CMS should ensure a level playing field for ACOs and MA plans, which assume financial risk (upside and downside) for care delivered to Medicare beneficiaries. ACOs and MA plans should face the same sets of rules and expectations; whether a policy is good for Medicare beneficiaries does not depend on whether a provider is part of an ACO or an MA network. Anthem supports providing certain ACOs with the ability to waive

cost sharing for items/services that treat a chronic condition so long as MA plans are afforded the same flexibility.

Expanding Access to Digital Coaching

The Working Group is considering 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. We support this effort and encourage the Working Group to require CMS to engage health plans in the development of these materials. MA plans have significant experience in creating and disseminating this type of information, with proven outcomes. Plans would be able to provide the Agency with insight into best practices to ensure that the information provided is effective.

In addition to digital coaching tools, Anthem urges the Working Group to consider the value of remote monitoring technologies in assisting beneficiaries with managing their own health. 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 average.

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.

Other Policies to Improve Care for the Chronically Ill

Increasing Transparency at the Center for Medicare & Medicaid Innovation (CMMI)

Anthem supports the Chronic Care Working Group's consideration of a policy that would improve transparency at CMMI. We support CMMI in testing various payment and service delivery models that aim to improve outcomes and reduce costs, but are often tasked with responding to Requests for Information (RFI) or other notices from CMMI in a short period of time. Requiring CMMI to adopt a formal rulemaking process for mandatory initiatives and a less stringent process for all other models would enable all stakeholders to take on a more active role in helping shape these models, while ensuring that CMMI is not overburdened by administrative requirements.

Study on Medicine Synchronization

The Working Group is considering requiring a study to determine how Part D prescription drug plans (PDPs) could coordinate the dispensing of prescription drugs so that multiple prescriptions can be dispensed to a beneficiary on the same day, to the extent feasible. Medication synchronization is already a component of our Part D plan practices, which support activities to improve medication adherence. Any policies targeting medication synchronization should emphasize best practices currently employed by Part D plans to ensure that beneficiaries are complying with prescription drug therapies.

Anthem appreciates this opportunity to provide our feedback on the Senate Finance Committee's Chronic Care Working Group Policy Options. We look forward to continuing our partnership with the Committee as it works towards producing legislation to improve chronic care management. Should you have any questions or wish to discuss our comments further, please contact Samuel Marchio at 202.628.7831 or Samuel.Marchio@Anthem.com.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elizabeth P. Hall', with a stylized flourish at the end.

Elizabeth P. Hall
Vice President